

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

+ + + + +

WEDNESDAY
JULY 27, 2011

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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 10:00 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
MG KARL R. HORST, Army (via phone)
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

KAREN MALEBRANCHE, VA

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C-O-N-T-E-N-T-S

Recap of Morning Group Session 5
Consolidated Voting Session 96
Adjourn 281

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

10:03 a.m.

MS. DAILEY: Good morning, ladies and gentlemen. I'd like to bring your session to order. We are still passing out what would be Tab F in your books. Tab F, I would like everyone in Tab F. That's the work that you did this morning, and Tab F is up on the screen. And my staff will be handing out what will be called Tab F to our attending public.

Before we get started, we would like to introduce Ms. Karen Malebranche. Could I get you to stand up, ma'am? Ms. Malebranche is from -- excuse me, Malebranche. Ms. Karen Malebranche. She is from the VA, and we've had Mr. Medvy here yesterday, and you're here today. Are you all trading out? Thank you, ma'am. Thank you for attending. We appreciate it.

All right. I'm happy to recap what, I want to recap what we did yesterday and what we're going to do this morning and what was

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1 accomplished from eight until ten. And I want
2 to go over what you all did in your morning
3 session.

4 First of all, I'm going to start
5 with group number two, and group number two
6 consisted of Dr. Phillips, Mr. Constantine, and
7 Dr. Turner. And they went over Recommendations
8 35 and 38, and these recommendations had to do
9 with the Interagency Program Office and the
10 information technology interoperability. These
11 were Recommendations 35 and 38. And in
12 yesterday's meeting, we asked them to -- we
13 tabled them. We asked them to go back and do
14 some additional work on them, and we would
15 reintroduce them to this forum today at ten.

16 In group number one, we looked at
17 Recommendation 2, which was the line unit
18 community and the wounded warrior units;
19 Recommendation 7, which was the concept of
20 transition units; Recommendation 8, which is
21 achieving the climate of healing; and
22 Recommendation 10, which is defining entrance

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1 criteria. Group one, which had Colonel Keane,
2 Lieutenant General Green, and Command Sergeant
3 Major DeJong, worked on those four
4 recommendations after we yesterday asked that
5 they be reworked and re-looked at for a vote
6 today.

7 Group number three looked at
8 Recommendation 3, which was the strategic
9 solutions for the Guard and the Reserve; and
10 Recommendations 15, which was the DCO for
11 psychological health and TBI and the DCOs for
12 hearing, vision, and extremity injury care. So
13 that was Master Sergeant MacKenzie, Mrs.
14 Crockett-Jones, and Mr. Rehbein. And we asked
15 them to take a look at these three
16 recommendations for re-crafting and for
17 presentation today.

18 We have a voting session between 10
19 and 12 today. We break for lunch, and then we
20 have another preparatory session between 1 and
21 2. And then we'll be back at 2 for another
22 voting session.

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1 Now, as we are missing at least one
2 critical member that we would like to have
3 here, I'm going to leave it up to the co-chairs
4 if they want to vote in this 10 to 12 session
5 or if you would like to hold off your vote
6 until 2. You know, you'll have to judge your
7 time and what you think is doable with the
8 remaining four hours if you don't vote during
9 this session. This session could be very
10 useful as a discussion period of what you all
11 accomplished this morning. So I'm going to
12 leave it up to the co-chairs on how they want
13 to move forward or use it as a discussion
14 period.

15 And I'm going to turn it over to the
16 chairs now. Thank you.

17 CO-CHAIR CROCKETT-JONES: Well, I
18 think that we would want to hold off the votes.

19 Welcome back, everyone, to the table. I think
20 we have enough members absent to be concerned
21 about feeling we really have a consensus when
22 we make those votes. So we will be holding off

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1 the vote. We can, perhaps, review the work
2 that was done this morning to see if we are
3 ready to put it before the Task Force
4 completely for a vote, and that's probably the
5 best use of our time. CO-CHAIR GREEN:

6 So are we going to start with the groups that
7 did 35 and 38, or do we want to start with this
8 one? Okay. Go ahead.

9 DR. PHILLIPS: We combined 35 and
10 38, the Interagency Program Office. The most
11 trouble we had was with the font because we're
12 old and we couldn't see. But the written in
13 green is what we have done to combine 35 and
14 38, and I will just read it and you can read it
15 along with me. Achieve information technology
16 interoperability between the Department of
17 Defense, VA, and disparate civilian medical
18 information systems. These record systems
19 include electronic, paper, and other legacy
20 medical information systems. Just note, and
21 we'll put this in the findings, the ability to
22 mine scanned documents for data is essential to

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1 both care and research. Fairly simple, broad,
2 and straightforward.

3 CSM DEJONG: I'm looking at some of
4 the recommendations further up at 33 and 34.
5 Under what's written in there, if you look at
6 it, we also, we charged a SOC with this, and
7 this is one of the main things that we look at,
8 at putting responsible towards the SOC to
9 handle this. So I don't know how that's going
10 to tie together with this recommendation.

11 CO-CHAIR GREEN: I think that
12 probably, because of the specific nature of the
13 recommendations for the SOC, that I would not
14 include them in this discussion. So for right
15 now, can I push back a little bit on that?
16 Because we didn't ask them to look at those,
17 and so, since we haven't gotten through those
18 yet, let's wait and see if we want to combine.

19 But my gut feel is that those are specific
20 enough that we probably don't want to try and
21 tie them into something else.

22 The one question I have on the way

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1 this is worded, I mean, this is motherhood and
2 apple pie, but interoperability means something
3 different to every department. And so when
4 we've actually gone out, it's amazing to me
5 that we actually have two electronic systems
6 that essentially one system requires the other
7 to print out everything before they'll consider
8 the disability. And so isn't it almost beyond
9 interoperability? I mean, it's almost whether
10 or not one will accept the other's system.

11 DR. PHILLIPS: We've had a robust
12 discussion related to the word
13 interoperability. And just wearing my IT hat,
14 the term that we usually use is harmonization.

15 But, again, we were sort of stumped on what
16 the exact terminology should be related to the
17 culture that is not an IT culture, and so we
18 chose interoperability, but perhaps Justin or
19 Russ would want to comment on how we should
20 proceed.

21 MR. CONSTANTINE: I would just add
22 when I worked on Capitol Hill with the Senate

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1 Veteran Affairs Committee, and they were
2 looking into this, terminology was a big issue,
3 and that was a stumbling block for even getting
4 started on some of these reforms was how do we
5 define what words like "interoperability"
6 means? But part of the solution, I assume is
7 ongoing, is coming to a common definition of
8 that between these different entities, and so
9 we thought it was important since it's a word
10 that everyone uses, albeit perhaps differently,
11 that we include it in here, period.

12 CO-CHAIR GREEN: The Department has
13 announced, DoD and VA have announced, and it's
14 actually been in the press, that SECDEF and
15 SECVA have agreed that we're going to go to a
16 single EHR. And, of course, the veto efforts
17 are also well publicized. I mean, this
18 basically encourages them to do some of the
19 things that they're already doing. Is there
20 anything we want to do in a shorter term?
21 Because, for instance, the EHR effort is
22 probably three to five years before we'll see

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1 them in the same record.

2 And then one final comment, and that
3 is, in visits to many civilian systems, the
4 problem even with other electronic health
5 records is that there are many now that take
6 care of anything within their system, and none
7 of them that are actually able to handle things
8 from outside of their system. And so it's a
9 problem nationwide.

10 DR. PHILLIPS: Well, that's why
11 perhaps we should change "interoperability" to
12 "harmonize" because, again, in the IT world,
13 when we use that term, when you have disparate
14 electronic health systems that you need to
15 integrate in some way, the IT people then
16 choose a critical list of things that need to
17 be shared. And then using computer
18 programming, you can at least harmonize that
19 issue and prevent the printing of papers. I
20 really don't have a solution to this big issue.

21 DR. TURNER: As far as the short
22 term, I know that, you know, grand efforts are

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1 being made in this area already. And I think
2 that this, you know, supports that and it's
3 what we want to do. From my very limited
4 experience in IT and IM, if you're able to do
5 this in three to five years, that's pretty
6 remarkable anyway just with the acquisition and
7 development framework in which we have to work.

8 So I think that if we support what's being
9 done now, I don't see where there would be a
10 short-term solution that would be worthwhile.
11 And I would press for a workable long-term
12 integration, and I would support the final
13 solution instead of a band-aid. Even a band-
14 aid would take two to three years with
15 acquisition the way it is.

16 CO-CHAIR GREEN: This wouldn't be a
17 recommendation, but in the finding it may be
18 useful to actually to commend or to support the
19 efforts of both departments to move to a single
20 record, and so we could actually give them
21 credit for the work that's being done. I do
22 think it's imperative that we move to a single

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1 record, and so the other question is do we want
2 to put anything in that, well, you say achieve
3 information technology interoperability? Do we
4 want to basically say continue movement to a
5 single record? In other words, do we want to
6 go beyond interoperability?

7 DR. TURNER: We talked about this,
8 as well, and I think the group would support
9 that as a whole. One of the reasons that we
10 chose the wording that we did was to also
11 ensure that systems like radiology records, you
12 know, all the different lab records and all of
13 those things, all the information systems,
14 dictation systems, all medical information
15 systems would be mineable and be able, you
16 know, to be used for decision-making.

17 MR. CONSTANTINE: And civilian
18 systems, too.

19 DR. PHILLIPS: I mean, perhaps
20 somewhat beyond the scope of what we're tasked
21 to do is that, I mean, if you went out somehow
22 to the scientific community and the IT

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1 community, the Googles and the Microsofts of
2 the world and some of the work we're doing at
3 the NIH, a new system, which is not something
4 that we can perhaps want to recommend, a new
5 system could be developed for the entire
6 country or the entire world. But, of course,
7 there are other factors that prevent something
8 like this from happening.

9 I also might add, just as an
10 anecdote, is that I agree, I mean, it is
11 critical to have a single electronic health
12 record system because so much fallout will
13 occur if we don't achieve that. I mean, we
14 cannot really fix the IDES efficiently without
15 having a single electronic health system
16 because they're connected and they can't be
17 separated. So, I mean, the three of us that
18 talked about this are more than willing to make
19 this as broad and as definitive as possible
20 within our task.

21 MSGT MACKENZIE: The question I have
22 is is in the meantime of this long-term

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1 solution, though, is there a way to interface
2 or interact with these individual systems?

3 CO-CHAIR GREEN: Well, one of the
4 questions that was clear to me is can we give
5 access to VA assessors for disability to the
6 electronic record and avoid printing, you know,
7 volumes of records?

8 MSGT MACKENZIE: That's kind of what
9 I was referring to. I mean, I know the
10 ultimate solution is a single electronic health
11 record. But the longer we wait for this we
12 continue to have these problems, and if there's
13 a way to interface or interact or access a
14 system on a case-by-case basis we're at least
15 getting a better solution while getting the
16 final solution. We're getting a better product
17 while getting to the final solution.

18 DR. PHILLIPS: There are technical
19 programs. There's something called APIs,
20 application program interfaces, which will take
21 disparate systems and try to harmonize certain
22 data points. But that's at a technical level

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1 that I don't know that we're supposed to be,
2 you know, really dealing with, but there are
3 ways of doing it.

4 DR. TURNER: I think Mac's talking
5 about, in addition to a hardware/software
6 solution, a process solution in the interim is
7 what I'm hearing you say, like allowing them
8 to, like, access the records, as you say, and
9 would you, just to change the verbiage, this is
10 a suggestion, you could say achieve information
11 technology interoperability and access and, you
12 know, basically make sure that the different
13 agencies had access to others' information
14 technology. Is that what you're aiming for?

15 MSGT MACKENZIE: In a way, yes,
16 because I think that this electronic health
17 record is solving, is creating a solution for
18 hundreds of thousands of people. We're talking
19 about those, you know, forty or fifty thousand
20 you know, people that we're working with right
21 now to get access to make this system flow more
22 smoothly. I mean, I know we're going to get to

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1 a solution that's going to cover the broad
2 spectrum. But like General Green said, the
3 fact that you've got to print out a 4,000-page
4 medical record for somebody because they don't
5 have access to look at the system, I mean,
6 let's get them access based on the fact that
7 this individual is going to, you know, just go
8 to the evaluation board, so now they're --

9 DR. TURNER: That makes perfect
10 sense to me. Would you be happy with the
11 wording "achieve information technology and
12 access interoperability," or "achieve
13 information technology interoperability and
14 access between DoD" and adding --

15 CO-CHAIR GREEN: Can I jump in here?
16 Because --

17 DR. TURNER: Please.

18 CO-CHAIR GREEN: -- the sentence
19 isn't bad the way it is. The only thing that
20 worries me about your first sentence is that it
21 really hones down to what was the previous
22 recommendation to medical systems because VLER,

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1 which the IPO is also overseeing is not a
2 medical system. It's actually personnel
3 information, and so we'll have to think about
4 whether we need to broaden it. What I think we
5 might be able to do to reach Mac's goal here is
6 to add a line which says find interim solutions
7 to grant access to EHR for disability
8 assessment because if we put that in there, so
9 interim solutions to grant access to EHR for
10 disability assessment.

11 MR. CONSTANTINE: I think that's
12 good. I have seen some places where folks from
13 the different departments sit side by side, and
14 that way they can at least share that computer
15 and look at it. Obviously, we're not going to
16 get in the weeds and say that, but that is a
17 solution some places are coming up with.
18 That's not mandated. They're trying to work
19 around.

20 CO-CHAIR GREEN: I'd put that as the
21 first sentence, and, though our recommendation
22 now is, you know, go after this while you

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1 continue to work towards, what our real dream
2 is is to have the interoperability. And then
3 the only other question I have is are we too
4 honed in on medical because your IT
5 interoperability between DoD, VA, and disparate
6 civilian medical information, do you take out
7 and just make it "and civilian information
8 systems," or do you make this civilian only
9 tied to medical? The VLER is really an issue
10 with personnel systems.

11 MR. CONSTANTINE: We have medical in
12 there and not just for civilian but for DoD,
13 VA, and civilian medical systems. We
14 originally did not have it in there, but then
15 we thought not having it would be really broad
16 and could apply to all sorts of systems that
17 are way beyond our charter.

18 MS. DAILEY: Sir, our tasking from
19 Congress is about interoperability of
20 electronic health records.

21 CO-CHAIR GREEN: Okay. Then we're
22 fine with this, as long as we don't have to

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1 talk to VLER. It's just that we put it under a
2 heading of IPO, and the IPO technically owns
3 VLER and the EHR. So are we close on this
4 language then? Any other comments? Go ahead.

5 DR. TURNER: So could you read the
6 sentence to be added one more time?

7 MS. DAILEY: Find interim solutions
8 to grant access to EHR for disability
9 assessment. First line.

10 DR. TURNER: Do we need to define
11 EHR?

12 MS. DAILEY: We can, yes.

13 DR. TURNER: Okay.

14 CO-CHAIR GREEN: Does that meet your
15 intent, Mac?

16 MSGT MACKENZIE: I think that's
17 meeting the intent of part of why we're here,
18 you know. We're trying to get these solutions
19 to the end user and assisting these guys in the
20 recovering warrior process, and that certainly
21 would give us, you know, because we brought it
22 up when they briefed us, and it was kind of

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1 like, well, nobody has really brought that up
2 to us, and that's kind of why I was like, you
3 know, can we look at that? Because that will
4 at least get a, you know, the process moving
5 along while this dream process is down the
6 road.

7 CO-CHAIR GREEN: Yes. The other
8 thing is I think that the finding needs to be
9 expanded to actually talk to the volumes of
10 paper that are being printed from DoD's
11 electronic health record for consideration by
12 VA. So we need to help them understand why
13 we're saying defined. So in the findings, we
14 need to basically incorporate, it's not just
15 paper, it's people required to basically copy
16 and group.

17 MSGT MACKENZIE: The process is
18 quite labor-intensive not only for the
19 recovering warrior but the medical
20 professionals to provide the documentation and
21 then the amount of people it takes to weed
22 through those. You know, I think about the

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1 recovering marine that was brought from one
2 facility to another, and there were literally
3 three cases of medical records that came along
4 with him, and it overwhelmed the facility as to
5 how do we get all this data to the providers to
6 come up with an appropriate continued treatment
7 plan. And it was pretty awe-inspiring to see
8 happen, to see --

9 CO-CHAIR GREEN: Unbeknownst to me,
10 they actually also, when talking with the
11 folks, they make three copies of everything:
12 one for the member, one for Department of
13 Labor, and one for the VA assessment. And so
14 it's not one volume, it's three volumes. So
15 our electronic system is actually probably
16 burning more paper than the paper record did in
17 the first place.

18 MSGT MACKENZIE: Talk to a caregiver
19 that's trying to help their member through
20 there, and they'll echo that on many things.
21 They're like what do I do with this case?

22 CSM DEJONG: The only thing we

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1 talked about yesterday was actually charging
2 somebody to do whatever the recommendation is.

3 So that's the only question I want to throw
4 out there is we have find interim solutions,
5 but who?

6 CO-CHAIR CROCKETT-JONES: Well,
7 we've --

8 MR. CONSTANTINE: We identify that
9 later, don't we, when we assign what category
10 it goes to?

11 CO-CHAIR CROCKETT-JONES: We can,
12 but there is an introductory paragraph
13 concerning the IPO. But, I mean, did we have
14 the IPO on the finding? To reiterate that, is
15 it enough to be in the finding? And, Denise,
16 can we move down the note so that it's easier
17 to read the, well, at the end of the
18 recommendation there's a 27 July group note
19 that we need to move out of the recommendation
20 or just give some space. I just need it for a
21 few minutes to look at it. Do we think that's
22 enough indication between the finding and the

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1 opening paragraph?

2 CO-CHAIR GREEN: I suspect that it
3 is. The hard part here is, because these
4 records are not, some are paper, some are
5 electronic, the question is how to put them all
6 into a single system for the reviewers and the
7 disability evaluators to essentially be able to
8 review the record. And so the IPO is probably
9 the best office to deal with this. I mean,
10 it's basically people from DoD and VA. You
11 could push it towards one or the other, but
12 both sides are going to have to provide
13 something. And so the IPO may well be the best
14 place to have them work this. And so the
15 interim solutions to grant access for
16 disability assessment is not a bad way to tell
17 because, honestly, DoD would have to grant the
18 access, VA would have to be willing to accept
19 it, and then there's still the paper record in
20 terms of how you're going to bring them
21 together. So this is a business process re-
22 engineering that that's why the IPO really

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1 exists. So I think we've actually covered it
2 fairly well.

3 Any further discussion? Because you
4 guys went out and saw multiple sites. I mean,
5 is this common across the sites?

6 MSGT MACKENZIE: It is common, and
7 even in my own care I deal with this all the
8 time of, you know, if you don't bring the right
9 information, your appointment doesn't go well
10 and you have to reschedule because they don't
11 have access to films or they don't have access
12 to the right documents or the way they word
13 their request isn't necessarily what's
14 interpreted by the worker bee actually
15 executing the request. And if you're a
16 helicopter guy like me, I don't know what half
17 of those abbreviations mean anyway, so I can't
18 even help get the right information and you
19 don't find out until you get there. And I
20 personally have had several appointments
21 rescheduled because the appropriate information
22 either was not hand-carried or was not provided

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1 to that next healthcare provider for me to get
2 treatment.

3 CO-CHAIR GREEN: There are some
4 other interim solutions, but I don't think
5 we've looked at them. I saw them on a recent
6 trip with personal health records that actually
7 may allow us to have a member actually own some
8 of these records. But I don't think we've
9 explored that yet, and it may be something to
10 explore next year.

11 DR. PHILLIPS: I can just comment
12 and say that there's no civilian model either
13 that works. We're not there in the civilian
14 sector either.

15 CO-CHAIR GREEN: Okay. Let's go on
16 to the next group.

17 CO-CHAIR CROCKETT-JONES: Why don't
18 we go to Recommendation 2 and 10?

19 CO-CHAIR GREEN: Take it on there,
20 Steve. You've gotten us through these before.

21 CSM DEJONG: Okay. There was much
22 discussion throughout the group. And before we

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1 even started rewriting any of these, a lot of
2 discussion with General Green, and where we
3 really needed to start with this before we got
4 down into what we came up with. And if you
5 want to kind of go through some of those. I
6 know she took some notes. And if you want to
7 go through some of the early conversation, I'll
8 take it from there, sir.

9 CO-CHAIR GREEN: The issue with 2,
10 7, 8, and 10, and the interrelatedness of them
11 had to do with the tension between the WTUs,
12 the WWR, and then units that were trying to
13 provide support to recovering warriors. And
14 then when you looked at the four different
15 recommendations that had been drafted, one
16 essentially said that there were some issues in
17 terms of unit, getting people to appointments,
18 and needed to be some rigor in terms of
19 ensuring that people were able to get their
20 rehabilitation. And then there was one that
21 talked about the success of providing services
22 through the WTU/WWR concept. And then there

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1 was another that talked to enforcement of
2 existing policy for who was in and who was not
3 in WTU or WWR. And so when we looked at all
4 four together, the real question -- oh, the
5 fourth one was basically recommending that the
6 WTU or the transition unit, not particularly
7 one service or another's answer, but, in
8 essence, a transition unit was something that
9 was seen as the right way to take care of
10 warriors.

11 And so the problem on this one is
12 that this was one that needs kind of large-
13 group discussion. Based on the visits we did
14 this year, we saw sites that did not have the
15 support that we thought they should have in the
16 unit level. We saw WTUs and WWRs that were not
17 enforcing or not basically exercising policy
18 exactly as it had been laid out to us and, yet,
19 we saw clearly that the WTU/WWR was providing
20 services that were desperately needed by
21 families and by the recovering warriors
22 themselves.

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1 And so that's where the
2 recommendations ended up coming. Yet, on the
3 other hand, we didn't look except for really
4 two sites where there were unit-level programs
5 in support of this. And so to essentially jump
6 to the finding that essentially said everyone
7 should be managed through a WTU or an WWRs was
8 somewhat concerning because of our limited
9 experience. The other part of that is that the
10 WTUs and WWRs, in terms of their codification,
11 is goodbye service but is not necessarily
12 codified at the DoD level in terms of when we
13 will establish these, what are the numbers of
14 casualties that drive it, and, of course, as we
15 come out of the war over the next few years,
16 how do we actually also look at how many of
17 these do we need to continue and what will be
18 the criteria? Each service has criteria now
19 for who goes in, but how will you make
20 decisions?

21 And so I'll use the Army's
22 experience, they started putting all wounded,

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1 ill, and injured in, and then realized that
2 their WTUs had gotten to be very large and
3 burdensome in several different ways, from
4 housing to services to just numbers for medical
5 access, and then went back to a mix of people
6 who were maintained in the unit and people who
7 were in the WTUs. That was done by policy with
8 their FRAGOs, and, as they did that, they
9 decreased their numbers by nearly half about a
10 year ago or two years ago.

11 And so the point being that if you
12 are not clear on your policy for who's in and
13 who's out, then it's very unclear for how many
14 and how big your WTUs and WWRs should be. And
15 if you're not going to have a WTU or a WWR,
16 then how are you going to provide the services
17 now when they go out to units around the world?

18 And so that was the complexity of 2,
19 7, 8, and 10, is really we can make a judgment
20 call early and say we think the WTUs and WWRs
21 are the way to manage all casualties or
22 wounded, ill, and injured, or we can basically

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1 continue to look at this to see what the right
2 mix between unit-level programs and centralized
3 programs are to see whether or not, you know,
4 how this shapes over the next, because
5 obviously we're in for the next four years.
6 And, clearly, when you review the press that's
7 been available to us, there are pros and cons
8 to each of the different models.

9 And so we took a little different
10 approach, and I'm going to stop talking so much
11 because I don't mean to guide this. I just am
12 kind of laying the groundwork. We talked for
13 nearly an hour between the three of us about
14 are we ready to say this is the right way and
15 all should move one way or the other, and,
16 ultimately, came back to perhaps we should come
17 back to existing policy. So, Steve, back to
18 you.

19 CSM DEJONG: So when we looked at
20 especially 2 and 10, there was multiple, all of
21 them had multiple I guess semi issues, smaller
22 issues embedded in them. So we put 2 and 10

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1 together, kind of incorporating Marine Corps as
2 regimental order stating the criteria for
3 entrance into a WWR. The Army has FRAGO 3 and
4 4, which are based off of WTU and CBWTU off of
5 executive order.

6 So with those being in
7 establishment, what we realized through the
8 findings and through the site visits is that
9 it's out there, it's just not being adhered to
10 or enforced across the forces. So instead of
11 trying to rewrite anything that says establish
12 a policy, the policy is there, we just need to
13 make sure that it's being enforced and adhered
14 to.

15 So that brought us to Recommendation
16 1, which was enforce the existing policy
17 guidance regarding transition unit entrance
18 criteria. And then when a successful recovery
19 rehab and reintegration is not occurring at the
20 unit level, establish clear criteria for
21 transfer to the WTU and WWR, which then takes
22 the burden onto the company commander that

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1 wants to keep an injured soldier in their ranks
2 and continue to provide them care.

3 If it is being case-managed, if the
4 case manager at some point feels that it is
5 beyond the control of the commander and it
6 meets the criteria for entry into a WTU, then
7 there's established criteria for that. And
8 then that takes pretty much that call of yes or
9 no from the commander, which we realized was an
10 issue of saying my commander won't let me go to
11 WTU, it takes that into policy that they can
12 then enforce. The case manager can fight for
13 them getting in.

14 That brought us to Recommendation, I
15 guess I'll call it 2.

16 CO-CHAIR GREEN: Let's stop there
17 for a second and have discussion on the first
18 one. So the actual recommendation, as it was
19 originally written, asked us to establish rules
20 or to go directly to line commanders with some
21 type of rule set that would guide them in terms
22 of decisions on when someone was not or when

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1 someone should be moved to the WTU or WWR. And
2 so all of us were uncomfortable with trying to,
3 you know, actually have us say this is how a
4 line commander should make this decision
5 because there's so many different things that
6 go into it. So by focusing on the successful
7 recovery, rehabilitation, and reintegration, if
8 that's not occurring or if there is controversy
9 as to whether it's occurring, then there should
10 be criteria and we could even say, you know,
11 review or some other type of activity that
12 allows that discussion to occur. And that's
13 where we were trying to go.

14 So now if we haven't got the words
15 right before we go into the other one, but
16 let's let you guys see whether we captured your
17 thoughts.

18 MR. CONSTANTINE: It seems to me,
19 based on that, in the second sentence, the
20 second clause should go first.

21 CO-CHAIR GREEN: No objection to
22 that.

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1 MR. CONSTANTINE: And you talked
2 about the case manager. Maybe that should be
3 in the findings because it's important that
4 someone outside of the line unit is in with
5 that.

6 CSM DEJONG: We have a lot of things
7 to add into the findings. And one other facet
8 of that recommendation was talking about the
9 fair treatment, fair and equal treatment
10 between combat wounded and then you've got the
11 ill and injured that are also in there, which
12 is a large percentage. There was in the
13 recommendation rolled into -- I'll have to find
14 it -- making sure that was in there. With
15 others, it's more appropriate to put that into
16 the findings, just showing that we do have a
17 large percentage that's not and they feel, a
18 large majority of them feel that they're not
19 being treated as equally or as fairly or being
20 afforded the same level of care as the combat
21 injured. But all the findings from both of
22 these original recommendations still have to be

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1 brought into this.

2 DR. PHILLIPS: There was one area,
3 one thing that we heard from WWR focus groups,
4 and I'm not sure if it was from any of the WTU
5 focus groups, was that some of the soldiers in
6 the line units did not even know that a WWR or
7 a WTU was available on their post. So I don't
8 know if we can add something related to
9 information, and I don't know if any of the
10 other members of the group remember that, but
11 just to be informed that this is available.

12 MSGT MACKENZIE: I do recall that
13 being discussed in both with the Army and with
14 the Marine Corps, but what I found interesting
15 about what you guys came up with was having
16 that professional provider being able to go to
17 the line unit and going to the WTU or WWR
18 saying, hey, this carrier isn't going the way
19 we need it to go, this guy needs to be moved
20 over, because I found with each of those cases,
21 where the individual was talking about they
22 weren't very familiar with it, the nurse case

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1 managers were very familiar with it and, for
2 lack of better terms, were beating head against
3 the wall trying to figure out how to get this
4 guy moved over because they really didn't have
5 any say in the process. So by providing the
6 tools for those folks to make this effort, I
7 think, because we went into this in trying to,
8 how do you get information out, you know, do
9 you go to the top leaders to get information
10 out or do you go to the lowest-level guy and
11 get information out? Right there in the middle
12 is really where it needs to, you know, that's
13 the point that assists these guys most
14 effectively. And so I think that covered it,
15 what we found in those areas.

16 CSM DEJONG: A lot of what drove
17 that was all the cases that we read through the
18 findings and those of you that were at that
19 site visit, it was a nurse case manager saying
20 I can't get him the level of care he needs
21 while he stays in the unit, but the unit
22 commander is not releasing him, so.

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1 CO-CHAIR GREEN: Justin, to your
2 point about reversing the sentence, the reason
3 we did it that way is because the issue was,
4 once they went to the unit level, when could
5 they go back? And so if you write it with
6 establish their criteria for transfer, it may
7 say the same thing, but it almost reads like
8 the first sentence does, that essentially
9 you're going to transfer them from the unit and
10 so either they're kind of in or out.

11 The other piece I'm hearing that we
12 might be able to make this clearer is it says
13 establish clear criteria, and you may want to
14 insert the phrase "and appeal process for case
15 manager," "and a case manager appeal process."

16 That would actually be very specific that now
17 the case manager has a voice. So establish
18 clear criteria and case manager appeal process
19 for transfer, like that.

20 MSGT MACKENZIE: Do we want to
21 specify down to case manager or care provider?

22 Because a doctor could, in a sense, or a

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1 primary care physician, in a sense, also be in
2 that same realm, or would they hand that out to
3 the case manager to do?

4 CO-CHAIR GREEN: The nice thing
5 about saying case manager is that anyone who is
6 actually having problems should have a case
7 manager, so this kind of infers that the person
8 would have a case manager who's making that
9 recommendation. I would not say "a." Take the
10 "a" out and just say "and case manager appeal
11 process." Yes, just take it out.

12 MR. CONSTANTINE: It seems to me
13 that when the sentence is in this order it's
14 almost saying if there's not a successful
15 recovery then we'll establish clear criteria.
16 If you put the second clause first then we know
17 that this problem exists and we're going to go
18 ahead and lay out, they're going to lay out
19 what the criteria is for when someone comes
20 into that situation, and that's why I suggested
21 it because we know it's going to happen because
22 it's happening right now. So why not --

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1 CO-CHAIR GREEN: Can we move the
2 phrase after the comma to the front of the
3 sentence, so "establish clear criteria," and
4 just move that whole phrase to the front of the
5 sentence?

6 MR. REHBEIN: I want to agree with
7 Justin on that because what we want is a single
8 set of criteria, and the way that sentence was
9 worded initially, every time failure occurred
10 we would establish another set of criteria. So
11 I think doing it up front -- the other question
12 I have who then would initiate the transfer and
13 who would the case manager appeal to?

14 MSGT MACKENZIE: Once again, that's
15 in the existing policy and those contact
16 people.

17 CO-CHAIR GREEN: That's why we say
18 appeal process because if there's not an appeal
19 process then they'd have to put that into their
20 policy. So Justin I bow, I think you're right.
21 It's better the way you've put it there.

22 MR. REHBEIN: The other minor change

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1 I would make is the second half of that
2 sentence. Make it singular to RW. Don't leave
3 the impression that this has to happen multiple
4 times. One person is enough to trigger this.

5 CO-CHAIR GREEN: So it would be of
6 RW is or of a recovering warrior -- yes, I got
7 it. And get rid of the "s." Leave it right
8 like it is, and reintegration of a, let's put
9 an "a" in front of RW in the last. Yes, I
10 agree. That's better.

11 DR. PHILLIPS: I might add that more
12 at the Marine level we heard that movement to a
13 WWR was demeaning and basically put the Marine
14 in a situation where he was no longer part of
15 the line unit. But I think this language at
16 least moves to removing some of that attitude
17 because they have clear criteria that would
18 help. I just wanted to get that on the record.

19 CO-CHAIR GREEN: I think you'll see
20 that we've addressed that in the second
21 finding. That's why we kept a second finding
22 or a separate recommendation. The other thing

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1 you should be aware of is the reason we
2 incorporated it into the finding is we expect
3 that the finding will start with those two
4 lines, that comparable treatment should be
5 expected regardless of whether the RW is combat
6 wounded, ill, or injured or where they are
7 assigned and the balance between military
8 discipline and rehabilitation must promote
9 healing and maintain esprit de corps, which
10 also addresses, in small part, what you're
11 saying, Steve.

12 And then the finding would go on to
13 the step that was incorporated under both 2 and
14 10, so we'll let them write the finding. But
15 you see how we're trying to shape it. Further
16 discussion?

17 Okay. So we can talk about 7 and 8
18 now. You're on a roll, Steve.

19 CSM DEJONG: Okay. Seven and eight
20 brought us to the large discussion we had
21 yesterday about the WTU being the model across
22 all forces for this type of unit. And we don't

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1 know if we have enough information to actually
2 make that recommendation, but what we do know
3 and what we put into our findings to start this
4 is that the Army and Marine Corps transition
5 units provide vital services to recovering
6 warriors and their families. With that, we
7 know, looking back at history, every time
8 there's a major, you know, these units have
9 come and gone so many times. We get into a
10 conflict or we get into numbers, and they quick
11 build this and then they kind of go away
12 through budgets and whatever other means that
13 they take away from. And then a few years
14 later we're re-doing this again from the ground
15 up.

16 So what we're looking at
17 establishing with that is DoD must specify
18 clear criteria for the numbers of casualties
19 that should drive the establishment or
20 expansion of transition units. What that's
21 looking at is what's going to motivate or
22 what's going to cause the creation of a WTU

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1 with the expansion of. Part of what we're
2 finding, you know, what I experienced in
3 talking to some of the local WTUs with having
4 soldiers there is there is no criteria for when
5 they are allowed or authorized to increase in
6 size. The WTU at Fort Knox right now has got
7 two companies. They should have three, but
8 they just double-up one company. So there is
9 nothing that gives them, at command level, the
10 authority to expand or, at higher echelons, to
11 actually your numbers aren't good enough, don't
12 meet such a criteria, so we're no longer going
13 to maintain this WTU.

14 With consideration for housing,
15 family support, medical, and non-medical case
16 management and the rehabilitation needs of
17 recovering warriors. Obviously, all the
18 findings are going to come into it. But if you
19 look at Recommendation 7, it originally
20 supports the concept for the WTU concepts, and
21 then 8 talked about both Army and Marine Corps
22 must cultivate an environment within a

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1 transition unit that promotes healing within a
2 military setting. Okay. We kind of rolled
3 that one back up into the other findings. So
4 I'm hoping that there's a lot of discussion on
5 this one as far as where to take it.

6 CO-CHAIR GREEN: In essence, we took
7 this a little different direction than what the
8 original recommendation was. Rather than
9 mandating that WTUs be the way of dealing with
10 wounded, ill and injured, we've basically said
11 we need some clear criteria for when a WTU
12 would be established. And the reason for going
13 that direction is to try and get the Department
14 to codify, you know, so that we don't do this
15 in every war. We bring them up, we bring them
16 down, and then we learn all the lessons again.

17 And so if we could actually get them to codify
18 what's been learned in terms of the services
19 that are required, that would then be very
20 helpful. Without necessarily mandating this
21 solution for every wounded, ill and injured, it
22 basically helps to make certain that we don't

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1 lose the lessons. So if we took this too far
2 in a different direction, then we need to hear
3 from the members.

4 MSGT MACKENZIE: One of the things
5 that I've dealt with personally working as a
6 liaison with the joint services was, in an
7 effort to manage the flow of personnel,
8 decisions were being made by numbers of
9 personnel, not necessarily by is this closer to
10 home, you know.

11 I had one particular soldier comment
12 to me, you know, this location is closest to my
13 home, it has the medical care, the doctors have
14 already agreed, but I can't go there because
15 they're too full. You know, if there's reason
16 to expand this location because we have
17 recovering warriors from that area have
18 exceeded what they initially thought might be
19 there, this certainly gives them the ability to
20 go, okay, we obviously need to expand this
21 place because, in the effort of doing the right
22 thing for the recovering warrior, this is

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1 something we have to do and have clear guidance
2 to do because I think that's very important to
3 these guys.

4 CSM DEJONG: The other part of this,
5 the other part of the conversation that needs
6 to be taken into consideration is we know that,
7 based off of presidential and in Congress now,
8 we're going to start winding things down. But
9 we're going to have to care for these soldiers
10 over the next ten years, and the numbers, you
11 know, we're estimating ten years. It could be
12 more based off of what they need. So looking
13 at how do we establish criteria to maintain
14 treatment facilities for these guys as the
15 numbers decline but keep the care the same, at
16 the same level that it is now.

17 DR. TURNER: Well, one of the things
18 that we had talked about earlier is also just
19 in this wording, and I'd just be interested in
20 discussion on that, is, you know, we talked a
21 lot about standardization and make sure that
22 everyone was getting the same care service to

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1 service, which I think is kind of what you're
2 talking to, as well.

3 Do you think that there's any need
4 to say, for instance, clear criteria for the
5 numbers of casualties that should drive
6 establishment expansion of standard transition
7 units or standard transition unit services to
8 ensure that the same types of services are
9 available across DoD and across the services?
10 Do you see where I'm going with that?

11 I'm not saying necessarily that
12 everybody has to have a WTU because each
13 service I understand has its magic. You could
14 say standard transition unit services, so at
15 least the services provided by each service are
16 standard or you could mandate, you know, we're
17 all going to use a WTU. So I'd be interested
18 in discussion on that.

19 LTCOL KEANE: I think we covered
20 that in the second part of the sentence, the
21 consideration of housing, family support, non-
22 medical case management --

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1 DR. TURNER: Right, I understand
2 that. Again, just making the, I guess I just
3 want to hammer home that it's going to be the
4 same throughout all the services, that each
5 service offers the same services to the
6 recovering warriors. And I guess I was just
7 interested in making it a much stronger point.

8 CO-CHAIR GREEN: Let's try something
9 and then we'll see how it changes the meaning.

10 After transition units right there, put a
11 slash and then RW services. Okay. And I don't
12 know whether that will stay or not stay, but I
13 think it addresses what you're getting to.

14 DR. TURNER: Right. I guess my big
15 thing is I just want every, you know, soldier,
16 sailor, airmen has the same access to the same
17 quality of services. And so there is one
18 standard for all recovering warriors no matter
19 where they are.

20 CSM DEJONG: Sir, a lot of the
21 discussion and what General Green had brought
22 up during our discussion on this point is that

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1 take the Air Force, for instance. They're
2 looking at, you know, Force-wide 230 -- is that
3 what you said? You know, low 200 numbers. Is
4 that number going to drive the Air Force to
5 establish their version of a WTU? Probably
6 not. But we need to then incorporate those
7 airmen into what has been established in this
8 level of care, and that's what we're looking at
9 trying to get out in the verbiage.

10 DR. TURNER: That's exactly what --
11 and we're saying the same thing. To me, it's
12 not how you do it, but it's what's provided is
13 the same and what's provided is a standard.

14 CSM DEJONG: Yes.

15 CO-CHAIR CROCKETT-JONES: I have a
16 concern. We have completely lost the original
17 intent of the original recommendation. The
18 original recommendation was not about the size
19 or appropriate levels, you know, infrastructure
20 for a WTU, but it was on the atmosphere between
21 recovering warriors and the people who are in
22 the chain of command and in that unit.

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1 If you go back and look, it was
2 about the environment that exists, and there
3 are significant problems that we see everywhere
4 we go on that environment, on whether there is
5 a cooperative and productive relationship
6 between the leadership and the WTs.

7 And I'm concerned that we are going
8 to totally wash the recommendation we had,
9 saying that higher, that higher leadership was
10 responsible for filtering down a better
11 environment. I mean, that was, as I understood
12 it, what drove, if you look at the finding on
13 the original, on Tab B, page seven, during the
14 site visits the members observed that
15 transition units have not yet succeeded in
16 creating a unit environment that effectively
17 balances the dual imperatives of healing and
18 military discipline. It is a significant
19 problem. We saw it absolutely everywhere, and
20 we have completely lost the work on that
21 finding.

22 CSM DEJONG: We discussed that. We

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1 took that out of seven. If you scroll back up
2 to the other, we address that in what I'm going
3 to call Recommendation 2.

4 CO-CHAIR GREEN: I agree. We
5 expected that that finding would actually be
6 under 2 based on the comment about promote
7 healing and maintain esprit de corps. So the
8 finding that you're talking about we thought
9 would be in this one.

10 CO-CHAIR CROCKETT-JONES: I don't
11 see it in that one. Perhaps it's just me.
12 That seems to be about getting in, staying in,
13 or getting back out, not about what happens
14 when you're in. And I know you might
15 incorporate that into the finding, but the
16 finding does not have nearly the power of the
17 recommendation.

18 And I think that this particular
19 topic is a sticky one. It's an uncomfortable
20 one, and I think it's going to be really easy
21 to say we don't want to challenge the culture
22 that is creating a conflict between what

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1 promotes healing and what maintains discipline
2 and how do we find the right balance. I know
3 it's an uncomfortable topic, but I think that
4 that's why we need to be, we can't leave it to
5 a finding.

6 CO-CHAIR GREEN: My question to you
7 would be can we go to nine? Can you scroll
8 down. Is nine next on this?

9 CSM DEJONG: Suzanne, I completely
10 understand your concern with that. And when we
11 talked about it, it's either we come up with a
12 different -- I think we covered that, and that
13 finding can go into multiple recommendations
14 that we have here.

15 Some of fostering that environment
16 is going to go into cadre selection, cadre
17 training. Some of fostering that environment
18 is going to be into this selection criteria and
19 maintaining or not maintaining a soldier of any
20 sort into a WTU type environment. That problem
21 falls under a lot of different fixes as to
22 where I think we kind of, we didn't try to

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1 brush over it, we added it in. But I also
2 think that, as we look at the findings through
3 other things, that finding can fall under
4 multiple recommendations to just reinforce that
5 that is a problem across all different levels
6 of the WTU.

7 DR. TURNER: I think Suzanne, maybe
8 if I listened to Suzanne right, and I agree
9 with you that, you know, it's addressed by a
10 lot of things. I think Suzanne sees value in
11 just being up-front and saying it somewhere, at
12 least one place just being up-front and saying
13 this is a problem and, you know, we need to
14 address it. That's all I'm hearing Suzanne
15 say.

16 DR. PHILLIPS: And, Suzanne, I can't
17 agree with you more. I absolutely have seen
18 that same issue and perhaps I wasn't strong
19 enough in bringing up the SOCOM model, you
20 know, what are they doing that we could
21 possibly replicate? So, again, I would suggest
22 that we consider this, as Dave said, I'm sorry,

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1 Russ said, as a separate thought to include.

2 CO-CHAIR GREEN: Can I just point
3 out that we actually, when we did number nine
4 and we tackled this with the cadre and talked
5 about this, I think that it may be we didn't
6 get to the final language on number nine and we
7 might be able to incorporate right up-front
8 into the recommendation --

9 CO-CHAIR CROCKETT-JONES: We voted
10 on nine.

11 CO-CHAIR GREEN: But did we get to
12 the final language?

13 MR. REHBEIN: There's a process by
14 which we can reconsider.

15 CO-CHAIR GREEN: I agree with your
16 point. I just am not certain how to
17 incorporate it into this.

18 DR. TURNER: I think it almost
19 doesn't matter where, it just has to be, I
20 think and I agree with Suzanne, somebody needs
21 to say it and just be up-front and be perhaps
22 less subtle about it is kind of what I'm

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1 hearing Suzanne say.

2 MS. DAILEY: Ladies and gentlemen, I
3 think the group did a good job of bringing four
4 down to two. I'm not averse to four becoming
5 three, which would be the two that you have in
6 here, and leaving number eight pretty much the
7 way it is. We can sort out the findings which
8 would apply to your new number, enforce
9 existing criteria in which findings would
10 support -- DoD must specify criteria, and leave
11 number eight in there as-is. I'm not averse to
12 that. You've still brought it down from four
13 to three.

14 CO-CHAIR CROCKETT-JONES: I just
15 want to say I feel strongly that this can't be
16 just a finding.

17 MR. CONSTANTINE: I went back and
18 just looked at the finding from Recommendation
19 7, like you said, and it does sound like it's
20 saying that the value of an environment during
21 healing, but other sentences after that talk
22 about, talks about soldiers not being in a WTU

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1 and Marines who weren't in a WTU and didn't
2 receive adequate care.

3 So when it talks about fostering
4 that environment, it means getting into a WTU
5 or other transition unit, and that's where that
6 environment is. They're not saying create that
7 environment in the line unit. And so I think
8 this recommendation does address, to a great
9 extent, the findings of the old Recommendation
10 7 because it's saying we have to identify how
11 you get these RWs into the transition units.

12 CO-CHAIR CROCKETT-JONES: I'm
13 talking about the findings for Recommendation
14 8, the original findings for Recommendation 8
15 in the original Recommendation 8.

16 MSGT MACKENZIE: There's actually
17 twofold problem here. It's getting in, you
18 know, how do you get in and so on and so forth,
19 which is covered here. But, once again, we
20 discovered that there is also a problem in the
21 WTUs in wounded warrior regiments. There's two
22 separate things here. There's a problem with

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1 the getting in and getting out process and
2 those who are off to the side, but there's also
3 a problem inside as well that we need to make
4 sure we're capturing, as well. And I think it
5 is, as Suzanne said, a separate topic.

6 CO-CHAIR GREEN: So just take eight
7 off of this right now, and so let's go down and
8 put another recommendation down below. So just
9 scroll down, and let's try another approach
10 here because we missed that, so, clearly, the
11 group was working a different issue. So let me
12 just propose some wording, and then we can,
13 what's going to have to happen is the findings
14 are going to have to be split up between these
15 three to basically cover this. But I think
16 that the wording that we may want to put is
17 define appropriate unit atmosphere and
18 disseminate corresponding guidance and
19 standards for achieving it. So let's be short
20 and sweet and then make sure that the finding
21 captures what you're alluding to in terms of
22 the visits, okay? It's just really the last

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1 part of the sentence, define appropriate unit
2 atmosphere and disseminate corresponding
3 guidance and standards for achieving it. And
4 we probably need to be specific if we're going
5 to say for a WWR or WTU or if we want to go to
6 a WTC, if you see what I'm saying, is that
7 something for WTC and WWR? Okay. So define
8 appropriate unit and disseminate corresponding
9 standards for achieving it through the WWC/WWR?

10 DR. TURNER: And, again, this is
11 what we were trying to do yesterday with
12 Recommendation 2, and then we actually had the
13 sentence about holding them accountable, but I
14 think this is, you know, straight and to the
15 point would be good.

16 CO-CHAIR GREEN: Yes, because we
17 actually missed that portion of this, so that's
18 a good catch. In our discussion, we weren't
19 talking about this particular angle of this.

20 CSM DEJONG: No. I want to leave it
21 at the, are we still talking about the WTC or
22 WTs? Make sure that whatever acronym we put in

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1 there or whatever abbreviation, we keep it at
2 the command level.

3 CO-CHAIR GREEN: Now, in the
4 original recommendation, it said senior
5 leadership of these two organizations, which is
6 why I think we're talking about WTC and WWR,
7 but it might be better to say WTC and WWR must
8 define because that's kind of what was in the
9 original recommendation.

10 LTCOL KEANE: You could even make it
11 more simple, sir, and say the Army and the
12 Marine Corps.

13 CO-CHAIR CROCKETT-JONES: No, I
14 think it should be done --

15 CO-CHAIR GREEN: Yes, and I will
16 tell you that, you know, when we were looking
17 at this, we just kind of missed that particular
18 aspect of that recommendation, so thank you.

19 DR. PHILLIPS: Can we go back to
20 number seven? I had a comment. Would that be
21 appropriate? Are we done?

22 MS. DAILEY: Where do you --

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1 DR. PHILLIPS: Number seven, just
2 what we were visiting just a little earlier.

3 MS. DAILEY: The first one or the
4 second one?

5 DR. PHILLIPS: The first one.

6 MS. DAILEY: Okay, we're there.

7 DR. PHILLIPS: Yes, the edit. I
8 wanted to perhaps amplify what Dr. Turner was
9 saying, and let me preface it by saying some of
10 the bases are awfully remote, like Twentynine
11 Palms, and no matter how big your WWR is and
12 how many people are in it, there's still
13 difficulty in access to the things that we're
14 talking about. And I'm looking at after the
15 comma of WR services, I wanted to suggest that
16 with consideration for housing, family support,
17 medical, and non-medical case management that
18 we might change the word "consideration" to
19 "with adherence to the criteria or standards
20 established for housing, family support,
21 medical, and non-medical case management."
22 Just in my mind, it really specifies and

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1 strengthens the fact that remote bases may not
2 be capable, no matter how good the intentions
3 are of providing this.

4 CO-CHAIR GREEN: Can I make an
5 alternative suggestion before we put
6 "adherence" in? Because, remember, we're
7 saying they have to develop the criteria, so
8 adhering to criteria that are not yet developed
9 are worrisome. You might be able to do what
10 you're saying by simply putting in criteria for
11 numbers of casualties that should drive
12 location, establishment expansion. And so what
13 that does is basically it ties it all into the
14 where.

15 DR. PHILLIPS: Perfect.

16 MR. CONSTANTINE: Well, while we're
17 here, I think casualties should be RWs because
18 not every RW is a casualty, right? And now
19 that we just put that comma, there has to be an
20 "and" I think somewhere because right now that
21 doesn't quite make sense.

22 CO-CHAIR GREEN: So location

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1 establishment, or expansion? Yes, and the
2 casualties should be RWs there. That's
3 correct. And so then it would be a comma after
4 establishment and an "or" instead of a slash.
5 Yes, and you've got an extra "and" there. You
6 don't need that. You can delete the "and" and
7 the slash, just leave it as "or." Is that
8 closer? Does that capture what you were
9 looking for, Steve?

10 DR. PHILLIPS: That works. Thank
11 you.

12 CO-CHAIR GREEN: And, Justin, thank
13 you for your sharp eye. Okay. So, basically,
14 we ended up with three recommendations here,
15 two and ten are combined, seven, which is
16 rewritten, and eight. So we need to put down
17 that that is a new recommendation right there.
18 Yes. It's actually eight. One would be
19 seven, and the other would be eight. And we
20 need to get rid of the "s" on atmosphere.

21 MR. CONSTANTINE: Well, plus, does
22 that mean that atmosphere is -- or what units?

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1 And for centers for achieving, it seems like
2 there has to be a word after that.

3 CO-CHAIR GREEN: It's supposed to be
4 "achieving it" for the unit atmosphere. Define
5 appropriate unit atmosphere and disseminate --

6 DR. LEDERER: Transition unit
7 atmosphere?

8 CO-CHAIR GREEN: We could make it
9 WTU. We could list all three if you wanted.

10 MR. CONSTANTINE: I think something
11 like transition unit.

12 CO-CHAIR GREEN: Transition? Okay.

13 MSGT MACKENZIE: Right. But because
14 it comes after WTC and WWR, that many units
15 they're going to define are their units, which
16 are recovering warrior units, whether Marine or
17 Army.

18 CO-CHAIR GREEN: So up in front of
19 the unit on the first line, we need to insert
20 transition.

21 MR. REHBEIN: Are we not just going
22 back to the original eight?

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1 CO-CHAIR GREEN: I don't recommend
2 it because there were portions of eight that,
3 you know, when you look at it, it wasn't a very
4 clear recommendation, which is why we missed
5 this. So I'm trying to make certain that the
6 elegance of the argument here is captured.

7 DR. TURNER: Do you, again, just for
8 the group discussion, we're talking about the
9 atmosphere in the transition unit, but somehow
10 I also remember that even within the line units
11 the atmosphere was not conducive if you had
12 injured people in the line unit. So should we
13 address the atmosphere towards recovering
14 warriors in line units?

15 CO-CHAIR CROCKETT-JONES: I'm going
16 to suggest, I think, that actually
17 standardizing the criteria for treatment levels
18 will probably address much of that. I think
19 that the poor atmosphere situations we saw in
20 line units had more to do with someone who
21 really could not get the proper care where they
22 were. And I think if we addressed that and get

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1 people in the right places, that will sort of
2 solve itself.

3 CO-CHAIR GREEN: The other thing is
4 the first sentence in the existing
5 recommendation which says the Army WTC and
6 Marine Corps WWR must cultivate an environment
7 within the transition unit that promotes
8 healing within a military setting, period,
9 really belongs as kind of a second sentence in
10 the finding because it pulls it all together.

11 MR. CONSTANTINE: But also the
12 second prong of that sentence is important,
13 too, because we've heard plenty of times that
14 people or warriors who are not combat-injured,
15 you know, they're treated differently, but the
16 policy is that they shouldn't be. So I think
17 it's also important to include in the findings
18 the second part of that about equal treatment.

19 CO-CHAIR GREEN: Just make it a
20 separate sentence. Okay, yes. And the one and
21 two, even in the findings, it would be better
22 if we kind of broke it into two separate

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1 sentences.

2 MS. DAILEY: Okay. So most of that
3 recommendation you want to capture in the
4 finding? And the original eight needs to be
5 captured, the original recommendation in eight
6 needs to be captured as a finding.

7 MR. CONSTANTINE: Well, the end
8 result would be that the Army will have one set
9 of, Army will have an atmosphere and Marine
10 Corps will have an atmosphere. We don't want
11 to -- right? Or we want to leave it up to the
12 discretion of the services on how they want to
13 do that?

14 CO-CHAIR CROCKETT-JONES: I don't
15 think that it would be possible when you're
16 talking about the atmosphere to be cross-
17 serviced. That's part of the culture of each
18 service's unique character is going to be how
19 that atmosphere balances out and pans out.
20 Right now, we know it's out of balance.
21 They've got to work on it to incorporate their
22 own service culture and the proper healing

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1 atmosphere.

2 CO-CHAIR GREEN: The only other
3 comment is that you incorporate, for those who
4 are writing the findings, when you incorporate
5 the recommendation that's currently written in
6 number eight, don't repeat what we put in the
7 recommendation. So we took the last part of
8 the last line and made it the recommendation,
9 so we don't want to repeat that in the finding.

10 Further discussion? Are we close? We'll vote
11 on this this afternoon, so you'll get another
12 look at it. And I've also asked that they --

13 MS. DAILEY: I really don't like it
14 like this, but I'd like to wordsmith it and
15 vote it. But just try and contain yourself
16 this afternoon.

17 CO-CHAIR GREEN: And we've also
18 asked that, as we get closer to the ones we've
19 voted on that we'll actually get another look
20 at all the recommendations so we can look at
21 them together and make certain that they come
22 together the way we are intending. Okay. I

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1 think we have one other group for number three
2 or two, whichever one it was. Two?

3 MS. DAILEY: Yes, we should be
4 looking at 3, 15, and 6 now, which was group
5 three.

6 MSGT MACKENZIE: Yes, that is
7 correct.

8 CO-CHAIR GREEN: How about, I see
9 somebody else who's needing to take a quick
10 bladder break. Why don't we take five or ten
11 minutes and let everybody relax a little bit?
12 We'll be right back in ten minutes. Thanks.

13 (Whereupon, the above-entitled
14 matter went off the record at 11:24 a.m. and
15 resumed at 11:42 a.m.)

16 MS. DAILEY: Okay. Ladies and
17 gentlemen, it's 20 minutes until our session
18 with the public. And we can work in a lunch if
19 you want to cut into your lunch a little bit.
20 We do have a 1:00 to 2:00 group session, so
21 after that we will return for a 2:00 session.
22 If you remember my ambitious plans from the

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1 last few weeks, that 2:00 to 6:00 session would
2 be our, we would finish voting from 2:00 to
3 6:00 today. Now, as I've published, if we are
4 not finished, we can continue to vote tomorrow.

5 CO-CHAIR GREEN: Okay. We had one
6 more group today.

7 MSGT MACKENZIE: Okay. It was the
8 group of myself, Ms. Crockett-Jones, and Dave
9 Rehbein. So we took a look at Recommendation
10 3. We were part of that long conversation with
11 the other group that was looking at 2, 7, 8,
12 and 10 to try to figure out how to put this in
13 the right context.

14 So what we did was we focused on
15 addressing those needs, you know, in a
16 strategic, you know, this being a part of the
17 strategic look at these things and a strategic
18 level deal. So I'll just go ahead and start
19 reading it.

20 What we came up with was shape
21 strategic solutions that address the unique
22 needs of reserve component recovering warriors,

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1 care for reserve component will meet active
2 duty standards and, specifically, and we went
3 into these multiple sub-bullets, was establish
4 a process to ensure communication between
5 sending physician, receiving WTU physician, and
6 community-based care provider; ensure
7 communication technology access for those in
8 CBWTUs equal to the technology available to
9 those in WTUs and appropriate to their
10 technological access; evaluate the adequacy of
11 civilian healthcare delivery systems to ensure
12 recovering warriors will receive appropriate
13 care before transfer to remote locations.

14 CO-CHAIR GREEN: Can I just ask how
15 is that one different than what you had in the
16 -- go up to the first one.

17 MSGT MACKENZIE: The establishing a
18 process?

19 CO-CHAIR GREEN: The process for --
20 yes, ensure communication between sending
21 physician and receiving physician and
22 community-based care provider, and then the one

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1 that you say adequacy of civilian healthcare
2 delivery system.

3 MSGT MACKENZIE: I think what we
4 were trying to provide, to get them to provide
5 a mechanism to those CBWTU physicians, you
6 know, much like, when you look at military
7 treatment facilities, everyone is documented as
8 to what level of care they have there. When
9 you're getting ready to transfer a warrior,
10 like in my case, I use my case in particular as
11 an example where, initially, when they looked
12 to move me out of Landstuhl, they said on
13 paper, you know, your major medical facility
14 near where you're at has X, Y, and Z, and you
15 can go there. It opened the floor for
16 discussion with my liaison to say, no, it's
17 better off that you go to Wilford Hall because
18 they have X, Y, Z, and more of A and B that you
19 really need.

20 CO-CHAIR GREEN: Okay, I got it.

21 DR. TURNER: That makes sense.

22 Communication is different than level of care.

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1 CO-CHAIR GREEN: Got it.

2 MSGT MACKENZIE: And then enforce
3 consistent application of policy on CBWTU
4 assignment, train nurse case managers who
5 support CBWTUs in applicable TRICARE benefits
6 for recovering warriors. We didn't want to
7 isolate out specific versions of TRICARE, just
8 making sure these folks were trained
9 appropriately for their area. And then reserve
10 component must develop policy and procedures to
11 effectively manage recovering warriors not in
12 transition units. And with that, we put a note
13 to say that, you know, we're going to be
14 looking at that, what those numbers mean, you
15 know, in our Section 3, where it's like what
16 we're looking at next year, because we were
17 made aware of the fact that they are tracking
18 this stuff. But when we looked at these areas,
19 we never asked for that information. So we
20 want that to continue in the following year,
21 take a look at that. We wanted to leave that
22 option in there but, yet, take a look more in-

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1 depth next year and ask the right questions
2 next year. And then we left the findings
3 unchanged. So I'll leave it open for input.

4 CO-CHAIR GREEN: Can we scroll back
5 up so we can see the first part of the
6 recommendation? There you go. Thanks. Can
7 you explain the note?

8 CO-CHAIR CROCKETT-JONES: Okay.
9 That's what Mac was trying to do. Basically,
10 we know that they are tracking numbers of RWs
11 still in their units. What we didn't know,
12 since we need to ask them next year --

13 MSGT MACKENZIE: And it was in the
14 original recommendation that General Stone
15 brought up. It was our responsibility to
16 assess, and so we moved it out of the
17 recommendation into let's go after that next
18 year.

19 CO-CHAIR GREEN: Not one word
20 change? Come on. I wanted to be on that
21 group.

22 MSGT MACKENZIE: He's got one more

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1 to do. You've got another chance.

2 CSM DEJONG: My only concern with
3 this is that we go into, I like the
4 recommendation as written, specifically some of
5 the bullets, because we start looking into
6 there's really not a separation between reserve
7 component soldiers that are assigned to a WTU.

8 This is almost, it almost leads you to the
9 impression that all reserve component soldiers
10 are in a CBWTU when I first look at it. So I
11 want to make sure that we differentiate between
12 reserve component soldiers that are assigned a
13 WTU, and then there's going to also be other
14 solutions that we need to come up with and
15 facilitate for the added difficulty of a CBWTU.

16 MSGT MACKENZIE: And that's what we
17 were going after. The information we had was
18 on the CBWTUs, and that's why we were focused
19 strictly on that and requesting to go back
20 after the ones who are not next year.

21 CSM DEJONG: Okay.

22 MSGT MACKENZIE: Because we don't

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1 have enough data to say that they are or are
2 not receiving appropriate care, but several
3 case studies showed an inconsistency or, you
4 know, several topics we discussed in the room
5 showed an inconsistency in how some of this
6 stuff is done, including our discussion with
7 you guys. And so we wanted to, you know, get
8 that standardized and make sure that the right
9 information is provided to them in the CBWTU
10 structure.

11 CSM DEJONG: And looking at that,
12 and that's what I was reading over was the
13 findings, and all the findings, as you said, do
14 basically reference a CBWTU. So looking at
15 that, if that's the recommendation and these
16 are the findings that back up this
17 recommendation, we almost might want to refine
18 that recommendation into shape strategic
19 solutions that address the unique needs of
20 reserve component recovering warriors assigned
21 to a CBWTU, care for the reserve component
22 soldiers assigned to these CBWTUs shall meet

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1 active duty standards. I don't know if we want
2 to address any other thing. I mean, with the
3 findings backing up everything, I think we need
4 to strengthen that recommendation.

5 CO-CHAIR GREEN: And so we don't
6 have to repeat ourselves, it would be care for
7 RC in these units? Is that what you want to
8 say, or do you want to actually say in the
9 CBWTU?

10 CSM DEJONG: I'd say shape strategic
11 solutions that address unique needs of reserve
12 component recovering warriors assigned to
13 CBWTUs. At that point in time, we've
14 identified who they are. Care for these
15 soldiers or care for these recovering warriors
16 shall meet, and we've already established the
17 continuum of care throughout the continuum of
18 service and meeting active duty standards. So
19 we've established that in prior
20 recommendations. This is just going to
21 reinforce it at the CBWTU level.

22 MR. CONSTANTINE: So, therefore,

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1 it's really care for RC RWs, right? So care
2 for these RWs?

3 CSM DEJONG: Right. Care for these
4 recovering warriors --

5 MR. CONSTANTINE: Right.

6 CSM DEJONG: -- or care for
7 recovering warriors assigned to -- we
8 identified them in the first sentence, so care
9 for these RWs shall meet.

10 LTCOL KEANE: What about the Reserve
11 Marines?

12 CSM DEJONG: Well, that's why I'm
13 covering this. When I say reserve components,
14 sir, because reserve components should cover
15 all reserve components across Army, Air Force,
16 every service.

17 LTCOL KEANE: Marines aren't
18 assigned to CBWTUs.

19 MSGT MACKENZIE: Okay.

20 CO-CHAIR CROCKETT-JONES: I think
21 this recommendation was specifically about the
22 CBWTU population. If we need to look at how

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1 Marines -- I'm not sure we have, did we collect
2 any evidence regarding Reserve Marines that are
3 in a transition unit?

4 CSM DEJONG: That question was
5 brought up when we were in with the Deputy
6 Secretary of the Navy or that business meeting
7 that we had not too long ago. I asked that
8 question, what do Reserve Marines do as far as
9 care? And the answer was primarily they were
10 returned or put on active duty orders and
11 brought to one of the transition units. So at
12 that point in time, they really don't even meet
13 the criteria for this recommendation, sir.

14 MS. DAILEY: I'm not sure you should
15 make this broader. Your last one, RC, not
16 community-based warrior transition units, but
17 at the bottom it says the reserve component,
18 which would include the Marines, reserve
19 component must develop policy and process to
20 effectively manage recovering warriors not in
21 transitional units. So that would cover the
22 Marine Reserve, the would cover the Navy

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1 Reserve, Air Force Reserve. So this
2 overarching statement at the top you might want
3 to keep more general.

4 CO-CHAIR GREEN: Yes, I suggest we
5 keep it more general, especially because we're
6 going to follow up on that last one next year.

7 So keep it more general so we can look across
8 services, and then the ones that are specific
9 to CBWTUs are actually in the sub-elements.

10 MR. CONSTANTINE: So we just only
11 assign to CBWTUs?

12 CO-CHAIR GREEN: Yes, so delete
13 that. And then it would just be care for RWs
14 or for -- yes, right.

15 MR. CONSTANTINE: Why is it care for
16 RC? Care for reserve component? Why isn't it
17 reserve component recovering warrior?

18 CO-CHAIR GREEN: Right. That's what
19 I was going to -- RCRW support.

20 MR. CONSTANTINE: It's not there in
21 the second sentence.

22 DR. TURNER: I think the point we

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1 want to make is exactly care for reserve
2 component recovering warriors will meet active
3 duty standards. That's the point we want to
4 make.

5 MSGT MACKENZIE: That point is made,
6 actually, because the first line is addressing
7 the unique needs of reserve component
8 recovering warriors, and by stating care for
9 these recovering warriors shall meet we have
10 hit --

11 DR. TURNER: That's what I want to
12 say. I want to make sure that it's there.

13 MR. CONSTANTINE: I agree. We're
14 done with that. I would like to --

15 CO-CHAIR GREEN: The one question
16 that I have on the recommendation is we've gone
17 from "will" to "shall," and do we want to say
18 will, shall, must meet active duty standards?
19 What are we trying to say? I think I would put
20 "must" in there. Now, Justin, go ahead.

21 MR. CONSTANTINE: I'd just like to
22 talk about the sentence where it says, a tiny

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1 question I think is ensure communication
2 technology access for those in CBWTUS is equal.

3 More importantly, at the end of the sentence,
4 where it says access I think should be needs
5 because you're saying access should be
6 appropriate to their technological needs, not
7 access.

8 MSGT MACKENZIE: The reason we did
9 that is because giving a guy a cell phone to
10 communicate with in an area that doesn't have a
11 cell phone tower, you haven't met any needs
12 there because he doesn't have access to it.
13 Same thing with if you look at a guy who
14 doesn't have access to broadband internet
15 service, you know, to ask him to take a laptop
16 and get on a CTP that requires broadband access
17 or any of those other programs that require
18 broadband access, you haven't met his needs
19 because you've given him stuff that he has no
20 access to. And that was something we saw at
21 Fort Campbell in some of the outlying areas
22 where the AKO access required more broadband to

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1 get an effective use of it and, because they
2 didn't have broadband access, he couldn't
3 access the CTP at home and required him to go
4 back to the base in order to do anything.

5 CSM DEJONG: A small verbiage change
6 might be "capability" instead of "access."
7 Technology capabilities versus technology
8 access.

9 CO-CHAIR GREEN: Capability, if you
10 change it, means the person's capability,
11 whereas the access is about -- so I --

12 MR. CONSTANTINE: But here providing
13 access appropriate to their access, so there
14 has to be, I recommend a word change.

15 DR. PHILLIPS: Appropriate to
16 available technology.

17 MSGT MACKENZIE: Just get rid of the
18 word "access."

19 CO-CHAIR GREEN: Yes, I agree. Just
20 delete that access.

21 MR. REHBEIN: I think maybe what
22 we're trying to say with that last access might

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1 be better said with the word "infrastructure."

2 MR. CONSTANTINE: And CBWTU has to
3 be plural, as well.

4 CO-CHAIR CROCKETT-JONES: We don't
5 really want to talk about the soldiers'
6 infrastructure, so to their technological
7 available --

8 MSGT MACKENZIE: It would be
9 available technological --

10 CO-CHAIR CROCKETT-JONES: Available
11 technological infrastructure.

12 MSGT MACKENZIE: -- infrastructure.

13 LTCOL KEANE: Are there any places
14 where we can take out CBWTU to be more
15 inclusive?

16 CSM DEJONG: With not being at the
17 Twentynine Palms visit, I don't know if that
18 was an issue they had out there. I don't know
19 what kind of access they had, if they were
20 afforded the same sort of information
21 technology, if they were given a laptop, if
22 they were given a cell phone, if they even

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1 worked out there. That's some feedback that
2 might feed into that to make it a little bit
3 more all-inclusive, sir. So any feedback on
4 that for those that were at that site visit
5 would --

6 LTCOL KEANE: I guess a more general
7 question, not just from a Marine Corps
8 perspective, but to be more inclusive of all
9 the services, are there any of those sub-
10 bullets that don't necessarily need to have
11 CBWTU?

12 MR. CONSTANTINE: Like the --

13 CO-CHAIR CROCKETT-JONES: I think
14 the only that I'd look at might be the training
15 the nurse case managers.

16 MR. CONSTANTINE: Yes, the last one.

17 I wasn't in a CBWTU. I was through Bethesda,
18 but I had plenty of TRICARE issues, and my case
19 manager really didn't know the answer.

20 MS. DAILEY: So train nurse case
21 managers to support recovering warriors in
22 applicable TRICARE benefits for recovery.

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1 CO-CHAIR GREEN: Should be RCRW, so
2 you need an RW there.

3 MR. REHBEIN: If you put it there,
4 then take it off the end and just put the word
5 down. Replace RW at the end with that.

6 MR. CONSTANTINE: RW and then an
7 "s."

8 MS. DAILEY: I got it. Talk among
9 yourselves.

10 CSM DEJONG: Just looking at the
11 findings, Colonel Keane, as far as the findings
12 in here that are going to back this up, I think
13 that's about as many as we could take the CBWTU
14 out of it because a lot of the frustrations are
15 pretty much specific to the patient transfer
16 from a WTU on an active, you know, on an active
17 duty post to community-based care and what the
18 challenges are that face both the physician
19 handoff and the care plan handoff into that
20 environment.

21 CO-CHAIR GREEN: Any other
22 discussion?

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1 MR. CONSTANTINE: RW needs to be put
2 on that bullet. That's it.

3 CO-CHAIR GREEN: Okay. Any other
4 comments? And so we'll let this one for vote
5 this afternoon, okay? Thanks. Now, that was
6 it in terms of what went to the group?

7 MSGT MACKENZIE: No, we had 15 and
8 16.

9 CO-CHAIR GREEN: Okay, go ahead.

10 MSGT MACKENZIE: When we sat down
11 and took a look at 15 and 16, we came to the
12 consensus amongst us that they were better
13 served being combined because the topics were
14 connected enough to combine the two. And so
15 what we did was start with the general
16 recommendation statement. Provide the needed
17 support for the Centers of Excellence to enable
18 full operational capability, specifically align
19 the DCoE for Psychological Health and TBI to
20 the Army as the executive agency to promote
21 more aggressive dissemination of clinical
22 practice guidelines and develop point-of-care

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1 decision tools for providers that are based on
2 guidelines and integrated into the existing
3 delivery system; resolve the following concerns
4 of the VCE, HCE, and EACE from the research
5 agendas and registries currently under
6 development by VCE, HCE, and the EACE; proceed
7 immediately on the headquarters placement
8 decisions and concept of operations decisions
9 for the EACE. It will then begin building its
10 staff and pursuing its priorities for research
11 on and treatment of extremity injury and
12 amputation. Proceed immediately on the concept
13 of operations decisions for the EACE. And then
14 left the findings intact with those two open
15 for discussion.

16 CO-CHAIR GREEN: I think I'd take
17 out, under the EACE, I'd take out the second
18 sentence because it's really just, yes, it's
19 unnecessary.

20 CSM DEJONG: It's kind of
21 speculative. It's kind of making a speculation
22 that we don't know.

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1 DR. PHILLIPS: Just a question. Do
2 we need to include VA in some of this? Because
3 dissemination of information to the military,
4 it may be not appropriate but the VA needs the
5 information, as well.

6 LTCOL KEANE: That was my question,
7 too. The VA does have two pages, a page and a
8 half that addresses 16. Master Sergeant, did
9 you take a look at the VA input when you
10 rewrote this?

11 MSGT MACKENZIE: No, we did not.

12 MS. DAILEY: Tab L. There are
13 places where it can be expanded to say --
14 include VA. It's on page 10 of the Tab L.

15 LTCOL KEANE: Ms. Dailey, can you
16 scroll down? I'm looking to see if there's a
17 reference to the VA in the findings.

18 CO-CHAIR CROCKETT-JONES: All right.
19 I do have some information. This was
20 accounted for a bit. They were, their
21 recommended edit is not to commit VA to funding
22 and staffing decisions. They are not in the

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1 new wording. The correction on the names of
2 the centers has been taken out, according to
3 the head of those Centers of Excellence. So I
4 think page ten's three recommendations we have
5 actually incorporated. CO-CHAIR GREEN:
6 Yes, and I'd also point out that the first
7 bullet ends at integrating into the existing
8 delivery systems, which would include the VA.
9 So without specifying, I think we've got it.
10 And so I guess the other question is are we
11 cognizant enough of what's in the research
12 agenda to actually say funded? In other words,
13 we say in this, it says fund research agendas
14 and registries currently under development by
15 them, and I know on the registries, for
16 example, that there's a lot of discussion as to
17 whether this can't be done within the existing
18 data warehouses versus funding them separately,
19 such as what the ophthalmology, the eye Center
20 of Excellence has done. And so I'm wondering
21 if we want to temper this a little bit and not
22 be so specific about the research agendas and

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1 registries and just say fund VCE, HCE, and
2 EACE, and not be specific as to what to fund.

3 MSGT MACKENZIE: Okay. I agree.
4 And the reason we left that in there because
5 that was what was brought up during the
6 briefings about what they had planned to do but
7 couldn't do it because they weren't getting any
8 funding for it.

9 CO-CHAIR GREEN: So perhaps because
10 we don't have any of the specifics on what the
11 research is, because, I mean, that way, if they
12 put in \$100 million, our recommendation would
13 be -- so I think that it would be provide
14 funding for VCE, HCE, and EACE would be a
15 broader statement without locking us into
16 something that we've heard sketches of.

17 MSGT MACKENZIE: I agree, sir.

18 CO-CHAIR GREEN: So can we change
19 that to provide funding and just probably for.
20 Right. Other discussion on this one?
21 Actually, I think you captured it very well.

22 MR. CONSTANTINE: Is there a

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1 difference between executive agent and
2 executive agency?

3 CO-CHAIR GREEN: If you're going to
4 place it to the Army as executive agent, it
5 would be agent. There would be a "t" there.
6 Any other discussion? Very nice. All done.
7 Okay. And I think that wraps up what we did in
8 groups this morning, and we'll take on the
9 additional recommendations this afternoon. So
10 why don't we go ahead and break for lunch?
11 Okay, thank you, everybody.

12 MS. DAILEY: Yes, we will be back
13 for a public session and a voting session at
14 2:00 this afternoon.

15 (Whereupon, the above-entitled
16 matter went off the record at 12:11 p.m. and
17 resumed at 2:04 p.m.)

18 MS. DAILEY: Okay. Ladies and
19 gentlemen, we are going to start. And, sir, we
20 did some work this morning and reviewed that in
21 the open session from 10 until 12. And the
22 real question is do you want to start at number

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1 24 where we left off yesterday?

2 CO-CHAIR GREEN: We'll vote on the
3 ones that are fresh in everybody's mind from
4 this morning.

5 MS. DAILEY: Okay. So then what I
6 need everyone to do, I believe you have Tab G.
7 Tab G is being put in front of you right now.
8 And what I need you to do then is to go down
9 to page, a page that starts with 24,
10 Recommendation 24. So you'll go past all the
11 colored recommendations, 2 through 10,
12 Recommendation 3, and you'll end up on a page
13 that actually says 26, and it says support to
14 family caregivers. Well, it would be page 26.
15 Keep going down. The numbers are very small,
16 and some of them aren't numbered, but you'll
17 see a page 26. So then on page 26 is
18 Recommendation 24, and that's where we left off
19 --

20 CO-CHAIR GREEN: We want to do the
21 ones we did this morning first.

22 MS. DAILEY: All right. I

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1 apologize. Flip all the way back. Go back
2 three pages. And you'll find a page that
3 starts with page Recommendation 210. At the
4 top of the page, it says 210. And, yes, that
5 is page 24. Those are the recommendations that
6 you did this morning.

7 CO-CHAIR GREEN: The first one we
8 did was number three, which is on page 20.
9 There was another one before that. It's okay.

10 We can start on page 24. That's fine. All
11 right. So, basically, the work that we did
12 this morning, we got to draft language that we
13 need to get familiar with. So let us go ahead
14 and read this one out loud, and then we'll look
15 at it again. So, in essence, what we did, we
16 took Recommendations 2 and 10 and combined them
17 to basically what you read now on the screen,
18 "Enforce the existing policy guidance regarding
19 transition unit entrance criteria, establish
20 clear criteria and case manager appeal process
21 for transfer to the WTU/WWR when the successful
22 recovery, rehabilitation, and integration of a

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1 recovering warrior is not occurring at unit
2 level." And so by stating it that way, we
3 essentially enforce existing guidance, and we
4 also create an appeal process which solves the
5 problem from one of the sites where we had
6 people that the case managers really felt they
7 had no say as to whether or not they should be
8 in a different program. And so it basically
9 asks the services to create policy to deal with
10 that.

11 MG HORST: Yes. This is General
12 Horst. It sounds like you're getting cut off.

13 CO-CHAIR GREEN: Okay. Well, you're
14 in right now.

15 MG HORST: Okay, good. Don't hang
16 up on me.

17 CO-CHAIR GREEN: We're not. Okay.
18 So since most of the folks have seen this, is
19 there anything you see that's objectionable in
20 this?

21 MG STONE: No, I don't.

22 CO-CHAIR GREEN: So, Karl, you're

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1 there on the phone. We're combining
2 Recommendations 2 and 10 --

3 MG HORST: Yes, sir.

4 CO-CHAIR GREEN: And, basically, the
5 wording will be, "Enforce the existing policy
6 guidance regarding transition unit entrance
7 criteria, establish clear criteria and case
8 manager appeal process for transfer to the
9 WTU/WWR when the successful recovery,
10 rehabilitation, and an integration of a
11 recovering warrior is not occurring at the unit
12 level."

13 MG HORST: Okay. I have a hard
14 copy, and I'm following along right with you.

15 CO-CHAIR GREEN: Okay, good. I'm
16 glad you got the hard copy.

17 MG HORST: Yes, sir. So if you all
18 can just refer me to where you're at and where
19 you're reading, I can follow you hard copy.

20 CO-CHAIR GREEN: We think it's the
21 first page, but on ours it's labeled as page
22 24.

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1 MG HORST: Yes, sir.

2 CO-CHAIR GREEN: Okay.

3 MS. DAILEY: Sir, it should say at
4 the top Recommendation 2/10.

5 MG HORST: Yes, ma'am, I got it. I
6 got it, Denise.

7 CO-CHAIR GREEN: Okay. Any further
8 discussion? And so I need someone to make the
9 motion.

10 DR. PHILLIPS: So moved.

11 MSGT MACKENZIE: I second the
12 motion.

13 CO-CHAIR GREEN: So we have a motion
14 to accept this as a recommendation, and so I'll
15 just do a vote. And so all in favor, raise
16 your hand. Okay.

17 MG HORST: Aye.

18 CO-CHAIR GREEN: Thanks, Karl. Any
19 opposed? And no abstentions. Okay, approved.

20 The next one is a recommendation on the same
21 page that's listed as Recommendation 7/8, and
22 it is, indeed, a combination of what was in the

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1 draft report. And this one reads, just so
2 everybody has it, "DoD must specify clear
3 criteria for numbers of recovering warriors
4 that should drive location, establishment, or
5 expansion of transition units/recovering
6 warrior services with consideration for
7 housing, family support, medical, and non-
8 medical case management and rehabilitation
9 needs of recovering warriors."

10 And just to clarify for the folks
11 who have joined us, there was some discussion
12 as to whether we should recommend the warrior
13 transition unit concept, the wounded warrior
14 regiment concept, or the unit concept. And
15 rather than choosing one as being the model for
16 care, in essence, what we're trying to do with
17 this recommendation is codify how we would make
18 decisions in the future as to what the sizing
19 construct should be and whether the numbers
20 drive the need for a transition unit. The
21 point being that, as we exist right now, each
22 service has criteria, which is fine, but we

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1 don't have anything that codifies the
2 establishment of these types of organizations
3 to provide this level of family support and
4 care for our wounded warriors.

5 So the goal of the rewrite was
6 essentially to get DoD to codify when, based on
7 things that may change in terms of being in war
8 or out of war, these types of activities would
9 be set up. Discussion?

10 MG STONE: I'm having some trouble
11 with the English here. It makes a lot more
12 sense, based on what you've said, than when I
13 read it. And specifically I'm having trouble
14 with DoD must specify clear criteria and then
15 this phrase of for numbers of recovering
16 warriors that should drive X decisions.
17 Shouldn't we be saying just what you said in
18 your comments, that as we make decisions on
19 where we should locate the future recovering
20 warrior complexes or whatever you want to call
21 them, there are certain criteria that must be
22 considered. One is location, one is numbers.

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1 But I just have this trouble with the English
2 here.

3 CO-CHAIR GREEN: The reason location
4 was placed up where it was is because before
5 you make changes to this, the reason that
6 location was placed where it was instead of
7 down with the other considerations was with
8 regards to -- well, Steve, who did it?

9 DR. PHILLIPS: Just some of the
10 remote bases, like Twentynine Palms, that
11 actually cannot fulfill the mission of
12 providing all of the medical and support
13 services needed. So we wanted to consider
14 that.

15 MR. CONSTANTINE: I know numbers of
16 RWs sounds a little awkward, but we were really
17 talking about the amount of, you know, the
18 amount there. How many wounded warriors does
19 it take before you throw them something or
20 throw them something out.

21 CSM DEJONG: Sir, part of what why
22 we took it into consideration on this was

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1 throughout history we've seen these units come
2 and go based off the need, so what can they
3 establish to say you need to keep this? And
4 what we're looking at is the next ten years of
5 care throughout as this war winds down. And
6 that's just a generous forecast of ten years;
7 it may be very short. But as far as an
8 estimation of how many years we're going to
9 have to keep this level of care up based on the
10 numbers of casualties that the services
11 together are dealing with.

12 MG STONE: I'm in complete agreement
13 with both of your comments. I think you're
14 going down the right path. It's just somehow
15 I'm having trouble with the phrase, and if I'm
16 the only one having trouble with the phrase, if
17 it's clear to everybody else, then I'll take a
18 step back. But there's clear criteria for
19 decisions to be made based upon numbers of
20 recovering warriors. I mean, there's some
21 phrase missing in that. And, remember, we
22 don't want to have to be standing there to

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1 explain what we meant by it. And if I'm the
2 only one that's got that, then I'll take a step
3 back on this. If everybody else it's clear to,
4 then I'll just take a step back.

5 CO-CHAIR CROCKETT-JONES: Here's a
6 possible. Specify population-based criteria to
7 drive decisions about location establishment or
8 expansion of transition units.

9 MR. CONSTANTINE: Yes, population-
10 based means numbers, but we can always rescind
11 that.

12 CO-CHAIR GREEN: Let me get it on
13 screen so everybody is looking at the same
14 thing.

15 CO-CHAIR CROCKETT-JONES: Specify
16 population-based, and there's a hyphen in
17 there, criteria to drive decisions about, and
18 then go right to location establishment.

19 MR. REHBEIN: It is much clearer.
20 I'm not sure, though, that it addresses Dr.
21 Phillips' comments, though. Population-based
22 data won't prevent you from having a Twentynine

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1 Palms.

2 CO-CHAIR GREEN: And on the other
3 hand, it does have expansion listed, and so the
4 population expansion would apply to what Dr.
5 Phillips was trying to say. So in other words,
6 if you've got some place -- by saying location,
7 we infer that it should be a place where you
8 can get the best resources. And then by saying
9 establishment or expansion, you're saying to
10 set up a new one or to expand one that already
11 exists. So I think it's covered.

12 MR. REHBEIN: True. With
13 consideration for medical.

14 CO-CHAIR GREEN: And that's actually
15 why we put location early in this because of
16 Dr. Phillips' comments.

17 CSM DEJONG: I believe we've got
18 some findings somewhere that reference that,
19 which will be added to that.

20 CO-CHAIR GREEN: Okay. Good call.
21 Further discussion? Karl, do you need us to
22 read it again?

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1 MG HORST: No, sir. I'm tracking
2 with you. The word that I think may be missing
3 in there is, the four criteria would be DoD
4 must specify clear standards and criteria to
5 drive decisions for numbers of wounded
6 warriors.

7 CO-CHAIR GREEN: So we can insert
8 standards in front of criteria.

9 MG HORST: Yes. And I think
10 standards establishes a threshold for criteria
11 to meet those standards. That would be my
12 recommendation on it to make it more clear, but
13 others may not agree.

14 CO-CHAIR GREEN: Okay. We captured
15 that. Any further discussion?

16 LTCOL KEANE: Sir, we did renumber
17 this. It should just be Recommendation 7,
18 though, right?

19 CO-CHAIR GREEN: That's correct. It
20 should be just number 7, although we did
21 combine some elements of 8, but it should just
22 be number 7 now. And, of course, all the

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1 numbers will change eventually, but, yes, I
2 understand what you're saying. Okay. So
3 further discussion? Ladies and gentlemen, help
4 me.

5 CSM DEJONG: I'll make a motion to
6 accept Recommendation 7 as written.

7 DR. TURNER: Second.

8 CO-CHAIR GREEN: Okay. We have a
9 motion and a second to accept the
10 recommendation as it's now been edited. All in
11 favor raise your right hand. Karl?

12 MG HORST: Aye.

13 CO-CHAIR GREEN: Any opposed? And
14 no abstentions. Okay. Approved. The next one
15 is on the same page under new recommendations.

16 It's actually listed as number 8. And as we
17 had tried to combine 7 and 8, we had missed one
18 of the significant findings and
19 recommendations, and so we actually put it back
20 in. And this essentially deals with the issue
21 of, I'll say command culture but, basically,
22 things that were seen in several different

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1 units that were visited. And so the
2 recommendation reads, "The WTC and the WWR must
3 define appropriate transition unit atmosphere
4 and disseminate corresponding standards for
5 achieving it." And when you look into the old
6 recommendation, it then talks very specifically
7 as to the command climate that was problematic
8 in several locations, and so that would be
9 captured under the finding. Discussion?

10 MR. REHBEIN: If there is no
11 discussion, sir, I would move adoption of this
12 recommendation.

13 MR. CONSTANTINE: Second.

14 CO-CHAIR GREEN: We have a second.
15 Thank you. You folks are helping me out.
16 Okay, all right. Any further discussion?
17 Karl, are you okay with where this is going?

18 MG HORST: No, sir, I'm fine with
19 where we're going now.

20 CO-CHAIR GREEN: And so I need all
21 those in favor of 8 as a recommendation.

22 MG STONE: What do we mean by unit

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1 atmosphere?

2 CSM DEJONG: Sir, we were talking
3 about just basically the command climate of the
4 difference of what's important. Is healing the
5 number one concern for some of these leaders,
6 and this one encompassed a lot of conversation
7 and a lot of other aspects, one of cadre
8 training, cadre selection, to basically foster
9 the environment of healing versus the
10 environment of being at formation on time, you
11 know, just the healing environment instead of
12 the basic training type environment that have
13 been reported.

14 DR. PHILLIPS: Let me add that
15 you're not demeaned if you go into a WWR. This
16 is something that you should be proud of, and
17 maybe we can say it differently, but it pretty
18 much came from some of the base visits where,
19 if you remember, going into a WWR -

20 MSGT MACKENZIE: If you look at Tab
21 B, page seven and eight, it shows the
22 recommendations under eight that drove this

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1 recommendation, of the original number eight
2 that drove this recommendation.

3 CO-CHAIR CROCKETT-JONES: Yes, the
4 finding for Recommendation 8 gives the best
5 explanation.

6 MG STONE: The single sentence
7 should stand alone as the recommendation.

8 CO-CHAIR GREEN: The way it's
9 proposed, we would put the current
10 Recommendation 8 into the finding just below
11 that. And so we essentially focused on the
12 last sentence in that paragraph to get it to be
13 something more actionable.

14 MG STONE: If we're dictating
15 command climate, then I think you have to put
16 it in terms that are understandable to the
17 people that are receiving it. You know, it's a
18 command climate. I understand where we want to
19 get to. I think we all agree to that. But
20 these words don't get us there. I think the
21 addition of what's in the findings helps
22 explain to what we're trying to get to, but

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1 none of us would understand the concept of unit
2 atmosphere, but it's much clearer when you say
3 command climate.

4 CO-CHAIR GREEN: And so I've got a
5 little problem with the Robert's Rules here, so
6 we've got a motion in a second. I think that
7 probably because it's been seconded we need to
8 vote, okay? And then if there needs to be
9 changes, we can essentially decide if we want
10 to go further. So all those in favor raise
11 your hand. Okay. All those opposed to it
12 written as it is currently? Okay, Karl?

13 MG HORST: I would vote no and allow
14 us to go back and continue the discussion.

15 CO-CHAIR GREEN: Okay. And so we
16 have now opposed this recommendation as
17 written, and now we're back to discussion. So
18 go ahead. Rich, you're just suggesting that we
19 basically put in appropriate transition unit
20 atmosphere, command climate, or take out unit
21 atmosphere?

22 MG STONE: Take out unit atmosphere

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1 and transition unit command climate.

2 MG HORST: I would agree with Rich.
3 Command climate is clearly understood by
4 everyone, probably a little more so than unit
5 atmosphere.

6 DR. PHILLIPS: After the word
7 "define" do we need to add the word
8 "encourage?" Define and encourage? Or is it
9 evident from what we have?

10 MSGT MACKENZIE: That would be, I
11 believe, would be covered under disseminate
12 corresponding standards for achieving. It
13 covers that exact requirement.

14 CO-CHAIR CROCKETT-JONES: Do we need
15 to add back in guidance on standards? If it's
16 not necessary, I'm fine with that. I just
17 don't want to miss it.

18 DR. PHILLIPS: Achieving it I think
19 indicates guidance.

20 DR. TURNER: If there's no further
21 discussion, I move we vote on the revised
22 writing.

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1 CSM DEJONG: I'll second that.

2 CO-CHAIR GREEN: Okay. It's been
3 moved and seconded that we approve
4 Recommendation 8, which has been amended to
5 read, "WTC and WWR must define appropriate
6 transition unit command climate and disseminate
7 corresponding standards for achieving it." All
8 in favor? Karl?

9 MG HORST: Aye.

10 CO-CHAIR GREEN: Any opposed? And
11 no abstentions. Thanks. The next page is the
12 next recommendation, which is listed as
13 Recommendation 3. And can I get somebody who
14 put that one together to talk to it?

15 MSGT MACKENZIE: Yes, sir. Once
16 again, as previously discussed this morning, we
17 took Recommendation 3 and restructured it,
18 obviously looking at number 3 as a strategic
19 impact recommendation and reading as, "Provide
20 the needed support for the Centers of
21 Excellence to enable full operational
22 capability, specifically," and then we

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1 continued with those bullet statements --

2 CO-CHAIR CROCKETT-JONES: Wait.

3 MSGT MACKENZIE: I'm sorry. Wow.
4 Okay. The screen kept moving, and I lost my
5 place. Okay. Recommendation 3 was, "Shape
6 strategic solutions that address unique needs
7 of reserve component recovering warriors. Care
8 for these recovering warriors must meet active
9 duty standards, specifically," and then we went
10 through and looked at some of these earlier
11 today, which was "establish a process to ensure
12 communication between sending physician,
13 receiving CBWTU physician, and community-based
14 care provider; ensure communication technology
15 for those in CBWTUs is equal to the technology
16 available to those in WTUs and appropriate to
17 their available technological infrastructure;
18 evaluate the adequacy of civilian healthcare
19 delivery systems to ensure recovering warriors
20 will receive appropriate care before transfer
21 to remote locations; enforce consistent
22 application of policy on CBWTU assignment;

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1 train nurse case managers who support reserve
2 component recovering warriors in applicable
3 TRICARE benefits; reserve component must
4 develop policy and processes to effectively
5 manage recovering warriors not in transition
6 units."

7 Now, unlike what's written up here,
8 when we took a look at this this afternoon, we
9 also made some adjustments to the findings. We
10 took a look at the findings to make sure that
11 through the rewrites we hadn't messed that up.

12 So we retained the original statement there to
13 add to chapter three about exploring
14 effectiveness of current tracking databases
15 within the reserve component because we didn't
16 request that information this year to see if
17 they were effectively tracking these guys and
18 providing the right level.

19 CO-CHAIR GREEN: So, in essence,
20 you're simply, when you say chapter three, you
21 mean that you're going to push it to future
22 years?

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1 MSGT MACKENZIE: Right. That
2 assessing effectiveness is obviously going to
3 have to be tackled next year or --

4 CO-CHAIR GREEN: So that particular
5 part of the recommendation --

6 MSGT MACKENZIE: Was removed.

7 CO-CHAIR GREEN: -- was pushed to a
8 future --

9 MSGT MACKENZIE: Yes, sir.

10 CO-CHAIR GREEN: -- report.

11 MSGT MACKENZIE: And that was based
12 on your recommendation, General Stone, that,
13 you know, assessing effectiveness is our
14 responsibility, and we never did quite ask for,
15 we didn't know to ask for that correct
16 information. So what we did was there was a
17 couple of findings that were in the original
18 number three that actually belonged in other
19 areas, so we moved those and so forth. But as
20 far as the recommendation, that's where we're
21 at with the recommendation.

22 MG STONE: So moved.

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1 MSGT MACKENZIE: Seconded.

2 CO-CHAIR CROCKETT-JONES: Okay.

3 Well, then I'd like to see a vote. Who votes
4 in favor of accepting it?

5 CO-CHAIR GREEN: Karl?

6 MG HORST: I'm okay with it the way
7 it's written right now, sir.

8 CO-CHAIR CROCKETT-JONES: Is that an
9 aye?

10 MG HORST: Aye.

11 CO-CHAIR CROCKETT-JONES: All
12 opposed or abstentions? It's voted in.

13 CO-CHAIR GREEN: And right below
14 that is number 15.

15 MSGT MACKENZIE: It still belongs to
16 me, but now I'll read it in the appropriate
17 order. Once again, the DCoE Recommendations 15
18 and 16 were combined into Recommendation 15.
19 And then what we did was create the one
20 recommendation, "Provide the needed support for
21 the Centers of Excellence to enable full
22 operational capability, specifically align the

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1 DcoE for Psychological Health and Traumatic
2 Brain Injury to the Army as the executive agent
3 to promote more aggressive dissemination of
4 clinical practice guidelines and develop point-
5 of-care decision tools for providers that are
6 based on guidelines and integrated into the
7 existing delivery systems; resolve the
8 following concerns of the Visual Center of
9 Excellence, Hearing Center of Excellence, and
10 Extremity Amputation Center of Excellence,
11 which is provide funding for the VCE, HCE, and
12 EACE, proceed immediately on the headquarters
13 placement decision and concept of operation
14 decision for the EACE, and proceed immediately
15 on the concept of operations decision for the
16 HCE."

17 CO-CHAIR CROCKETT-JONES: Is there
18 any commentary?

19 MSGT MACKENZIE: And there we are.

20 DR. PHILLIPS: Move for approval.

21 MR. REHBEIN: Second.

22 CO-CHAIR CROCKETT-JONES: All those

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1 in favor? General Horst?

2 MG HORST: Aye.

3 CO-CHAIR CROCKETT-JONES: Any nays?

4 Any abstentions? It has passed.

5 CO-CHAIR GREEN: Was that the sum
6 total of this morning?

7 CO-CHAIR CROCKETT-JONES: That was
8 everything from this morning.

9 CO-CHAIR GREEN: Okay. And so now
10 we're back to where we left off yesterday which
11 I think is 24, which is on page 26.

12 MSGT MACKENZIE: Excuse me, sir. We
13 did the 35, 38, the interoperability?

14 CO-CHAIR CROCKETT-JONES: We don't
15 have copies in here.

16 MS. DAILEY: We'll get it. I don't
17 know where it is.

18 CO-CHAIR CROCKETT-JONES: You guys
19 on page 34? Would one of those who worked on
20 it please read it off and give us any
21 commentary?

22 DR. PHILLIPS: Recommendation number

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1 35, the IPO should continue to push the
2 capability to scan for full-image sharing --

3 DR. TURNER: That's the original.

4 DR. PHILLIPS: Oh, I'm sorry. Find
5 interim solutions to grant access to electronic
6 health records for disability assessment;
7 achieve information technology interoperability
8 between DoD, VA, and disparate civilian medical
9 information systems. These record systems
10 include electronic, paper, and other legacy
11 medical information systems. Note: make sure
12 this sentence stays. Finishing up with the
13 ability to mine scanned documents for data is
14 essential to both care and research.

15 MR. REHBEIN: If I understood
16 correctly, I think we ended that right where
17 she just put the carriage return.

18 MR. CONSTANTINE: And, Denise,
19 you're going to spell out electronic health
20 records or leave it as an acronym?

21 MS. DAILEY: We'll spell it out.

22 CO-CHAIR GREEN: Just by way of

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1 discussion, so the combination here is really a
2 combination of 35 and 38. The first statement
3 that was added in this, the find interim
4 solutions to grant access to EHR for disability
5 assessment, and in the findings what will be
6 added is something regarding our experience
7 with people printing out the electronic health
8 record in multiple volumes for consideration by
9 the disability system and the need for us to
10 find interim solutions to avoid going from
11 electronic to paper and back to electronic. So
12 if we need to be clearer on this, that would be
13 a good discussion item. But the idea here was,
14 in broad terms, to give credit to the two
15 departments for agreeing to move towards a
16 single record as we move into the future but to
17 still hold them accountable for doing things
18 now that would decrease the tremendous workload
19 associated with having to create paper records
20 from electronic records for consideration by
21 the disability evaluators. Comments?

22 CO-CHAIR CROCKETT-JONES: If there's

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1 no commentary, does anyone have a motion?

2 MR. CONSTANTINE: I move that we
3 approve this recommendation as written.

4 MG STONE: Interim to what? Interim
5 to a final electronic medical record system
6 that's fully integrated? Interim --

7 MSGT MACKENZIE: That is correct,
8 sir. The number of years that it's going to
9 take for this to finally happen, you know, I
10 brought this up earlier was the fact that we
11 have to have some way of accessing this stuff
12 now to facilitate the disability system for the
13 recovering warrior while reaching that --

14 CO-CHAIR GREEN: So are you asking,
15 Rich, if we put in pending the adoption of a
16 common record? Is that what you'd like to
17 have?

18 MG STONE: Sir, you're the world's
19 expert in this one. I think it's so familiar.

20 I mean, we see the need for an interim bridge,
21 but we have to define the end point that we
22 want to bridge ourselves to.

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1 CO-CHAIR GREEN: So if I could -- do
2 we have a motion on the floor or can I go
3 ahead?

4 CO-CHAIR CROCKETT-JONES: You can go
5 --

6 CO-CHAIR GREEN: Okay. So right
7 after find interim solutions, put a comma.
8 Let's see. Okay. So at the beginning, before
9 that, get rid of the comma and go back to the
10 sentence. Yes, so this would be pending the
11 adoption of a common record.

12 MSGT MACKENZIE: Would it be
13 adopting or implementing or the implementation?

14 CO-CHAIR GREEN: Pending the
15 implementation of a common EHR. Probably we
16 should be more specific, too.

17 CO-CHAIR CROCKETT-JONES: Yes, so
18 implementation.

19 CO-CHAIR GREEN: You don't need the
20 commas, and you don't need the adopt and
21 record. Yes, you don't need either comma. Oh,
22 no, you do need that one. That's fine. Karl,

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1 now what it reads is, "Pending the
2 implementation of a common EHR, find interim
3 solutions to grant access to EHR for disability
4 assessment; achieve information technology
5 interoperability between DoD, VA, and disparate
6 civilian medical information systems, and these
7 record systems include electronic, paper, and
8 other legacy medical information systems." And
9 that would be the recommendation.

10 MG HORST: So that last sentence,
11 the ability to mine scanned data documents is
12 essential for both care and research?

13 MR. REHBEIN: That's going to move
14 into a finding.

15 MG HORST: Okay, got it. I
16 understand.

17 CO-CHAIR GREEN: Okay. And so any
18 further discussion?

19 DR. TURNER: Move for adoption.

20 LTCOL KEANE: Second.

21 CO-CHAIR GREEN: All those in favor
22 raise your hand.

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1 MG HORST: Aye.

2 CO-CHAIR GREEN: And I voted for
3 Rich. I had his proxy here for a short minute.
4 And so with that, this one -- oh, I'm sorry.
5 Any negatives? Any abstentions? Okay. So
6 this one is approved.

7 And now we go to page 26, I believe
8 it was, for Recommendation 24.

9 MG HORST: Did I understand
10 correctly we're going to back to Recommendation
11 24?

12 DR. TURNER: Yes, sir.

13 MG HORST: Okay, got it.

14 CO-CHAIR GREEN: Okay. I'm not sure
15 which group worked this yesterday.

16 MR. CONSTANTINE: We got it, sir.

17 CO-CHAIR GREEN: Okay. Go ahead,
18 Justin.

19 MR. CONSTANTINE: Family caregivers
20 are essential to the recovery of many
21 recovering warriors. Caregivers should be
22 empowered with access information and resources

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1 for a successful recovery. These resources
2 include, but are not limited to, lodging,
3 orders, support groups, childcare, liaison
4 officers, and appropriate credentialing, as
5 needed. And there should be a comma after
6 limited to, not a colon.

7 CO-CHAIR GREEN: And so we're
8 opening this one for discussion. I guess one
9 of the things I'm struggling with is what's the
10 actual recommendation?

11 CSM DEJONG: I'm looking at this,
12 and some of the other ones that we kind of
13 shortened up. I like the first sentence, but
14 it's really a statement and I think it should
15 go into findings. It is a true statement, a
16 very true statement, but we're clouding the
17 actual recommendation of empowerment of
18 caregivers. And I think the only other thing
19 we need to look at is who is going to do that
20 empowering? I like the shorter, more powerful
21 -- I mean, look at the original. It was
22 empower family caregivers with resources they

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1 need to fulfill the roles expected of them.
2 Got it. I would just add who's going to do the
3 empowering.

4 CO-CHAIR CROCKETT-JONES: Part of
5 the problem is different resources in that list
6 would be connected to caregivers from different
7 sources.

8 DR. PHILLIPS: So we need to spell
9 that out?

10 MSGT MACKENZIE: The thing about
11 this recommendation, one of the big driving
12 power factors of this recommendation was,
13 obviously, through our focus groups, through
14 the information we gathered across the
15 spectrum, was that the family caregivers were
16 on invitational travel orders. They were on
17 non-medical attendant orders. They were
18 responsible for caring for this warrior.
19 However, beyond the initial phase, they were
20 being dismissed at many, many locations in many
21 areas as being responsible but not having any
22 of the tools, resources, or respect of the

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1 position they held. And I know at one point we
2 discussed, I think it was after one of our
3 focus groups and we had approached this
4 subject, was that, you know, if a spouse is on
5 orders to be a caregiver, just because the
6 recovering warrior is awake doesn't mean the
7 recovering warrior is going to remember, and
8 that spouse must be included in that
9 conversation if they are there as a caregiver.

10 And I believe it was Fort Campbell where we
11 had that first exposure to that where a spouse
12 was taken off of non-medical attendant orders
13 because they weren't making sure that the
14 service member got to their appointments, yet
15 the WTU was not informing the spouse at all as
16 to what the schedule of events were or anything
17 else.

18 CO-CHAIR GREEN: I think, though,
19 that the new wording that has been proposed is
20 actually a wonderful first paragraph to the
21 finding. In other words, it clarifies the
22 recommendation. But I kind of agree with Steve

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1 that the shorter recommendation, which was to
2 empower family caregivers with the resources
3 they need to fill the roles expected of them is
4 a little bit crisper in terms of a
5 recommendation. And the new language simply
6 clarifies that, which would make it excellent
7 as the first paragraph of the finding, unless
8 that's objectionable.

9 MR. CONSTANTINE: It's not
10 objectionable to me. I just didn't really like
11 the words "expected of them," and so that's why
12 we took it out in our recommendation, to
13 fulfill the roles for a successful recovery.

14 DR. TURNER: I would agree with
15 Justin. I don't like the "expected of them"
16 either.

17 MSGT MACKENZIE: And from a hospital
18 liaison, it is expected of them, regardless of
19 whether they're capable of accepting it or not.

20 It's a reality. That is a reality. And the
21 other thing is is that it's actually, and it
22 was brought up here, was that it's caregivers.

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1 They're not always family. Sometimes, this is
2 somebody's best friend or --

3 CO-CHAIR CROCKETT-JONES: We also
4 have the issue that some transition units
5 actually do make the family situation and
6 support, including driving, chauffeuring, those
7 issues conditional to their entrance into that
8 unit. So there are times when these are roles
9 that they are designated as having. I think if
10 we want to change the words "expected of them,"
11 I think that we just need to, in some way, if
12 we can, acknowledge that these are sometimes
13 specifically delineated in unit criteria. So I
14 don't want us to lose that aspect that they are
15 being asked to do this specifically.

16 CO-CHAIR GREEN: I'm thinking the
17 language, you know, just listening, so if we
18 said empower family caregivers with the
19 resources they need to fulfill their roles,
20 plural, in successful recovery of recovering
21 warriors, that captures both the expectation
22 and -- okay. So up there, go up to the one

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1 above all that text. Oh, you've already
2 rewritten it. Okay. To fill their, T-H-E-I-R,
3 roles in successful recovery of RWs.

4 CSM DEJONG: Do we still need to
5 identify the who?

6 DR. PHILLIPS: To fulfill their
7 roles, rather than fill? Fulfill.

8 CO-CHAIR GREEN: So it now reads,
9 "Empower family caregivers with the resources
10 they need to fulfill their roles in the
11 successful recovery of recovering warriors."

12 CO-CHAIR CROCKETT-JONES: I'm just
13 asking this question. Will a fiancé be covered
14 by this?

15 DR. PHILLIPS: Well, if we eliminate
16 the word family.

17 CO-CHAIR GREEN: I believe that
18 family caregivers is solely used to basically
19 get it so that they don't think of the medical
20 system. Now, so family caregiver is a broader
21 term to anybody who is not part of the
22 professional staff that's maintained.

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1 CO-CHAIR CROCKETT-JONES: That's
2 yes.

3 MR. CONSTANTINE: Maybe we should
4 say that in the finding. Unless that's
5 absolutely clear to everyone, maybe we should
6 make sure that -- because when I was in the
7 hospital that was a big issue.

8 DR. TURNER: I would agree. We need
9 to be absolutely unambiguous about that.

10 MS. DAILEY: One way of doing it is
11 just take out the word "family" and use the
12 word "caregivers."

13 CO-CHAIR CROCKETT-JONES: No,
14 because that will cover a whole other group.

15 MSGT MACKENZIE: Non-medical
16 caregivers.

17 DR. TURNER: Or nonprofessional
18 caregivers.

19 CO-CHAIR CROCKETT-JONES: No, I
20 think we just need to define the term either in
21 the findings. Do we have a glossary type
22 definition? That is a term that needs to be in

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1 there, family caregivers.

2 CO-CHAIR GREEN: That would be my
3 recommendation. Put the family caregivers and
4 give a broad definition in the glossary. So
5 family caregiver would be maybe family, maybe
6 friend, maybe fiance. I guess you could use
7 nonprofessional assistant who's providing
8 significant care and any designated individual.

9 MSGT MACKENZIE: And some of that
10 wording was clarified in JFTR on non-medical
11 attendant orders and so forth. It was re-
12 clarified when they opened this up to the broad
13 spectrum of people. So that may be another
14 source of correct definition.

15 CO-CHAIR GREEN: So just in the
16 glossary, we'll take what's in the JFTR and try
17 and make it broad.

18 DR. LEDERER: It turns out we do not
19 have a glossary, per se. But we can footnote
20 in the blurb that begins the "Support for
21 Family Caregiver" section. That immediately
22 precedes that's on the screen.

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1 CO-CHAIR CROCKETT-JONES: Thank you.
2 That's sufficient. The specifics in the
3 original, were those at all moved to findings
4 or were those excised?

5 MR. CONSTANTINE: I recommend an
6 amendment be in the findings.

7 CSM DEJONG: I concur with that.

8 CO-CHAIR GREEN: Actually, because
9 it's actually more than findings, we may want
10 to take a sentence out of this and put it with
11 this. So particularly we actually ask for a
12 database, so whether we want it as a DoD level
13 database, which I think would be much harder,
14 or as a local database, but they really should
15 know at a warrior transition unit or WWR who
16 are the family caregivers so that they can
17 provide tools to them. So I would probably say
18 establish local database or establish a
19 database, not specifying, of family caregivers
20 so that tools may be more easily provided.
21 That would probably be a good extension of this
22 recommendation. So I kind of think that it's

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1 strong enough that you could link the two of
2 them. The bullet above. Go up to --

3 CO-CHAIR CROCKETT-JONES: Establish.

4 CO-CHAIR GREEN: Yes.

5 CO-CHAIR CROCKETT-JONES: And just
6 take out DoD level centralized.

7 CO-CHAIR GREEN: I think we're
8 better off just writing it. Can you go down to
9 the phrase where we were adding and let me just
10 -- so not there, but at the end of RWs. Okay,
11 there. And so databases, a database of family
12 caregivers should be maintained or establish a
13 database of family caregivers so that tools may
14 be more easily disseminated. It's actually a
15 listing so you would know who the family
16 caregiver was because what you're trying to do
17 is find a way to get information to the
18 caregiver. It may not be said well yet but
19 that's --

20 CSM DEJONG: Basically, what you're
21 looking at is in addition to the in-processing
22 of establishing, having each recovering warrior

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1 establish caregivers.

2 CO-CHAIR GREEN: And I'm not sure.
3 You could probably take the "more" out, as
4 well. So it would just be establish a database
5 of family caregivers.

6 MS. DAILEY: Establish a database of
7 family caregivers to ensure tools may be more
8 easily disseminated.

9 CO-CHAIR GREEN: Take out the word
10 "more." May be easily disseminated. Now, is
11 there anything else in the paragraphs above? I
12 mean, we can let the riders take some of this
13 into findings, if that's what we want. But is
14 there anything else that we need to include in
15 the recommendation to ensure that it meets our
16 intent?

17 CSM DEJONG: Do we want to add the
18 rest of the green verbiage there? Is that what
19 we wanted to add into the findings, or do we
20 just want the above bullets in there?

21 CO-CHAIR GREEN: No, the green is
22 actually going to be the first paragraph of

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1 findings. And so it's just those two lines
2 right now that would be the actual
3 recommendation.

4 CSM DEJONG: Okay.

5 DR. TURNER: Do we really want to
6 direct how they disseminate the tools to the
7 family caregivers?

8 CO-CHAIR GREEN: Right now, the
9 recommendation is simply to --

10 DR. TURNER: Well, establish a
11 database to do it, so we're directing them how
12 to do it.

13 CO-CHAIR GREEN: Only because, from
14 our visits, we found that they didn't
15 necessarily always know who the caregiver was
16 and, therefore, you couldn't give them the
17 information they need.

18 MSGT MACKENZIE: The point is that
19 the tools are out there, but it depends on what
20 base you go to as to what you get. Do you
21 understand what I'm saying?

22 DR. TURNER: Oh, absolutely.

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1 There's just something about, we've made a big
2 point about not directing them on how to do it,
3 just telling them what to do. And this is
4 telling them how to do it.

5 CO-CHAIR CROCKETT-JONES: I'm not
6 sure that we're telling them how to do that. I
7 think we're telling them they have to create
8 this tool to support them in doing that. I
9 don't think we're telling them how. There are
10 many ways that they can use that database.
11 There are different ways that they can use that
12 database to get those tools. And, really,
13 we're telling them how to do a lot of things.
14 We really have. We've had no hesitation to
15 tell them how to do many things. They can
16 certainly, we might not want to tell line units
17 how to do things, but our job is to give them
18 recommendations on what we want them to do.

19 MSGT MACKENZIE: And, unfortunately,
20 every single medical situation is going to
21 dictate a different set of tools that the
22 caregiver needs in order to facilitate the

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1 recovery. So you can't identify the tools.

2 MR. REHBEIN: This isn't a database
3 of tools. This is a database of who the
4 caregivers are. All we're telling them to do
5 is make sure you know who the caregivers are.

6 CSM DEJONG: My only question with
7 the database is at what level do we want the
8 database? Is it a company-level database? Is
9 it a battalion level? Is it WTC? Is it
10 regimental level? I mean, depending on the
11 level.

12 CO-CHAIR GREEN: Yes, I think that
13 it's probably local because family caregivers
14 can change. And so I think it's a local tool,
15 which is why I took out the national database.

16 It would be very difficult to maintain, so if
17 we need to specify we can.

18 CSM DEJONG: Well, then instead of
19 just establish a database, which is what Dr.
20 Turner is looking at, of us mandating anything,
21 we can say ensure the establishment of a
22 database.

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1 MR. CONSTANTINE: You might as well
2 keep it. If you're going to say ensure it,
3 then do it.

4 CSM DEJONG: Okay.

5 DR. PHILLIPS: One point. After the
6 "fulfill their roles in the successful
7 recovery," do we need to add "and transition?"

8 I just don't want someone to say, well, you're
9 recovered and we don't have to help you any
10 longer. Maybe I'm being too specific, but
11 successful recovery and transition of RWs.

12 MR. CONSTANTINE: I appreciate that
13 comment, but I think we're recovery
14 encapsulates, all the list resources we have
15 for there all deals with recovery, generally
16 while they're in the hospital. So I think it's
17 sufficient.

18 MR. REHBEIN: I think, you know, a
19 bed set of circumstances, the caregiver is
20 going to walk away when the caregiver walks
21 away, and there's nothing we can do about it.

22 LTCOL KEANE: I agree with Dr.

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1 Turner in that I think this is directive in
2 nature. How about local units must ensure that
3 family caregivers are provided all the tools
4 necessary to provide the care they need to
5 give?

6 MSGT MACKENZIE: The only thing I
7 look at that is that we're sending this to DoD.
8 If DoD deems that they can keep it on a
9 national level, then let's let them have that
10 opportunity at a national level. If we already
11 try to nail it down to the local units then
12 that's where it will stay. If it can be held
13 at a national level, then it's a more national
14 product. But I guess I didn't want to fine-
15 tune it down unless they see it as better
16 managed at a lower level.

17 MS. DAILEY: Ladies and gentlemen, I
18 concur with a local database, but we have a
19 reference in here that there is a
20 congressionally-mandated database for
21 collecting caregiver information and
22 maintaining it, populating it, and using it to

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1 ensure that caregivers have the appropriate
2 access.

3 DR. TURNER: That already exists.

4 MSGT MACKENZIE: It may be mandated,
5 but it doesn't exist.

6 MR. CONSTANTINE: Maybe we use
7 language like in an earlier recommendation
8 saying --

9 MS. DAILEY: No, it's all in this
10 recommendation, the fourth line. Congress
11 directed the establishment of the recommended
12 centralized database several years ago.

13 CSM DEJONG: But what we're hearing
14 from the field is that it's not being utilized
15 or the mandate is not being followed.

16 DR. TURNER: Then I would be
17 somewhat more comfortable with previous
18 language that ensure that it's done.

19 CSM DEJONG: Or adhered to.

20 MR. CONSTANTINE: Let's just list
21 the language from an earlier recommendation --

22 CO-CHAIR GREEN: Honestly, folks,

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1 let me help, okay? So we can leave it as
2 establish. Instead of saying "a," we can say
3 "the database" and then you can take the
4 Congress directed the establishment of the
5 recommended central database and put it into
6 the finding, and it's very clear that we're not
7 telling them to do this, we're telling them to
8 obey the law.

9 MS. DAILEY: Correct.

10 CO-CHAIR GREEN: So I suggest that
11 we keep it simple in the recommendation and
12 push the congressional establishment into the
13 finding, which then captures why we've said to
14 do it.

15 DR. TURNER: Yes. If it's "the
16 database," that's okay.

17 CO-CHAIR GREEN: So we'll make it
18 "the database." So change "a" to "the."

19 MS. DAILEY: Do I use the term
20 "congressionally-mandated database?"

21 CO-CHAIR GREEN: Right. So we could
22 say "establish the congressionally-mandated

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1 database." That would be even better. It
2 should be congressionally probably.

3 MS. DAILEY: So Congress
4 congressionally-mandated the database of family
5 caregivers.

6 CO-CHAIR GREEN: And "ensure" is
7 spelled wrong. You need an "r." All right.
8 So let me just read it again, and then we'll go
9 back to discussion. So it currently reads,
10 "Empower family caregivers with the resources
11 they need to fulfill their roles in the
12 successful recovery of recovering warriors.
13 Establish the congressionally-mandated database
14 of family caregivers to ensure tools may be
15 easily disseminated."

16 CO-CHAIR CROCKETT-JONES: Can we put
17 some space between the recommendation and the
18 findings? Just to make it a little easier for
19 me to read. Thank you.

20 MS. DAILEY: So here's the
21 recommendation. My only other concern here,
22 ladies and gentlemen, is did I miss the

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1 discussion? Is there another better word for
2 tools? Information? Resources?

3 MR. CONSTANTINE: I think, instead
4 of saying to ensure tools, we can say something
5 like to ensure appropriate resources or
6 necessary resources or maybe just resources.
7 But I agree tools isn't the best word.

8 CO-CHAIR GREEN: Yes, there's really
9 no reason to qualify it then. Just say to
10 ensure resources may be easily disseminated.

11 DR. TURNER: Pending any further
12 discussion, move we adopt as written.

13 LTCOL KEANE: I object. Well, I
14 don't object. Additional comment. Do we still
15 need to define who's empowering is the first
16 thing?

17 CSM DEJONG: As soon as we through
18 that congressional mandated in there, we know
19 whose --

20 LTCOL KEANE: The second thing is on
21 number 26 it talks about rolling in 26 as a
22 footnote, as a finding. I don't know if we

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1 need to discuss that at this point or if we
2 need to look at 26 before we devote on 24.

3 CSM DEJONG: I think we covered
4 that, sir, with looking at resources because
5 with that one mainly was DoD credentials, and
6 some of that was from the presentations we had,
7 not being able to access, getting IDs,
8 accessing post facilities or being authorized
9 certain --

10 MS. DAILEY: And that is the
11 congressionally-mandated database right there.

12 CO-CHAIR GREEN: So let's take this.
13 So we have a motion that has not been
14 seconded, and so let me table that motion for a
15 second. So we have another recommendation here
16 under Recommendation 26 that essentially this
17 language be rolled in to Recommendation 24 as a
18 finding. And so based on what has now been
19 recommended for what's in 24 with the
20 congressionally-mandated database to distribute
21 resources, which is what 26 is about, the
22 question is do we need to discuss that or is

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1 there a motion to basically agree with putting
2 these two together?

3 MSGT MACKENZIE: I would agree that
4 the finding is what needs to be moved over, not
5 the actual recommendation as written of 26.
6 I'd say the finding supports 24, which covers
7 that.

8 DR. PHILLIPS: Actually, 26
9 recommendation could be a finding, as well, if
10 we want to really elaborate on it.

11 MSGT MACKENZIE: That finding is
12 what created that recommendation, so just
13 putting that finding over is right there.

14 MR. CONSTANTINE: I think just
15 rolling the finding over is better because the
16 recommendation has mandatory language in there,
17 you know, as a recommendation, like, for
18 instance, family caregivers followed by saying
19 something they have to do, and that would be
20 accurate because the recommendation is the only
21 thing that should tell them what to do.

22 CO-CHAIR GREEN: The hard part here

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1 in terms of the vote is that if we approve 24
2 first, and then we get to 26 and say, yes, we
3 want to roll it in to that recommendation, then
4 the question becomes do we need to go back to
5 24? So I'm kind of looking at 26 and saying we
6 need to agree that we're going to have, that 26
7 is covered by 24, and then we can vote on 24.
8 They'll move the finding without us doing that,
9 but the big deal is in the recommendation on
10 26, whoever put that together, are we
11 comfortable with that being covered under 24?
12 So that's why I've got you looking at 26 right
13 now.

14 DR. TURNER: Who was in group two?
15 Did you all mean to roll this into the findings
16 of 24? Is that what you all meant? I mean, I
17 could certainly see where you could roll a lot
18 of 26 into the findings of 24.

19 CO-CHAIR CROCKETT-JONES: I think
20 Justin was the only, is the only present member
21 from that group. And the language for this
22 recommendation, I know, Denise, you helped me a

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1 lot with that in its original form. Is it
2 covered now by 24?

3 MSGT MACKENZIE: I do believe it is.

4 DR. TURNER: As I read it, all of 26
5 is empowering the adjunct caregivers, which is
6 what 24 is doing.

7 MR. CONSTANTINE: And when we
8 drafted 24, we included the language again "and
9 appropriate credentialing, as needed" because
10 that was a major part of 26. So now that's
11 included in the findings, so it's there.

12 DR. LEDERER: The credentialing
13 recommendation number 26, if it's rolled into
14 the recommendations for 24, it will not have
15 any visibility. It will be embedded in the
16 findings for 24, and that credentialing piece,
17 if it's important to you, will pack no punch.

18 CO-CHAIR CROCKETT-JONES: I'm just a
19 little concerned about the folks who lose their
20 ability to, lose their access when NMA orders
21 expire or are changed because of PCSing. I'm
22 concerned that because we're talking about, you

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1 know, they'll still be in the database, but
2 will that action of their orders and will they
3 still be guaranteed the credentialing based on
4 the language in 24?

5 CO-CHAIR GREEN: So the simple thing
6 to do would be to take the last paragraph in 24
7 or the last sentence in 24 on what was drafted.

8 So "these resources include, but are not
9 limited to," and put that up into the
10 recommendation.

11 MR. CONSTANTINE: That would be good
12 with us, if you would like us to do that.

13 CO-CHAIR GREEN: So basically put
14 that up into the recommendation itself.

15 DR. TURNER: And then bring some of
16 26 into the findings.

17 CO-CHAIR GREEN: And then that
18 brings 26 into the findings, but this is why I
19 needed to 26 before we did 24.

20 MR. CONSTANTINE: However, I think
21 the order is now a little odd because the
22 second sentence talks about resources that will

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1 be disseminated due to the database. We're
2 talking about resources in the third sentence.

3 That's going back to the resources from the
4 first sentence.

5 CO-CHAIR GREEN: Well, actually,
6 they should be the same, so we say in the first
7 one "with the resources they need to fulfill
8 their roles," and then in the second one we say
9 "to ensure resources may be easily
10 disseminated," and then we say, "these
11 resources include."

12 MR. CONSTANTINE: If it's all the
13 same resources, but resources, like lodging,
14 childcare, liaison office, those aren't things
15 that are disseminated due to a database. Those
16 are resources that are used to fulfill their
17 roles.

18 MSGT MACKENZIE: They are used in
19 both realms, actually, because what we found at
20 Fort Campbell and I found this in several
21 realms, if you are not a spouse, an ID, DoD ID
22 card-holding spouse, once you fall off of non-

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1 medical attendant orders, then you no longer
2 have access to childcare, you no longer have
3 access to support groups or base access or that
4 kind of stuff. So the same needs for
5 supporting the recovering warrior also needs to
6 be identified as family caregivers with that
7 database that will have that post ITOs or non-
8 medical attendant orders.

9 MR. CONSTANTINE: I agree with that.

10 But when you say to ensure resources may be
11 easily disseminated --

12 CO-CHAIR CROCKETT-JONES:
13 Information about these resources or knowledge
14 of these resources might be what's being
15 disseminated. We can get that language --

16 DR. TURNER: It almost works if you
17 just swap the two sentences.

18 MS. DAILEY: This database ensures,
19 obviously, some visibility. It's intended
20 mostly to provide access. So, yes, it can be
21 used to disseminate information to those in the
22 database. Those people need the information.

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1 But it's been designed by Congress and by DoD
2 for access.

3 CO-CHAIR GREEN: I think it's clear
4 if we just insert there, after "to ensure"
5 information on resources may be easily
6 disseminated.

7 DR. TURNER: I think we're all
8 agreeing on the content. I think it's just the
9 form, and I would agree with Justin.

10 CO-CHAIR GREEN: So, Justin, are we
11 closer with this, or do you want to change the
12 order of the sentences?

13 MR. CONSTANTINE: I'm good with
14 that, sir.

15 DR. LEDERER: May I just ask that
16 it's only the Air Force that family liaison
17 officers, but that's not a purple resource in
18 the last line there.

19 MSGT MACKENZIE: Yes, it is, ma'am.
20 There are liaisons across the services.

21 DR. LEDERER: Family liaisons?

22 MSGT MACKENZIE: This sentence does

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1 not say family liaison. The family liaison
2 officer program is an Air Force-specific name.

3 However, the liaison officers are purple.

4 DR. LEDERER: I stand corrected.

5 CO-CHAIR GREEN: I don't even see
6 where you're talking. Where do you get family
7 liaison? Oh, just liaison officers. Yes.

8 MR. CONSTANTINE: I don't know if we
9 have to get into the nitty-gritty or it's just
10 cleaned up, but congressionally we have, dash,
11 mandated, and database is one word. And if
12 those are things that we shouldn't be
13 commenting on now, let me know and I'll stop.

14 CO-CHAIR GREEN: Yes, I don't think
15 you need the dash technically, but the database
16 should be one word.

17 MS. DAILEY: We will clean all that
18 up.

19 CO-CHAIR GREEN: All right. Now, I
20 have to move us back to 26 because the question
21 that we're trying to make certain of is that 26
22 can be rolled into 24 because we have a

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1 recommendation. So I'm not sure we have to
2 vote on it, but I kind of need to make certain
3 that whoever put this together is comfortable
4 with us going that way.

5 MR. CONSTANTINE: I wasn't on the
6 original, this came from the original group,
7 which wasn't us yesterday.

8 CO-CHAIR GREEN: Suzanne?

9 CO-CHAIR CROCKETT-JONES: I'm good
10 with it.

11 CO-CHAIR GREEN: Okay. So now if I
12 can have a motion suggesting that we accept the
13 language in 24, which is incorporated 26 and
14 24, that would, I think, get us where we need
15 to go. So I need a motion to accept the
16 language in 24 and that 26 and 24 have been
17 combined.

18 DR. TURNER: So moved.

19 MSGT MACKENZIE: Second.

20 CO-CHAIR GREEN: Okay. So all in
21 favor?

22 MG HORST: Aye.

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1 CO-CHAIR GREEN: Okay. Any opposed?

2

3 MR. CONSTANTINE: Will all the
4 findings from 26 go into 24?

5 CO-CHAIR GREEN: Right. And so no
6 abstentions. So this is approved. And, yes,
7 the findings will go over from 26 to 24. Why
8 don't we take a five-minute break and come
9 back? Okay, folks. Okay. We'll reconvene
10 here at 25 after the hour. Thanks.

11 (Whereupon, the above-entitled
12 matter went off the record at 3:19 p.m. and
13 resumed at 3:31 p.m.)

14 MS. DAILEY: Sir, we still have to
15 vote on 24. We just voted, to the best of my
16 recollection, to include 26 in 24, but we have
17 not voted on 24 yet.

18 CO-CHAIR GREEN: No, the actual
19 vote, the motion was that we incorporate 24 and
20 26 and approve the language as written for 24.
21 And so that was actually the motion that
22 carried.

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1 MS. DAILEY: Okay, all right.

2 CO-CHAIR GREEN: Correct me if I'm
3 wrong, Russ. It was your motion.

4 DR. TURNER: That was the intent.

5 MS. DAILEY: So this is the final
6 language. Can I get someone to read it for the
7 record?

8 MSGT MACKENZIE: "Empower family
9 caregivers with the resources they need to
10 fulfill their roles in the successful recovery
11 of recovering warriors. Establish the
12 congressionally-mandated database of family
13 caregivers to ensure information on resources
14 may be easily disseminated. These resources
15 include, but are not limited to, lodging,
16 orders, support groups, childcare, liaison
17 officers, and appropriate credentialing as
18 needed."

19 CO-CHAIR GREEN: Okay. And we move
20 on to 25. Did any of the groups take this one
21 on?

22 MR. CONSTANTINE: Oh, yes, we

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1 thought it better if we address this next year.

2 CO-CHAIR CROCKETT-JONES: And can
3 you give us any reason why?

4 MG STONE: Well, we did not feel
5 that we fully understood the complexity of this
6 training. And we felt we just needed to spend
7 some more time taking a look at RCC training
8 before we could make recommendations regarding
9 it. It was as simple as that, and we respect
10 the rest of the committee may have more
11 expertise than we did sitting at the table, but
12 none of us felt comfortable we fully understood
13 what we were asking for.

14 MS. DAILEY: Ladies and gentlemen,
15 there was some discussion that instead of move
16 to next year. One of the reasons we would not
17 put this up for a vote would be because it's a
18 good new story and we're making a
19 recommendation on a good new story. I hesitate
20 to keep saying we don't know enough. This is
21 actually a very well-documented finding with
22 lots of data associated with it so --

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1 CO-CHAIR CROCKETT-JONES: So is this
2 better moved to best practices?

3 MS. DAILEY: Yes, that would be a
4 better reason to realign it as a best practice
5 or it's not a bad recommendation in that we're
6 basically saying strengthening, what we're
7 recommending here is strengthening even more
8 reserve the RCC training to support families.
9 They're so highly valued. Let's put some more
10 emphasis on their support to families and more
11 training and better tools for them to assist
12 families. Again, you've already got a good
13 news story here.

14 DR. PHILLIPS: I agree with that.
15 The only thought I had was that in all of our
16 visits, if I remember correctly, there just
17 weren't enough of the RCCs. But they were all
18 very positively looked at, so I wonder if we
19 shouldn't reconsider rewording this
20 recommendation and approving something like it.

21 MSGT MACKENZIE: The findings are,
22 you know, they do allude to the fact, the

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1 findings that are written here allude to the
2 fact that the RCCs are doing an outstanding
3 job. The finding almost supports a
4 recommendation to continue and enhance support,
5 you know, continue to enhance the RCC program
6 or continue to -- I can't think of the right
7 words right now, but the idea is keep RCCs
8 going and give them more stuff to do their job.

9 CO-CHAIR GREEN: It's not a strongly
10 written recommendation. It's actually a very
11 nicely written best practice or finding, yes.
12 So if we're going to make a recommendation,
13 that's fine. But based on what's currently
14 presented, which is examine RCC training, I
15 understand why the group suggest it go to next
16 year. On the other hand, with all the positive
17 data, this would be an excellent one to move
18 into the best practice.

19 DR. TURNER: I would agree that this
20 is a good new story and we need to hold it up
21 as a model, and as a best practice it is held
22 up as a model.

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1 MR. REHBEIN: That provided with,
2 and I don't know if this was the final 19 or
3 not. I think it is. But in recommendation 19,
4 there is a statement that we should ensure that
5 RCCs, FRCs, and NMCMS are fully staffed across
6 all components and sites. So I think we've
7 addressed the point that you were saying,
8 Steve.

9 CO-CHAIR CROCKETT-JONES: I'd be
10 satisfied with moving this to best practices.

11 DR. TURNER: I would move then that
12 we move it to best practices.

13 CSM DEJONG: I'd second that.

14 CO-CHAIR CROCKETT-JONES: Do I
15 understand correctly that when we move
16 something to best practices that we need to
17 vote on that?

18 MS. DAILEY: What you're doing is
19 appropriate. I would like it on the record
20 that you are moving this to a best practice.

21 DR. TURNER: It can be more
22 specific. I'm moving we strike this as a

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1 recommendation and move this as a best
2 practice.

3 CSM DEJONG: I still second that.

4 CO-CHAIR CROCKETT-JONES: All right
5 then. All in favor?

6 MG HORST: Aye.

7 CO-CHAIR CROCKETT-JONES: All
8 opposed or abstaining? None. So moved.

9 CO-CHAIR GREEN: Okay. So we've
10 covered number 26, and so we're now on number
11 27. Which group had number 27?

12 MR. CONSTANTINE: We had that one,
13 too, sir.

14 CO-CHAIR GREEN: Okay, go ahead.

15 MR. CONSTANTINE: The DoD should
16 promulgate policy to provide special
17 compensation for members of the uniformed
18 services for catastrophic injuries or illnesses
19 requiring assistance in everyday living as
20 directed by Section 603 of the NDAA 2010. This
21 legislation amends federal law to authorize
22 monthly compensation to recovery of service

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1 members to pay for aid and attendant care
2 without which they would require
3 hospitalization, nursing home care, or other
4 residential institutional care.

5 DR. TURNER: That was part of the
6 old, but he was reading the new text. If you
7 look down to the --

8 MSGT MACKENZIE: Oh, okay.

9 CSM DEJONG: I like the
10 recommendation, but I think it should stop
11 right after NDAA 2010. And then again we go
12 into a statement just kind of justifying and
13 explaining what that is.

14 MG STONE: I think that part of the
15 statement came in because, in my confusion, the
16 VA can pay an attendant directly. DoD has to
17 pay the service member, and then the service
18 member pays the attendant. Is that correct,
19 Suzanne? Do I have that right?

20 MS. DAILEY: Yes, sir, that is
21 correct.

22 MG STONE: Yes, okay. And so that

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1 may have been added just because we're having
2 the discussion. I'm not sure it adds anything
3 to the recommendation.

4 DR. PHILLIPS: Is it worth anything
5 to recommend that the DoD follow VA standards
6 or vice versa?

7 MS. DAILEY: That's already in the
8 legislation. As they promulgate that policy,
9 it has to be synced up with, there's a cost and
10 that's already been determined in legislation
11 but that they sync their policies up with the
12 VA's caregivers omnibus policies. That would
13 be a strengthen to this also so that there is a
14 continuum of the special compensation into the
15 VA's omnibus caregiver.

16 DR. PHILLIPS: That's what I meant,
17 yes.

18 MR. CONSTANTINE: And that would be
19 a significant change from what we have here, I
20 think.

21 DR. TURNER: It's my understanding,
22 Justin, that all we're doing is telling the DoD

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1 to follow the law.

2 MR. CONSTANTINE: As it's stated
3 here, yes, that's fine. But then we have to,
4 about syncing up with the VA. The caregivers
5 is about paying a caregiver the rate that they
6 would have to pay a hospital to take care of
7 the service member. Here, this is saying the
8 service member will receive pay while he's on
9 active duty, so there are differences.

10 MS. DAILEY: Okay.

11 DR. TURNER: So the recommendation
12 is for the DoD to follow the law.

13 MR. CONSTANTINE: To follow the
14 policy.

15 DR. TURNER: Policy based on the
16 law.

17 CO-CHAIR GREEN: So let me make sure
18 we're all on the same wavelength here. So the
19 second sentence in this will be moved to the
20 finding; is that correct? The legislation,
21 amends, federal, all that will be finding?

22 MR. CONSTANTINE: Yes, sir.

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1 CO-CHAIR GREEN: Okay. And we've
2 corrected the language several times where we
3 said promulgate. Do we want to say promulgate,
4 establish? Is there another --

5 DR. TURNER: I would suggest
6 expedite policy.

7 CO-CHAIR GREEN: I have no objection
8 to that. Anybody?

9 MR. CONSTANTINE: It's fine with me.

10 DR. PHILLIPS: Again, just to avoid
11 my own confusion, for the sentence that we're
12 moving into the findings, again, would we not
13 be better off harmonizing the VA policy with
14 the DoD policy or vice versa in saying that? I
15 guess the issue is related to the caregiver
16 receiving money and then paying an aide, versus
17 the aide being paid directly. Maybe I'm
18 confused.

19 MS. DAILEY: Don't have that type of
20 harmonization, we really don't have any leeway
21 with. The DoD policy is to the service member,
22 the VA. Omnibus is to the caregiver.

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1 MG STONE: I think the advantage
2 here, Steve, is that there's already a law, and
3 what we're saying to DoD is come on, get on
4 with it. Now, if we want to change law, you
5 know how long that takes, and maybe we do want
6 to change law in the future. But right now
7 what we'd like them to do is to what was in
8 NDAA 2010. Come on, get on with it.

9 DR. PHILLIPS: Got it.

10 CSM DEJONG: And if you look at the
11 findings in the top of that page there, it
12 further kind of clarifies it.

13 CO-CHAIR GREEN: So the final
14 language that's currently on tap here is that
15 DoD should expedite policy to provide special
16 compensation for members of the uniformed
17 services with catastrophic injuries or
18 illnesses requiring assistance in everyday
19 living, as directed by Section 603 of the NDAA
20 2010. Any further discussion?

21 DR. TURNER: And we'll be moving
22 that second sentence to the first sentence of

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1 the finding.

2 CO-CHAIR GREEN: I'm leaving it out
3 because it's now finding.

4 DR. TURNER: Okay.

5 MR. CONSTANTINE: I do have one
6 question here, sir. In the last sentence of
7 the first paragraph says, "DoD has not yet
8 taken action to afford comparable benefits to
9 caregivers of warriors." And our
10 recommendation is saying, when it's talking
11 about the Section 603, it's talking about
12 compensation to members of the uniformed
13 services. So those are two different things.
14 And I haven't looked at Section 603, so I don't
15 know who's authorizing the payment go to, but
16 we should be consistent.

17 DR. PHILLIPS: Justin, should that
18 last sentence be moved to the first sentence of
19 the findings so it explains what we're
20 recommending?

21 MS. DAILEY: No, I think Justin's
22 point here is that this legislation, that it is

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1 not correct. This line indicates that DoD is
2 to pay caregivers, which is incorrect. DoD
3 cannot pay caregivers. DoD can only pay the
4 service member. Consequently, this last line
5 is factually incorrect and should come out.

6 MR. REHBEIN: That could be
7 corrected simply by changing it to read afford
8 comparable benefits to warriors.

9 MS. DAILEY: To service members who
10 have caregivers.

11 MR. REHBEIN: Yes, just remove the
12 caregivers out of that sentence and you're
13 fine.

14 CO-CHAIR CROCKETT-JONES: Correct.
15 But those are in findings and not on the matter
16 on which we are voting. I just want to make
17 sure that the recommendation seems to be stated
18 correctly and the findings are where there's a
19 dispute.

20 MR. CONSTANTINE: I was clarifying
21 that.

22 CO-CHAIR CROCKETT-JONES: Yes.

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1 CO-CHAIR GREEN: All right. So I
2 don't know if we had a motion on this one yet.

3 So, in essence, they'll clean up the findings,
4 and that's going to be required in several of
5 these, and it's a good catch, Justin. So is
6 there further discussion regarding the
7 recommendation?

8 MR. CONSTANTINE: No, sir. I move
9 that we approve this recommendation as written.

10 DR. TURNER: Second.

11 CO-CHAIR GREEN: Okay. All in
12 favor?

13 MG HORST: Aye.

14 CO-CHAIR GREEN: Any opposed? And
15 so there are no abstentions, and we are good.
16 It's approved. So we're now to number 28. And
17 I was on the group that worked with this one,
18 and there is some overlap between 28 and 37.
19 And so we would ask that we look at 37 first
20 because the issues that I will raise are more
21 tied to 37, which is on page 36.

22 So the problem in the earlier one in

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1 terms of 28 was that it was about getting
2 adequate legal support to advise members. And
3 the difficulty that has arisen is that the Army
4 in particular, but we're not yet certain if
5 it's going to be beyond the Army, has made the
6 decision that the PEBLOs are not advocates for
7 the patients. And so if the PEBLOs are not
8 advocates, that may change the requirements for
9 legal support. And so these two are very
10 integrally tied based on if there's a changing
11 role for the PEBLOs because, in the past, the
12 PEBLOs have been the principal advisor to the
13 member who's going through a disability process
14 and actually gets them to appropriate legal
15 counsel when there's a challenge or need for
16 it. But if the PEBLOs are going to be strictly
17 process-focused and not the advocates for the
18 patients, then it may drive another level of
19 advisement in terms of legal counsel.

20 And so what we had suggested in
21 Recommendation 37, and there is a small change,
22 our group suggested that this read, "Develop

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1 accurate methods for measuring manpower
2 requirements for PEBLOs," and then the insert,
3 the addition that we're suggesting is, "and
4 legal support to provide more comprehensive and
5 systematic education to recovering warriors and
6 family caregivers regarding the DES process.
7 Sustain adequate PEBLO staffing levels."

8 And so the addition in this is to
9 put under what we actually came to you with,
10 "requirements for PEBLOs and legal support"
11 would be what I would add to this. And we can
12 go back and look at this other one to see
13 whether we're capturing the intent of 28, and
14 then we leave the findings pretty much intact.

15 The one other thing that the group
16 we worked with is this would probably be the
17 major recommendation under DES, and so there
18 was also a statement that we added to the
19 findings, or it was actually to the text of the
20 report. And so we reworked. So on the page
21 previous, on page 35, we also reworked the
22 language in terms of what it says about the

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1 IDES. And as you can see it there, it says,
2 "The DES was redesigned in 2007 to better meet
3 the needs of recovering warriors. Through the
4 SOC, the IDES began first as a pilot program
5 and is nearing worldwide implementation," and
6 that's why we recommend to see Recommendation 5
7 which is where combine the other IDES issues.
8 "In the course of its research, the Recovering
9 Warrior Task Force learned of the lingering DES
10 issues that impede the transition process with
11 some RWs. The Recovering Warrior Task Force
12 also heard from supporters and opponents of
13 IDES about IDES benefits and challenges. The
14 Task Force will explore continued IDES redesign
15 in future reports."

16 So one of the reasons we combine
17 things with number 5 was because this is not
18 fully implemented yet, and we felt that some of
19 the DES issues should be moved to a future
20 report. So the only finding that would be
21 under the IDES right now would be this one on
22 PEBLOs that I just shared that's up on the

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1 screen right now. So let's discuss this
2 wording for a second, and then we're going to
3 have to do what we did on the other one and go
4 back and look at the legal before we can say
5 that we want to combine these two.

6 CO-CHAIR CROCKETT-JONES: Can we
7 insert "legal support" behind "sustain adequate
8 PEBLO staffing levels?" Can we also say add
9 the legal support to the staffing
10 recommendation?

11 CO-CHAIR GREEN: So adequate PEBLO
12 and legal staffing --

13 CO-CHAIR CROCKETT-JONES: Levels.
14 And I have one more question, and I know this
15 might be opening up a lot more discussion and
16 if it needs to be tabled you can explain that
17 to me. But one of our concerns is the change
18 from having an advocate in the PEBLO to
19 potentially not having an advocate in the
20 PEBLO. Do we want to shift that role of
21 advocacy to legal support and say so in here by
22 saying develop accurate methods for measuring

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1 manpower requirements to provide more
2 comprehensive and systematic education and
3 advocacy to recovering warrior and family
4 caregivers regarding the DES process.

5 DR. TURNER: I was going to glom on
6 to that and say would the intent be better
7 reflected by saying develop accurate methods to
8 measure and then institute manpower and legal
9 support requirements for PEBLOs to provide.
10 And that way, it's cogent with the last
11 sentence.

12 CSM DEJONG: Except the PEBLO can't
13 provide legal support.

14 DR. TURNER: But --

15 CO-CHAIR GREEN: Can I make this a
16 little simpler? I'm not sure why we're saying
17 accurate methods for measuring. I think that
18 probably we need to say develop manpower
19 requirements, okay?

20 DR. TURNER: That's what I'm trying
21 to say.

22 CO-CHAIR GREEN: So drop out the

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1 accurate methods for measuring.

2 DR. TURNER: So it would be develop
3 accurate manpower requirements for --

4 CO-CHAIR GREEN: I'd just say
5 develop manpower -- oh, I see. I think
6 developing manpower requirements, based on the
7 finding, wouldn't be bad. But I see where
8 you're going. If you say adequate, anything
9 you do to essentially qualify it is odd.

10 MS. DAILEY: The finding that
11 originated in Wilford Hall where they tried to
12 document PEBLO staffing levels based on one
13 manpower model, and they cannot achieve that
14 manpower level for their PEBLOs because there
15 is another model being used. So the term
16 "accurate" refers to the finding where there
17 are two different models being used to
18 determine the load.

19 MG STONE: Then the response is you
20 want a uniform model, manpower modeling system
21 across the delivery system. So develop a
22 uniform manpower model.

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1 CO-CHAIR GREEN: I think that's
2 better because you're actually starting to talk
3 staffing and not manpower, so you have to go a
4 different way. So develop a uniform manpower
5 model.

6 CSM DEJONG: And if you say for
7 PEBLOs and legal, if you look at 28, that's
8 pretty much what we're talking about is the
9 difference between the forces and the numbers
10 of legal support versus numbers of wounded
11 warriors, whereas the Marine Corps has four for
12 pretty much the entire country, the Army has
13 24, Air Force has four, so I think we're
14 catching 28 in that also.

15 CO-CHAIR GREEN: So before we lose
16 the things we've started, develop a uniform
17 manpower model for PEBLOs and legal support.

18 MG STONE: In order to --

19 CO-CHAIR GREEN: To provide more
20 comprehensive and systematic education to
21 recovering --

22 MG STONE: In order to. After

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1 support --

2 CO-CHAIR GREEN: Right.

3 MG STONE: -- in order to --

4 CO-CHAIR GREEN: Provide more
5 comprehensive systematic education and
6 advocacy. Is that what you wanted to add?

7 CSM DEJONG: I'd probably go
8 education or representation.

9 CO-CHAIR GREEN: We'll say education
10 and advocacy. And I'd take out the "more" and
11 just make it comprehensive, comma, systematic
12 education and advocacy. So take out "more,"
13 and make it a comma there, and get rid of the
14 "and." Comprehensive, systematic education and
15 advocacy to recovering warriors and family
16 caregivers regarding the DES process.

17 DR. TURNER: Just to go with the
18 general, who do you want to aim this at?
19 Develop a uniform DoD manpower? I just need a
20 little on how you want to aim this.

21 MG STONE: If it's going to be
22 uniform, it's got to be DoD-wide so that,

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1 regardless of service, you have the same
2 standards. I'm not sure I understand what
3 systematic means. I know what comprehensive
4 education means. What I want is appropriate
5 education based on the needs of the patient and
6 the family.

7 DR. TURNER: And, again, to be
8 unambiguous, I would ask that we say develop a
9 uniform DoD manpower model.

10 CO-CHAIR CROCKETT-JONES: My
11 impression of the word "systematic," and I
12 didn't come up with this so I don't know if
13 it's correct, implies across the process. The
14 IDES process lasts a long time. There are
15 different steps. You don't need to know, you
16 don't need education on step five when you're
17 entrenched in step two. And when I saw that
18 word "systematic," I thought that it implied
19 that this was to develop education that moved
20 with you through the process.

21 MG STONE: Then we've got to talk
22 about aligning this effort with the disability

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1 system. So instead of using the word
2 "systematic," we ought to say something about
3 aligning this education with the phases in the
4 DES process. We talk about we're talking to
5 them about the DES process, but it's about
6 alignment.

7 CO-CHAIR GREEN: And legal support,
8 in order to provide -- why don't we change it
9 to -- let's get rid of both comprehensive and
10 systematic. Take both out. Just delete those
11 and put in "appropriate."

12 MS. DAILEY: I just want to
13 highlight something, ladies and gentlemen. The
14 actions, the noun here is model. A manpower
15 model will not provide education and advocacy.
16 This manpower model is to ensure appropriate
17 staffing levels. You can't tie these, you
18 can't tie a manpower model to providing
19 education and advocacy.

20 CO-CHAIR GREEN: Let's finish one
21 thought at a time. Appropriate in terms of
22 education. No, go back to before education.

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1 And make it "appropriate DES education," to be
2 specific. And then go to the end of that
3 sentence and change "regarding" after family
4 caregivers, take out the "regarding" and make
5 it "throughout." This gets to your point. And
6 now go up after "manpower" and make it
7 "manpower and staffing model," so just add "and
8 staffing." Okay. So it now reads, "Develop a
9 uniform DoD manpower and staffing model for
10 PEBLOs and legal support in order to provide
11 appropriate DES education and advocacy to
12 recovering warriors and family caregivers
13 throughout the DES process. Sustain adequate
14 PEBLOs and legal staffing levels." Now, by
15 saying staffing in both places, it's
16 interesting, but it still probably emphasizes
17 that we're actually looking at fills, not just
18 models. Okay. Discussion. I'm sorry. I
19 think we captured everybody's ideas in this
20 way.

21 MG STONE: So in the second
22 sentence, and I don't know if this is

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1 appropriate for the other services but when I,
2 in the Army, am told to sustain something,
3 they're telling me I'm doing something really
4 well, just keep doing it. Is that what we're
5 trying to say with using the word "sustain?" I
6 don't know if that's just unique to the Army or
7 whether it's also the same in the other
8 services.

9 MR. CONSTANTINE: I was going to
10 make the same point, sir.

11 MSGT MACKENZIE: Should it be
12 "achieve?"

13 MR. REHBEIN: Or "maintain."

14 MG STONE: If we've already told
15 them to develop a unified staffing model that
16 will drive their staffing, do we need to tell
17 them a second time to do that? Are we just
18 trying to say we really mean it? I think
19 achieve may be the --

20 CO-CHAIR CROCKETT-JONES: I'm just
21 not sure a model and a staffing level are the
22 same thing.

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1 CSM DEJONG: Well, it is. I think
2 we need to further clarify that statement of
3 something similar, to develop a uniform DoD
4 manpower and staffing model for PEBLOs and
5 legal support to equalize representation
6 throughout -- and help me out here. We have to
7 justify that statement as to why we want that
8 model.

9 CO-CHAIR GREEN: How about, because
10 of the second sentence, I think the second
11 sentence gets us there. But why don't we,
12 instead of "sustain," say "ensure adequate
13 PEBLO and staffing levels?" Because that then
14 says don't just build a model, ensure you've
15 got the staffing.

16 CSM DEJONG: I still think we
17 captured it all. I think we need to justify
18 why we need to build the model and ensure the
19 staffing in order to then provide --

20 CO-CHAIR CROCKETT-JONES: I think
21 the findings justify it. We know there's been
22 more than one model. We know that there are

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1 differences regarding the role of PEBLOs. We
2 know that there were lack of staffing and
3 legal, and we know that there are -- we have
4 findings for all of those statements. I'm not
5 sure what part you think we don't have
6 justification for yet.

7 CSM DEJONG: It's not that we don't
8 have justification. It's just how it's, again,
9 we're developing a manpower model to provide
10 education and advocacy. The staffing model is,
11 I think we need to justify the staffing model
12 to ensure staffing in order to provide.

13 MR. REHBEIN: Yes, if you take that
14 phrase that starts with "in order to" through
15 the end of that sentence and just append it on
16 to the end of the second sentence, I think that
17 addresses what you're saying, doesn't it? That
18 we would ensure adequate PEBLO and legal
19 staffing models in order to provide.

20 CO-CHAIR GREEN: I actually think
21 that's good. So get rid of the, yes, just put
22 a period after "legal support." Get rid of "in

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1 order to." Just delete it. We don't need it.

2 And then take the "provide appropriate DES
3 education" -- well, you're going to take it and
4 put it at the end of that second sentence.

5

6 MR. REHBEIN: It should be the third
7 sentence.

8 CO-CHAIR GREEN: Well, no, just put
9 it, yes, it's the end of the second. Say
10 "Ensure adequate PEBLO and legal staffing
11 levels to provide appropriate DES education and
12 advocacy." No, wrong place. Yes, wrong
13 phrase. Get rid of --

14 MR. CONSTANTINE: Cut and paste the
15 last sentence and put it in front of the second
16 sentence.

17 CO-CHAIR GREEN: Just take from the
18 "provide" there on the second line at the
19 beginning of the sentence, copy that down to
20 the end of the sentence. Right there. Now
21 take it and just move it over to the end of
22 that. And now go back to the beginning of that

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1 line, so after "staffing levels."

2 CO-CHAIR CROCKETT-JONES: Between
3 "levels" and "provide" beneath the word "to."

4 CO-CHAIR GREEN: "To." Just put T-
5 O.

6 MR. CONSTANTINE: And RW needs an
7 "s" after it.

8 CO-CHAIR GREEN: And, yes, you need
9 to get rid of the extra periods. Okay. So it
10 now reads, "Develop a uniform DoD manpower and
11 staffing model for PEBLOs and legal support.
12 Ensure adequate PEBLO and legal staffing levels
13 to provide appropriate DES education and
14 advocacy to recovering warriors and family
15 caregivers throughout the DES process."

16 MR. CONSTANTINE: Does it matter if
17 we're moving into IDES versus DES?

18 MS. DAILEY: We'll refer to all of
19 them as IDES.

20 CO-CHAIR GREEN: It should all be
21 IDES, right. Any further discussion? Okay.
22 Now, this is another tricky one because what

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1 we've done is really we've combined 37 and 28,
2 and so I now need you to look at 28 and make
3 certain that we've captured the gist of 28's
4 recommendation. Do we actually want to
5 highlight the Air Force? That's the other
6 thing that's in number 28.

7 MSGT MACKENZIE: I think that's
8 automatic with what's said. If you don't have
9 it and obviously the statement does, you got to
10 get it.

11 MR. CONSTANTINE: Because it said --

12 CO-CHAIR GREEN: And, in essence,
13 they would then take the findings and
14 incorporate the findings from legal over to the
15 findings from the PEBLOs. So if we're in
16 concurrence it sounds like, then essentially I
17 need a motion that would say we combine 28 and
18 37.

19 MSGT MACKENZIE: I need to make an
20 input before we do that, sir.

21 CO-CHAIR GREEN: Okay.

22 MSGT MACKENZIE: One of the things

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1 that was discussed in several of the site
2 visits and some of the other discussions, it's
3 in 28, and I just want to make sure that we're
4 capturing that, was it seems like the focus for
5 the amount of staffing dealing with the DES
6 process was only focused towards, in the cases
7 of the Army where it's focused towards the size
8 of the WTU and it's not taking into
9 consideration the entire base population, you
10 know, the additional people that are trying to
11 do their DES stuff. Have we missed something
12 there? I saw it in one of the -- where was it?
13 The recommendation.

14 DR. LEDERER: It's in the fourth row
15 of Recommendation 28, but the Army WTC feedback
16 said that they have addressed this or are in
17 the process of addressing this.

18 MSGT MACKENZIE: So they haven't
19 done anything. They're just addressing it.

20 DR. LEDERER: We can look at the
21 feedback, if you'd like.

22 MSGT MACKENZIE: No, I'm throwing

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1 the question out there for discussion just to
2 make sure we've covered that part.

3 CO-CHAIR CROCKETT-JONES: I think
4 that the language that we've used for the new
5 37 actually seems broad enough. I think it
6 will be covered. I mean --

7 DR. TURNER: I think the intent is
8 clear.

9 CO-CHAIR CROCKETT-JONES: The intent
10 is covered.

11 MSGT MACKENZIE: And I believe the
12 same thing. It doesn't say anything in there
13 regarding a recovering warrior unit. I just
14 want to make sure that we've all, you asked if
15 anything else was out there, so.

16 LTCOL KEANE: I have an additional
17 comment. I'm not sure if the Marine Corps'
18 comment on number 28 has been incorporated. If
19 I could read their input. The findings
20 inaccurately depict the availability of legal
21 support to the Marines. For example, attorneys
22 assigned to the Navy Legal Service Office North

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1 Central Detachment provide DES counsel to all
2 Marines being referred to a formal PEB.
3 Additionally, Navy Judge Advocate General Corps
4 attorneys assigned to or near military
5 treatment facilities also provide DES counsel
6 to assist Marines. To clarify, the Marine
7 Corps has four dedicated Marines within the
8 regiment that do it, in addition to the normal
9 legal.

10 CO-CHAIR GREEN: Yes. The Air Force
11 would argue the exact same thing, so I think
12 that needs to be, when we say manpower and
13 staffing models, I think that that would take
14 into account if you're going to include the
15 base legal offices or not. If you're going to
16 have a distributed system, you almost have to
17 incorporate the base legal systems and what the
18 workload is at those base legal systems in your
19 model. So from my perspective, it would cover
20 the Air Force's concerns, which would be
21 identical to the Marines' concerns on this,
22 other than the fact that the Navy is providing

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1 those legal offices to the Marines.

2 LTCOL KEANE: I think an improved
3 statement would be, "In addition to the normal
4 legal services provided, the Marine Corps has
5 four dedicated."

6 MSGT MACKENZIE: The problem with
7 the normal legal services is that's only if the
8 recovering warrior or the service member thinks
9 he needs legal counsel. There's no effort by
10 legal counsel to come in and provide you this
11 education or advocacy. You have to ask for it.

12 And that's what we're trying to capture here
13 is --

14 CO-CHAIR GREEN: Right. And the
15 other problem with those four, if they're like
16 the Air Force and I'm assuming they are, they
17 probably sit at the physical evaluation board.

18 So in other words, they advise members, but
19 they advise them from a distance. And so
20 that's where the modeling would come into play.

21 So the same thing with what Mac is saying. If
22 we feel that there needs to be, because of the

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1 new definition of PEBLOs, if they're no longer
2 advocates, then you would have to build the
3 legal model so that they would actually meet
4 with everyone going through the DES system,
5 which changes whether four is adequate down at
6 the PEB or even with the legal office
7 augmentation. That becomes part of the
8 modeling and the staffing.

9 So this whole idea about the PEBLOs,
10 that's why we're tying them together. If the
11 PEBLO's role changes, the legal staffing model
12 also should change.

13 DR. TURNER: And the way the
14 recommendation is worded, it covers that, and
15 DoD decides. So I move that we combine these
16 two and go with current wording, barring any
17 further discussion.

18 MR. CONSTANTINE: Second.

19 CO-CHAIR GREEN: So we have a motion
20 to accept the recommendation, the combined
21 number 28 and 37, and go with the language that
22 has been drafted on the board. Karl, do you

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1 need me to read it again for you? General
2 Horst?

3 MG HORST: Sir, I'm with you on
4 Recommendation 37. So I'm current with what
5 you have, sir.

6 CO-CHAIR GREEN: Okay. So all in
7 favor? Karl? Okay. And anyone opposed? Go
8 ahead.

9 LTCOL KEANE: I'm in favor of the
10 recommendation, but I still think the finding
11 needs to be adjusted.

12 CO-CHAIR CROCKETT-JONES: We don't
13 have to vote on this one.

14 LTCOL KEANE: Okay.

15 CO-CHAIR GREEN: And so you're
16 talking about the legal findings. Okay. So we
17 will ask that there is attention paid to the
18 findings to make certain that it matches up
19 with what our recommendation is.

20 LTCOL KEANE: Yes, sir.

21 CO-CHAIR GREEN: Okay. So we have
22 consensus on the recommendation?

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1 LTCOL KEANE: Yes, sir.

2 CO-CHAIR GREEN: Okay. All right.
3 Thank you very much, everybody. Sorry about
4 the difficulty with these combined ones, but it
5 helps if we can do them in a certain order and
6 then it's, obviously, serving us well in terms
7 of the language. So I believe we're on 29.
8 Which group had those?

9 MR. REHBEIN: I think you and I did
10 initially, sir. Actually, we didn't do a great
11 deal of change to the initial recommendation.
12 Let me read you the new recommendation that
13 will be on the board in front of you in a few
14 minutes. "Ensure that the VA Vocational
15 Rehabilitation and Employment (VR&E) Program is
16 available and accessible to RWs before their
17 separation from the services. This will
18 require that Congress extend or remove the
19 sunset provision that currently allows pre-DD-
20 214 access to the VA program set to expire in
21 December 2012 and that DoD issue policy to
22 encourage service member participation in

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1 VR&E." The only change that you see in there
2 is the change of the word "promulgate" to
3 "issue." Other than that, we left it stand as-
4 is.

5 CO-CHAIR CROCKETT-JONES: Maybe I'm
6 missing something. The sentence, "This will
7 require that Congress extend or remove the
8 sunset provision," am I just reading it wrong?

9 MR. REHBEIN: This is a program
10 that's already in effect --

11 CO-CHAIR CROCKETT-JONES: Okay. So
12 I can understand --

13 MR. REHBEIN: -- that can be
14 accessed now, but December 2012 it goes away.

15 CO-CHAIR CROCKETT-JONES: Oh, I see.
16 They need to either extend the program or
17 remove the sunset provision.

18 MR. REHBEIN: Or remove the sunset -
19 -

20 CO-CHAIR CROCKETT-JONES: Okay.

21 MR. REHBEIN: And that's really two
22 ways of saying the same thing.

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1 CO-CHAIR CROCKETT-JONES: Yes, I was
2 just misreading.

3 MG STONE: So if they extend, then
4 there's still a sunset provision and we've got
5 to come back and deal with it again. Why don't
6 we just get rid of the word "extend" and just
7 say "remove?"

8 MR. REHBEIN: I see no reason not
9 to.

10 MR. CONSTANTINE: I would say the
11 reason you don't do that is because Congress
12 has decided to have a sunset provision, you
13 know, at some point. And so we've got a
14 choice. We extend it out, or do we remove it?

15 And to remove it is a big step if they decide
16 to have it in at some point. If we extend it
17 out, it gives more time for debate on that
18 issue.

19 DR. PHILLIPS: Can we say extend the
20 sunset provision indefinitely?

21 CO-CHAIR GREEN: Let me come back
22 just a second. So why don't we, instead of

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1 saying this will require that, we should just
2 say, "Congress should extend or remove the
3 sunset provision." And the only reason I would
4 leave the language just like that is because we
5 want this to happen rather quickly. It may be
6 easier for them to extend something than to
7 change the language. And so, since we don't
8 know how difficult this will be, let's not cut
9 our throats and remove something that's pretty
10 valuable to these folks by decreasing
11 congressional options. That's my personal
12 recommendation.

13 CSM DEJONG: To caveat that, sir, I
14 think that if we can actually get them to
15 extend it and we can follow up in the next year
16 or two with more substantiating documentation
17 of how effective it is, we can possibly
18 convince them to then lift it all together.

19 CO-CHAIR GREEN: It just is never
20 good to decrease congressional options.

21 DR. PHILLIPS: One other quick
22 thought. In front of "ensure," the first word,

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1 should we put "to ensure," or is it adequate?

2 CO-CHAIR GREEN: I think it's
3 consistent with the way we've been doing
4 recommendations. Other discussion?

5 CSM DEJONG: I make a motion to
6 accept Recommendation 29 as written.

7 MR. REHBEIN: Second.

8 CO-CHAIR GREEN: And so with a
9 motion to accept the language as written with
10 the minor edits that have been made this
11 afternoon, I'll take a vote. All in favor of
12 accepting this language, raise your hand.

13 (Show of hands.)

14 CO-CHAIR GREEN: Karl?

15 MG HORST: Aye.

16 CO-CHAIR GREEN: Okay. Any
17 objections? And no abstentions. So, again,
18 consensus. Excellent. Thank you. Okay. So
19 number 30.

20 MR. CONSTANTINE: Thirty is one that
21 we're going to discuss next year because we
22 didn't look into state agencies at all this

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1 year.

2 CO-CHAIR GREEN: And so we've
3 already voted, so 30 is gone. Thirty-one? We
4 rolled it into number 5, and so that's been
5 approved as part of number 5. Okay. Thirty-
6 two?

7 MR. REHBEIN: Thirty-two was dealt
8 with in our group yesterday, and we made no
9 changes to it. The only recommendation that we
10 made was that we thought it would tell a
11 coherent story if this recommendation came in a
12 specific place. So what we were doing was
13 putting, we'd like to see this one -- if you
14 approve, we'd like to see this one and 29
15 appear back to back because it tells a coherent
16 story.

17 MSGT MACKENZIE: And, actually, it
18 will, with the other two in the middle being
19 moved or combined, and it falls under that
20 actual section of optimizing ability. So they
21 will fall one right after the other.

22 MR. CONSTANTINE: You know, when we

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1 were discussing this in our original group,
2 where it says institute mandatory refresher
3 training, we said, well, when would that
4 happen? Could that happen after you leave the
5 service? How often? I thought that when we
6 discussed it, we said institute or some
7 language that would mandate training or
8 refresher training within 90 days of separation
9 to ensure that, even if they had it early on
10 after their injury, they would have it very
11 close to when they leave the service. That
12 way, it wouldn't be ambiguous as to when they
13 or how often the services have to provide this
14 training. It's not here. I think it was a
15 good idea, so I'd like to hear what other folks
16 have to say about that.

17 MS. SOBOTA: Ladies and gentlemen,
18 there is a clarification that needs to be made
19 on that. For transitions, this is the program.

20 There are five parts to it. One part is DoD
21 at the pre-separation counseling. The other
22 parts are both DOL and VA requirements, so you

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1 need to determine what you are meaning by
2 mandatory TAP and refresher training. Is it
3 the DoD portion, the DOL portion, the VA
4 portion?

5 MSGT MACKENZIE: It is the entire
6 program was what was discussed by that group.
7 When we said TAP, we meant TAP, all-inclusive
8 of the subsets of TAP.

9 MG STONE: And it needs to become
10 mandatory for who? Because if you tell me it's
11 going to be like weapons qualification, it
12 means that every six months for my entire
13 career I get TAP training.

14 MR. CONSTANTINE: Yes, we had also
15 recommended that be out of there.

16 MSGT MACKENZIE: With the TAP, the
17 discussion amongst our group of optimizing
18 ability was making this training mandatory for
19 recovering warriors. That was the discussion
20 within the group.

21 MG STONE: So that's fine, except
22 then we need to put that into the

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1 recommendation. What population are we talking
2 about?

3 MSGT MACKENZIE: I think it was just
4 worded that way because the Recovering Warrior
5 Task Force, and I think that's probably where
6 it fell out --

7 MG STONE: And I would not align
8 this to some other type of training, such as
9 sexual harassment, weapons qualifications.

10 MSGT MACKENZIE: I know, especially
11 through the phone conversations, you know, my
12 wording was, you know, like we, as flyers, have
13 a currency training. We weren't sure exactly
14 how to fit that in, but some of these guys,
15 especially when dealing with WTUs and so forth,
16 are briefed this program as soon as they enter
17 the WTU. Now, they may be in that WTU for a
18 year, year and a half. During that year or
19 year and a half, they're having to make
20 decisions of how they're going to recover,
21 rehabilitate, what their choices are. And
22 having these refreshers, whether it be 90 days,

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1 you know, I was thinking, like 180 days into
2 your time, there should be a refresher course.

3 I don't know how to set the timeline, but this
4 stuff needs to be refreshed because these guys
5 and their caregivers, if applicable, forget
6 what they are taught, and it needs to be
7 refreshed in a more timely fashion throughout
8 the course of recovery. So this is a
9 discussion point.

10 CO-CHAIR GREEN: One of the ways to
11 do this, because there's potentially huge costs
12 based on what interval you choose and how
13 frequently, one of the other things that you
14 might be able to do on this one is simply, say,
15 make TAP attendance mandatory for RWs, and
16 then, auditing this training within one year of
17 separation should be encouraged. So in
18 essence, any time within your last year, if you
19 did it two or three years ago, you could audit
20 a course to get the refresher training, but it
21 would be optional. And so they wouldn't build
22 the curriculums to handle the large numbers of

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1 auditors or the people who may want to do it
2 more than once. I think that might be an
3 easier pill to swallow, which then allows
4 people to go back and get refresher when they
5 know they're within one year of separation.

6 MR. CONSTANTINE: I hate to sound
7 paternalistic or tell someone I know what's
8 good for them or better for them, because I
9 don't. But if we're making it mandatory,
10 there's a reason for that. And if we're going
11 to make it mandatory, it should be at a time
12 most beneficial to them, which would be on
13 their path out the door. So I'm concerned,
14 just like we see if people don't go to things
15 when they come back from their appointment
16 unless they're forced to do it, if it's not
17 mandatory, if it's encouraged, they're not
18 going to know to do that.

19 CO-CHAIR GREEN: But the difference
20 is, we are recommending that it be mandatory
21 for all recovering warriors. So they would
22 have to get the training. It's just that if

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1 you got the training and now, instead of going
2 through the DES process expeditiously, it took
3 three years, you could then audit the course
4 again, so you could get refresher. If you try
5 and mandate the refresher training, now you're
6 really getting into -- all right, so how often,
7 how close to retirement? It drives a whole
8 different scenario.

9 CO-CHAIR CROCKETT-JONES: I think
10 making one refresher close to separation
11 mandatory is not unreasonable. I think that
12 we've looked, in looking at this population in
13 the focus groups, we're seeing that the process
14 of transition, when they get that first
15 mandatory TAP, they may not be thinking they'll
16 ever need it. And making it optional I'm
17 afraid that -- because the transition process
18 is difficult and some struggle with it -- that
19 we may not catch them again unless we push them
20 through it one more time close to separation.
21 I would even be more comfortable with that
22 first TAP, not worrying as much about that

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1 first TAP, as the mandatory TAP before
2 separation to get them really on their feet as
3 they walk out the door.

4 CO-CHAIR GREEN: But the way to do
5 it is to say it's mandatory TAP attendance,
6 make TAP attendance mandatory for recovering
7 warriors within the last year of service. So
8 now they basically try and time it so that
9 they've got it within a year.

10 MR. CONSTANTINE: Yes. That's exactly
11 right. If you're going to make it mandatory,
12 put a time frame on there, whatever we think is
13 appropriate.

14 CO-CHAIR GREEN: You could go with
15 two years, but what they recommend at TAP is
16 that it should be one year. So, ideally, you'd
17 do this one year, 18 months prior to
18 separation.

19 CSM DEJONG: It's kind of similar
20 with the Force's alumni programs. I know ACAP
21 is within your -- right as you start
22 retirement or ETS paper, they schedule you for

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1 ACAP and you run through it. It should be
2 something similar to that, so that it's fresh
3 into a transition.

4 MSGT MACKENZIE: Let me reiterate
5 what we brought up. That works when you don't
6 have a TBI, when you don't have PTSD, when
7 you're not on a narcotic roller coaster, when
8 you're not trying to heal from wounds. Doing
9 it within a year, you are correct, that does
10 work. What I was alluding to and I was trying
11 to think of how would you word this, perhaps
12 something along the lines of, you know, when
13 recovery exceeds 180 days, servicemembers
14 should re-attend TAP 90 days prior to -- or
15 something along those lines. I mean, I don't
16 know how to do it, because when we briefed with
17 some of these recovering warriors, they forgot
18 all about it. So to say that it's available to
19 them later on, is somebody covering that
20 reminder or --

21 CO-CHAIR GREEN: The problem is that
22 the TAP course itself teaches you that you need

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1 to start about a year prior. So if you wait
2 until 90 days before, I mean, I realize it
3 really gets in -- that should be vocational
4 training, frankly. So I think if you say make
5 TAP attendance mandatory for recovering
6 warriors within 18 months of separation, you
7 may be capturing the optimal time for people to
8 do it. And so that would then try to get
9 everybody through it in their last 18 months.
10 I could say one year, if you'd prefer, but 18
11 months gives them actually a little more time
12 to get resumes and to work through the process.

13
14 CSM DEJONG: I guess what I'm
15 looking at -- I'm not opposed to 18 months. I
16 guess, for Mac, what I'm looking at is if we've
17 reached a 12-month decision point on their
18 career, if we're giving a guy one more year
19 based off the decision that was made, you've
20 either got 12 months because you're going to be
21 in the disability evaluation system, or you've
22 got 12 months and you're going to be RTD or

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1 just transitioned out. At that point in time,
2 they should be -- I guess in my mind, what I'm
3 looking at is, the TBI is not fresh, the
4 medical -- the drug-induced roller coasters are
5 pretty much maintained, and they've got a
6 handle on it to where they have a light at the
7 end of the tunnel for their care, and now we're
8 going to implement this transition.

9 MSGT MACKENZIE: So are we saying
10 that, in a sense, quit making these guys go to
11 TAP when they first enter a WTU and push it to
12 they're within a year of getting out?

13 CSM DEJONG: I mean, that would be
14 like sending a private through ACAP and then
15 have him go through a career. I mean, he's not
16 going to remember it. We might as well line
17 this up with a time in which it's going to be
18 most beneficial to them.

19 MS. SOBOTA: VA has already placed
20 the slides that are used in their program
21 online so that they can be viewed 24/7. So if
22 there's something that they've missed or if

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1 they had some issues with drugs or TBI, they
2 can go back and get that refreshment. There's
3 also online the decision career toolkit that is
4 put out so that they can use that as a backup,
5 in addition to going to the various phases of
6 TAP, whether it be the DOL's portion, the VA's
7 portion, or the pre-separation counseling
8 that's required and already mandatory.

9 MSGT MACKENZIE: I agree with you
10 about availability of resources.
11 Unfortunately, this relying on -- we've seen
12 time and time again when you're talking to
13 these guys, that information is not being
14 retained, which is why that attendance must be
15 mandatory.

16 CSM DEJONG: Right. It has to be
17 facilitated and mandatory.

18 MR. CONSTANTINE: Right. Is DTAP
19 already mandatory?

20 MS. DAILEY: It depends on what
21 service. Most all the services have mandated
22 DTAP for their recovering warriors. We have a

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1 chart in the effectiveness documents that shows
2 the breakdown.

3 MR. CONSTANTINE: So when we write
4 this recommendation, we should probably combine
5 it and say, TAP and DTAP mandatory within 12
6 months of separation, period.

7 DR. TURNER: That sounds like the
8 recommendation.

9 CO-CHAIR GREEN: DTAP is just the
10 Defense TAP portion of this?

11 MS. DAILEY: It's disability.
12 Disabled Transition Assistance Program. It
13 deals with the disability, getting into VR&E,
14 filling out the form.

15 CO-CHAIR GREEN: And so we want to
16 say, make DTAP and TAP attendance mandatory for
17 RWs within -- are we going to say 12 months?
18 Within 12 months of separation.

19 MS. DAILEY: So you don't want the
20 full five components? When you say TAP and you
21 say the five components of TAP, you've
22 encompassed DOL, VA, DTAP, and DoD.

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1 CO-CHAIR GREEN: That's what I
2 thought. That's kind of what I was asking.
3 So I thought "all five components" incorporated
4 DTAP.

5 MS. DAILEY: Correct.

6 CO-CHAIR GREEN: Okay. So we've got
7 it. So make TAP all five components,
8 attendance mandatory for RWs within 12 months
9 of separation and probably eliminate the
10 remainder.

11 DR. LEDERER: But I just want to
12 point out that within DoD, outside of the
13 recovering warrior community, there is a push
14 toward transition assistance and education
15 throughout the career. There's a push towards
16 starting it early and refreshing on a regular
17 basis, so, in one sense, this is somewhat
18 anathema to that, perhaps.

19 MSGT MACKENZIE: But, once again,
20 this is setting a plan in motion that's
21 tangible and achievable. Somebody's discussion
22 point out there of trying to change something

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1 doesn't give anything to those guys to use, so
2 that's why I think we need to focus.

3 DR. LEDERER: Sure.

4 CO-CHAIR GREEN: And the nice part
5 is that if they change it for DoD to make it
6 part of everyone's career, it will capture all
7 the RWs anyway.

8 MR. CONSTANTINE: So does DTAP need
9 to be specifically mentioned here, or is DTAP a
10 subset? It's one of the five?

11 CO-CHAIR GREEN: It's a subset. We
12 do need to change the language on the screen.
13 So make TAP all five components, attendance
14 mandatory for recovering warriors within 12
15 months of separation.

16 DR. TURNER: Period, end of
17 recommendation.

18 CO-CHAIR GREEN: Correct. So then
19 the remainder would be deleted.

20 MS. DAILEY: So no refresher
21 training?

22 CO-CHAIR GREEN: No refresher

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1 training. Delete the rest.

2 LTCOL KEANE: Sir, I have one
3 comment.

4 CO-CHAIR GREEN: Please.

5 LTCOL KEANE: I don't want to get us
6 bogged down, but do we need to -- and I don't
7 know the rules of TAP. Do we need to make a
8 statement in findings regarding spouses'
9 ability to attend also with the member?

10 CO-CHAIR CROCKETT-JONES: It is
11 already -- as it's set up, TAP is available to
12 spouses.

13 LTCOL KEANE: I've never been. I
14 don't know.

15 CO-CHAIR GREEN: Further discussion?

16

17 MSGT MACKENZIE: If no further
18 discussion, I move to accept it as written.

19 MR. REHBEIN: Second.

20 CO-CHAIR GREEN: Okay. We have a
21 motion to accept Recommendation 32 as written,
22 which is make TAP -- all five TAP components,

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1 attendance mandatory for recovering warriors
2 within 12 months of separation. All in favor?

3 (Show of hands.)

4 MG HORST: Aye.

5 CSM DEJONG: Within 12 months, just
6 the only verbiage change. If I say within 12
7 months of separation, that could be within 12
8 months after I separate, not 12 months prior
9 to.

10 MR. CONSTANTINE: Well, you're
11 technically correct. Realistically, the
12 service is, you're no longer going to have a
13 DD-214 access to the base. You won't have a
14 military ID. They're not going to provide
15 services for you once you're out. But if we
16 can go back and change it --

17 CO-CHAIR GREEN: It is a friendly
18 amendment. Did we actually vote on this
19 already? We did. Okay. So I need a motion.

20 DR. TURNER: Motion that we amend
21 the current adopted to occur prior to
22 separation.

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1 CO-CHAIR GREEN: So we need to look
2 at, make TAP attendance mandatory for
3 recovering warriors 12 months prior to
4 separation.

5 MSGT MACKENZIE: I'll second.

6 CO-CHAIR GREEN: Well, there's a bit
7 of a problem. Within 12 months prior. How are
8 you going to word it? You've got to figure out
9 the wording here. When you say 12 months
10 prior, that means they're going to do it one
11 year in advance.

12 CSM DEJONG: I think looking at what
13 we have to do, 12 months prior to separation.

14 CO-CHAIR GREEN: Okay.

15 CSM DEJONG: The hard part with that
16 with the recovering warrior or with the
17 disabled is, sometimes you can't forecast when
18 that 12 months is. It's not like me dropping
19 my retirement date of such and such, and now we
20 can back that up 12 months --

21 CO-CHAIR GREEN: How about we make
22 it within the 12 months prior to separation?

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1 CSM DEJONG: I concur.

2 MSGT MACKENZIE: Do you want to put
3 separation -- does that encompass retirement as
4 well? Yes? I just want to make sure.

5 CO-CHAIR GREEN: Okay. So we have a
6 motion, I think.

7 DR. TURNER: To amend the
8 recommendation as written.

9 CO-CHAIR GREEN: To amend the
10 approved language to this language, which now
11 states within the 12 months prior to
12 separation.

13 DR. TURNER: Yes.

14 MSGT MACKENZIE: And I second that.

15 CO-CHAIR GREEN: And we have a
16 second. All in favor?

17 (Show of hands.)

18 MG HORST: Aye.

19 CO-CHAIR GREEN: Okay. Any opposed?
20 And no abstentions. So this is the approved
21 language that will go forward. Number 33,
22 group three.

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1 MR. REHBEIN: Mr. Chairman, if I may
2 for just a moment. If you look at 33 and 34,
3 you will see that they are completely opposed
4 to one another. One of them strengthens the
5 SOC and the other one does away with the SOC.
6 So, as we debate this issue, everyone needs to
7 be aware of that because if we approve one, we
8 don't dare approve both of these because that
9 would put us on record as doing two opposite
10 things. So if we approve one, we need to
11 reject the other. So I think we really should
12 debate these as an issue rather than as two
13 separate recommendations.

14 MSGT MACKENZIE: As a member of
15 group number three yesterday, I believe that
16 that piece is missing out of this document
17 because I believe we did roll the two of them
18 together and changed the language. I don't
19 know how it got missed, somehow it got missed
20 in this.

21 DR. PHILLIPS: If you look at 34, I
22 think your language is in there.

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1 MSGT MACKENZIE: And the other
2 thing, too, was we wanted to -- we felt this
3 topic was too broad for just the three of us to
4 handle, and so we wanted to open it up to the
5 entire group to get a refinement. But we felt
6 that we had encompassed that under 34, if I'm
7 correct. I'm trying to remember.

8 MG STONE: May I suggest to the
9 Chairs then that we consider 34 first and then,
10 depending on the results of 34, will drive
11 whether we consider 33?

12 MSGT MACKENZIE: I concur.

13 CO-CHAIR GREEN: Okay.

14 MSGT MACKENZIE: So 34. We took a
15 look at this, and the recommendation re-worded,
16 as we came up with it, is as follows,
17 "Consolidate the Senior Oversight Committee
18 into the Joint Executive Council with a
19 consolidated JEC co-chaired by the Deputy
20 Secretaries of DoD and VA. SOC issues will be
21 clarified and defined. Any SOC issues
22 currently not within the purview of JEC will

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1 become an equal part of JEC's responsibility.
2 Congressional action is needed to achieve this
3 consideration, and administrative reform of JEC
4 is recommended." And that's how we came up
5 with that.

6 CO-CHAIR GREEN: So the JEC, in
7 terms of congressional actions. So is anyone
8 familiar with the charter of the JEC?

9 MR. REHBEIN: I think, from what
10 digging I've done, the primary change that this
11 would make to the Joint Executive Council would
12 be to make the Deputy Secretary of DoD the co-
13 chair, as opposed to the Assistant Secretary,
14 as it is currently. Right now, JEC is co-
15 chaired by the Deputy Secretary of VA, and I
16 don't know his title, Dr. Stanley. You know
17 the person, so I don't have to try to define
18 the title. The JEC has several issues given to
19 it by Congress, amongst which are some larger
20 issues of things that the SOC has worked on,
21 like electronic health records. But what drove
22 me to write this recommendation -- and don't

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1 throw stones at the staff, throw stones at me,
2 because I wrote it -- as we interviewed the SOC
3 participants, I was not seeing any kind of, not
4 only not unanimity but direction, as to where
5 they thought it should go. It was almost like
6 the SOC had fulfilled its purpose, and I know
7 how hard it is for groups and agencies to go
8 away, but sometimes when the purpose is
9 fulfilled that's the best thing to do, although
10 there is important work yet to be done.

11 And I don't want anyone to think
12 that I am criticizing Dr. Stanley's work at
13 all. But one of the things that also was
14 communicated was the power inherent in having
15 the Deputy Secretary as co-chair of the SOC,
16 and I didn't want to lose that. So that's the
17 motivation, but that was my understanding of
18 the issues that the SOC has been dealing with
19 are also part of some of the issues that JEC
20 has been dealing with. And so consolidation
21 seemed to be a way to go.

22 DR. PHILLIPS: I concur strongly

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1 with that. And I regret that I didn't think
2 about writing the recommendation, but I'm glad
3 someone else from Iowa did. No, I attended
4 those meetings as well. And to put it mildly,
5 there was tremendous confusion as to what the
6 individuals who we interviewed thought the role
7 of SOC was. And when we got specific, they
8 really just threw the issues upstairs to the
9 JEC, and so I think it's appropriate for two
10 reasons. One, because the SOC seems to have
11 lost its enthusiasm to address these issues,
12 except at a very strategic level. And, two, I
13 think a lot can be accomplished internally to
14 improve the situation of the RWs by having a
15 JEC leadership there.

16 CO-CHAIR GREEN: So this would also
17 effectively formalize the SOC because, by
18 taking the two Deputy Secretaries and having
19 them chair the JEC, in essence, you're taking
20 the SOC function and making it a JEC function.

21 MSGT MACKENZIE: We're adding to the
22 JEC function, which is why we made that

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1 statement to make sure that it retains that
2 equal level of importance.

3 CO-CHAIR GREEN: Okay. Let me work
4 a couple of things on language here. So right
5 now it says, "Consolidate the Senior Oversight
6 Committee into the Joint Executive Council with
7 the consolidated JEC co-chaired by the Deputy
8 Secretaries of DoD and VA." I think the next
9 line is not necessary. Yes, so I would drop
10 the "SOC issues will be clarified and defined."

11 I think that we could eliminate that. The
12 other one is also questionable, "Any SOC issues
13 currently not within the purview of the JEC,"
14 technically, when you put the DEPSECs in there,
15 suddenly the JEC has that purview. So I'm not
16 sure we need that line. And then I would again
17 leave congressional action the option of
18 Congress, but I would say "congressional action
19 may be required to establish DEPSECDEF and
20 DEPSECVA to chair the JEC."

21 MS. DAILEY: It is required. JEC is
22 involved with the Unders as the co-chairs.

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1 CO-CHAIR GREEN: Okay. So we can
2 say "is required" if we know that for a fact.
3 But I think that that would clean up the
4 language and, basically, solidify that the SOC
5 functions would now be permanently assigned to
6 the JEC.

7 MG STONE: Let me speak to this for
8 a minute. I think that the SOC was a response
9 to the 2007 events. It served a purpose early
10 on but lacks focus today. We need to firmly go
11 on record saying, okay, you've served your
12 purpose, let's not have duplicative. I just
13 sat at the SOC recently last week. It was a
14 difficult, painful discussion of an
15 organization that lacks significant focus, not
16 because anybody is less than well-meaning, but
17 because they're not mission-focused. They were
18 a response to a specific event. We need to go
19 on record that the JEC can do this work, give
20 it to the JEC, put the right people in the
21 room, and let's not have duplicative processes
22 in which there's substantial potential for

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1 crossover and then confusion throughout DoD.

2 CO-CHAIR GREEN: So the only other
3 question is: do we have to go after the
4 congressional action? Do we believe that the
5 Deputy Secretaries have to chair this group?

6 MR. REHBEIN: I think having the DoD
7 Deputy Secretary co-chair of SOC was one of the
8 real advantages that they had, and I personally
9 would hate to lose that. I think that brings a
10 power that is needed.

11 CO-CHAIR GREEN: Well, I would add
12 to that that the formation of the IPO and VLER
13 and IEHR, and even IDES, to some degree, right
14 now are under the purview of the DEPSECDEF. So
15 DEPSECVA, because of how they've had the IPO
16 report and how the advisory board is reporting
17 to the Deputy Secretary, so I'm just arguing
18 that I think you're right, that it really
19 should be changed. So let's look at the
20 language again. "Consolidate the Senior
21 Oversight Committee into the Joint Executive
22 Council with a consolidated JEC co-chaired by

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1 the Deputy Secretaries. Congressional action
2 is needed to achieve this consolidation, and
3 administrative reform of JEC is recommended."
4 I'm not sure that we need to say
5 "administrative reform." You can probably get
6 it just by saying "this consolidation of JEC."
7 "Congressional action is needed to achieve
8 this consolidation of JEC." Truthfully, the
9 only thing I think we need congressional action
10 is to establish DEPSECDEF and DEPSECVA to chair
11 that. That's all that's really required,
12 right?

13 MR. REHBEIN: Yes, DEPSEC of VA is
14 already the co-chair of JEC by congressional
15 mandate, so it's simply the other Deputy
16 Secretary of DoD.

17 CO-CHAIR GREEN: So why don't we be
18 specific? So congressional action is needed to
19 achieve this -- I wouldn't even say to achieve
20 the consolidation. Congressional action is
21 required to establish DEPSECDEF as co-chair.

22 MS. DAILEY: I am not sure that that

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1 is at the Deputy Secretary level of the VA.

2 CO-CHAIR GREEN: So then include
3 both. Congressional action is required to
4 establish the Deputy Secretaries as the co-
5 chairs.

6 CSM DEJONG: And then, if you wanted
7 to take General Stone's comments and justify
8 the 2007 issue and the completion of that, if
9 we took basically the recommendation for 33
10 combined with the findings somehow, I think we
11 will address that on top of giving them an
12 option as to our recommendation as to what to
13 do with the SOC.

14 DR. PHILLIPS: Let me follow up on
15 that.

16 CO-CHAIR GREEN: It has to be plural
17 of "secretaries." I'm sorry. So say again. I
18 need to understand what you're saying.

19 CSM DEJONG: Sir, I was just reading
20 over 33, which basically was saying in a
21 roundabout way what General Stone said, that
22 they were established for a reason in 2007,

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1 they accomplished that mission, and right now
2 they're kind of without direction, and
3 Recommendation 34 goes into an option as to
4 consolidate them and still utilize. But if we
5 put Recommendation 33 along with its findings
6 into the findings of 34, it may justify why
7 we're looking at combining them.

8 DR. PHILLIPS: Let me extend that
9 and just throw out the thought: can we
10 recommend that the SOC just be dissolved? I
11 mean, from what we heard and, again, it was
12 only a one-hour or a two-hour meeting, is there
13 really any necessity to keep the SOC? I'd just
14 throw that out.

15 MS. DAILEY: It's a wasted
16 recommendation, if you're going to now bring
17 co-chairs to the JEC and roll the functions up
18 into it. I mean, it's going to dissolve. It's
19 implied.

20 DR. PHILLIPS: That's what most of
21 the members that we spoke to thought should
22 happen.

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1 CSM DEJONG: It's a nice way of
2 saying it.

3 CO-CHAIR CROCKETT-JONES: I also
4 want to say that -- check out the second
5 paragraph of the findings on 34 for what you
6 were talking about regarding the findings for
7 33 and what General Stone said.

8 CSM DEJONG: No, I agree with that.
9 I just think that some of the findings with
10 Recommendation 33 clearly states why it was
11 formed. It shows that the mission was
12 accomplished, and it kind of leaves it right
13 there and then it falls into that paragraph.

14 CO-CHAIR GREEN: I think we can
15 combine the findings to give credit to the SOC
16 as we dissolve the SOC. So I think that's what
17 you're really asking.

18 CSM DEJONG: In a nice way.

19 CO-CHAIR GREEN: In a nice way, we
20 say we dissolve the SOC. And I think that it
21 can be rolled in to your paragraph, too, about
22 the SOC, so it works well. I need to bring us

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1 back to the recommendation language and not as
2 much in the finding. So on the recommendation,
3 are we recommending consolidation or are we
4 recommending dissolve the Senior Oversight
5 Committee and move these oversight functions
6 into the Joint Executive Committee? Do we want
7 to say dissolve the SOC?

8 DR. PHILLIPS: As a surgeon, I would
9 be more specific and agree with that.

10 MG STONE: I think that we need to
11 recognize that, just like Congress, I believe
12 the DEPSECDEF takes his view of oversight
13 seriously. And I think that you need to be
14 very politically astute as you do this. I
15 think identifying the need to combine for
16 efficiencies, a need to combine for effect is
17 not removing the DEPSECDEF's ability to provide
18 his oversight to this process. And so I really
19 like the idea of saying, combine these
20 functions, and you take one of them. You know,
21 roll the SOC into the JEC. And then allow him
22 to continue the process of oversight. If we

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1 just say get rid of it, in essence, I don't
2 think that's going to go very far.

3 DR. TURNER: I would concur with
4 let's consolidate.

5 CO-CHAIR GREEN: Any further
6 discussion?

7 MR. CONSTANTINE: I think you have
8 to actually add a couple of words in the
9 beginning of the second line, with a
10 consolidated JEC, and then it should say "to be
11 co-chaired."

12 CO-CHAIR GREEN: Understand. So
13 you're just clarifying. So to be co-chaired by
14 -- okay. So, Karl, the recommendation now
15 reads, "Consolidate the Senior Oversight
16 Committee into the Joint Executive Council with
17 the consolidated JEC to be co-chaired by Deputy
18 Secretaries of DoD and VA. Congressional
19 action is required to establish the Deputy
20 Secretaries as co-chairs of the JEC."

21 MG HORST: Yes, I'm tracking with
22 you, sir. I would tell you that, in a very

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1 practical sense, I agree with Dr. Phillips that
2 elimination is probably the best. It was very
3 clear the time we spent with the Army's
4 Assistant Secretary for Manpower and Reserve
5 Affairs is that he was totally detached and he
6 saw his duties as pro forma. That said, I agree
7 that, from a political standpoint, it is
8 probably best to merge them and, through the
9 merger, effectively eliminate the SOC.

10 MR. CONSTANTINE: If it's going to
11 be consolidated then, will it just be called --
12 consolidate means you combine, not rolled up.
13 Those are two different things. So now it will
14 be the JEC?

15 MG HORST: I think to stand alone on
16 its own merit, it has to have the inclusion of
17 the Assistant Secretaries and the functions
18 that they performed as the SOC. I think that
19 their time has come. They've fulfilled their
20 mission, and it's now a check the box, pro
21 forma ordeal for them. So maybe we just follow
22 Dr. Phillips' recommendation and say eliminate

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1 it, it is no longer required and recommend that
2 it is now subsumed or is now taken over by the
3 JEC.

4 DR. PHILLIPS: I just don't want to
5 be in the middle of two storms.

6 MG HORST: Yes, but if there was a
7 storm, we would have a very frank discussion
8 about reality, and that the reality of it was
9 check the box, pro forma performance at the
10 Assistant Secretary level and, based on the
11 Army's standpoint, I can't speak to the other
12 services, but our experience with the Army
13 Secretary, totally detached.

14 DR. PHILLIPS: I agree. I think the
15 SOC members would be relieved not to have to go
16 to these frequent meetings. They may go in
17 wearing another hat.

18 MG HORST: I think we're just going
19 to call it what it is.

20 CO-CHAIR GREEN: The other way of
21 doing this is to simply say consolidate the
22 Senior Oversight Committee functions into the

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1 Joint Executive Council.

2 MG HORST: That's probably much
3 better, sir.

4 CO-CHAIR GREEN: And then you can,
5 in the findings, basically be specific that the
6 SOC has served its purpose and should be
7 dissolved. And so that's kind of, you know,
8 what we're talking about with the findings. So
9 why don't we say consolidate the Senior
10 Oversight Committee functions into the Joint
11 Executive Council.

12 MG HORST: Yes, I think that's a
13 real good fix, sir.

14 MR. CONSTANTINE: I think then there
15 should be a period there and then have the next
16 half be a separate sentence.

17 CO-CHAIR GREEN: So then we'll take
18 out the "with."

19 MR. CONSTANTINE: The consolidated
20 JEC will be co-chaired --

21 CO-CHAIR GREEN: I wouldn't even say
22 "consolidated." The JEC should be co-chaired -

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1 -

2 MSGT MACKENZIE: Do you want to go
3 with "should" or go strong with "will?"

4 MS. DAILEY: Yes, you are talking to
5 Congress now.

6 DR. TURNER: The JEC then will be --

7 CO-CHAIR GREEN: I think "will" is
8 fine, "will be co-chaired." Yes.

9 CSM DEJONG: Or we could just put: it
10 is recommended that the JEC be co-chaired by --

11 MSGT MACKENZIE: I think what we're
12 trying to establish that we want that level.
13 By doing this, we want to retain that level in
14 this deal, so we need to make it clear that's
15 what we want and we don't want to leave it open
16 for them. I mean, they're going to interpret
17 it anyway, but we don't want to give them a
18 garage-door-sized opening to interpret it
19 however they want to.

20 CSM DEJONG: I just look back at
21 some of the conference calls that we had, and
22 there was more than one member that was

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1 cautious about demanding or ordering Congress
2 to do anything. So I think wording on this is
3 going to be kind of critical.

4 DR. TURNER: I think also --

5 CO-CHAIR GREEN: You know, we could
6 actually just take this out because we could
7 say congressional action is recommended to
8 establish the deputy secretaries as co-chairs
9 of the JEC and take out the middle sentence all
10 together.

11 DR. TURNER: I think with the new
12 first sentence, you can totally delete the
13 last.

14 CO-CHAIR GREEN: I'd take out the
15 middle sentence. Take out the JEC will be co-
16 chaired by the deputy secretaries and make
17 congressional action is --

18 MS. DAILEY: I mean, I think you're
19 weakening it, and do you want a chance of
20 losing the SOC and losing that level of senior
21 oversight and then the issues go back to the
22 services.

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1 CO-CHAIR GREEN: So you're saying
2 leave it as-is? "The JEC will be co-chaired by
3 the deputy secretaries of DoD and VA.
4 Congressional action is required to establish
5 the deputy secretaries as the co-chairs of the
6 JEC."

7 DR. TURNER: And then that bottom
8 sentence you can take out is what I was saying.

9 CO-CHAIR GREEN: Oh, yes, the one
10 below that.

11 DR. TURNER: Right.

12 CO-CHAIR GREEN: Yes, we don't need
13 that. Karl, I think we've met your
14 requirements here by saying functions, and I
15 think we have still met Rich's requirement.
16 Okay. Any further discussion? I would tell
17 the writers that this is going to require some
18 finesse in the finding because when we combine
19 33 and 34 there's clearly a mismatch of
20 language that needs to be rectified.

21 So at this point in time, I need a
22 motion. I'm thinking that what we want to do

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1 is combine the findings and probably delete 33.

2 So we don't have to, we can either delete or
3 combine them. I'm not sure how you want to go
4 with this.

5 MSGT MACKENZIE: Do we have any
6 other discussions on this?

7 CO-CHAIR GREEN: All right. So
8 let's look at 34 first since that's the
9 language in front of us. Do I have a motion?

10 DR. PHILLIPS: I move we approve.

11 CO-CHAIR GREEN: As written in 34.
12 And we have a second. All in favor?

13 MG HORST: Aye.

14 CO-CHAIR GREEN: And any opposed?
15 And no abstentions. And so we're good with 34.

16 And now we'll just do 33 separately. In
17 essence, 33 I believe we are deleting.

18 MSGT MACKENZIE: Motion to strike 33
19 and move the appropriately worded findings into
20 34.

21 MR. REHBEIN: Second.

22 CO-CHAIR GREEN: All in favor?

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1 Karl?

2 MG HORST: Aye.

3 CO-CHAIR GREEN: And any opposed?
4 Okay. And no abstentions. Great. Is that the
5 last finding we have? We've dealt with 35 and
6 36. Thirty-six was approved. Thirty-seven was
7 approved. Thirty-five and thirty-eight were
8 combined. I believe --

9 MSGT MACKENZIE: We still left it to
10 be voted, didn't we?

11 CO-CHAIR GREEN: I think we combined
12 35 and 38 and voted on them already, didn't we?

13 CSM DEJONG: That was voted and
14 passed. I have it marked in as under
15 Recommendation 35 as passed.

16 CO-CHAIR GREEN: Yes, that's what I
17 have, as well, that we had already voted and
18 approved. Okay. I think it's a good time to
19 take a break, and we'll come back and kind of
20 see if our researchers see any other
21 recommendations we haven't covered here.
22 Thanks, everybody.

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1 (Whereupon, the above-entitled
2 matter went off the record at 5:04 p.m. and
3 resumed at 5:17 p.m.)

4 CO-CHAIR GREEN: Okay, folks, if I
5 can get your attention. So all the folks are
6 working real hard to try to collate now the
7 changes and get all the recommendations
8 together. Clearly, there's some work that has
9 to be done in order to get the findings to
10 match up the way we expect. What I've asked
11 for them to do is to take all the
12 recommendations, the final language on the
13 recommendations, to put that into a single
14 document that will be shared with all of us.
15 And the one other thing I asked is to try and
16 keep the report, the draft report in the same
17 construct to basically see if our
18 recommendations can align with the four sub
19 areas, restoring hope, and how we basically
20 broke into the original groups.

21 What will happen is that, as they do
22 that, there may be some recommendations that

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1 fit into certain areas that are not the ones
2 that came from that particular group. And I've
3 talked with all of you here but, in essence, I
4 think we come together now as a whole to
5 essentially say these fit in one place or
6 another.

7 There are several questions that
8 have to be answered by us when we look at the
9 total numbers of recommendations, which we're
10 believing will be somewhere between 18 and 22.

11 We need to look and see if there are some that
12 are overarching and don't fit within one of the
13 four categories, in which case we also have to
14 determine if we're going to elevate some to
15 overarching, just the way we did when we
16 brought in the draft.

17 So they've got the first eight or so
18 that we did yesterday done. They're working on
19 the ones we just have approved based on our
20 votes this afternoon. And then I'm guessing it
21 will take them a little longer to look at what
22 fits in each of the categories. And I,

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1 unfortunately, don't even have a rough draft of
2 all of the ones we've approved. Go ahead.

3 MS. DAILEY: Sorry, sir. I'm in
4 agreement. We don't have a rough draft yet of
5 all the approved ones.

6 CO-CHAIR GREEN: And so we have
7 several options. We can, I don't know if there
8 are any administrative processes that need to
9 be taken care of. I would like for you to have
10 that tonight to think about if we can get it
11 before you leave, or we can adjourn and they
12 can email it to us and so everybody would have
13 it to look at. But tomorrow morning when we
14 come together, we need to look at those
15 recommendations that we've now approved what
16 the final language is and make certain that we
17 like the way it fits into the report. And
18 then, from there, Denise will have to take us
19 to whatever else is required.

20 CO-CHAIR CROCKETT-JONES: Do we have
21 a sense of the amount of time they will need?

22 MS. DAILEY: Not really. I didn't

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1 fill this piece in. So you can take as much
2 time as you want. I have a full agenda
3 tomorrow, but some get pushed off until you're
4 happy with it.

5 CO-CHAIR CROCKETT-JONES: I meant do
6 we have a sense of time before the staff has a
7 rough draft for us?

8 MS. DAILEY: Oh, they've been
9 working on it for about 15 minutes now. Let me
10 ask.

11 CO-CHAIR GREEN: A follow-on
12 question Denise, is there anything else that we
13 could do tonight to have the time we need to
14 get to the final report tomorrow?

15 MS. DAILEY: Well, we can start
16 tomorrow's agenda pieces. I mean, everyone is
17 really curious and wants to talk about
18 installation visits and the schedule for next
19 year, so that's in Tab I. You can do some
20 preliminary discussion on that.

21 CO-CHAIR GREEN: So I'm looking at
22 Tab I, and I'm hoping somebody else understands

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1 the color scheme.

2 CSM DEJONG: I was asking you, sir.

3 CO-CHAIR GREEN: And, no, you can't
4 all go to Landstuhl, so I'm sorry.

5 MG STONE: I'm going to Germany
6 already in October.

7 DR. TURNER: This is probably for
8 Oktoberfest, sir.

9 MG STONE: Yes, that's why I'm going
10 to Germany. No, no, I've already got to go out
11 there.

12 CO-CHAIR GREEN: Honestly, I don't
13 know where to take this right now.

14 DR. PHILLIPS: I had asked Denise
15 yesterday about the business meetings, if they
16 were written in stone, and she said not really,
17 so I just looked at these meetings related to
18 my schedule, and maybe that's what, if we can,
19 look at these long-term meetings. I do have a
20 conflict October 4th and 5th. I have an NIH
21 Board of Regents meeting.

22 MG STONE: I think what would be

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1 helpful to me, because I don't understand, as
2 we submit this document from this year and we
3 think about, number one, our ability to respond
4 to either questions from those that we submit
5 it to, the formality of that presentation, how
6 we turn it over -- I assume it will go to Dr.
7 Stanley or will it go directly to SECDEF? And
8 then sort of what happens from there, you know,
9 how do we drive this work? And I'm hesitant to
10 get into the nuances of a schedule until I
11 understand the complexity of work that is
12 expected of us. We've put off a number of
13 issues that we need to begin to tackle and
14 decide. Does this schedule really attack the
15 issues that we've put off and the new issues
16 that we want to put on? I think with the
17 intention to really tackle that in October, as
18 far as next year's work, or was the intention
19 to have October as part of our response to any
20 questions that may arise from the submitted
21 report?

22 CO-CHAIR GREEN: So, Denise, can you

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1 clarify? As we submit the report, who are we
2 submitting the report? Who will receive the
3 report?

4 MS. DAILEY: The report goes to the
5 Secretary of Defense. And General Stone is
6 correct, there is no standard in the Department
7 of the Defense on how it gets there. We could
8 submit it to Deputy Secretary Stanley.
9 However, the last task force, the task force
10 from suicide prevention, Colonel Joanne
11 McPherson submitted it through Legislative
12 Affairs. Since it is a report to Congress and
13 will have to be compiled and services, its
14 responses will have to be compiled, it went
15 through Legislative Affairs and then up to the
16 Secretary of Defense.

17 Traditionally, there is some amount
18 of walking around the building and talking to
19 the services. Now, we've done a lot of that by
20 allowing them to comment on the draft and
21 incorporate in a draft, so there are no
22 surprises out there. There is some amount of

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1 press, i.e. talked to the Pentagon news
2 channel, articles, things along those lines.

3 We are an advisory committee. We
4 are making recommendations. Our only
5 requirement is to give this report to the
6 Department of Defense. We have no
7 requirements, and I will use your words sir,
8 to drive it. Our only requirement is to give
9 it to the Department of Defense. Department of
10 Defense has a requirement to then report to
11 Congress on how they plan, and I'll use the
12 language of the legislation, implement the
13 recommendations.

14 Our business starts over on 3
15 September when we move forward to the next
16 year. 3 September is the date we provide it to
17 the Secretary of Defense. CO-CHAIR

18 GREEN: So, in essence, once we submit the
19 report to DoD, they have whatever time they
20 take to answer to Congress. Probably 90 days -
21 -

22 MS. DAILEY: Correct.

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1 Legislatively-mandated 90 days, so by 3
2 December Department of Defense is to turn it
3 over to Congress and their action steps to
4 implement it, to use the language. All the
5 recommendations were Sergeant Major DeJong
6 thought he might like to talk to the service
7 sergeant majors about the report. So, I mean,
8 there are a number of things like that.

9 CO-CHAIR GREEN: Okay. So I think,
10 basically, the answer to General Stone's
11 question then is, once the report is submitted,
12 the Department may well ask us to do
13 presentations of findings or some other things,
14 based on our presentation of the report, but
15 that's all separate from what's in the business
16 plan. So we're really starting anew for next
17 year instead of having just the last really, we
18 had what? Six months. Well, this time we'll
19 have a full year to basically look and work
20 through issues.

21 MS. DAILEY: Yes, sir.

22 MG STONE: So then I think the next

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1 question is we have a schedule. I'd like to
2 see from staff an idea of how the deferred
3 subjects from this year and the anticipated
4 subjects for year two that had been anticipated
5 already roll into how we're accomplishing this
6 in the schedule. I'm not asking you to be
7 prepared to do that at this minute --

8 MS. DAILEY: But we are, sir.

9 MG STONE: Well, then that is just
10 amazing, and wasn't that a great segue, if that
11 is acceptable to the Chairs.

12 MS. DAILEY: There's just one
13 problem. I can't find it. No. It's here
14 somewhere. I just have a different document
15 then what you're looking at in front of you,
16 and it has my notes on it so that I can --
17 Steven, where's the S drive? It's on the disk
18 which isn't here. And I think Anne has brought
19 up a good point. We've deferred a number of
20 items. However, we still have a requirement to
21 cover the 14 areas Congress legislated that we
22 cover every year. But there is a plan based on

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1 each one of these installation visits to cover
2 the areas that we are deferring.

3 Well, sir, you didn't exactly need a
4 recommendation on every topic. You need to
5 show them. I think we did cover all 14.

6 MSGT MACKENZIE: I think I have the
7 unique honor of not having a schedule written
8 this far in advance, so I'm quite flexible in
9 this schedule.

10 MS. DAILEY: Sorry, gentlemen and
11 ladies.

12 MSGT MACKENZIE: The only thing I
13 have is depending upon the completion of my
14 treatment at the Shepherd Center will determine
15 if I'm available or not for that first business
16 meeting. I haven't missed one yet, so I'm
17 hoping to keep that roll going.

18 MS. DAILEY: All right. Up on the
19 screen is a document that kind of lays out what
20 we're hoping to accomplish. Business meeting
21 in October would be an information briefing.
22 We're going to bring in information briefings

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1 from the services and try and capture -- we can
2 ask them to answer some of our recommendations
3 or we can dig deeper into topics like IPO. We
4 can utilize to explore what's going on again in
5 IDES. We can take all our briefings into a
6 little deeper investigation, and my plan would
7 be to have four information briefings.

8 The Landstuhl and Kaiserslautern is
9 designed to talk to this key transit point in
10 the recovering warriors system. I wanted to
11 touch with an Air Force installation, an Air
12 Force entity at this installation. And once we
13 spent two days at Landstuhl, and it's covering
14 a lot. It's a joint operation. There's the
15 liaison officers. It's an Air Force look. We
16 would then go down the street to an Army WTU.

17 Installation visit number three is
18 to Fort Knox, and Fort Knox, there's an Army
19 WTU there and we could come and use Fort Knox
20 like we did Fort Benning, which was also to
21 talk to Army Reserve. And also the Army
22 recruiting command is at Fort Knox, and you all

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1 have expressed some interest, although it
2 didn't get any documentation, but you all have
3 expressed some interest in the recruiting
4 issues that may be contributing to long-term
5 recovering wounded warrior issues. So Army
6 recruiting command is at Fort Knox, and we
7 would touch and have an opportunity to touch
8 that issue at Fort Knox.

9 From there, it's almost a back-to-
10 back. We would head up to the Indiana Joint
11 Forces Headquarters, and this would be a joint
12 forces look. But Sergeant Major DeJong had
13 tossed up his headquarters as a model for Guard
14 family programs, but it would be a full look at
15 a joint forces headquarters, in addition to the
16 family programs. But that's what put it on the
17 radar was Sergeant Major DeJong kind of pitched
18 it at us as an opportunity to look at Guard
19 family programs.

20 Fort Carson, Colorado, Army WTU.
21 But we also have special operators out there,
22 special forces, and I would like to reach and

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1 you all have expressed an interest into
2 reaching farther into the special operations
3 and special forces communities and understand
4 their performance in the recovering warrior
5 process.

6 The Massachusetts Joint Forces
7 Headquarters, two things there. Once again,
8 it's a joint forces headquarters and we can
9 look at Guard and Reserve issues. But this is
10 also a good location where we'd like to reach
11 out and bring in the VA services in the area,
12 VA liaisons, OEF/OAF program managers. We
13 reach out to a VA touch point here. And then
14 we found it works well to go to a joint forces
15 headquarters in a community-based warrior
16 transition unit, so we'd be at a CBWTU for the
17 other two days.

18 The San Antonio installation visit
19 and an San Antonio business meeting. So we
20 would move our business meeting in December out
21 to San Antonio, and we would hold it in
22 conjunction with a two-day installation visit.

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1 Now, the installation visit six and seven
2 covers areas we didn't get to last year with
3 much depth. AFW2 asked us for a closer look.
4 This is also the home of AFPC, which is also a
5 recruiting look. There is Army training for
6 the Army cadre there. The classes are
7 conducted there. So we would, you know, we
8 could do a more in-depth look at how training
9 is done for the Army cadre. And the next two
10 days we could also bring people in for
11 informational briefings, briefing us at a hotel
12 in San Antonio. The staff, everybody would be
13 attending.

14 The installation visit to Camp
15 Lejeune. You only got two Marine units,
16 Lejeune and Pendleton, and we didn't go to
17 either one last year, so we really need to
18 touch base with one of the major Marine
19 recovering warrior organizations. So we picked
20 Lejeune.

21 MSGT MACKENZIE: And you also have
22 Marine special operations there, as well.

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1 MS. DAILEY: Do you really?

2 MSGT MACKENZIE: Yes, you do.

3 MS. DAILEY: Okay.

4 MSGT MACKENZIE: Much like
5 headquarters and several of the battalions are
6 there.

7 MS. DAILEY: Good. That's good
8 info. So we could use it to also reach out to
9 special ops and their recovering warrior.
10 Information briefing in middle of January
11 again, and then we're going out to Arkansas
12 again, Joint Forces Headquarters, and we'd also
13 use this as a touch point for the VA, local VA
14 services. That rolls us into the community-
15 based warrior transition unit in Arkansas.

16 Portsmouth would be a Navy look. We
17 didn't go to Portsmouth last year. I know
18 there's something down there. And there's also
19 special ops, but this is our Navy look is to go
20 to the patient squadron or patient unit or
21 patient detachment in Portsmouth and reach as
22 many people as we can. And there's a Marine

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1 detachment, too. But primarily I would like to
2 reach into the Navy recovering warrior
3 community with this look.

4 Fort Stewart, we have Army WTU, we
5 have special ops. And there's also, Mr. Lorain
6 has an outreach program. He was the SOCOM
7 coalition outreach --

8 MSGT MACKENZIE: He was the director
9 of the care coalition.

10 MS. DAILEY: -- and he's got a good
11 program that he's running out of Savannah that
12 we thought would be helpful.

13 MSGT MACKENZIE: I believe it's
14 actually Augusta, Georgia where he's working
15 out of.

16 MS. DAILEY: Yes? Okay. We will
17 check that. I heard you say Augusta. Suzanne
18 think it's Savannah, but we'll check. But it's
19 an information briefings again, and this time
20 carry it for the February meeting. And then we
21 want to return to Twentynine Palms.

22 Our next meeting, ladies and

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1 gentlemen, in which the last of our
2 installation visits are in California, we would
3 give the staff -- and we'll have more focus
4 groups, and they're going to need a little more
5 time to sort out and collate their focus group
6 data. But by 1 May you all would get a focus
7 group report, like you did last year, and it
8 would be, we would be able to review it at the
9 15 - 16 May meeting. And then we do what we
10 had to do on the telephone this year in this
11 May meeting is we would start crafting
12 recommendations, and you would do what you've
13 done from the onset, from the inception of your
14 recommendations in this 15 May meeting. You
15 would be able to start your development
16 together as a group, so you understand each
17 other's mindsets better. That's what would be
18 happening at this meeting. So this meeting
19 would be we'd be finished with our
20 informational briefings and we would be working
21 now on developing recommendations.

22 Your next meeting would be with the

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1 effectiveness documents. We would utilize the
2 effectiveness documents, get them to you early,
3 and then come back for this next meeting in
4 June, middle of June, and you would use those
5 to finalize your recommendations. And then we
6 would pull it all together, put your findings,
7 and in a meeting in the last week of July do
8 what you're doing now.

9 LTCOL KEANE: Denise, for the
10 October and November plans, do you envision the
11 same Task Force members going to the back-to-
12 back ones like we did in California or -

13 MS. DAILEY: For the November ones
14 here in Massachusetts?

15 LTCOL KEANE: October and November,
16 yes.

17 MS. DAILEY: They're not a
18 requirement. If you've got the time, that will
19 be fine. If you do not then you can come
20 independently, you can come one to the other.

21 MG STONE: And I wonder if you can
22 now cross-reference the delayed issues that we

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1 bumped from this year into year two and how
2 those are accomplished as part of these visits.

3 MS. DAILEY: Well, the SOCOM issue,
4 the special operations issues are accomplished
5 at Fort Bragg, Portsmouth, and I have another
6 location. Not Fort Bragg, Colorado. So those
7 are a crosswalk so --

8 MG HORST: Hey, Denise?

9 MS. DAILEY: Yes, sir.

10 MG HORST: I can't see the slide,
11 but just to the point of the Carson visit. If
12 you're looking for a WTU for a good
13 representation of special forces, I would
14 recommend Bragg. The WTI at Bragg is bigger
15 than Carson, and the representation of special
16 forces community is much larger at Bragg than
17 it is at Carson. Carson is very, very small.
18 If we catch anyone in deployments we won't
19 catch many folks at all. I think you'd get a
20 better representation of Army special forces
21 and special operations if you visit Fort Bragg.

22 MS. DAILEY: Okay, sir.

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1 MSGT MACKENZIE: But, unfortunately,
2 the difficult part to that, sir, is there's a
3 significant deployment cycle going on, as well
4 as a move cycle going on. I mean, we'll still
5 get a good piece, but you're going to be
6 missing a big chunk because at that same time
7 is the transition of 7th Group down to Florida
8 and a deployment cycle for several groups of
9 individuals.

10 So, I mean, we'll still get a good
11 piece. Just keep that in mind that there is a
12 transition chunk happening.

13 MG STONE: The second question, as
14 we look at Joint Force Headquarters, how did we
15 choose Arkansas?

16 MS. DAILEY: Sir, it was arbitrary.
17 It is a Joint Forces Headquarters.

18 MG STONE: Let me suggest to you
19 that we bring in a BCT home to Iowa in the next
20 few months. It looks like that unit has got
21 3,000 LODs. They've taken substantial deaths
22 and casualties. They will have been home at

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1 this point about four or five months.

2 MR. REHBEIN: That unit is returning
3 right now.

4 MG STONE: Yes. And so it would be
5 an excellent time to consider Iowa as a state
6 to go to. January in Iowa is not a terribly
7 pleasant time, but I think that that is a unit
8 that we could get a very good view of what the
9 processes are and the challenges faced for a
10 unit.

11 MS. DAILEY: Okay. All right. Find
12 the downstream community-based warrior
13 transition unit from that Iowa unit and/or
14 WTUs, frankly. But, yes, that's just the type
15 of information I need. I'm not wedded to this,
16 ladies and gentlemen. I can pull in your
17 requirements to most all of these visits.

18 CO-CHAIR GREEN: The other thing that I
19 would point out is in the Landstuhl visit the
20 hospital there is Army hospital, 300 Air Force
21 people working in the hospital, but the Air
22 Force is really a clinic there. What you might

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1 want to do is when you visit Portsmouth to look
2 at maybe, the Langley facility is now a much
3 larger Air Force hospital. And if you're
4 looking for a larger setting where there might
5 be a patient squadron, that would be probably a
6 better site.

7 MS. DAILEY: Okay.

8 CO-CHAIR GREEN: At Landstuhl, it
9 would be integrated with Army operations.

10 MSGT MACKENZIE: Right. And the
11 only thing about Landstuhl, Denise and I talked
12 about it earlier, just to bring it up to the
13 group, is the fact that the uniqueness of
14 Landstuhl is it's always considered or quickly
15 looked at as a transition spot, but you also
16 got to remember that Landstuhl is the senior
17 NTF for that region. So there are dual things
18 to look at at that hospital, the challenges of
19 being the primary NTF, as well as being the
20 transition point for all casualties coming out
21 of the battlefield.

22 MG STONE: It is, except we're not

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1 going to do the IDES program there. We're
2 going to PCS everybody that's waiting to go
3 through IDES back to the continental United
4 States because the VA can't support. So I'm
5 not sure what we're going to see there. Now,
6 October in Germany is attractive. That said,
7 I'm not sure that it's going to get us to where
8 we need to be in the issues that we need to
9 hit.

10 CSM DEJONG: Part of what Mac and I
11 talked about on a sidebar conversation is part
12 of Landstuhl I think that's important is what
13 are the, is looking at what are the
14 determination points for where you're going to
15 go based on WTUs. Because we were getting
16 reports that the WTU that they're being flown
17 to or directed to or ordered to is based on
18 numbers, not based on medical condition. So
19 what we want to qualify and quantify is what
20 criteria are they using when they do evacuate
21 somebody to the United States and try to
22 standardize that or see if there's anything

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1 with that.

2 CO-CHAIR GREEN: Yes. I was going
3 to say actually the advantage of Landstuhl is
4 probably to look at the reception of casualties
5 which starts the process and their family
6 support services because they do bring a lot of
7 family there to join casualties, as well as the
8 patient regulating portion which then puts them
9 on the airplane, and the ASF which actually
10 transports them. So for the Air Force to go
11 there, as you go there, I would encourage you
12 to look at air medical staging facility
13 operations, as well as the patient regulating
14 portion.

15 And, essentially, then look at
16 support to families, in large part where
17 they're entering their last leg coming back to
18 the States because it feeds into what Steve is
19 talking about.

20 MS. DAILEY: Any of these locations,
21 the Army locations in particular are and will
22 have been in the new IDES, and we can dig in to

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1 IDES issues at particularly the Army locations.

2 CO-CHAIR GREEN: The other
3 interesting one that's not included here and
4 may not be for next year but one that you
5 should consider is that the operations at
6 Elmendorf and Fort Richardson are somewhat
7 unique wherein the warrior transition unit is,
8 indeed, Army, but the care is all provided in
9 an Air Force facility. And so looking at the
10 integration of those two programs would
11 probably be very interesting, and they're
12 actually probably the second largest facility
13 after Wilford Hall in terms of the numbers of
14 wounded warriors that they deal with because of
15 the Army presence there.

16 MS. DAILEY: And we would kind of
17 have to make some choices. It is too
18 expensive, I can only do one or the other.

19 CO-CHAIR GREEN: What I'm suggesting
20 is that it may be something you want to put on
21 a future schedule.

22 MS. DAILEY: We've discussed that.

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1 I thought, you know, they were saying Pacific
2 Hawaii, I was saying Alaska in December so -

3 MG HORST: Oh, you go to Alaska in
4 January.

5 MS. DAILEY: Where you don't see the
6 sun for 60 days.

7 DR. PHILLIPS: It's like going to
8 Iowa any time.

9 CO-CHAIR GREEN: For scheduling
10 purposes, folks, you now kind of see this. If
11 you can look at your schedules, tomorrow we
12 should have the same type of, if you remember
13 in one of our first sessions we actually had
14 sign-ups for what was going to work for people.

15 It would be nice to start putting together
16 tentative schedules so we can try and do the
17 same thing that we did with this last year to
18 try to get people matched up to what looks like
19 would match with their schedules. And so I
20 would anticipate that we'd try and do it
21 roughly the same way. We have experience doing
22 it in three-person or four-person groups. And

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1 so we'll try and stick to kind of the same
2 format based on our experience. And then if we
3 want to look at different aspects, we need to
4 talk about it through something that we did
5 last year that we'd like to either augment or
6 remove from the way we did the visits.

7 MS. DAILEY: And some of the things
8 that we put off until next year was a SOCOM
9 look. Another one was a DES, the DES redesign,
10 the psychological health program for the
11 National Guard. Those all got tabled, and I
12 think I can cover them with these installation
13 visits. And we need to peel back our
14 information briefings one more layer to an
15 agency briefing of just one hour. We need a
16 topic from an agency to brief us for an hour.

17 CO-CHAIR CROCKETT-JONES: One of the
18 other things we put off was extending robust
19 SFAC style centers to other services, so I
20 would hope that at any of the other services
21 visits that we do that that would be prominent
22 for us to look at.

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1 MSGT MACKENZIE: And going to see
2 these special ops sites I think is critical,
3 but I also think we need a more detailed
4 request from the care coalition, information to
5 answer some of these questions that were
6 brought up by the information originally
7 presented in that first briefing.

8 CO-CHAIR GREEN: For the Air Force,
9 the Airman and Family Readiness Centers, which
10 provide most of those family services, are at
11 all of our bases, and so that would be another
12 area to visit and even something to get a
13 briefing from our AI side of the house in terms
14 of how we do family support because it's a
15 distributed system. So the one thing I was
16 going to say, though, not related to the Air
17 Force is we really should make it a point at
18 every site we go to this year, because IDES
19 will be fully implemented, we need to look at
20 it at every site we go to to see what the
21 issues are, what the timing is. And so we
22 probably need to standardize our questions to

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1 get DES input from all the sites we go to to
2 see variation now in something that is
3 supposedly standardized.

4 MS. DAILEY: Okay. Good, good,
5 good. There's a pretty robust information
6 system for IDES, so we could probably walk into
7 any installation and we'll be able to see their
8 numbers and be able to see their times on
9 station. So that's pretty robust.

10 CO-CHAIR GREEN: The other thing
11 that I would encourage, I was quite taken aback
12 at a site visit up at Madigan. As we do the
13 tour, ask to see the site that is actually
14 doing the paper records for transfer to the VA.

15 So walk in and look at how much paper they're
16 actually managing and ask some questions as to
17 how many people it takes to manage just the
18 paper part of the DES. So it's just one of
19 those things that I think when you see it it
20 will be startling.

21 MS. DAILEY: So you've got more
22 installation visits and you've got more

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1 meetings scheduled into this. I have found
2 over the years, ladies and gentlemen, that,
3 generally, Task Force members can handle about
4 this many business meetings and maybe two, at
5 least two installation visits. Every one needs
6 to do at least two. I found that when you all
7 start trying to do three and four installation
8 visits, your tongues are hanging out at the end
9 of the year. So I've got more installation
10 visits here, so I would ask to pace yourself.
11 And the business meetings, I've got two more
12 business meetings, three more installation
13 visits. We'll try and keep a full load of
14 members on board. If everyone does two, we've
15 covered it.

16 We have our 14 topics to cover. And
17 we are going to peel back the onion a lot more.

18 Is there anything else, and I've done a
19 checklist here, the recommendations and those
20 that we put off for next year, which all make
21 for a pretty good checklist. If there's
22 anything else that we need to get into, I need

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1 to know.

2 CO-CHAIR GREEN: They should have
3 just given you a listing. The total number of
4 recommendations that we've approved, as I count
5 them, first blush is 20. Rather than
6 discussing them here because of the hour, what
7 I'm going to recommend is that each member look
8 at these this evening individually. I'm trying
9 to get you to look at where they fit in terms
10 of are they an overarching recommendation, are
11 they under one of the four categories of
12 restoring health? Let's see. Anyway, the four
13 sub-categories, wellness and function,
14 restoring into society, optimizing ability, and
15 enabling a better future.

16 So what I'd like to have you do is
17 look at these 20 and see which ones you think
18 fit best in those four categories and then
19 which ones you think should be in an
20 overarching, if there's something that we need
21 to bring to the front. But the idea is to see
22 if we can't ensure that our recommendations and

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1 findings fit into the current format of the
2 report.

3 And I think we're close. Denise,
4 what other closing business do you have?

5 MS. DAILEY: I don't have anymore.
6 You all have done a very good job. Thank you
7 very much for your very hard work. I agree,
8 sir, if we could get a fresh set of eyes on
9 this tomorrow morning, and we've already done
10 the bulk of the work I wanted to do on the
11 installation visits/business meetings. I would
12 ask, most of you are going home, that you give
13 this calendar to your secretary, spouse, office
14 assistant, so they can bounce it against their
15 schedule and coordinate lives. It's very
16 difficult for me to get up to an installation
17 visit and not have anyone able to go or a
18 business meeting that's only partially
19 participated in. So I need you to see how
20 realistic it is. I need you to give me a
21 realistic look at it against your schedules.

22 MR. REHBEIN: Let me ask you a

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1 question on the schedules, Denise.

2 MS. DAILEY: Yes.

3 MR. REHBEIN: I see that the Joint
4 Forces Headquarters each have two days and the
5 CBWTU also has two days.

6 MS. DAILEY: Yes.

7 MR. REHBEIN: Was that intended? I
8 think last year, I know in California we did
9 one day at each. Do we really have two days
10 worth of business at each?

11 MS. DAILEY: Yes, sir, we do. You
12 know, we learned that last year that there's a
13 lot of information at Joint Forces Headquarters
14 that we did not even scratch: case management
15 issues, the referral process from the
16 reassessments, how they're managing it, what
17 their numbers are. So they can be discrete
18 events. You can go the Joint Forces
19 Headquarters without going to the community-
20 based warrior transition unit. You can do one
21 or the other. There's 14 discrete events here.

22 CSM DEJONG: Denise, did we research

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1 the Massachusetts, the distance between their
2 CBWTU and their JFHQ? Because, for instance,
3 Indiana is Rock Island, Illinois, which you're
4 looking at a four and a half hour drive in the
5 separation between the two. So it might be
6 something you want your staff to look at.

7 MS. DAILEY: It is a smaller state,
8 but, yes, we will build in the appropriate
9 time.

10 MSGT MACKENZIE: I'd say it's only
11 about two and a half hours end to end. Lived
12 there for 16 years so -

13 MS. DAILEY: And I don't have LaKia
14 here, but yes.

15 CO-CHAIR GREEN: And so time for
16 starting in the morning?

17 MS. DAILEY: 8:00, sir.

18 CO-CHAIR GREEN: And is that a
19 public session or is that again --

20 MS. DAILEY: We roll right into the
21 first item on the agenda, which was the
22 installation visit.

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1 CO-CHAIR GREEN: Okay. And so
2 tomorrow morning we'll start off talking about
3 these findings and how they fit. And so if you
4 could come prepared to talk to that, okay?

5 MS. DAILEY: And all day tomorrow is
6 an open session. We will have no small groups
7 tomorrow.

8 CO-CHAIR GREEN: Okay.

9 MG HORST: Denise, if you would be
10 so kind if you could send me the attachments
11 tonight via email, as well as the proposed
12 schedule for next year so that I can look at it
13 and be prepared to talk about it tomorrow
14 morning.

15 MS. DAILEY: Great. Yes, sir, I
16 will.

17 CO-CHAIR GREEN: Is there anyone
18 else? I'd like to receive this electronically
19 for my sorting. Is there anyone else who would
20 like it electronically?

21 MS. DAILEY: Okay. We're talking
22 about this tab. Okay. Electronically, okay.

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1 Very good. Electronically. Okay.

2 CO-CHAIR GREEN: Okay. Thank you,
3 everybody. And we'll see you in the morning.

4 (Whereupon, the above-entitled
5 matter went off the record at 5:59 p.m.)
6

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