

U.S. DEPARTMENT OF DEFENSE (DoD)

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TASK FORCE ON THE CARE, MANAGEMENT AND
TRANSITION OF RECOVERING WOUNDED, ILL AND
INJURED MEMBERS OF THE ARMED FORCES
(RECOVERING WARRIOR TASK FORCE)

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MEETING

+ + + + +

TUESDAY
JULY 26, 2011

+ + + + +

The Task Force met in Suites A and B of the Commonwealth Ballroom at the Holiday Inn & Suites Alexandria-Historic District, 625 First Street, Alexandria, Virginia, at 8:00 a.m., Lt Gen Charles B. Green, M.D., USAF, DoD Co-Chair, and Suzanne Crockett-Jones, Non-DoD Co-Chair, presiding.

PRESENT

LT GEN CHARLES B. GREEN, M.D., USAF, DoD
Co-Chair

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair

JUSTIN CONSTANTINE, JD

CSM STEVEN D. DEJONG, ARNG

RONALD DRACH

LTCOL SEAN P.K. KEANE, USMC

MSGT CHRISTIAN MACKENZIE, USAF & SOCOM

STEVEN J. PHILLIPS, M.D.

DAVID REHBEIN, MS

MG RICHARD A. STONE, M.D., USAR

RUSSELL A. TURNER, M.D.

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ALSO PRESENT

DENISE F. DAILEY, PMP, Executive Director,
Designated Federal Official

ANNE E. SOBOTA, Alternate Designated Federal
Official

JOHN BOOTON, PMP, Operations Staff

LAKIA BROCKENBERRY, Operations Staff

PHILIP KARASH, MA, Operations Staff

STEPHEN LU, Operations Staff

HEATHER JANE MOORE, Operations Staff

DEQUETTA TYREE, Operations Staff

JAMES B. WOOD, Operations Staff

ALLEN BEDIAKO, Research Staff

DIANE BOYD, PhD, Research Staff

ASHLEIGH DAVIS, Research Staff

SAMUEL GOLENBOCK, Research Staff

KATHI HANNA, PhD, Research Staff

JESSICA JAGGER, PhD, MSW, Research Staff

SUZANNE LEDERER, PhD, Research Staff

SARA MADDOX, MA, Research Staff

KAREN PULLIAM, MA, Research Staff

VICTORIA E. BRUNER, Walter Reed Army Medical
Center

ANGELA McCONNELL, Integrative Healthcare
Consulting

MAJ GABRIELLA PASEK, Army

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1 P-R-O-C-E-E-D-I-N-G-S

2 8:04 a.m.

3 MS. DAILEY: Good morning everyone.

4 Would members be seated? We're going to start
5 with the public forum and introduce our
6 chairpersons and our new chairperson Mrs.
7 Crockett-Jones. Thank you, ma'am and
8 Lieutenant General Green. And I'm going to
9 turn it over to them now.

10 CO-CHAIR GREEN: Okay, folks.

11 Welcome to the fifth meeting of the Recovering
12 Warrior Task Force. Congratulations again,
13 Suzanne, okay, we're glad to have you up here.

14 And Russ, I think I'm good-looking too, so
15 just --

16 (Laughter)

17 CO-CHAIR GREEN: For the minutes.

18 For the record, that's right, for the minutes.

19 Suzanne, over to you.

20 CO-CHAIR CROCKETT-JONES: Thank you.

21 During this meeting we will be reviewing and

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1 voting on the draft report from July 15th, but
2 before we begin that discussion we need to
3 start our public forum session which is covered
4 under Tab L. I believe that first we will be
5 talking to Ms. Victoria Bruner, the clinical
6 director of the DoD's Deployment Health Center
7 at Walter Reed Medical Center on behalf of the
8 Coming Home Project. Ms. Bruner?

9 MS. BRUNER: Good morning, ladies
10 and gentlemen. I am Victoria Bruner and I
11 served as a volunteer for the Coming Home
12 Project. Coming Home Project is a non-profit
13 501(c)(3) charitable organization committed to
14 alleviating the unseen injuries of war faced by
15 Iraq and Afghanistan veterans, servicemembers
16 and most especially their families. We promote
17 well-being across the deployment cycle and
18 provide support for successful reintegration
19 into civilian life. Although many of the
20 participants are actually active duty members
21 our programs address the whole person with an
22 integrated, evidence-based, bio-, psycho-,

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1 social and spiritual approach. We help
2 veterans and families rebuild the important
3 connections between the body, the mind, the
4 heart and the soul that can be affected by
5 deployments renew relationships with loved ones
6 and create vital new peer-supportive networks.

7 Ours is an interdisciplinary team composed of
8 volunteer psychotherapists, veterans, chaplains
9 and interfaith leaders. Coming Home builds a
10 community where veterans can reintegrate with
11 their families, peers and communities, and
12 within themselves. They share stories,
13 struggles and accomplishments, and learn key
14 resilience skills, and connect with needed
15 services and resources in their region. So
16 it's a very important function, the Coming Home
17 Project, to make sure that we are well
18 connected with those who can continue the
19 service to them and any access to resources.

20 Since 2007 the Coming Home Project
21 has served 3,000 people from 45 states in four
22 regions around the country without government

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1 funding. In April 2011 we were recognized by
2 the DCoE, Defense Centers of Excellence, for
3 psychological health in TBI as a top
4 reintegration program in the country. Coming
5 Home partners with numerous public, private and
6 academic institutions. Our online training
7 videos developed with the University of
8 Southern California have been cited as
9 noteworthy by iTunes U and downloaded over 2
10 million times.

11 What is provided? The services are
12 free, they are confidential and non-
13 denominational, and they form this wonderful
14 holding environment and continuum of education
15 primarily, support and clinical services. It's
16 important to emphasize that we are not
17 providing psychotherapy. However, all the
18 elements that are offered in the retreats are
19 very therapeutic. They have a sense of safety
20 and belonging, community, where they can share
21 their stories, experiences, learn stress
22 management, enjoy expressive arts and also

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1 outdoor recreation, participate in secular
2 ritual that recognizes, honors and helps
3 integrate experiences. And that also applies
4 to the children who come. I want to emphasize
5 that it's not just the servicemember and their
6 spouse, but there is a separate professional
7 volunteer team that addresses the children's
8 needs from ages 3 on up to 18. So all of the
9 people who participate like me are volunteers,
10 but we're very experienced, licensed
11 psychotherapists and trained older veterans and
12 chaplains.

13 In independently conducted outcome
14 studies, participants reported statistically
15 significant reductions in stress, exhaustion,
16 feeling burned out, anxiety, isolation and
17 hopelessness and numbness. They have reported
18 increases in happiness and relaxation and
19 energy, and feeling connected with their loved
20 ones. What's most important is there is a
21 sense of hopefulness and also many skills are
22 given so that they can self-regulate. Retreats

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1 eliminate the stigma of asking for help, yet
2 they also encourage the openness for additional
3 support and help. Resources are brought in on
4 one afternoon that look at employment, VA
5 services, mental health, housing, educational,
6 legal benefits and other services, both within
7 their communities but also nationwide. The
8 other significant service that is provided is
9 that for the providers who are caring for our
10 servicemen and women and their families. This
11 is provided through compassion fatigue-based
12 seminars and retreats for providers, and most
13 of them are from MTFs, military treatment
14 facilities, and from VA services who care for
15 our wounded warriors directly. We know that
16 these providers bear the burden and the cost of
17 service so it's very important that we be able
18 to find a way to sustain them also. So this
19 includes education, restorative self-care,
20 wellness retreats, small group support, and
21 indeed it does create a safe environment where
22 they can freely discuss the challenges that

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1 they are facing and be supportive in offering
2 care.

3 Also, Coming Home Project is
4 offering psychological services in the southern
5 -- excuse me, northern California area by
6 licensed professional psychotherapists. And
7 this is done through an access to outpatient
8 psychological counseling, medication management
9 and screening. Our therapists' reach is
10 expanding via Skype to include more
11 servicemembers and most especially to be able
12 to direct them to services. The community
13 education and support provides to the community
14 the possibility of more education to families
15 and veterans, and the alumni of the retreats
16 can come back and attend the retreats as many
17 times as they wish. In fact, when I
18 volunteered for one of the retreats we had a
19 family who had participated once who had come
20 back and then the female servicemember also
21 attended a retreat strictly for military women.

22 So this is a very integrative model.

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1 There is a new initiative called Combat to
2 Community, C2C, which has established an
3 integrated network of services operating from
4 the organizational headquarters in the Bay
5 Area. This has been primarily supported by
6 networking and virtual components of expansion
7 with their trusted partner which is Google. If
8 you have any other questions that I can provide
9 answers to please let me know, and I want thank
10 you very much for this time on behalf of Coming
11 Home Project.

12 CO-CHAIR GREEN: Thank you. A
13 couple of quick questions. Can you give me an
14 idea of how you organize around the warrior
15 transition units, the WTUs?

16 MS. BRUNER: No, not at this point.
17 However, there is currently an initiative that
18 the Operation Homecoming organization has made
19 with an MOU to Warrior Transition Brigades.
20 Our outreach is extensive, into the primary
21 installations that have the larger Warrior
22 Transition Brigades. So there is a network in

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1 which we spread the word and do the advertising
2 if you will about the retreats that are coming
3 up to solicit inclusion of Warrior Transition
4 Brigade members.

5 CO-CHAIR GREEN: As I look through
6 your paperwork what I was really trying to get
7 a sense of is the size of your organization.
8 Is it membership-driven? Can you give me a
9 number of people that are working with you on
10 that?

11 MS. BRUNER: Well, keep in mind that
12 everyone who works with the Coming Home Project
13 is a volunteer. So -- except for a very small
14 core staff. So the core staff consists of Dr.
15 Joseph Bobrow who was the originator and a
16 logistics manager and then another person who
17 serves in the office staff. So it's a very
18 small organization in terms of the utilization
19 of core staff. Then there is the network of
20 volunteers which I would estimate at this point
21 it's probably around 40 to 50 people. And once
22 Coming Home Project retreats went regional we

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1 thought it was very important to build upon the
2 local resources of psychotherapists, chaplains
3 and experienced veterans from those particular
4 areas.

5 CO-CHAIR GREEN: Thank you very
6 much.

7 MS. BRUNER: You're welcome.

8 CO-CHAIR GREEN: Go ahead.

9 DR. PHILLIPS: Thank you for the
10 presentation. Do you do any crisis
11 intervention?

12 MS. BRUNER: Crisis intervention is
13 handled -- yes, the simple answer is yes. If
14 we have a participant from a retreat or if
15 someone has seen the website for example and
16 they call and they need further services then
17 they are triaged to reach into their community
18 for services.

19 CO-CHAIR GREEN: Okay, thank you.

20 MS. BRUNER: Thank you.

21 CO-CHAIR GREEN: Okay. I think back
22 on script here, so. Oh, go ahead. All right.

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1 MS. MCCONNELL: Good morning. I'm
2 Angela McConnell. Thanks for having me back.
3 I'm an integrated health care consultant
4 serving over 22 years in our military branches,
5 be active Army, Army National Guard and Air
6 Force Reserves. I think I need to work my golf
7 game so I transferred to the Air Force.

8 (Laughter)

9 MS. MCCONNELL: It didn't help. I
10 serve on both the veterans advisory and health
11 advisory councils for Congressman Whitman of
12 Virginia's 1st District and I also volunteer
13 for the Wounded Warrior mentoring program which
14 are programs across the area that serve
15 directly in the WTUs with the wounded warriors.

16 I'm here to support recovering servicemembers
17 through facilitating an integrated approach to
18 their health care that will give our warriors
19 the ability to take responsibility for their
20 individual health and recovery, get them
21 educated on what works for them and give them
22 the tools to use long after they leave the

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1 WTUs.

2 The Fort Bliss Restoration and
3 Resilience Center uses an effective integrated
4 approach to those suffering from PTSD. The
5 cost of treating a soldier at this center which
6 uses many health mentoring therapies in
7 conjunction with allopathic treatments is about
8 \$14,000 to \$20,000 each compared to our
9 estimated \$2 billion a year to treat PTSD
10 servicemembers.

11 I spoke to you all in May on the
12 necessity of non-pharmaceutical options for
13 care and recovery in order to diminish
14 dependencies and addictions to meds and
15 facilitate responsible self-care, healing,
16 self-confidence and long-term health
17 maintenance. I was asked specific questions by
18 General Stone about the understanding that many
19 of our complimentary therapies are being
20 offered to our servicemembers at the WTU. So
21 to follow up, after talking with multiple
22 soldiers at the Belvoir WTU, squad leaders,

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1 nurse case managers and working in the system I
2 discovered that minimal to no options are
3 available. Soldiers are not instructed nor
4 required to try the ones that are. None of the
5 soldiers I spoke with were aware of any mind-
6 body stress programs like yoga, acupuncture,
7 acupressure, biofeedback, tai chi, which are
8 the types of programs and therapies offered at
9 the Restoration and Resilience Center among
10 other centers across our military. Acupuncture
11 I found is available and can be prescribed.
12 However, there is not a specific program to
13 coordinate and outline a treatment plan and
14 goals using these therapies. I want you to
15 know that integrated health care programs that
16 include complimentary therapies are being used
17 in specific military programs but mainly for
18 those who have severe PTSD and severe TBI and
19 have been unresponsive to other forms of
20 therapy. There is the Warrior Combat Stress
21 Reset Program at Fort Hood, we have a very good
22 program here at the Deployment Health Clinical

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1 Center that I had the opportunity to tour and
2 experience a couple of years ago with auricular
3 acupuncture, yoga and other therapies. Then of
4 course we have the NICO that I think you guys
5 visited not too long ago which also offers
6 wonderful integrated health services but to
7 those with severe TBI.

8 Interestingly, these exceptional
9 integrated health programs are offered as a
10 last resort or at Fort Bliss as a means for
11 those to heal and become fit for duty. If this
12 relatively inexpensive integrated approach to
13 health and healing is being offered and used
14 with very good results, minimal to no side
15 effects and the potential for outstanding long-
16 term health maintenance and benefit then I hope
17 we can agree that it should be offered to our
18 recovering servicemembers at the onset of care.

19 It's not cost-effective nor beneficial to
20 exhaust all other pharmaceutical and allopathic
21 treatments before offering a program designed
22 for self-management, decreased meds and

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1 increased health.

2 My recommendation is to provide an
3 integrated approach to health and recovery at
4 the onset of care using both evidence-based and
5 complimentary therapies and regular allopathic
6 medicine as required to include increased
7 nutrition, sleep hygiene, group therapy, and to
8 give our servicemembers options that resonate,
9 that they connect with and be committed to. I
10 briefly read through some of your
11 recommendations and I think this is a point you
12 guys pointed out as well. There should be
13 structured programs attended to daily with
14 goals, steps to achieve those goals, deadlines
15 and follow-up. I noticed that accountability,
16 engagement and charted progress wasn't
17 necessarily being done on their recovery
18 transition plans. The goals were set but there
19 was no follow-up, there was no commitment,
20 there was no accountability on either side,
21 either servicemembers or those administering
22 the programs.

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1 I mentored a motivated young soldier
2 at Fort Belvoir WTU. Though suffering from
3 various PTS symptoms, chronic pain,
4 frustrations with the medical care system, and
5 a year and a half still waiting in the WTU she
6 has taken it upon herself to find the yoga, the
7 Weight Watchers programs, so she can cope and
8 heal. She says she feels mornings less pain,
9 able to take on her day and more hopeful for
10 her future. It has not only helped her
11 emotionally, spiritually and with her physical
12 disability, but has decreased her pain and use
13 of one-to-one medication.

14 This is awesome. I applaud her for
15 her ability to recognize her need, but the
16 needs are not isolated to this soldier.
17 Feelings of low self-esteem, chronic pain is
18 prevalent. I've seen it all through the WTUs.

19 If we want our servicemembers not addicted to
20 multiple medications, not addicted to dangerous
21 behaviors, not homeless, depressed or worse,
22 then we need to give them other treatment

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1 options and we need to make it a solid,
2 structured program that will support their
3 whole person, their recovery and their future
4 health. Thank you. I'd be happy to answer any
5 questions about what I saw, my assessment. I
6 also included four slides which is aside from
7 the non-pharmaceutical approach, the integrated
8 health care approach and those slides just
9 report some of the findings as a volunteer
10 going through the WTUs, some of the
11 redundancies, some of the inefficiencies that
12 you all have found as well I believe.

13 CO-CHAIR GREEN: Any questions from
14 the panel? Thank you.

15 MS. MCCONNELL: Thank you.

16 CO-CHAIR GREEN: I think we've also
17 received some other written statements both
18 from the public and also from the services, a
19 DCoE annual report, those are also in Tab L and
20 I think will come up later as we have the
21 discussions.

22 MS. DAILEY: Good morning, ladies

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1 and gentlemen. We're going to move right into
2 our work on the report today. We have two
3 hours in which we will be working through each
4 recommendation. We've talked a little bit
5 about ones we want to consolidate. We've
6 talked about ones that we would like to wait
7 till next year on. And so I would like you to
8 go to Tab B, please. We're going to work on
9 this tab. I'm going to start on page 3 and
10 we're going to start with the recommendations.

11 So we're in the report and we're on page 3 of
12 the report. Also, other tools that I have in
13 front of you ladies and gentlemen is what I
14 call the quick reference for the
15 recommendations. It looks like this. It's on
16 the left-hand side of your book. And it is
17 very short, topics, names of topics. Looks
18 like this. So very, one-pager, gets you to the
19 recommendation, gives you the page number,
20 gives you a quick name of the recommendation.
21 So if we're going, well, we think one of those
22 recommendations is already covered in the back.

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1 We'll go okay, maybe it's communications,
2 let's look at recommendation 32. No, that's
3 mandatory TAP. So that's just kind of a quick
4 reference for everyone, one page on where these
5 are found.

6 And then the other tool I have for
7 you is we have talked about consolidating,
8 ladies and gentlemen, and I would like you to
9 look at the tab, excuse me, it's not a tab.
10 It's a handout. It looks like this. And it
11 was -- it is a recommendation sheet for
12 consolidating. Looks like this. This is the
13 sheets of paper I'd like you to be on. This
14 will be helpful for you in your deliberations.

15 There we go. So we talked about combining,
16 we've talked about binning some items for next
17 year. And you have a quick reference.

18 Okay. These are all tools that'll
19 help us move through this. We're not
20 interested right now in the voting guidelines
21 or anything along those lines. We want to try
22 and get our arms around the recommendations and

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1 consolidating those recommendations or creating
2 ones that are going to be crisper. I think
3 those were some of your concerns, more to the
4 point. All right, so we have 38
5 recommendations. And it will take a minute
6 here or a few to kind of warm up.

7 So let's just kind of you know relax
8 and we'll start with the first one. It is a
9 recommendation that addresses everyone's
10 concern I think across the board which has to
11 do with standardization of nomenclatures. The
12 first six, ladies and gentlemen, and just a
13 reminder, the first six are overarching
14 recommendations. They didn't belong to any
15 particular group. They are considered
16 overarching because they addressed all the
17 services, they addressed interagency issues,
18 DoD and VA, and they had scope that transcended
19 all of our topics. So the first one talks
20 about standardization of the task of DoD and VA
21 and services nomenclatures. Anyone like to
22 talk about why they feel that's an important

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1 one? Let's put this on the table for your
2 work.

3 MR. CONSTANTINE: Denise, what about
4 new recommendation 1 in the handout? Are we
5 not looking at that right now?

6 MS. DAILEY: We can. Let's just --
7 we'll get there.

8 MR. CONSTANTINE: So right now we
9 aren't even --

10 MS. DAILEY: Yes. Let's take a look
11 at this one and we'll get there. This has been
12 nominated, this first recommendation has been
13 nominated as a catch-all, as a recommendation
14 to include a number of other recommendations in
15 it. So let's discuss this.

16 DR. TURNER: I guess I'll lead off,
17 or Dr. Phillips and I. We feel very strongly
18 that this should be included because there's no
19 way for us really to make any decisions about
20 what's going on out there unless we have some
21 standard nomenclature, some standard language
22 with which to discuss the products. We feel

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1 very strongly that, 1, recommendation 1 is
2 very, very important and we had also talked
3 about in our small group about the combination
4 with the others as you see in your handout
5 here. And I think these are very well
6 supported for perhaps a consolidation because
7 it all comes down basically to standards and we
8 feel very strongly that the establishment of
9 standards in all of these areas which was a
10 very common theme, I think all of us saw that.

11 We are very supportive of adopting some form
12 of recommendation supporting standards and I
13 think Dr. Phillips will talk a little bit about
14 how we feel we can consolidate these. Steve?

15 DR. PHILLIPS: Thank you. Again,
16 just to emphasize what Dr. Turner said, we need
17 a common language and I think you all agree the
18 different services describe things slightly
19 differently which as you go downhill this --
20 these descriptions can change in definition and
21 even in implementation of strategies and at the
22 tactical level. So basically again we want to

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1 have a common dictionary, a common standard,
2 set the bar for certain levels, for metrics
3 which include everything from again definitions
4 to cadre-training and outcomes. So I'm not
5 sure if anybody really disagrees with this. I
6 think it's just a matter of defining the
7 recommendation and establishing a commonality
8 among the group.

9 CO-CHAIR GREEN: Can I just make an
10 observation? I think we're going to have
11 advocacy for all 38 of these recommendations.
12 Clearly they wouldn't have made it to this
13 point if we didn't. And so I believe that the
14 first step, my recommendation is we agree if
15 these can be tied together in a certain way and
16 then we can talk from an overarching to then go
17 through the ones that have been grouped in that
18 way to see if they fit or if they don't fit or
19 if the other option I would say if we don't yet
20 have enough information then we want to
21 basically garner more next year, then it would
22 be things that we would be able to table. But

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1 I don't know that we want to talk specifically
2 to every recommendation until we decide if
3 we're going to group these or not because
4 technically it could go forward with all 38.
5 But I think all of us are a little
6 uncomfortable that that's kind of diffuse. And
7 so the question becomes are there some of these
8 things that we can tie together. So if I'm
9 hearing you right now, rather than supporting
10 number 1 what you're really saying is we think
11 that standardization should be one of the ways
12 that we link these things.

13 DR. TURNER: Yes, exactly, and like
14 on the handout, you know, you all see what's
15 written there. I think they did a very good
16 job of combining the theme of standardization
17 in these and I'd like to hear discussion from
18 the group if we could combine these into the
19 two recommendations that they do on page 3 of
20 your handout.

21 CO-CHAIR GREEN: Before we jump to
22 doing that are there any other suggestions for

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1 commonalities? So in other words, if we're
2 going to use standardization and I realize
3 we've got a sheet here that's put a lot of
4 things into the standardization kind of
5 envelope if you will, is there another envelope
6 in terms of things that you've seen as you've
7 gone through the report that might be a
8 linkage? So is there another envelope of
9 these?

10 And then the other question I would
11 ask you folks is -- I'll just use envelope
12 because it's not used anywhere in here -- are
13 there other folders or envelopes of findings
14 that you'd like to propose? If we can get --
15 and I say that really wondering do we want
16 three, do we want five, do we want ten folders
17 of findings? Do you see what I'm asking? I'm
18 not trying to take away from anything that's
19 written in one of these findings right now.
20 Rather, I'm trying to define what are the
21 groups and how many groups do we want to have
22 as a task force. Because without that I think

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1 it makes our next steps a little harder. If we
2 kind of understand we're going to group them
3 then when we go to the group and look at the --
4 at how we grouped them then we can kind of see
5 which ones we feel strongest about and where we
6 think there's more information we need to
7 collect. But maybe I'm going the wrong way.
8 So maybe we should take one group at a time.
9 It's just nice if you know how you're going to
10 sort them before you start saying yes, this is
11 in, and yes, that's out.

12 DR. PHILLIPS: In my mind, and I
13 don't know if this will work, I was trying to
14 divide up these recommendations into strategies
15 versus tactics of implementation. And the
16 exact format of the way we have them now
17 doesn't quite fit that way and that's what I
18 was struggling to because we have a
19 recommendation and a finding. And there seems
20 to be some common threads between different
21 recommendations at the strategic level and also
22 at the implementation or tactic level. But

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1 then I could not wordsmith the findings to
2 match those and I don't know if that's
3 something we want to talk about or not. But
4 strategy versus implementation.

5 CO-CHAIR CROCKETT-JONES: I'm going
6 to suggest that we've all been looking at these
7 for a good bit and I think we should be fairly
8 familiar with them. And I think that if we
9 have a sense that one of the new
10 recommendations, the grouping into one or
11 grouping into two makes sense based on our
12 review then I don't think we need to over-
13 analyze it. If anyone has strong feelings
14 about leaving them out separately and
15 addressing each one separately then I'd like to
16 hear that. If everyone has a sense that one of
17 these alternate sets is sufficient or covers it
18 well, if everyone has that sense then I think
19 we can just move on and eliminate a lot of fine
20 analysis.

21 CO-CHAIR GREEN: I guess, so help me
22 because you folks have been talking a little

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1 bit more and I've been outside the group so I
2 need to kind of understand where you all are.
3 So if we go with the standardization for
4 instance and I'll just use what's on this sheet
5 where it combined nine different
6 recommendations into one folder. Okay, all
7 right. So is it just that all the others then
8 stand alone? Maybe that's what you've decided
9 and that's where I'm not quite keyed in. So do
10 all the others then stand alone after you take
11 the nine to 12 and put them into these folders?

12 CO-CHAIR CROCKETT-JONES: I think
13 there's a second group that is also going to be
14 combined because they fell under a commonality
15 of category and even possibly a commonality of
16 accountability, who was responsible. And that
17 would be -- it's also addressed on this list,
18 this combination. I think that from what I saw
19 this -- I don't think that there's any other
20 major consolidation that we can do of multiple
21 recommendations.

22 MG. STONE: I think that the

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1 grouping actually gets maybe not in an overt
2 statement, but gets to the point you'd like to
3 get to as a folder. What are -- how do we
4 define it, what entrance criteria and
5 management criteria do we use, and actually I
6 think strengthens the recommendation
7 significantly by grouping this together in a
8 folder. And although it's not called a folder
9 I think it is in essence a folder.

10 CO-CHAIR GREEN: Yes, the idea is
11 not to take anything away from any of the
12 specific recommendations. It's really how
13 we're going to deal with this. And so
14 basically then, again, this is the first time
15 I've seen this document so I'm struggling a
16 little bit to catch up here.

17 MS. DAILEY: This is the first time
18 everyone has seen it. You're not catching up.

19 It's the first time everyone has seen it. We
20 had lots of discussion about -- sir, this is
21 the first time everyone has seen it. We had
22 lots of discussion over the last few days --

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1 commonalities, grouping items, what might fit
2 well and we just pulled this together to assist
3 you in your thought processes.

4 CO-CHAIR GREEN: So why don't we
5 take a few minutes and let us read this, okay?

6 So why don't we kind of break for a second,
7 let everybody read this so we can see where
8 you're coming from because right now I think
9 we're all struggling with new material that,
10 you know, it's not new in terms of the findings
11 but it's new in terms of the grouping.

12 MS. DAILEY: Okay.

13 CO-CHAIR GREEN: Because we don't
14 have a process right yet to go forward in terms
15 of if we're going to group.

16 MS. DAILEY: Okay.

17 CO-CHAIR GREEN: So why don't we
18 take about -- let's just take till 9 o'clock,
19 give everybody a chance to read through this
20 and work that way, all right?

21 MS. DAILEY: Okay.

22 CO-CHAIR GREEN: Thanks.

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1 (Whereupon, the above-entitled
2 matter went off the record at 8:39 p.m. and
3 resumed at 8:52 p.m.)

4 CO-CHAIR CROCKETT-JONES: I'd like
5 to hear from people if they're comfortable with
6 the combination of the recommendations into new
7 recommendation 1 and 2. Has everyone looked at
8 that? And that would be a consolidation of,
9 let's see, 1, 5, 10, 9. I don't have the
10 numbers --

11 DR. TURNER: It's on the front page.

12 CO-CHAIR CROCKETT-JONES: Is that
13 the --

14 DR. TURNER: Well, 1, 4, 5, 9, 10,
15 19, 20, 26 and 28.

16 CO-CHAIR CROCKETT-JONES: Okay.

17 DR. TURNER: And then
18 recommendations they want to talk about
19 consolidating communications plan of 20, 21, 22
20 and 23.

21 CO-CHAIR CROCKETT-JONES: Right.

22 DR. TURNER: So that's -- that to me

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1 is a very succinct way to do it.

2 CO-CHAIR CROCKETT-JONES: Are we all
3 comfortable with that consolidation? Is there
4 anyone who feels strongly that these
5 recommendations can't be -- is there anyone who
6 feels strongly that any of these combined
7 recommendations should stand alone and isn't
8 appropriate in this consolidation?

9 CSM DEJONG: My only concern with
10 consolidation is it allows for an 80 or 90
11 percent product in the end. So you may or may
12 not reach 100 percent based on how much you
13 consolidate. So I guess look at -- I'm okay
14 with consolidating some things, but look at
15 what do you really want to get out of this
16 recommendation. If you want the true
17 recommendation to be answered it probably
18 shouldn't be consolidated.

19 CO-CHAIR CROCKETT-JONES: Is there
20 any -- so you feel that each of these should be
21 maintained on their own and decided, or do you
22 think that is there -- in looking at them

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1 specifically do you feel that any of these, the
2 recommendations that would be consolidated
3 would be lost in the consolidation?

4 DR. PHILLIPS: Can we go through
5 them a little slower? Because I lost track.

6 CO-CHAIR CROCKETT-JONES: Sure.
7 It's 1 -- let me get the list -- which was
8 adopting common standards, 4, the
9 standardization of the CRP/CTP, 5, the medical
10 management decision points, 9, effective well-
11 trained cadre, 10, defined entrance criteria,
12 19, standardizing the roles of the RCC, FRC and
13 non-medical case managers, 20, a communications
14 plan, 26, the non-DoD beneficiary caregiver's
15 access, and 28, legal support. Of that list,
16 my only personal concern would be for the non-
17 DoD beneficiary caregiver's access. I'm not
18 sure that that is a standardization, more of a
19 redefinition and so that's -- that would be my
20 only concern on consolidating these is in
21 losing that. But I also know I'm happy if the
22 language is clear if it goes into the

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1 consolidation.

2 MG. STONE: I have a lot of -- I'm
3 sorry, I have a lot of trouble with combining
4 the medical management decision point and the
5 demand for evidence-based accumulation. I
6 think one of the things we've seen across the
7 entire delivery system is a failure to develop
8 true evidence and to enforce the medical
9 decision point which seems variable across the
10 system and unique to each soldier we can
11 accept, but there still needs to be that
12 standardization. I think if you roll this in I
13 think the sergeant major has it exactly
14 correct, you can reach an 80 percent solution
15 and some of the key recommendations will fall
16 out. And so I would speak against including
17 recommendation 5 in any sort of combination.

18 DR. PHILLIPS: And rethinking that I
19 would support that because that is a critical
20 point and perhaps that should be a stand-alone
21 recommendation.

22 MR. CONSTANTINE: I also wonder why

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1 we combine all these, some of the original
2 language in the recommendations has fallen out.

3 When we've put them here on the new
4 recommendation, for instance in the fourth one
5 down, the cadre staffing ratios and the next
6 one about the CTP and CRT, the language is
7 different and it's less language. It doesn't
8 include all the stuff in the original
9 recommendation. That to me is almost showing
10 an 80 percent solution unfolding even in the
11 language here. If we're accepting less than
12 what we all spent a lot of time on in getting
13 these recommendations. So I'm not opposed to
14 wrapping some of these things together. I'm
15 already concerned that these don't accurately
16 display what we spent a lot of time developing
17 earlier.

18 CO-CHAIR CROCKETT-JONES: I'm
19 wondering if we could see the recommendations
20 that are being considered for consolidation in
21 their original language grouped together
22 without the findings, just something to look at

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1 them, you know, not in this punctuated, you
2 know, abbreviated format.

3 MS. DAILEY: That would be a major
4 rewrite right here in front of the, you know.
5 It would be cut and pasted. Yes, we'd be cut
6 and pasting a new document right here, so let's
7 work with what we've got. You're doing good.
8 The objective of this hour and a half, two
9 hours, is to try and work through this.

10 CSM DEJONG: I mean as far as
11 recommendations 20 through 23 you've got
12 communications, a national resource, keeping it
13 together for military one source and then tying
14 it all together with the SFAC. That I think is
15 -- I would recommend, you know, I would be okay
16 with consolidating that. I mean, we're coming
17 up with something better than -- an 80 percent
18 product on that is better than what we have
19 right now. And then we can -- something we can
20 always improve on. The other recommendations
21 coming through, you know, nomenclature and some
22 of the other things, I don't think we have room

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1 to so much get an 80 percent product on that.

2 MR. CONSTANTINE: I guess I'll throw
3 this out there. What is -- taking a step back,
4 why are we looking for ways to combine these?
5 If it's to reduce the number of recommendations
6 we have that's just form over substance because
7 each one, you know, all of these subcategories
8 are still equally important, and while they may
9 not have a number in front of them they're
10 really their own recommendations, they're just
11 consolidated. If it's because they share a
12 commonality, I'm not sure if they all do. They
13 are strategic but that doesn't necessarily mean
14 they need to be consolidated.

15 CO-CHAIR CROCKETT-JONES: So, have
16 we moved to decide not to consolidate? How
17 strongly do folks feel?

18 CO-CHAIR GREEN: Can I back it up
19 just one second? So, we're into the lumping
20 and splitting, okay, issues. For those of you
21 who are splitters, okay, we've got 38 and
22 obviously the split is good right now. And for

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1 those who are lumpers, you know, the question
2 is are there things that are overlapping that
3 we basically should be bringing together. So I
4 was trying to find early was a mechanism for us
5 to at least put like subjects together. So I'm
6 sorter, okay? It's not that I want to change
7 the language or that I want -- I'd like for us
8 to look at it in an organized fashion so that
9 we can kind of see what's alike and where
10 there's overlap in the language, where perhaps
11 you might see something that things roll
12 together. Because we did this in four groups
13 you really have to bring the groups together
14 and basically see if they were talking about
15 the same thing. As you read through this
16 because of the length of the document you know
17 you don't see a lot of overlap, I mean you see
18 things that are related to one another, but the
19 question is is there a way to sort this which
20 is kind of where I was starting. Rather than
21 trying to talk consolidation which will get us
22 into the tough talk, okay, in terms of what

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1 everybody's, you know, there will be certain
2 things that are very important to each
3 individual in this room, is are there things
4 that we should talk to in different groups than
5 what we did when we first formed these.
6 Because once you put us together in different
7 groups we'll see some of the commonalities and
8 be able to basically look at do we have enough
9 information to go forward with this or is there
10 something we should be collecting more
11 information since it is the 5-year task force.

12 So I'm not trying to rewrite the report right
13 now. Where I was going with the earlier
14 conversation was is there a way to sort this so
15 that we can do the discussion as we look at
16 smaller numbers because it's a little bit
17 overwhelming to look at all 38 at the same
18 time. And we could also go back and go through
19 each one which is what Denise had suggested to
20 see if we have any problems with the wording or
21 take what's been given to us in public comment
22 to see if we want to make changes, if we're

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1 going to keep all 38, but there seems to be
2 another element here that needs to happen which
3 is are we happy with having 38 recommendations?

4 And then now we can go through that and we can
5 -- when we get to the voting part we'll decide
6 if we have enough information to keep all 38
7 and it may come down or it may go up, who
8 knows, but the point I'm trying to make is
9 early on if you can sort these then it makes it
10 a little bit easier as we go through the
11 language because you may see something that it
12 doesn't have to be a finding on its own, but it
13 needs to be a -- incorporated into another
14 that's actually very much related. I'll use
15 what Dr. Turner brought to our attention.
16 There's at least four of these that mention the
17 DES, okay? And so is the DES a way to sort?
18 Not because we're going to change any language
19 right now, but just because when we talk about
20 DES wouldn't it be nice to look at those four
21 recommendations to see if there's any overlap,
22 okay? Are there other areas that we should

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1 sort by, okay, without changing any language.

2 Again, I'm not trying to combine
3 these or basically lump them together. I'd
4 really rather that we just were able to look at
5 three or four together if they're related.
6 Now, there may be some that are not related at
7 all, but that's why I was looking for a sorting
8 mechanism. And I think that some of the work
9 that's been done on the sheets that we were
10 given are about whether the language should be
11 consolidated or not. And if we could make that
12 decision it would be easier, but if we can't
13 make that decision then it may be easier to
14 sort and now be able to look at two, three, I
15 mean even when we put eight together it was
16 useful to see that we don't think that for
17 instance the evidence-based medical management
18 decision points, is that what it was? Medical
19 management and medical decision points, that
20 that one shouldn't be part of that group. Even
21 if they're in or out of a group where we all
22 understand what the group represents. So if

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1 one of the groups is standardization and one of
2 the groups is DES then we can get them down to
3 three or four things, and now we can look at
4 those three or four recommendations and go,
5 well, is there overlap? Is there an
6 opportunity to combine or not? That's what I
7 was searching for as I tried to help us find a
8 sorting, because I've done this a few times and
9 when you start trying to consolidate language
10 from the get-go pretty much you run into the
11 same problem where everybody likes the language
12 they came up with and so when you try to
13 wordsmith this it's impossible. But if you can
14 see three or four different findings together
15 sometimes you'll find commonality and ways that
16 they do make sense, or actually improve what
17 we're saying when we do that.

18 So that's kind of what I was looking
19 for. And so I think that maybe we have a
20 couple of these right now. So in a word,
21 standardization may be a way to sort. In a
22 word, DES may be a way to sort. Are there any

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1 other, you know, if we can get to three or four
2 or you know, whatever the number is that these
3 things sort we might be better off. So how
4 about taking a look at the red sheet here and
5 see if you see any commonalities. So, why
6 don't I let -- in fact we can do this I mean
7 right here. Suzanne has suggested a few that
8 were for the standardization and in fact on the
9 little white sheet here on the very first page
10 it lists the same one she just went through.
11 And so --

12 CO-CHAIR CROCKETT-JONES: We want to
13 eliminate some from the --

14 CO-CHAIR GREEN: But you're getting
15 to the consolidation. Before you jump with
16 that let's just --

17 CO-CHAIR CROCKETT-JONES: Okay.

18 CO-CHAIR GREEN: So right now we've
19 already heard that number 5 should not be in
20 that category of standardization. Is there
21 another one in that grouping of -- that you see
22 on that front page that you say shouldn't be in

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1 standardization?

2 MR. CONSTANTINE: Suzanne had said -
3 - I don't know what number it is, but 26.

4 CO-CHAIR GREEN: Twenty-six. So
5 that should not be in that sorting.

6 MR. CONSTANTINE: And I think others
7 are covered under that communications plan
8 which is probably 20. That should be broken
9 out. If we're going to consolidate 20 through
10 23, right?

11 CO-CHAIR CROCKETT-JONES: Yes, 20,
12 21. Actually 20 through 23 are all very
13 specific recommendations on communication
14 plans.

15 MR. CONSTANTINE: That should fall
16 out of this.

17 MR. REHBEIN: As I look through that
18 list and let me refer to them by bullet points.

19 There was about four or -- four that I could
20 see were strictly standardization, the first
21 one being nomenclature, second one being
22 entrance criteria, third one dealing with cadre

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1 staffing and the fourth one dealing with
2 eligibility criteria. The evidence-based
3 medical decision points is a standardization
4 issue but it may be important enough to be a
5 stand-alone rather than being folded in. One
6 of the things that I thought about as I read
7 this recommendation was how do you go about
8 writing a finding for a recommendation this
9 broad. Because that's important. This -- the
10 recommendation says what we want to do, the
11 finding says why we should do it. And writing
12 a finding for something this broad is going to
13 be difficult. The ones I dropped out, the non-
14 DoD beneficiary access, the legal support,
15 communications plan, the comprehensive recovery
16 plan. I wasn't sure if what standardization
17 was needed there. It seems to me that that's
18 already been defined but that's in
19 implementation. So those were just some
20 thoughts that as I looked through that list as
21 I considered what does standardization mean to
22 me and which of these fits into my definition

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1 of standardization.

2 CO-CHAIR GREEN: Let me try and
3 capture this a little bit. So right now from
4 what we're working with I think we have three
5 potential I'm just going to call it sorting,
6 okay, groups, okay. So on the COM one I've
7 heard fairly good consensus that this 20, 21,
8 22 and 23 probably could go under
9 communications. All right. Under the
10 standardization I would need you, Dave, to talk
11 again to the ones that you think clearly are
12 standardization so I just didn't capture them
13 quick enough. And then Russ, if you could tell
14 us the ones that you think go to DES. So you
15 see what's happening. Now when we go to talk
16 about standardization without ever talking
17 language we can look at those four or five and
18 say we want to do any consolidation or we
19 don't, and then we can basically work
20 backwards. So right now I've got a
21 communications, a standardization and a DES.
22 So Russ, do you have the DES numbers?

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1 DR. TURNER: Yes, sir.
2 Recommendation number 6 is the redesign of the
3 DES system, recommendation 36 is concurrent DES
4 which is, you know, how it's implemented, and
5 then 37 is the DES staffing. If for another,
6 again, whatever the group thinks, for another
7 grouping one of those was strategic leadership
8 or the basic construct of how the wounded
9 warrior care is administrated, or what is the
10 overall leadership structure of the wounded
11 warrior program. And that would be
12 recommendations -- and again I'm just proposing
13 -- recommendations 3, 8, 12, 14, 21, 30 and
14 again, sort of a loose association, but they
15 all deal with how overarching the program is
16 somehow put together or administrated. And
17 again, if -- just as a suggesting, as a
18 grouping I'd be interested in what the group
19 thought about that.

20 CO-CHAIR CROCKETT-JONES: I think we
21 might be able to add 2, recommendation number 2
22 to that, but I think that --

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1 DR. TURNER: Yes, yes.

2 CO-CHAIR CROCKETT-JONES: -- that 20
3 might be able to come out. Was that one you
4 said? Or no, 21. Yes, 21 I think.

5 DR. TURNER: That's fine. Yes,
6 that's -- I agree.

7 CO-CHAIR GREEN: Do we have time to
8 look at what you --

9 MR. REHBEIN: Yes, actually Sean was
10 writing numbers down as I was trying to talk.
11 Those recommendations seem to be numbers 1, 9,
12 10 and 19. Does that agree with the numbers
13 that you?

14 LTCOL KEANE: Yes, sir.

15 CO-CHAIR GREEN: Okay. So just so
16 we all have the same thing, under
17 standardization right now we think that one of
18 the groupings could be 1, 9, 10 and 19 as just
19 mentioned. Under COM it would be 20, 21, 22
20 and 23. Under the disability system it's 6, 36
21 and 37. And then we had a proposal for a
22 strategic leadership which was 3, 8, 12, 14, 30

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1 and then Suzanne suggested possibly number 2.

2 MG. STONE: What about the SOC, the
3 recommendations regarding --

4 DR. TURNER: Yes, I think on
5 retrospect I think that's right. I think the
6 SOC should be in that as well.

7 CO-CHAIR GREEN: So you guys would
8 add 33 and 34.

9 DR. TURNER: Yes, it all has to do
10 with the organization of the overall structure
11 of wounded warrior care.

12 CO-CHAIR GREEN: Okay. And so what
13 I'm -- now what I need to do, and I'm not good
14 at doing this in public forum, is figure out
15 what's left, okay. So hang on just a minute.

16 MR. CONSTANTINE: Sir, can we start
17 -- can we, before we look at all those, can we
18 just focus on the new recommendation 1 and make
19 sure that what Dave has suggested is good to
20 go? I think it's appropriate. I'd kind of
21 like to wrap that up before -- and I'll need 15
22 minutes to look through all the ones that Russ

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1 suggested for leadership. Just like we said 15
2 minutes to do this one, I'll need a few minutes
3 to do that.

4 CO-CHAIR GREEN: And before we give
5 you that 15 minutes because I agree
6 wholeheartedly on the sorting, we're going to
7 let you have some time to look at it. What I
8 wanted to know is what haven't we covered that
9 might be left. So I was just going to go
10 through and see if I could rapidly mop up the
11 ones --

12 MR. REHBEIN: Determine what numbers
13 are missing.

14 CO-CHAIR GREEN: What's missing,
15 yes, what haven't we tackled.

16 CSM DEJONG: Sir, if we're looking
17 at just taking these into groups to analyze.
18 General Stone, I left the SOC as 33 and 34 as
19 kind of its own, took it out of the leadership
20 part and just took the SOC, any recommendations
21 to the SOC separately. And then I added
22 caregivers of 26 and 24 because those pretty

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1 much covered caregivers.

2 MSGT MACKENZIE: I tend to concur
3 with the command sergeant major that probably
4 the family caregiver piece should be an
5 independent piece unto itself to make sure we
6 hit that as hard as possible. Because that is,
7 I mean we've got a lot of findings in that
8 aspect, so.

9 MR. CONSTANTINE: General Green, you
10 just want the numbers that we haven't used to
11 consolidate, I can give those to you. Unless
12 you're -- okay, you have them.

13 CO-CHAIR GREEN: Yes, I've actually
14 got them now.

15 MR. CONSTANTINE: Okay.

16 CO-CHAIR GREEN: Thank you. So
17 essentially then right now the CRP/CTP, the
18 medical management which is number 4, I'm
19 sorry, number 5, number 7, number 11, number
20 13, number 15, 16 and 17 and 18, and then 24
21 through 29, 31, 32 and 35. Okay. So --

22 MR. CONSTANTINE: Did you say 8 as

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1 well, sir?

2 CO-CHAIR GREEN: Eight we had
3 actually put right in the strategic leadership
4 for right now. Okay. So one of them that
5 obviously kind of stands out is 15, 16 and 17.

6 Well, 15 and 16 clearly I was going to say in
7 terms of centers of excellence. So, clearly we
8 have, you know, a specific thing in our charter
9 to talk to the centers of excellence. So that
10 one might be another sort, okay. So that would
11 take 15 and 16 would become specific to centers
12 of excellence. And I don't know if any of the
13 others actually link right now as I look at
14 them.

15 MR. CONSTANTINE: If we can find a
16 way to link just a couple more we'll have an
17 even 20 recommendations I think. I think we're
18 at 23 now, or 22 or 23. So maybe as we go
19 along we can keep that in mind, if we can have
20 an even 20 is mentally I guess a little better
21 than 22 or 23.

22 DR. PHILLIPS: It may be a bit of a

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1 stretch, but 7, concept of transition units,
2 may go in the standards. And I might add that
3 the comment that command sergeant major made
4 about the SOC, there seems to be an awful lot
5 of energy and time at the Pentagon spent
6 related to the SOC so maybe that, we should
7 consider that as a separate recommendation so
8 it's not buried.

9 CO-CHAIR GREEN: Please don't
10 misunderstand, all of these that we're putting
11 into these may be separate recommendations. So
12 let's not jump there. It's really how we're
13 going to do the next piece which I think the
14 next piece, it's important that we cross-
15 pollinate groups and essentially have people --
16 so somebody's going to look at COM and look at
17 these four things that are in there, and
18 somebody needs to look at standardization of
19 these four things that are in there to see are
20 we happy in terms of the wording and is there
21 an overarching recommendation, or is it -- do
22 they need to be four separate because of just

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1 what Steve just brought up. There may be
2 things that really we want to, you know,
3 emphasize. But again, I'm trying to get it to
4 where we have people from different groups
5 looking at the recommendations together so that
6 we can kind of -- and then see if there's an
7 opportunity. If there's no opportunity these
8 all stand independently.

9 Anything else that comes out when
10 you look across these things? So, in the group
11 that 24 through 28, let's see, I guess some of
12 those were talked about in standardization but
13 in terms of the ones in 24, 25, 26, 27 and 28,
14 even 29, is there any common element there that
15 links those?

16 CO-CHAIR CROCKETT-JONES: Twenty-
17 four through 26 are caregivers.

18 CO-CHAIR GREEN: And caregivers in
19 terms of skills or?

20 CO-CHAIR CROCKETT-JONES: Yes.

21 MSGT MACKENZIE: That's skills,
22 access to resources, access to military

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1 facilities, and most importantly level of
2 responsibility.

3 DR. TURNER: And see to me that is a
4 standards issue because the standards have to
5 apply nationally to what that is. We cannot
6 have individual access standards.

7 MSGT MACKENZIE: Well, once again
8 though, let's be careful. I think we need to
9 look at the fact that this is a DoD
10 publication. It's going to be across the
11 board. So I mean, I don't know that it's
12 necessarily standards as much as it is -- I
13 mean, it could be listed either way. It's a
14 standard for caregivers, but if there's a
15 unique focus to caregivers it's different than
16 the military personnel as well, so.

17 DR. TURNER: I would agree with Mac.
18 It's kind of how you want to spin it to some
19 degree and being a malignant lumper --

20 CO-CHAIR GREEN: I was going to say
21 we can tell you're a lumper.

22 DR. TURNER: I will take that.

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1 CO-CHAIR GREEN: How about for right
2 now for sorting if we use skills and training.

3 Instead of talking about standardization of
4 skills and training, just talk about skills and
5 training. Perhaps that's one that we could put
6 some into. Are there some of these that fall
7 into the skills and training?

8 DR. TURNER: Well, there's several -
9 - there's others, and someone can help me here,
10 on the cadre training as well.

11 CO-CHAIR GREEN: So caregivers
12 instead of skills and training. So just talk
13 caregivers.

14 MSGT MACKENZIE: I was going to say
15 there is a definite movement underfoot and
16 there is an extreme focus on caregivers across
17 the board as far as what hasn't been done and
18 what needs to be done.

19 CO-CHAIR GREEN: No problem. So
20 which ones would you sort into caregivers?

21 MSGT MACKENZIE: Twenty-four and 26
22 right off the bat and then I believe 25 also

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1 applies as well.

2 CO-CHAIR GREEN: What about the
3 legal support?

4 MR. CONSTANTINE: That's separate,
5 sir. That's not really under caregivers. That
6 probably has to do with DES.

7 CO-CHAIR GREEN: So 28 to DES
8 perhaps. Okay.

9 DR. PHILLIPS: Would you look at
10 number 17, case loads, appropriate staffing of
11 medical case managers. Perhaps that can go
12 under standards as well.

13 CO-CHAIR GREEN: Could be part of
14 caregivers. No. Okay. So standards. You
15 vote for standards. Anybody who objects to
16 standards? So 17 goes under standards. Okay.

17 MR. CONSTANTINE: And sir, 28 should
18 go under DES as legal support now that I look
19 at it. It's specifically all about legal
20 support to the DES process.

21 MR. REHBEIN: Just a question. I
22 haven't looked at these two sets in any detail,

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1 but I just want to get some feeling from the
2 group. We talk about the caregivers area. It
3 seems to me a lot of the deficiencies there,
4 not all, but a fair number of them deal in the
5 communications area. And I'm wondering if we
6 should just combine communications and
7 caregivers. That's -- I'm asking the question,
8 I'm not advocating a position.

9 MSGT MACKENZIE: I would agree with
10 you because there is a big problem in
11 communication, but once again I just, I think
12 we -- if we're looking for that big solution I
13 think we need to highlight caregivers as a
14 separate sorting process and perhaps a separate
15 recommendation focus. Although it's going to
16 combine a few things, care, communication,
17 standards, but it's still going to be focused
18 towards the caregiver and I think we want to
19 keep that --

20 DR. TURNER: I would agree. I think
21 at least in this position it puts a finer point
22 on it to keep them separated.

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1 CO-CHAIR GREEN: Okay, so then the
2 ones that are still kind of out there are the
3 CRP/CTP, number 4. Is that a standardization
4 question? Is it a caregiver question? It's
5 the tool that they're supposedly using,
6 correct?

7 MR. CONSTANTINE: I wouldn't put it
8 in caregiver, sir. I mean, I know caregiver is
9 listed there but it's really for the recovering
10 warrior.

11 CO-CHAIR GREEN: That's okay.

12 MR. CONSTANTINE: So I wouldn't put
13 it in the caregiver group.

14 CO-CHAIR GREEN: So it's a stand-
15 alone.

16 MR. CONSTANTINE: Or standardize. I
17 would hate to think that just because you're in
18 one service means you have a different recovery
19 plan than another one.

20 DR. TURNER: I would agree again.
21 How are we going to make decisions or how are
22 we going to make comparisons across services if

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1 we're not having the same kind of plan
2 structure.

3 CO-CHAIR GREEN: What I'm doing is
4 trying to narrow us down to what are the stand-
5 alones right now. So number 5 which is the
6 medical management and medical decision points
7 evidence-based, is that a stand-alone?

8 DR. TURNER: And I think, again,
9 it's a -- I think -- I don't want to speak for
10 General Stone, but I think it's actually a
11 standards issue, but to give it enough
12 horsepower it needs to stand alone because it's
13 a strong issue.

14 MG. STONE: To me the endpoint is
15 what we're trying to get to. If by putting it
16 with something else it allows the report to be
17 stronger in the way it's interpreted by senior
18 leaders I would certainly accept that approach
19 and let's see what comes out of it. But if we
20 come to the other end of this discussion and it
21 just would allow a 70 percent solution rather
22 than really implementing the recommendation

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1 then I think we have to reexamine this process.

2 So at this point in the discussion if you want
3 to lump it together with we admit a patient, we
4 develop a care plan, we develop a process that
5 leads us to a decision point, that makes
6 decisions on where people are going to be for
7 the rest of their life, or the next phase in
8 their life. I'm okay with that. Let's see how
9 we come out on the other end of this. So if it
10 facilitates a discussion let's put it back in
11 and see where we're going. But I tend to agree
12 with the sergeant major that we run some risk
13 in this approach.

14 CO-CHAIR GREEN: And remember, we're
15 not trying to consolidate or change any
16 language right now. In fact, if we leave it
17 separate it'll be one of the first ones we can
18 talk about because it's fairly straightforward.

19 We can go to the language and say we think
20 this is important and so for right now I'm
21 going to keep it separate. Number 7 is concept
22 of transition units.

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1 MR. CONSTANTINE: I'd like to
2 comment on 7, sir, and this was not my group so
3 I'll defer to that group. But really 7 doesn't
4 sound like a recommendation, it almost sounds
5 like a finding. It just says it supports the
6 idea of a transition unit. And I would just
7 like to hear a little discussion on why that
8 should remain as a recommendation. CO-

9 CHAIR GREEN: Which is the other useful thing
10 about the stand-outs here is we can see the
11 things that we -- they don't quite fit and so
12 it's easier to talk about them.

13 CO-CHAIR CROCKETT-JONES: Is number
14 7 more of a best practice? If there's a
15 recommendation in there I'm not clear on what
16 is being recommended. So if the group that
17 proposed it could just clear it up, what they
18 meant.

19 DR. PHILLIPS: That was our group
20 and I think we -- we discussed the fact that,
21 again, the concept or the strategy of a
22 transition unit is a good concept, but when you

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1 get down to the findings, even though the
2 concept is valid we found that the
3 implementation of the concept and there's some
4 quotes here and this is perhaps referred more
5 to the Marine unit that we saw, was not being
6 carried out. Again, I don't want to get into a
7 further discussion but what I think we meant
8 was that there were more recovering warriors in
9 the line unit and the unit commanders were not
10 perhaps embracing the concept of a WWR or WTU
11 for that particular base. So that we wanted to
12 push the fact that this is what -- and this
13 ties into the medical decision as well. If I'm
14 --

15 CO-CHAIR GREEN: Can I make a
16 suggestion? It looks to me -- so as you
17 endorse the concept of transition units, when
18 you look at number 8 which is also about trying
19 to cultivate an environment within the
20 transition unit that's healing I'm wondering if
21 we couldn't combine -- this is one where you
22 might be able to combine the language between 7

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1 and 8 and achieve both. So we think 7 would
2 drop off and consolidate with 8, would that be?

3 So consolidate 7 and 8? Any objection to
4 doing that? Okay. All right. That's why I'm
5 looking for the outliers, okay? So that was
6 useful. Let's go on and see, the next one
7 would be number 11, exploring the SOCOM model.

8 DR. PHILLIPS: For whatever it's
9 worth our group agreed to put that off till
10 next year.

11 CO-CHAIR GREEN: So number 11 we're
12 thinking right now should probably be something
13 we basically push back. So it would come off
14 the findings list this year as well. Okay.
15 Any objection to that? Okay, 13, PTSD care in
16 accordance with TRICARE access standards.

17 MG. STONE: This is about access to
18 care and I'm not sure that -- I struggled with
19 this whole recommendation and what it was
20 about. It combines a payment method which is
21 TRICARE and access to care and therefore from
22 my standpoint it needed a substantial rewrite

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1 about what we were trying to accomplish.

2 CO-CHAIR GREEN: My question is is
3 this a standardization issue for access to care
4 across all beneficiary categories? I'm
5 wondering if we couldn't put it in with the
6 standardization group and see if it's not
7 something else we want to talk about access, so
8 standardizing access. So that would then put
9 it into -- so that's number 13. So that would
10 go into standardization.

11 MR. REHBEIN: I'm going to agree
12 with Dr. Stone about the financial parts of
13 this recommendation. I think if we're going to
14 put our foot into the swamp that is TRICARE
15 benefits we're going to need much more time I
16 think. So I would limit -- I think we ought to
17 rewrite this as limit it to access and yes,
18 standardization seems to fit, but the financial
19 stuff is very difficult.

20 DR. TURNER: Do you feel if -- do
21 you feel we need more time on this or would you
22 put it off to look at it further?

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1 MS. DAILEY: Sorry for the
2 interpretations. It is about access. There is
3 no intent in this recommendation at all to
4 address costs. This is all about in accordance
5 with TRICARE standard access, or it should be
6 TRICARE access standards. This is not about
7 whether it's standard or prime or -- that's not
8 the intent. It is right after the word TRICARE
9 should be access standards. It is only about
10 access.

11 CO-CHAIR GREEN: Let's -- for right
12 now, again, we're not trying to do
13 wordsmithing. I think we've agreed that it can
14 go into standards. So if we're agreed on the
15 sorting then as we look at these in groups some
16 of these other things will become more obvious
17 I hope. Okay. And so let's see. The next one
18 is -- actually I think we put 17 into standards
19 already. And so 18 would be the next one,
20 transitioning cases between medical case
21 managers. By focusing on these outliers
22 sometimes, you know, it helps us.

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1 DR. PHILLIPS: In my mind I had put
2 that into standards.

3 CO-CHAIR GREEN: It's caregivers. I
4 mean.

5 CO-CHAIR CROCKETT-JONES: I think
6 we're using two different definitions of
7 caregivers. Family caregivers versus medical
8 caregivers.

9 CO-CHAIR GREEN: Okay. Again, I
10 just was looking for one-word sorting titles so
11 I'm letting you folks tell me what they mean.
12 So caregivers, you're saying that's really
13 family caregivers. Okay, I got it, no problem.
14 Then I won't link anything with that. Thanks.
15 All right.

16 So we're still on 18. So really
17 number 18 is about length of time. Is that a
18 standardization question? If we're trying to
19 put them so that they have more continuity and
20 therefore you want 2-year or 3-year
21 assignments.

22 CSM DEJONG: Sir, I think if we just

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1 -- sorry. Looking at number 17, if we put 17
2 and 18 together for the discussion I think
3 we're going to come up with the right answer.

4 CO-CHAIR GREEN: So you would say
5 that we could combine 17 and 18?

6 CSM DEJONG: No, I'm just looking at
7 putting it under standardization because --

8 CO-CHAIR GREEN: Oh, standards.

9 CSM DEJONG: -- by the time we
10 discuss 17 then along with 18 I think we're
11 going to come up with the -- what we're looking
12 for.

13 CO-CHAIR GREEN: Any objection to
14 putting it under standards? Standardization?
15 Okay. All right. So 27 is implementation of
16 DoD special compensation.

17 MS. DAILEY: There has been some
18 movement in the area on this. So you could
19 keep it in mind for taking it off the table.
20 However, movement is not a completed action so
21 the services have been given guidance to
22 implement, to develop their implementing

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1 instructions.

2 MSGT MACKENZIE: It doesn't fall
3 under family caregiver because you have to --
4 this takes into consideration the single
5 soldier or the single wounded warrior who's
6 going to need these benefits just as much as
7 anybody else. So I think it -- it wouldn't
8 fall under family caregiver.

9 MS. DAILEY: The way they're going
10 to write it is they have to have a caregiver to
11 receive this compensation. If they're going
12 into a facility or if there is no one they can
13 designate they're not going to be eligible for
14 the compensation. That's actually the way
15 Congress kind of wrote it.

16 MSGT MACKENZIE: Which if they're a
17 single soldier they would have aid and
18 attendants by a commercial outlying facility
19 which would then receive this pay, correct?

20 MS. DAILEY: They would be eligible
21 for that pay under TRICARE.

22 MSGT MACKENZIE: So this is a

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1 separate aid and attendants thing?

2 MS. DAILEY: Correct.

3 MSGT MACKENZIE: Going to the
4 families if they are caring for that
5 individual?

6 CO-CHAIR GREEN: My recommendation,
7 okay, there's two things coming out of here.
8 One is I don't think we have enough information
9 on this, okay, and so but -- and so obviously,
10 Denise, you do but we don't. And since we
11 don't all we know right now is that it hasn't
12 been implemented in this discussion item. I
13 would suggest we link it with caregiver for
14 right now because I think it is a statement
15 that's probably going to be made, but so let's
16 just link it for right now. So under caregiver
17 that would be number 27, is that what it was?
18 Okay. Number 29, VR&E. So my question on this
19 one is do we have enough information at this
20 point to make a recommendation? Or is this
21 something similar to looking at the SOCOM model
22 we want to take on next year? We've had one

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1 day of kind of briefings. Is this something we
2 want to put into this report?

3 MR. DRACH: There's an issue with
4 the expiration in December 2012 of allowing the
5 transitioning servicemember or the wounded
6 recovering warrior to participate in the pre-
7 DD-214 access to the program. So I guess the
8 question is if that's going to expire a year
9 from this December if we hold this off and we
10 want this law to be changed I think if we hold
11 off it may be too late. I think if we're going
12 to try to get legislation enacted we need to
13 start now.

14 CO-CHAIR GREEN: Okay. So then my
15 follow-on question is if this is about the TAP
16 question and the mandatory versus non-
17 mandatory. I mean I'm seeing there's two
18 different parts to this thing right now.

19 MSGT MACKENZIE: Twenty-nine, sir,
20 is VR&E, not TAP.

21 CO-CHAIR GREEN: It actually does
22 have the TAP in it, right? As I read it that's

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1 also part of it.

2 MR. DRACH: Well, the VR&E process
3 can start really before the TAP process starts,
4 but yes, I think it could be incorporated and
5 made part of.

6 MR. REHBEIN: Just a thought here.
7 I'm wondering if the DES grouping is too
8 narrow, if maybe we shouldn't set up a grouping
9 that deal with future civilian life. Because
10 DES and vocational rehabilitation and TAP are
11 all aimed at preparing the individual for the
12 day that they take the uniform off. So I'm
13 wondering if the DES grouping is a little bit
14 too narrow and we should put some of these, the
15 vocational rehab and the TAP, and fold them all
16 into a single group there.

17 CO-CHAIR GREEN: So let me -- that's
18 a great idea. So why don't we say
19 DES/transition and then 29 and 32 which is --
20 29 is the VR&E and 32, I see why I'm confusing
21 the two right now so I apologize. But then we
22 could put both 29 and 32 in the DES/transition

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1 group. Does that work for folks?

2 CSM DEJONG: Put 31 in there.

3 MR. CONSTANTINE: Thirty we're
4 pushing off till next year. I don't know if
5 you got the memo.

6 CO-CHAIR GREEN: So 30 was right now
7 under strategic. So is that one that's going
8 to be --

9 MR. CONSTANTINE: Yes, sir.

10 CO-CHAIR GREEN: -- pushed?

11 MR. CONSTANTINE: Yes, sir.

12 CO-CHAIR GREEN: So --

13 MR. CONSTANTINE: Thirty-one could
14 go in that same, the last folder you're talking
15 about.

16 CO-CHAIR GREEN: So 31 would go into
17 the DES transition folder. All right. Thirty-
18 two, 31, 29. So 35 is the last one.

19 MR. CONSTANTINE: I don't know if
20 it's a standard. It's just one office, right?

21 CO-CHAIR GREEN: I'm wondering about
22 35 and 38, actually. Fairly related.

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1 MR. CONSTANTINE: I would recommend
2 together. Like Dr. Turner said, they're both
3 interoperability, they're both about the
4 electronic medical records, everyone being able
5 to view them.

6 CO-CHAIR GREEN: The other question
7 is so we can link 35 and 38, that's not a
8 problem. The only question is does it fit with
9 another one of the sorting groups or is it a
10 stand-alone?

11 MR. CONSTANTINE: I think it should
12 be stand-alone because I don't think it falls
13 into the standardization and that's the only
14 one considered.

15 CO-CHAIR GREEN: All right. So,
16 we've now kind of looked through all of them.
17 The only one that I think we've got that's
18 truly -- there's two stand-alones that we
19 actually said, 35 and 38 may be looked at to be
20 combined, and number 5 which is management and
21 medical decision points. And then all the rest
22 we've got linked in one manner or another

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1 through six groups. All right. Number 4 is
2 under standardization, CRP/CTP is
3 standardization.

4 Now, when we do the breakouts,
5 Denise, a question. When we do breakouts
6 later, how many groups were you planning us
7 sitting in?

8 MS. DAILEY: You know, sir, I
9 apologize. I'm organized into four groups
10 around the original four categories.

11 CO-CHAIR GREEN: We're okay.

12 MS. DAILEY: Ability and --

13 CO-CHAIR GREEN: So the --

14 MS. DAILEY: -- society, et cetera.

15 CO-CHAIR GREEN: No problem. So the
16 question is we've got the COE and family
17 caregivers, communication, standardization, DES
18 and strat leadership. And so I'm wondering if
19 we can -- basically I'm going to do a little
20 lumping now of only the sorting categories so
21 that when we break into four groups we can look
22 at these things in that way. And so because of

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1 the way the numbers are broken out I'm thinking
2 that we might want to take the COE issues and
3 put them under strat leadership? Because in
4 that group when they look at those things that
5 we listed there before we can also look at the
6 COE in terms of what's going on. And then the
7 caregivers is also a standout there and I don't
8 know if we want to, just because of numbers
9 again, because when we break into four groups
10 and look at these things we could take the
11 caregivers and put them with the COM. I'm not
12 saying they're the same thing, don't
13 misunderstand, just that that group that looks
14 at strategic COM would also look at the
15 caregiver issues. And so we'd have four groups
16 this afternoon that essentially will try and
17 look at these areas to see if there's actually
18 places that they might come together. You see
19 where I'm going, Denise? Okay? And so
20 basically I'm taking what you've done now in
21 terms of sorting and in the groups this
22 afternoon, instead of doing it by your original

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1 groups we'll break you up or we may leave you
2 the same but give you a different topic area,
3 and that way you can look at these things to
4 see where it makes sense to pull them together
5 one way or another or to break them out if they
6 truly need emphasis. And then we'll just --
7 the other three I think we can take on as a
8 group probably for the ones we left out, for
9 the EHR piece and the medical management and
10 medical decision points, so we can actually do
11 those as a larger group. Does that sound like
12 a reasonable plan?

13 DR. TURNER: Just to bring something
14 up, as far as these groups this afternoon I
15 know we were going to get together in the
16 groups that we were teleconferencing on. And
17 again, just thinking out loud, would there be
18 any benefit added to making those groups
19 interdisciplinary? Mixing like health care and
20 you know, whatever.

21 CO-CHAIR GREEN: So try and get as
22 close as we can to have a representative for

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1 each of the other work groups that were on the
2 phone so you can represent --

3 DR. TURNER: Right, just a more
4 interdisciplinary approach.

5 CO-CHAIR GREEN: I agree. If we can
6 -- I think that now is the time we need to mix
7 and match because we're going to come back to
8 this group and we don't want there to be
9 surprises. So hopefully we can essentially
10 when we come back for voting be comfortable
11 that each group was represented as we work
12 this. So right now we'll have four sorted
13 groups of findings.

14 MS. DAILEY: Okay, let's -- sir, can
15 we go over that? And I do have it up here on
16 the screen and let's capture it for everybody
17 so that we can take it to each group. My staff
18 will print it out and we'll have it on one
19 sheet of paper so everybody knows what they're
20 working. So let's get it all on one sheet of
21 paper right here.

22 CO-CHAIR GREEN: First of all, the

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1 independent stand-alone, that can all -- the
2 only ones that are independent stand-alone is
3 number 5, 35 and 38.

4 MS. DAILEY: Say again?

5 CO-CHAIR GREEN: Five, 35 and 38.

6 And we've already decided that 35 and 38 can be
7 combined in a way. So just put parentheses
8 around 35 and 38. Five stands alone. Okay.
9 And then the standardization should be 1, 4,
10 nope, wrong place. Standardization, 1, then 4,
11 then 9, then 10, then 13, and then 17, 18 and
12 19. Okay?

13 MS. DAILEY: We wanted to
14 consolidate 7 and 8.

15 CO-CHAIR GREEN: That's correct and
16 7 and 8 are going to go to the strategic
17 communication. Strategic leadership. Yes, so
18 under the leadership, yes. So just put those
19 in parentheses just like we did up above for 7
20 and 8.

21 MS. DAILEY: Communications?

22 CO-CHAIR GREEN: So communications

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1 was yes, 20 through 27, right. Because we
2 included the family caregiver there, but that
3 group will basically look at 20 through 27.
4 Two zero through 27. I just, I think everybody
5 understands. I'm trying to get cross-feed
6 amongst the groups that did the -- and
7 basically trying to see. And so if they all
8 stand alone please, there should be no one who
9 walks into these groups this afternoon thinking
10 that there's any agenda to either combine them
11 or separate them or change the wording. It's
12 really just getting a separate look at them.

13 MS. DAILEY: That's correct for
14 communication.

15 CO-CHAIR GREEN: Twenty through 27,
16 that's correct.

17 MSGT MACKENZIE:
18 Communication/caregiver are all those.

19 CO-CHAIR GREEN: Right.

20 MS. DAILEY: Okay, so that was slash
21 caregiver.

22 CO-CHAIR GREEN: Right. They have

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1 two different groups. Under the leadership
2 you've got the 7 and 8 that goes up there, you
3 can copy that up. Just put it in parentheses.

4 So 7 and 8 are the ones that are consolidated.

5 If you look down below, yes. Just -- you have
6 2, 3, 12, 14 and then 30, 33 and 34. And then
7 we also gave them 15 and 16 which are COE.

8 MS. DAILEY: That's your leadership.

9 CO-CHAIR GREEN: Right and the COE,
10 but that's okay. All right.

11 DR. TURNER: Not to screw things up.

12 Do you think that number 30 might fit better
13 under the transitioning to, you know, under TAP
14 and other things like that?

15 MSGT MACKENZIE: Once again, 30 is
16 actually being -- is voted to be pushed to next
17 year.

18 DR. TURNER: I'm sorry, I missed
19 that. Thanks.

20 CO-CHAIR GREEN: We'll let the group
21 tell us that. That's, okay, because
22 technically we're not voting yet. So I think

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1 there was one other that way too, the number 11
2 and 30 are both. So, all right. And we have
3 one final group which is transition and DES
4 which is 6, 28, 29, 31, 32, 36 and 37. Did I
5 miss any?

6 CO-CHAIR CROCKETT-JONES: We don't
7 have 11 anywhere.

8 CO-CHAIR GREEN: Eleven is the one
9 that was to evaluate the DCoE. Yes. I was
10 going to say we're looking at number 11 since
11 we didn't put it anywhere. So we put 11 under
12 leadership for now and then basically the two
13 that are, 30 and 11 are in the same group. Sop
14 us number 11, yes, in leadership. And if you
15 would, put the parentheses around that 7 and 8
16 consolidated so that there's no confusion.
17 Yes, there. Okay. So it's always hard to do
18 this stuff in a public forum and we didn't get
19 a chance to talk a whole lot. Denise and I
20 have talked but Suzanne and I haven't really
21 discussed this. And so after a couple of
22 interesting starts here I think this gives us a

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1 way ahead this afternoon so that folks can look
2 at subject areas. We'll do our best to split
3 the groups up to try and have representation
4 across the various groups. It should be -- and
5 then we've got a couple of floaters. So if we
6 actually need to even move people around the
7 groups based on certain discussions because I
8 think there were three people in a group. So
9 we've got four groups so it's going to be
10 interesting to try and make sure we've got it
11 covered. But this will allow us to now look at
12 these things and see if we need to, if stand-
13 alone or if there's areas where they might be
14 able to be consolidated and then let the groups
15 bring things back and kind of present them in
16 here. So I think that's still consistent,
17 Denise, with what you were trying to get us to
18 do?

19 MS. DAILEY: Yes, and we're there.
20 We still have a little more time. We do like
21 to align members with a group. We have a
22 breakout session starting in half an hour,

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1 10:30, so if we can get at it this morning. We
2 will be 10:30 to 12:00 for the breakout
3 session. At 12:00 you have lunch and you have
4 another breakout session from 1:00 to 2:00. At
5 2:00 we have a consolidated session in here
6 with everybody that is open to the public --
7 and it is open to the public, but our breakout
8 session starts at 10:30 and we'll be back at
9 2:00.

10 CO-CHAIR GREEN: Okay. So I don't
11 know who was -- I don't have the listing of all
12 the groups right in front of me. I probably
13 have it in my notes pages here somewhere.

14 MS. DAILEY: It's on this. The
15 bottom of this, your quick reference, who's
16 who.

17 CO-CHAIR GREEN: So why don't we
18 just do one, two, threes so that there's three
19 people on each group pretty much, and then
20 essentially we'll -- unless somebody wants to
21 be on a different one of these groups. I mean,
22 do we want to do it randomly or do we want to

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1 have people pick? Either way.

2 DR. PHILLIPS: We're missing two
3 people.

4 MR. CONSTANTINE: If you're asking
5 for volunteers, sir.

6 CO-CHAIR GREEN: It's probably
7 easiest just to do it randomly unless somebody
8 has real strong feelings about wanting to be on
9 one of these groups. So why don't we just
10 label the groups one through four and then
11 we'll just start on one end of the table and
12 whatever your number is is kind of where you're
13 going to be working, okay? So standardization,
14 number one. Okay. Two, three, four. One,
15 two. I'll be on three. Okay. So, basically
16 if those were numbered up there, yes, exactly.

17 Who's at number one? So Dave.

18 MS. DAILEY: Who else?
19 Communications? Leadership?

20 CO-CHAIR GREEN: As they capture the
21 last transitional, so all the number fours, who
22 are the number fours? Okay. And so let me ask

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1 a couple of questions. Are there any of these
2 where we have two of the same group members?
3 Because we just did this randomly. Do we have
4 representation, did we break up the groups
5 adequately or do we have same group members
6 that did the initial design on any of these?
7 So no, we did pretty well that way randomly
8 worked. And so on the leadership piece, based
9 on the, you know, the other question is do we
10 want to split up civilian and military mix at
11 all in any of these to make certain that we've
12 got representation? So, looks like group one
13 is not bad, group two is again good
14 representation, group three we have good
15 civilian and military mix, and group four we
16 have civilians only. So do we want to put a
17 military member onto the -- or switch
18 membership on the transitional to have one
19 civilian on the number three? Suzanne, do you
20 have a preference? Do you have a preference?
21 Chosen leadership? Well Suzanne, why don't you
22 and I just switch? So I'll take the transition

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1 and you take the leadership.

2 CO-CHAIR CROCKETT-JONES: That's
3 fine.

4 CO-CHAIR GREEN: The caregivers were
5 put into transition, is that where we put them?

6 MSGT MACKENZIE: No, they were put
7 into communication.

8 CO-CHAIR GREEN: Okay. So I know
9 you have a special interest there so all right.
10 So we'll switch it that way and I'll work on
11 the transition and let you take the leadership.

12 CO-CHAIR CROCKETT-JONES: That's
13 fine. Now the question of we had the two -- we
14 had two that we were considering postponing to
15 next year fairly clearly. Do we want to take
16 this time to try and --

17 CO-CHAIR GREEN: On number 11 and
18 30?

19 CO-CHAIR CROCKETT-JONES: Eleven and
20 30.

21 CO-CHAIR GREEN: That'd be good.
22 Right. So we'll start with --

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1 CO-CHAIR CROCKETT-JONES: Can we do
2 that?

3 CO-CHAIR GREEN: Okay. Everybody
4 comfortable with these groups and how we're
5 going to break out this next session? Okay.
6 And so really the goal is to look at -- now
7 we've broken them into smaller groups again, to
8 look at those, see where there may be overlap,
9 see if there's some proposals for anything that
10 could be combined or if there's anything that
11 we think are, you know, if we should change it
12 into some type of overarching recommendation.
13 But there's not an emphasis here on trying to
14 drop recommendations or to lump or to split.
15 So really it's just the group needs to look at
16 them now that we've said as we sort them we see
17 commonalities. Now the question is is there
18 overlap. So I'll let you folks then take it
19 from there. All right.

20 So we want to deal with number 11
21 and number 30. So number 11 is the one about
22 exploring the SOCOM model. Discussion. Who's

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1 the group?

2 DR. PHILLIPS: That was our group.
3 You know, based on some of the evidence which -
4 - one of the reasons we wanted to put it off is
5 because we don't have enough information I
6 think. The discussion and the reports
7 indicated that the return to duty for the SOCOM
8 model was over 80 percent and that for the
9 other services it was less than 10 percent.
10 Understanding the motivation and so forth of
11 the special ops folks, but looking to see if
12 there's some sort of common thread or
13 commonality or some model that could be
14 translated over to the rest of the services.

15 CO-CHAIR GREEN: So I'm hearing a
16 proposal from the group that developed this to
17 push this into next year's evaluation. And so
18 basically it could be mentioned as a comment
19 that we will be looking at this next year but
20 it would not be a finding.

21 DR. PHILLIPS: Exactly, because I
22 don't think we have enough information to make

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1 a recommendation.

2 CO-CHAIR GREEN: So now I have to
3 get you into the Robert's Rules of Order and I
4 need someone to move.

5 DR. PHILLIPS: So moved.

6 CO-CHAIR GREEN: And I need a second
7 that we would push number 11, the motion is
8 that we were going to push number 11 for
9 consideration for next year. So I have a
10 moved, do I have a second?

11 LTCOL KEANE: Our group also made
12 that same decision when we met to push number
13 11 to next year.

14 MSGT MACKENZIE: I second it.

15 CO-CHAIR GREEN: So we have a motion
16 and a second. And so basically it would remove
17 number 11 from this and potentially could leave
18 a comment that this is something we would look
19 at in next year's plan. So all in favor?

20 (Chorus of ayes)

21 CO-CHAIR GREEN: Any opposed?

22 (No response)

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1 CO-CHAIR GREEN: Any abstentions?

2 (No response)

3 CO-CHAIR GREEN: So number 11 is
4 less work for that group this afternoon, okay.

5 And number 30 is the other one. And so which
6 group put forward number 30?

7 MR. CONSTANTINE: We did, sir. I
8 make a motion that we push number 30 off to
9 next year and include a note that potentially
10 it will be -- or potentially include a note
11 that say.

12 CO-CHAIR GREEN: Okay, so very
13 similar to number 11 that we would take it out
14 of the findings this year and make it something
15 we would look at in more depth next year, and a
16 comment to that effect in the report. Any
17 second?

18 DR. TURNER: Second.

19 CO-CHAIR GREEN: All in favor?

20 (Chorus of ayes)

21 CO-CHAIR GREEN: Okay. Any opposed?

22 (No response)

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1 CO-CHAIR GREEN: Any abstentions?

2 (No response)

3 CO-CHAIR GREEN: Okay. Thank you,
4 Suzanne. Okay, thank you very much, and let's
5 take a break and we'll reconvene at 10:30 in
6 the smaller groups.

7 (Whereupon, the above-entitled
8 matter went off the record at 10:08 p.m. and
9 resumed at 2:00 p.m.)

10 MS. DAILEY: The next session is
11 going to be a document in which we fold
12 together all your comments and it will be up on
13 this screen so if we cannot get it printed out
14 in time it will be displayed on the screen so
15 that we can work through it. So each group and
16 each group will be able to comment on the work
17 of the other group. And so it might be a
18 little distracting because they will also be
19 making copies simultaneously and we'll make
20 sure the members of the public get a copy of
21 the work that was done in the preparatory
22 sessions this morning so that everyone can have

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1 a view of that work.

2 The other purpose of this session
3 from 2:00 to 6:00, ladies and gentlemen, is
4 that we do want to vote. We want to kind of
5 get into that voting mode. We want to tee
6 these items up for vote. So that again is a
7 big step and we need to get our arms around it.

8 So any questions about what we'll be doing in
9 this session? And some of it's going to be
10 familiarization, but primarily from 2:00 to
11 6:00 today we want to get something voted on.
12 We've got to break through that barrier and
13 start that vote process. Questions? Yes.
14 Would you go get the report and tell them to
15 bring it in so that I can show it up on this
16 screen, Jim?

17 I would very much like for you all
18 to, if we've got a moment here, to take a look
19 at the voting session guidelines. They are in
20 the left cover of your book, it says Voting
21 Session Guidelines. And long story short you
22 are kind of using a Robert's Rules of Order.

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1 You do make a motion. I need a second on the
2 table and I need a, according to the notes
3 there, I need -- I can't -- I need to have over
4 half, I need over half of the people who are
5 here today voting to vote for it. A split down
6 the middle should not be the case as I have 13
7 here. It doesn't carry. So good opportunity
8 to take a look at the voting session guidelines
9 here.

10 (Whereupon, the above-entitled
11 matter went off the record at 2:03 p.m. and
12 resumed at 2:05 p.m.)

13 MS. DAILEY: Okay, we had group 1
14 with recommendation number 1, ladies and
15 gentlemen. And this was a standardization
16 effort. Was this the only change you all made
17 to this? Does this look familiar? Is this
18 what you all worked? Okay. So, there's no
19 changes essentially. We don't have anything
20 here other than any nomenclatures.

21 CSM DEJONG: The only discussion up
22 there really that we left out there was whether

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1 we want to leave it as recovering warrior or
2 recovering servicemember. There was discussion
3 back and forth throughout the group about
4 different services and what's been really,
5 truly has been adopted over the services is
6 recovering servicemember. And then there was
7 more discussion into does that -- that
8 eliminates the delineation between the ill and
9 injured versus the true combat wounded or vice
10 versa. So we're hoping to get some feedback on
11 whether we leave it as recovering warrior or we
12 go to recovering servicemember. The rest of
13 the -- other than that red line right there,
14 "DoD should define recovering warrior and adopt
15 common standards and nomenclature," that
16 acronym would change and then programs and
17 policies. That is the recommendation and the
18 rest of that paragraph that was in the copy
19 that's there we moved into findings.

20 DR. PHILLIPS: Now, we're asking the
21 group for comment as to whether or not we
22 should again use recovering servicemember or

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1 recovering warrior. I think Army's comment was
2 recovering servicemember.

3 DR. TURNER: I would say just add,
4 whichever we decide, we need to be consistent
5 throughout the entire document.

6 MR. REHBEIN: I'm almost wondering
7 if we do make the change and go with the Army
8 nomenclature and go forward with that
9 recommendation then we need to adopt that
10 recommendation ourselves and look at our own
11 name.

12 CO-CHAIR GREEN: So let me ask this
13 question. So, this issue of servicemember
14 versus warrior. Okay, I realize that you're
15 tying warrior into someone who came back from
16 the theater. But if we weren't at war and
17 you're in the Army, the Navy, the Air Force,
18 the Marines, are you still a warrior?

19 MG. STONE: The answer is yes, and
20 there's a warrior ethos that we live within and
21 therefore we need to just stay with recovering
22 warrior and discard what the Army's input was

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1 of servicemember.

2 CO-CHAIR GREEN: That's the way I
3 feel. I think that regardless of war or no
4 war, when you're in the service you're a
5 warrior. I mean --

6 DR. TURNER: Thus the old saying,
7 "Those who serve also stay and wait at home"
8 are also warriors.

9 MAJ PASEK: The terminology in the
10 NDAA was -- the terminology in NDAA was
11 recovering servicemember, not recovering
12 warrior. We didn't just make that up on the
13 Army side, that was something that we were
14 going back to validate whether or not it was
15 recovering warrior versus recovering
16 servicemember in the documents that were
17 outside of the Army purview. And that was all
18 we -- we had brought that up as something for
19 the group to consider.

20 CO-CHAIR GREEN: I still think that
21 we have the ability to basically define warrior
22 as servicemember and essentially they're

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1 interchangeably so therefore we don't have to
2 change names in the whole report. So if we
3 need to put something in the beginning of the
4 report saying that, you know, defining a
5 warrior as a member of the armed forces then in
6 essence -- a uniformed member for the armed
7 forces, then in essence we've got this covered.

8 Unless there's some legal requirement that we
9 say it servicemember. Denise, do you know?

10 MS. DAILEY: Sir, there is not a
11 legal requirement. Yes, there are definitions
12 for recovering servicemember. Some are used
13 consistently across the services and some are
14 not, and I do agree with you that this task
15 force refers to servicemembers in these
16 programs as recovering warriors is within your
17 purview.

18 CO-CHAIR GREEN: We up for our first
19 vote?

20 (Laughter)

21 DR. PHILLIPS: So moved.

22 CO-CHAIR GREEN: Second?

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1 DR. TURNER: Second.

2 MS. DAILEY: We don't really need to
3 vote on this, ladies and gentlemen. We
4 appreciate the Army's input very much and
5 you've considered it. That is what's required.

6 Doesn't require a vote. All I need you to do
7 is vote on your recommendations.

8 CSM DEJONG: Well, then if there's
9 no other discussion on it I'll make a motion to
10 vote on recommendation 1 as written.

11 DR. TURNER: Second.

12 CO-CHAIR GREEN: Is it scrolling off
13 the screen or is that everything that we're
14 seeing up there? I just want to make sure
15 we're all looking at the entirety of it if you
16 will.

17 CSM DEJONG: Sir, as I mentioned
18 earlier, all we did was we moved it, part of
19 the -- the last part of that paragraph that was
20 in the original recommendation. If you scroll
21 down a little bit we put that at the bottom of
22 the findings as further clarification.

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1 CO-CHAIR GREEN: I don't want us
2 voting on things unless we've seen the full
3 text, okay? So.

4 MR. CONSTANTINE: What is the red
5 there? Is that -- where it says integrate.
6 Are you telling us anything after that in the
7 above?

8 CO-CHAIR GREEN: I think, if I could
9 ask, I think that right now the problem is when
10 you say integrate that means you're going to
11 put it somewhere into the text. Is that what
12 you mean?

13 CSM DEJONG: Correct, it's just
14 going to go somewhere into the findings text.

15 CO-CHAIR GREEN: Okay. So I would -
16 - let me take the vote off the table then
17 because until it's integrated we shouldn't
18 vote. Now, under Robert's Rules of Orders I
19 guess technically I can't do that, okay, so
20 I'll come back to you and say are you certain
21 you want to ask for a vote when the
22 documentation is not yet in final form.

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1 MS. DAILEY: Okay. Now let me
2 clarify something. Is this going in the
3 finding, or do you want it up in the
4 recommendation?

5 CO-CHAIR GREEN: Just into the
6 findings, ma'am.

7 MS. DAILEY: Okay. Then it doesn't
8 need to be voted on.

9 CO-CHAIR GREEN: Okay. So now we're
10 only talking about the text of the
11 recommendation itself. So go back up and let
12 us look at the text. I guess -- so we have a
13 proposal to vote and I think I heard a second?
14 Is that right? Okay. I have one more comment
15 and that is that I am worried a little bit
16 about the fact that we say create a common
17 definition for recovering warrior and we just
18 had the discussion about servicemember. And so
19 do we want to change it in any way so that the
20 servicemember and recovering warrior are both
21 specified in the finding?

22 MR. DRACH: Couldn't we somewhere

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1 identify that recovering warrior is all-
2 inclusive and that warrior is synonymous with
3 servicemember? I mean, footnote it somewhere?

4 CO-CHAIR GREEN: So, it doesn't have
5 to be in the finding, but that's the question
6 is does it need to be in the introduction that
7 we're referring to servicemembers and warriors
8 as the same thing. CO-CHAIR CROCKETT-

9 JONES: I believe as long as we make that
10 request it will be included, correct?

11 MS. DAILEY: Correct, and I'm not
12 sure that we didn't already include that,
13 frankly, in our introduction where we said we
14 would be addressing all wounded, ill and
15 injured. Even in our introduction.

16 CO-CHAIR GREEN: Okay. So we call
17 the vote to approve recommendation 1 as written
18 in front of you on the screen. All those in
19 favor raise your hand.

20 (All in favor)

21 CO-CHAIR GREEN: Okay. Anyone
22 opposed?

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1 (No response)

2 CO-CHAIR GREEN: Any abstentions?

3 (No response)

4 CO-CHAIR GREEN: Approved. Okay.

5 The other problem that's going to come up is
6 that I think that we're going to run into how
7 they should be ordered will be an issue. So as
8 we approve a recommendation and get to the
9 final list of recommendations the order of
10 these may not stay the same. It may well be
11 that that's number 1, but it could be number
12 10. So I just want to make sure everybody
13 understands as you vote we're approving the
14 wording for a recommendation and then we have
15 another kind of an ordering to be done.

16 MSGT MACKENZIE: Okay, on
17 recommendation number 2 the key there was the
18 body of the text which in blue, in aqua there
19 you'll see that it has been rewritten as we
20 feel to be a more effective statement.

21 MR. CONSTANTINE: Just a quick
22 question. Why isn't it chains of command? Why

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1 is it singular?

2 MS. DAILEY: Read it out loud. I do
3 have -- and I'm happy to read it too. But I do
4 have people in the back who are looking very
5 strained to try and read everything that's up
6 there. So let's start with just reading this
7 new one out which would sound like, "Department
8 of Defense will direct line chain of command to
9 better coordinate access to recovering warrior
10 programs and transition units in supporting the
11 successful recovery, rehabilitation and
12 reintegration of recovering warriors. Line
13 chain of commands will identify, initiate,
14 track and report standardized action steps to
15 DoD."

16 CO-CHAIR GREEN: I think we need a
17 little discussion here. So --

18 MS. DAILEY: Good.

19 CO-CHAIR GREEN: -- the issue in my
20 mind on this one is whether or not we have
21 evidence other than at one site of problems --

22 MG. STONE: Point of order, sir.

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1 CO-CHAIR GREEN: Yes?

2 MG. STONE: This -- there's not been
3 a motion to consider yet, or seconded. So we
4 can't speak to the motion unless it's been
5 actually submitted.

6 CO-CHAIR GREEN: But there's not a
7 vote pending as I know of right now. We're
8 just discussing the findings.

9 MG. STONE: Okay.

10 CO-CHAIR GREEN: So, I mean we can
11 move it to that level but right now the issue
12 is really the group has changed the wording and
13 so we have a recommendation up with some
14 different words and the -- and so for the rest
15 of us as we -- this is the first time to
16 discuss it in the full group, right? Other
17 than the small group. So the small group has
18 changed the words to basically say this but
19 hasn't addressed whether or not, you know, so
20 you basically agree with this finding, the
21 small group does.

22 MSGT MACKENZIE: Correct.

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1 CO-CHAIR GREEN: Okay, and so help
2 me understand what we're saying in this finding
3 then. Are we saying that a WTU is the way to
4 go?

5 MS. DAILEY: No, sir. I think that
6 what's being said here is that the task force
7 would like to see better coordination between
8 line units and the recovering warrior units.
9 Line units and those who are caring for
10 recovering warriors in their units.

11 CO-CHAIR CROCKETT-JONES: Yes, I
12 think what we were trying to get at here is
13 that our data is incomplete unless line units
14 start doing a better job of tracking those who
15 are in recovery while still -- while remaining
16 in their unit. It's a -- we won't be able to
17 fold that evidence and data into assessments
18 until we get a grasp of who is in line units
19 and what kinds of programs they're needing.

20 MR. CONSTANTINE: It doesn't seem to
21 me that -- I definitely understand what you're
22 saying, but it doesn't seem to me that this

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1 recommendation does that because it says they
2 have to coordinate with the WTU or wounded
3 warrior regiment or whatever unit is there and
4 that's different than doing what you just said
5 to -- and I know the second sentence says
6 identify, track, report standardized action
7 steps, but that doesn't mean you're going to
8 find out how well they're taking care of those
9 warriors while they're still in their units.
10 Action steps could be -- unless I don't
11 understand maybe what you mean by action steps.

12
13 DR. TURNER: Mr. Constantine, how
14 would you reword it?

15 MR. CONSTANTINE: Before I answer
16 that, my concern is if we want to make sure
17 that the line units are taken care of -- the
18 line units are taken care of, those warriors,
19 while they still belong to them, that first
20 sentence talks about coordinating with the
21 recovering warrior programs. It sounds to me
22 like -- it seems to me that the warriors don't

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1 have access to those programs unless they're
2 part of the WTU. Or is that incorrect?

3 CO-CHAIR CROCKETT-JONES: I'm not
4 sure that's correct because just from personal
5 experience I know while my husband was still in
6 a regular unit he was also doing some programs
7 for -- they would farm him out and let him
8 attend programs for, you know, various
9 treatment and therapies.

10 MS. DAILEY: Okay, so the intent
11 here is that line units who have recovering
12 warriors in them who might be limited duty or
13 on profile as we say in the Army, limited duty
14 is the term used in the Marine Corps and the
15 Navy. The units that are supporting those
16 individuals, the intent here is of this is to
17 have a formalized tracking system for those
18 types of individuals.

19 MG. STONE: If I may because I'm
20 going to have trouble supporting this at all.
21 First of all, the concept that DoD would reach
22 past the services into the line chain of

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1 command is an inappropriate recommendation and
2 violates the concepts of the way we operate in
3 the military. Secondly, the concept is that
4 recovering warriors should have equal access to
5 care and equal access to programs regardless of
6 where they're housed. If in fact the line
7 believes as in some of the services that we saw
8 that servicemembers are better cared for by
9 remaining in the line then we need to guarantee
10 that there are standardization programs to make
11 sure that they get equal access and equal
12 opportunity to recover equal to if they're
13 housed within a warrior transition unit or
14 command as might be done with some of the
15 warriors. I'm not sure that we do any of that
16 with this recommendation.

17 DR. TURNER: Many of your concerns -
18 - oh, sorry. I believe that many of your
19 concerns are addressed in some following
20 recommendations like number 5 that you had
21 mentioned before. And could we perhaps table
22 this one and move to number 5 to address

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1 General Stone's or would you rather go ahead
2 and finish this one now?

3 CO-CHAIR GREEN: I'm happy to brief
4 on number 5. Just to continue the discussion
5 here, I'm not sure that this wording yet gets
6 to what we're trying to achieve. So if what
7 we're trying to achieve is equal access to
8 services regardless of whether you are assigned
9 to a WTU or maintained in a line unit, such as
10 the Marines and the Air Force do, I think that
11 we all agree to that, that they should have
12 access to those services. But I'm not -- I'm
13 having a bit of a hard time getting that out of
14 the wording that's here. That -- I mean it's
15 not that I disagree with the concept, it's that
16 I'm not certain that the wording gets it here.

17 I'm uncomfortable with the same things Rich
18 was in terms of directing line units and line
19 chain of command to do this because I'm not
20 certain we're telling them what we want them to
21 do yet. And so that's my struggle with this
22 one. But it's not that I'm against the

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1 recommendation, don't misunderstand my -- I
2 just, I'm having some trouble with the language
3 right now.

4 MR. REHBEIN: Reading these two, the
5 original and the new one, I personally like the
6 language "partner with" better than "coordinate
7 access to." To me "partner with" is stronger
8 and it implies a relationship, an ongoing
9 relationship rather than a one hand feeding the
10 other. So those, I would -- I could support
11 "coordinate access to" but I think it would be
12 stronger if we returned to "partner with."

13 DR. PHILLIPS: As one Iowan to
14 another I'm going to disagree. I personally
15 did not like the word "partner" because I did
16 not want to overburden the line unit command
17 because they have a different mission and
18 that's why I was trying to soften that term to
19 either "coordinate" or "interact" with -- it
20 just struck me wrong.

21 DR. TURNER: Perhaps if -- where
22 this came from, and please, the group, jump in.

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1 Where this came from was it was felt in the
2 findings that sometimes the line was not as
3 supportive of the recovering warriors getting
4 their care. And the reason this was placed in
5 the leadership section was to foster a more
6 cooperative, enabling leadership environment in
7 the line unit to work with the recovering
8 warriors so that they may get their care. I
9 think perhaps some may be reading too much into
10 this when the primary goal of this
11 recommendation was simply to set an environment
12 where the line would better cooperate to enable
13 care of their recovering warriors to work
14 within whatever framework they're working into
15 which we would address in other
16 recommendations. Does that help? And I would
17 be very interested in any particular rewrites
18 if you have a better way to say it.

19 DR. PHILLIPS: Let me add to that.
20 We've come across issues where medical
21 recommendations or medical orders were
22 superseded and considered only as

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1 recommendations. And so again as a physician
2 and one who served I feel that the medical
3 issues should supersede, unless there's some
4 extraordinary circumstance, the line orders or
5 recommendation. And I think that's where the
6 crux of this comes into being. And it just
7 depends on how we word this so it's appropriate
8 and fits in with everything else.

9 MR. CONSTANTINE: But this doesn't
10 say that. Now believe me, I understand exactly
11 where you're coming from, but this doesn't say
12 that -- that's a different recommendation, that
13 the doctor's recommendation is final. I do
14 think the language has to include what Dr.
15 Stone said, that the line units -- someone in
16 the line unit will receive equal access to
17 equal care to someone who's in the RW program
18 and it doesn't specifically say that.

19 DR. TURNER: How best would you --
20 how best would it be to say that?

21 MG. STONE: I think we have to
22 acknowledge that there are two models. There's

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1 a warrior transition command model and there's
2 a model which keeps the recovering warrior in
3 the line. There must be standardization that
4 assures equal treatment. And DoD has to
5 establish the standards that assures equal
6 treatment and equal access. And that may be a
7 way to say this and get at what frustration we
8 heard from families and especially the Marine
9 Corps uses this as a model in well over 80
10 percent of their recovering warriors.

11 DR. TURNER: Exactly. I think we're
12 all on the same side on this and we want to say
13 the same thing. And perhaps I'm wrong, but
14 again, I think General Stone's primary concern
15 that it would be equal care standards for
16 everyone is somewhat addressed in
17 recommendation 5 where we talk about standard
18 medical care management. And this, the purpose
19 of this one, of this particular writing was
20 only to encourage a more supportive environment
21 by leadership towards the recovering warrior.

22 MSGT MACKENZIE: Well, let me add to

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1 that. One of the things we have to look here
2 too is be careful how narrow we get this
3 focused. Because this isn't just -- because
4 the recovering warrior is not just about
5 medical care, okay? This is addressing the
6 whole package deal. This is all the access to
7 that stuff and providing that access seamlessly
8 and fluidly whether you're retained in the line
9 unit or you actually end up into a WTU or, you
10 know, wounded warrior battalion, or patient
11 squadron. Is that -- that focus is towards
12 recovering warrior in the entire spectrum of
13 assets. And that this still happens. I know
14 from a community that I come from that's what
15 we do is ensure that kind of stuff. The
16 different services we work different
17 arrangements with. I mean, we have an MOA with
18 the Army specifically for that reason, to get
19 access to the care that you can't get unless
20 you're assigned to a WTU while still remaining
21 in the line unit under the C2 of the
22 individual's unit. But that should be across

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1 the board, that shouldn't be something unique
2 to a specific organization or because of where
3 they come from, that should be across the board
4 that that should be able to happen and that
5 should be directed so that happens in that
6 realm.

7 CO-CHAIR CROCKETT-JONES: I just
8 wanted to say, and I think that one of the
9 significant things in this recommendation is
10 that in asking them to identify and track those
11 recovering warriors that they want to keep in
12 the line unit who don't warrant transition, you
13 know, a movement to a transition unit we still
14 need to know what is being done with those
15 folks as far as are they slipping through the
16 cracks, are they. You know, there might be
17 some real information that we are missing from
18 line units because unless you're in the
19 transition unit the amount of tracking is --
20 and information is much lower.

21 DR. TURNER: The intent of the last
22 sentence was accountability. And if the group

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1 has perhaps a better way to add accountability
2 we would -- I mean, we certainly would like to
3 do a better job of that.

4 CO-CHAIR GREEN: Yes. I think that
5 we're struggling a little bit because the words
6 are meaning different things to different
7 people. And so, and just in the discussions
8 there's things that I'm very comfortable with
9 and things that I'm very uncomfortable with.
10 Just for the record, okay, a medical officer's
11 recommendation on a profile for instance is
12 just that, it's a recommendation. And it's
13 always that for the commander with some risk to
14 himself as to whether they're going to do that,
15 but that's a very old adage that we need to
16 kind of not necessarily take on in this
17 recommendation.

18 DR. TURNER: This has nothing to do
19 with that.

20 CO-CHAIR GREEN: Correct. I'm just
21 saying that it's problematic in terms of how
22 different people are interpreting this. So I

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1 think that what we're trying to get at is once
2 identified as a recovering warrior, regardless
3 of how assigned or tracked there should be
4 equal services and access because that's what
5 you're really trying to get at. So once you
6 identify the person as being a recovering
7 warrior and that goes back to recommendation
8 number 1, regardless of how you track them or
9 where you place them they should have equal
10 access to services. And so I'm not sure that
11 that's the right wording either but I think we
12 need to think about this one for a little bit
13 because there's some different things coming
14 out here and the real question if I go back to
15 Russ, what you said earlier, that the goal was
16 to make certain that regardless of where
17 they're assigned, whether to a WTU or to a line
18 unit that in essence they were going to have
19 access to the necessary services.

20 DR. TURNER: That's not what this is
21 about at all.

22 CO-CHAIR GREEN: I keep

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1 misunderstanding then. Go ahead.

2 DR. TURNER: If you look at the
3 original -- let's start with the original
4 recommendation, okay? Oh, sorry. And please,
5 Mac, jump in and save me.

6 (Laughter)

7 DR. TURNER: Direct line units and
8 line chain of command need to better partner or
9 coordinate with recovering warrior programs and
10 transition units in supporting the recovery,
11 rehabilitation, integration of recovering
12 warriors. That's all this says. It's just
13 they want -- the whole idea of this, and I
14 think some -- again, I appreciate that
15 different people are reading more into this.
16 This is actually quite simple. All we want to
17 do is promote a culture of where the line and
18 the recovering warrior units work better
19 together. That's all. And we would like a way
20 to somehow watch that which is why we added the
21 accountability. This has nothing to do with
22 access, this has just we need to work better

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1 together. Now, there are some more specific
2 things where we talk about access I mean in
3 other things. If you would like to add access
4 into this one then yes, we can do that. This -
5 - and again, group, correct me if I'm -- I
6 don't want to speak out of turn, but this --
7 this was actually very straightforward, let's,
8 you know, we need to work better to get the
9 line -- something to promote the line and the
10 medical -- the recovering warrior units to work
11 better together. That's what we're saying.
12 And there was some way -- if there was some way
13 we could document or hold them accountable
14 where they do that.

15 CSM DEJONG: I guess my question is
16 what are you expecting to gain from a line unit
17 working with a warrior transition unit? Is it
18 a level of care? Is it a level of access?
19 Because then we can go back to what General
20 Green and General Stone said and just ensure
21 standardization of care across the board.

22 DR. TURNER: Those kind of come up

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1 in some other recommendations, but go ahead.

2 CO-CHAIR CROCKETT-JONES: I was
3 looking at this not only as working well with
4 the units, in other words, knowing when to send
5 you know, being comfortable with sending. It's
6 not just about determining, defining who gets
7 to go to the transition unit. But there's a,
8 perhaps it's a cultural aspect of resisting in
9 some places this moving soldiers into them.
10 That's one thing. But mostly also, I was
11 looking at this as the access to the programs
12 themselves, that if -- when a line unit
13 determines that it is best or when the
14 standards say that a soldier or a servicemember
15 needs to be kept in a line unit but they are
16 still in recovery and need treatment we need
17 them to be able to get to those programs that
18 are reasonable and appropriate for that
19 recovery. There seems to be some resistance
20 and some obstacles in that connection. Part of
21 the reason why we don't know how much of a
22 problem this is is because those folks are not

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1 tracked nearly as well or identified as
2 completely as those who do get to warrior
3 transition units. And we won't know if they
4 have equal access to care, we won't know what
5 levels of care they are receiving until we
6 start getting a clear sense of the recovering
7 warriors that are still in line units and
8 what's going on with them. And this
9 recommendation as I understood it was just an
10 attempt to encourage line units to get those
11 folks into programs and holding them
12 accountable to do -- for doing so by
13 identifying them, tracking them and reporting
14 that they have completed therapy sessions,
15 whatever.

16 DR. PHILLIPS: Let me suggest some
17 language that might compromise or perhaps
18 confuse the issue even more, but I just put
19 down direct line units and the chain of command
20 should coordinate and acknowledge that for RWs
21 medical authority should supersede routine
22 military authority and allow equal access to

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1 care and track that effort.

2 MR. CONSTANTINE: I don't think we -
3 - there's any point in us talking about medical
4 officer having more weight than the OI officer.
5 That's inappropriate for this recommendation.
6 And further, I just heard two different things
7 from Dr. Turner and from Suzanne about whether
8 or not we're talking about equal access to
9 equal services which I think we all agree with
10 which seems appropriate and what Dr. Turner is
11 saying, that we want to tell these two people
12 to get along. And there's no way of measuring
13 that. And I think we should go ahead and make
14 the statement that equal access to equal
15 services is what we want.

16 CSM DEJONG: Because furthermore,
17 from what General Stone said before, DoD cannot
18 direct a line unit.

19 CO-CHAIR GREEN: Let me suggest that
20 the language is confusing enough right now that
21 everyone's taking away a different message.
22 Let's table this one and move on, okay? I

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1 think, you know, each of us has tried to add
2 some clarity, I tried to do the once identified
3 as a recovering warrior whether access or
4 services -- I don't know, but right now we're
5 getting a general understanding of where you
6 want to go but the wording is not getting us
7 there. And when we look at the finding, the
8 finding is specifically directed, or is at
9 least coming from a place where we had
10 recovering warriors assigned outside of a
11 warrior transition unit. And so the question
12 is regardless of where they're assigned how do
13 we make certain that they're getting the same
14 level of care or service because you say care
15 and everybody thinks medical, but this is about
16 family support and all of it. So I think we
17 know where we want this to go, but we can't
18 quite get there with the wording. And so we'll
19 have to work on this one a little bit. So
20 let's table it and move on. We're not getting
21 rid of it, don't misunderstand, we're simply
22 tabling it. Number 3.

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1 MSGT MACKENZIE: Okay, number 3 was
2 also a reword of the recommendation to give it
3 more impact as well as we also made some
4 corrections to -- or some rewording to the
5 findings as well and how they're worded, trying
6 to make them flow better. So the correction we
7 went with on number 3 was, "Shape strategic
8 solutions that address the unique needs of
9 Guard and Reserve recovering warriors. Care
10 for Guard and Reserve will meet active duty
11 standards." And then we -- when we got into
12 the findings, into the -- yes, into the
13 findings, the -- I'm sorry, the bullet
14 statements that supported the recommendation
15 was where we made some additional changes. And
16 I can read those if you'd like. That first
17 bullet statement was, "Ensure adequacy of
18 civilian health care delivery systems to meet
19 military health care standards. Develop access
20 standards and ensure parity among civilian and
21 military systems." The second bullet was, we
22 adjusted it to read, "Access to local care

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1 through TRICARE Remote will be expanded to
2 recovering warriors assigned to community-based
3 warrior transition units as recommended" and in
4 this it was recommended by one CBWTU. The next
5 bullet was to train nurse case managers who
6 support CBWTUs in utilizing TRICARE and TRICARE
7 Remote. And then we, the next bullet with
8 respect to the management of the CBWTUs,
9 clarify the process for assigning recovering
10 warriors to CBWTUs and resource CBWTU
11 facilities, cadre and recovering warriors with
12 the technology appropriate to their remote
13 environments. On the next bullet, "Assess how
14 effectively the National Guard chain of command
15 will identify, track and report to DoD the
16 status of the recovering Guard members who are
17 not assigned to a CBWTU." And then the final
18 bullet we left the same.

19 CO-CHAIR GREEN: This is going to be
20 -- rather than discussing the meat of this
21 topic, let me ask that for clarification, GAR
22 for Guard and Reserve is the first time I've

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1 seen this in the report here. Typically we see
2 active and reserve component. And so I saw
3 that I believe it was the Army who was also
4 questioning why we were using GAR. Is that a
5 new lexicon?

6 MS. DAILEY: We'll take it out. We
7 have seen it used, but we will take it out.

8 CO-CHAIR GREEN: Okay. And so we're
9 talking about reserve component and trying to
10 make certain the reserve component has the same
11 services as the active duty standards. Were
12 these the only things that were -- because this
13 is not a combined, this is one that actually
14 came from the group, right? As it is. And so
15 is this pretty much the extent of what we got
16 from our visits in terms of the things that
17 need to be addressed? Any other discussion?
18 Anybody with any concerns about this one?
19 Comments?

20 MG. STONE: I'm not comfortable with
21 this one at all. We've got a lot of things
22 mixed into it as far as the training of the

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1 cadre. The TRICARE Remote is not -- there's
2 TRICARE Prime, there's Prime Remote, there's
3 TRICARE Standard. TRICARE Remote is not an
4 insurance product in and of itself. So you're
5 talking about a method of payment that's mixed
6 into this in the second bullet.

7 You're talking about utilizing in
8 the first bullet the civilian health care
9 delivery system when appropriate and I'm not
10 sure how you develop access standards and
11 ensure parity in a civilian system when we
12 don't own that system. In the -- the how
13 assessing effectiveness in the second to the
14 last bullet, how the chain of command
15 identifies, tracks and reports should be a
16 recommendation to all of the reserve
17 components, not a specific portion of the
18 reserve components. So, I'm struggling with
19 this one.

20 MSGT MACKENZIE: One of the things,
21 I don't think it was the intention to say that
22 we're trying to change the civilian health care

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1 system at all or meet them up to standards, but
2 it's the identification that those medical
3 resources available to that warrior in his
4 remote location actually meet those standards.

5 MG. STONE: Let me come at
6 this with a different method. I think it's
7 clear that the reserve components have asked
8 for the existence of community-based places to
9 serve that portion of our population because of
10 proximity to their homes. There is no evidence
11 that the delivery system is prepared to deliver
12 care that is appropriate in those centers and
13 we saw that down in Florida. We saw tremendous
14 struggle to get those warriors in for the care
15 that they needed, and although conveniently
16 located to their homes there was substantial
17 evidence that it might not have been the best
18 place to house them. Now, the Army has just
19 dealt with this in one of its WTUs that is
20 conveniently located but doesn't really provide
21 the broad spectrum of services that are needed.
22 I'm not sure that we're answering the right

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1 question here. The model of CBWTU is not well
2 enough developed in the delivery system to do
3 what we need it to. And so you're coming at it
4 in a number of ways but I think you're -- the
5 broader question that we ought to be
6 approaching is show us some evidence that CBWTU
7 is the right model to use.

8 CO-CHAIR GREEN: Actually, a couple
9 of things on this. I do think that in the
10 wording that there's some things here that
11 would be difficult to basically make happen.
12 So in the first sub-bullet, developing access
13 standards to ensure parity among civilian and
14 military systems. Although that's clearly what
15 is hoped for when you make that transition, I
16 think that you don't have to include that when
17 you say ensure adequacy of civilian health care
18 delivery systems to meet the health care
19 standards. So in other words, before you make
20 the referral, make sure there's adequate care.

21 So if we could just take off the second line
22 it would make it a little cleaner. I don't

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1 know if that's a problem with folks. Okay.

2 And so the -- the second sub-bullet,
3 it really should read access to local care
4 through TRICARE Prime Remote, and instead of
5 saying will be expanded probably "will" is you
6 know, the question is who. If we're making the
7 recommendation it probably should be "should be
8 expanded" to recovering warriors assigned to
9 community-based warrior transition units. And
10 I am not certain I agree with that. I
11 understand the concerns but my guess is that if
12 we want to make it a recommendation to use
13 TRICARE Prime Remote we can do that. And then
14 the rest of it, I'm -- I'm actually okay with I
15 think. Rich, what was the other? There was
16 another couple of areas that you were very
17 uncomfortable with.

18 MG. STONE: The second to the last
19 bullet needs to move from National Guard to
20 reserve components. Should or will, the
21 reserve components. And as we move from access
22 to care in the civilian delivery system we then

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1 throw in this formalize a mechanism to
2 identify, track and reach out to the family
3 members of reserve component warriors. I'm not
4 sure how that fits in with the rest of this
5 access to health care. But clearly if we're
6 going to use the community-based WTU model
7 we're going to have to use a civilian health
8 care system in order to do that which gets us
9 into all of these issues that you know again my
10 primary concern is are we really asking the
11 department the right question and that is is
12 this the right model. We've talked about
13 warriors that are kept with the line and their
14 access. We're going to come to some
15 recommendations on the WTU model. This is a
16 third model, the community-based WTU, that we
17 saw some huge concerns in as we visited them.

18 CO-CHAIR CROCKETT-JONES: I would
19 say that the last bullet probably can be
20 eliminated because I believe it will be covered
21 in later recommendations under communication.

22 CO-CHAIR GREEN: The other thing

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1 that I would -- I'm not sure what we mean by
2 assess how effectively the chain of command
3 will identify. Are we telling them in our
4 recommendation that we want the reserve
5 component chain of command to identify, track
6 and report? And in which case why are we being
7 so passive? Why assess how effectively? Why
8 not say the reserve component chain of command
9 will. So.

10 MSGT MACKENZIE: I concur with that.

11 We were on a warpath of making things more
12 succinct and somehow we missed that so that's
13 probably better.

14 MS. DAILEY: Ladies and gentlemen,
15 they do in fact -- the reserve component has a
16 limited duty process and we did not get into it
17 this year, but when I go into a joint forces
18 headquarters, if I wanted to ask a list of
19 4,000 people who are on -- being case managed
20 were on a line of duty investigation then
21 they'll hand it to me. We didn't -- I didn't
22 ask for it this year, I didn't know to ask for

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1 it, but based on their briefings to us those
2 people who are in the community-based warrior
3 transition units are a very small number of
4 people and those who are being referred based
5 on their follow-up, 90 days, are being tracked
6 and those individuals on a line of duty
7 investigation are being tracked.

8 MG. STONE: So Denise, how do we
9 reconcile that and the fact that there's an LOD
10 tracking system, we've got it, with the
11 frustration we heard from medical NCOs in St.
12 Augustine about the large number of wounded,
13 ill and injured they had from their BCT and the
14 lack of people they had to really case manage
15 and care coordinate for them?

16 MS. DAILEY: That's a correct
17 observation. That was the issue at St.
18 Augustine was that they had this large number
19 of people that they're trying to keep track of
20 that did not go to a WTU and did not go to
21 community-based warrior transition unit.
22 They're -- if you, you know, another

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1 recommendation which we don't -- I wouldn't go
2 down any more recommendations roads. But this
3 is, this recommendation is in my mind one of
4 the things that we assess, we go out and assess
5 how effectively the RC chain of command is
6 identifying, tracking, reporting to Department
7 of Defense. That's one of the reasons we're
8 going to two joint forces headquarters, I think
9 almost three joint forces headquarters this
10 upcoming year. So. And I think this is one of
11 the things Congress wants us to look at.

12 CO-CHAIR GREEN: Because of the
13 number of word changes that have gone in I'm
14 going to table this one for just a little while
15 till we can actually see final. But again, I
16 think that we're close to having consensus that
17 we need to address the unique needs of the
18 reserve component as a recommendation. But
19 we'll table it for right now and go on to
20 number 4.

21 CSM DEJONG: Okay, so the red print
22 is what we kind of reworded it into as a

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1 suggestion. DoD should create standards and
2 provide oversight and guidance for the
3 implementation of the comprehensive recovery
4 plan and comprehensive treatment plan. DoD
5 should clarify which member of the recovery
6 team is responsible for engaging the recovering
7 warrior and family in ensuring they actively
8 participate throughout the entire care plan or
9 treatment plan process. Ensure that the plan
10 is meaningful -- ensure the plan is a
11 meaningful tool that is utilized to foster
12 meaningful dialogue and make a well-planned
13 decision among the recovering warrior's
14 families, caregivers and providers.

15 MG. STONE: A motion to accept.

16 DR. PHILLIPS: Second.

17 CO-CHAIR GREEN: Any further
18 discussion?

19 (No response)

20 CO-CHAIR GREEN: All in favor, raise
21 your right hand.

22 (All in favor)

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1 CO-CHAIR GREEN: Opposed?

2 (No response)

3 CO-CHAIR GREEN: Abstentions?

4 (No response)

5 CO-CHAIR GREEN: Approved. We'll go
6 on to number 5 and number 5 is going to take
7 some explanation. Okay. So in our group when
8 number 5 was one that was a stand-alone so it
9 was not necessarily to be addressed. However,
10 in the transitional DES group when we looked at
11 some of the recommendations that were in ours
12 there were things that tied very clearly back
13 to recommendation 5. And so we, without the
14 consensus of the group, will make some
15 suggestions here in terms of the consolidation
16 of number 5 with number 36 and number 31.

17 So you're going to have to have some
18 time to read through this, but in essence when
19 we combine 36 and 31 with number 5 I'll let you
20 folks read it, but the actual recommendation
21 that we came up with for number 5 is the
22 department should utilize population-based data

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1 to project probable outcomes for servicemembers
2 based on their specific condition. Better
3 information on prognosis and retention allows
4 completion of the IDES earlier and concurrently
5 with the member reaching maximum medical
6 benefit. Ensure that recovering warriors have
7 accurate, consistent and timely information
8 about options for returning to duty across all
9 services. Now, what we are doing with this is
10 essentially tying this into the experience of
11 10 years of war and trying to share that
12 information with the member themselves and
13 their families earlier so they can make
14 decisions on getting into vocational rehab and
15 looking beyond where they are. Because in the
16 past this has been done sequentially. So this
17 is how we've kind of changed the language and
18 then you really need to look at the finding
19 because you'll see how we combined. So I'm
20 going to let you all read the finding as it
21 scrolls up and then we can come back and
22 discuss. So if you'll scroll up just a little

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1 bit.

2 MS. DAILEY: And you all should have
3 all this in front of you now. You have hard
4 copies in front of you. Tab D.

5 CO-CHAIR GREEN: Tab D,
6 recommendation 5.

7 MS. DAILEY: Page 7.

8 CO-CHAIR GREEN: Page 7. So you can
9 see that what we did was we basically combined
10 the findings information and clarified the
11 recommendation. And so back to the
12 recommendation. It was important to read the
13 finding on this one because we did take some of
14 the language that was in the original finding -
15 - I'm sorry, in the original recommendation and
16 put it into the finding in support of what
17 we're proposing.

18 DR. TURNER: One of the things I was
19 going to suggest is if you get back to the
20 original recommendation you -- you talked
21 about, you know, you want to develop the
22 probable outcomes. When I saw the original

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1 recommendation there was actually a call for
2 them to develop standardized protocols. And I
3 would -- there was a -- where ASD and DCoE will
4 develop standardized data-driven protocols.
5 And I was wondering if there was any need to
6 add that from the original because it seems
7 like the new one dropped that out and I would
8 just suggest perhaps we look at putting that
9 back in.

10 CO-CHAIR GREEN: We thought that
11 population-based data, in other words defining
12 a population of amputees for instance, to then
13 bring that experience back to the individual
14 would be -- was the equivalent of having the
15 protocol. So we weren't certain when it said
16 protocol, usually that means a series of steps
17 that gets you to a certain level. So we took
18 that out thinking that we were saying the same
19 thing with the population-based data.

20 DR. TURNER: I guess perhaps when I
21 read it I didn't -- when I read the first one
22 and I read yours I don't get that you're

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1 developing a standard treatment protocol which
2 is what I got from reading the original. Dr.
3 Stone, any comments?

4 MG. STONE: What I'm looking at
5 there is different words than what you have
6 printed here. Because it has protocols for
7 condition-specific recovery care. I've got a
8 different sheet. Okay. I have too many
9 versions here.

10 DR. TURNER: And that's exactly what
11 I was saying. That was with the original and I
12 was --

13 MS. DAILEY: Sir, I need you on your
14 mic, please.

15 DR. TURNER: Oh, sorry. And I was
16 wondering if we could just perhaps re-insert
17 the sentence where ASD and ASDHA and DCoE will
18 develop standardized data-driven protocols for
19 condition-specific recovery care. That to me
20 says something different or adds a little bit
21 to what you guys said, that was in the original
22 that I don't -- I personally don't get out of

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1 the rewrite. Does that make sense?

2 MG. STONE: Yes.

3 MR. REHBEIN: It does and I don't
4 think we intended to drop that out but I think
5 our intention was to take that population-based
6 data and broaden the use. So I don't think
7 putting that back in would be a -- would in any
8 way go against what we were discussing.

9 DR. TURNER: I guess my agenda item
10 on this one is standardized treatment protocols
11 and that's what I would really like to see
12 added to this recommendation.

13 MG. STONE: I think predictability
14 comes from good data. Our frustration is that
15 we have these large populations of patients and
16 there's really been no ongoing effort to
17 capture the data. You know, the Army and the
18 Marine Corps just has large populations. We
19 ought to be able to provide predictability for
20 families and for servicemembers based on this.
21 What you're asking for is the development not
22 of clinical algorithms but of protocols that

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1 get us to a point and that we can predict that.

2 We ought to be able to say there is 10 percent
3 chance you'll be in this group and 90 percent
4 chance you'll be in this group. Here's our
5 decision points and branches that we go down to
6 do that and those algorithms. So I would
7 strongly support doing what you have suggested.

8 CO-CHAIR CROCKETT-JONES: The only
9 other thing I would ask is the new language
10 says to project probable outcomes but I'd like
11 us to project hallmark decision points and
12 outcomes. I want us to be clear that we're not
13 just trying to give people a prediction for a
14 distant future, but a prediction for a
15 transition path. Do you see what I'm saying?
16 So I would like us to include milestones or
17 decision points in front of that as well as the
18 probable outcomes.

19 DR. TURNER: The sentence that we
20 had talked about just over lunch was ASDHA and
21 DCoE will develop standardized data-driven
22 protocols for condition-specific recovery care

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1 including medical decision point treatment
2 milestones and outcome measures. And however
3 you might want to edit that to best fit in. As
4 far as -- I mean the original says ASDHA and
5 DCoE. I would be interested in the group's
6 opinion on actually maybe narrowing down the
7 accountability to ASDHA or do you think the
8 accountability should be in the DCoEs?

9 CO-CHAIR GREEN: I'm really not sure
10 we need to be that specific and so we can just
11 say develop. So, if we take the develop a
12 standardized data-driven protocol for
13 condition-specific recovery care to include
14 medical decision points, related milestones and
15 well-defined outcomes, can you insert that
16 phrase? That still doesn't get you to -- well,
17 I guess it does mention protocols. But can we
18 take that and insert it somewhere in the
19 current recommendation?

20 DR. TURNER: Just like it was in the
21 original.

22 MS. DAILEY: It's in the original.

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1 Would you like it inserted in the second one?

2 CO-CHAIR CROCKETT-JONES: Yes,
3 starting with the word "develop." You've got a
4 lot more than what we've indicated in that copy
5 and paste. I think we just want to go from
6 "develop" to "outcomes."

7 CO-CHAIR GREEN: Just put that right
8 in the front as the recommendation. So put it
9 at the very front of that paragraph. So does
10 that now incorporate?

11 DR. TURNER: It's closer to the
12 original.

13 CO-CHAIR GREEN: Rich?

14 MS. DAILEY: Ladies and gentlemen, I
15 do want to keep your awareness of you're going
16 to have to identify eventually who you think
17 should be tackling these. So some of them have
18 a ASD, OSD, DoD. Is it your intent just to say
19 DoD develop and not? Or versus the services,
20 or versus --

21 DR. TURNER: Well, that's like when
22 I brought up you know should the primary be ASD

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1 or the centers of excellence.

2 CO-CHAIR GREEN: You can say -- when
3 you go broadly you can say ASDHA. Why don't we
4 start off with "ASDHA should develop" and then
5 we kind of end the --

6 DR. TURNER: On them.

7 CO-CHAIR GREEN: Yes. Should
8 develop. And then probably we want to make it,
9 instead of being "a standardized" it should be,
10 take out the "a" and make it "standardized" and
11 make "protocols" plural.

12 MG. STONE: Before we go too far
13 down this road I'm not sure I agree with the
14 basic premise. Our job I think is to inform
15 the Secretary of our findings. I think the
16 Secretary decides who in his organization needs
17 to execute if he accepts the recommendation.
18 By the same token, by limiting this to ASD
19 Health Affairs have we inherently limited the
20 response that might be a better product by
21 engaging another portion that we don't
22 understand who should participate? So I also

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1 am hesitant to be tasking sub-members of
2 organizations when you know I think it's pretty
3 clear who we report to. So.

4 MS. DAILEY: Okay. I'm -- that's --
5 that can be the standard, yes, that you direct
6 everything to Department of Defense and then
7 let them sort it out from there. And that's
8 fine, that's clear guidance.

9 CO-CHAIR GREEN: Yes, I too am more
10 comfortable with that because it could be
11 assigned somewhere else within the department,
12 so.

13 MS. DAILEY: That works. That takes
14 a lot -- that's one whole hour out of Thursday
15 where we were going to try and sort this out
16 versus DoD versus the service versus an OSD
17 office. That's fine.

18 CO-CHAIR GREEN: I think it's still
19 worth the discussion when we get together as we
20 get through other recommendations, but for
21 right now I don't think we need to be worried
22 about that.

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1 MS. DAILEY: Okay, good.

2 CO-CHAIR GREEN: Okay. So, take a
3 look at this recommendation. So I'll just read
4 it again. Develop standardized data-driven
5 protocols for condition-specific recovery care
6 to include medical decision points, related
7 milestones and well-defined outcomes. The
8 department should utilize population-based data
9 to project probable outcomes for servicemembers
10 based on their specific conditions. Better
11 information on prognosis and retention allows
12 completion of the IDES earlier and concurrently
13 with the member reaching maximum medical
14 benefit. Ensure that the recovering warriors
15 have accurate, consistent and timely
16 information about options for return to duty
17 across all services. Now, and the last
18 sentence based on the first sentence, "options
19 for returning to duty" or do we need to make
20 that broader or is that? Or in other words,
21 should it be about options for returning to
22 duty or transitioning?

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1 DR. TURNER: You could simply say
2 "career options" or something like that,
3 broaden it.

4 CO-CHAIR CROCKETT-JONES: I'm
5 inclined to leave it as for returning to duty
6 since that is specifically a difficulty. As
7 opposed to we know that those who are not going
8 to return to duty we are looking for
9 transitions. That has been the standard. The
10 concept of returning to duty after some serious
11 injuries and recovery is what in my opinion is
12 a new factor in recovering warrior care.

13 CO-CHAIR GREEN: The only advantage
14 of including the phrase "or transitioning out
15 of uniform" is to get them thinking about
16 vocational rehab earlier. And so the advantage
17 is that if you really are given the best data
18 available that it's less than 5 percent chance
19 you'll return to duty then it would be very
20 nice for people to be able to get into other
21 types of vocational. So why don't we add after
22 "for returning to duty" the phrase "or

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1 transitioning out of uniform" in front of the
2 comma, please. I'm not sure that's exactly the
3 right words but I think you get the gist. It's
4 important that not only do they know whether
5 they can have a high probability of staying in
6 uniform or staying on duty, or transitioning so
7 that they can think about what they want to do
8 with their future.

9 MS. DAILEY: And this is one that
10 the VA made a comment on as to language that it
11 would not only be across DoD but would be
12 across the VA and including them in the
13 standardized protocol developments. Yes, no?

14 CO-CHAIR GREEN: Yes, I like that
15 even better. So instead of the department
16 then, what would be the right language? VA and
17 DoD?

18 MS. DAILEY: Correct.

19 CO-CHAIR GREEN: So VA and DoD
20 should utilized population-based data, just
21 leave it there.

22 MS. DAILEY: Right.

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1 CO-CHAIR GREEN: All right. So up
2 there in the second line at the end, it says
3 "that department," make it "VA and DoD."

4 DR. PHILLIPS: Can I suggest that
5 they work together on this so they don't
6 develop different protocols? Some language
7 like that?

8 CO-CHAIR GREEN: Yes. I don't
9 disagree because they -- is it just VA/DoD?
10 How do you say VA and? I'm not trying to say
11 they're separate, but.

12 CSM DEJONG: The third sentence in
13 there starting with "Better information allows
14 for" to me that seems like more of a finding
15 than a recommendation. I don't know if we want
16 to shorten recommendation and put that into
17 findings and just leave the recommendation
18 based right on the -- as specific?

19 CO-CHAIR GREEN: Why don't we take
20 that line, "Better information" right up to the
21 period and take it down to the findings and
22 right at the end of "October '11" in the

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1 finding there. So just make it the second
2 sentence in that paragraph under finding.

3 MR. CONSTANTINE: I think if we're
4 going to say the department and VA we should
5 say the Department of Defense because VA is a
6 department also. And similarly, a very small
7 grammatical thing but population-based should
8 have a dash between it.

9 CO-CHAIR GREEN: Yes. And just make
10 it -- yes, right. Just make it DoD and VA.
11 And I'm sorry, the dash should be where?

12 MR. CONSTANTINE: A few words down
13 between population and based.

14 CO-CHAIR GREEN: Yes. VA should
15 utilize population-based data. Okay. So I
16 think that this recommendation is getting
17 close. Do we have a motion? Are we going to
18 table this one? Which way do you want to go?

19 MR. REHBEIN: I'd move we accept.

20 CSM DEJONG: I'll second that.

21 CO-CHAIR GREEN: Any further
22 discussion?

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1 MR. CONSTANTINE: I also wanted to
2 ask can that -- the one sentence we say
3 servicemembers instead of RWs. Is there a
4 reason for that or should we say RWs to be
5 consistent?

6 CO-CHAIR GREEN: RWs is fine, yes.
7 I think we just modified the language that was
8 there, so.

9 LTCOL KEANE: Sir, one minor
10 comment.

11 CO-CHAIR GREEN: Please.

12 LTCOL KEANE: The last sentence,
13 "Information about options for returning to
14 duty or transitioning out of uniform" I would
15 like to suggest "returning to duty and
16 transitioning out of uniform," give them both
17 pieces of the puzzle. They should be aware of
18 both return to duty and as opposed to --

19 CO-CHAIR GREEN: Sure. That's fine.
20 Just on the last line instead of -- between
21 duty and transitioning right there make it
22 "and" instead of "or." Okay. Any further

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1 discussion? We have a motion and a second.
2 All in favor of maintaining -- actually, I
3 should be more specific. This was a
4 combination of 36, 31 and 5 into the new
5 recommendation which is currently labeled as 5.

6 All in favor of using this language for what's
7 now recommendation 5 raise your right hand.

8 (All in favor)

9 CO-CHAIR GREEN: Any opposed?

10 (No response)

11 CO-CHAIR GREEN: And any
12 abstentions?

13 (No response)

14 CO-CHAIR GREEN: Okay. Number 6.
15 Dave, can you take this one?

16 MR. REHBEIN: My apologies.
17 Recommendation number 6 read, "Complete a
18 redesign of the DES. Accomplish this through
19 immediate legislative change." We're
20 suggesting that this be held, that we do some
21 further consideration next year, that we let
22 the DES as it exists now get into full

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1 implementation and spend more time looking at
2 what a major overhaul should be. So our
3 recommendation is to hold off on this and spend
4 some more time on it next year.

5 DR. TURNER: Move to vote.

6 CO-CHAIR CROCKETT-JONES: I believe
7 we can table without voting. Isn't that
8 correct? We can table a recommendation for
9 next year, to more consideration next year
10 without voting on it.

11 MS. DAILEY: Correct.

12 DR. TURNER: Okay.

13 CO-CHAIR GREEN: Okay. So without
14 voting I just need to make certain about the
15 discussion. So is there any objection to
16 essentially pushing this to future deliberation
17 in future sessions? More specifically, to next
18 year's report.

19 MSGT MACKENZIE: I think it's
20 probably appropriate considering we haven't
21 reached full implementation yet and we're
22 already trying to change it.

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1 CO-CHAIR GREEN: That's what our
2 group went to, since we hadn't fully
3 implemented it didn't make sense yet to tackle
4 this one. So, okay, thank you. You'll see
5 mention of that in a recommendation later. So,
6 number 7.

7 MSGT MACKENZIE: Okay. On number 7
8 it was discussed with the group earlier about
9 combining number 7 and number 8. Our
10 discussion group concurred with that and
11 created an adjusted recommendation number 8 to
12 include the combined findings. So, "The Army
13 WTC and the Marine Corps Wounded Warrior
14 Regiment will improve the environment within
15 the transition units to, number one, promote
16 healing within the military setting, and two,
17 provide equal treatment regardless of whether
18 the recovering warrior is combat-wounded, ill
19 or injured. Senior leadership will define
20 official policies on the appropriate unit
21 atmosphere and direct standards for achieving
22 them. The recovering warrior task force

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1 recommends that the transition unit model be
2 adopted as a strategic solution across all
3 services for managing wounded, ill and injured
4 personnel with protracted recovery timelines in
5 an environment focused on healing."

6 CO-CHAIR GREEN: Discussion.

7 MSGT MACKENZIE: I mean, as you can
8 see minus the wording adjustments we just
9 combined 7 and 8 and added in the findings from
10 both 7 and 8 to create the one recommendation.

11 CO-CHAIR GREEN: Can you clarify
12 what you mean in the last sentence, "Transition
13 unit model be adopted as a strategic solution
14 across all services for managing wounded, ill
15 and injured with protracted recovery
16 timelines."

17 MSGT MACKENZIE: That is the wording
18 of recommendation number 7, sir, and you know
19 to speak to that I don't know. I didn't write
20 the recommendation so I'm not certain of the
21 basis behind it.

22 CO-CHAIR GREEN: Can the group that

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1 put that forward talk to that?

2 MS. DAILEY: Well, we picked it out
3 of you all's brains and it was basically
4 designed to talk about support for this model
5 of transition care, all right? And to say
6 generally they're working.

7 CSM DEJONG: I think what's
8 confusing here is we start out with mandating
9 recommendations for Army and Marine Corps
10 specifically and we close it out with "across
11 all services." We need to further specify who
12 we're directing this at.

13 MSGT MACKENZIE: The fact of the
14 matter is the only two units in existence that
15 are affected with this are the Army and Marine
16 Corps. And to add that model to the other
17 services, then you have to end up being more
18 broad because obviously they have to look at
19 where that applies and be able to, you know,
20 extrapolate that information to create a
21 better.

22 CSM DEJONG: No, I understand that.

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1 I'm just -- from the just someone not being
2 involved in all this discussion, just sitting
3 down and reading that I think it's distracting
4 when you first specify and then you broaden.

5 MG. STONE: The way the wounded, ill
6 and injured I think most effectively described
7 this to us was saying "I was moved to a place
8 where my primary mission was to recover. I no
9 longer was in another place." And it was a
10 compelling argument from both their families
11 and their spouses as well as from the wounded,
12 ill and injured. I'm not -- we've got a lot of
13 stuff here and I think that the final sentence
14 really gets at it. Are we really comfortable
15 as a committee by saying that this is the
16 model, this is the only model? I think the
17 Marine Corps would surely non-concur with that
18 because there is certain patients that need a
19 mission criteria that that should be their sole
20 mission. There are others that are best served
21 by being back with the line and being allowed
22 to recover from their wounds or illnesses or

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1 their injuries while still providing additional
2 support to their fellow servicemembers. So
3 this goes beyond where I'm comfortable. It
4 also, although I firmly believe in the role of
5 the Warrior Transition Command and the Wounded
6 Warrior Regiment it just goes further than I'm
7 comfortable with at this point.

8 CO-CHAIR CROCKETT-JONES: Yes, I
9 think the intention as I read it was just to
10 say that that -- not that all wounded warriors,
11 all recovering warriors should be moved into a
12 transition unit, but that the transition unit
13 model should be available even for Air Force
14 and Navy and when it's appropriate. And if
15 that isn't clear in this recommendation then
16 yes, we do need to rewrite it because that's, I
17 believe that's what the intention was and
18 that's where I would be comfortable, not
19 insisting that all recovering warriors have to
20 be in transition units, but that the model
21 should be available to all the services.

22 DR. PHILLIPS: Let me take that one

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1 step further. I had difficulty combining the
2 two because I think the two had different
3 intentions. Recommendation 7 really, as you
4 pointed out, was just -- the model is one of
5 many strategies but perhaps a primary strategy,
6 and that we agreed with that strategy. And
7 number 8 really talks about how the environment
8 and what the transition unit should do to
9 support the recovery. So I had difficulty
10 combining the two.

11 MR. CONSTANTINE: I think for the --
12 as long as we're still talking about it, the
13 first sentence from number 2 we say "Provide
14 equal treatment regardless." I think we have
15 to say what kind of treatment. Is it provide
16 equal medical treatment, equal, you know,
17 whatever treatment because it's kind of vague
18 right now. We also have to account for access,
19 it's not just treatment. So we have to
20 incorporate that as well.

21 CO-CHAIR GREEN: My impression is
22 that finding -- or recommendation number 2,

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1 number 7 and number 8 are related, okay?
2 Whether they should each be separate or if
3 there's enough individual merit to each one of
4 the -- but essentially in number 2 we'd had a
5 long discussion about line units that are
6 keeping recovering warriors. And now in 7 and
7 8 we talk about the model for protracted
8 recovery being the transition unit. And then I
9 think that's 7. And then number 8 I'm having a
10 little more trouble understanding the
11 separateness of number 8 because there we kind
12 of comment on the value of the WTU and the WWR.
13 And so can somebody explain?

14 CO-CHAIR CROCKETT-JONES: There is
15 no new number 8.

16 CO-CHAIR GREEN: Well, the old
17 number 8 I mean. Right. But in the old number
18 8 what were we trying to say with the old
19 number 8 that's different than the WTU being
20 the right way to support protracted recovery?
21 It's just language, I'm trying to understand
22 what was intended. Again, all three of these

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1 are valid, 2, 7 and 8. The 7 and 8 that's now
2 been combined when you read it it basically
3 reads as if all the services need to form WTUs.

4 And so if that's what we're saying then
5 that's, you know, what we need to talk about.
6 But if that's not what we're saying then the
7 question is and how do we define protracted
8 recovery is the other question. Because if
9 you're going to differentiate between who can
10 go into a line unit and who can go into a WTU
11 based on, quote, "protracted recovery," then
12 we're not helping the department very much in
13 terms of standardization.

14 Let me do this a little differently.

15 How about instead of voting on 7 and 8 that we
16 form some small groups and look at 7 and 8 and
17 2. I think there's some -- there's some merit
18 in terms of what we're trying to do here but we
19 haven't quite sorted our thoughts out in terms
20 of how we want to put it to paper. So maybe we
21 can kind of link 2, 7 and 8 for a discussion
22 and perhaps even look at it in smaller groups

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1 and come back again. But right now I'm not --
2 again, I'm not saying there's not merit here,
3 it's just that when we go back and say
4 everybody has to have a WTU we've got to be
5 clear on what we're trying to drive.

6 MSGT MACKENZIE: And I think that
7 might have been wording, using the words
8 "transition unit" versus you know these models,
9 you know. I mean, each model in and of itself
10 like you said has exceptional merit. I don't
11 think we were trying to combine the two to
12 create one model, but these individual models
13 obviously with the other services would be a
14 very valuable resource to working with their
15 long-term recovery folks. So I think that was
16 choice of words that automatically got labeled
17 with the WTU versus you know folks who were in
18 transition or folks who were in long recovery.

19 MG. STONE: I'd support the movement
20 to table and rebuild these. I think that
21 clearly this is at the heart of a lot of
22 discussion. In addition, we have lived in the

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1 Army where we had very broad admission criteria
2 to our WTUs. It's a very expensive model.
3 It's not the right model for every recovering
4 warrior and so I'd like to see a rewrite and
5 I'd support the motion to table and rewrite,
6 bring it back tomorrow.

7 CO-CHAIR GREEN: And the good news
8 is that we're not voting on this. We're only
9 voting on approvals so I think we're okay to
10 say we're going to have this one tabled for
11 right now. Okay. So number 9.
12 Standardization group. Who took this one on?

13 CSM DEJONG: Number 9 is based a lot
14 on cadre selection. And we kind of cleaned it
15 up a little bit for it to say, "DoD leadership
16 should develop selection criteria for
17 transition unit cadre with emphasis on the
18 small group leader who play a pivotal role
19 within these organizations. The approach must
20 address the following: resourcing, allocate
21 resources to create additional cadre positions
22 and remove obstacles preventing these positions

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1 from being filled in a timely manner, continue
2 to develop institutional knowledge and promote
3 continuity of care within a transition unit,
4 recruitment and retention to attract high-
5 caliber transition unit cadre, make them
6 prestigious and career-enhancing opportunities
7 for example to create a branch within the Medic
8 Corps or offer WTU cadre certification
9 promotion points or special skill pay. I do
10 want to do some discussion on this one. And
11 then training, continue to refine the cadre
12 training curricula and make participation
13 mandatory for all cadre members. Ensure parity
14 across Army and Marine Corps programs of
15 instruction.

16 We got into a lot of discussion on
17 this, especially the recruitment and retention.

18 I know that they had -- there was a model that
19 you had talked about, General Stone, that they
20 wanted to be able to bring forward and talk
21 about with the Medical Corps portion on that.

22 LTCOL KEANE: General Stone and I

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1 discussed this morning briefly having possibly
2 a specialty within the Medic Corps in the Army
3 to have the medics be the cadre. The
4 commanding sergeant major didn't agree with
5 that. I don't know if General Stone had any
6 other -- being a soldier had stronger views how
7 the Medic Corps works, if you could have a
8 specialty within the Medic Corps that was a
9 cadre for a few years and then go back to the
10 line unit. Then they'd come back in and you'd
11 have people who are.

12 MG. STONE: I think the complexity
13 of recovery is such that having an additional
14 skill identifier in rehabilitative management
15 is really essential. I think it's very
16 difficult for the line to come in and get the
17 right understanding of the complexity of care
18 recovery. I don't underestimate the skill sets
19 that people bring in in leadership but it's
20 very, very difficult and it takes a long
21 training process for a non-medical management
22 system. Now, even amongst our medics I think

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1 providing additional training to that cadre
2 would be very effective in providing the
3 rehabilitative skills of understanding the
4 complexity of these disease process in these
5 wounds.

6 DR. PHILLIPS: I agree with that.
7 It's just not treatment of a particular injury.

8 It's much broader. And we need -- it's like
9 the difference between emergency room medicine
10 and disaster medicine. You need to have many
11 components involved in the care and treatment
12 of these folks.

13 CSM DEJONG: It's not that I
14 disagree with that. What we're looking at,
15 what we're recommending is a -- is sort of a
16 quick fix on this in filling vacancies. And I
17 think it's a great long-term solution as far as
18 implementing, setting the criteria for a
19 special skill identifier and doing the
20 training. That doesn't help us now try to fill
21 the cadre, the vacancies in the cadre that we
22 have and still meeting the needs of the

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1 soldier.

2 DR. TURNER: I don't see any reason
3 why you can't address both the tactical and
4 strategic needs in the recommendation. I would
5 ask General Stone what his thoughts are. I
6 agree from what I have learned that I believe
7 that recovery management is enough of a skill
8 set that it takes somebody that knows what the
9 heck they're doing to do it. Do you think
10 there -- I would ask the group do you think
11 there is value-added in recommending to all the
12 services that they have an identifier for a
13 recovery management individual?

14 MG. STONE: Yes.

15 CO-CHAIR GREEN: I guess in a way
16 we're saying that. So develop selection
17 criteria for transition unit cadre with
18 emphasis on small group leaders. I mean, we
19 can add into the top line what the criteria,
20 you know, what we want in terms of we have
21 specific criteria. I would try and keep the
22 recommendation fairly crisp and so the second

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1 sub-bullet where you say "for example" with all
2 these different things, that's a great thing to
3 put into the finding, okay, but not necessarily
4 would I put it into the -- just because
5 there's, in each of those there's going to be
6 something that's objectionable to somebody.
7 But I mean, I'm not saying we should take it
8 out, I just think that it's good in the finding
9 to give examples. Because we're not telling
10 them to do special pay or AFSCs or special
11 MOSES or you know, we're saying all of these
12 things could be considered as you try to create
13 prestigious and career-enhancing opportunities
14 for these folks. So I'd probably put that into
15 the findings.

16 And then to address what you folks
17 just talked about, the question is should we be
18 more specific in the lead-in, that first
19 overarching statement in terms of we say
20 develop selection criteria, but are we really
21 talking about beyond selection criteria? Are
22 we talking about job qualifications?

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1 CSM DEJONG: Yes, sir. That's kind
2 of -- in the bullets we addressed more than
3 just selection criteria. So another way of
4 putting that would be, "Leadership should
5 develop the warrior unit cadre with emphasis on
6 small group leaders" or something similar to
7 that.

8 CO-CHAIR GREEN: My worry if we take
9 it to that much of a vanilla statement is that
10 they'll say well, we've already said we have to
11 have recovery coordinators and we have to --
12 you know, and case managers. And so there's,
13 you know, the problem then is what are we
14 trying to drive towards? I mean, I hear what
15 you're saying and I don't disagree, I'm just
16 wondering if we want to be more specific in
17 terms of what we're actually trying to get them
18 to do rather than just identifying positions
19 because seriously, they'll come back and say
20 well we've already established that we have to
21 have case managers and recovery care
22 coordinators. And so I think we're talking a

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1 little bit beyond just identifying the
2 positions.

3 DR. TURNER: I think at least for me
4 a lot of what I saw is they would take other
5 people, and this was like additional duty or
6 they would take something out of other training
7 specialties and say oh, by the way, you're
8 doing this, and they would give them a little
9 spin-up and go. And what I'm hearing is that
10 for retention and recruitment is to give this
11 the prestige of its own MOS AFSC or whatever
12 and let's you know do this right and have
13 someone who's a professional in recovering
14 warrior and transition, that's what I'm
15 hearing. Is that?

16 CO-CHAIR GREEN: So would it be
17 better to say, instead of selection criteria to
18 say "should develop minimum qualifications for
19 transition unit cadre." In other words, you
20 know, so now you have to get them qualified at
21 least to a certain level to do that job.

22 CSM DEJONG: I'm okay with that.

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1 DR. TURNER: Some standardization of
2 training I think is -- yes. Some training
3 standards.

4 CO-CHAIR GREEN: So just substitute
5 for "selection criteria" to "minimum
6 qualifications." And then if you want to go on
7 and talk about -- well, it actually talks to
8 the career development down below though.

9 MS. DAILEY: And they do do that.
10 There's two weeks of training being provided
11 for the Army out at San Antonio in fact. The
12 Marine Corps has a training program also. I
13 thought this recommendation was taking us
14 beyond what's going on now. The observation is
15 it's -- you've got this, but you really need a
16 professional corps of NCOs doing this work.

17 DR. TURNER: And that's what I would
18 support as well.

19 CO-CHAIR GREEN: I'll just point out
20 that it doesn't necessarily say that yet.

21 DR. TURNER: I agree.

22 CO-CHAIR GREEN: So the language, I

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1 mean, develop selection criteria is not getting
2 to what you're saying.

3 DR. TURNER: Could you say developed
4 a profession? And again, I'm just, you know,
5 to sponsor to scheduling would a sentence be
6 develop a professional corps of recovery and
7 transition specialists or something along that
8 line. Or is that too much for these
9 recommendations?

10 DR. LEDERER: General Stone? This
11 is Suzanne Lederer right behind you. This
12 recommendation if I may was really about the
13 small group leaders, the squad leaders within
14 the Army WTUs and the section leaders within
15 the wounded warrior detachments. It was that
16 level of cadre that this one was directed at I
17 believe.

18 MG. STONE: Yes, I think where this
19 came from is we had, in discussion with the
20 cadre at one of the sites they identified
21 amongst their peers a medical NCO who had come
22 down and was mentoring the line NCOs, and they

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1 were all great NCOs but they were talking about
2 the fact that geez, without this one NCO we
3 wouldn't know what we're doing. And they had
4 all been through the training, they had all
5 been through the course, but they identified
6 for us their concern that there may need to be
7 an additional skill identifier at a higher
8 level and was the combat medic NCO a better fit
9 for the cadre. And I think that's where this
10 was going based on that conversation that we
11 had at one of the sites and I don't remember
12 which one it was.

13 MSGT MACKENZIE: I know one of the
14 other discussions that came both from the
15 Marines and Army and through multiple
16 discussions was the lack of recognition for
17 promotability of any of these members that
18 worked for a WTU or Wounded Warrior Regiment or
19 any of that stuff. And every unit we went to
20 other than a select few that did that on their
21 own to try to overcome that hurdle there was no
22 incentive to actually recruit quality people.

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1 Many, many times, especially like at Fort
2 Campbell talking to some of the first
3 sergeants, some of the quality NCOs they
4 thought would be outstanding WTU folks refused
5 to go to WTU because it would actually hurt
6 their accession through the Army, their
7 promotion, their ideals of where their Army
8 career wanted to go and so therefore they could
9 not get these quality NCOs because of that
10 problem. And I know that was another part of
11 this discussion and where that started was
12 fixing that problem.

13 CO-CHAIR GREEN: What if we made the
14 wording in the top group 1 edit to basically
15 read, "Develop minimum qualifications, ongoing
16 training and skill identifiers for transition
17 unit cadre." So by putting all three of those
18 things in and then putting the sub-bullets we -
19 - and then we kind of capture this. So take
20 out the "DoD leadership should" and just make
21 it active. So develop minimum qualifications
22 comma ongoing training, it's up there, and

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1 skill identifiers. And then we leave it to
2 them to decide if it's a corps or a special
3 duty identifier or whatever.

4 LTCOL KEANE: Sir, did you want to
5 add after skill identifiers in recovery and
6 transition? Just in recovery and transition.

7 CO-CHAIR GREEN: Yes, I didn't mean
8 to change that. So before transition unit
9 cadre within -- so you want to add specialty in
10 recovery and transition --

11 DR. TURNER: Specialty identifier in
12 transition.

13 LTCOL KEANE: Specializing in
14 recovery and transition.

15 MSGT MACKENZIE: And once again I
16 ask -- I direct this toward you sirs, are we,
17 by using the words "transition unit" are we
18 simply looking at the Army or is there a
19 specific term, especially because I know the
20 Army uses cadre. Does the Marine Corps
21 actually use cadre? We need to make sure that
22 we clarify so we're getting across the board

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1 there.

2 LTCOL KEANE: I'm looking at it just
3 from the Army perspective. Marine Corps
4 doesn't have medics. Use -- maybe for
5 corpsmen. So I was looking at this from an
6 Army perspective.

7 CO-CHAIR GREEN: It should be for
8 transition unit cadre and now we're talking
9 about whether we want to change the transition
10 unit cadre to something else. So, do we want
11 to change it from transition unit to cadre to
12 for recovering warrior support cadre? I mean,
13 there's -- if you're trying -- the problem is
14 that the transition unit as they're using it is
15 broader than Army or. I mean they could say
16 transition regiment and then it would be
17 Marine. Or you could call it -- or you could,
18 you know, whichever, but I think when we say
19 transition unit we're kind of talking about
20 wherever you have recovering warriors being
21 treated. So the question is is that broad
22 enough language or do we need to broaden the

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1 language? I don't think it's saying Army. I
2 think it would be equally applicable to the
3 Wounded Warrior Regiment on the Marines side.
4 And honestly equally for our wounded warrior
5 tracking that we have on our AI side for the
6 Air Force. I really think that it kind of goes
7 beyond, although it is focused on unit cadre
8 right now. And that's where the finding came
9 from. So I mean it's really focused on the
10 people who are actually in the unit cadre,
11 whether regiment or Army WTU.

12 MR. CONSTANTINE: Why can't we just
13 substitute cadre, whatever cadre means.
14 Support personnel or. We have it as -- because
15 cadre is an Army term.

16 CO-CHAIR GREEN: Are we diffusing
17 this so much so we lose the meaning? This was
18 about squad leaders, right?

19 MSGT MACKENZIE: The original was
20 for both organizations, not just the Army. So
21 that was --

22 LTCOL KEANE: Section leader. But

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1 they're basically the line. We don't have
2 medics.

3 CO-CHAIR CROCKETT-JONES: No, but
4 you have section leaders in the Wounded Warrior
5 Regiment?

6 LTCOL KEANE: We do.

7 CO-CHAIR CROCKETT-JONES: There you
8 go. So let's say for -- well, we're talking
9 about squad leaders and section leaders so why
10 not just say it. Transition criteria, recovery
11 and transition special identifiers. Skill
12 identifiers specializing in recovery and
13 transition for transition section and squad
14 leaders.

15 CO-CHAIR GREEN: For transition unit
16 section and squad leaders. Would that cover it
17 more broadly?

18 CO-CHAIR CROCKETT-JONES: Yes.

19 MR. CONSTANTINE: And does
20 specializing there, are we talking about
21 focusing? I'm just not really familiar with
22 skill identifiers. When we use skill

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1 identifiers what does that mean?

2 LTCOL KEANE: That's the problem I
3 have also. I was looking at this from an Army
4 perspective. I can't see -- a medic in the
5 Army I think is a good fit for the WTU.
6 There's no MOS in the Marine Corps that --
7 unless you're creating a new skill identifier.

8 In the Army I don't think you need to create a
9 new skill identifier, just medic.

10 CSM DEJONG: Looking at the way that
11 this is written right now it's not MOS-
12 specific. It's a skill identifier similar to
13 the drill sergeant skill identifier that you
14 can be selected, request to go, get the
15 training, get the skill identifier. Now you
16 would be a recovery transition specialist.
17 Does that make sense?

18 LTCOL KEANE: That's a great way of
19 putting it, yes. An additional.

20 CO-CHAIR GREEN: A special
21 experience identifier would be kind of the
22 minimum and then you could go beyond that if

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1 you wanted to. But yes, I think we've actually
2 got it pretty well covered with this right now.

3 So which group looked at this? Group 1. Any
4 recommendation on this? Do we table this and
5 come back to it or are we close enough to say
6 yea?

7 CSM DEJONG: Without further
8 discussion I think we're close enough to I'll
9 make a motion to accept as written.

10 DR. PHILLIPS: I'll second that.

11 CO-CHAIR GREEN: Any further
12 discussion?

13 MR. CONSTANTINE: I would just say
14 that we use cadre again in the second bullet
15 point there. We might want to consider.

16 CO-CHAIR GREEN: So, where it says
17 to attract high-caliber transition unit,
18 instead of cadre we'd say section -- are we
19 talking specifically to the section and squad
20 leaders?

21 MR. CONSTANTINE: I think so because
22 that's who we're talking about.

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1 MSGT MACKENZIE: Yes, we're talking
2 about NCOs, officers. Or just NCOs. So it
3 would be NCOs in that realm.

4 CSM DEJONG: We're really focusing
5 on the end user, the squad leader, section
6 leader, the guy that has daily interaction
7 with. That's what this was really focused on.

8 MSGT MACKENZIE: Correct, which are
9 NCOs in any service that would be working with
10 these guys.

11 CSM DEJONG: Correct.

12 MAJ PASEK: Except for in our CBWTUs
13 we don't have squad leaders, we only have
14 platoon sergeants.

15 CO-CHAIR GREEN: And so just make it
16 to attract high-caliber transition unit section
17 and squad leaders. So put -- you need to put
18 "section" in there in front of the "and."

19 MSGT MACKENZIE: Or broaden it up
20 more and just put "leaders." Or NCOs. I mean
21 that's --

22 CO-CHAIR GREEN: The good news is by

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1 not specifying NCO or officer it really depends
2 on who's managing it. I realize the unit
3 section and squad leaders infers NCO but there
4 may be a place where you have an officer that's
5 in charge of this. And so it would be the same
6 question is how do you basically make sure
7 you're hiring the right people.

8 MSGT MACKENZIE: I think personnel
9 would work right in there perfectly. To
10 attract high-caliber personnel make them
11 prestigious and career-enhancing opportunities.

12 CO-CHAIR GREEN: Okay. That's
13 simpler.

14 MS. DAILEY: So we're taking out
15 section and squad leaders and just using the
16 word personnel?

17 CO-CHAIR GREEN: Yes. On the sub-
18 bullet only down below. To attract high-
19 caliber personnel and take out that.

20 MR. CONSTANTINE: Is it significant,
21 just as a -- the comment from the back, that in
22 the CBWTUs they are platoon sergeants? Does

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1 that affect this?

2 MSGT MACKENZIE: So we go back to
3 the original comment when we had the WTC brief
4 and we talked with Brigadier General Williams.

5 Was the fact that the corps of people working
6 with recovering warriors, it was not a
7 promotable situation. It was not a promotable
8 position unless craftily written or additional
9 accolades provided at the local unit.
10 Otherwise it did not rate anywhere within the
11 promotion chain of any service. And so that
12 was, I think that's what started us down this
13 path to go are we really giving enough credit
14 where credit is due to these people who by far
15 are taking on a very honorable mission.

16 So that's the focus, but how do we
17 inter-service word that to cover the broad
18 spectrum. Because when this happens and if
19 this becomes effective I'll tell you right now
20 within Special Operations Command I'm going to
21 have sailors, I'm going to have airmen who are
22 doing the same thing. I'm doing the same exact

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1 thing and if we word it to focus -- the impact
2 has to be focused not necessarily -- the
3 personnel has to be broadened enough so that
4 all servicemembers or military members that are
5 working hands-on with these recovering warriors
6 are getting the credit where credit is due. I
7 don't know properly how to word that, but
8 that's -- that is the impact of what we're
9 doing.

10 CO-CHAIR GREEN: I think we're all
11 thinking the same things, Mac. I guess the
12 question is is there somebody we're excluding
13 in the wording we've got up there now. Or have
14 we made it broad enough to capture everybody?

15 MR. CONSTANTINE: I think we need to
16 take -- on the top one I think we need to take
17 out section and squad leaders and say personnel
18 because that encapsulates everyone. And right
19 after that comment we say with emphasis on the
20 small group leaders. So that means squad and
21 the section leaders.

22 CSM DEJONG: I'd like to leave the

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1 motion on the table. I think we need to just
2 read through this from start to finish because
3 we've added our little pieces and just kind of
4 clean up a little bit of wording. Once we
5 change that to personnel. I still want to
6 leave the motion to accept but I want to
7 change. I think the word "criteria" isn't
8 needed in there. I think it's just kind of an
9 extra word that. So if we can change the
10 "section and squad leaders" to "personnel" and
11 then just kind of give it a once-over and do
12 some refinement.

13 MR. CONSTANTINE: As far as that
14 goes, the second bullet, I think it should say
15 "to attract high-caliber transition unit
16 personnel make the positions" and we say them
17 and that makes it sound like we're referring
18 back to personnel. Make the positions
19 prestigious.

20 CSM DEJONG: Yes, let's read it.
21 And then bullet number 1, we still have the
22 word cadre. If we're going to get that

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1 specific we can go bullet number 1 into unit
2 personnel. Then just for a once-over, you
3 know, develop minimum --

4 MR. REHBEIN: There's another cadre
5 in bullet number 3.

6 CSM DEJONG: So to continue, okay
7 develop minimum qualifications, ongoing
8 training and skill identifiers specializing in
9 recovery and transition for transition unit
10 personnel with emphasis on small group leaders
11 who play a pivotal role in these organizations.

12 The approach must address the following.

13 CO-CHAIR GREEN: All in favor,
14 current wording, raise your hand.

15 (Hands were raised)

16 CO-CHAIR GREEN: Opposed?

17 (Two opposed)

18 CO-CHAIR GREEN: Okay. We have two
19 opposed. Any further discussion?

20 MR. CONSTANTINE: I'm only opposed
21 because we still have cadre in there.

22 CO-CHAIR GREEN: Where is that?

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1 MR. CONSTANTINE: In the first
2 bullet. It's right after "personnel."

3 CO-CHAIR GREEN: Okay. Any other
4 changes? I think we have a motion on the floor
5 so I think we're still caught trying to vote on
6 this one. So in favor of this one raise your
7 right hand.

8 (Hands were raised)

9 CO-CHAIR GREEN: Opposed?

10 (Hands were raised)

11 CO-CHAIR GREEN: And abstentions?

12 (No response)

13 CO-CHAIR GREEN: And this one's
14 good. Okay. I think it's time for a 10-minute
15 break, that's what I was going to suggest.
16 Good. Thanks.

17 (Whereupon, the above-entitled
18 matter went off the record at 4:06 p.m. and
19 resumed at 4:19 p.m.)

20 CO-CHAIR GREEN: All right, I
21 believe we're on number 10. And so
22 standardization group is up again.

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1 CSM DEJONG: I know this
2 recommendation seems pretty straightforward but
3 if you looked at some of the criteria that went
4 into changing this recommendation to the
5 sentence that it is which I'll read. The
6 sentence is, "Services should enforce the
7 implementation and knowledge of existing policy
8 guidance regarding transition unit entrance
9 criteria." So with that I'm looking at the
10 findings and looking at the response that we
11 got back from the Army. I'm trying to find it
12 right now. Both the Army and the Marine Corps
13 have existing op orders, regimental orders in
14 existence. What those numbers are I'm not
15 going to try to -- it's in here somewhere. So
16 as we read through the findings it's obviously
17 not being implemented in accordance with either
18 one of those orders. So this is just kind of
19 trying to say here's the findings that we have
20 and here's our recommendation that from a
21 Department of the Army, Department of the
22 Marine Corps level you need to go in and you

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1 need to enforce the implementation and
2 knowledge of these policies down to the end
3 user.

4 DR. PHILLIPS: I just might add from
5 the original recommendation the Marine Corps
6 response was non-compliant. They did not agree
7 with it.

8 LTCOL KEANE: It wasn't that they
9 non-complied, it was that they -- no, on page
10 10, "We concur with recommendation 10 with the
11 following edit as indicated on track changes."
12 When asked how Marines are assigned to their
13 Wounded Warrior Regiment, for example, the
14 Wounded Warrior Regiment replied that they are
15 assigned by battalion commanders on a case-by-
16 case basis. This is the addition. Based upon
17 criteria established in the Wounded Warrior
18 Regiment policy and they title it Acceptance of
19 Wounds, Ill and Injured Personnel to the
20 Wounded Warrior Regiment, Wounded Warrior
21 Regimental Order 6300.1. Just they added that
22 for clarity. They concurred, just wanted to

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1 add that for clarity.

2 DR. PHILLIPS: Sorry, I
3 misremembered.

4 MR. REHBEIN: This may seem like a
5 small thing but is it possible to enforce
6 knowledge? Isn't really just implementation
7 what we're interested in here?

8 DR. PHILLIPS: I think the issue
9 was, and again, this is not totally giving my
10 opinion. The issue was that the designation as
11 to whether or not a soldier goes into -- a
12 Marine goes into a unit was individualized and
13 based on the commander's opinion. And in our
14 review at least at Twentynine Palms this did
15 not seem to be a very good criteria. And so I
16 think we were driving at trying to have them
17 adhere to some other standard rather than have
18 a commander or whatever, first sergeant, make
19 that decision. More on medical need.

20 MR. CONSTANTINE: That's different
21 than what we're talking about here. We're
22 talking about, again, it seems like you're

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1 getting back to saying someone in the medical
2 field should make that determination and maybe
3 you don't agree with the policy of a commander
4 making that determination. This is saying
5 whatever that policy is, if it's a commander
6 making the determination that's done
7 consistently and everyone needs to have
8 knowledge of that policy.

9 CO-CHAIR GREEN: You know, I'm
10 struggling because I'm trying to sort out the
11 differences between 2, 7, 8 and 10 right now.
12 And so we're really coming up on the same
13 arguments each time with each of these because
14 it's really about are you in, are you out and
15 once you're out how do you get services of
16 those who are in. And so my recommendation as
17 simple as this one is, I think we should tie it
18 into the 2/7/8/10 discussion. Because once we
19 get the wording right this is going to be very
20 clear in terms of are you in, are you out. If
21 you're out how do you get the services as if
22 you were in. And we kind of need to get it to

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1 where it's that simple because we're struggling
2 with it. It'd be nice if we could figure out
3 how to make others not struggle with it.

4 CSM DEJONG: That actually might
5 help solidify 2, 7 and 8 because now we're
6 looking at op orders and regimental orders that
7 are already in existence to further facilitate
8 writing those recommendations. So I concur.

9 DR. PHILLIPS: I agree.

10 CO-CHAIR GREEN: Let's table this
11 one for right now and make that kind of a
12 combined discussion. I really do think it's
13 going to come into are you in, are you out. If
14 you're out how do you get the services as if
15 you were in. And are we going to try and pick
16 one as kind of the model. I'm not sure.
17 Number 11. Did we already -- we already voted
18 on that one too. So, that's right, we don't
19 have to vote on delayed. So that one's one
20 we're going to take into next year. Okay, got
21 it. Number 12.

22 MSGT MACKENZIE: Okay, we took a

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1 look at number 12 and felt that that was -- we
2 did not have enough information to even make
3 that a recommendation at this time, that that
4 is a very -- that is a very large thing that
5 we're asking in this recommendation and we're
6 not certain that we've really approached that
7 subject appropriately to even make it a
8 recommendation this year. So it may be
9 something that we want to look at next year,
10 but the -- I balk at the idea of once again
11 trying to force separate services into a
12 combined unified approach and once again around
13 medical treatment facilities. I mean there's
14 still, as I stated in our group, there is still
15 a sense of pride amongst the individual
16 services and you know how do you manage, if
17 you've got a quad of four servicemembers from
18 different branches of service how do you manage
19 that under one umbrella when each service has
20 their own unique thing. So I recommended that
21 we table that for -- we recommended that we
22 table that for something to look at next year,

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1 on next year's deal.

2 MG. STONE: I would speak against
3 tabling and suggest that we just plain
4 disapprove and get rid of this one. I'm not
5 sure we even need to come back to this one. I
6 think once we see some evidence-based responses
7 some of this will become clearer as we begin to
8 see some data come forward. So I would speak
9 against tabling and suggest that we just vote
10 this one down.

11 DR. PHILLIPS: Second.

12 CO-CHAIR GREEN: All in favor of
13 deleting this recommendation raise your right
14 hand.

15 (All in favor)

16 CO-CHAIR GREEN: Opposed?

17 (No response)

18 CO-CHAIR GREEN: Abstentions? Oh,
19 so you're opposed? Oh, okay. All right. So
20 was there anyone against deleting this one?

21 (No response)

22 CO-CHAIR GREEN: And were there any

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1 abstentions?

2 (No response)

3 CO-CHAIR GREEN: Okay, thank you.

4 Number 13. Standardization.

5 CSM DEJONG: This one's going to
6 need a lot of discussion. We looked at editing
7 it again but we're trying to -- we're throwing
8 a lot of different things together. So I'll
9 just go through what we tried to make it into.

10 "Ensure all recovering warriors have prompt
11 access to PTSD care" -- we've got to decide
12 whether we're going to go with PTSD or PTS
13 based off of what medical terminology you want
14 to follow on that -- "including those who are
15 not critical, high-risk and reserve components
16 who have been released from active duty.
17 Leverage alternative behavioral health
18 modalities such as group counseling, military
19 family life counselors in a given hour.
20 Additional resources should include approved
21 civilian health care providers. TRICARE policy
22 must also adapt to medical needs versus

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1 administrative requirements." Basically the
2 TRICARE piece, what we found through the
3 findings is you've got soldiers now that aren't
4 really truly being diagnosed with PTS for maybe
5 a year, year and a half after. You're on
6 active duty, that's okay, you're covered. Now
7 you take the reserve component and you throw it
8 into there, if a soldier that's been released
9 from active duty for a 12-month or 16-month
10 period is now diagnosed with PTS or PTSD and
11 how are we going to ensure them the adequate
12 care and the adequate coverage to afford that
13 care?

14 MG. STONE: What you're trying to do
15 with a lot of words is to say something fairly
16 simple and that is that the Department of
17 Defense and the VA must ensure access to PTSD
18 care across the continuum of service.

19 CO-CHAIR GREEN: Yes, I kind of
20 agree with Rich. I think that if we went to
21 something that simple then the rest of the
22 discussion that's there becomes part of the

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1 finding because we can identify those things
2 where we've seen instances where there was gaps
3 in coverage, et cetera. And so, Rich, can I
4 ask if you could just give them that language?

5 MS. DAILEY: And let me -- before we
6 get there on that one let me just interject
7 what I thought part of the intent of this was,
8 which was there seemed to be care for acute
9 cases out there but even the finding in the
10 quote in here talks about care when you're not
11 acute. Six-eight weeks for getting an
12 appointment for someone who's not acute, and it
13 was talked about in our point panel, our
14 counterpoint panel. If you're not in crisis
15 you're not getting care for your PTSD.

16 MG. STONE: The Army has
17 specifically added hundreds of providers with
18 very little reduction in chronic care follow-
19 up. You are exactly correct that standards
20 across our delivery system are that you can get
21 in pretty quickly if you're in crisis or for a
22 first patient visit, but the ability to get in

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1 for follow-up care and non-crisis intervention
2 can take a number of weeks. In spite of adding
3 more than 700 providers we haven't been able to
4 bring that number down. Now if you want to
5 capture that in this that's something different
6 than late-arising PTSD when soldiers are in
7 different statuses outside their TANT benefit.

8 I thought that this was going towards really
9 the continuum of service argument that PTSD is
10 just a disease process that doesn't fit into
11 the standard orders concepts of am I on active
12 duty, am I on a TANT benefit status of 180 days
13 post demobilization. And then when I fall out
14 of that 180 days I just don't have access to
15 care if I'm a reserve component soldier.

16 CSM DEJONG: Yes, sir, that's the
17 approach we took to this recommendation also.

18 DR. PHILLIPS: And we specifically,
19 and it may not be appropriate, left TRICARE in
20 there because that was addressed in the
21 original recommendation. And we viewed part of
22 the problem being the administration of TRICARE

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1 based on the appointment availability and
2 perhaps reimbursement as opposed to medical
3 need. So that's why we switched that around.

4 CO-CHAIR GREEN: So, help me
5 understand the issue here. So when I've heard
6 this talked about from a reserve component
7 standpoint typically the question is about
8 whether or not they have the same access as
9 dependents do -- or as family members do to the
10 eight visits that basically don't require any
11 type of referral, et cetera, et cetera. And so
12 there's been a lot of folks who pushed to
13 essentially let our reserve component have the
14 same benefit in essence as do family members
15 for mental health care. We're obviously
16 talking PTSD and so I'm not trying to
17 generalize this, but the other question I have
18 is do we want to be more specific in terms of
19 our recommendation. Right now we're saying
20 they should have PTSD care across the
21 continuum, but if we're specifically gearing
22 this towards reservists in particular do we

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1 want to actually speak to a benefit change?

2 CSM DEJONG: I think one of the past
3 recommendations was making -- and maybe it's
4 coming up -- is ensuring that the reserve
5 components also have the exact, you know, same
6 level of care as our active counterparts. So
7 if we can capture that continuum of care in a
8 recommendation of reserve components being,
9 once they're re-fretted are not still having
10 the same level of care as active components.
11 We've captured that part and then we could
12 probably take this recommendation more focused
13 on the PTSD itself.

14 CO-CHAIR CROCKETT-JONES: Yes, I
15 really don't want us to lose sight of the
16 ability for someone who is not in crisis to get
17 seen in a fairly timely manner. I think one of
18 the concerns that we heard implied in the focus
19 groups was that you're basically encouraged to
20 get into crisis in order to be seen, or you're
21 allowed to go untreated and unhelped until it
22 is a crisis. That does not seem like the best

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1 method of treatment. I don't want us to lose
2 sight of that as being, according to the
3 finding, the motivator for this recommendation.
4

5 MS. DAILEY: As much as I hate to
6 add a recommendation we can split this up. We
7 can talk about a recommendation for currently
8 serving, whether they're Guard or Reserve who
9 are not in crisis and need services for PTSD.
10 And then you can break it up into across the
11 continuum of care. After they've left.

12 CO-CHAIR GREEN: You can also do it
13 as sub-bullets. I mean, this is broad enough
14 when you say, "DoD and VA must ensure access to
15 PTSD care across the continuum of service" you
16 can make your, you know, the second line saying
17 that not just emergent services but routine
18 care to avoid you know, to avoid crisis. And
19 then the other part of this is if we think that
20 there's a problem, if we think. I should
21 recognize that there is a problem on the
22 reserve component then basically then also add

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1 something about reserve component access to
2 mental health, you know. And we can be as
3 specific as we want to be in terms of what we,
4 you know, what we'd like to see.

5 CSM DEJONG: Do you just want to
6 table this one for further discussion and
7 rewrite or do you think we can get it done?
8 Okay.

9 DR. PHILLIPS: I would recommend
10 taking out the TRICARE. I'm not sure that adds
11 anything. It's assumed.

12 CO-CHAIR GREEN: I think you can say
13 just policy. You don't have to say TRICARE
14 because TRICARE is going to infer the private
15 sector, the health plan, whereas this also
16 affects direct care systems. So in essence
17 what we're saying is DoD and VA must ensure
18 access to PTSD care across the continuum of
19 service, okay. Routine care to -- must be
20 included. Yes. Or availability of routine
21 care. Must be included to. Because we have
22 emergent services so it's not just -- it really

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1 needs to be on the availability of routine
2 care. Routine care must be timely to avoid
3 crises, right.

4 MR. CONSTANTINE: When we talk about
5 routine care does that mean when someone calls
6 and says I'd like to come see somebody is that
7 routine care?

8 CO-CHAIR GREEN: So I'm having
9 trouble sleeping, and I'm having some
10 difficulties with my family and so, you know,
11 timely care would, you know. So our usual
12 criteria for a routine appointment is seven
13 days, right? So right now it can take up to 60
14 days in some areas which is the problem. So
15 routine care must be timely to avoid crisis. I
16 think that's a simple addition. And then
17 reserve component access to mental health care
18 should be commensurate with active duty? Is
19 that what we're saying?

20 CSM DEJONG: We're looking at number
21 14. It's going to throw a whole 'nother issue
22 into this. Because that gets into NGB and NGB

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1 psychological health program and who should be
2 funding it. So with one recommendation we're
3 asking for reserve component care to be equal
4 to active component care. Then I think we
5 should stick with that and move forward with it
6 and then we'll talk about 14.

7 MG. STONE: Continuum of service
8 implies regardless of what your order status
9 is. Right? But you know, if you just added,
10 "DoD and VA must ensure timely access to PTSD
11 care across the continuum of service" period
12 you've taken care of one of the bullets below.

13 MR. CONSTANTINE: If you add ensure
14 timely access then you take out the other
15 bullet.

16 MG. STONE: Right.

17 CO-CHAIR CROCKETT-JONES: So if you
18 put "timely" between "ensure" and "access?"

19 MG. STONE: One of the reasons we
20 use the term "continuum of service" is we've
21 got multiple order statuses across, especially
22 in the National Guard, between Title 32 and

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1 Title 10 statuses it can be very confusing and
2 block access to care.

3 CO-CHAIR GREEN: Okay, so Denise it
4 should say, "DoD and VA must ensure timely
5 access to" and in front of "PTSD" put "routine"
6 -- "across a continuum of service to avoid the
7 development of crises." To avoid crisis
8 intervention. That's the way to do it. To
9 avoid crisis intervention.

10 CO-CHAIR CROCKETT-JONES: Routine
11 was correct.

12 CO-CHAIR GREEN: Yes. Routine PTSD.
13 And at the end of the sentence to avoid crisis
14 intervention.

15 MR. CONSTANTINE: Is it really
16 crisis intervention we're avoiding? We're
17 avoiding crises.

18 CO-CHAIR GREEN: To avoid crises,
19 okay.

20 DR. LEDERER: Excuse me, when we say
21 continuum of service are we talking about
22 services as in counseling or are we talking

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1 about military statuses?

2 CO-CHAIR GREEN: Should be a capital
3 S on service. Right.

4 MG. STONE: The other way to say
5 that, Suzanne, is you could say across all
6 military statuses would be another way. I
7 think those of us in uniform understand the
8 concept of continuum of service.

9 CO-CHAIR GREEN: If you just
10 capitalize the S on service it's fine. Then we
11 can eliminate the other two lines.

12 MR. DRACH: Can you have an
13 exacerbation of a condition before it becomes a
14 crisis? So should that say to avoid
15 exacerbation of the condition and/or crisis?

16 CO-CHAIR GREEN: So then the other
17 two -- so the other two lines can actually be
18 deleted. All right so that becomes the
19 recommendation. "DoD and VA must ensure timely
20 access to routine PTSD care across the
21 continuum of Service to avoid exacerbation and
22 crises." Is that a reasonable recommendation?

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1 Any other wordsmithing?

2 DR. PHILLIPS: Just sort of a
3 clarification. I've been hearing more and more
4 PTS rather than PTSD. Is there any preference?

5 MG. STONE: I think all of us that
6 have served in combat have post-traumatic
7 stress. The question is does it become a
8 disorder or not. I need therapy when it
9 becomes a disorder. I need to de-conflict
10 issues when it's just simply stress and you
11 know, lots of different venues that you don't
12 need professional help for in order to handle
13 that stress and reintegrate into society. At
14 the point it becomes a disorder we need
15 professional assistance beyond our own units
16 and families.

17 CO-CHAIR GREEN: And PTS is
18 relatively universal so I think by going to the
19 disorder we're at least making something that's
20 probably doable here.

21 MR. DRACH: I'm not sure if I heard
22 the comments correctly. Are we suggesting to

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1 drop the D? Oh, okay. Thank you.

2 DR. PHILLIPS: I was just asking
3 because I hear these terms interchangeable.

4 CO-CHAIR GREEN: So folks, if we're
5 comfortable with this as a recommendation I
6 need to have a motion from the floor.

7 DR. PHILLIPS: So moved.

8 CSM DEJONG: Second.

9 CO-CHAIR GREEN: And so all in favor
10 of this recommendation for 13, this language
11 for recommendation 13, right hand this time.

12 (All in favor)

13 CO-CHAIR GREEN: All opposed?

14 (No response)

15 CO-CHAIR GREEN: Any abstentions?

16 (No response)

17 CO-CHAIR GREEN: We're good. Okay.

18 Number 14.

19 MSGT MACKENZIE: Okay, on number 14
20 obviously there's an error in the -- it should
21 be reserve component or should it be National
22 Guard Bureau? I'm really not certain, once

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1 again I fall back on the fact that I'm an
2 active duty guy, but I'll go ahead and read it
3 as we've got it written. "The National Guard
4 Bureau will fully fund the NGB Psychological
5 Health Program to ensure that each state and
6 territory has sufficient behavioral health
7 assets to provide timely professional
8 assessment and referral for all recovering
9 reservists. NGB should pursue legislative
10 support if necessary." We found the
11 recommendation as it was written and as much
12 information as we had being correct. We just
13 simply adjusted the "should" to "will" to make
14 it more direct or give more punch.

15 MR. CONSTANTINE: I think we have to
16 have some language instead of recovering
17 reservist.

18 MSGT MACKENZIE: Right.

19 MR. CONSTANTINE: Because we're
20 talking about reservists who are suffering and
21 we have to describe that. It could be anything
22 right now.

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1 DR. PHILLIPS: The question I have
2 is should we have NGB pursuing legislative
3 support for what might be an unfunded mandate.

4 I mean, should this be done by some other
5 authority to ensure that they are properly
6 funded? If you follow my.

7 MR. CONSTANTINE: I understand what
8 you're saying. But I just remember now that
9 when we were going through 13 and commander
10 sergeant major said wait till we get to 14 and
11 now I see why, because we said reservists will
12 have the same access as active duty folks. And
13 if that's true then why does NGB have to fund
14 anything?

15 LTCOL KEANE: They already have it.
16 The program is in existence, right? They want
17 to just continue it --

18 CSM DEJONG: I believe the program
19 is in existence and I'm really not that read in
20 on what the program is but if they're going to
21 -- looking through the findings, mandated in
22 all 54 states and territories, make a directive

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1 for psychological health by contracted licensed
2 providers whose mission is to advocate to
3 support. I guess you could look at that as
4 just one step in helping diagnose the problem
5 at the state level and then leading into the
6 continuum of care once they -- once that
7 medical professional does determine that.

8 MSGT MACKENZIE: And this finding,
9 or this recommendation was brought up based on
10 NGB actually briefing us on the inadequate
11 resources and large geographic expanses to
12 cover. And I think they kind of came to us as
13 a task force to -- about a recommendation upon
14 -- higher to back this up.

15 MG. STONE: The National Guard has a
16 little over 450 behavioral health professionals
17 of various types distributed across the states
18 and territories. The Army Reserve has three,
19 mainly based on funding differences. Now,
20 clearly the reserve components need an
21 effective population health screening program
22 which this ties to get at. Now, just to

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1 belabor this discussion a bit, there is very
2 little evidence that population screening
3 through the touch points across the Army Force
4 generation systems have true value to improving
5 population health and that's additional
6 research that has to be done in the future.
7 Regardless, the Congress has mandated a number
8 of touch points across the generating cycles
9 that we have for the Army.

10 So my suggestion is, number one, we
11 need to change this to the reserve components
12 will fully develop a psychological health
13 program to ensure that each state and territory
14 has sufficient behavioral health assets to
15 provide timely professional assessment and
16 referral for all recovering reservists. The
17 reserve component should pursue adequate
18 funding and legislative support if necessary.

19 CO-CHAIR GREEN: The other problem
20 with this one and so now I'm in my other hat
21 when I'm not here with you folks I have argued
22 fairly strenuously against these directors of

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1 psychological health, not because I don't
2 believe that our Guard and reservists need the
3 mental health support, but I'm -- we're having
4 enough trouble in terms of all the contract
5 fails and now the additional mental health
6 that's been added to put a director of
7 psychological health, presuming that that's
8 going to be a psychologist or a social worker,
9 nurse practitioner, who's basically in a
10 position that they're not treating the
11 patients. The problem is the director of
12 psychological health as it's defined is
13 basically an advisor to the wing. And so
14 almost what we would call airmen and family
15 readiness support or family support. And so
16 the way they've done the directors of
17 psychological health in essence they're going
18 to be pulling people and pinning them salaries
19 as if they were credentialed therapists when in
20 reality they're not seeing patients which is
21 problematic to me because there's already a
22 shortage and so I really don't want to see us

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1 take mental health assets out of the pool if
2 you will. And because the National Guard bases
3 tend to be fairly locale-specific, I'll use the
4 wings, unlike the Reserves where you may have
5 people from all over the country who come to a
6 particular unit, particularly with the Guard
7 bases that means you're probably pulling
8 somebody out of the community that you're going
9 to put on a contract to essentially be an
10 advisor to the wing leadership. And obviously
11 do work and help with individual cases, but not
12 seeing patients every day. And so I had some
13 problem with this and proposed at least on the
14 Air Force side that we as an active duty really
15 owed some follow-up here. And so in terms of
16 be an advisor we were looking at regional
17 psychological health advisors for the wings
18 versus having an individual director of
19 psychological health at every site.

20 So just my two cents in this is that
21 there's some problems in terms of what's being
22 proposed here and this is very specific in

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1 terms of the recommendation to essentially
2 direct someone to pay for a director of
3 psychological health who may not be providing
4 psychological health. So just a caveat from me
5 on this, not that I'm not supportive of our
6 Guard and Reserve having the same access to
7 mental health. It's just that I'm not certain
8 that this particular initiative gets us there.

9 So just devil's advocate if you will.

10 CO-CHAIR CROCKETT-JONES: So I'm
11 trying to understand if the original intent of
12 this recommendation was about the reserve
13 component. It was not? It was National Guard.

14
15 CO-CHAIR GREEN: Right, it's one of
16 two.

17 CO-CHAIR CROCKETT-JONES: Yes, I was
18 just trying to understand General Stone's
19 comments regarding there being providers for
20 National Guard and less for reservists.

21 CO-CHAIR GREEN: But the reason --
22 again, it depends on how they're using the

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1 people. So they may have them on their books
2 for deployment purposes but when they do their
3 UTA weekends and those kind of things they're
4 not actually treating or providing counseling
5 if they're in the Reserves or in the Guard. So
6 that's part of the problem is if you put them
7 into the Guard you think well, when you come to
8 a UTA weekend you could do that, but they're
9 not distributed in a way that that works.

10 MG. STONE: So the individuals that
11 are -- this is a population screening effort.
12 So during the annual periodic health assessment
13 when referrals are made for behavioral health
14 follow-up who manages that? There is no system
15 to manage that today unless you're in an active
16 status. If you're a reserve component, a
17 Guardsmen or an Army Reserve soldier or Air
18 Guard there's no system in place to provide
19 assurance that that servicemember gets in for
20 care and follow-up. What this effort is is to
21 provide that type of structure. And that's
22 where the Guard when they gave testimony to us

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1 said look, we're not funded well enough to get
2 this up and running.

3 CO-CHAIR GREEN: But to add to that,
4 my concern is are they hiring the right people.

5 So if you need a case manager that can get
6 them to see a psychologist aren't you better
7 off to have the psychologist in the community
8 and the case manager working your psychological
9 health to get the referral to the person who's
10 actually seeing patients? Because these folks
11 won't be providing treatment. So it's kind of
12 an interesting dynamic that the way they've
13 gone on this is not necessarily to provide
14 mental health. What -- the director of
15 psychological health does not equate to them
16 having somebody who's going to provide
17 psychological treatment.

18 CO-CHAIR CROCKETT-JONES: Okay. It
19 sounds to me like the recommendation doesn't
20 address the intent that we think it -- the
21 outcome, doesn't get us to the outcome. Is
22 that what I'm hearing you all say, that it may

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1 not -- that this recommendation may not get us
2 to the outcome of increasing care and therapy
3 to folks who need it and follow-up? Is that
4 the concern? If that's the case then perhaps
5 this recommendation needs lots more work, or it
6 needs to be a different recommendation than
7 this.

8 CO-CHAIR GREEN: It's the reason why
9 I asked the question on the last one. When
10 we're talking about trying to get the same
11 access to mental health care as active duty
12 that I guess the question is are we trying to
13 solve a screening problem with these directors
14 of psychological health, and so somebody who's
15 going to look at the surveys, but I don't think
16 we need that. Are we trying to find a way to
17 give psychological health to the Reserves? I
18 think that this particular effort does not
19 necessarily provide that. And so although it
20 gives someone who can -- who knows the
21 community and may be able to help, the other
22 question if we really feel that there's not

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1 enough access to mental health, again, I'm back
2 to my recommendation would be to essentially
3 give them the same benefit to go after
4 legislative relief to give them the same
5 benefit as what our family members have and
6 give them a mental health benefit for eight
7 visits unfettered if they need to seek help.
8 Because now they could actually go see a mental
9 health and get a referral from that mental
10 health person back into the system if they've
11 got a more serious problem. But that's my
12 concern on this one is I think that the funding
13 on this by the way is millions of dollars,
14 okay? I'm not sure it's quite -- well, if we
15 include the Army. Just for the Air Force it
16 was nearly \$10 million annually. And so it's
17 about a \$50 to \$70 to \$80 million over the
18 five-year cycle. And the question was how much
19 mental health is really going to be provided
20 for that, and before you spend the money why
21 don't you think about actually getting
22 something that's going to do the care.

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1 MG. STONE: Okay, so in the previous
2 recommendation we had said look, there needs to
3 be access to care. This is something entirely
4 different. This is about the fact that if I
5 have a half a million people annually going
6 through periodic health assessments we're
7 generating thousands of referrals for follow-up
8 and right now it is on the commander in order
9 to really assure that follow-up. The commander
10 has no assets to do that with. This is about
11 providing the commander the tool to manage this
12 so that if I go through my periodic health
13 assessment and somebody decide that I need
14 psychological care -- please do not comment,
15 Suzanne -- somebody decides I need
16 psychological care that there is assurance that
17 there's a facilitation of that process. It
18 just doesn't sit without anybody following that
19 up. If I decide not to go for that care, that
20 there is a process that captures that in order
21 to provide care coordination and really enhance
22 my ability to get that done.

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1 CO-CHAIR GREEN: And the only thing
2 I would add to that is these folks are actual
3 psychologists, social workers, not medical
4 social workers, mental health social workers so
5 the people they're hiring are the same people
6 who could be providing treatment. And so from
7 my own perspective they -- I mean, this is
8 something that could be done with somebody that
9 the commander hired, you know, a family member
10 who has a great interest in taking care of the
11 unit who basically makes certain that they get
12 the care that they need. And so that's why I'm
13 a little wary of going forward with this one
14 just from my own perspective. But I know more
15 than the rest of you do because of my
16 interaction on the Guard side with this. So I
17 apologize, I'm bringing things in from my other
18 hat.

19 CSM DEJONG: Would you rather look
20 at making a recommendation I mean of utilizing
21 the funding but looking at case management side
22 of it? Or is that getting too deep into the

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1 weeds of stuff that we've never even been
2 provided?

3 CO-CHAIR GREEN: The safer bet on
4 this one would be to table it, see what comes
5 out of the POM because there is some
6 programming that's going in in support of this
7 program and we will find out this next year and
8 decide whether we want to actually advocate for
9 the people who are going to manage the care as
10 Rich is alluding to, or are we advocating for
11 actual provision of mental health services to
12 these folks. And I mean, we can advocate for
13 both, it's not an either/or, it's just right
14 now I'm not sure we have all the information we
15 need to act on this one. Rich?

16 MG. STONE: This has been a very
17 difficult one that we've been working on for a
18 long time. I thought that the National Guard
19 when they were in made a very eloquent
20 presentation of the fact that they perceived
21 that there was significant problem. I think we
22 need more before we can make an informed

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1 recommendation and that is from my standpoint
2 what this really is is care coordination that
3 does not need a licensed professional to do it.

4 There is -- these are simply referrals from
5 the PHA primarily. And therefore I would
6 suggest that we table this, really put it on
7 the tasks for next year to drive our work to
8 understand what this program ought to look
9 like. That does not reduce the fact that
10 there's substantial need out here. This
11 population has very substantial need.

12 MS. DAILEY: Okay. We've got a
13 couple more joint forces headquarters laid on
14 to talk to and we can bring the National Guard
15 back in to talk to us about their program. So
16 that's fine. You only got on briefing and you
17 talked with -- we did expose you to the
18 surgeons in the joint forces headquarters, both
19 Army and Air Force, Air Guard surgeons. So we
20 can continue to work this, that's fine.

21 CO-CHAIR GREEN: The other
22 possibility just to throw one more. I mean, I

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1 think we all agree that there is a need for
2 mental health counseling with the reserve
3 component. And so it may be important enough
4 that we mention this without saying fund this
5 program and say -- and make our recommendation
6 for a team, something to the effect that mental
7 health care available for our reserve component
8 must be expanded. Now, that may be captured in
9 13 by the continuum of, but we -- whether in 13
10 or in a separate we could actually talk to the
11 need to expand services to our reserve
12 component.

13 CO-CHAIR CROCKETT-JONES: Perhaps we
14 could add a line to 13 to focus that the access
15 is -- we can't change because we voted on it.
16 Okay.

17 CO-CHAIR GREEN: We can table 14 for
18 now and then when we go back and do the final
19 review we've agreed that we need to have 13 as
20 a recommendation. Maybe it's just in the
21 findings that somebody inserts something with
22 regard to the reserve component and perhaps

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1 even mentions the director of psychological
2 health as one of the venues for doing this. I
3 just, so maybe in the findings we can find a
4 way to capture this without a specific
5 recommendation since we don't have everything
6 we need right now. Any objections to tabling
7 this? Okay. Fifteen.

8 MSGT MACKENZIE: Okay. Fifteen was
9 part of the DCoE piece. So we took a look at
10 it and made some minor adjustments to the
11 wording so I'll go ahead and read it and then
12 see what you all like. It says, "Working with
13 other appropriate DoD and VA entities the DCoE
14 psychological health and TBI will more
15 aggressively disseminate most current clinical
16 practice guidelines and develop practical
17 point-of-care decision tools for front-line
18 providers that are based on these guidelines."

19 DR. TURNER: I'd just like to point
20 out that this is also somewhat mentioned in 5.

21 CSM DEJONG: I see where you're
22 going with that. I think this one is more

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1 addressing the fact that when the centers of
2 excellence was here they really had nothing
3 established to collect any sort of data in any
4 sort of an organize fashion to come up with any
5 recommendations for future care.

6 CO-CHAIR CROCKETT-JONES: Also, I
7 think we should remember that the centers of
8 excellence were highlighted in our mandate. So
9 we probably should leave these out.

10 DR. TURNER: I agree, I just wanted
11 to point that out.

12 CO-CHAIR CROCKETT-JONES: Yes.

13 CO-CHAIR GREEN: I'll even go
14 further to say the protocols we're talking
15 about with regards to disability and likelihood
16 or probability of being retained are different
17 than the clinical practice guidelines that I
18 think are being addressed here.

19 DR. TURNER: Just so that everyone's
20 just aware of it, that's all.

21 MR. DRACH: I'm not sure that I'm
22 real comfortable on voting on a recommendation

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1 without first reading the recent GAO report
2 that just came out I believe last month. I
3 don't know if anybody has seen that yet. I
4 haven't read it. And there might be something
5 in there that might be worth our attention.

6 MG. STONE: You know, the Defense
7 Centers of Excellence are these sort of
8 freestanding orphans that came up because of
9 congressional great ideas. They have little
10 accountability and therefore often do not
11 integrate in any way. And I would feel more
12 comfortable taking this whole group of DCoE
13 recommendations and especially when we get to
14 the next one that talks about enhancing funding
15 and talk about placing DCoE under executive
16 agency of the services. And I'm sure General
17 Green has an opinion on that one, but the DCoE
18 has to become an accountable agent. They are
19 out doing sometimes very good work but it
20 doesn't connect to our delivery systems in any
21 way. So the idea of getting knowledge out, we
22 heard some really very nice testimony early on

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1 in I think our first meeting of the fact that
2 they were getting some good information out
3 recently and we applaud them for that. And I
4 think their leadership has worked really hard
5 to improve. But I do not believe the whole
6 concept of a center of excellence will work
7 until it integrates into the rest of our
8 delivery system. And therefore I think we
9 ought to reference executive agency of these
10 organizations. And I'll be quiet at this
11 point, sir.

12 MS. DAILEY: Well, the hearing,
13 vision and amputation, they all have executive
14 agency. So you're only talking an executive
15 agency for the DCoE for psychological health
16 and TBI. And you know sir, if we'd been able
17 to pick that out of your brain we would have
18 done a recommendation to that effect so we're
19 crafting a whole new one here if that's the
20 direction you want to go. We thought your
21 intent here was to get a product, get it faster
22 to the field, standardize these processes in

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1 particular for TBI, PTSD. We've done a lot of
2 work in TBI. The focus was even more towards
3 PTSD.

4 CO-CHAIR GREEN: Yes, the internal
5 politics of the DCoE are that for the last two
6 and a half years the one thing that all three
7 surgeon generals have been completely in
8 agreement on in terms of how to move forward is
9 to get the DCoE aligned to executive agency.
10 Actually all of us agreed to MRMC but it isn't
11 -- no action has been taken, okay. And so it's
12 been held at the -- actually, even now with
13 concurrence from Health Affairs it's still been
14 held at the -- and so I mean there's really no
15 controversy amongst the services in terms of
16 alignment and where this should go, but it
17 today still works for Health Affairs and TMA.
18 And so the difficulty as Rich points out is
19 that they're doing a lot of wonderful work but
20 it's not tied back into how the services
21 execute. And so a lot of rework is done as
22 it's essentially, as things are brought back

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1 over to try and get the services to actually
2 execute. It's a DoD unique governance problem
3 but that's the reality of where we are.

4 MS. DAILEY: Okay, would you then
5 like to make a recommendation that personnel
6 and readiness turn over the DCoE to one of the
7 services? I'm game to do that. If that's
8 where we're at then let's do it.

9 DR. PHILLIPS: We should. If you're
10 all in agreement I mean we have to bow to that.

11 CO-CHAIR GREEN: Yes, the solution
12 set is that the recommendation has been from
13 the surgeon generals to align the DCoE to the
14 Army and basically to ensure that that
15 executive agency then takes things across to
16 all the services. So similar to the other COEs
17 in the way they've been aligned the feeling was
18 the DCoE should be aligned in the same way. I
19 have no idea -- in fairness the only problem
20 with this I have no concept whatsoever because
21 everyone I work with is in agreement on this
22 why it hasn't happened. So whatever the

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1 alternative argument is which I think has
2 something to do with visibility to Congress,
3 you know, that's what's gone on. And in terms
4 of the politics of this it's tied into JTF
5 CapMed and the NICO and you know a whole host
6 of other political entities in terms of why
7 this has not happened. So.

8 MR. REHBEIN: I nearly asked the
9 question when we toured the other day and
10 didn't. I'll my other hat on for a minute
11 because I was involved in the National Science
12 Foundation Center of Excellence and those
13 centers were all required to have an industrial
14 board to ensure that we were working on
15 problems of importance to them and coming up
16 with solutions of relevance to them. Too many
17 instances had occurred to them of centers of
18 excellence being formed and then not being --
19 not doing any work that really applied to
20 anything. And I think if this center does not
21 have that kind of governance structure it
22 desperately needs it. So yes, I definitely

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1 support a recommendation that one of the
2 services, probably the Army being the most
3 appropriate would be that they would be aligned
4 there.

5 DR. TURNER: Then just to add to the
6 discussion --

7 CO-CHAIR GREEN: Yes, I was going to
8 say the other difference, just so, again, is in
9 16 you'll see that essentially the only center
10 of excellence that had dollars actually given
11 to it was the DCoE and everything else was a
12 realignment of internal dollars within DoD.

13 DR. TURNER: Well, that's where I
14 was going. Just from a practical point of view
15 would you want to make this recommendation as a
16 part of one of these? Or do you think it would
17 be stronger as a freestanding recommendation?

18 CO-CHAIR GREEN: Honestly I think
19 that both 15 and 16 are exactly why we
20 recommended it go through a single service as
21 executive agent. One, because it would be able
22 to disseminate concepts quicker which is 15 and

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1 two, because we were trying not to duplicate
2 budget expenditures in terms of legislative
3 liaison work and public affairs and conference
4 development. So we were trying to take it to a
5 place that already had those services.

6 DR. TURNER: So what I'm hearing --
7 again, so what I'm hearing then is the
8 recommendation is make the recommendation for
9 executive agency and then 15 and 16 become sub-
10 bullets to that.

11 CO-CHAIR GREEN: If you were talking
12 with myself and my counterparts the answer
13 would be yes.

14 DR. TURNER: Well then does everyone
15 -- just consensus, does that sound like a way
16 to go? Is everyone happy with that? Then that
17 would make recommendation 15 prime, designate
18 execute agency for DCoE as Department of the
19 Army, is that how you would say that? And then
20 that would put recommendations 15 and 16 as
21 written as sub-bullets to that. Or what is the
22 best way to word the primary recommendation?

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1 CO-CHAIR GREEN: I say align DCoE to
2 service executive agency, okay, and that would
3 be the recommendation. And then underneath
4 that you can say --

5 DR. TURNER: Fifteen and 16.

6 CO-CHAIR GREEN: Yes, whatever 15
7 and 16 need to say because this will enhance
8 dissemination of information and avoid
9 unnecessary costs and duplication.

10 DR. TURNER: And thus makes the
11 initial, the original -- thus makes the new
12 recommendation stronger.

13 CO-CHAIR GREEN: Correct. And the
14 only thing you need to be specific, I mean you
15 could say to the Army as executive agency or
16 you can just say to a service executive agency.

17 But all of us agree that it's the Army.

18 DR. TURNER: Then why don't we just
19 say Army?

20 CO-CHAIR GREEN: Yes, that's fine.

21 MR. CONSTANTINE: So the
22 recommendation as opposed to the one that is up

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1 there right now should start with a verb,
2 right? And say align DCoE TBI and PH --

3 DR. TURNER: To the Department of
4 the Army as the executive agent and then sub-
5 bullet 1 would be working with other
6 appropriate agencies, you know, recommendation
7 15. And then the next sub-bullet would be
8 recommendation 16.

9 MSGT MACKENZIE: Once again we're
10 making this recommendation to DoD and they will
11 disseminate. Do we want to really get into
12 specifics as to what service we're identifying?

13 It sounds to me sir that this would pan out to
14 be the correct location regardless if they take
15 this recommendation and actually executed it,
16 that that would fall back to what you guys
17 recommend anyway. Does that sound incorrect?

18 CO-CHAIR GREEN: Yes, I also don't
19 think you need to say TBI and PTSD in that
20 sentence. Just align the DCoE to the Army as
21 executive agent. Right.

22 MR. CONSTANTINE: Agency.

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1 MS. DAILEY: So 16 comes out.

2 DR. TURNER: Sixteen becomes a sub-
3 bullet. Fifteen becomes the first sub-bullet
4 where it says "Through this," the first sub-
5 bullet. And then recommendation 16 becomes the
6 second sub-bullet. Yes.

7 CO-CHAIR CROCKETT-JONES: Do we want
8 to take the current sub-bullets of 16 and move
9 them into findings, or are we going to leave
10 them there?

11 MS. DAILEY: The intent of 16 is to
12 address a specific resourcing and request we
13 made of the Centers of Excellence to tell us
14 what their issues were. And these were picked
15 right off their slides as what they need
16 addressed.

17 CO-CHAIR CROCKETT-JONES: I think my
18 real question is are any of these sub-bullets
19 affected by the new initial recommendation.

20 MS. DAILEY: Not really.

21 CO-CHAIR CROCKETT-JONES: Okay.

22 MS. DAILEY: They are now addressing

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1 four separate agencies. One is the service
2 alignment and then the other ones that are
3 already service-aligned need decisions made on
4 funding facilities and concept of operation.

5 CO-CHAIR GREEN: I do think the
6 language needs to be cleaned up underneath
7 here. And so I'm not sure we need to create
8 sausage here, but the language needs to be
9 cleaned up in terms of what's below there.

10 DR. TURNER: Do you want to work on
11 this tonight, table it for tomorrow?

12 CO-CHAIR GREEN: Yes, let's kind of
13 -- we haven't really voted on this one so let's
14 table it to see if we can get the language
15 because it's such a drastic change but
16 essentially 15 and 16 would be wordsmithed.
17 And so we can put this to a smaller group that
18 can come back to us. Seventeen?

19 CSM DEJONG: All right, 17 and 18 we
20 combined into one recommendation. Keep
21 scrolling, please. All the way to right there.
22 So we took 17 and 18, basically said DoD must

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1 ensure that there's sufficient numbers of
2 medical care case managers available at warrior
3 transition units and community-based warrior
4 transition units. DoD should establish an
5 implement acuity-based staffing standards. In
6 addition, care should be taken when
7 transitioning medical care case managers among
8 recovering warriors to ensure continuity of
9 care within DoD and between VA and DoD.

10 CO-CHAIR GREEN: Is this solely WTU
11 or is this WWR as well?

12 MR. CONSTANTINE: Right, it should
13 have both in there, or all three.

14 CO-CHAIR GREEN: So we can just
15 insert WWR and then comma WTUs and CBWTUs.

16 CSM DEJONG: Why it was written as
17 is most of the findings were all based on site
18 visits to WTUs so.

19 MR. CONSTANTINE: Even so we want to
20 make sure everyone --

21 CSM DEJONG: No, we want to make
22 sure we cross both services, I agree.

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1 DR. TURNER: Motion to support.

2 DR. PHILLIPS: Second.

3 CO-CHAIR GREEN: All in favor?

4 Right hand up. Okay.

5 (All in favor)

6 CO-CHAIR GREEN: And the new
7 language. Anybody objecting to the language
8 with adding WWR but approving the group one
9 language for combining?

10 MR. CONSTANTINE: It should just
11 have an S after it for referral.

12 CO-CHAIR GREEN: I'm sorry? Oh,
13 WWRs. I see. All right. So, Justin, do you
14 support? Okay. Any negatives?

15 (No response)

16 CO-CHAIR GREEN: Any abstentions?

17 (No response)

18 CO-CHAIR GREEN: Okay. So 17 and 18
19 are combined and the language is good.
20 Nineteen.

21 CSM DEJONG: All right, 19. Our
22 final one for standardization. I think it's

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1 there somewhere. There it is. We kind of
2 reworded it to "Standardize and clearly define
3 the roles and responsibilities of the RCC, FRC
4 non-medical case manager and VA liaison for
5 health care and VA polytrauma case managers
6 serving a recovering warrior and his or her
7 family. Also standardize the criteria for who
8 is eligible to be assigned an RCC or
9 equivalent. What that -- it was just a lot of
10 wording in there that we tried to clean it up a
11 little bit and the VA liaison for health care
12 and VA polytrauma, that verbiage came from
13 feedback from the VA based off of their read of
14 these recommendations. And in looking at it
15 and how we put it into words that further puts
16 DoD and VA together into a continuity of care,
17 bring it into that one hand-off because
18 everybody's kind of on the same page.

19 DR. PHILLIPS: Just a technical
20 thing. We need to define RCC, write it out
21 fully, and NMCM just for completeness.

22 CO-CHAIR GREEN: I think that they

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1 have a lexicon in the back that tells all the
2 acronyms in the report so I think we're okay.

3 DR. PHILLIPS: I was just saying
4 because we do write out federal recovery
5 coordinator, FRC. I mean it's just apples and
6 oranges.

7 CO-CHAIR GREEN: So it should be
8 consistent, either just the acronym or just the
9 abbreviation or yes, agreed.

10 DR. TURNER: On the last sentence
11 would it miss the meaning if we said also
12 standardize the criteria and training for who
13 was legible to be assigned an RCC or
14 equivalent.

15 DR. PHILLIPS: Good point.

16 MR. CONSTANTINE: Well, the training
17 criteria is for the recovering warrior, right?

18 CSM DEJONG: Right. This came down
19 to -- there was a lot of -- go ahead.

20 MR. REHBEIN: As I read it this
21 sentence talks about who is eligible -- which
22 RW is eligible to be assigned an RCC. Yes,

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1 it's easy to read the other way, yes.

2 DR. TURNER: Okay, I misread it.

3 CSM DEJONG: So in a way, without
4 going through all the acronyms and all the
5 abbreviations the bottom line up front on this
6 one was to standardize and clearly define the
7 roles and responsibilities of the care
8 coordinators serving a recovering warrior and
9 his or her family, and then also standardize
10 the criteria of who is eligible to be assigned
11 an RCC or an equivalent to an RCC.

12 CO-CHAIR GREEN: Can I suggest to
13 clean up the last line so it wouldn't be read
14 both ways to make it be assigned to an RCC?

15 DR. TURNER: Yes, exactly.

16 MS. DAILEY: And also if we're going
17 to kind of do it that way are we looking to de-
18 conflict it with the FRC? So we have RCC and
19 FRC, also a standardized criteria who's
20 eligible to be assigned an RCC and an FRC?

21 CO-CHAIR GREEN: To be assigned to
22 an RCC or FRC. But when they say "or

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1 equivalent" I thought that captured the FRC,
2 but if we need to be more specific that's fine.

3 CSM DEJONG: Now one of these and I
4 can't remember which one. I don't have my
5 notes, Ms. Dailey, from -- someone brought up --
6 -- someone in this group brought up the fact
7 that Dr. Geiss did not want the FRC brought up
8 in one of the recommendations based off of some
9 criteria. I don't know if that was this one or
10 not.

11 MS. DAILEY: Yes, it's this one.
12 Dr. Geiss is concerned about putting the FRC in
13 the categories that we call the non-medical
14 case management. The FRC is and does medical
15 case management. So she felt that it confused
16 their roles.

17 CO-CHAIR CROCKETT-JONES: Yes, I
18 think we should not try to make RCCs and FRCs
19 equivalent. But I think that we do want to say
20 RCC or equivalent.

21 CO-CHAIR GREEN: So take it out of
22 parentheses and just get rid of the FRC there?

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1 CO-CHAIR CROCKETT-JONES: Yes.

2 CO-CHAIR GREEN: Yes. I think if
3 you just say at the end there, take off the
4 "and FRC" and then take the parentheses off
5 "the equivalent" would be okay. No, take the
6 FRC completely out.

7 MS. DAILEY: I think our VA rep here
8 is thinking on this as an opportunity to break
9 out RCC and FRC roles by not clearly defining
10 and including FRC in this particular line. So
11 you have competing VA interests.

12 MR. REHBEIN: This is a little bit
13 of my ignorance but who is equivalent to an
14 RCC?

15 CSM DEJONG: AW2 I believe in the
16 Army.

17 MS. DAILEY: AW2s, squad leaders.

18 CO-CHAIR GREEN: So the VA
19 representative is asking us to make it RCC
20 comma FRC or equivalent?

21 MS. DAILEY: Yes.

22 LTCOL KEANE: I would disagree

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1 because this is an issue that's underfoot to
2 standardize and clearly define those roles,
3 whether or not FRC is -- I think it needs to be
4 in there. Because the FRC program manager is a
5 sailor --

6 CO-CHAIR GREEN: I think we're
7 violently agreed.

8 LTCOL KEANE: Oh, right.

9 CO-CHAIR GREEN: So putting RCC
10 comma FRC or equivalent. Isn't that what you
11 want? Good.

12 CSM DEJONG: I'm okay with it
13 because if they're confused it might further
14 take them back to recommendation 1 to further
15 clarify.

16 CO-CHAIR GREEN: Steve, you're doing
17 really good. All we need is a motion on this
18 and we're probably there.

19 MR. CONSTANTINE: We just need to in
20 the first line, beginning of the second, delete
21 "federal recovery coordinator" and those
22 parentheses around that first three. Right.

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1 CO-CHAIR GREEN: Correct. I think
2 that -- so what we'll say is it will be
3 consistent either in putting all the names in
4 within the parentheses or if it's not necessary
5 because it's in an annex somewhere then to put
6 only the abbreviations in. And so with that
7 consistency when they make that change now can
8 we go towards a motion? Sorry.

9 CO-CHAIR CROCKETT-JONES: I'm sorry,
10 I just think that there might be a little
11 change. Instead of who is eligible to be
12 assigned an RCC, FRC or equivalent, why don't
13 we just use the same list and say to be
14 assigned to these providers? That way we're
15 standardizing a criteria for who is eligible to
16 get VA liaisons for health care as well. Why
17 not standardize the criteria across this group?

18 CO-CHAIR GREEN: So if I'm hearing
19 you right you'd say standardize and clearly
20 define the roles and responsibility comma and
21 who is eligible to be assigned to an RCC, FRC.

22 CO-CHAIR CROCKETT-JONES: Yes.

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1 CO-CHAIR GREEN: So you just want to
2 take the phrase and shorten the language.

3 CO-CHAIR CROCKETT-JONES: Yes. And
4 there's an "of" after the word
5 "responsibilities" right?

6 CO-CHAIR GREEN: You don't need the
7 "of."

8 CO-CHAIR CROCKETT-JONES: I don't?

9 CO-CHAIR GREEN: No.

10 MR. CONSTANTINE: We said there's a
11 comma after "responsibilities" and then after -
12 - or two.

13 CO-CHAIR GREEN: You can actually
14 put a comma after "roles" and take out the
15 first "and." Then put a comma after
16 "responsibilities." And what was the other
17 one, Justin?

18 MR. CONSTANTINE: We talked about
19 having it after "assigned to" comma but now I'm
20 not sure.

21 CO-CHAIR CROCKETT-JONES: I think
22 they're good.

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1 MR. CONSTANTINE: Yes, now it's
2 fine.

3 MR. REHBEIN: I've got to disagree.
4 I'd put it back. We're clearly defining the
5 roles and responsibilities of the RCC but when
6 we're talking about who is eligible we're
7 talking about the RW. So we've got -- I think
8 we're confusing ourselves here. I think we're
9 opening that up for confusion.

10 CO-CHAIR GREEN: Yes, the problem
11 being that the roles and responsibilities of
12 these folks is important and then the who's
13 assigned to them based on those roles and
14 responsibilities is why --

15 MR. REHBEIN: We're talking about
16 the roles and responsibilities of one person
17 and the eligibility of another person.

18 CO-CHAIR GREEN: Right.

19 MR. REHBEIN: And those two groups
20 don't intersect.

21 MR. CONSTANTINE: If you put a comma
22 after the word "to" then you're -- all three of

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1 those things are talking about RCC, the roles
2 and responsibilities and who is eligible to be
3 assigned to the RCC. Okay, but you have to
4 have a comma after the word "to." We're
5 talking about the roles of the RCC and the
6 responsibilities of RCC and who's -- no, I'm
7 sorry, it's the next "to."

8 CO-CHAIR GREEN: I don't think it's
9 going to work, Justin, because you've still got
10 two different groups. You really want to
11 define the roles and responsibilities of the
12 RCC, the FRC, the NMCM and the VA liaison and
13 so you need to make it a separate sentence. So
14 the way --

15 CSM DEJONG: How about if we just
16 define the who? We standardize and clearly
17 define the roles and responsibilities and which
18 recovering warriors are eligible to be assigned
19 to.

20 CO-CHAIR GREEN: Any way you do it
21 it's going to lead to confusion. Two sentences
22 is better.

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1 CO-CHAIR CROCKETT-JONES: So in the
2 second sentence --

3 MR. CONSTANTINE: Let's do the first
4 sentence, okay? Standardize and clearly define
5 the roles and responsibilities of the list,
6 right?

7 CO-CHAIR CROCKETT-JONES: Yes.

8 MR. CONSTANTINE: Period. So it's
9 roles and responsibilities.

10 MS. DAILEY: So this comes out.
11 Clearly define --

12 CO-CHAIR GREEN: Just that phrase
13 right there, who is eligible to be assigned.

14 MS. DAILEY: So that's out.

15 CO-CHAIR GREEN: That's out. And we
16 -- and put an "of" right there, O-F. Take the
17 comma after "roles" and put -- take the comma
18 after "roles" and insert an "and." And then
19 the other sentence at the bottom you just need
20 to move back up into place.

21 CO-CHAIR CROCKETT-JONES: And make -
22 - instead of assigned to, instead of an RCC,

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1 FRC or equivalent on the end of that second
2 sentence just say assigned to these providers.

3 MSGT MACKENZIE: Or assigned to the
4 previously mentioned.

5 CO-CHAIR CROCKETT-JONES: Or
6 assigned to these.

7 MSGT MACKENZIE: Services.

8 CO-CHAIR GREEN: I'm not sure why to
9 do that.

10 CO-CHAIR CROCKETT-JONES: Because we
11 only want to worry about -- okay. I don't
12 think we should only worry about who's eligible
13 for RCCs or FRCs. I think if we're saying we
14 need to standardize and define the roles for
15 all those folks don't we also want to know,
16 standardize the eligibility for all those
17 folks? And I'm not sure that we've got -- that
18 all of those folks will consider themselves RCC
19 equivalent. That's my concern.

20 CO-CHAIR GREEN: Yes. Honestly, I'd
21 probably take off the "or equivalent" because
22 the real issue is whether or not they get an

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1 RCC or an FRC. Because all the others are
2 assigned based on their injuries, but the RCC
3 and FRC are the ones that we're seeing
4 variation in. And so I'd probably take out the
5 "or equivalent" and just focus on the RCC and
6 the FRC where we're having troubles.

7 CO-CHAIR CROCKETT-JONES: Okay.

8 CO-CHAIR GREEN: And the other thing
9 I'd take out is the "also" and make
10 "standardize" a capital letter. Because it's a
11 separate. And are they assigned to both an RCC
12 and an FRC, or is it an RCC or an FRC? Both?
13 Okay.

14 DR. LEDERER: Excuse me. This does
15 not take into account the AW2 advocates who are
16 RCC-like. And there are issues about who gets
17 one if you're in the Army.

18 CO-CHAIR GREEN: So put in
19 parentheses after RCC -- yes. So after RCC
20 just put parentheses and put "or AW2." No.

21 MR. CONSTANTINE: After RCC.

22 CO-CHAIR GREEN: Because they're an

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1 equivalent of an RCC so.

2 DR. LEDERER: We've heard about
3 eligibility issues regarding RCCs, AW2
4 advocates and FRCs. We haven't heard anything
5 yet about eligibility issues regarding NMCMS
6 and the VA case managers.

7 DR. PHILLIPS: I might add this is
8 this year's recommendation. We can always
9 follow up next year if we need to add more.

10 MR. CONSTANTINE: If the VA liaison
11 is separate from the VA polytrauma case manager
12 then we need to take out the word "and" before
13 VA liaison.

14 MS. DAILEY: Ready to vote?

15 CO-CHAIR GREEN: I don't think -- do
16 we have a motion on this one? You stopped the
17 motion the last time.

18 MSGT MACKENZIE: My motion as read.

19 DR. PHILLIPS: Second.

20 CO-CHAIR GREEN: All in favor?

21 (All in favor)

22 CO-CHAIR GREEN: Any opposed?

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1 (No response)

2 CO-CHAIR GREEN: Approved. It is
3 about 5:30 and so I think everybody's getting a
4 little tired. Why don't we take a brief break
5 and decide if we want to continue tonight or if
6 we're going to do some of this tomorrow.

7 CSM DEJONG: Sir, if we can take
8 five minutes, I mean we combined a lot of --
9 the next group combined quite a few, right? So
10 I mean we're looking at probably knocking out
11 several just in a few minutes because you guys
12 combined at least four.

13 CO-CHAIR GREEN: Okay. Well, for my
14 weak bladder we're going to take a 5-minute
15 break.

16 (Whereupon, the above-entitled
17 matter went off the record at 5:40 p.m. and
18 resumed at 5:49 p.m.)

19 MS. DAILEY: We have lost Mr. Drach.
20 He won't be back until Thursday. He had a
21 family emergency. So he had, Justin, did he
22 give you a proxy? So Justin can vote his

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1 proxy. However, what we will do for you, you
2 have a working session tomorrow morning. In
3 anticipation of tough nuts that you all will
4 probably encounter during this voting session
5 we have two hours tomorrow morning, 8:00 to
6 10:00, to go back into your groups. So we've
7 got good material to split out and put you in
8 those groups. Now, my thought was we wouldn't
9 need to go back into four groups because we're
10 losing people and if I just split you into two
11 groups instead of four, let you work in a
12 little larger groups you could work through the
13 recommendations that we've tabled and the
14 recommendations that we were going to recommend
15 putting into trying to group them again which
16 I've indicated on this. And so you would come
17 in tomorrow morning, this will be printed out
18 and you've clearly identified which ones you
19 have tabled and which ones you need to
20 consolidate. And you will start again, same
21 process you did today from 10:00 until 2:00.
22 That's what you did from 10:00 till 2:00 today.

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1 At 10:00 tomorrow I have to bring you back for
2 an open session of some sort. We can work
3 through it and then not vote until 2:00 when we
4 know General Stone will be back.

5 MR. CONSTANTINE: I have his proxy?

6 MS. DAILEY: You have his -- no.

7 (Laughter)

8 MS. DAILEY: The risk is I can't
9 afford to lose any more of my military. If
10 General Stone isn't here during the voting
11 session tomorrow and Command Sergeant Major
12 Keane drops dead in the swimming pool tonight
13 from exercising it too hard --

14 (Laughter)

15 MS. DAILEY: -- I don't have a
16 quorum and we cannot vote at all. I'm worried
17 about a quorum. I'm sorry, but it's my little
18 rock and I'm worried about it. So. The real
19 me is coming out. So, General Stone's
20 advocated his case to be at the Walter Reed
21 event tomorrow and so again we can continue
22 what we've done today which is just kind of

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1 work through the 10:00 to the 2:00 hour in an
2 open session in discussion, not a vote and not
3 vote until he comes back. And I'd like to
4 include my other two members, the other two
5 military members ladies and gentlemen as -- and
6 they've made valiant efforts to get here and we
7 will continue to try and bring them in the
8 loop. However, at this point there is some
9 case to be made that it'd be tough to include
10 them because of the amount of work that we've
11 done without them.

12 CO-CHAIR GREEN: Just a recap of
13 where we are. So, we've got work to do on
14 number 3. We have 2, 7, 8 and 10 that we said
15 we were going to look at what we were going to
16 do with them together. On, let's see, 14 I
17 think we ended up putting off. That was the
18 one about -- okay. Next year. And so 15 and
19 16 needs a rewrite. And then we haven't gotten
20 to them yet, but 35 and 38, no one really
21 tackled those that I'm aware of in terms of the
22 interoperability issues. And so that one will

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1 also need to have a group look at it. And so
2 we're back to 20. Okay. So communications
3 group, who was that?

4 MR. CONSTANTINE: Okay, for 20 we
5 combined 20, 21, and 22. The new text for 20
6 says, "As part of the intake process and on a
7 regular and recurring basis there is a review
8 of available resources for support as well as a
9 defined plan that facilitates and ensures
10 effective communication between caregivers,
11 support personnel, family and the recovering
12 warrior. We then have an asterisk after
13 recovering warrior because we want to have a
14 note going down in the best practices talking
15 about this. It says, "Available resources for
16 support include but are not limited to a
17 National Resource Directory and the Keeping it
18 All Together binder for Military OneSource.
19 Family assistance centers appear to be an
20 effective model for the delivery of information
21 to these resources and ongoing support. A
22 robust expansion of family assistance centers

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1 across the services would be an effective
2 method for promoting these means of support."
3 Twenty-one was just about National Resource
4 Directory and 22 was about the Keeping it All
5 Together. So we wrap those in here.

6 MG. STONE: And then because of the
7 final sentence in the reference that is under
8 best practices 23 would be deferred to next
9 year in order to accumulate some additional
10 information on the family assistance center.

11 DR. PHILLIPS: Question. Will you
12 be keeping the quote in? Since you combined
13 them.

14 MR. CONSTANTINE: Which quote?

15 DR. PHILLIPS: Under 20. I know the
16 intentions are good, but we're not being, et
17 cetera, et cetera. I'm just asking.

18 MS. DAILEY: When it comes to the
19 findings and the quotes we will be keeping
20 those as you're really combining three things
21 and they are there to create some illustrative
22 comments about how you got to that

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1 recommendation. If we're taking a
2 recommendation completely out we probably -- if
3 it's got an associated quote and a finding all
4 that would come out with it. But combined
5 recommendations, rewritten recommendations are
6 going to keep their findings and their quotes.

7 MR. CONSTANTINE: Yes, that quote is
8 about the information that's being passed to
9 the recovering warrior and that relates to
10 recommendation 20 that we have a plan. We talk
11 about this plan where we review the resources
12 and the support amongst all the personnel
13 employers.

14 CO-CHAIR GREEN: So just to make
15 sure I'm understanding, we're actually
16 combining 20, 21, 22 and 23? No.

17 MR. CONSTANTINE: Twenty-three we're
18 deferring to next year. Twenty-three relates
19 to the family -- the SFACs.

20 CO-CHAIR GREEN: Let's keep things
21 clear then. Let's not talk about 23 yet.
22 Let's just do 20, 21 and 22, and then we'll --

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1 MR. CONSTANTINE: Yes, exactly.

2 CO-CHAIR GREEN: Okay, all right.

3 Russ? I'm sorry.

4 DR. TURNER: I was just going to say
5 it's an awful long sentence. That's all.

6 DR. LEDERER: May I point something
7 out? The NRD and Keeping it All Together,
8 these are two information resources that there
9 are issues with. There's not a lot of
10 familiarity with the NRD. People don't know
11 how to navigate it very well in many cases.
12 And Keeping it All Together is not readily
13 available from Military OneSource. I think we
14 have to order them piecemeal. So there are
15 some issues here that might render them
16 ineligible for inclusion among best practices.
17 Maybe make it more appropriate to highlight
18 them as a finding and recommendation.
19 Possibly.

20 MR. CONSTANTINE: Well, we didn't
21 want to keep -- we did not want to keep them in
22 the recommendation because really for what

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1 reasons you just said, they may go away, they
2 may not exist next year. However, we were all
3 impressed from what I remember with that
4 Keeping it All Together binder. I think the
5 Marine Corps is the one who briefed that one.
6 And the Military OneSource, the NRD has lots
7 and lots of information. The people who have
8 accessed it we learned from the surveys, the
9 people who did access it talked very highly of
10 it. The problem was not very many people did
11 access it. So we want to highlight it, we want
12 to make sure people are talking about it, but
13 those are just examples. And again, we're not
14 limited to those.

15 CO-CHAIR CROCKETT-JONES: Can I
16 suggest an alternative to a best practice
17 reference be bullets of expand, you know,
18 increase promotion of NRD, increase access to
19 the Keeping it All Together binder for groups,
20 not just individuals, as bullets under this
21 reviewing available resources for support? As
22 secondary.

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1 MR. CONSTANTINE: I understand what
2 you're saying and we talked about this as a
3 group. We're concerned with the timeliness
4 factor that these things may go away, they may
5 not exist. So we want to highlight them but
6 not make -- not mandate anyone does anything
7 with them.

8 CO-CHAIR CROCKETT-JONES: Are we --
9 if we're saying they're a best practice aren't
10 we basically recommending that they continue to
11 exist? I mean, isn't that the point of making
12 the recommendation is that we think they should
13 continue to exist and should be better utilized
14 and expanded? I mean, I think there's a lot of
15 things that might not be in a year. I'm not
16 sure that that's necessarily the way to go on
17 this.

18 MR. CONSTANTINE: And also it's hard
19 to say -- we think it's a good recommendation
20 that say more effectively promote NRD. Because
21 as a senior leader if you look at that what
22 does that mean? Who does that? And how? And

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1 at what level?

2 CSM DEJONG: Suzanne, I think you're
3 getting away from it. I think the focus of
4 this is to establish an initial intake and
5 regular reoccurring basis a review of the
6 resources and communications that the soldier
7 and the families have with just highlighting a
8 few of these as resources, not mandating that
9 these are what you need. The highlight of this
10 recommendation is to review it with them as
11 they come in and then continuously review with
12 them whether they're receiving enough
13 communication through different means. With
14 this being just kind of a side note of these
15 are some places you can go.

16 MG. STONE: You're exactly right and
17 you can take the asterisk out. What we're
18 trying to do is recognize the fact that there
19 are some resources that weren't generally
20 understood but appeared to have some capacity.
21 If we've reached too far in the National
22 Resource Directory and the Keeping it All

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1 Together then it ought to just come out
2 completely. But the key is that on -- what we
3 heard over and over again from families and
4 from servicemembers is that they didn't fully
5 understand the communication process and they
6 didn't know who to call. And so the crux of
7 this is that when you first take them in and on
8 a regular and recurring basis we communicate
9 and we bring the team together to do that
10 communication. But you're exactly right, so
11 just erase the asterisk.

12 CO-CHAIR CROCKETT-JONES: Okay, then
13 we're basically deleting several of the
14 recommendations. And I'm just going to -- then
15 I want them in as individuals because I want to
16 give you the reasons why I feel strongly about
17 those recommendations.

18 MG. STONE: You're arguing for the
19 asterisk.

20 CO-CHAIR CROCKETT-JONES: I'm
21 arguing that the asterisk isn't even good
22 enough. Specifically, the National Resource

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1 Directory, those who used it had great
2 satisfaction and connection to their resources.

3 It's effective. But it is -- until people
4 know it exists they don't use it. Keeping it
5 All Together as a binder was highly successful
6 when used. It is a best practice when used,
7 but there is a simple fix. It is now only
8 available when an individual requests it. A
9 simple fix is to let units request it or
10 assistance centers request it in quantity.
11 Those are simple fixes to make something that
12 we have evidence works more accessible to
13 families and I think it would be a shame to
14 drop those recommendations. The legislation
15 specifically mentions NRD and Military
16 OneSource.

17 CO-CHAIR GREEN: Let me help a
18 little bit. I have a bit of a problem with the
19 sentence structure so it's really just
20 grammatical but -- yes, but it plays well with
21 what Suzanne would like to do. And so as part
22 of the intake process, comma, and on a regular

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1 and recurring basis, comma, and then take --
2 and get rid of "there is a" and just say
3 "review." And get rid of the "of." Review
4 available resources for support. Now put in
5 there to include the National Resource
6 Directory and the Keeping it All Together
7 binder from Military OneSource. And then I'd
8 say period after that, but then I have to ask a
9 question on this second part of this as well as
10 defined plan. Is the defined plan the CTP or
11 no? So it's a separate defined plan?

12 MG. STONE: What we heard was and
13 Suzanne, you commented on this, was that
14 different wounded, ill and injured warriors
15 have different communication skills, technology
16 availability, families were struggling and
17 therefore it was about defining a communication
18 plan. And are we best to text, are we best to
19 email or are we best to voice or do we need
20 face-to-face.

21 CO-CHAIR GREEN: Okay. So the
22 second sentence based on what you just said --

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1 so the second sentence. So there's a period
2 after OneSource there. And then the second
3 sentence says a defined plan that facilitates
4 and ensures effective communication between
5 caregiver support personnel, family of the
6 recovering warrior should be reviewed at the
7 same time.

8 MS. DAILEY: What about define a
9 plan?

10 MR. CONSTANTINE: Define.

11 CO-CHAIR GREEN: That's fine. So
12 define --

13 MR. CONSTANTINE: No D, just define
14 a plan and then delete the asterisk.

15 CO-CHAIR CROCKETT-JONES: So the
16 word "define" is no D.

17 MS. DAILEY: And does this need to
18 be -- my only concern is here and I like how
19 Mrs. Crockett-Jones advocated for specificity
20 here. The one concern I have is they do have
21 an intake process. All of them have an initial
22 assessment process. They do have periodic

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1 reviews. So I just want you to keep that in
2 mind. So it's part of the intake process and
3 on a regular and recurring basis review
4 available resources for support to include the
5 National Resource Directory and Keeping it
6 Together from Military OneSource.

7 CO-CHAIR CROCKETT-JONES: Yes, I
8 think we specifically would want this to be in
9 the context of family caregivers having this
10 information as well. So I have to think about
11 this a minute.

12 CO-CHAIR GREEN: Just add to the end
13 of it. So on the altogether, you need to
14 separate the altogether to make it two words
15 for Keeping it A-L-L Together.

16 MS. DAILEY: Okay.

17 CO-CHAIR GREEN: Okay?

18 DR. PHILLIPS: Do we need to say who
19 should define the plan?

20 CO-CHAIR GREEN: Well, I assume that
21 there's some different groups of people that
22 may do that. But I think you can just add at

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1 the end of that sentence All Together from
2 Military OneSource with the family caregiver.
3 That's who we're really focused on. With the
4 RW and family caregiver.

5 DR. LEDERER: Is the plan
6 personalized? Do we want to say tailor a plan
7 that facilitates?

8 MR. CONSTANTINE: Yes. So the
9 second sentence should start off by saying
10 tailor a plan instead of define a plan. And
11 while it maybe should, and there is an initial
12 intake process and it may -- there may be some
13 sort of recurring basis we heard from the
14 captain's wife who came up and said once she --
15 once they were no longer inpatients they rarely
16 heard from Walter Reed, they were no longer
17 part of the system. We want to make sure
18 there's, you know, recurring.

19 CO-CHAIR GREEN: I think we can make
20 the "tailor a plan" the second sentence. Put
21 it up there. And then you don't need an
22 asterisk. Yes. So now the question is do you

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1 still need the asterisk after what we've
2 reworded.

3 MR. CONSTANTINE: No.

4 CO-CHAIR GREEN: So you can get rid
5 of that whole paragraph on the --

6 MS. DAILEY: I am going to ask that
7 this, the Military OneSource, the Keeping it
8 All Together are -- is put in the best
9 practices.

10 CO-CHAIR GREEN: That's fine, but
11 you don't need to have it here referenced.
12 Delete the asterisk. And obviously you've got
13 a Military OneSource capitalization.

14 MS. DAILEY: Yes. Right.

15 CO-CHAIR GREEN: Do we have a motion
16 or is there further discussion?

17 DR. PHILLIPS: I'll so move.

18 DR. TURNER: Second.

19 CO-CHAIR CROCKETT-JONES: All in
20 favor?

21 (All in favor)

22 CO-CHAIR CROCKETT-JONES: All right,

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1 then any against?

2 (No response)

3 CO-CHAIR CROCKETT-JONES: No. Any
4 opposed or any abstain? I'm so tired.

5 (No response)

6 CO-CHAIR CROCKETT-JONES: Then we're
7 good. Are we done?

8 MS. DAILEY: Okay. My last thought
9 on that one and you might want to think about
10 it for next year is that you have not held
11 WWCTP in that particular recommendation
12 accountable for their level of promotion of the
13 NRD. You kind of pushed it down to the service
14 level to talk about it during intake and
15 reviews and patients like that.

16 MSGT MACKENZIE: Isn't that what
17 WWCTP is going to do anyway? I mean, we hold
18 them accountable just to push it down there
19 anyway. The fact that it is still listed in
20 there as a finding, I think that still puts
21 that in there.

22 CO-CHAIR GREEN: Yes, it was the

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1 first thing in the finding so I don't think
2 we've left it out.

3 MS. DAILEY: Okay.

4 CO-CHAIR GREEN: Okay. Number 23
5 that I asked we keep separate is the one that's
6 been recommended for I guess delay. And does
7 it really require a vote to delay it? Is there
8 any objection to pushing it into future years?

9 MSGT MACKENZIE: I'm just trying to
10 -- I'd like to just ask the question again.
11 For what reason do we think we don't have
12 enough information to make this recommendation?

13 MR. CONSTANTINE: Well, we didn't
14 think that we had had anyone from SFAC come in
15 and talk to us specifically about that. We
16 hadn't looked at what other services did
17 because in here it says SFAC which is Army-
18 specific, a best practice, and that's the last
19 single paragraph says other -- the sister
20 services should do that. And we don't know
21 what other services do and if it even needs to
22 do that at all. So we thought we should try to

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1 have one of our hearings we should have
2 something on this and we would go to a site
3 besides Fort Campbell. We should look and see
4 what other places are doing.

5 MS. DAILEY: I just don't want that
6 on the record. The fact is is that we had a
7 briefing on the SFACs from the Army. At every
8 installation we've been to we have either been
9 to an SFAC or we have sought the SFAC and
10 family services equivalents at the Navy, at the
11 Air Force to come and brief us. Now, I'm not
12 adverse to this being moved into next year.
13 You know, Congress specifically asked us about
14 SFACs so I am a little concerned about us not
15 addressing it. As Dr. Turner said, if we don't
16 do it someone's going to ask why not. So.

17 CO-CHAIR CROCKETT-JONES: I would
18 also like to point out that the SFACs were one
19 of the few briefings we got that included hard
20 numerical data regarding utilization and
21 quality surveys. They gave us really good
22 evidence for their efficacy and product

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1 quality.

2 MS. DAILEY: Yes. They are part of
3 what's called IMCOM. IMCOM is a service-
4 oriented command within the Army and they're
5 required to keep that statistic so they were
6 easy to capture data from.

7 CO-CHAIR GREEN: I think the point
8 that's being made though is that in the first
9 paragraph up there there's no recommendation.
10 And in the second one we haven't talked with
11 the other services to find out if they have
12 similar. So the Air Force has an airmen and
13 family readiness center. Are they actually
14 doing any of this? Okay, I don't know. And so
15 the question is what would the recommendation
16 be. So the other alternative might be to
17 simply mention the SFAC as a best practice and
18 not have a recommendation because the problem
19 with what's written is that I think we're not
20 ready to answer the second part which is what
21 Justin was telling us, to say that they should
22 have one in every service, and yet we do think

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1 it was a best practice where we saw it. So I
2 mean we can make a recommendation but right now
3 it's not written as if it's a recommendation.

4 MSGT MACKENZIE: The only
5 comparative data we had was when we went to
6 Wilford Hall where the airmen that were there
7 weren't getting the support of the SFAC-type
8 services that the Army was getting and they
9 were dying for it. They were just -- I mean
10 every one of them was like I went over there
11 and was like wow and the thought process they
12 couldn't achieve those kind of services. So
13 that was really our only comparative data per
14 se was the fact that at an Air Force
15 installation that had an SFAC nearby that they
16 all wanted it because they weren't getting it.

17 So.

18 DR. TURNER: I think just like you
19 said I would -- and we need to put that in
20 there somehow, whether it be a practice but
21 also talk about the contrast as you point out,
22 that when it's available it really made a

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1 difference.

2 CO-CHAIR GREEN: And we can write it
3 as a recommendation, continue to support
4 soldier and family assistance centers. It can
5 be as simple as that as a recommendation and
6 then all of the rest of it could be part of the
7 findings. So just as it's written it can say a
8 best practice that can be further strengthened
9 and then you know you've got the whole finding
10 there. So if we do, I mean if that one's
11 really that popular out there and you want to
12 incorporate it then you just simply say
13 continues to support SFACs.

14 DR. LEDERER: Regarding the SFACs,
15 there is strong indication that they are
16 unevenly utilized, that they are under-utilized
17 in some settings. We heard that from the Army
18 IG report as well as from Brigadier General
19 Williams when he briefed in February. That
20 seems actionable.

21 MSGT MACKENZIE: I agree with
22 General Green though, that first bullet

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1 statement there is you know continue to support
2 the SFAC program, take steps to increase
3 utilization, et cetera, et cetera. Just that
4 second bullet about the other services
5 exploring this stuff, we may need to gather
6 more data before we make that part of the
7 recommendation.

8 CSM DEJONG: And some of the
9 findings with this also is going to reflect
10 back to when we were going back and forth about
11 the services and the WTUs, the line units and
12 the WTUs working together. The only working
13 knowledge I have is Fort Knox, Kentucky and the
14 other battalion brigade commanders came to the
15 WTU and asked can you open this up to our
16 soldiers because this is a one-stop shop for
17 these guys. Otherwise they're running all over
18 post to find these answers. And across the
19 Army from what I've researched post commanders
20 are starting to open the SFAC which is geared
21 towards the WTU, towards the entire post thus
22 increasing that cooperation between WTU and the

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1 line units.

2 MSGT MACKENZIE: Which also falls
3 under the complication right now between ACS
4 and SFAC, and that ongoing battle, so.

5 CO-CHAIR GREEN: So they can take --
6 work on the findings and stuff. So do we want
7 to be as simple as continue to support the
8 SFACs and take steps to increase utilization?
9 Is that a recommendation that we want to go
10 after?

11 CSM DEJONG: So moved.

12 CO-CHAIR GREEN: Do we hear a
13 second?

14 DR. PHILLIPS: Second.

15 MSGT MACKENZIE: I'm still -- almost
16 taking out that first sentence, the remaining
17 sentence in that thing is what we're trying to
18 say.

19 CO-CHAIR GREEN: Now let me clarify.
20 None of the rest of that will be in this.
21 Everything will be moved down into the
22 findings. So the only recommendation that

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1 you're voting on is continue to support the
2 SFACs and take steps to increase utilization,
3 that one short line is the recommendation. And
4 all the rest will be rolled into the findings.

5 They'll change the wording. Because the
6 findings, remember we're not wordsmithing all
7 the findings right now. Right, we'll have to
8 delete the third sentence. So I think the
9 motion on the floor is solely for the short
10 sentence at the top, continue to support the
11 SFACs and take steps to increase utilization,
12 and then the finding would need to be
13 rewritten.

14 CSM DEJONG: Correct.

15 CO-CHAIR GREEN: Okay. All in favor
16 of that short recommendation raise your right
17 hand. Justin, both hands.

18 (All in favor)

19 CO-CHAIR GREEN: Good. Okay. Any
20 objections or --

21 (No response)

22 CO-CHAIR GREEN: No. And any

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1 abstentions?

2 (No response)

3 CO-CHAIR GREEN: No. Thank you.

4 Twenty-four. Communications.

5 MR. CONSTANTINE: Are we going to
6 push through all the communications today?

7 CO-CHAIR GREEN: I don't know. Did
8 we want to --

9 MR. CONSTANTINE: Well, I thought we
10 were going to get steaks and I have -- I'm
11 going to be late for something, so.

12 CO-CHAIR GREEN: I have no objection
13 to calling it and we can finish this off
14 tomorrow if everybody needs to go. So
15 obviously we've already lost one member so.
16 Denise?

17 MS. DAILEY: Yes. I'm happy to
18 close the session, let everyone go. You've
19 done good and you're on a roll. We -- if you
20 get through this tomorrow afternoon from 2:00
21 to 6:00 you will be doing very good. We will
22 break into groups tomorrow morning. Do you

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1 have any preferences for groups? Can I just
2 re-jigger you and mix you according to skills
3 in some of the groups? But I want to break
4 into two groups tomorrow instead of four. And
5 we will break out what still needs to be
6 revised for you to work on tomorrow morning.

7 CO-CHAIR GREEN: My recommendation,
8 Denise, is you break us into three groups.
9 Just the smaller the group probably the easier
10 it will be to actually get to common wording.
11 And so go ahead and break us into three groups.

12 I was just looking, we've got -- clearly we've
13 got three areas now that are going to have to
14 be redone and depending on whether you want us
15 to help with the rewording of the findings
16 they're not. But the DCoE is going to have to
17 be rewritten, the interoperability on 35 and 38
18 is going to be rewritten. The 14 on mental --
19 I'm sorry, the 2, 7, 8 and 10 and then number
20 3. So three groups would be better.

21 MS. DAILEY: Okay.

22 CO-CHAIR GREEN: Okay?

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1 MS. DAILEY: All right, sir, so it
2 was just two of you in one of those groups, you
3 and Mr. Rehbein and I split you into one of
4 those other two groups, you and Mr. Rehbein?

5 CO-CHAIR GREEN: I don't know, we
6 were pretty good together.

7 MS. DAILEY: I know you were.

8 (Laughter)

9 MS. DAILEY: All right. So tomorrow
10 morning 8:00 in the -- right here. So 8:00 to
11 10:00 is a group session. Thank you all. Well
12 done. Thank you very much. Well done.

13 CO-CHAIR GREEN: One final piece of
14 non-business here but I believe that it is Dr.
15 Phillips' birthday today.

16 (Applause)

17 (Whereupon, the above-entitled
18 matter went off the record at 6:24 p.m.)
19
20
21
22

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