U.S. DEPARTMENT OF DEFENSE

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

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MEETING

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WEDNESDAY

OCTOBER 5, 2011

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The Task Force met in Salon E of the Regency Ballroom of the Hyatt Regency Crystal City, 2799 Jefferson Davis Highway, Arlington, Virginia, at 8:30 a.m., Suzanne Crockett-Jones, Non-DoD Co-Chair, and MG Richard A. Stone, M.D., Acting DoD Co-Chair, presiding.

PRESENT:

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
MG RICHARD A. STONE, M.D., USAR, Acting DoD Co-Chair
JUSTIN CONSTANTINE, J.D.
CSM STEVEN DeJONG, ARNG

RONALD DRACH
LTC SEAN P.K. KEANE, USMC
STEVEN J. PHILLIPS, M.D., USAR

ALSO PRESENT:
DENISE F. DAILEY, Executive Director, Designated Federal Officer
ANNE E. SOBOTA, Alternate Designated Federal Officer
SUZANNE LEDERER, Task Force Research Team
JESSICA JAGGER, Task Force Research Team
JOHN R. CAMPBELL, Deputy Assistant Secretary of Defense, Wounded Warrior Care and Transition Policy
PHILIP A. BURDETTE, Principal Director, Wounded Warrior Care and Transition Policy
SUSAN S. KELLY, Wounded Warrior Care and Transition Policy
KOBY J. LANGLEY, Wounded Warrior Care and Transition Policy
COL JILL FARIS, Deputy Surgeon, Army National Guard
RAY HOLDEMAN, Acting Division Chief for Personnel, Army National Guard G-1
ERIC SCOTT, Branch Chief, Medical Administrative Actions Branch
GINNEAN C. QUISENBERRY, Director, Population Health, Medical Management and Patient-Centered Medical Home Division, Office of the Chief Medical Officer, TRICARE Management Activity
DORINDA LOVELACE, Population Health, Medical Management and Patient-Centered Medical Home Division, Office of the Chief Medical Officer, TRICARE Management Activity
COL CHRISTIAN MACEDONIA, Medical Sciences Advisor to the Chairman of the Joint Chiefs of Staff
ISMAEL ORTIZ, JR., Deputy Assistant Secretary, Veteransþ Employment and Training Services
GORDON BURKE, JR., Veteransþ Employment and Training Services

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

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

2 (8:28 a.m.)

3 MS. DAILEY: I'd like to get

4 started. We are still waiting on

5 representatives from the WWCTP, Wounded

6 Warrior Care and Transition Policy. They're

7 due in about 8:45. I will bring them up to

8 the podium as soon as they arrive.

9 Meanwhile, Jess from our Research

10 Team is going to talk about the Focus Group

11 instruments. They are at Tab H. They're

12 right behind the briefing that Suzanne

13 finished yesterday.

14 We're going to kind of go through

15 these, familiarize you a little bit with the

16 Focus Group instruments. And as soon as the

17 Wounded Warrior Care and Transition Policy

18 office gets here, we will transition into

19 their briefings. But this is just kind of

20 familiarization, help you walk through it, get

21 you familiarized with the instruments. Good

22 morning.

DR. JAGGER: Okay. So, we'll show it on the screen, and you also have it in your binders, and I'll just walk you through some of the changes that have been made, and point out some of the key points.

Much like last year, we start with about two pages of introduction material. It's been shortened a little bit, did want to have highlight that for you. I won't say that it's been shortened a lot, but it has been shortened a little bit. So, you start with your welcome, your introduction of what the Task Force is and why it's there. Describe how the Focus Group sessions will work, emphasize that participation is voluntary, talk about confidentiality.

You get the forms out that need to be signed, the consent forms. And then you get the mini surveys out once the consent forms are done.

And as Suzanne mentioned, while they're doing the mini surveys, you're going

to let them do that before you start any discussion, and wait for the mini surveys to be collected back so that the scribe is back in his or her seat ready to scribe.

We've got some ground rules to cover, and some of those last few sections are the sections that have been shortened since last year.

On the start of the protocol, you'll notice that with the warm up and introductions, it's on page 3 of the RW Protocol, the Recovering Warrior Protocol, we have taken out the question about what service individuals are in because we'll know that there, and added a question about whether they're AC or RC, so Active Component or Reserve Component.

In the initial questions, sort of halfway down on page 3, we've taken out some of the questions about what makes that key player, key team member, valuable, and we've taken out the question about how active they

are. We found last year they just þ- those sort of things came out naturally, so you don't need to ask that question as explicitly; so, a little bit of trimming to make room for some more.

The RC questions, those that say "RC Only," those are new based on the Task Force's interest in exploring some of the RC issues particularly.

On page 4 when we start with non-medical, or with medical case management and continue on with non-medical case management, you might notice a trend, and that is that the best practice question has been taken out. We didn't find it to be particularly fruitful to ask RWs and family members what best practices they've identified. We get best practices themes out of those focus groups, so it's not that you'll lose that information. It's just that that's not language þ- that's not parlance that they use, so we took that question out.

1 The services for TBI and PTSD
2 starts at the bottom of page 4. That's moved
3 up from last year's protocol because sometimes
4 it didn't get addressed at the end of the
5 protocols last year.
6 The top of page 5, "What prevents
7 higher utilization, and how did you learn
8 about services for TBI and PTSD," those
9 questions are gone, mostly because they didn't
10 really yield results. And the information
11 that we need about how they learn of services
12 we get without asking that question
13 explicitly. It was one that people skipped
14 consistently last year. It was one that
15 didn't get a lot of response when it was
16 asked, so it's taken out.
17 The return to duty section is new
18 this year based on the interest of the Task
19 Force, so there are some new questions there.
20 And in the disability evaluation system we've
21 changed a little bit of the language in the
22 first question, "Who has heard the term

1 disability evaluation system," as opposed to,
2 "Who is in." So, it's more than just are you
3 in it, but have you heard of it, are you
4 starting to learn about it, whether or not
5 you're at that stage yet.
6 On page 6, the question þ- we had
7 a question last year. I'm not sure how many
8 of you remember it because it didn't get asked
9 very often about whether or not the
10 combination rating affected their confidence
11 in their transition from the DoD to the VA,
12 and that question is out. It wasn't asked a
13 lot, didn't yield a lot of fruitful results.
14 We have some mini survey stuff that sort of
15 gets at the same thing a little more
16 efficiently.
17 Again with legal support, the how
18 did you learn and what prevents higher
19 utilization questions are gone. People just
20 sort of said oh, yes, so and so referred me
21 to, without us ever having to ask the
22 question, how did you learn explicitly about

1 legal services. And the same thing is true
2 with vocational support.
3 Also, the mentoring questions are
4 out of the vocational support this year. We
5 didn't get a lot of information from the
6 mentoring questions when they were asked last
7 year, so we took them out.
8 And you'll see that the wrap-up
9 question this year is a little different. So,
10 last year we had asked, "What has been
11 particularly helpful?" This year we asked, "If
12 you were king or queen for a day," question.
13 And that takes us through the entire RW
14 Protocol.
15 On the family member protocol þ-
16 DR. LEDERER: Before you move on,
17 on page þ- on the first page, Jess, when we
18 ask them to introduce themselves, is number 3
19 þ- isn't number 3 new, when we ask them to
20 tell us if they're in a line unit or a
21 transition unit? We didn't know to ask that
22 last year. We didn't realize that we would be

1 talking to people both from operational units
2 and line units, excuse me, and the WTUs, and
3 the Wounded Warrior Regiments. This way
4 you'll get that information from the get-go.
5 The other thing is, there's also a
6 couple of specific questions about the
7 comprehensive transition plan; whereas, they
8 weren't focused on it specifically last year,
9 we know now this year that this is something
10 that you want to gather more specific details
11 on.
12 DR. JAGGER: Okay. With family
13 members, again, the introduction material has
14 been condensed just a bit, save us a little
15 bit of time.
16 Starting with the warm up and
17 introductions, we've added a couple of new
18 questions. The relationship to the service
19 member, this was asked in the mini survey and
20 it's still asked in the mini survey, but just
21 to get everybody talking about it. It was one
22 of those things that came up when people

1 introduced themselves last year, and we just
2 want to make sure that we're getting that
3 right from the beginning so you know who they
4 are, and how they relate to the service
5 member.
6 And then the transition goal,
7 that's a new question. Where are they in the
8 recovery process and what is the current
9 transition goal, if the family member is able
10 to speak to that.
11 In the initial questions, the
12 question about what additional skills they
13 wish they had has been taken out, didn't get
14 a lot of response last year, wasn't
15 consistently asked. And you'll notice that
16 the tone of the questions focuses on what is
17 most valuable to the family member, what needs
18 the family member has as opposed to the RW, so
19 we made that really explicit this year, that
20 we want to hear what they need, what they're
21 experiencing.
22 On page 4, again I'll point out

1 that the best practices questions are gone for
2 all the topics starting with the support for
3 family care giver topic.
4 There is a question about
5 resources for the severely wounded or injured,
6 and that question is gone. We didn't get a
7 lot of response on that question last year so
8 it's gone this year.
9 The RCC and chain of command
10 protocol for communication, that question is
11 out. We found that they weren't really
12 familiar with a protocol for communication,
13 but they did speak rather candidly about
14 whether or not they were communicating, and
15 that's effective enough information for us.
16 The CRP/CTP, the Comprehensive
17 Recovery Plan or Transition Plan, depending
18 upon whether or not you're at an Army
19 installation, that section is new in the
20 family member protocol.
21 On page 5, there are a couple of
22 questions that have been taken out to make a

1 little more room. The question about which
2 hotline, if they've used hotlines as an
3 information resource has been taken out. And
4 the more direct questions about NRD, Military
5 OneSource, Family Assistance Centers, those
6 have been moved up in the protocol, so we just
7 get to them a little sooner.
8 Services for TBI and PTSD we did
9 not ask family members last year, and we're
10 going to try to ask it this year in this
11 protocol, so that's at the top of page 6.
12 And we took out þ- there were some questions
13 about interagency matters for family members
14 last year, what other services were they using
15 outside of DoD, were they using any VA
16 services, et cetera. They weren't asked
17 consistently, and when they were asked they
18 weren't getting a lot of answers. And you'll
19 notice again we have the king and queen
20 question as the wrap up question.
21 That takes us through the two
22 focus group protocols. Hopefully, a good

1 refresher as you all embark on the trip to
2 Germany. And just really quickly in the mini
3 survey, I'll just highlight very briefly what
4 changes were made there, and let you take a
5 look at them.
6 The first page on the mini survey
7 for Recovering Warriors, "Where are you in the
8 process of recovery, rehabilitation, and
9 transition?" This replaced a question that we
10 asked last year about whether you're inpatient
11 or outpatient, and what kind of services
12 you're receiving. It was difficult for
13 participants to know how to fill it out
14 correctly, so as Suzanne mentioned yesterday
15 we took it out and put in a new question. So,
16 we've really tried to operationally define
17 these phases of the recovery and transition
18 process. So, there's early, middle, return to
19 duty, and in the IDES system as the options
20 for them to fill out.
21 MR. DRACH: Jessica?
22 DR. JAGGER: Yes?

1 MR. DRACH: Given the discussion we
2 had yesterday about voc rehab, and when voc
3 rehab services are going to start to be
4 provided, I'm wondering if under the mini
5 survey you've got the four subjects. If
6 you've started the DES, which steps have been
7 completed, C&P medical evaluation. I'm
8 wondering if we should add another one,
9 vocational rehabilitation services?
10 DR. JAGGER: Well, we know with
11 what they're piloting with VR&E that they
12 would be getting that first meeting with the
13 counselor right about the same time as
14 starting the PEB process. So, we can almost
15 proxy for the pilot sites that we know exist.
16 MR. DRACH: Okay.
17 DR. JAGGER: There are other
18 questions about whether they've interacted
19 with VR&E later on in the protocol, so see if
20 you think they get it. Then if it's still a
21 concern, let us know.
22 The next thing, as Suzanne had

1 pointed out yesterday, there's a few more non-
2 medical case managers at the bottom of the
3 second page added to the list.
4 You may or may not remember from
5 last year the information resources. We asked
6 them if they've used a military hotline and
7 then we used to say please specify branch, and
8 instead of branch we now say which hotline,
9 please specify the hotline. So, just a little
10 clarity change to get them answering more
11 clearly.
12 At the bottom of the third page,
13 you'll see we no longer ask about PEBLOs, we
14 ask about the VA MSCs. So, the PEBLO
15 questions are out of this section, and
16 replaced with MSC questions. We do still ask
17 about the PEBLO. It's in the 15th question,
18 which is the last page. We'll get to that in
19 a second.
20 And the last change that happened
21 in the mini survey for recovering warriors is
22 that we've added a few more vocational

1 programs to the list on the second to last
2 page. So, you see E2I and EEI up there.
3 And then as I mentioned, just so
4 that you're not concerned that we're not going
5 to ask anything about the PEBLO, we are still
6 asking whether or not they've had contact with
7 þ- whether they've utilized a PEBLO. That's
8 15-J. And then how helpful that resource has
9 been.
10 With the family members, there's
11 really nothing substantial to point out
12 because it's the exact same as what we just
13 went through with the recovering warriors.
14 So, where are they in the process, is question
15 number 4 on this protocol instead of question
16 number 1, but it's the same question changed
17 from the inpatient/outpatient question. Same
18 non-medical case managers have been added to
19 that chart. The same changes to the
20 information resources asking to specify the
21 hotline and the family assistance center, as
22 opposed to their branch of service, because a

lot of times þ- for example, in San Antonio they would answer that they were using þ- we would know that they were using the SFAC at the Army installation, but they were maybe Air Force, or Marines. So, they would fill in Air Force or Marines as their branch of service rather than who was providing that SFAC. So, we wanted to specify that what we're looking for is who's providing the SFAC, not which service they belong to.

And that's pretty much it. Do you all have any questions?

MS. DAILEY: Okay. I do have Wounded Warrior Care and Transition Policy Office in the wings here, so if I get can the staff to set up the table and get our name plates out, we will be ready to go for them. So, we'll take just a minute break here.

(Whereupon, the above-entitled matter went off the record at 8:43 a.m. and resumed at 8:50 a.m.)

CO-CHAIR CROCKETT-JONES: Good

1 morning, folks. We are going to move on to
2 our Wounded Warrior Care and Transition Policy
3 briefing from Mr. Campbell, the Deputy
4 Assistant Secretary, Defense for Wounded
5 Warrior Care and Transition Policy; Mr. Philip
6 Burdette, Principal Director; Dr. Susan Kelly,
7 the Senior Advisor for Transition Assistance
8 Program; and Mr. Koby Langley, the Special
9 Assistant. Our material is under Tab J. I
10 think we're all there. Looking forward to
11 hearing from you.
12 MR. CAMPBELL: Thank you. Well,
13 good morning everybody. I want to just say
14 that we're pleased to be back to be able to
15 update you again on the work that we're doing
16 for Wounded and Injured, and our transitioning
17 service members. The work that you do is
18 terribly important, so we are pleased to be
19 back here to give you some ideas about what
20 we're doing with regard to the recommendations
21 that you've made in your final report for this
22 year.

1 What we're going to talk about
2 today, however, will not be a formal response
3 to that. That will come, we're working with
4 the Secretary's office right now on that
5 deliverable in December.
6 I understand that some of you are
7 going to be going to Germany in a couple of
8 weeks. I wanted to just comment on my two
9 trips to Landstuhl and what that meant to me.
10 To see firsthand just the quality
11 of the care that these young men and women
12 receive coming back, to realize that 99
13 percent of the people that get to Landstuhl
14 survive, realize that this is the only Level
15 2 Trauma Center recognized outside the U.S.
16 And all this is done by in an aging plant
17 which, as you will see, the hospital is quite
18 old, all this being done by 3,000 staff, a
19 combination of all five services, German
20 Nationals and civilians. And it's quite
21 remarkable. And I'm sure that you'll come
22 away with the same feeling of pride in what

1 we're being able to do for these young men and
2 women, which to me is a measure, is a bar for
3 this Department, that we need to at least
4 provide that kind of quality in the policies
5 and programs that we run.
6 I'll give you the briefing order
7 today. Mr. Koby Langley will start with
8 strategic communications and outreach,
9 followed by Phil Burdette, who will talk about
10 the disability evaluation system, as well as
11 the new DD policy on care giver compensation.
12 And then we'll end up with last but not least,
13 Dr. Susan Kelly, a new addition to our staff
14 SES brought in as a Special Advisor to me on
15 transition assistance, which is a special
16 request of yours today. Next slide.
17 The organization really hasn't
18 changed with the exception of Dr. Kelly, but
19 I think it's important that the work that
20 we're doing matches the level of importance
21 that the President has placed on transition.
22 So, we brought in a senior experienced

1 executive to handle our Transition Assistance
2 Policy. Next slide.
3 You've seen the overview of the
4 policies and programs of this Department. I
5 just want to highlight the transition piece,
6 which Dr. Kelly will talk about, and the
7 Disability Evaluation system which Mr.
8 Burdette will talk about in terms of the
9 successful rollout, global rollout of the
10 Integrated Disability Evaluation System, which
11 began and ended this September, as well as
12 discussion about the anticipated changes and
13 proof of concept that we're working on with
14 the reformed IDES.
15 We'll not be talking about
16 Recovery Care Coordination Program. We will
17 be testifying tomorrow at the HFAC Health
18 Subcommittee on the issue of FRC/RCC
19 combination or consolidation, so I just
20 mention that we're going to be doing that.
21 But we're still working very closely with VA
22 on a successful resolution of those two

1 important care management systems.
2 So, without further ado, I'll turn
3 this over to Mr. Langley.
4 MR. LANGLEY: Thank you, sir. Next
5 slide.
6 So, the Recovering Warrior Task
7 Force report annotated a couple of different
8 things, and in our last testimony our
9 colleagues here in the Task Force mentioned
10 that the knowledge and understanding of the
11 benefits and services that are provided by the
12 National Resource Directory were not
13 particularly well known in the Wounded Warrior
14 community. So, I just wanted to highlight
15 several additional efforts that have been made
16 since that last meeting.
17 I want to start by beginning with
18 stating that we have increased both our
19 budget, as well as the resources related to
20 outreach for the National Resource Directory,
21 and that has yielded significant returns in
22 the past six months.

1 Very specifically, in the Task
2 Force report, the Task Force annotated that
3 they would like to see additional information
4 provided to Recovery Care coordinators on the
5 National Resource Directory.
6 I'm happy to report that as of
7 today the IT tool that is used by Recovery
8 Care Coordinators to help create a
9 Comprehensive Recovery Care Plan for
10 recovering service members who are assigned an
11 RCC and/or FRCP, that IT platform, RCPSS, is
12 embedded now with the National Resource
13 Directory. So, every time the RCC Coordinator
14 pulls up his or her file to discuss options
15 for meeting the needs of a recovering service
16 member and his or her family that Recovery
17 Care Coordinator cannot help but see the
18 National Resource Directory on there.
19 In addition, it's also included as
20 a counseling checklist item for RCPSS. And
21 lastly, each Recovery Care Coordinator is
22 trained on a quarterly basis. They're looking

1 at adding follow-on training, but they don't
2 currently do that. So, for new Recovery Care
3 Coordinators they receive independent and
4 individual counseling on the National Resource
5 Directory through our outreach efforts with
6 the National Resource Directory.
7 As it relates to new media, we
8 have significantly improved our outreach
9 efforts to the community, and that has been
10 reflective in the number of individuals that
11 come to visit the National Resource Directory.
12 That number has grown. If you remember last
13 time, it was around 100,000. It's now close
14 to 180,000 individual unique URL hits. What
15 that means is somebody actually comes on to
16 the web page and we know it's one person
17 and/or one computer that comes.
18 In addition to that, registrants
19 have risen by approximately 5,000, and now
20 well over 20,000 registrants on the National
21 Resource Directory.
22 That's important because in order

1 to register, you actually have to provide
2 information about yourself, and you actually
3 have to select what sort of information that
4 you want to receive on the National Resource
5 Directory, and have that information pushed to
6 you on a daily basis, on a weekly basis, or
7 however often you want to receive that
8 information.
9 So, as a subscriber I would go on
10 the National Resource Directory. I would
11 create a profile, and I would select "I want
12 information about education resources, as
13 those resources are updated on the National
14 Resource Directory," and/or "I want
15 information about health care benefits as they
16 relate to my area where I live," and that
17 information would be pushed to me via email on
18 a daily basis.
19 So, one of the specific criticisms
20 in our last þ- excuse me, one of the specific
21 critiques and/or observations in the last
22 hearing was that we lack the ability to

1 actually identify whether or not recovering
2 service members are using the resources, so
3 it's great to say that we have an increase of
4 50,000 or so users on the National Resource
5 Directory. And we anticipate that number to
6 hit 200,000. That far exceeds the Joint
7 Strategic Plan goal set by both DoD and VA.
8 It's over 100 percent increase since the JSP
9 was published. That goal was 30 percent for
10 this year, so we think we're doing pretty
11 good. We need to increase our efforts.
12 And to the specific critique of
13 how do we know that we're reaching wounded
14 warriors specifically, and/or family members,
15 and/or care givers, we're going to add a new
16 capability to the National Resource Directory
17 within the next fiscal year that will allow
18 individual users to actually go online, and in
19 addition to providing information about
20 themselves and what they want to see, the can
21 self-identify if they want to self-identify
22 whether they are a care giver, whether they

are a family member, whether they are an active duty service member, or whether or not they're a wounded warrior.

The last category does present us with some challenges, and we're working through that, which is why þ- why we're going to þ- it's going to take probably a year or so before we can work through the widgets of deciding how we can have somebody identify themselves as a wounded warrior, self-identify themselves as a wounded warrior while still maintaining, PII, Personally Identifiable Information requirements that our lawyers require us to do. We also want to respect the privacy of service members, and of wounded warriors.

We have added a specific Twitter feed, and we know that growing members of the community are using Twitter to receive information on a daily basis. That usership was started about a week ago, and approved by the Board. We have also a new Facebook

1 feature to the National Resource Directory.
2 And, lastly, we have brought on an individual
3 that will specifically blog about the
4 resources on the National Resource Directory
5 inside of the blogging community, so she'll
6 actually go on to different blog sites and
7 submit information to community blog sites for
8 wounded warriors and others and tell
9 individuals in those communities about the
10 resources in the National Resource Directory.
11 MR. CONSTANTINE: A quick question.
12 Is the singular purpose for creating a profile
13 on National Resource Directory so you can have
14 the information pushed to you, or do you get
15 other benefits out of doing that?
16 MR. LANGLEY: So, it was
17 specifically created to disaggregate the
18 information, to push the information to the
19 service members so they don't have to always
20 come to the National Resource Directory. Once
21 you register on your mobile app, or on your
22 iPhone, or at your computer in your daily

1 email you'll get information pushed to you.
2 So, that's why it was created. But we are
3 exploring, based upon your observations at the
4 last Recovering Warrior Task Force hearing,
5 the options of self-identifying. And that
6 creates more or less a community environment
7 where other people that are using the
8 resources can say oh, so this individual went
9 to look at homelessness assistance in Detroit,
10 Michigan, and made a comment that it was
11 either useful or not useful. And as a
12 community member that's particularly helpful
13 to you, because if another wounded warrior
14 mentioned that or if a care giver mentioned
15 that that was of particular assistance, that
16 would have more utility for you. So, we're
17 expanding the scope of what it was originally
18 designed for to meet the intent of touching
19 the community in meaningful ways.
20 MR. CONSTANTINE: Now, the second
21 part of what you described sounds similar to
22 Warrior Gateway. Are you tied in with them,

or you work þ- how is it þ-

MR. LANGLEY: It is similar to Warrior Gateway, and the Warrior Gateway has specifically asked to help share information for the National Resource Directory. So, this year we actually created a capability for any private entity to include the wounded warrior þ- excuse me, to include the Warrior Gateway to take that information and pre-populate their sites. It's not a realtime feed, but it is an aggregate feed of information, and we've entered into, I believe, four or five agreements with different private organizations since we last met to provide them with that information. And that's how we're interacting with other entities and agencies that use this information. Next slide.

So, on the way forward þ- I'm not going to read through this slide, but I will just annotate a couple of different highlights that show that we're making progress in

1 reaching the community in accordance with your
2 findings and recommendations.
3 We're going to move into paid
4 media. Specifically, we're going to look at
5 a paid media on Facebook, which has shown a
6 lot of promise and a lot of return on
7 investments for other organizations that are
8 using paid media on Facebook for a number of
9 different reasons.
10 We're going to increase our own
11 media profile and advertisements about the
12 nationalresourcedirectory.gov in Turbotap.org.
13 If you go to the bottom right-hand corner in
14 social media, we're going to look this year to
15 help synchronize all of our new media
16 platforms to help deliver a coordinated
17 message.
18 And, as I mentioned before, we're
19 looking to increase data feed partnerships
20 with other private entities in addition to
21 embedding the National Resource Directory into
22 private entity organizations. A good example

1 of that is an agreement that we just entered
2 into with Wounded Warrior Project, Mr.
3 Constantine, you're familiar with the Wounded
4 Warrior Project, obviously, as a member of the
5 Board, but for the first time the Wounded
6 Warrior Project has a National Resource
7 Directory embedded into their own website in
8 a customized way. That's important because it
9 disaggregates the information, so we don't own
10 the information. The information is being
11 shared with the community and the advocates in
12 those communities so that we can reach a
13 broader segment, and we know that we're
14 touching wounded warriors.
15 The reason why it took us so long
16 to do that, to be completely honest with you,
17 is because the search capability in the
18 National Resource Directory wasn't quite up to
19 par, so the Department of Defense, and
20 Department of Veterans Affairs, and Department
21 of Labor made a specific requirement to
22 improve that search function before we entered

1 into these partnerships with private entities
2 so that we're delivering a quality product for
3 private organizations.
4 On the upper right-hand corner,
5 you'll see what I'll call in-person touches,
6 so we're going to increase the number of
7 events that we attend where our stakeholders
8 are visiting. And I'm going to flesh out our
9 strategic objectives with the Department of
10 Labor and with the Department of Veterans
11 Affairs as it relates to Recovery Care
12 Coordinator and Federal Recovery Care
13 Coordinator training on the National Resource
14 Directory. We hope to have that curriculum
15 identified and completed within a year, and
16 that will meet, hopefully, your findings and
17 recommendations for this year.
18 Barring any questions, that's all
19 I have. The next speaker is Mr. Burdette.
20 MR. BURDETTE: Thanks, and I'm
21 ready for the next one.
22 Good morning. Thanks for having

1 us back today. We're excited to report to you
2 on the progress. We really appreciate the 21
3 recommendations that you provided in
4 September, and that's really given us a really
5 good roadmap inside the building, and where we
6 can generate real discussion, put real
7 investments, and really focus our resources
8 on. So, look forward to your next one. I
9 thank Ms. Dailey for the constant coordination
10 between our office and your Task Force. It
11 really is, I think, a terrific relationship
12 and really helps us folks. I appreciate that
13 outside look.
14 I'm going to brief a couple of
15 areas today; the Integrated Disability
16 Evaluation System, and then the Care Giver
17 Compensation on the DoD side of the house,
18 remains two of the more high profile
19 portfolios that we have, and the IDES, in
20 particular, is of particular interest to not
21 only us in this room, but also the some 17,000
22 recovering service members and their families

1 that are in the process now.
2 As a way of history, Slide 9 says
3 "Where we go." The goals were fairer, faster
4 and reduce benefits gap, so the benefits gap
5 being eliminated I think is cause for
6 celebration right there as you talk to the
7 wounded warriors. That takes out the
8 uncertainty between them and the VA
9 relationship. It makes it a seamless
10 transition. Pay and benefits attach as soon
11 as they're legally allowed to. Let's them
12 have that connection with VA. Real success
13 story there.
14 We'll get to the fairer part in a
15 minute. We have some statistics that we
16 gather on a monthly basis to make sure that
17 that's a true statement. And the faster,
18 against the history backdrop of 540 days, the
19 legacy system is certainly there. And we're
20 going to talk in whatever depth you want to
21 about the timeliness, but I can tell you that
22 timeliness gets the attention at the highest

levels of the Department on a weekly basis by phase.

It's refreshing as a citizen and as a veteran to see the Deputy Secretary of Defense that can tell you every 11 steps and how everybody is doing. And when the SOC comes together, I think one of the most useful outputs of the SOC is that we break it down phase by phase, and look at phase by phase, month by month performance, see where we're under-performing, see where we can add resources. And you'll see some of the mitigation steps we've taken to make the IDES work even better.

I'll talk briefly, we're calling it reformed IDES. We were very happy to celebrate that 139 sites on-time came on station, and that all new enrollees will be into the integrated system, so legacy system, the people that are in that will continue to matriculate through it. And when they're finished with that, all new accessions will

1 come into the integrated system.
2 That was field on time at all
3 sites, and that's up and running. But we
4 weren't happy just with that. We wanted to
5 realize that just fielding it doesn't get us
6 home, necessarily, so what can we learn, and
7 then deploy immediately? And we think we've
8 got some great ideas, and we're calling it
9 reformed IDES. We're going to three sites by
10 the end of the calendar year. Teams from the
11 field, from the services, from the policy
12 makers, from the VA all sit in weekly meetings
13 to make sure that we've written the policy
14 correctly, to do the best we can to make it an
15 even better process for the service member,
16 maintaining that service member-centric. But,
17 also, we've got to get our timeliness better.
18 So, where we hang our hat on the
19 two, I think, cornerstone accomplishment of
20 the rides, and it's less hand-offs, three
21 instead of eight, and also max concurrent
22 processing. So, if I'm a VA person, I don't

1 want to wait if there's a piece that I can do
2 for the DoD to hand the football back to me.
3 So, that max concurrent processing is
4 happening.
5 And there's also a significant IT
6 piece that we are learning as we go. And
7 although we agreed as a Department with the VA
8 to use the Veterans' tracking application as
9 the system of record for IT, we've learned in
10 practice, and you've seen on your visits, it's
11 clunky. How many times have you seen a
12 corpsman, and she sits at her desk and she has
13 to input into a local tracking system, and
14 then she'll swivel to the other screen, and
15 then input into the VTA.
16 I'm happy to report that slides of
17 those corpsmen that are doing that input are
18 briefed at the SOC, and they are jaw dropping,
19 and has led us to another internal working
20 group. We've taken a strong look at how are
21 we investing in IT. Is VTA the answer for us?
22 Let's have a harmonized, synergetic approach

1 to this IT piece with two focuses; case
2 management, which is crucial for both sides of
3 the house that are tracking an application.
4 And also, if we can get some electronic file
5 transfer capability.
6 We have been active consumers of
7 the VLER. I mean, that is what's going to get
8 us there, NIHER being a subset of that, the
9 electronic health record, but we're finding
10 local place posting stations, as you have
11 seen, are not waiting for that. They're
12 scanning, they're making their own CD copies.
13 They're doing what basis posting stations do,
14 they're innovating locally, and that's
15 terrific, but from a policy standpoint, from
16 where Secretary Campbell sits, we've got to
17 have a harmonized approach.
18 The VA has been with us at every
19 step in that, and we're getting there, so a
20 real focus area for us at the end of this
21 calendar year and into the spring.
22 I think I'm done with that slide.

1 Can we go to the next one, please? Thanks.
2 Talk about satisfaction. This is
3 the þ- one of the real problems with the
4 legacy system is lack of data, so we have
5 invested a lot in data gathering on this.
6 Most important, if you're going to have a
7 service member-centric system you better ask
8 the service members and their families how
9 they feel about it a lot.
10 We have done that. We are happy
11 that it's higher quality ratings and fairness
12 ratings from the service member perspective.
13 We report that every month in our IDES
14 reports. We collect it. It's a sea of data
15 that we give to the services, but we think
16 this is one of the most important things we
17 ask, is what does the customer feel about it?
18 I think I'm ready for the next one. Thanks.
19 This is our global map that we've
20 used throughout the rollout. The takeaway on
21 this is that we have completed the rollout at
22 139 sites, so we're there. And IDES is the

1 system that we are all using both in the VA
2 and DoD side of the house.
3 The IDES system is just the three
4 locations for now and planned Shaw, Lejeune,
5 and Carson, and will be there in the month of
6 December using the new process for that.
7 Okay, the timeliness slide.
8 First, a disclaimer on this. This is the slide
9 we have used for many months now in all
10 forums, from the Hill, to this room, to the
11 SOC, any other brief. I can tell you as a
12 rearview mirror slide, it doesn't tell the
13 whole story, so I think we'll get into the
14 whole story going forward.
15 And what I mean by that is simply
16 this: If I were to say to you that the big
17 circle on the right in August '11, it took 418
18 days for a service member to complete the
19 process, true statement. But in my rearview
20 mirror there's nothing I could do to effect
21 that performance, so we're developing better
22 tools now to say well, how are you doing month

over month? And those trends are the ones that we're looking at now, because it's the changes and investments that we make now that in 400, or actually substantially less, well, then how will that service member be affected going forward? So, we're looking at predictive models now rather than historic models.

There's nothing we can do to affect who's going to have their benefits attach this month. They're at the end of the pipeline. But if we can do phase by phase performance, then we can really see where the bottlenecks are, and we can really effect change with our resources, and with our attention from the leadership level to affect it going forward. That's why we go phase by phase month over month, and I'll talk to those specifically in a couple of slides from now.

Hats off to the VA. They have done a fantastic job, in my opinion. In their five phases, in the examination period, in

1 particular, they have driven it and we'll see
2 in a moment now, and I think 49 days from
3 where they were tracking at 83. I think that
4 happens for two reasons, leadership attention
5 and accountability.
6 Much credit goes to Mr. Gingrich
7 from the VA who has led video teleconferences
8 with bases, posts, and stations sitting
9 alongside uniformed colleagues, and people
10 that oversee the medical treatment facilities.
11 That has driven real change. We have seen
12 real benefits from that, and that really
13 accounts for their performance improvement.
14 We've learned from that model. We
15 do the same thing in house now. We're seeing
16 some good trends in some of our phases, and
17 we're seeing some phases which are either
18 stagnant or heading in the wrong direction.
19 Good news side of that, if you're a glass half
20 full person, I am, is that once we've briefed
21 that at the SOC with the service chiefs at the
22 table it's clear where they need to invest,

1 it's clear where we need to improve. And then
2 you see that it really happens. Go to the
3 next slide, please.
4 We have 11 stages. I brought out
5 just four here to tell, I think, some brief
6 stories. As I said, all 11 get briefed at the
7 SOC. All 11 get briefed to the Deputy
8 Secretary of Defense, and the Under Secretary
9 of Defense on a weekly basis where we chart
10 performance, and then mitigation measures to
11 improve.
12 The bottom right, I mention how
13 great the VA is doing, and the steps we'll see
14 that they have taken around the next slide,
15 but the numbers speak for themselves. They're
16 month over month performance in getting the
17 medical exams completed, has met goals. So,
18 they're doing a terrific job.
19 We are doing a better job
20 trending, if you look from March 11 to August
21 11, at our top left in the MEB stage, we had
22 a big problem with staffing MEBs correctly and

1 making sure that we tried to get near our MEB
2 time lines. That trend line is good. That
3 makes our predictive models look much better
4 than the 418 who are hitting the finish line
5 now.
6 Our investments in scrutiny and
7 focus on the MEB are paying the dividends that
8 we hoped to, less so on the MEB which is top
9 right a little bit. That needs to continue to
10 be a focus area. And one thing that we really
11 continue to be hamstrung by is the bottom
12 left, the transition processing times.
13 Our service members are coming
14 back with an extraordinary amount of leave,
15 and we have never restricted two things in the
16 process, either in IDES or the remodeled IDES,
17 and that's your ability to challenge and
18 execute due process, and say I would like to
19 have another hearing and full appeals, never
20 been restricted. And we've never said no to
21 service member when she wants to take leave.
22 The downside of that is we

1 predicted the yellow line on the bottom left
2 leave and transition to be about 45 days.
3 Since we're granting all the leave she has
4 earned, we're seeing her take leave at the 87,
5 95-day level to include the TAP class which is
6 a week, and you're out processing, you've got
7 to turn in your weapon, you've got to do those
8 things that happen at our base, posts, and
9 stations. But if you're taking 60 or 75 days
10 of leave, there's no way I can get in front of
11 that unless I say no to leave. And as a
12 policy level, we just haven't decided to do
13 that.
14 These service members have given
15 too much, and have earned that. And if you're
16 a service member and you would know, you're
17 not going to want to sell your leave back.
18 You're going to want the VA that attaches to
19 it, the incentives pays that attach to it, the
20 tenure that builds up in your time in service,
21 so there are smart reasons for a service
22 member to want to take that leave on active

duty and not sell it back.

We get that. We've asked for some studies where we could do cost models, where we could incentivize them selling it back on a voluntary basis, and then perhaps they could accelerate their transition and not be counting against us in this time line.

But I spend the time to talk about that, just þ- that's just not something we can change unless we make a policy change to restrict due process, and to limit leave. So, it will hamstring us for the near future, but we're investigating policy options to say is this something that should be counting against us in the model?

To date we've left it in just on the issue of complete transparency and complete obviousness as to what contributes to the time, but it's hurting us. No doubt about it.

MR. CONSTANTINE: So, the top left, I understand why you said in March you didn't

1 have it quite figured out and the trending
2 down, looks like last three or four months
3 it's kind of plateaued, and really the same as
4 it was a year ago, so what are going to do if
5 you þ-
6 MR. BURDETTE: I think the effect
7 you're seeing there is you've heard of the
8 Pinellas Park experience. So, in Pinellas
9 Park, Florida we have the huge number of
10 reservist cases for the Army specifically that
11 are being adjudicated, and then a lot of those
12 are going into the DES. That inflow of people
13 into the DES is not matching the resources we
14 have matched up to it.
15 And, also, as the system of record
16 is IDES, all we have now, with every service
17 member going into IDES, I still don't think we
18 have staffed the MEBs appropriately enough.
19 And I'll get into a couple of mitigations we
20 have taken on the MEBs -- can we go to the
21 next slide? -- that I think may speak
22 specifically to what we're doing MEB-wise.

1 I should also publicly thank
2 General Corelli as he ends his active service.
3 He has been a vocal, and obvious, and
4 incredible influence on getting the issues
5 brought to light and making it happen.
6 He holds VTCs with all of the
7 medical treatment facilities, some start at
8 6:30 p.m. I've seen them go as late as 10
9 p.m. at night. The medical treatment facility
10 commanders are on the phone with him, looking
11 him in the eye. There are no excused absences
12 unless they speak to him directly. That has
13 a great effect on attendance, as you might
14 imagine. And that's scrutiny that he is
15 driving personally, had led to sharing best
16 practices. He has led the Army to really
17 relook at how they invest in the MEB and other
18 under-performing stages. And we think will
19 have some impact going into the fall and later
20 months of this calendar year.
21 I mentioned that we have the
22 quarterly meetings. I can tell you there will

1 be an October meeting between the Secretary of
2 Defense and the Secretary of the VA: four
3 topic areas, IDES is one of them. So, it's on
4 their scan, which is terrific. It's a great
5 forcing function for us. They both care
6 tremendously about it. The fact that they
7 take the briefs on it, and I mentioned the
8 Under Secretary of Defense takes the briefs on
9 a weekly basis, and the Deputy Secretary.
10 Their leadership, hands-on
11 involvement in this has been terrific, and I
12 think has us trending in the right way for
13 investments. They've led the IT rework as
14 well.
15 We think if we can get an IT
16 solution, we'll shave 22 days off that frankly
17 we're spending on FedEx right now. If you
18 hand off the football eight times between the
19 two families, that's at least 16 days of
20 FedEx, not to mention your FedEx bill, first
21 of all. And if you've seen these cases, and
22 you have, they're phonebook thick. If we

1 can't get electronic case transfer soon, we're
2 going to continue to eat those 22 days. So,
3 those are the type of efficiencies that we're
4 driving in these calls.
5 Site by site performance tracking.
6 I've only put a few of the slides that we take
7 into the room. We go every 11 of the phases,
8 we go station, base, and post performance. We
9 go service performance. We go that in depth
10 in the meetings to make sure that everybody
11 understands performance at every level.
12 We had an outlier slide that I
13 mentioned earlier, the corpsman that you've
14 all seen, and when she has to input in the VTA
15 and then has to input in the local tracking
16 system, a lot of times I think as a fact of
17 life, the VTA falls off the radar scope, and
18 that doesn't always get updated because she's
19 got a pile of records she's got to get to, to
20 get them to the MEB and other local processes.
21 So, we found some 1,300 or so
22 incomplete VTA applications that look to be

incredibly long cases. Some when we first started looking were 1,300, 1,400 days. As we did the data scrutiny into it, we just found that the bases, posts, and stations had not updated the VTA. So, we led a real service-wide level effort to make sure we went in and checked on every single person. And we found people had gotten out, people had returned to duty. And some of those 1,300 or 1,600 records have been updated, which gives us better data, which is great. And it also closes those cases out, and gives us a better idea of who the 18,000 people in the system are.

Teaching those two systems to talk to each other will be the answer, and we're focused on that with that IT working group, but for now that's where we're at.

I guess the outlier slide that we spoke to you in the case management system, the services have been great in this calendar year and said okay, we get it. Here's where

1 we're stuck, and they've asked the Secretary
2 of Defense for some relief in some cases.
3 We've been happy to be part of that dialogue
4 with the services. The Army, particularly,
5 has asked for the psychiatrist exclusion on
6 the MEB, and we've entertained that. So, it's
7 great to see that the services are asking hey,
8 here's what we're seeing at the ground level,
9 and we need to do þ- as I mentioned, with the
10 remodeled one, in particular, the services are
11 in the room with us on a weekly basis, so the
12 policy makers and the practitioners are both
13 tied, saying how can we make this remodeled
14 thing work, and what makes most sense?
15 Dr. Stanley's guidance to us was
16 clear, fix this as best you can without
17 breaking the law. When you hit a law, stop
18 there, and then let's have another group look
19 at the strategic impact of what we need to
20 change law-wise. That group meets. That
21 group will report to the two secretaries on
22 the 17th of October on ideas for legislative

1 change. That may give us some relief in the
2 process that we've been executing for decades
3 now with a new generation of new veterans.
4 I think that's all I have on IDES.
5 I'll welcome your questions on that, or we can
6 turn to the compensation.
7 CO-CHAIR CROCKETT-JONES: Can you
8 tell me a little more about the bullet to fund
9 consideration of additional claimed conditions
10 post-C&P exam? Just let me know þ-
11 MR. BURDETTE: Can I take that for
12 the record? I just don't know the degree of
13 difficulty. I realize it's on there and I'm
14 briefing it, but I just wouldn't be the expert
15 on that today.
16 CO-CHAIR CROCKETT-JONES: Okay,
17 that's fine. Just give me an idea of -- well,
18 who's the driver on that?
19 MR. BURDETTE: So, Wes Hinges in
20 the room is the practitioner on it. And the
21 point of the slide there is to say these are
22 the things the services have asked us for, so

1 I would be a little over my head to answer
2 exactly what it is. But it's great to have
3 the services asking for these tweaks in the
4 system in how we field it. So, I'd be happy
5 to get you a written response, if I could,
6 after this. Would that be acceptable?
7 CO-CHAIR CROCKETT-JONES: That will
8 be sufficient. Thank you.
9 MR. BURDETTE: Okay, great. Thanks
10 very much. Anything else on IDES? Great.
11 Thanks.
12 So, we'll go into the DoD Care
13 Giver Compensation, which is one of the
14 hardest acronyms that we have right now.
15 Special Compensation for Assistance with the
16 Activities of Daily Living.
17 I thank the Task Force for their
18 recommendation on this. It was a great
19 forcing function for us to say we really need
20 to get this published. Deputy Secretary Lynn
21 whose last week is this week with us in the
22 Pentagon, made this a real point, said we're

1 going to get this done before I get out of the
2 building, so much thanks to him for really
3 making it happen.
4 His personal interest in this has
5 made a many months long process in doing
6 anything, we timed it in days instead. I'm
7 happy to report that over 100 servicemembers
8 today are enrolled and receiving compensation
9 under this program through DoD.
10 One hundred is great, we thought
11 350 was going to be the number. We've had
12 some problems with language and
13 interpretation. The steps that you have to go
14 through to get this are: a doctor has to
15 certify that you're eligible for this program
16 in that you need a caregiver in bathing,
17 toilet functions, in the daily living
18 functions.
19 And the real part we had some
20 sticky problems with was, picking our
21 language was, would otherwise be in a nursing
22 home, or another medical treatment facility.

1 So, we've continued to put amplifying guidance
2 out to the field. We want to make sure all
3 four services are executing this the same way,
4 and we want to have a harmonized approach.
5 Our team has led if not daily,
6 certainly weekly meetings with the services to
7 make sure what does the word "home-bound"
8 mean, what does "daily living" mean, and make
9 sure that the doctors who make the assessments
10 understand it, they understand the Deputy
11 Secretary of Defense's intent, which is to be
12 inclusive as possible, and that we harmonize
13 it with the VA Care Giver Program downstream.
14 This is one area where the word
15 "care giver" on our side, and the word "care
16 giver" on the other side is going to lead to
17 some understandable friction. I think it's
18 really akin to what we did with the Recovery
19 Care Coordinators. I think the biggest
20 mistake we made there is we called them both
21 Recovery Care Coordinators.
22 They're a little bit different,

1 and although our policy doesn't exactly match
2 up with what the VA does, the intent does.
3 And where it doesn't, with particularly the
4 ill people, the VA has another policy that
5 kicks in to help that. So, what we have done
6 is mapped, and this work is almost completed,
7 mapped every DoD wounded policy to a VA
8 policy, and then the intent being we don't
9 want a service member on our side of the house
10 to fall off and not be eligible or
11 understanding of a benefit on the VA side of
12 the house.
13 That mapping is almost complete,
14 and when it is, we'll be happy to share it
15 with the Task Force. We think it's an
16 incredibly important document, not only at the
17 policy level, but also to make sure at the
18 practitioner level, so that when the continuum
19 of care is briefing a new family into the
20 process that they understand, well, today
21 you're under the SCAADL program, and then you
22 will matriculate into either the VA Care Giver

1 or another VA program, so that they feel like
2 there's a continuum there.
3 This didn't happen overnight, and
4 that's by design. We wanted to make sure we
5 have as much harmony as we could, and that we
6 have vetted the language as thoroughly as we
7 could with the services. Despite that
8 intentional get it right phase, we're still
9 finding some inconsistencies with service
10 interpretation. And this comes down to the
11 doctor level, saying, what does the word "home
12 bound" mean?
13 So, we have driven that right down
14 to the doctor level. We now have VTCs at the
15 treatment facility level, where we take the
16 form out and we talk about exactly what the
17 expectations of the diagnoses are. And that's
18 going to get better, and when that does happen
19 you'll see more Army enrollees. To date, and
20 we only started this on October 15th, or
21 excuse me, September 15th was the first
22 payouts. You'll see more Army enrollees

today. If you were to look at the number of Marine enrollees, 88 last time I checked it, and number of Army enrollees much less than 88. You would say that doesn't make sense with an Army of over 500,000, and Marine Corps of nearly 300,000. So, we're driving that. It's important to us.

MR. CONSTANTINE: That's not retroactive at all, is it?

MR. BURDETTE: It is retroactive to the date of entry into the program, so the date that the doctor certifies you into the program. If DFAS doesn't kick it in, the Defense Finance doesn't kick in. The date the doctor certified you, if she certified you on 1 October, you'll be paid from 1 October.

MR. CONSTANTINE: I mean, say two years ago.

MR. BURDETTE: It is not. Ready to go the next slide, please. I think I covered all that, unless there's any questions on that.

1 As you've taught us, and we
2 appreciate the scrutiny, having a program is
3 great. If you don't get the word out, what's
4 the point? So, once we get the language
5 harmonized and we make sure that the services
6 have understood the Deputy Secretary of
7 Defense's intent with this, we're going to
8 splash it as wide and far as we can.
9 We have not waited to make sure.
10 We know the population. We estimated about
11 350 people would be eligible through the
12 Warrior Transition Units and the Wounded
13 Warrior Regiments, and the Army þ- Navy Safe
14 Harbor and the Air Force Program, as well.
15 We've made sure that we're reached out to all
16 eligible people through those channels. We'll
17 then go very public and make sure that other
18 people throughout the Wounded Warrior
19 community are aware of the program, who's
20 eligible, how to get into it, and things of
21 that nature.
22 I think that completes my formal

1 remarks, unless there's any questions on
2 either of those portfolios.
3 Okay. So, I get the pleasure of
4 introducing Dr. Susan Kelly. Despite what you
5 hear or read sometimes, the investment on the
6 Department in this portfolio is significant
7 and increasing. And Dr. Kelly's presence here
8 recognizes that, and represents that. To add
9 executive talent at a time where executive
10 talent is diminishing in the Department of
11 Defense, I think represents the Department's
12 commitment to getting it right in this
13 portfolio.
14 As the active campaigns dwindle
15 down, the investment in our recovering
16 servicemembers will continue to increase. And
17 the Department recognizes that. The fact that
18 Dr. Kelly is here leading such an important
19 effort in the areas of transition assistance
20 programs, I think really speak to that, and so
21 does our budget investment, as well. So, I'm
22 pleased to welcome you, Dr. Kelly. Thanks for

1 doing this.

2 DR. KELLY: Well, as both Mr.

3 Campbell and Mr. Burdette have said, I'm the

4 new kid on the block. I have only been in this

5 position for just over 60 days, and it's

6 already been quite a ride just in those last

7 two months.

8 And if you look to the next slide,

9 you'll see why it's been very, very exciting.

10 And that is: we've had a Presidential call to

11 build a career-ready military. This was

12 announced August the 5th, four days after I

13 came on board. That gives you a sense of how

14 my days have been so far along with everyone

15 else here on this table.

16 The President gave us two

17 mandates, and you see those below the

18 Presidential seal there. The first one is to

19 develop reforms pertaining to training,

20 education, and credentials for military

21 members. Training, education, and credentials

22 cannot be provided in a month, 60 days,

1 whatever. This is a long-term perspective on
2 how we want to get our military members
3 career-ready.
4 The second piece you see refers to
5 a reverse boot camp, and the specifics are to
6 give them more counseling and guidance,
7 getting them career-ready.
8 We're looking at this as a mandate
9 to look specifically at the services we can
10 provide right now. So, we're taking two
11 perspectives, a long-term perspective trying
12 to embed transition assistance across the
13 military life cycle.
14 So, at their first permanent duty
15 station, we start then. Starting to plant the
16 seeds that every military member, whether
17 you're going to stay four years, six years, or
18 30 years, or however long our lifetimes allow
19 us to as our quality of life increases, you
20 will at one point separate from the military.
21 So, we want to marry up the skills that you
22 gain during your military career to what you

1 want to do, or what your goals are once you
2 separate from the armed forces. So, we're
3 looking at a long-term perspective.
4 We're also looking at what we need
5 to do now for military members to get them
6 career-ready, especially with the economic
7 situation in the country. So, two mandates.
8 The next slide will show you some of the
9 actions that we're taking to address those
10 mandates.
11 On the current, we have been in
12 progress of improving the pre-separation
13 counseling, not only from making the checklist
14 and the list of topics that military members
15 have to review more holistic rather than just
16 very narrowly focused, more holistic, but also
17 improving the training of those men and women
18 who provide the career counseling, or the pre-
19 separation counseling themselves.
20 There you see on the second bullet
21 this changed approach, preparing for
22 transition across the military life cycle.

1 And, again, starting at first accession, all
2 the way through, and embedding IT web-based
3 tools that they can use, that military career
4 counselors can use. I'm told that even
5 recruiters use at times to help recruit
6 members, and to get them into the services, to
7 show them across the military life cycle, this
8 is what we can give you. This is what your
9 part is going to be, and filling the gap
10 between what you want, and what we can give
11 you, so that when you leave, you're set.
12 We are using a new delivery
13 method. We're trying to take advantage of
14 technology as much as we can. Webinars, we
15 have two or three of those going on every
16 month via the TurboTAP on a variety of topics.
17 How to apply, how to build a better resume,
18 networking. And we're looking at the
19 development of the second spiral of those
20 webinar topics now. And we're looking at
21 perhaps partnering with our DOL and our VA
22 partners to give military members more

information about what those services are that they can latch on to from those two organizations.

TurboTAP gives þ- connects our members immediately to the eBenefits, where they register now for eBenefits online. They don't have to wait until the end of their careers, or when they're getting ready to separate. They register now. That's been a very strong push from our VA partners. And DoD has made quite a monetary investment in allowing members þ- or giving members DS logon, again, a capability provided by DoD.

You've heard Mr. Langley talk about the National Resource Directory. All of those tools we're using as much as we can, capitalizing on technology. However, I do want to tell you that we do have populations that cannot þ- do not have easy access to the internet at all times, and we've provided those þ- provided tools for them via CDs. They don't have the bandwidth on ships at some

1 points. They don't have that accessibility
2 sometimes on the subs, so we have certain
3 populations that we need to provide those CDs
4 or those other tools. And we will continue to
5 provide those brick and mortar services also.
6 But we're looking at a multi-level approach.
7 We have been very strongly engaged
8 with the Department of Labor over the last
9 year, and even since I came on board
10 evaluating a new curriculum for the employment
11 workshop that will be part of TAP. That is
12 the DOL's contribution to the TAP partnership.
13 It is a much improved curriculum.
14 They have heard the servicemembers' voices in
15 what they need in that curriculum and they
16 have responded. I think it will be a very
17 exciting rollout. We're piloting that in the
18 next two weeks across several installations.
19 We'll be evaluating that curriculum, and we'll
20 soon have that curriculum finalized.
21 Part of that is an assessment
22 process that every member will go through

1 before they enter that workshop, because the
2 workshop has to be þ- is a three track
3 workshop. So, whether you are not ready at all
4 for employment, whether you are moderately
5 ready, or whether you are very ready, you've
6 been preparing well on your own, you get
7 placed in the DOL curriculum in those modules
8 that you need. So, it is no longer one-size
9 fits all, and we're very excited about that.
10 And you'll be hearing from the Department of
11 Labor later today, I believe.
12 Strong collaboration, I've already
13 mentioned, with VA to give military members
14 access to information about eBenefits, and
15 registering for their benefits right away, to
16 the point that they actually get emails. When
17 sometimes in their life cycle they perhaps are
18 looking at buying a home, and using the VA
19 Home Loan. So, those kinds of tweaks and
20 letting them know what's available to them.
21 We'll be working on that very hard also in the
22 President's Initiative, capitalizing upon

1 that.

2 Emerging issues, again, the

3 economic downturn, that's a very strong sense

4 of urgency in the Department. How do we

5 prepare our military members for an economy

6 that is not ready to absorb them in many ways,

7 particularly for military members who are

8 returning to home in areas where the

9 unemployment rate is very, very high. That is

10 a real challenge.

11 We are updating our DoDIs to

12 reflect the changes, military life cycle, and

13 these other changes that we're making.

14 There's also a question, of course, of

15 mandatory TAP. You see some of those

16 legislative proposals being entertained right

17 now. We welcome mandatory TAP with the

18 understanding to allow our commanders to also

19 weigh the need for mission. We cannot always

20 defer to mission needs, and we're asking for

21 at least that flexibility.

22 Credentialing and licensing. We

1 are working with a group with the American
2 Legion now, looking at strengthening
3 credentialing and licensing. That is a
4 subgroup specific with President Obama's Task
5 Force focusing on that very strongly,
6 identifying what are the gaps in most
7 occupations for military, and how we enable
8 our military members to fill those gaps more
9 quickly so that they can leave with
10 credentialing and licensing in their pocket
11 when they're leaving the military. Again,
12 building on a partnership, what would DoD do,
13 what's the responsibility of the service
14 member, and how can we work together to make
15 those come to fruition?
16 So, that's what we've been working
17 on one side. I can tell you on the developing
18 side, we see that, again, the President's
19 mandate, develop reforms, the design of a
20 transition boot camp to leave members career-
21 ready. That Task Force charter, I believe, is
22 still in draft and about to be signed we think

1 at the October meeting between the two Deputy
2 Secretaries.
3 We are working. There are
4 actually four subgroups that have had full
5 week all site two weeks ago. Those subgroups
6 are meeting weekly every day to continue
7 developing recommendations, fleshing out those
8 recommendations, costing those
9 recommendations, and preparing a report for
10 the President that's due by the end of the
11 year. Also, giving him recommendations for
12 the Veterans Day of this year. So, a
13 tremendous amount of work is going on.
14 And I will tell you that the three
15 gentlemen on either side of me keep that
16 Wounded Warrior perspective on my scope day in
17 and day out. And that is being discussed
18 significantly in the transition subgroup that
19 I'm co-chairing with my VA partner.
20 If I can have the next slide. I'm
21 just going to þ-
22 MR. CONSTANTINE: Dr. Kelly, before

1 you move on.

2 DR. KELLY: Yes?

3 MR. CONSTANTINE: If you wouldn't

4 mind going back to the previous slide. Last

5 time when you were here when we had this

6 conversation, there were some þ- we were

7 talking about mandatory TAP.

8 DR. KELLY: Yes.

9 MR. CONSTANTINE: I think we all

10 saw eye to eye on whether it should be

11 mandatory or not. And from what you just

12 said, it sounds like you think it should be

13 mandatory, but you want to leave the

14 commanders the flexibility to decide whether

15 it fits in the mission. Obviously, the Marine

16 Corps has pushed forward on that, and has

17 decided that they can do both.

18 DR. KELLY: Yes.

19 MR. CONSTANTINE: So, it looks

20 like, in keeping with what President Obama has

21 said, that you are going to have some sort of

22 boot camp, which sounds like a þ- it will be

1 mandatory. If it's going to ensure every
2 service member receives this, then that means
3 they would have to go through it. So, do you
4 anticipate that TAP will þ- that will be part
5 of TAP, and that it will be mandatory?
6 DR. KELLY: All of those very
7 issues are being discussed right now within
8 the Task Force. And there are recommendations
9 that are being developed. I'm not at liberty
10 to discuss all of those today. We haven't
11 provided the report to the President. We
12 haven't even given him a preliminary report
13 yet. But those very issues are being
14 discussed every hour across all of the
15 subgroups.
16 We are particularly sensitive to
17 the issues of the draw-down, and those that
18 are going to be impacted by involuntary
19 separations. We are also trying to weigh what
20 we see as þ- and what the unemployment rates
21 tell us who our most vulnerable populations
22 are. And that clearly is that 19 to 25-year-

1 old group.

2 We're also looking at those who

3 have had less than 10 years of service, and

4 what does this involuntary separation mean to

5 them? What kind of skills do they have?

6 So, all of those pieces are being

7 weighed. We don't have a clear answer yet,

8 but we are looking at all aspects and saying

9 what þ- and trying to determine what we can do

10 for across the board those at-risk

11 populations. And how do we move this system

12 from providing transition assistance, skills,

13 information, and education from an end-of-

14 career event, this one week workshop that we

15 provide where we squeeze everything in in one

16 week, to preparing across the military life

17 cycle. So, we are trying to weigh both needs

18 right now. But, clearly what our long-term

19 efforts are is to make this þ- to harmonize,

20 using one of Mr. Burdette's favor words, to

21 harmonize what your personal goals are when

22 you are going to leave the military because

1 you will, and harmonize that with what you are
2 getting and your career development as a
3 military member. What is our responsibility
4 from DoD, what is your responsibility as a
5 military member? What can you do with tuition
6 assistance? How wise are you in choosing what
7 college courses you can take? And even for
8 you to consider when you do go back what
9 geographic area are you going into, and what
10 are the labor market demands when you get
11 there?
12 A lot of serious discussion going
13 on about the abilities of our military members
14 to become entrepreneurs. We have trained them
15 to be leaders. Maybe that area of
16 entrepreneurship is ripe right now given the
17 economic downturn and the skills of our
18 military, and how do we marry those up? So,
19 there are þ- this is a very complex situation,
20 a lot of people are working very diligently.
21 There were 86 people in the
22 offside working on different aspects of

1 responding to the President's Initiative.
2 Employment, transition, entrepreneurship,
3 credentialing and licensing, trying to really
4 ferret out what is the best avenue for us.
5 So, I can tell you I don't have a concrete
6 answer for you right now, but there are a lot
7 of people working on that.
8 MR. CONSTANTINE: That's refreshing
9 to hear. That's great to hear. I know these
10 are complicated issues, and I just þ- I'm not
11 looking for an answer from you now, but just
12 strategically, if some components are having
13 trouble even making TAP mandatory, at the very
14 end of the career, itþs still mission
15 essential at the very end, I have trouble
16 imagining how they're going to incorporate,
17 besides saying on your own time go to these þ-
18 I really don't see how they're going to say
19 okay, you're in the Army, but I'm encouraging
20 you to look for another job while we're trying
21 to do this. I hope that you'll be able to
22 come up with something because it's critical.

1 And I'll be interested to see how that works
2 out.
3 DR. KELLY: Right. And we're
4 trying to balance þ- or trying to find a best
5 way, and given that the services each have a
6 somewhat unique population, have unique
7 mission and demands, trying to give a little
8 bit of autonomy to have different perspectives
9 or different approaches, but also defer þ-
10 always deferring to what we think are the
11 needs of the military members who will be
12 leaving.
13 MR. CONSTANTINE: Thank you.
14 DR. KELLY: Any other questions?
15 Well, thank you. It was a pleasure.
16 MR. CAMPBELL: Thank you very
17 much, Susan. That concludes our formal
18 presentation, and pending any further
19 questions, I would like to say that we do
20 welcome your suggestions, your comments, your
21 recommendations. I look upon this body as
22 being maybe the only one that is looking at us

1 critically, has only the agenda of what is in
2 the best interest of the recovering Wounded
3 Warriors, ill and injured, and transitioning
4 servicemembers. There is no other agenda that
5 I see that you have other than that, so I do
6 want you to know how much we appreciate the
7 work that you do, and we look forward to
8 working with you going forward in years to
9 come. Thank you.
10 CO-CHAIR CROCKETT-JONES: Thank you
11 very much. Are we ready to move on to the
12 National Guard Bureau Medical Management
13 Processing System with Colonel Jill Faris.
14 Are we ready? Very good.
15 MS. DAILEY: Thank you, Wounded
16 Warrior Care and Transition Policy office.
17 Very appreciative of your efforts here, and we
18 will be in touch with you again. Thank you
19 very much.
20 CO-CHAIR CROCKETT-JONES: Can I
21 ask, will we be getting a copy of the eventual
22 report that goes out regarding þ- she

mentioned a report that will be out in December.

DR. KELLY: The President's report.

CO-CHAIR CROCKETT-JONES: The President's report on that þ- will we be getting a copy of that report when it goes public?

DR. KELLY: If it's a public report, we'll be þ-

MR. BURDETTE: Yes, so whenever we can, we will. Sure. Absolutely.

MS. DAILEY: Okay. Very good.

(Whereupon, the above-entitled matter went off the record at 9:48 a.m. and resumed at 10:00 a.m.)

CO-CHAIR CROCKETT-JONES: I'm going to welcome Mr. Ray Holdeman, Colonel Jill Faris, and Mr. Eric Scott. And we're getting a briefing on the National Guard Bureau's Medical Management Processing System.

I'm not 100 percent confident that I have your correct positions, but Mr.

1 Holdeman is the Acting Division Chief for
2 Personnel under the Army National Guard G-1.
3 Is that correct? Very good. And Colonel
4 Faris is Deputy Surgeon Army National Guard.
5 And Mr. Scott is the Branch Chief Medical
6 Administrative Actions Branch. That's Tab K,
7 if you guys need the reference. Very good,
8 we're ready.
9 COL. FARIS: Well, good morning.
10 Once again, my name is Colonel Jill Faris. I'm
11 the Deputy Surgeon for the Army National
12 Guard, and I'd like to send warm regards on
13 behalf of our Acting Director, Ray Carpenter,
14 the G-1, Tammy Miracle, and my Surgeon and
15 boss, John Grote. We're very thankful that
16 Ms. Dailey asked us to come and present to you
17 today.
18 And what we're going to talk about
19 is something that the Army is just now kind of
20 putting their hands around. And we would
21 selfishly like to say from the Guard
22 perspective that we are setting the standard

1 again for the Army in the way ahead and how we
2 manage soldiers that are ill and injured. So,
3 without further ado, slide man.
4 Do you guys have an issue if I
5 kind of stand up? I'm not used to talking
6 sitting down. I'm raised by a Field Artillery
7 father who always said a moving target is a
8 harder target to hit, so that's why I move.
9 This is our agenda today, what
10 we're going to talk to you about. We're going
11 to talk about the Army National Guard Medical
12 Management Processing System. There are some
13 sub-components that are articulated here, the
14 MMA, eProfile and eCase, which we will talk
15 about specifically. Then we're also going to
16 talk about some of the things the Army
17 National Guard has done to reinforce this
18 effort. Ray, next slide, please.
19 And this is the list of items that
20 we will discuss with you today. It takes more
21 than just one individual to assist soldiers
22 when they're injured or ill, whether it's in

1 the line of duty or not in the line of duty.
2 We're going to talk about all those
3 physicians.
4 The reason why we have this slide
5 up here is I just want to give you a scope of
6 what we're facing in the Army National Guard.
7 This is as of 1st of September of 2011, and we
8 have a beautiful pie chart here. And what the
9 color display will tell you here, the blue
10 piece at 18 percent, those are people that
11 have known medical deficiencies. In the Army,
12 we have þ- and forgive me if I'm speaking down
13 to anyone. We have medical readiness
14 indicators, and if you're Medical Readiness
15 Indicator 1 or 2, you are ready to deploy
16 within three daysþ time. If you have a dental
17 deficiency, you're coded as a 3 Alpha. 3
18 Bravos, which is what this chart is depicted
19 for you are those people that have known
20 deficiencies that are going to take more than
21 30 days to resolve, so we call those Medical
22 Readiness Category 3Bs.

1 So, that 18 percent pie there in
2 blue are soldiers that we know in the National
3 Guard have this known deficiency, and it's
4 been greater than six months. The reddish
5 slice there at 12 percent is greater than nine
6 months, the lime green one there at 11 percent
7 is 12 months, and then the largest part of the
8 pie at 59 percent are people that are þ- have
9 known deficiencies for greater than 15 months.
10 So, as we had seen over the course
11 of the years, especially through these past
12 two wars, since 2001 an increase in this
13 population that we knew that we needed to do
14 something to get way ahead to help soldiers,
15 families, and employers with issues. Slide
16 please, Ray.
17 So, the first thing that you need
18 to understand from a Guard perspective, back
19 in 2000 there was nobody that was held
20 responsible for medical readiness. Nobody.
21 I think the closest thing, Mr. Scott, was your
22 health system specialist. And we didn't have

1 anybody, so from an Army National Guard
2 perspective we said: what can we do to help
3 the States?
4 We created a position called the
5 Deputy State Surgeon. They are the person,
6 the full-time representative for that adjutant
7 General, anything that relates to medical,
8 Band-Aids, blood, LODs, deployment,
9 everything, soup to nuts medical. So, these
10 are some of the things that they do. And
11 they're very busy people. It is actually a
12 technician position, a GS-12 position. In
13 some states they have translated and have
14 taken other authorizations to make it a full-
15 time AGR authorization, very important
16 position.
17 They have a large budget to help
18 support medical readiness. They have staff.
19 They work with Homeland Defense in supporting
20 ESF-8 functionality, medical functionality.
21 They prepare soldiers for mobilization,
22 demobilization.

1 And a big component, which is the
2 last one here on the slide, they oversee case
3 managers. And I'm going to talk about the
4 case manager piece, I believe, next.
5 Case management is something that
6 is relatively new. Our first national case
7 management contract went into effect in the
8 year 2005. And since we've expanded that
9 contract, so now nationally we have over 100
10 nurse case managers. They're either nurses,
11 or social workers, nurse practitioners, and
12 then we have one staffed at 100 strength, 336
13 care coordinators.
14 And what our care coordinator is,
15 as defined by the National Guard, is they're
16 like the administrative assistant to that case
17 manager. And they will work with the soldier
18 in obtaining medical documentation, because
19 you understand we're dealing with soldiers
20 that have their own civilian providers. They
21 may go to the VA because they qualify for the
22 VA because they deployed, or they have an

1 approved line of duty where they can go there
2 for care. They may be getting care through
3 the TRICARE network, or they may not be
4 getting care. So, these care coordinators
5 help facilitate getting medical documentation
6 that will determine whether or not a soldier
7 needs to get a permanent profile issued, or if
8 they don't meet retention standards any more.
9 So, they help facilitate with this.
10 Up until 2005, we had very few
11 people doing this, so that pie chart kept
12 getting bigger and bigger, and we didn't
13 really have anybody there in the system to
14 action that. So, the Army Reserve is just
15 getting on board with bringing case managers.
16 Right now they have 12 compared to 436 we have
17 in the National Guard. Next slide please,
18 Ray.
19 So, here are some of the duties of
20 the case management care coordinator in the
21 State. And as you can see, they, too, are
22 very busy people. They work directly for the

1 Deputy State Surgeon, and they help review all
2 the medical documentation that comes in to
3 make a determination on what actions we need
4 to do with a soldier. Then we have them in
5 all 54 states and territories. And, by the
6 way, coincidentally, we also harvested one
7 care coordinator and case manager for the
8 Readiness Center here in the National Capitol
9 region, because we do have soldiers that get
10 hurt and injured on deployment, or doing their
11 normal duties, and we felt the need to
12 replicate what we're doing in the states with
13 the medical management processing system at
14 our own headquarters in Arlington. Slide,
15 please.
16 So, newest to the team of fighting
17 effort towards building medical readiness and
18 caring for soldiers is the 68W Medical
19 Readiness NCO. We have authorized 420, I
20 believe, full-time AGR Medical Managers, and
21 they were assessed to each state to be
22 utilized at a battalion or a brigade higher

1 organization, and they are to be the belly
2 button or touch point, if you will, for the
3 commanders, first sergeants, sergeant majors
4 in being able to get an awareness of what's
5 going medically with their soldiers. They
6 also have responsibilities because 68W are
7 combat medics, they're EMT basic certified and
8 they need to keep credentialed in this every
9 two years, so they help monitor and manage
10 that for their soldiers that have that MOS in
11 their organizations.
12 They also help very diligently in
13 pre-mobilization and post-mobilization, and
14 help facilitate in getting that document up
15 the chain of command to the case managers and
16 care coordinators. Slide, please.
17 I'm now going to turn it over to
18 my good friend, Mr. Holdeman.
19 MR. HOLDEMAN: Thanks, Colonel
20 Faris. What she just said is really important
21 to the Army National Guard. We've already
22 shown that because of our close relationship

1 between the personnel and surgeon þ- personnel
2 community and the surgeons in the states,
3 we've gained some efficiencies, and been able
4 to turn around medical readiness for the Army
5 National Guard, or at least get it moving in
6 the right direction relatively quickly. And
7 in comparison to our other two counterparts in
8 the Army, have led the way in developing the
9 programs and policies that represent the level
10 of effort that we know is important to
11 insuring that we have the right force mix
12 ready to deploy, ready to meet the Governor's
13 needs or the adjutant general needs at the
14 state level.
15 Medical Management Processing
16 System, this is a relatively new policy, but
17 what it did was it codified for the Army
18 National Guard those pieces and parts that the
19 states needed guidance on with regard to how
20 to utilize the 68W, the Deputy State Surgeon,
21 and case managers.
22 It also established with the

1 Department of the Army, for the Army National
2 Guard, our foothold in developing case
3 management processes that put the right effort
4 towards medical management, the medical
5 management systems that we're developing. Two
6 key points. It's comprehensive medical case
7 management and it's a system of case
8 management support.
9 This is a real quick overview of
10 the processing system workflow. It starts all
11 the way on the left side where a service
12 member is identified or self-identifies during
13 a PDHRA, or Post Deployment Health Assessment.
14 And then it moves across a defined time line,
15 and during that time, that 12-month time line,
16 specific time hacks are managed and monitored
17 to ensure the soldier receives the right care
18 at the right time, and also moves through the
19 process in a timely fashion.
20 One thing we identified very early
21 on was access to care, access to the
22 disability evaluation system seemed to only be

1 important to the soldier if somebody helped
2 them get there. Oftentimes, individuals only
3 do what their senior leaders þ- what their
4 leaders and senior leaders require them to do.
5 So, developing this time line was extremely
6 important because what was it, Colonel Faris,
7 about 400 days þ- a little over 400 days it
8 took a soldier from identification to medical
9 evaluation board, and then entry into the
10 disability evaluation system.
11 COL. FARIS: What we were telling
12 people is once we identified a soldier with an
13 issue, realistically it would take up to three
14 years because we have up to one year to come
15 to what's called a Medical Retention Decision
16 Point, MRDP. And that's the art and science
17 of doing medical. And the provider would say
18 this condition is not going to get any better,
19 and as a result they don't meet Medical
20 Retention Standards.
21 So, then we would put the packet
22 together to forward into the Integrated

1 Disability Evaluation System, and it would sit
2 at an MTF for anywhere up to a year. And then
3 by that point the documentation would be old,
4 and it would come back to the state, and we'd
5 have to do it. And then once the soldier got
6 into the system, it would take about a year to
7 get through the system. So, we felt that that
8 wasn't appropriate.
9 MR. HOLDEMAN: So, Medical
10 Management Processing System, the policy set
11 the stage for the next logical step. How do
12 we manage these soldiers while they're going
13 through this process, and how do we mitigate
14 or minimize the impact on the deployable
15 force, or the ability of the commanders at the
16 state level or the TAG to recruit against
17 those positions where we can pretty much tell
18 early on in the process the soldier will be
19 determined to have a disability, be retired or
20 medically separated. And how soon in that
21 process can we start looking for backfill or
22 recruitment þ- a recruit to fill that

1 position?

2 So, we came up with MMA, which

3 supports and works in coordination with the

4 Medical Management Processing. MMA basically

5 allows the state to assign a soldier to a

6 temporary position outside of the force

7 structure, not unlike the Army's TTHS Program,

8 Temporary Training Hold or Schools. And gives

9 us some latitude in managing the force more

10 effectively and efficiently.

11 COL. FARIS: Because what we were

12 running into is a unit would be getting ready

13 for mobilization. We had identified there

14 were 27 people in that unit that had medical

15 deficiencies that made them a 3B, and so we

16 were feverishly working trying to get them

17 ready to deploy, and then they couldn't

18 deploy. And then we had to do just in time

19 fill, so we were robbing Peter to pay Paul.

20 And by utilizing the MMA, we're able to use a

21 þ- three positions within a TDA unit for an

22 officer, an enlisted, and warrant officer, and

1 we can then move that soldier that we're
2 pretty confident is going to have to go
3 through either an MEB or a PEB, and we can
4 move him over to that position, thus creating
5 a vacancy, and putting þ- promoting a soldier
6 or transferring a soldier into that position
7 so then that force structure is set. So, we
8 are focusing on getting that unit ready;
9 meanwhile, we're also focusing on that soldier
10 to give them the proper care and feeding that
11 they need to make a determination are they
12 retainable, or do we send them down the MEB-
13 PEB road?
14 MR. HOLDEMAN: Options for active
15 duty. With the advent of the MMPS and the
16 MMA, we were able recently to convince the
17 Assistant Secretary of the Army for Manpower
18 and Reserve Affairs that the Guards should
19 have the authority under Title 10 USC
20 12.301(h), which is Medical Treatment or
21 Evaluation Active Duty.
22 We should have that authority to

1 place the member in an active status for a
2 couple of different reasons. First, it's
3 probably the right thing to do. If they're
4 injured, ill, or can't þ- and they can't
5 perform the functions of their civilian job,
6 and they're probably not coming to drill
7 because they're also having issues with
8 meeting the medical standards for the
9 performance of their MOS. If we place them in
10 an active status, it gives us two things. It
11 gives us an opportunity to make sure the
12 soldier can take care of himself and his
13 family, or herself or her family, and it also
14 gives us positive control over where that
15 individual is every single day.
16 From a Reserve component
17 standpoint, if they're not at the drill hall
18 when they're in an active status, then they're
19 either on leave, or they're at a medical
20 appointment. So, we bring them into the
21 Reserve Center in an active status. We have
22 positive control with supervision, and we can

1 get them to their appointments, their physical
2 therapy þ- their appointments, their surgery,
3 and recovery through physical therapy in a
4 timely manner.
5 The goal is initially six months,
6 179 days is the first order. We only extend
7 that under extreme circumstances, but that
8 program is called the Reserve Component
9 Managed Care Program Mobilization and
10 Training.
11 The key here is -- there are
12 several critical things about this program for
13 the Army National Guard. One, the injury or
14 illness has to be related to active service
15 for contingency operation. It's not for
16 everybody, it's only for those individuals who
17 became injured or ill during a contingency
18 operation.
19 Secondly, it's only those cases
20 that are low-risk or low acuity. The
21 expectation is we can get them well, or we can
22 get them to a medical determination and

retention point within six months. Things like arthroscopic surgery for a bad knee, a shoulder injury, an elbow injury. There has to also come with this a recommendation from a medical doctor. And, Jill, correct me if I'm wrong here, that shows a positive diagnosis. We don't treat for things like pain. Pain isn't a diagnosis, but a serrated disc, or herniated disc is a diagnosis in the back.

COL. FARIS: So, what we're looking for is low risk, low acuity. So, what does that mean? That means Jill's got a bad knee, Jill's got a bad shoulder, not that Jill has a bad knee, bad shoulder, and has PTSD. That's not low risk low acuity.

We are not equipped in our state, I'll just be honest with you, because the National Guard is not authorized to provide care. We can give care to soldiers when they're injured in a duty status, either Title 10 or Title 32, but we, ourselves, we're not

1 given the authority to give care. So, we have
2 to look at what we have locally. And some of
3 our places are in very remote locations, so
4 when it comes to anything that deals with
5 behavioral health, mild traumatic brain
6 injury, those types of soldiers would then
7 qualify to go back into a Warrior Transition
8 Unit, or go on active duty medical extension,
9 which are programs that Mr. Scott is going to
10 talk about.
11 The thing I want to share with you
12 on this is this is significant. And why is it
13 so significant? We're doing this pilot
14 program for 13, 14 states? Yes, 14 states.
15 And what we have been doing is we've been þ-
16 our bridging strategy is using incapacitation
17 pay, and all that þ- it's not Aflac. All that
18 does is pay for your wages. Okay?
19 This gives them wages, gives them
20 housing, gives them TRICARE benefits for their
21 family, puts them back in that active duty
22 status, which is significant.

1 MR. HOLDEMAN: And let me just go
2 back a second. You have to remember, these are
3 soldiers who were injured or became ill while
4 in an active status in support of contingency
5 operation. It's not for everybody.
6 The last thing is, for those high
7 risk high acute cases we have a program, a
8 longstanding program for them. It's called
9 the WTU. And there are ways to get soldiers
10 who leave the mob station, don't go directly
11 into a WTU, back into a WTU, or back through
12 the ADME process. And we'll talk more about
13 that in just a second. But there is an active
14 status for just about everybody who needs
15 care, and deserves care.
16 MR. DRACH: Is there any
17 distinction between your Title 32 activations
18 and your Title 10 activations, because Title
19 32 doesn't convey veteran status.
20 MR. HOLDEMAN: Well, it does in
21 some instances.
22 MR. DRACH: It does in some.

1 MR. HOLDEMAN: Recent changes to
2 Public Law, specifically status þ- Title 10
3 USC þ- or Title 32 USC 502(f)(2), when ordered
4 or directed by the President or Secretary of
5 Defense does convey the same benefits and
6 entitlements as Title 10 active status. It
7 has to be for things like þ- I don't know,
8 maybe you heard about Katrina, Rita, border
9 patrol duties. Some of those things directed
10 by the President and Secretary of Defense do
11 confer what was historically Guard missions,
12 state-run missions, those new things do
13 receive federal benefits now.
14 LTC KEANE: Sir, does the Army have
15 a program for those soldiers who get injured
16 during AT to keep them on active duty? Say a
17 guy blows out his knee and he needs þ-
18 MR. HOLDEMAN: Yes, during AT
19 there's þ- right. Line of duty is
20 established, and Mr. Scott will talk about
21 that in just a little bit. But if it's during
22 AT, it's service connected, line of duty is

established. If they can't return to work, they can receive incapacitation pay, which is a form of compensation. It's only base pay. We don't return them to an active status, but they are entitled to incapacitation pay, which kind of bridges a gap between returning to their civilian job, if they have one þ- had one prior to AT.

There are some gaps in the programs for Reserve Component Soldiers. We're trying to bridge those with these new policies and guidance, and new authorities. Quite frankly, this is a brand new precedence for the Director of the Army National Guard to have the authority to place a member in a Title 10 Active Duty status is þ- has never been done before. So, it's a new venue for us, but historically incap pay would bridge that gap for that soldier who was injured on AT.

We're looking at if the training is connected to mobilization and they have a mob order, and they're at IDT and AT getting

ready to go to a contingency op, then they would be eligible for RCMC-T because it's training connected to preparation for mobilization.

Does that answer your question, sir?

LTC KEANE: Yes.

MR. HOLDEMAN: Okay. So, there are options, MPR2, ADME and WTU for others, for those high risk cases that need the care and deserve to get the care.

CSM DeJONG: Sir, we're leading into that. In the history of this, incap pay has notoriously been misused. And you said, ma'am, that you've got 13 pilots out there.

COL. FARIS: Yes.

CSM DeJONG: Some of it is þ- are you guys selecting where this is going to be implemented based off of cases of misuse and trying to get this pushed forward?

COL. FARIS: No, that's a great question. How we þ- we didn't throw the darts

on the board and pick states. What we did is we looked at medical readiness categories, states that have þ- we have small, medium, and large population states. We also have states that we selected that have really good readiness, and some states that don't have the great of readiness.

We also looked at states that had brigade combat teams that would be coming back, because we feel that there's a real niche, because what we are seeing þ- what our track history has been, it's like the horse seeing the barn. They're at the demob station. Ahh, the knee isn't that bad. I just want to go home. And then they get home, and then they're at home for a couple of weeks, and then they're on the assembly line standing on that knee and it swells up like a grapefruit, and then they're like I've got to get care.

Well, they try to apply to come back on to active duty, and because it's not

high risk high acuity, it's kind of a low risk thing, their packets get denied. And then we use, inappropriately, incapacitation pay.

What this program will do will take care þ- and that's a big population for us in the National Guard, are people that have the 179 day bumps and bruises, if you will, that can be fixed through this program.

CSM DeJONG: Okay, thank you.

MS. DAILEY: May I also point out that what it also does is it keeps them at home, and it doesn't swell the ranks of the WTUs managing or the community-based Warrior Transition Units managing low acuity low risk injuries.

COL. FARIS: I was in a planning meeting here a few weeks ago at the WTU, and we're talking about swim lanes, if you will, you know, the Olympic swimming pool, you've got your lane that's marked on. So, you have a WTU lane, you have a CBWTU lane, so we þ- very loosely related. WTU is like critical

1 care. CBWTU is like inpatient care.

2 Now, this new swim lane that we're

3 experimenting with with this program would be

4 an outpatient care, low risk low acuity.

5 MR. HOLDEMAN: That's the Reserve

6 Component Managed Care process. We have built

7 in þ- I have to say, we have built in to this

8 þ- the policy was about nine pages long, and

9 then there was annexes and documents that

10 physicians, and leaders, and commanders have

11 to sign and review periodically.

12 The requirements, the management

13 controls that we put into this program assured

14 the Army two things. We were going to do this

15 right. There wasn't going to be any room for

16 misuse or abuse of the active duty authority.

17 And the soldiers would come off of orders as

18 soon as they possibly could.

19 When the physician returns them to

20 duty it's either full duty or partial duty,

21 temporary profile, or they get to a point

22 where they have to be processed for an MEB or

1 PEB depending on the outcome of their care and
2 recovery.
3 Those decisions points are
4 codified in the RCMC program guidance, and
5 they are managed and monitored every 30 days
6 throughout the process.
7 COL. FARIS: It's very similar, if
8 you're familiar with the triad of care. I
9 mean, we have the case manager care
10 coordinator, we have the commander, we have
11 the soldier, we have the Deputy State Surgeon,
12 and we are meeting every 30 days to see how
13 that case is doing, because what may end up
14 happening through the course of fixing that
15 knee, something happens, and the soldier gets
16 diagnosed with a mild traumatic brain injury.
17 Well, now that's not low risk low
18 acuity any more. Now, we need to put
19 paperwork in to get that soldier in the
20 appropriate, if you will, swim lane back up to
21 the Warrior Transition Unit. And we're able
22 to do that with this program.

1 CSM DeJONG: Ma'am, are the WTUs
2 going to be able to look across their
3 formations and figure out who could be best
4 suited for this care, and actually take some
5 of the work load off of them?
6 COL. FARIS: So, that's a great
7 question. And those were some of the things
8 we're exploring.
9 Now, keep in mind, this is a pilot
10 program. We've got to get full buy-in, and
11 hopefully full implementation in February to
12 put it out to all 54 states and territories,
13 at which point that's the dialogue that we're
14 having then with the WTU. Low risk low acuity
15 people could come back to the state.
16 Now, keep in mind, we don't have
17 infinite resources, so every state will be
18 different. Maybe you can manage 15 in your
19 state with the resources you have, alongside
20 all the other medical things that you're
21 managing. And every state will know what that
22 is. So, it would be like the WTU calling up

1 the State Surgeon from Ohio and saying I have
2 a low risk low acuity, do you have space?
3 Yes, I do. It will be very similar. But
4 that's the future. We see it. We're not there
5 yet, but that is the future.
6 CO-CHAIR CROCKETT-JONES: So, how
7 long have you had this standing up?
8 MR. HOLDEMAN: Well, we got the
9 authority from Mr. Lamont, the Assistant
10 Secretary of Manpower and Reserve Affairs, on
11 4 August. We had our policy teed up ready to
12 go, and it was signed by the Director of the
13 Army National Guard in late August, and we're
14 just now þ- just this week putting the first
15 packets into Dan Sokol I&D for orders to start
16 processing soldiers.
17 COL. FARIS: What we had to do is
18 come up with a mechanism that would provide
19 some visibility to the big Army. So, we're
20 using a system called Tour of Duty, and we
21 have to kind of þ- it's a modification to a
22 system that we use to generate orders to be

able to be transparent so the Army could watch what we're doing with this program. So, we went through an Alpha Test, Beta Test, and we've just gotten our first packets through the process.

CO-CHAIR CROCKETT-JONES: Do you have any ideas þ- any anticipation on what your percentage of return to duty will be?

MR. HOLDEMAN: Well, they're low risk low acuity, so the expectation is it will be fairly high. These are things like a bad knee.

COL. FARIS: It's ortho, torn meniscus, torn rotator cuff, plantar fasciitis. Those things that we can fix in 179 days, can't do everything in that amount of time. So, if it goes beyond that, then they're not a candidate for this program. Then they're more of a candidate to apply to go on to programs Mr. Scott þ- we will eventually let Eric speak.

MR. HOLDEMAN: Yes. As a matter of

1 fact, are there any other questions? We'll
2 turn it over to Eric, then.
3 I do have to say, Mr. Scott is my
4 right-hand man in the Division with regard to
5 medical processing, medical actions and
6 processing those. His team does the lion's
7 share of the work for the Army National Guard
8 in these programs, and we wouldn't get this
9 stuff done without him. Thanks.
10 MR. SCOTT: Thank you, sir. Good
11 morning.
12 All the programs we have developed
13 so far are fantastic, but if we can't identify
14 those soldiers from the beginning when they
15 first touch soil U.S., then we've got
16 problems. And this is what we were doing
17 wrong, not really doing wrong, but where we
18 have problems.
19 We have problems identifying those
20 soldiers who need help, because once the
21 soldier reached the Continental United States,
22 he's got one thing on his mind, that's going

1 home. Okay? That's going home. So, for him to
2 come up and say I have a problem with my knee,
3 because when he says this now we have to do þ-
4 we do it anyway, but we're going to take him
5 and we're going to run him through a complete
6 evaluation and find out how severe is that
7 knee, or how severe is that shoulder. Does he
8 have a problem that we need to take care of
9 right now?
10 When that happens, now he goes
11 into a WTU, if it's long-term. And he þ- and
12 somehow if you root him out, he knows that.
13 So, he's not too apt to saying that right
14 away. So, what happens is that he leaves that
15 mob station and he goes home. And once he's
16 home, he's there for about 90 days.
17 What happened was the Army
18 developed a system called PDHRA. The PDHRA is
19 how we identify these soldiers 90 days after
20 they've back in the country. Because right
21 now our greatest ally, and will always be our
22 greatest ally, is who? That soldier's family.

1 That's our greatest ally, because that
2 soldier's family, his son will tell us dad is
3 not sleeping well. He's talking in his sleep,
4 or mommy really screamed at me yesterday, and
5 I don't know why.
6 So, here's a chance for those
7 families to say what's þ- to come with the
8 soldier. Matter of fact, we have what is
9 known as Yellow Ribbon events. Yellow Ribbon
10 events is where we get the PDHRA. Okay? We've
11 got a team þ- a medical team that comes in,
12 and the soldier, all he has to do is say þ-
13 just tell us what's wrong with you.
14 Well, we were unloading boxes from
15 the Connex and I kind of scraped my knee a
16 little bit, I bumped my knee. Well, all he
17 has to do is right there þ- right then a
18 referral is done for him. That referral goes
19 þ- gives him þ- how do you say it? It gives
20 him insight to a hospital, to a medical
21 treatment facility where he can be evaluated,
22 a medical treatment facility, either the VA,

or a civilian. Okay? Or a civilian hospital, and that document stays with him until we actually do what is known as a Line of Duty on him. Okay?

The Line of Duty actually documents from us þ- it documents exactly what's wrong with him. And that document stays with him throughout his career, and even beyond, because once he gets out, he goes to the VA and says I got this problem, I had this problem before and it still bothers me now. Guess what, the VA says okay, come in. Because this gives the VA more leverage, or it gives the soldier more leverage for his VA compensation and disability rating. So, this is how they use this document.

The Line of Duty is one of the most important documents we could give that soldier, especially when he's just coming back. We try to get all of them to go through the þ- we get all of them to go through. Right now we're at about 98 percent. We get

1 them to go through a PDHRA, we get them
2 screened.
3 Now, mind you, they can go seven
4 times to a doctor, seven visits, up to seven
5 visits just for that doctor to tell him what's
6 wrong, be specific. Don't tell us it's just
7 pain, tell me what's wrong with this soldier.
8 And that doctor, orthopedic, or whoever, can
9 tell us right there okay, here's the deal on
10 this soldier. He has a torn meniscus. Fine,
11 we got it now.
12 Now we do the Line of Duty on him.
13 The Line of Duty documents that injury. He
14 can get care for that injury. Now he goes into
15 one of the programs that Colonel Faris and Mr.
16 Holdeman spoke of. He goes into those
17 programs, and they will take care of him.
18 While he's in that program, if he
19 cannot go back to work, his regular job
20 because of that injury, or he has to have
21 surgery because of that injury, we bridge that
22 time in between the program that we spoke of

1 and the time it takes us to evaluate him and
2 get him in with incap pay, incapacitation pay.
3 It is law. We have to pay it to him. Okay?
4 Yes? Okay.
5 Now, at the same time, let's say
6 that soldier goes in and he gets his knee
7 done, and þ-
8 LTC KEANE: Excuse me, sir?
9 MR. SCOTT: Yes?
10 LTC KEANE: Could you please
11 explain incap pay? So, if a soldier is
12 getting $4,000 a month on active duty.
13 MR. SCOTT: Yes, sir.
14 LTC KEANE: What does he expect to
15 get in incap pay?
16 MR. SCOTT: He gets the same rank
17 pay as if he was on active duty, sir.
18 LTC KEANE: But he doesn't get
19 credit þ-
20 COL. FARIS: He doesn't get BH.
21 MR. SCOTT: Right.
22 COL. FARIS: All he gets is his

1 salary, pay and allowance.
2 MR. SCOTT: Salary pay and
3 allowance, same as if he was on active duty.
4 COL. FARIS: Now, keep in mind, if
5 he has a civilian job, it'll be whatever is
6 the lowest of the two.
7 MR. SCOTT: Right.
8 COL. FARIS: So, if he's a general
9 in the Army, and works at Hardee's, it'll be
10 whatever is the greater of the two. Okay? Or
11 less. Excuse me, less.
12 MR. SCOTT: There are two tiers to
13 it. Tier one says he can't go to drill any
14 more because of his injury, and he can't go
15 back to work, as well. Now, we have to pay him
16 full military pay. Okay?
17 Tier two says lost civilian wages
18 only. In other words, he can still go to
19 drill. Okay? He can still go to drill, and
20 they can give him work to do at drill as long
21 as it doesn't þ- as long as they keep him
22 within the limitations of his profile, what

his limitations are.

MR. HOLDEMAN: How that often happens is we have police officers or firefighters that are Reserve Component Members. They can't perform the duties of that job, but they can go and be a clerk at the unit on the weekend.

MR. SCOTT: Right.

MR. HOLDEMAN: So, much less stringent þ- not the same physical requirements. And that's how that usually unfolds.

LTC KEANE: So, if a sergeant was receiving incap pay for the month, he'd receive his full month of military pay?

MR. SCOTT: If he couldn't go to work for that full month, sir, yes.

COL. FARIS: Yes. And then keep in mind, the thing þ- one of the other downsides of incap pay is the fact that you get paid the month after the month happens, so if you can't work the whole month of January and the doctor

says you can't do your civilian job, you apply for it in February. So, you don't þ- it's after-the-fact. Yes, it's retro, retroactively processed.

LTC KEANE: I'm sorry. So, he'll get paid for January, or for February only?

COL. FARIS: Yes, so þ-

LTC KEANE: February þ-

COL. FARIS: Let's say you have a bad knee. Your doctor says you can't do your civilian job as a plumber for 32 days, the whole month of January, two days into February. In the month of February, your paperwork will be submitted for the fact that you couldn't pay þ- get paid in January. So, you won't receive your pay in January, you'll receive your pay in February for January.

LTC KEANE: Last question. Do they receive drill days or credits towards their Reserve retirement for that time?

MR. SCOTT: No. If they can attend drill, yes. If they only receive lost

1 civilian wages, and they are able to go to
2 drill, yes. If they're receiving full pay, no.
3 LTC KEANE: Thank you.
4 MR. SCOTT: Okay, sir.
5 The last program that we have, or
6 the most recent one that we actually stood up
7 was Reserve Component Soldier Medical Support
8 Center. And it's located in Pinellas Park,
9 Florida. Okay? There's a contingency that
10 was set up with the blessings of the Vice
11 Chief of Staff. This unit, or actually the
12 guys who are our records, medical records for
13 our soldiers, for those soldiers who are non-
14 retainable, their profile þ- these are the
15 guys that are þ-
16 COL. FARIS: They don't meet
17 medical retention standards.
18 MR. SCOTT: They don't meet medical
19 retention standards. There you go. Thank
20 you, ma'am. They don't meet medical retention
21 standards.
22 What these guys do is we have a

1 state, send that medical record, complete
2 medical packet based on that injury to that
3 element in Florida. Those guys take the
4 packet and just like your photo in front of
5 you, they evaluate that packet. They look to
6 see if all the documents are there. They look
7 to see if all the necessary appointments, or
8 let's say evaluations that are needed.
9 Those records go to the Medical
10 Evaluation Board, and the Physical Evaluation
11 Board. Those are the guys for the Army sit
12 there and say okay, let's find out what his
13 limitations are. Can he really stay in, or do
14 we really need to send him home, because we
15 can't retain him?
16 MR. HOLDEMAN: What's important
17 about the work that the folks at Pinellas Park
18 do is they're the clearinghouse for the
19 Administrative Medical Evaluation Board
20 process. The intent is that they get the
21 records to a Army hospital where the MEB can
22 be adjudicated, the soldier gets on orders and

1 goes, and appears before the MEB, if that's
2 required, or gets an evaluation done, a
3 medical evaluation done, and gets through the
4 process in a timely manner.
5 To go back to what we said
6 earlier, it was taking almost þ- it was taking
7 almost three years to get a soldier all the
8 way through the process. Now we're around 400
9 to 500 days, and we've got to get that down to
10 under 200; 195, I think is the Chief of Staff,
11 the Vice Chief of Staff of the Army's new
12 edict, so this multi-compo organization was
13 set up with about 38 people, mostly medical-
14 type folks, medical records-type folks, and
15 they're our clearinghouse.
16 CO-CHAIR CROCKETT-JONES: Now, I
17 just want to understand. Do they obtain the
18 diverse private medical records for a soldier,
19 or does the soldier compile them and bring
20 them?
21 MR. HOLDEMAN: The state puts
22 together the MEB packet, and what þ- one thing

1 that did come out of this, we had about 20
2 some military treatment facilities out there
3 that had different standards for MEB packets.
4 What came out of the implementation of this
5 process at Pinellas Park is a standardized MEB
6 checklist. So, now the Army has one standard.
7 That's a great thing.
8 The MEB packet was boiled down to
9 the 19 documents that absolutely have to be
10 there for the MTF, the Medical Treatment
11 Facility, to process the MEB.
12 COL. FARIS: Many of those
13 documents of those 19 are not necessarily for
14 the actual MEB itself. They're carried over
15 into the PEB, because it talks about duty, and
16 potential duty, and workability. So, there
17 has been talk well, maybe we just give you the
18 certain records that you need for the MEB, and
19 then when it gets to the PEB we're going to
20 give you the rest of the records. But the
21 reality is having them all up front, getting
22 all the work done þ- what Pinellas Park does

1 for us is it validates. Because sometimes
2 what happens is a packet will go down there,
3 because they're looking at and adjudicating
4 USAR, and Army National Guard packets. They
5 may review a packet and say you know what,
6 this soldier does meet Medical Retention
7 Standards, and does not need to go to an MEB,
8 and the packet gets sent back to the RSC or
9 state with a new profile.
10 So, what it's been able to do with
11 the standardized checklist, which has been
12 significant. And then currently right now all
13 the states, all the RSCs send their packets to
14 Pinellas Park. Once they've validated there,
15 they go to Eisenhower, and Eisenhower is the
16 sole place where all those MEBs are being
17 processed until they get to the point where
18 they can't handle the throughput of MEB
19 packets that are coming from the Reserve
20 Component. Then the Army is going to look at
21 standing another entity up to share the load
22 of Reserve Component MEBs.

1 MR. CONSTANTINE: The question was
2 about who is responsible for getting the
3 private medical records, the state or the
4 service member, if they've gone to civilian
5 providers?
6 COL. FARIS: Well, it's the
7 soldier's responsibility to provide those
8 records. What will happen is, if they have
9 somebody in the state that will say to them I
10 need your þ- I don't need your medical records
11 for your ingrown toenail. I need your medical
12 records for your knee surgery that you had.
13 And then it's the soldier's responsibility to
14 provide those records for the outcome.
15 MR. HOLDEMAN: We have teams in the
16 state that drive this process.
17 MR. SCOTT: And those are the same
18 numbers that Colonel Faris brought up earlier.
19 It goes back to the case managers.
20 MR. HOLDEMAN: The Care
21 Coordinators.
22 MR. SCOTT: The Care Coordinators,

1 the 68Ws. All these guys as he's going
2 through those programs, they're putting
3 together this packet on that injury. Okay?
4 So, a lot of these documents are already
5 there. Okay? We've also established automated
6 processes to carry these documents right
7 through the system.
8 MR. HOLDEMAN: But to your point,
9 Mr. Constantine, yes, a soldier has þ-
10 MR. SCOTT: Right.
11 MR. HOLDEMAN: þ- some requirement
12 to provide civilian care documentation where
13 they've gotten that care. Sometimes we have to
14 get documents from the VA, as well, because
15 soldiers will þ- one thing we tell soldiers
16 when they leave the mobilization station is go
17 see the VA if you have problems. Well, they
18 do, but as an organization we don't always
19 know that. And we're working on better ways
20 to communicate with the Department of Veterans
21 Affairs so that when a soldier does get care
22 or treatment at the VA, we can have some

1 visibility of that.

2 CSM DeJONG: Sir, you brought up a

3 good point that I was going to try to lead

4 into. I think we've done a better job of it

5 over the last several years, but there are a

6 lot of demobilization sites that instead of

7 trying to move the soldier into and actually

8 recommending a WTU, or further care, they

9 actually start, I guess, pushing the soldier

10 more to the VA care with that.

11 I think þ- like I said, I think

12 we've done a better job over time, but there's

13 a large population that's out there that have

14 been receiving care, both civilian and VA,

15 that we've never captured. That's come up in

16 multiple conversations between different parts

17 of that population of how to capture them, and

18 how to make sure that they are getting the

19 care that they deserve. And also with that,

20 hopefully, from the policy side, instead of

21 always, I guess, pushing VA over WTU or Army

22 Medical Care, if we can figure out some way to

1 standardize that.

2 COL. FARIS: You know, I would say

3 one of the friction points, I got to serve on

4 the Demobilization Assessment Tiger Team where

5 we went around through the Army and said we

6 had different standards going on, and we were

7 reviewing best practices. We made some

8 recommendations. And one of the things we

9 talked about was extending demob time to do it

10 requirement-based, not time-based, and do it

11 in 10 to 14 days.

12 Another thing that we talked about

13 is the fact in that time frame then doing a

14 good assessment and determining þ- getting an

15 MRI and those kinds of things done, which swim

16 lane, if you will, do you need to go to.

17 So many soldiers are worried that

18 they're going to go to swim lane one, into the

19 WTU, and never make their way back home. And

20 there are certain requirements to get locally

21 based in a CBWTU. And if their injuries are

22 so significant, they don't qualify for that.

1 Then they know they're going to be displaced
2 from their family. That's not appealing. How
3 do we move forward to that?
4 So, some of the programs that the
5 Guard has come up with is to do that. Now,
6 it's not going to fix it for every soldier.
7 Face it, there are soldiers with some really
8 significant injuries and illnesses that we
9 cannot give them the adequate type of care and
10 supervision, and feeding, if you will, back in
11 the state. But these programs, as you've
12 demonstrated, well, what about if the WTU has
13 a soldier that's now low þ- has moved from
14 high risk high acuity and has been in the
15 system long enough, and now it's just we're
16 doing physical therapy. Maybe we can get the
17 soldier back to the state.
18 So, we are looking ahead of þ-
19 ultimately, we realize that if we can get
20 soldiers closer to home that they heal faster
21 and better. And that is the end of what we're
22 trying to do with these programs, is to do

that. But understand what our limitations are. And we understand that. There are certain things we just cannot do in the state that is more adequately served back at a medical treatment facility.

MR. HOLDEMAN: Okay. My aviator senses are telling me we're running over time here, so we'll go through these last couple of slides.

MS. DAILEY: Please don't rush. You're doing fine. You're doing fine. Don't rush.

MR. HOLDEMAN: The policy piece we've already run down.

MS. DAILEY: Unless you really want to leave quickly.

(Laughter.)

MR. HOLDEMAN: No, not at all.

COL. FARIS: My flight to Italy is not until 4:30 this afternoon.

MR. HOLDEMAN: We do allow our Surgeon and Deputy Surgeon to take leave,

1 believe it or not.

2 I'm going to turn it back over to

3 Colonel Faris. She'll close for us, and we'll

4 be happy to answer any of your questions.

5 COL. FARIS: All right. We've got

6 a couple of more slides here. Once again, I'm

7 a moving target.

8 So, I think you all are getting

9 the sense that our number one priority is that

10 top bullet, to make sure our soldiers, and

11 families, and employers understand that we are

12 taking care of our soldiers, and getting them

13 the right kind of care, the best kind of care.

14 And that we are supervising that care that's

15 going on, and tracking, and monitoring it to

16 the best we can.

17 Another point to your question

18 about sending people to the VA for their care.

19 One of the points that we saw at the 90-day

20 post appointment health reassessment events,

21 the third Yellow Ribbon event for the Guard,

22 is that we were traditionally referring our

1 soldiers to the VA for their assessments to
2 determine whether or not this condition is a
3 line of duty condition. And we weren't
4 getting a lot of medical documentation back,
5 we weren't getting a lot of visibility on it.
6 So, this past spring, the Army National Guard
7 changed its policy, and now what we do at post
8 appointment health reassessment events is that
9 we refer soldiers to the TRICARE network.
10 They're either seen at an MTF, they're seen at
11 an authorized TRICARE provider in the hopes,
12 and we have seen it, that we get documentation
13 back more readily on the care and treatment,
14 so we have much more of a visibility on what's
15 going on with that soldier.
16 So, as you've seen, we've talked
17 about þ- one thing we didn't talk about is
18 eProfile and eCase. eProfile in the Army is
19 an electronic system that puts down a person's
20 profile. A profile is a PULES. P stands for
21 the whole body, U stands for upper, L is for
22 lower, E is for eyesight, and S is for psych.

1 Obviously, whoever put the acronym together þ-
2 oh, hearing, and then psych. So, psych
3 doesn't start with an S, but I guess PULEP
4 didn't work very well, so it was PULES.
5 So, with that profile that we
6 have, every job that we have has a certain
7 profile. If you're a supply sergeant, you need
8 to have upper body strength to move stuff
9 around. So, having a three in your lower
10 would not be conducive to having that
11 particular duty. So, we do profiles every
12 time we medically touch a soldier, we do an
13 assessment as to what their PULES should be.
14 eProfile is an
15 electronic mechanism to have visibility. What
16 was happening is, we were doing paper profiles
17 and nobody had any visibility unless you
18 actually had the soldier's medical record to
19 see that they had this profile. Now with
20 eProfile, a profile is written electronically.
21 Instantaneously, that information is shared
22 with MEDPROS and that profile is updated.

1 That way if we're getting ready to go on a
2 mobilization, I can look in the system and say
3 þSergeant Holdeman, you have a three in your
4 hearing.þ Let's make sure that you've had a
5 MAR2 so you can mobilize. It gives us better
6 visibility on what's going on with the
7 soldier.
8 What we've done in our þ- in the
9 National Guard is, there was really never a
10 good system þ- within eProfile, there's a very
11 limited case management piece where you can
12 take notes. What we did in the National Guard
13 is we created our own case management system
14 called eCase. And eCase is a mechanism where
15 because I have super user powers at National
16 Guard Bureau, I can go in and drill in in any
17 soldier in any state, and someone calls me and
18 says we're having a problem with this person,
19 I can pull up their case management notes and
20 take a look at what's going on with them, and
21 provide input and insight.
22 So, when a soldier is a member of

1 the Ohio Guard, and they're going to do an
2 interstate transfer to the Indiana Guard, all
3 that information is shared, and goes from
4 state to state.
5 So, this is the first time that we
6 have this holistic visibility on what's going
7 on medically with our soldiers, and we found
8 to be very beneficial. Yes, and it's HIPAA
9 compliant, yes. Thank you. Next slide,
10 please. Is that it?
11 We've created þ- speaking of HIPAA
12 compliance, all of our applications, we have
13 something called dent class for dental
14 readiness, we have the health readiness
15 record, which is an electronic record. We've
16 had in the National Guard to create our own
17 systems, because we don't provide treatment.
18 We don't have a medical treatment facility so,
19 therefore, we're not able to use Alta and
20 CHCS. We've created our own system, so we're
21 in the process of trying to figure out a way
22 to have our system talk to not only the VA,

1 but to talk to the big Army, and that's the
2 quandary everyone is at right now, is that
3 interoperability between the sharing of
4 information.
5 But subject to any of your
6 questions you all might have, that's the end
7 of our presentation for you today.
8 MS. DAILEY: Very complex system,
9 and I know some of you are kind of being
10 indoctrinated for the very first time. But
11 the piece of this that attracted me to it, and
12 which wanted to get the National Guard up here
13 to talk to you about it was to address some of
14 the concerns we heard last year, i.e.,
15 demobing, coming back, didn't want to go to
16 the WTU, or didn't realize they needed to go
17 to the WTU, back at home, not able to hold
18 down their civilian job any more because of a
19 bad knee, or torn rotator cuff, or bad back.
20 And we all have used incap pay pretty loosely
21 here. When we were out listening to people,
22 incap pay was coming three, four months later,

maybe six months. So, we were having scenarios of a significant amount of stress being placed on individuals no longer employed, can't get into the medical care system. So, I was very attracted to this, and very attracted to you all talking to the members about how you're addressing these issues. And it's not anything we've heard from any of the other Reserve Components. It's not an Air Guard program, Reserve þ- Army Reserve is just coming on board, and we don't have visibility of the other Reserve, Navy Reserve, Marine Reserve, Air Force Reserve, and how they address their redeployed, injured but kind of under the radar members.

CO-CHAIR CROCKETT-JONES: I have to say, one of the concerns I'd like to get some sight on over time is that in transitioning maybe between programs, and then the gaps sometimes between the PDHRA and finding either of the programs that might be appropriate, CBWTU, WTU, or this new þ- the MMA. You're

1 dealing with a lot of different systems for
2 record keeping for medical records. And one
3 of the things we did hear from doctors working
4 with injured soldiers was that compiling a
5 very good medical þ- seeing the full picture
6 medically was sometimes hard, that it required
7 some personal phone calls to other physicians,
8 and realizing that there are limitations.
9 Electronic records happening in the military
10 side is not necessarily happening in the
11 civilian sector yet, at least not in an
12 interoperable way, as we've talked about.
13 So, going forward trying to
14 streamline that and make sure we have accurate
15 pictures of those soldiers we are tracking
16 does seem like something you have to keep an
17 eye on, and that we are interested in.
18 MR. HOLDEMAN: Absolutely. And
19 I'll just þ- I'd just like to go back to the
20 fact that we have about 420 medical readiness
21 NCOs across the force that are dedicated to
22 this cause. In coordination with that are the

1 Care Coordinators, 336, and over 100 case
2 managers. So, we're trying to put the right
3 level of emphasis on that record keeping, and
4 tracking, and management of the case files in
5 eCase and the notes that are necessary to get
6 the soldier the care they deserve and need.
7 Absolutely, that was þ- we
8 identified that early on. I think we're
9 probably doing a better job than the other two
10 components, and we're proud of that. And the
11 other two components, and the Air Guard and
12 the Air Force Reserve are now þ- they have our
13 policies, our guidance, and plagiarism is
14 encouraged. We don't have any owner þ- we
15 don't have any copyrights on this stuff, but
16 we certainly, in my mind, have done a fair job
17 of putting the right effort on this problem.
18 CO-CHAIR CROCKETT-JONES: Do you
19 have any written information on þ- that you
20 could send me on like the workload ratios that
21 you think are appropriate for those medical
22 records NCOs?

1 MR. HOLDEMAN: We have some
2 metrics.
3 COL. FARIS: Yes.
4 MR. HOLDEMAN: I don't know how
5 involved they are.
6 COL. FARIS: I don't want to get
7 yelled at by not talking in the microphone.
8 Yes, we keep monthly metrics as to the
9 appropriate ratio. And it's just like any
10 problem, you don't realize how big a problem
11 is until you start digging into it, and then
12 you realize Holy Hannah, I don't have enough
13 people, and now I've got to figure out what
14 the right ratio is. So, we're working that.
15 And then, of course, there's a big
16 price tag that goes along with having a
17 National Case Management contract. And to the
18 tune of the fact that it is next to the health
19 readiness program, our biggest part of our
20 budget that we have in the National Guard
21 Bureau.
22 MR. HOLDEMAN: You know, the other

1 thing about ratios is they're somewhat
2 deceiving. When the Army standard for PEBLOs,
3 for example, is 1-40 for case management. But
4 some PEBLOs are overwhelmed depending on the
5 size of the WTU they help support, and the
6 MTF, the caseloads of the MTFs, so their
7 throughput is significantly low depending on
8 how many times they have to stop what they're
9 doing and go help somebody with a personal
10 issue, or case management problem.
11 We have other PEBLOs where the
12 ratio is 1-198, and their throughput is high,
13 so trying to figure out what that secret sauce
14 is is difficult, at best.
15 CO-CHAIR CROCKETT-JONES: Thank you
16 very much.
17 MS. DAILEY: Thank you. We are, in
18 fact, ahead of schedule. It's 11:00, and so
19 we're an hour ahead. I can probably get lunch
20 served a little earlier, maybe 11:30, but I'm
21 not expecting my next briefer until 1:00. So
22 for our members, I'd like to give us a 10-

1 minute break and be back here to discuss
2 what's next.
3 (Whereupon, the above-entitled
4 matter went off the record at 11:03 a.m. and
5 resumed at 12:56 p.m.)
6 CO-CHAIR CROCKETT-JONES: All
7 right, gentlemen, we're back from lunch.
8 We're going to hear from Ms. Ginnean
9 Quisenberry, Director of Population Health,
10 Medical Management and Patient Centered
11 Medical Home Division, and with the Office of
12 Chief Medical Officer, TRICARE Management
13 Activity. And we also have Mrs. Dorinda
14 Lovelace, but I don't know þ- I can't quote
15 your whole spec, so if you'd like to introduce
16 yourselves and give us your briefing.
17 MS. QUISENBERRY: Well, good
18 afternoon, ladies and gentlemen. I wanted to
19 take the opportunity to thank all of you for
20 giving us the privilege of being able to be
21 here and go over what efforts we are putting
22 in place, and supporting our case managers in

1 how they are working with all the not only
2 wounded, ill, and injured members, but the
3 TRICARE members across the Military Health
4 System.
5 So, accompanying me here today is
6 Ms. Dorinda Lovelace, and she is a Case
7 Management Nurse Consultant within the
8 Division of the Office of the Chief Medical
9 Officer.
10 So, in response to being here
11 today I'm going to go ahead and just start out
12 talking about the opportunities that are
13 available not only within the Directive Type
14 Memorandum that is currently in place for case
15 managers, but additionally for those training
16 opportunities for multi-disciplinary team
17 members.
18 So, specifically, I'll be
19 providing the overview to the Military Health
20 System model that is currently adopted and in
21 place, so that would be our overarching model
22 that we will utilize, as well as the medical

1 management model that we incorporate within
2 our training for these members.
3 Both are reflecting activities and
4 initiatives that are meant to drive optimal
5 health care outcomes for those members that we
6 serve. For our purposes here today, we will
7 also provide that detailed overview of that
8 medical management model, so we can recognize
9 the unique requirements that are available in
10 there for the clinical case managers as
11 they'll need to know the different types of
12 platforms of care in executing the services
13 that they provide across the Military Health
14 System.
15 I'll also be discussing the case
16 management goals and qualifications that are
17 currently highlighted, and in the Directive
18 Type Memo currently in place, a review of the
19 Triservice required modules that are within
20 the Directive Type Memo for clinical case
21 managers. And I also wanted to bring to you
22 today just to give you a glimpse of þ- we

1 don't just stay within that Directive Type
2 Memo for the training. The additional
3 training that the TRICARE Management Activity
4 out of our office that provides to our
5 members, just so you can see those additional
6 efforts, and how they work with the case
7 managers and the other team members that they
8 interact with.
9 So, in starting out I just wanted
10 to go over the Military Health System module
11 þ- model overall. And this is identified as
12 a centerpiece for the efforts within our
13 efforts, basically. And it identifies you can
14 see separate but integral domains that affect
15 the care across the system. And those are
16 identified as population health, cost for our
17 members, experience of care, and readiness,
18 and how those quadrants are identified not
19 only in an ever-changing health care
20 environment, but we also need to keep in mind
21 that we have a growing population base within
22 our Military Health System. I believe in 2011,

1 Rear Admiral Hunter identified we had over
2 400,000 increase in our Military Health System
3 base.
4 So, within the population health
5 domain that we identify up here, we drive and
6 encourage healthy lifestyles and behaviors.
7 And we do that through focus, prevention, and
8 wellness activities, ultimately driving those
9 health care outcomes. Perhaps many of you
10 would þ- a good analogy would be for our
11 clinical preventive services that are part of
12 our TRICARE benefit, helping drive those
13 healthy behaviors, getting to a better
14 outcome.
15 We also look at cost. And when we
16 look at this cost within this model, it's not
17 looking at how individuals will access this
18 cost or drive the cost. They're looking at
19 the overall cost, where that trend is, and
20 opportunities that we can drive and eliminate
21 waste out of the system.
22 We also have the experience of

1 care within this model, and we're looking at
2 how can we drive compassionate care that looks
3 not only at the member but the family, as
4 well, and how that care can be looked at and
5 ensuring that it's accessible care for
6 individuals. And then readiness within this
7 domain in the fact that we certainly recognize
8 that we're a military force, and that we have
9 to be ready to deploy. But we also have to
10 look at the fact that we're ready to provide
11 this medical care any time, anywhere, not only
12 in support of our military operations, but the
13 many humanitarian missions that the Military
14 Health System supports.
15 So, in concert with this model,
16 and the next model we'll discuss, which is our
17 medical management model, we take both of this
18 and incorporate it within our individual
19 training efforts to drive these type of
20 outcomes in teaching our case management
21 personnel. Next slide.
22 So, I wanted þ- I'm not sure if

1 you've had the opportunity to see this, but
2 this is our medical management model. And
3 this is what we will utilize at the TRICARE
4 Management Activity when we are doing our
5 courses, when we are working with our web-
6 based training requirements within the DTM.
7 And I want to point out here that
8 superimposed on this, because I wanted to make
9 sure I highlighted this for you, is I've added
10 in the Veterans Benefits, or the VA, Veterans
11 Administration on this. And I'm trying to
12 include this in, and incorporating it and
13 talking with our multi-disciplinary team
14 members as we're looking at our model. And do
15 we have the aspects of care that need to be in
16 there? Are we identifying everybody? So,
17 giving you kind of the first look and input
18 into this.
19 So, in keeping in line with the
20 Quadruple Aim, the medical management model
21 utilized here not only you can see addresses
22 our case management efforts here, but it's

1 important to note that we recognize our
2 utilization management efforts that identify
3 resources, costs, and services, how we access
4 and utilize those, as well as our disease
5 management individuals. Because remember in
6 the other model, we had the population health.
7 So, when we're working with our wounded, ill,
8 and injured members, we can't be so narrow
9 that we just see the injury. They may have
10 comorbidities associated with that that needs
11 to be recognized. So, when we're working with
12 and teaching this with our multi-disciplinary
13 team members we're trying to take the whole
14 person, the whole effect, and what we need to
15 be driving towards a healthy outcome.
16 Other aspects of this model I
17 wanted to identify is that we provide, or our
18 clinical case managers provide and navigate
19 care across different platforms within the
20 Military Health System. And you can see
21 highlighted in yellow there the first box is
22 our Triservice representation of the direct

1 care, so that would be our military treatment
2 facilities. But they also must be able to
3 move outside of that and navigate regionally
4 based type of networks of providers that are
5 in our private sector care in which they work
6 with our managed care support contractor
7 partners. And we all know they'll go back and
8 forth and how they're accessing that care.
9 And, additionally, just carving
10 out the VA side of it, because we know that
11 our active duty members don't necessarily
12 retire when they're just accessing the VA
13 care, but they may be needing additional
14 resources available to them, and stay in an
15 active duty status, or in some cases retiring
16 and transitioning over to the VA for care, or
17 for long-term type of support. So, we want to
18 recognize the VA within this model.
19 So, understanding and having the
20 opportunity at looking at these models, and
21 addressing them, and how the clinical case
22 managers will navigate and access the care

1 here, one question posed by the Task Force to
2 us is, how do you define case management
3 success? So, to understand and achieve how we
4 define that, we have looked at the Case
5 Management Society of America, who is a
6 nationally recognized organization, who drives
7 the standards and practices for our case
8 management personnel, and we have expanded on
9 that definition; so, taking that to address to
10 our unique military population.
11 So, you can see the definition up
12 there, but primarily the aspects that drive
13 clinical case management decision making would
14 be the promotion of the quality outcomes
15 through the collaborative processes in
16 addressing assessment, planning, the
17 implementation and facilitation across the
18 different networks, advocacy. We want to make
19 sure we're advocating not only for the member,
20 but the services within the multi-disciplinary
21 team member, interacting with the family
22 members, and then ultimately communicating and

1 working with them on outcomes. So, when we're
2 looking at this, plainly stated, we are
3 driving to a consistent equitable and high
4 levels of quality outcomes for our members.
5 A second question posed to us by
6 the Task Force is, what exactly are the
7 qualifications that we're looking at for our
8 case management personnel? And currently
9 within the Directive Type Memo, it's
10 identified that these individuals are licensed
11 registered nurses, as well as degreed social
12 workers. And right up front, I wanted to þ- I
13 know you're here from a lot of different
14 individuals, but right up front for our
15 efforts here, we're talking about the clinical
16 case managers, so when we're looking within
17 this Directive Type Memo we are not addressing
18 those non-clinical case managers, such as our
19 partners in the Recovery Care Programs, those
20 PEBLOs or liaison officers that are helping
21 our members navigate through either medical
22 boards of physical evaluation boards, as well

1 as our partners over in the VA, those Federal
2 Recovery Coordinators.
3 For our purposes here, we're
4 addressing the licensed registered nurses, and
5 degreed social workers are considered our
6 clinical members that we're targeting at
7 within this Directive Type Memo.
8 Another question posed was, are we
9 a certifying body? And we are not a
10 certifying body. What we do with the training
11 and education is, our effort is to make sure
12 that these individuals have the basic
13 functions and roles and how they need to
14 effect and be able to implement, and be able
15 to function, and make a difference for these
16 individuals. So, I just wanted to be able to
17 point out and answer that question for this
18 Task Force.
19 And although we are not requiring
20 the case management certification within the
21 DTM, we do identify that it would be highly
22 recommended that individuals receive this.

1 And in working with our service
2 representatives across the services they, too,
3 are looking at incorporating that type of
4 support within individual position
5 descriptions as they're reviewing that and
6 possibly implementing that within them.
7 So, just kind of giving an
8 overview on where we're going to next,
9 specifically, what are our case management
10 training opportunities that we have available
11 for these clinical case managers. The
12 additional training that we at the TRICARE
13 Management Activity provide our members with
14 that advanced and basic course, and as well as
15 looking at a newly identified module that we
16 are getting ready to deploy October 2011, so
17 we are eagerly awaiting this being able to
18 come and access for our members.
19 So, in starting out, we
20 specifically wanted to look at what is
21 required within the Directive Type Memo? What
22 modules do we have in there that are available

1 for these clinical case managers? And you can
2 see we give a very broad type of training that
3 not only speaks to basics of clinical case
4 management, but we also have varied type of
5 platforms, so they have the understanding and
6 knowledge behind that.
7 So, courses are ranging þ- their
8 case management that will address their job
9 roles and functions. And included in that we
10 have surface specific modules that are basic
11 for case managers that our Navy and Air Force
12 partners have implemented.
13 Also, we've included the TRICARE
14 Fundamentals course, because as we know,
15 individual case managers will move in and out
16 of that role, so being able to understand what
17 is TRICARE, what are they working within?
18 What is the history, what is our mission? How
19 is a benefit made, how do you access those?
20 So, having just a fundamental understanding of
21 that in accordance with our services was
22 identified as something we needed to include.

1 I also had the opportunity to work
2 a while back with Dr. Lussier over at the VA
3 and pull in the TBI and the PTSD courses that
4 are currently available within these modules.
5 So, certainly a collaborative effort here and
6 available to our members to not only
7 understand what are these injuries, what is
8 PTSD? What is TBI? But it goes further into
9 physiologic and pharmacological aspects of
10 consideration, so these case managers can have
11 a basic understanding of what other aspects
12 they need to take into consideration.
13 We also have included something
14 called Clinical Decision Support Tools, and
15 those tools are algorithm-based inpatient and
16 outpatient type of tools that help with
17 decision making. So, more if this, than that,
18 you know, they're moving towards if somebody
19 has a diagnosis of this, then they'll go
20 through a series of questions and identify
21 what would be the next step so they can work
22 with their multi-disciplinary team members.

1 It also helps them identify do we need to be
2 thinking about discharge planning? Are there
3 outpatient type of equipment we need to be
4 working towards? Is there physical or
5 occupational therapy we need to be looking
6 towards? So, it's just an algorithm-based
7 type of tool, if an individual is an
8 outpatient setting, as opposed to an inpatient
9 setting, that's available to them.
10 We also have collaborated with our
11 VA again, and had the opportunity to have a
12 basic VA-type of course included in this, so
13 they understand the VA mission, and they
14 understand that it's just not VA, that there
15 is the VBA in there, and how do they access
16 maybe housing benefits for somebody, or
17 prosthetics that somebody may need. What the
18 difference of us is regionally-based versus
19 VISN-based.
20 Those type of differences are
21 critical, especially when members are moving
22 from Walter Reed back home. How are they

1 going to access those outpatient-based type of
2 VA clinics, because they may be geographically
3 separated. How do they get hold of somebody?
4 The other is, we worked with our
5 Military Medical Support office, and we asked
6 that they get involved in and get a module in
7 there so they understand how the members work
8 with our active duty that are maybe more in
9 the TRICARE prime remote type of setting. And
10 how they work with Line of Action type of
11 reviews, and how authorizations can be set,
12 and how they work with them. It's just another
13 platform for them to understand, get familiar
14 with.
15 So, the current DTM guidance
16 requires that these modules are completed.
17 And what we are doing at the TRICARE
18 Management Activity is we are certainly
19 working with our services in the
20 identification of these training efforts, as
21 well as providing them a monthly type of
22 report, and seeing who has completed those

1 modules, where gaps may be, just feeding them
2 who needs to get this up-to-date, and where
3 they are with their current training efforts.
4 So, how do we do that? How do we
5 help our services get those numbers and
6 identify that? Where do our clinical case
7 managers go to access this information? So we
8 within the Military Health System have a
9 Military Health System-learned type of
10 platform, or MHS Learn, and it's important
11 here to note that this is a CAC-enabled web-
12 based, so it's web-based, it's not specific to
13 any type of service, so they can be able to
14 access this any time, anywhere. And it's
15 online and they can move through specific web-
16 based type of self-paced modules. So, you
17 have individuals that are moving into these
18 roles that may be more of an expert but maybe
19 more starting out, so they can move at their
20 own pace than their web-based, and can be an
21 easy reference for them. But it's important
22 to know that this is web-based, and they can

1 access it at any time.
2 Also, we work with our MHS Learn
3 partners here, and they are able to capture
4 the training. So, if you and I were to go in
5 there, there'll be role drop downs, and we'll
6 be able to identify ourselves as to what role
7 we have, get that back to our services, so
8 they know that Ginnean Quisenberry, who's
9 located at Fort Belvoir, completed seven of
10 here eleven modules. Where is she falling
11 down? Where does she need to get help? Why
12 isn't she able to get that? How can I help
13 her get there? Does she know that it can be
14 accessed beyond duty hours, or whatever I
15 needed, they can get right to that individual.
16 Another thing we also utilized
17 here that's important to note, MHS Learn works
18 with us, too, on virtual type of classroom
19 training. And this is an additional thing.
20 I talked about this, clinical decision support
21 tools. Well, what we do is we engage with the
22 subject matter experts, and we ask them to do

1 virtual training that they can access through
2 this platform. And we open it up and let them
3 actually move through the slides of the tool
4 and show the individuals that are on this
5 training, and let a free flow of question and
6 answers. So, they'll not only show the tool
7 and how you access that, but they'll let them
8 run through specific scenarios. I ran into
9 this today, how can I really use this to help
10 me get to an outcome that I need? I wasn't
11 real sure where to go. So, it's important to
12 know this isn't only self-paced, but we do
13 work with them on virtual aspects of training.
14 So, this next slide identifies one
15 of the metrics identified within the Directive
16 Type Memo that asks us to identify the number
17 and the percent of the service case managers
18 who again have completed all of these 11
19 modules. And to date we are still I can say,
20 happy to say that we are still driving up the
21 slope and making sure we are seeing an
22 increase in completions. And right now, all

1 the services we're looking at a 74 percent
2 completion rate, and we continue to go up.
3 Some barriers that our service-
4 specific colleagues run into with this is
5 certainly, we have active duty members that
6 may be transitioning out of the case
7 management role and moving into other roles,
8 individuals deploy, retire, move on to other
9 positions, as well as individuals moving newly
10 into the position. So, there's always a flux,
11 certainly, in how they're completing these
12 modules, so the report that we're providing to
13 our service members allows them continually to
14 look at where they are, how do we improve?
15 And we need to keep looking and working with
16 them with our MHS Learn modules on what will
17 help you better identify these pockets and
18 gaps.
19 MR. CONSTANTINE: Ma'am, how do you
20 feel about that 74 percent number, and do you
21 have a goal you are trying to reach regarding
22 that?

1 MS. QUISENBERRY: That's a great
2 question. We work with our services on that.
3 We are not content with the 74 percent,
4 certainly. We would like to see it much, much
5 higher. So, the services that we work with,
6 they will take this and they will scrub the
7 lists that they get, because we can give it to
8 them by name, so they would be able to see
9 that Ginnean Quisenberry only got seven of
10 those eleven done. And then that allows you
11 as my service lead to come back and say what's
12 going on? What barriers are you running into
13 that you're not able to reach the 100 percent
14 goal here?
15 So, we have been trying to
16 steadily drive this up, but again with the
17 challenges of having funded case management
18 coming in, and then they get counted in their
19 totals, will help drive down that percent
20 until they get the person actually in the
21 position. So, we need to look at how we're
22 reporting that, and how we're counting those,

because if you have a position, yet you've not hired for somebody, you need to recognize that a different way in our numbers. But, certainly, we have seen steady increase.

MR. CONSTANTINE: Do you have þ- do you pass on to them that within a year you have to be at this percentage, or is there þ- are you just hoping they get there?

MS. QUISENBERRY: Oh, no. The services þ- we allow þ- the services to work directly with them. They want to see that 100 percent fill. And they every month will go out to them. I would have to get specifically from the services what they are giving as their deadline to them. Our goal is to monitor, and our role within this Directive Type Memo is to make sure we have these available. We are watching and monitoring that, and working with our services and saying where we are, where we need to be. So, I don't know if the services have specifically gone out.

1 I know the Army goes out and they
2 actually go their units and say I want to see
3 the certificate. So, they go verify on site
4 with their case managers.
5 DR. PHILLIPS: Ma'am?
6 MS. QUISENBERRY: Yes, I'm sorry.
7 DR. PHILLIPS: Are you able to
8 review the contents of the modules to
9 potentially identify any knowledge gaps that
10 may exist?
11 MS. QUISENBERRY: Yes. Yes, that's
12 a great question, and one that we're driving
13 to right now in the fact that we do review
14 this with our services, and they look at that
15 as far as we need to update the content. And
16 when we're looking at case management and we
17 drive to the national standards of practice
18 within our Case Management Society of America,
19 they have updated their standards as of 2010,
20 and hadn't done so for some time. So, we are
21 looking right now at trying to take these
22 modules with funding available, certainly, and

1 updating these. And we do not do this in a
2 vacuum. We make sure that all the services
3 are at the table, and the subject matter
4 experts are in the field, so if there is
5 something that we are missing, we address it.
6 And we're also trying to,
7 especially with our new module that's coming
8 out, trying to drive more of a scenario-based
9 type of training. It's hard when you're not
10 face-to-face with somebody to be able to have
11 that question and answer, so how do you do
12 that? So, we're trying to take realtime
13 scenarios and build that in to make them think
14 a little bit. I should have gone right instead
15 of left. So, we're trying to change in how
16 we're doing that, too. And, hopefully,
17 that'll give us that type of feedback of where
18 we can improve.
19 The medical management training, I
20 wanted to point out, is in addition to this
21 Directive Type Memo. And that is something
22 that we at the TRICARE Management Activity

1 have been doing for some time now. But we
2 have rolled out a new training this year, and
3 I'll be able to go over that, but basically
4 when we're looking at this training, it is a
5 four-day on site regionally-based type of
6 training. We work with our partners within
7 the military treatment facilities, and we try
8 to get an Army, Navy, and Air Force type of
9 partner.
10 For the first time this year,
11 coming back, I just back from the VA side of
12 the house, so I tried a new venture in trying
13 to have this at a VA site. And I took a shot
14 to try to have it at a polytrauma site,
15 because I'm sure you'll hear from the VA when
16 you talk about polytrauma care, it's not just
17 at a polytrauma site. There are levels of
18 care within polytrauma. And it kind of
19 exponentially goes out so they can make sure
20 they get hold of people.
21 But wouldn't it be great if we
22 could do this at a VA site and work with our

1 polytrauma representatives, or work hand-in-
2 hand and invite them in?
3 We weren't able to þ- the site
4 that we had looked at, one of the polytrauma
5 sites wasn't able to get it launched this
6 year. We turned to the Lovell, it's a brand
7 new VA site in Chicago, the VA Lovell Medical
8 Center. And, unfortunately, we were at the
9 end of the fiscal year so we didn't have a lot
10 of enrollment. So, that doesn't mean that we
11 give up on that. It's certainly another new
12 thing that we're looking to partner with,
13 because wouldn't it be great to have them
14 right in the audience sitting right next to
15 our clinical case managers? Wouldn't that
16 make for a whole lot better discussion? Yes,
17 sir?
18 MG STONE: So, Ginnean, are you
19 saying that at the polytrauma centers there is
20 not case management today?
21 MS. QUISENBERRY: Oh, there
22 certainly is. What I'm trying to is, we've

1 always done this training, our DoD side
2 training just within our military treatment
3 facilities. I want to see if I can jump over
4 to their side and get our case managers to sit
5 next with theirs.
6 MG STONE: As you're well aware,
7 those polytrauma centers are taking active
8 duty family þ-
9 MS. QUISENBERRY: Absolutely.
10 MG STONE: þ- active duty service
11 members and providing care on behalf of our
12 Department.
13 MS. QUISENBERRY: Yes.
14 MG STONE: So, the idea of having
15 case managers with the same qualifications
16 would certainly be of interest to us.
17 MS. QUISENBERRY: Yes. Yes. And
18 having them being able to interact directly
19 right with them. Even for our case managers
20 who might not necessarily be able to walk out
21 and see what a polytrauma site looks like, I
22 think would just be a tremendous thing for

1 them. And we have tried to work, if we could
2 have it there, of just in the evening after
3 the course, just can you walk us around and
4 see what a polytrauma site is.
5 I know when I had the opportunity
6 to have the medical management course at
7 Brooks, I had the opportunity to walk up on
8 the burn unit and actually sit with the
9 families and meet some of the patients, and
10 talk with the staff. It just þ- it makes more
11 of a mark. I think if you can see it, you
12 understand it, you can touch it, you can feel
13 it, you can smell it type of thing. And it's
14 just kind of a new venture that I just really
15 want to try. And, hopefully, it will be a
16 great success. I'm not sure, we haven't tried
17 it. We'll go down that road.
18 So, within our basic course we
19 take, and this is a multi-disciplinary type of
20 approach now. Clinical case managers are
21 involved in this, but we do a basic
22 introduction of what the medical management

1 core concepts are within the case utilization
2 and disease management. We do an initial
3 review of our clinical decision support tools,
4 so they're aware how þ- what outcomes they can
5 impact, what they look like, because they may
6 not necessarily in what they do every day get
7 to see those, as well as how those business
8 tools can affect their outcomes, and how they
9 obtain services and needed benefits for
10 individuals.
11 And just rolling out this year is
12 an advanced medical management course. We've
13 never had that, and we rolled it out for the
14 first time, and I'm happy to say we were able
15 to launch it on three separate occasions.
16 This is a little different. We have much more
17 of a hands-on type of approach where they're
18 going to have to now use it. It's not going to
19 be hearing us talking to them. They're going
20 to have to actually work with it.
21 And we have realtime scenario-
22 driven type of processes with that, as well as

1 reporting out. So, our clinical case managers
2 get an idea of what it is to report it out to
3 leadership. What a report like that might
4 look like. How do they get up and talk about
5 that? Because, remember, we have brand new
6 case managers, as well as our more experienced
7 case managers, so being able to give them that
8 opportunity could be beneficial.
9 So, in looking at the components
10 or the elements within that basic medical
11 management course, again we had the
12 opportunity to identify that we have the
13 regionally-based MTF type of care, but we also
14 have the private sector. So, we're working
15 with our managed care support contract
16 partners. Overview, again, of the medical
17 management components based on the model.
18 Clinical and business planning tools.
19 So, who comes in there, and who do
20 we get as our partners in? Well, we invite
21 our TRICARE regional offices there, and we get
22 them realtime in the room with them so they

1 get an idea of what does a TRICARE regional
2 office exist for, what do they do, how can
3 they help you?
4 They certainly have our Benefits,
5 Counseling, and Assistance Coordinators, or
6 our BCACs, as well as our debt collection
7 officers, or our DCOs. And if they need
8 assistance, how can they reach out to them?
9 We also have our managed care
10 support contractor partners in there. There
11 are a lot of web-based training that goes on
12 during the month for medical managers overall,
13 but having these managed care support
14 contractors and the topics that may be of
15 interest to them as far as referral
16 management, behavioral health, how do they
17 access this? How do they get that?
18 So, they can ask freely with their
19 questions, and have that managed care support
20 contractor representative in the room right
21 there with them and be able to answer those
22 questions.

1 We also invite our partner, VA.
2 We try to have a VA representative there, as
3 well, because certainly VA isn't just VA. We
4 have VBA and VCA, so we have the whole gamut
5 that they're able þ- there to hear access and
6 ask questions about.
7 The next is the Advanced Medical
8 Management course. And, again, we just rolled
9 that out this year. Again, it happened in
10 three separate occasions, and through this
11 they are basically at a computer. And they
12 will use the population health portal and be
13 able to drive it down. We have a physician
14 expert that comes in and is able to gain
15 access into that, and drive scenarios so they
16 can use the tool. How can they use that in
17 outcomes? We put them in multi-disciplinary
18 teams, so how are they going to work with
19 their partners on that, just not all case
20 managers at the same site sitting together.
21 So, it adds for a much richer discussion,
22 identification of best practices. We didn't

1 know you were doing it that way there, we'll
2 try it at our site.
3 And so far with this first roll
4 out, I'm happy to just give you an example of
5 the feedback that we were able to get from our
6 clinical case management personnel, and multi-
7 disciplinary team members there overall. It
8 was challenging for them. We worked with even
9 the financial type of tools, those M2. We
10 have a tendency þ- I know when I was a
11 clinical case manager here at Fort Belvoir, I
12 would kind of go to my M2 expert, and I really
13 didn't understand the workings of it, or how
14 to use it, but this is þ- this gives them the
15 opportunity to learn more of what that tool
16 and the power behind that can provide these
17 individuals so they can take a more holistic
18 look at what they're getting for
19 beneficiaries. And we intend to keep rolling
20 this out. We got great feedback.
21 To support this effort and make
22 sure we have our multi-disciplinary team

1 members there, we have worked with the
2 Uniformed Services University of the Health
3 Sciences, and put our course up to the Board
4 there, both our basic and advanced. And we
5 included our social workers, our nurses, our
6 docs, as well as our individuals for the
7 Health Care Executives, because we want to
8 make sure we have our business partners in the
9 room with us. And you can see in our advanced
10 course we were able to support them with a
11 significant amount of continuing education, as
12 well as our basic course.
13 Another tool that we have
14 available is our 2009 Medical Management Tool,
15 and this is also web-access. We have it on
16 our Office of the Chief Medical Officer, is
17 where I am, and we have a Medical Management
18 Access where they can get this resource. It's
19 also available on a designated Medical
20 Management website, and those individuals that
21 attend the courses must actually go to that
22 website to register, so they know where

1 they're located. And the guide is basically
2 broken down into not only clinical case
3 management, but will address our utilization,
4 disease management, go over the tools, give a
5 little bit on the VA.
6 Oh, it's important to note, too,
7 again, we don't create any of these in a
8 vacuum. The teams that we work with, mainly
9 that Dorinda and I work with are Surgeon
10 General representatives for the services, and
11 they're the case management representatives.
12 And we work directly with them, we create the
13 stuff. Everything that we put out we try to
14 have everybody's mark on this.
15 And the new course that we're
16 getting ready to deploy, I'm very proud to be
17 able to say that October, so this month we
18 expect this to roll out, addressing the
19 Integrated Disability Evaluation System. It's
20 not to make these clinical case managers be
21 the ones that are driving the whole intent,
22 but how do they interact with the individuals

1 on these teams to be able to assist these
2 members through this process? Do they
3 understand it well enough?
4 So, we developed a course that
5 would drive right to those points. And when
6 we worked on this course, we made sure that we
7 had our non-clinical case managers, our
8 clinical case managers, we had seasoned
9 Federal Recovery Coordinators at the table
10 with us, as well as our Veteran Benefits
11 Administration and VA representatives, so this
12 was a truly collaborative type of effort in
13 trying to put that focus on case management,
14 and what they need to understand within this
15 process.
16 This kind of gives you the first
17 look, the first preview of the slide. It's
18 probably very small for you to be able to see,
19 but it goes through the objectives that we
20 worked with the services and VA on, on what we
21 wanted to drive through this course. And as
22 the case management process, as well as basic

1 nursing process, we go through certain steps.
2 And we want to make sure that they're applying
3 those steps throughout every aspect as an
4 individual moves through this process. So, we
5 keep highlighting the need for the
6 facilitation, the advocating, communicating.
7 It's a multi-disciplinary team, you can't work
8 in a vacuum. The collaboration not only with
9 that service member, but also with the
10 families in this, and educating outcomes, and
11 the status of where individuals are with this.
12 Information is so important for them, so
13 hopefully this þ- our intent here is to drive
14 that information. And we will certainly look
15 at the feedback that we get, and hopefully it
16 will be very positive.
17 Our target audience that we looked
18 at in making sure we incorporated in
19 developing this, and is certainly available
20 for members, that gives you an idea both of
21 our medical and non-medical case management
22 personnel. And with all of our modules, it

1 isn't just the clinical case managers that are
2 accessing these web-based courses, but we find
3 that there are a lot of different roles. Our
4 physicians will go in and take these web-based
5 courses. We see that out of the MHS reports
6 that we get.
7 So, at this time I wanted to just
8 kind of turn it over to you, and see if you
9 had any questions with this broad overview of
10 the training we have available.
11 DR. PHILLIPS: Quick question.
12 MS. QUISENBERRY: Yes?
13 DR. PHILLIPS: Early on in one of
14 your earlier slides, you mentioned that
15 patients move between TRICARE, purchase care
16 in the private sector, and the VA.
17 MS. QUISENBERRY: Yes.
18 DR. PHILLIPS: Could you tell us
19 how the information about each of those
20 different visits are transferred back and
21 forth? Do you have an electronic system, or
22 is it paper?

1 MS. QUISENBERRY: Well, that is
2 actually on two platforms. It's having it on
3 a platform of a medical record type of medical
4 system, but also in getting the feedback from
5 our purchase care when they see a physician or
6 a visit. And that is certainly something that
7 we work very hard to get that information
8 back, but þ- and it's known as the clear and
9 legible reports. Right, sir?
10 So, we work very hard on trying to
11 obtain that information. I believe the
12 transition in the contracts, if I'm not
13 mistaken, is at the VA side, but that the
14 military treatment facilities have taken on
15 that role, and they will work with their
16 families. Because we certainly want to make
17 sure that when they're accessing care, when
18 they're moving into a disability, that having
19 that information is critical, because that's
20 going to affect the outcomes for them. But at
21 this time, the VA has a medical-based system,
22 but we have the Alta, and we have the

1 Accentra.

2 DR. PHILLIPS: Is it þ- the real

3 question I was going to, is it working in a

4 timely fashion, or does it need more support

5 and work? The VA electronic health record

6 doesn't really harmonize with the DoD

7 electronic health record, and certainly not

8 with the private sector.

9 MS. QUISENBERRY: Right. And I

10 guess I would be speaking out of my bounds on

11 training and I'd be speaking to an IMIT type

12 of solution, so I don't want to go outside of

13 my bounds. That, again, goes back to our

14 advocacy of communicating, and trying to make

15 sure that if they have that information.

16 One thing I try to get to our case

17 managers is to get that information, and to do

18 the best we can to get that back and in the

19 records. It's a challenge for us. I don't

20 think that's not known.

21 CSM DeJONG: Ma'am, you guys are

22 doing a superior job, and even looking at last

1 year, the nurse case managers are always the
2 go-to person that have the answers. And your
3 training clearly shows that, it's far
4 superior.
5 As far as looking at, I guess,
6 your lane and what it is. Part of what we
7 looked at last year was case loads for nurse
8 case managers, and along with that, what þ-
9 and it may not be your lane either. What are
10 you guys doing for like recruiting and
11 retention of it, because what we've noticed,
12 and it's been kind of a resounding across all
13 forces, is that you get a soldier and their
14 family going through the process with the
15 nurse case manager and then they change over.
16 And it's very frustrating because sometimes
17 then it starts over. And we realize that we
18 can't control all of that, but are there
19 efforts for recruiting for case load
20 management, and retention for the nurse case
21 managers that are there?
22 MS. QUISENBERRY: I know that it's

1 service-specific when it comes to that, us at
2 the TRICARE Management Activity, I think
3 they're just points of light from our case
4 managers. And I wish I could just do anything
5 I could to keep them there.
6 I know that individual services þ-
7 I don't want to þ- I know that some services
8 are doing a little bit to do that, but I don't
9 know if it's codified as far as instructions
10 or within their methods. So, I would have to
11 go back to the services on that one.
12 CSM DeJONG: Okay.
13 MS. QUISENBERRY: As far as case
14 mix and acuity, that is certainly something
15 that we definitely look to do, and have been
16 working on. That is certainly within the
17 Directive Type Memo. We have to make sure,
18 and don't drive to the fact with our case
19 managers that we overload them to the point
20 that they're just þ- they throw up their
21 hands, and then we lose those seasoned.
22 Because certainly even with our training, when

1 we approach it, I go off my nursing theorist,
2 Pat Benner, and I approach all of our training
3 in a novice to expert type of approach. I've
4 got to find a way to reach them at all
5 platforms. How am I going to make this be
6 something that you're going to be effective
7 in, understand it, and find worthwhile for
8 yourself?
9 So, when we look at the case
10 management and acuity base, I know that we're
11 working right now þ- we had an opportunity to
12 take a look at what the Army is using to drive
13 to that. So, we're still trying to get that
14 solid.
15 CO-CHAIR CROCKETT-JONES: I have a
16 question for you. In the training þ- well, let
17 me step back to make the question
18 comprehensible.
19 There are programs emerging almost
20 all the time to address especially sometimes
21 the TBI and PTSD issues. Is there anything in
22 the training for creating þ- to connect case

1 managers to a resource for new programs, and
2 sort of a connection to professional þ-
3 MS. QUISENBERRY: There is. What I
4 did þ- well, what our division did was, we
5 have dedicated support for medical management,
6 and we had the opportunity to build in a
7 registration website where the services go.
8 And on that, I kind of tried to þ- a lot of
9 them refer to the Medical Management Guidance,
10 the bible. That's really a very important
11 resource for them. And the way you saw the
12 model go across is almost like there's
13 different aspects, so we built our website to
14 reflect that. And we added in a useful link,
15 and tried to make sure we drive to that. If
16 they're out there, the different resources
17 that are available. And we invite the
18 opportunity to add those links on there.
19 We've also added case management
20 rosters on there, as well. And, certainly, we
21 want to get more of a standardized, because we
22 want to be responsive to the point that we put

1 individual names on there, because we want you
2 to be able to get right to that right person,
3 so maybe we need to step back and identify
4 maybe we ought to put the Department and how
5 you find that person, because they may
6 transition, deploy, retire.
7 But we do have a useful link, and
8 invite that. We have the Case Management
9 Society out there, we have our guide, we have
10 others. We hear back from our behavioral
11 health sides. We try to get everything in
12 there. And if somebody identifies something,
13 it's pretty quick for me to be able to get
14 that. Our contract support will add that
15 right on there.
16 MG STONE: Ginnean, you talked
17 about the DTM that drives the certification þ-
18 the hiring of case managers as either licensed
19 registered nurses or degreed social workers.
20 What DTM drives the training that is ongoing,
21 and enforces the standardization of that
22 training?

1 MS. QUISENBERRY: The DTM for the
2 TRICARE Management Activity that drives that
3 is within here. I know the separate services,
4 like the Recovery Coordinator Program, 1300.24
5 will help drive directly to that program
6 itself.
7 When we work with the services,
8 this is my understanding what they reference,
9 because they identify these 11 modules, and
10 the feedback out of this as their
11 requirements. So, in answering your question,
12 my understanding is this DTM.
13 MG STONE: So, we can be assured
14 that this is the single-source document that
15 drives a unified approach across the services,
16 and across the Department of Defense for case
17 managers?
18 MS. QUISENBERRY: I would say yes.
19 And that's speaking for the TRICARE Management
20 Activity. We all have þ-
21 MS. DAILEY: Ms. Quisenberry, pages
22 8 and 9 of our Task Force report, you don't

1 need to pull it out, talk about medical care
2 case management. And in reference to
3 training, our Recommendation 8 on page 9 talks
4 about trained nurse case managers who support
5 Reserve Component Recovering Warriors in
6 applicable TRICARE benefits.
7 I think what our members saw, and
8 you'll see some findings below that
9 recommendation, I think what our members saw
10 was in the community-based Warrior Transition
11 Units where nurse case managers were having to
12 interface with the purchased care and the
13 TRICARE regional offices, and the case
14 managers for TRICARE, that their skills
15 weren't þ- there wasn't þ- there was some lack
16 of confidence in their skills to reach into
17 the purchased care, and to the TRICARE
18 regional offices and get those services to
19 them. So, that's why we put that
20 recommendation in there, was that this
21 particular area for the Reserve Component be
22 beefed up, be recognized it might be a

1 learning shortfall for your case managers.
2 MS. QUISENBERRY: Okay. And we see
3 having those managed care support contractors
4 right there so they can kind of face-to-face,
5 and be able to ask them. And, certainly, our
6 training is open to anybody and everybody. I'm
7 not going to say a multi-disciplinary team
8 member who's going to in some way touch a
9 wounded, ill, and injured member, or one of
10 the TRICARE population beneficiaries, that I'm
11 dedicated to serve each and every day, I am
12 one. So, I want this open to any and
13 everybody, so certainly we can þ- if there's
14 somebody there that maybe you could put me in
15 contact, maybe I could give them information
16 on this, or answer any questions, invite them
17 personally to the course, or whatever I can do
18 to þ- maybe they don't know about it. I don't
19 þ- I just don't know.
20 And we are regionally-based. We
21 try to use þ- the TRICARE regional
22 offices also do virtual type of training, that

1 I know they use the DCO, the Defense Connect
2 Online, where that's also additional training.
3 And they'll have those regional managed care
4 support contractors there, so I know a lot of
5 the military treatment facilities will take
6 advantage of that. So, that would be really
7 easy. There's not funding or anything
8 involved in that, and they could just jump
9 right on that. Happy to talk to them about
10 it.
11 MR. DRACH: I apologize if I missed
12 this in your presentation. Does your training
13 qualify somebody to be certified by this --
14 whatever it is?
15 MS. QUISENBERRY: No.
16 MR. DRACH: No.
17 MS. QUISENBERRY: Our training
18 drives the basic functions and requirements
19 that a case manager would need to have to be
20 able to function in their role. TRICARE
21 Management Activity is not a certifying body.
22 There is a lot that goes þ- you have to have

1 the accreditation and certification to do
2 that. However, we can certainly help those
3 individuals link to þ- there are a number of
4 agencies that require that.
5 None of the services at this time
6 require a certification. It's just highly
7 desirable at this time. Because, as we know,
8 there is a shortage of nurses, and then it
9 gets even shorter with case managers. And if
10 we make a sweeping þyou all have to be
11 qualified,þ we may lose a lot of them.
12 MR. DRACH: If somebody becomes a
13 certified case manager, whatever the title,
14 are they required to have updated CEUs to keep
15 that certification?
16 MS. QUISENBERRY: Yes. There's a
17 certified case manager sitting right next to
18 me.
19 MS. LOVELACE: Yes, you are. It's
20 usually in a five-year period you have to come
21 þ- I'm sorry. In a five-year period you have
22 to maintain certain qualifications in terms of

1 CEUs or present at conferences, or publish
2 articles. It's very, very specific. The two
3 main certifying bodies require those.
4 MS. DAILEY: Thank you.
5 MS. QUISENBERRY: Can I ask a
6 question? Is that okay?
7 CO-CHAIR CROCKETT-JONES: Ask away.
8 MS. QUISENBERRY: So, I'm always
9 looking at how to make it better. What do we
10 need to do? So, I would ask if you're looking
11 over these modules, and we have missed
12 something, you're out there. You're touching
13 people that I might not touch. You can þ- I
14 think you have all of my contact information.
15 We would so much want to make sure that we
16 incorporate this, and make it þ- we want the
17 best out there. We want the best, and that's
18 who needs to be there with these service
19 members. And they have to know that they're
20 in the hands of individuals that are going to
21 do the very, very best at every step of the
22 way. And we can't ensure that unless we have

1 the right training. So, this is great
2 training. Can we do better? I think so. So,
3 if there's anything that you know we're
4 missing, I want to know.
5 CSM DeJONG: I think to kind of add
6 on to where Ms. Dailey had started with it,
7 that there has to be more of an outreach to þ-
8 I think from a centralized office to the
9 CBWTUs, and to the remote locations, and those
10 case managers, because that's where it really
11 seems to be falling off.
12 MS. QUISENBERRY: Okay.
13 CSM DeJONG: If they don't know
14 that this is out there, they're not reaching
15 for it, and they're not being þ- from the
16 feedback that we're getting, those are the
17 most frustrating. A lot of times it's one
18 case þ- it's one or two case managers out in
19 remote location dealing with a regional
20 office, and then also doing purchased care in
21 order to do that because of the location. So,
22 they don't þ- they sometimes don't have the

1 peer support that you have in a military
2 treatment facility that you can ask. So, I
3 guess to take it one step further would be to
4 þ- for your office to start reaching out to
5 these remote locations and trying to push it
6 forward. And push your products into their
7 lap.
8 MS. QUISENBERRY: And do it
9 virtually, and web-based, because I don't how
10 they're going to get to us. So, don't just do
11 it one way, where they can't get there. Okay.
12 MG STONE: Ginnean, I will tell you
13 that all of us emerged last year from our
14 visits with the impression that the
15 extraordinary linkage that these case managers
16 provide, whether they be nurses, whether they
17 be social workers, these are the real heroes
18 bringing a disparate system together, and what
19 modules you give to train them.
20 I don't know how you train people
21 that reach out to senior service leadership
22 and say what's happening with this service

1 member is wrong, and that's exactly what we
2 got across every single visit. And one of the
3 reasons we wanted you here today was to
4 understand exactly what you're doing that
5 makes people do this in such an extraordinary
6 manner.
7 Are there some weak points?
8 Absolutely. There are some weak points in how
9 we reach out, but the one really positive
10 linkage we saw was in this type of employee.
11 And they really are the heroes that are
12 bringing this together in areas that just
13 don't work very well, or communicate well.
14 You were extraordinarily
15 politically correct in not going down the road
16 of how do the information systems talk to each
17 other, because we all recognize they don't
18 talk to each other. And what the VA systems
19 and the DoD systems, and then an
20 extraordinarily dysfunction civilian care
21 system in which we just really labor, and it
22 is the case managers that are really laboring

with that civilian delivery system to draw back in the information that allows us, and allows your case managers to manage. So, we congratulate you. I don't think þ- if anybody disagrees please speak up, but we congratulate you on what you're doing. This is one of the real highlights of this system.

MS. QUISENBERRY: Oh, good. That's good to hear.

DR. PHILLIPS: I would echo that, but since you asked for suggestions þ-

MS. QUISENBERRY: I am sincere.

DR. PHILLIPS: By the books we look at the ratios of case managers to patients, and most of the case managers that I've met with, the ratios far exceed the recommended levels.

The other significant aspect of this is the acuity. And I think we need to develop some metrics for acuity, I mean really be specific. You can even develop a mathematical formula, for example. Case

1 manager equals acuity, which may be 1-10, or
2 1-20 depending on what their injury and issues
3 are.
4 MS. QUISENBERRY: And we have that
5 a little bit in the DTM. We have the 1-5, and
6 we're looking at þ- because there's three or
7 four other metrics that we look at in here,
8 and that is something that is within there.
9 How much interaction is it taking you? What
10 are you doing for that individual?
11 And, again, we will look to the
12 leader, the Case Management Society of
13 America, and you correct me if I'm wrong, but
14 they don't even identify a number. Because I
15 know they had a big meeting, I believe, if I'm
16 not speaking out of turn for Ms. Latimer, was
17 that they even met with the Social Work
18 Society, the larger one, and it's very hard to
19 drive to that. And it just goes back to being
20 on the floor and looking at the acuity level
21 of who we're taking care of on a shift.
22 DR. PHILLIPS: That and the

1 movement of case managers from place to place.
2 If their husbands are transferred, especially
3 in the remote areas, recruiting case managers.
4 I mean, it's a real issue that þ-
5 MS. QUISENBERRY: It is difficult.
6 And I was Air Force Flight Nurse, so in
7 working with that, in working with the Air
8 Staging Facilities in what they did and how we
9 moved, not only the beneficiary itself, but
10 those family members across those lines. I
11 know we've come a long way, and we continue to
12 improve, but how do we make that better?
13 DR. PHILLIPS: I'm sorry to take
14 time, but one more quick comment or question.
15 The communication of the case managers with
16 the family members, not just simply the
17 patient, the family members seems to be an
18 issue at times.
19 MS. QUISENBERRY: Okay. How? Do
20 they give you an idea how that's an issue? Is
21 it just not enough? Is it þ-
22 DR. PHILLIPS: Many times, and

1 correct me, please, wives, or mothers, or care
2 givers would say I didn't know this was going
3 on. I didn't know that they had an
4 appointment. I didn't þ- it's not being shared
5 with me. And, of course, a lot of this is
6 confidential, but I think we need to look at
7 the broad area that the patient or the service
8 member is not always, for whatever reason,
9 going to share the issues with the care giver.
10 MS. QUISENBERRY: They could have a
11 head injury.
12 DR. PHILLIPS: Or forget. Yes, for
13 whatever the reason is, it's not communicated.
14 MS. QUISENBERRY: So, we need to þ-
15 so, that would be something in just hearing
16 that, when we're driving to a new type of
17 education, you'll see it. I would invite þ- I
18 would hope þ- invite you all, go take our new
19 course and see if we got the scenarios right,
20 because that would be a scenario that we would
21 drive in there. When you're looking at the
22 communication aspect, because we give the

1 acronym of FACCE, F-A-C-C-E, Facilitating,
2 Advocating þ- that in the communication
3 aspect, that we are identifying. So, if you
4 have a member with a head injury and they're
5 not making their appointments, and you're
6 using this tool, such as our TRICARE
7 Operations Center tool where you can see the
8 appointment templates, and they're missing all
9 these, what are you going to do? What are you
10 going to think of?
11 DR. PHILLIPS: Exactly. I think
12 your all strategic approach is terrific. It's
13 the tactical implementation of some of this.
14 MS. QUISENBERRY: So, we need to
15 get the word out more, is what I'm hearing.
16 MR. CONSTANTINE: Well, plus a case
17 manager often has meetings with the service
18 member and the wife, or husband, whoever is
19 there at the same time writing down the notes,
20 not just the service member. Because when
21 we're in the hospital, we're on a whole lot of
22 medications, and we're not thinking about that

1 concept, but the care giver is. So,
2 obviously, I would see this all withstanding
3 incorporating the family member as much as
4 possible is a no-brainer.
5 MS. QUISENBERRY: Yes. And I guess
6 it gets tricky as the one possible þ- because
7 the private health information and the þ-
8 because sometimes it's not always a positive
9 family relationship. There's all that that
10 comes into play, so that said, it still needs
11 to be considered.
12 MR. CONSTANTINE: I tell you in my
13 situation, I wasn't married to my wife then.
14 At that point we were boyfriend and
15 girlfriend, and when I was in the hospital it
16 wasn't such a big deal because I was there and
17 she was there. When I went home and I was an
18 outpatient, though, it was a real laborious
19 process for them to give her any information
20 because we weren't married, even though she
21 knew everything and was my care giver. It
22 wasn't until þ- well into the process where

1 someone said oh, why don't you fill out this
2 form and pass it to us. I mean, months later
3 when we had gone þ- and I couldn't talk very
4 well at the time. I mean, I hated using the
5 phone. That should have been something that
6 was þ- when I left the hospital, or at the
7 hospital, or left with me. And I know you're
8 not worried about individual cases here as
9 strategic, but that was something I couldn't
10 believe that wasn't part of the standard out
11 process or something like that.
12 MS. QUISENBERRY: You just gave me
13 an idea. You know one thing we need to þ-
14 maybe we can talk to þ- so, everything is
15 taped, so this is going to be like on the
16 record. Maybe we can look at our like general
17 counsel with þ- how do we get like a medical
18 power of attorney, and things like that. How
19 do our novice case managers out there know to
20 go down that road in the case for you. So,
21 maybe that's another aspect of the training.
22 Why don't we have that in there? So, we'll

1 look at that. Thank you.
2 CO-CHAIR CROCKETT-JONES: All
3 right. Thank you very much.
4 MS. QUISENBERRY: Okay.
5 CO-CHAIR CROCKETT-JONES: We need
6 four minutes.
7 (Whereupon, the above-entitled
8 matter went off the record at 1:57 p.m. and
9 resumed at 2:09 p.m.)
10 CO-CHAIR CROCKETT-JONES: Okay. As
11 long as we're all ready, we're now going to
12 hear from þ- we're ready to hear from Colonel
13 Christian Macedonia, the Medical Sciences
14 Advisor to the Chairman of the Joints Chiefs
15 of Staff, General Dempsey. His information
16 can be found at Tab M for our members.
17 Welcome.
18 COL. MACEDONIA: Well, thank you
19 very much, and it's a great honor to be here.
20 I intentionally had the slide presentation be
21 very short, because it's probably more
22 important to have interactive Q&A, let you

1 guys get as deep as you want to into Gray
2 Team. Can you go to the next slide?
3 Of course, I get asked this a lot
4 of times because we don't do þ- Gray Team
5 doesn't do a lot of advertising about who we
6 are. We consider ourselves a tool really of
7 decision makers, so our job is to not really
8 be out there beating the drum or tooting the
9 horn. It's really about serving our combat
10 wounded, and also serving the senior
11 leadership that we work for.
12 So, within the context of þ- I'm
13 going to go through these slides, and then
14 please interrupt me at any time if you have
15 questions, and then we can go into a deeper
16 question and answer after at the end of the
17 slides. But I'm going to get into what
18 exactly is Gray Team, what our methodology is,
19 and kind of in distinction/contradistinction
20 to some other ways that you might gather
21 information. And then who does the team
22 actually report to, or who does it work for,

1 and then what have been the findings.
2 And I should say that Gray Team is
3 a creation first under Admiral Mullen. And,
4 of course, it serves a larger group of senior
5 leaders. It evolved into that later on. And
6 to some degree I'll get a little bit into the
7 relationship I had in the very beginning with
8 Admiral Mullen as we created Gray Team. Next
9 slide.
10 So, various times we told people
11 well, you know, it's Gray Team because
12 everybody on the team has gray hair. We've
13 told people that it has to do with gray
14 matters, traumatic brain injury, post
15 traumatic stress, and because red, white, and
16 blue were already taken. But the truth of the
17 matter is þ- next slide.
18 The gray part of Gray Team is
19 really about the fact that yes, we're taking
20 on matters involving traumatic brain injury,
21 post traumatic stress. We haven't limited
22 ourselves to that. We've gone into issues like

1 pain relief and other things. But it's really
2 about entering into very unbounded gray
3 matters, meaning sometimes þ- we in the
4 military, of course, like things to be very
5 cut and dried, left and right, very þ- black
6 and white. I mean, that's the way we like
7 things. The reality that gets handed to us
8 quite frequently is that we're handed very
9 squishy, gray topics that are not easily
10 bounded, and they're very vexing to the senior
11 leaders. And, of course þ- and this is an age
12 old military problem, not just a medical
13 problem.
14 But just to read my own slide,
15 "Gray Team is a tool. It's exercised by the
16 Chairman of the Joint Chiefs of Staff to
17 investigate, report, recommend courses of
18 action on areas of interest where the problem
19 set is uncertain or poorly bounded." And I
20 want to make this very clear.
21 There's nothing that we do in Gray
22 Team þ- and, in fact, many of the things that

1 Gray Team reports out are not original ideas
2 from the Gray Team. In fact, by and large
3 what gets reported out from Gray Team are the
4 great ideas of non-commissioned officers,
5 soldiers, Marines, mid-grade officers, senior
6 officers. In other words, we're very
7 derivative in what we report out. We
8 basically take the best ideas from people.
9 We have experts who kind of vet
10 those ideas, but what bubbles to the surface
11 are not our ideas, they're the ideas of the
12 people who are closest to the problem. But I
13 do want to say that we borrow from þ- next
14 slide þ- very heavily from Colonel John Boyd.
15 Now, now many people in the room
16 have ever heard of John Boyd? So, I only see
17 one hand go up in the room, but þ- yes, so
18 John Boyd is one of these guys who kind of
19 died in anonymity but his þ- now with the
20 book, his biography out and some of the
21 things, I mean, he's getting the rightful
22 respect from history.

He was a father of the F-16. He was an Air Force theorist, fighter pilot, and he came up with this term that people þ- it used to irritate him when he'd hear people say OODA, but it's become commonly the OODA loop, Observe, Orient, Decide, Act. He originally came up with the concept to talk about air-to-air combat and dogfighting, but he cautioned people that OODA, Observe, Orient, Decide, Act could be used in all sorts of decision making where you go into very rapidly changing complex environments, and you have to make decisions.

And on my first day, or my first interview with the Chairman it started out the most contentious job interview þ- Admiral Mullen, the previous Chairman. Very contentious job interview. He sat me down. He was very polite going in the door, but then he sat me down and he said, "Who are you, and what are you doing in my office?" And he was not joking. He was þ- later on he told me he

1 just was having a bad day. But, anyway þ- but
2 one of the things that I showed him was þ- by
3 the way, this graphic that you see on the
4 board was from a PowerPoint presentation that
5 Boyd did back in the early '90s describing the
6 OODA loop. And I described it to him, and I
7 said, "Sir" þ- and this was interviewing to be
8 his Medical Sciences Advisor at the time to
9 work on Wounded Warrior issues. And I said,
10 "Your problem is, is that you don't have
11 anybody right now who is immersing themselves
12 in the issues, and then immediately coming
13 back to you so that you can make decisions,
14 and make actions, and have it as a continuous
15 quality improvement cycle loop."
16 The problem is that we were so
17 slow and iterative, particularly on the Joint
18 Staff and the way we went about things, very
19 bureaucratic, that we needed some type of
20 process where somebody was going into the
21 scrum, bringing information back and giving it
22 to him in realtime so he could then go out and

make actions, whether it's addressing Congress, or talking to the Sec Def, or the President, or whatever actions the bully pulpit of the Chairman can bring. So, that's essentially where it started.

Now, I want to make some observations about the OODA loop, and how it relates to Gray Team. So, we make no bones about this. We are not in the decide or the act part of the equation. That is not Gray Team's role. The people who þ- you know, in the old Army days we used to call them green tabbers, but in the Navy it's who wears the service stars, but it's whoever has the responsibility to make decisions and actions. That's who does that. But they can't do it unless they're able to observe and orient.

And the problem is this þ- and if you look at that sort of pentagram down there that Boyd wrote with culture, traditions, and genetic heritage, where in the day did Admiral Mullen have the ability to go to medical

school, learn about traumatic brain injury, learn about axonal injury, learn about blast kinetics? He doesn't.

It was really incumbent upon somebody that he had to hire to be able to assemble that kind of heritage, that kind of skill set to be able to do the first two parts of the OODA loop. And we talked extensively about it. And lo and behold, it turned out that Admiral Mullen, who is a Systems Engineer by training, was a huge fan of the OODA loop. He sort of helped seal the deal. At the very end of my talk I'll tell you actually what sealed the deal in my job interview with Admiral Mullen. If we could go to the next slide.

So, I want to explain how, for instance, we've done four Gray Teams, but I'll talk about how the first and the second Gray Team had an effect on the traumatic brain injury dynamic. And I say an effect on it, we haven't þ- I'm here to declare victory on how

1 we deal with traumatic brain injury, but I am
2 here to say that I think we did change the
3 dynamic, and I'll explain how.
4 So, Gray Team 1 went into theater
5 in January 2009, and it's funny, you would get
6 the presentations on, for instance, what we're
7 doing in theater with traumatic brain injury.
8 And we'd get these slides that say greater
9 than 90 percent compliance with the MACE. And
10 this is what we're doing, and they would have
11 these beautiful diagrams about the flow of
12 patients, and how they're examined, and so
13 forth. So, what did was we assembled a team,
14 and a very important tenet of the assembly of
15 the Gray Teams. One is that everybody who
16 goes on the team has to be a previous combat
17 deployer. So, if they haven't had a previous
18 combat deployment, if they haven't lived the
19 life, then we don't bring them along, largely
20 because we're not around to try to explain at
21 every stop what RSOI is, or whatever. It's þ-
22 the work is too important, and we don't get

too much time on the ground. We have to have people that are previous combat deployers, with the exception of our civilian experts who we have incorporated into a couple of teams.

The second is, we try to bring in stakeholders. So, we try to bring in the people who actually are eventually going to be given the homework assignments that come out of the Gray Team. So, for instance, in Gray Team 1, we had the head of the Defense in Veterans Brain Injury Center at the time was Mike Jaffe, to come along with us.

Now, it was hilarious in Gray Team 1 to go out in the field and to walk up to a medical corpsman and say okay, tell us how you do MACE exams. And then we would put our hand on Mike's shoulder, Mike Jaffe's shoulder and say don't say a word, just let the guy talk, because he would want to go þ- Mike, just be quiet. And the medic or the corpsman would dutifully say, "Sir, I'd tell you how I do it if I knew what a MACE exam was."

1 And very clearly in this initial
2 deep dive we found that a lot of this
3 reporting that was coming out of theater was
4 being pencil whipped. Now, when we tried to
5 go to the next layer and say well, why is it
6 that people are sort of reporting that they're
7 doing MACE exams, reporting that they're
8 working on traumatic brain injury, but not.
9 And we had a lot of non-attributional
10 discussions with people, and they would say
11 things like well, there's þ- everyone knows
12 there's really nothing you can do about
13 traumatic brain injury. It's just a
14 concussion. When I was in high school and I
15 got knocked out, we just shook it off. Why
16 don't these people just toughen up?
17 And you would get things like
18 that, so there were a lot of myths being
19 perpetuated, and not a lot of training. So,
20 out of that came a list of recommendations we
21 call the Chairman's 13, and I'll get þ- I'll
22 show you that in a second.

1 But the other thing that came out
2 of that initial foray in the theater was the
3 Chairman was so energized by the things that
4 we found, was he said, "I want on my desk
5 tomorrow a memo to the Sec Def on this topic.
6 I want to jump on this."
7 And he þ- obviously, sort of the
8 rest is history. We maintained the momentum.
9 Gray Team 2 we did the Directive Type
10 Memorandum 09-033 that's currently in
11 force. That came as a result of these deep
12 dives, coming back, briefing senior leadership
13 at all levels, usually at the Vice Chief level
14 along with the Chairman. But we don't
15 consider any Gray Team completely closed. The
16 loop is always open, and every time we go back
17 into theater, in many cases we'll readdress
18 some of the same issues that we did before,
19 largely because we want to calibrate how well
20 we did with the last stuff, plus we realize
21 that the þ- even the theaters of operation are
22 evolving. Remarkable how different not only

1 Iraq and Afghanistan were, and have been, but
2 remarkably different how RC East is from RC
3 South, from RC Southwest, for anybody who has
4 ever been into Afghanistan.
5 So, if you know something from
6 six, eight months ago, to some degree that
7 information is old. You have to update it, and
8 you have to continuously do that. You have to
9 be like a fighter pilot and continuously
10 update your site pictures, and know where you
11 are. Next slide.
12 So, this was part of the original
13 recommendations back in early 2009. And
14 handed to each of the Vice Chiefs, this was
15 delivered to the Secretary of Defense. I
16 might add, it was hand carried by the Chairman
17 to the Secretary of Defense, and the only
18 reason it was hand carried by the Chairman to
19 the Secretary of Defense is because someone
20 within OSD decided that it was information
21 that the Secretary shouldn't see. And when the
22 Chairman found out about that, he literally

1 had me go and find the original copy, bring it
2 to him and he walked it into the Secretary's
3 office.
4 So, let me go through. These are
5 the original 13 recommendations that came out.
6 This was dating back in January of 2009.
7 Improve guidance for duty limiting profiles
8 and return to duty recommendations. Well,
9 that became þ- that, ultimately, became DTM
10 09-033.
11 Improve training for all health
12 care providers on ID-related injuries, focus
13 specifically on evaluation and management of
14 TBI as described in the current clinical
15 practice guidelines. DVBIC has done legion
16 work along with the AMEDD Center and School,
17 and others to update combat med training, and
18 also training for providers.
19 I would still say that it's
20 spotty. And let me give you a couple of
21 examples where I think that we're lacking. I
22 would say that training for medical forces, in

1 general, is really wanting within the National
2 Guard and the Reserve. And that's not to
3 blame those guys. It's shame on active
4 component, shame on the training base, shame
5 on like TRADOC and others for not
6 incorporating that training in the train up of
7 the National Guard and the Reserves.
8 So, as þ- what you find is the
9 Guard and Reserves are very spotty in terms of
10 their þ- some you'll find they have
11 outstanding TBI training, and so on, but it's
12 usually because they were docs in the
13 Cleveland Clinic, and that's what they do for
14 a living, or whatever. So, you find that in
15 the Guard and Reserves. You find these really
16 spectacular people that are þ- their game is
17 way above the active component because that's
18 their specialty that you draw from. And then
19 you'll find others who were at Camp McCoy
20 doing their train up, and they got zero
21 training. So, that's an area that continues
22 to need work.

1 Now, provide focused education for
2 providers who care for individuals with high
3 exposure specialties and ratings, EOD, route
4 clearance, units, MPs, combat engineers.
5 On our most recent foray into
6 theater, which was just a couple of weeks ago,
7 one of the things that was really shocking to
8 me was þ- and this is really a bogey against
9 the Joint Staff, was that Task Force Paladin,
10 which does the route clearance, supervises
11 1,500 individuals in the IED Task Force, they
12 had put in a special request for medical
13 personnel to manage their database internally,
14 and also to assist in specialty evaluations
15 for the guys that are getting blown up far
16 more frequently than say the food handlers, or
17 whatever on Bagram. And for whatever reason,
18 that request had gotten turned down. I'm
19 still tracking that bogey down, but that's
20 shame on us back here in D.C. for not sourcing
21 that appropriately.
22 What we're advocating in the Gray

1 Team 4 report, and by the way, that's not on
2 the street yet, so I can't give you a copy.
3 It's still in edit, and it has to be vetted
4 through JSAP. But one of the things that's
5 going to be recommended within there is that
6 we actually create a specialty in medicine
7 called a SAPPERDOC, or we're calling a
8 SAPPERDOC. So, the equivalent to a flight
9 surgeon, but for combat engineer, route
10 clearance units. And these people would be
11 specially trained on IED-related injuries and
12 illnesses, with TBI being a large component.
13 But also the post traumatic stress related to
14 þ- I mean, it's not just about TBI.
15 Accelerate the fielding of
16 personnel and vehicle mounted blast sensors,
17 what we're calling blast dosimeters. I can
18 tell you now that we're in the initial phases
19 of a fielding of the DARPA blast dosimeter.
20 It's gotten rave reviews from the units that
21 are using it down range. It's being used by
22 Special Operations, and it's being used by 2/4

1 Infantry in a fielding that's being sponsored
2 by General Corelli.
3 Ensure that robust electronic
4 medical records from Role I facilities to the
5 VA are easy to use, enhance sufficiency, are
6 well supported with the requisite bandwidth.
7 And I wish I had a magic wand to make that
8 happen.
9 I will tell you this. This is not
10 a hopeless discussion. I can tell you that
11 when we were in Afghanistan in early 2009, the
12 penetration of electronic medical records down
13 to Role I was abysmal in the Marine
14 territories, was almost non-existent. And in
15 the Army areas it was really spotty.
16 I can tell you that our most
17 recent visit, the Marines have gone from
18 having 27 percent of their Role I facilities
19 with IT capability at Role I with electronic
20 medical records, TMIP, all the way up now to
21 100 percent in RC Southwest. We just got
22 briefed on that, and that really took þ- that

1 was yeoman work. They had to, obviously, not
2 only order the equipment, but do in theater
3 training, and the personnel was not easy, but
4 it just goes to show you that when you have
5 the ACMAC say we're going to do this, I mean,
6 it will happen.
7 And I guess it points out one
8 thing that's important to talk about with Gray
9 Team. Yes, we bring a lot of medical
10 specialists, but the actions by and large tend
11 to take place not through medical channels.
12 Not that they can't, but because there's a
13 partnership between medical and line. And
14 it's really þ- a lot of these things have þ-
15 medical would like to do them, but they don't
16 þ- they can't do it without their line
17 brothers and sisters shoulder-to-shoulder with
18 them.
19 Field joint tracking applications
20 to allow documentation. At that time, we
21 didn't give it a name. I can tell you that it
22 does have a name now. It's called the CIDNE

1 BECIR report, or BECI report some people call
2 it. B-E-C-I-R. And that's where whenever
3 there is a blast to a vehicle or dismounted
4 group, by battle roster number those names are
5 loaded into a database that is connected to
6 the combat database, CIDNE, and that way that
7 there is a way to verify that this person was
8 exposed to a particular blast event at a
9 particular period of time.
10 One the blast dosimeters are fully
11 integrated into the force, we're going to be
12 able to incorporate that data into the report.
13 It will provide really an unprecedented level
14 þ- top level look at the impact of blast
15 injury, not just on TBI, but other kinds of
16 injuries.
17 Establish a comprehensive brain
18 database. Now, the great news story just
19 about two months ago, the MRMC and NIH through
20 NINDS inked a deal to create a comprehensive
21 brain injury database using common data
22 elements. This is a great story about

1 interagency cooperation.
2 Establish consultative networks, a
3 full-time neurologist. We have that. We have
4 a theater neurologist now full-time whose job
5 is to manage the neurological assets in
6 theater, provide phone back up to PAs and
7 primary care docs. That's been done.
8 Develop a suite of diagnostic
9 tools to support evacuation RTD
10 determinations. I can tell you that the MRI
11 systems landed today in Afghanistan, two of
12 the three. And I can tell you that there are
13 a whole host of diagnostic tools that are
14 flooding into theater right now, including
15 NeuroCon balance equipment and other kinds of
16 things.
17 So, I will say that right now one
18 of the most important pieces of objective
19 measures of return to duty is the use of the
20 ANAM. Credit goes to Steve Stucey, who set up
21 the þ- I'm going to mess this up. It's now
22 called the CCC, but the Camp Leatherneck

1 Center. He started to use ANAM as a return to
2 duty criteria, improvement in ANAM, and that's
3 been þ- now been adopted in RC East by the
4 Army, and the proliferation of that is really
5 outstanding.
6 I think the fact that þ- there are
7 a lot of opinions about ANAM, and I don't
8 think there's a single perfect neuro cognitive
9 assessment tool out there. But the fact of
10 the matter is, we put þ- we made people take
11 these examinations. We invested heavily in
12 it, and for us not to use a validated tool in
13 our quest to safely return people to duty was
14 mind boggling. But the fact is that they
15 broke the code, and it's now being used, and
16 it's a great victory. Again, not a Gray Team
17 victory. This is a victory for the great
18 people like Commander Stuckey, who made it
19 happen.
20 Provide readily available
21 neurosurgical support to all regions of
22 theater. This may seem laughable now, but at

1 the time, there was talk about having only one
2 neurosurgeon in Afghanistan, because they said
3 the work load didn't require any more.
4 Increase þ- and I should say that there is --
5 not plentiful, but there is adequate
6 neurosurgical support in theater.
7 Increase the availability of
8 mental health professionals and counselors
9 embedded into the deployed force. We're only
10 halfway there. Now, at the time that comment
11 was written, we had less than half of the
12 mental health providers we have today.
13 Actually, we have per capita, we had per
14 capita less than half, so we had probably a
15 quarter of what we have today.
16 And the reason why this was very
17 important is that despite the fact that we
18 have scientists who want us to clearly
19 delineate traumatic brain injury from post
20 traumatic stress, and that they're two
21 separate things. Got it. One is caused from
22 an injury to axons, one is caused from

1 emotional impact of something. But you cannot
2 pull the two completely apart.
3 Anybody who has traumatic brain
4 injury is probably going to have to undergo
5 some period of counseling, if for no other
6 reason, because they might have nightmares, or
7 sleeplessness, or anxiety that's related to
8 the TBI and have to undergo a period of
9 counseling.
10 Well, you can't have that happen
11 if you don't have the assets on the ground to
12 provide that support. And then in addition to
13 that, it was just þ- Gray Team doesn't limit
14 itself entirely to one topic. So, when we
15 came back we briefed General Corelli on this.
16 He had immediate meetings with OTSG and they
17 ramped up þ- and I should say, it wasn't just
18 the ramp up of the þ- of prescribing
19 psychologists and psychiatrists. I think one
20 of the great success stories I'll get into in
21 a second is this issue of using, for instance,
22 occupational therapists in traumatic brain

1 injury, because they do have training in
2 psychological counseling, and they're able to
3 perform some type of triage. And I think
4 Colonel Amaker gets a lot of credit for the
5 establishment of þ- I was not a big fan of the
6 OT Center TBI programs in RC East when they
7 originally rolled out, but they've done a
8 fabulous job of setting up these centers,
9 regional centers at Role II, and it just
10 points out that you don't necessarily need to
11 have a psychiatrist or psychologist providing
12 embedded care. It could be, for instance, a 68
13 X-ray, a mental health tech.
14 But I should mention that
15 embedding þ- everybody believes, and our most
16 recent experience in theater bears this out,
17 that units that have embedded mental health
18 had much better relationship with their mental
19 health providers. People, by and large, from
20 the senior leader all the way down to the
21 soldier recruit have the impression that that
22 reduces mental health stigma, and we should be

1 doing more embedded behavioral health
2 counseling.
3 The use of third location
4 decompression. There are units that use third
5 location decompression right now. We don't
6 have a lot of science to back that up. That's
7 why we said examine. But I can tell you that
8 there's now þ- there was interest þ-there was
9 a whole team that went to Cyprus and looked at
10 how the Brits and the Canadians do third
11 location decompression. We do have places in
12 Germany and in Rota, Spain where some units
13 take their people. We also have third
14 location decompression programs in CONUS, so
15 for those who don't know what that means, that
16 means take the unit to some place other than
17 immediately back to their home to give people
18 a kind of intermediate stage of the ability to
19 mentally decompress before they return back to
20 their families. And it's based on theories
21 where people talked about the use of troop
22 ships in World War II, allowed people to talk

1 and decompress in the two-week journey back
2 home.
3 I can tell you that there's
4 renewed interest in that. I talked to General
5 Robb, who's the Joint Staff Surgeon, and
6 they're going to be reexamining that issue.
7 And then coordinate the position
8 in Role II trauma, and evacuation assets based
9 on the frequency and lethality of enemy
10 contact. That really had to do with the fact
11 that in the more severe cases of traumatic
12 brain injury, that there were huge gaps, and
13 it was really the lottery of luck and location
14 when you got injured as to what kind of care
15 you were going to get, largely because
16 commanders would grip and hold on to their
17 trauma assets very vigorously, even though
18 they were not in the kinetic fight. And,
19 meanwhile, their partner who's in the next
20 region over or whatever is getting hammered,
21 and they're left without any of these trauma
22 assets. And it was very frustrating. And I'm

1 not saying the problem is solved completely,
2 but by having a medical group in theater that
3 does a lot of the force management and having
4 more autonomy amongst the medical leadership
5 to make those decisions and a better
6 partnership of line, that that problem is a
7 lot less than it was back in 2009. Next
8 slide.
9 So, I want to talk a little bit
10 about this slide, and it's not meant to be
11 cute. It's really meant to þ- so, this very
12 contentious job interview I had with Admiral
13 Mullen, it lasted about 30 minutes. It felt
14 like 10 hours, but anyway sort of was winding
15 down. And, clearly, he was þ- he told me from
16 the beginning that he was not hiring a Medical
17 Science Advisor. It was not going to happen,
18 not on his watch. And I told him up front I
19 wasn't there to convince him he needed to have
20 one, but he needed to consider why he didn't
21 have one, is the way I approached it.
22 But toward the end he was like

now, you realize you come work for me, this is a pretty rough place. The Joint Staff is not an easy place to work in. I mean, you're going to have to go toe-to-toe with general officers and flags, and it's a rough place to work, let me tell you, son. And I said well þ- so he's like, you know, so you understand, you're going to be working directly for me.

And I said, "Sir, not to blow my chances of being hired by you, but I'm going to disagree with you right off the bat. My job is not to work for you, it's to work for our wounded." And he said, "Okay, Colonel, we're done." And he said, "Take a step out in the hallway."

So, I went out in the hall, and a few minutes later people came out and they said, you know, "You have the job." And I knew it immediately just based on the look on his face. And I didn't say it to be cute. I really was at a point þ- this may sound weird but I was at a point where I had become so

1 disillusioned with the way we were taking care
2 of our wounded, not just our wounded, the way
3 we were taking care of our veterans in
4 general, that I was so upset with the guy
5 sitting in front of me as I was going in that
6 if he didn't have the time of day for me,
7 that's fine. I don't really care. I don't want
8 to work with somebody who's kind of doing this
9 for political reasons, political reasons only.
10 So, when we had that conversation
11 that was kind of a test. Like if you can't
12 take that, if you can't take the fact that I'm
13 going to go in and I'm going to come back, and
14 I'm going to tell you things that make you
15 feel uncomfortable. And if you don't like
16 that, then I don't want to work for you. And
17 I have to say, we had a tremendous
18 relationship because of that. And he's a
19 tremendous person. I can say that, and it's
20 not boot licking because he's gone. But,
21 anyway, this really was the relationship.
22 And I can tell you that the

1 beautiful thing that I found after getting
2 through the green door and working for Admiral
3 Mullen is, I found that that attitude that he
4 had about no, that's okay with me. You go out,
5 you be aggressive about taking care of our
6 wounded, I found in many other corners in the
7 Pentagon, not everywhere, but in many other
8 corners you had people who their attitude was
9 whatever it takes, whatever it takes, whatever
10 I can do. So, it's been very satisfying doing
11 these teams, because every time we've asked
12 for members of the team, my biggest challenge
13 as the team leader is to stanch the enthusiasm
14 to throw more and more people on the team. To
15 say, "Sir, I got it, I've got þ- give me your
16 best guy. I know you've got best five. Just
17 give me one." I mean, it's like that, and I'm
18 talking about all the services in the way
19 they've come forward with the teams.
20 So, I apologize for being so
21 loquacious and for running on about this.
22 But, anyway, I'd like to open it up for

1 anybody to ask questions.

2 MG STONE: Colonel, can you talk a

3 little bit about the follow-on Gray Teams and

4 the primary focus of those? You talked about

5 the original.

6 COL. MACEDONIA: So, the first

7 three Gray Teams were about 70 percent TBI, 30

8 percent post traumatic stress in each of the

9 teams, the composition, and the reports. The

10 reason þ- and we have very deliberate reason

11 of doing that. And it wasn't the fact that TBI

12 was the more important of the two main

13 invisible wounds of war. It had to do with the

14 fact that quite honestly we needed to have

15 forward momentum and forward progress on one

16 of those two issues. And we felt that TBI was

17 a more bounded problem. In other words, it

18 was less unbounded, if you will. We had more

19 of a chance of actually pulling the decision

20 loop and getting some concrete momentum moving

21 on that topic than we did on combat and

22 operational stress. And that wasn't just

1 Chris Macedonia's opinion, that was the
2 Chairman's opinion, that was the opinion of a
3 lot of senior medical leadership, was that of
4 the two issues, the one that had more
5 likelihood to actually get some positive
6 momentum and change, and to actually ratchet
7 down the nuts and get it actually a solid
8 product was that.
9 And it was a challenge, so Gray
10 Team 1 went out. We had þ- essentially, we
11 found, I don't want to say no system of care,
12 but there was really no system. There was a
13 lot of caring, and there was a lot of system
14 of trauma care, so a system that did an
15 excellent job of getting somebody who had a
16 bullet wound to the leg, or a penetrating
17 wound to the head, but for more minor
18 injuries, if you will, we didn't have an
19 organized system of triage.
20 And that was apparent to everybody
21 who came on the trip, including the DVBIC
22 Director, who came back a changed man, and

1 immediately went back to his troops within
2 DVBIC to revamp the guidelines and really
3 change the dynamic.
4 When we went back in Gray Team 2,
5 what we were pleasantly surprised by was that
6 within the six months of being there for Gray
7 Team 1, without a lot of these changes from
8 D.C. causing momentum changes in theater, a
9 lot of the places that we had visited, just by
10 the mere fact that we had visited and some
11 clinicians and some people got interested in
12 the topic, they themselves started to generate
13 new centers. And probably the hero of Gray
14 Team 2 was a young major who now works at the
15 NICoE, the National Center for the Intrepid by
16 the name of Jen Bell worked þ- was a surgeon
17 in Tenth Mountain, who established really the
18 first organized concussion care center in
19 Afghanistan based on principles that we're
20 using today. It, essentially þ- her practice
21 þ- she's an internist. She uses a sports
22 medicine model to deal with mild traumatic

1 brain injury. Not only is a model for us now
2 in theater, but I can tell you that recently
3 General Corelli brought several senior
4 scientists, civilian senior scientists, I
5 brought several scientists in Gray Team 3. I
6 can tell you that that Jen Bell model, if you
7 will, is now being embraced and being looked
8 at by the civilian community to start
9 concussion care in the civilian community. I
10 mean, it was that good.
11 Gray Team 3 was a real change
12 because we brought civilian scientists with us
13 and it was not easy. It's one thing to bring
14 CAC card carrying DoD civilian scientists.
15 That's one thing. But bringing people from
16 academia, never been on a military base in
17 their lives, let alone anything else, is not
18 easy. But it was well worth it, and for a
19 variety of reasons, not the least of which was
20 because we also, while that was going on, were
21 having to have discussions in theater with
22 people about MRI, and the fielding of MRI.

1 And I had with me Dave Brody, who is a
2 professor at Washington University in St.
3 Louis, and wrote the article, the New England
4 Journal of Medicine article on the use of MRI
5 for mild traumatic brain injury out of
6 Landstuhl, along with Christy McDonald. So,
7 that was the different flavor.
8 So, when we went and briefed in
9 March to the SGs, and several others were
10 assembled. We had Paul Hammer from DCoE, the
11 Chairman congratulated the SGs on fantastic
12 work in moving the ball forward on mild
13 traumatic brain injury. And then before
14 getting up from the table, and I can tell you
15 totally unscripted because he and I talked
16 probably for 45 minutes before he went in the
17 room, and he kind of blindsided me with a
18 comment. At the end he goes, "Guys, I wish we
19 were somewhere close on the issue of post
20 traumatic stress as we've gotten with
21 traumatic brain injury." And he goes, "It's
22 really a shame because" þ- he waxed about þ-

his big thing is he wants to eliminate stigma for mental health disorders. And he said, "I just see us as being years behind."

So, I pulled him aside afterwards and I said, "Sir, are you serious about that? Was that just sort of you þ- was that a rhetorical question to the group?" Because they all nodded in agreement. He said, "No, I really want to do something like that." And I said, "Well, we can do something about that but you've got to come to a decision about that." And that's how Gray Team 4 came about. So he contacted General Mattis and talked to him first, and one of the reasons why is because I said, "With each one of the Gray Teams, we've had more and more cooperation with CENTCOM. We need to eliminate this idea that this is somehow a team from D.C. that's doing this stuff. This is really about bringing all the stakeholders to the table, including bringing the docs from the medical group, from theater to come along with us and

be part of the Gray Team, and they are part þ- so when we go into theater and we bring the senior docs from the command groups, they're part of the team. And they write parts of the report. They're not an extension."

So, as you know, General Mattis has been tremendously supportive, sent Colonel Edgar, who is his Command Surgeon to be part of Gray Team 4, and I'm really excited about what this report is going to do.

But the other key thing about this Gray Team 4, even without the report was the fact that we brought along senior leaders from the NICoE and the DCoE. And I'm sure that you guys have discussed to some degree that everyone is kind of wondering well, how do these two organizations fit with each other? Is one supposed to be on top of the other, are they conjoined twins, is one supposed to go away?

It was a beautiful symbiosis of the two groups. They got exactly þ- each got

exactly what they needed to do and go back and talk to their people. And I think that NICoE and DCoE can pull on the same rope together without having one tromp on the other. It's actually þ- it's a great relationship.

And I think Paul Hammer probably wrote a third of the entire Gray Team 4 report, who head of the DCoE. He did a fabulous job in his edits, so I think that when the report comes out, when you see a lot of the stuff on alterations in the way we deal with psychological health in theater, the guy who should get credited is Paul Hammer.

I just carry the luggage. I just make sure people have country clearance, and get in and out of the country okay.

MG STONE: So, let me ask you to go down a road that you're going to think I'm crazy when I start talking about this. What you've done is taking emerging bodies of knowledge regarding disease processes that are just very poorly understood, and you've gone

1 out to the forward edge and recognized the
2 fact that doctrine is being developed well
3 forward, well outside the organized system.
4 One of the frustrations that we
5 have in these sorts of disease processes is
6 that medical knowledge moves so
7 extraordinarily slowly. We publish articles.
8 We heard this yesterday. We publish articles,
9 we expect people to read them, we expect
10 consensus to be developed, and then a period
11 of seven to ten years goes by.
12 How should we develop doctrine for
13 the handling of emerging medical processes
14 like TBI and PTSD in this kind of model? Now,
15 let me add one other piece. The new Chairman
16 of the Joint Chiefs, when he was head of
17 TRADOC, talked about wiki-based doctrine
18 development. Where do we go with that?
19 COL. MACEDONIA: Well, I think the
20 first thing we do is we þ- it's kind of like
21 a 12-step program. We recognize that we have
22 a problem. We admit to the fact that we have

this problem that there's nothing wrong with DOTMLPF, there's nothing wrong with having doctrine. I think if were to dig up General Depew, who was the first commander of TRADOC, and a dear family friend of ours, the Macedonia family, and had Bill Depew sit here, he would probably be as frustrated as everybody else with how slowly doctrine gets developed in the age of supercomputers, supercomputers in your pocket, when you look at the speed of an iPhone or whatever.

I think that our þ- I do, and I may be biased, I do see a value in a teams approach rather than one that þ- I think our problem is that we're so serial and iterative in the way we do things. I look at the Joint Staff, for instance, and if you look at the JSAP process, it is very iterative. It takes a document that everybody thinks should be done and signed, a totally non-controversial document maybe on the refueling of drones, that there's no disagreement among the

1 services, and it will take months and months
2 to get something done that there's no
3 disagreement on.
4 You add any bit of
5 contentiousness, and virtually every medical
6 topic has some contention, and it takes a very
7 long time to do. I think if you're going to
8 close those loops, you actually have to have
9 a teams process built somewhere into that.
10 I've been asked þ- I actually work
11 very closely with the J-7, the Doctrines
12 Division, and the Joint Staff, and we had
13 these discussions, but we've not gotten beyond
14 the discussion stage. But if anybody here in
15 a position of þ- particularly key stakeholders
16 here in this room, I'm more than happy to work
17 with them on that. But I think that that's
18 one. And the second is that we cannot divorce
19 ourselves from the power that social networks
20 and other kinds of things have.
21 I have to tell you that all of
22 those innovations I talked about that emerged

1 from theater emerged because there was a dense
2 social network of people. And I'm talking
3 everybody from specialists and lance
4 corporals, through the physicians, all the way
5 up to the leaders. And we have to do a better
6 job of leveraging that.
7 MG STONE: Chris, thank you so much
8 for a thought provoking presentation. We
9 appreciate it. We are a few minutes ahead of
10 time. We'll take five minutes before the next
11 presentation.
12 (Whereupon, the above-entitled
13 matter went off the record at 2:52 p.m. and
14 resumed at 3:16 p.m.)
15 MS. DAILEY: Okay, members, let's
16 take a seat. I'm going to talk a little bit
17 about our upcoming installation visits. And
18 can I also get you to go to Tab H. In Tab H,
19 we have the same file you see up on the
20 screen, color coded, so that's Tab H. Yes,
21 there you are. That's where I want you to be.
22 Right there. Yes.

1 So, what we loaded in there for
2 you was our current matrix of participation in
3 the upcoming installation visits. Justin
4 asked for a copy, and I said well, we'll just
5 make one for everybody. And we'll use this as
6 a little bit of a tool to identify who's going
7 where. Can I use that pointer? Hey, it
8 works. All right.
9 So, Ms. Crockett-Jones pointed out
10 to me, we do want to seek some balance on
11 these installation visits, and I've got Fort
12 Knox coming up, and Fort Carson. Fort Knox on
13 the 1st and 2nd, and Fort Carson on the 8th and
14 9th of November, for which we don't have any
15 military representation. So, I just want to
16 heighten your awareness to that. If you want
17 to volunteer, I'll put you on there right now,
18 but I will seek out my other military members
19 to participate in these two events. Right now
20 I have three of my civilian or non-DoD members
21 going, Mr. Constantine. Justin, if that's
22 still on your calendar, Fort Knox for the 1st

1 and 2nd, Dr. Phillips and Ms. Crockett-Jones.
2 And then for Fort Carson I've got Mr. Rehbein,
3 Dr. Phillips and Mr. Drach going out to Fort
4 Carson.
5 So, I just want to keep those
6 items on your radar for my civilian members
7 who volunteered, and then I am seeking a
8 military member to attend these installation
9 visits also.
10 Yes, going farther into the next
11 year, Camp Lejeune's visit is also unattended.
12 Steven, can I get you to go to that next
13 slide. There it is. Yes, Camp Lejeune, I
14 have no military members attending that.
15 Military is identified by the green. I meant
16 to put purple, and somehow or another green
17 popped up. And the tan indicates my civilian
18 members. So, keep that in mind. I'll be
19 sending out an email to my military members
20 for participation in those three military
21 installation visits.
22 Any questions? And then just let

me heighten, we do have our next business meeting, is going to be in San Antonio. The business meeting is in San Antonio. We have an installation visit two days before, so move me back, would you please, Steven, so I don't screw these dates up. There they are, right there. San Antonio will be at the Air Force, Air Force Personnel Command on the 6th and 7th. We're spending all day there both days, and then we will then immediately the next day roll into a business meeting. Same format as this business meeting, two days of business meeting briefings.

And, Steven, can I get you to go to business meetings, and go to the San Antonio business meeting. I have an agenda which is þ- this is an excellent opportunity to talk to you about the agenda that I'm proposing, it's all proposal for San Antonio. There we go.

All right. We'll do the same thing we've done in the past for the San

1 Antonio business meeting. We will have done
2 a significant number of installation visits by
3 the time we get to December, and the business
4 meeting in December. So, we'll have a lot of
5 installations to review. And that's be our
6 first opportunity as a Task Force to review
7 those installation visits.
8 So, first thing on the morning of
9 the 8th in San Antonio we will have an hour
10 and a half of round robin by the members of
11 how their installation visit went. A lot to
12 cover. That's kind of our standard process
13 after a bunch of installation visits.
14 MG STONE: Denise, we had some
15 discussion during the time that we were on
16 break.
17 MS. DAILEY: Oh, good.
18 MG STONE: It would be very helpful
19 to follow the Congressional model of hearings
20 in which you bring in individuals that are
21 affected by a process, and then following that
22 at some period of time to actually hear the

1 PowerPoint briefs.
2 I think that if you brought in
3 some recently separated service members in the
4 30 to 45 minutes before we hear the panel talk
5 we would get a lot more honest discussion than
6 what we're getting now.
7 Many of you are sitting this Task
8 Force because you have endured the, you know,
9 processes that aren't working very well, and
10 as you mentioned earlier, why did it happen
11 this way? I think we have seen in this þ- in
12 these sessions, we get the PowerPoint but we
13 don't get reality until we get out into the
14 field.
15 I think that this panel on pre-
16 separation, you'll get the answers to your
17 questions, but you won't really get your
18 questions answered until you start talking to
19 people that have endured it.
20 MS. DAILEY: Okay, sir. Correct.
21 So, for pre-separation you want me to look for
22 service members who might be in the þ- who be

being case-managed right now, or taking the Transition Assistance Program. Okay.

MG STONE: I just spent two days last week down at the VA Polytrauma Center, as I mentioned to some of you. It was very interesting discussing with them and a number of those families the movement back and forth between Fort Stewart and that VA Polytrauma Center in Tampa. It revealed tremendous disconnects in how we were approaching the care of these very complicated battle injuries that are being cared for in Tampa.

MS. DAILEY: Okay.

MG STONE: So, when you begin to bring the VA Polytrauma in, I'd like to talk to somebody who's gone back and forth between the DoD system and the VA Polytrauma Center.

MS. DAILEY: Okay.

MG STONE: And if they can't come in, certainly their families could to talk to us.

MS. DAILEY: Okay.

1 MG STONE: Now, it may make it
2 somewhat uncomfortable for our panelists, but
3 that's okay.
4 MS. DAILEY: Okay.
5 MG STONE: We have to get past the
6 PowerPoint presentations.
7 MS. DAILEY: Okay. Okay. All
8 right. Yes, I þ- this hour and a half actually
9 was þ- I was going to try and bring in þ- now,
10 keep in mind I'm not þ- I don't own the VA
11 people. I was going to try and bring in the
12 VA case managers, the liaisons, and the OEF
13 OIF case managers. I was going to try to bring
14 them in and talk to them about what can be
15 done pre-separation to better prepare service
16 members going to their system and going to
17 separation.
18 But what I'm hearing is let's talk
19 to people being case-managed by the VA pre-
20 separation, and let's get them in to talk
21 about their experience. Okay.
22 CO-CHAIR CROCKETT-JONES: At least

in that case they can be one of the panelists, or they can present separately if it would be more comfortable for them. But especially when we hear from people at policy and program direction level, we need a person who has experienced the results of those policies and programs to kind of balance what þ-

MS. DAILEY: Okay. One of our ways þ- and then we're going to break for lunch. All right. So, I need to þ- maybe I have two and two here, maybe I have two case managers and two recipients, two case managers and two case managees. Okay? Okay. Yes?

MR. DRACH: I don't disagree with that totally except that if we're going to have those that are still on active duty, we can do that with the focus groups. What I would like to see is somebody that's post-discharge, because they're þ- somebody that's still on active duty could be intimidated. Here's a Two Star General, you know, there's all these high ranking officers. Somebody

1 that's been through the system and has been
2 discharged may be willing to be a little bit
3 more honest, because they're out of the system
4 now. They're not accountable.
5 MS. DAILEY: Okay. Yes, I can ask.
6 I can try and find someone who's no longer a
7 service member, a soldier, or someone like
8 that to be on these panels. So, I have þ-
9 keep in mind I can reach only so far beyond
10 the DD-214, not my charter all together. Go
11 on.
12 MR. CONSTANTINE: In San Antonio,
13 Ron and I can certainly help locate people
14 because the Wounded Warrior Project has a
15 school there, so there's plenty of Wounded
16 Warriors who are there who are out of the
17 system now, probably went through it pretty
18 recently, who can speak intelligently on this
19 topic.
20 MS. DAILEY: Okay. Okay. Yes,
21 that would be helpful. Yes, finding those
22 people is key.

1 Going down, the next þ- so, I was
2 going to do that almost all morning. So, I'll
3 make those changes. We haven't sent this out
4 yet. We haven't started recruiting for this
5 yet. So, the next one, Steven, can I get you
6 to scroll down a tad? Oops, nope, not that
7 much.
8 This panel was þ- again, we are þ-
9 we want to know þ- one of the ways you can
10 assess effectiveness is to talk to the people
11 who have left the military. Again, tough to
12 get to those people because they aren't
13 service members any more. And the transition
14 is in our charter, but how far it goes is
15 still somewhat fuzzy.
16 So, we wanted to talk to people
17 who are dealing with post-DD-214 who are
18 providing services to people post-DD-214. RCCs
19 have that mission, DISCs have those missions,
20 AW2 have those missions to take people beyond
21 the DD-214. So, the intent of this panel was
22 to talk to these people about their clients

after the DD-214, and to talk to these individuals about what could be done before the DD-214 to prepare their clients for post-DD-214. So, that's what this touch point is here.

LTC KEANE: Ma'am, this panel might be the panel you'd like to go to, or you could go to to provide those þ- that's to come to an earlier panel. I know if you talk to the DISC in San Antonio, he can probably get you a couple of Marines. I mean, this might be the group of people that you ask to bring those veterans.

MS. DAILEY: Okay. Okay. Do you think this set of resources would þ- might have better clientele in the post DD-214? Okay. Okay. All right. Good, good.

Next day, or next hour, what's my next hour? Talking to þ- again, we're talking to the VA Service Coordinators, working þ- this panel is strictly a VA view of IDES.

Next day. Let me switch down here

1 really quick. There we go. Oh, cadre
2 training. One of the things we wanted to
3 understand, and we'll have very close access
4 to in San Antonio is the cadre training, the
5 Army cadre training. The school is there. I
6 was going to have them come in and talk to us.
7 Next briefing, this þ- the FLO
8 briefing, this is the Family Liaison Briefing.
9 This is an Air Force asset. This is an asset
10 that works only with the Air Force Casualty
11 Assistance Offices. And, in fact, this FLO
12 who's coming in is going to talk to his role
13 to assist Air Force families, particularly of
14 explosive ordinance devices blasts and
15 injuries. He's been strictly an EOD FLO for
16 the last two years. So, he's going to talk
17 about the services he provides in the Air
18 Force for injuries from explosive blast.
19 And then the afternoon, or the
20 next one, I was hoping to bring in Vet Center
21 Counselors. This would be strictly Vet Center
22 Counselors. And then ask them to come talk to

us about their clientele, and their services.

In the afternoon, since I have the hearing, Center of Excellence in San Antonio, I was going to have them come in and give us an update. And then from 2:00 to 3:45, MSOs and VSOs from the local area to talk to us about their clientele.

Now, I'm being vague. These sets of questions underneath each one of these is what they would be briefing us on. So, I get the message. I hear you. We want to bring in individuals who have left the service who are þ- have an opinion and a voice in how well prepared they were to transition. And that's within our charter. The transition piece is within our charter.

So, that's the business meeting, or recommendation on the business meeting. I'll send out the agenda, and comments are welcome.

MG STONE: Let me make a couple of other suggestions.

1 MS. DAILEY: Yes.
2 MG STONE: You are heavy on the
3 management and transition.
4 MS. DAILEY: Yes, we are.
5 MG STONE: You are light on the
6 care, and you are at one of the Meccas of non-
7 National Capital Region care for our wounded.
8 You need to reach out to the care system and
9 make sure, that is now a joint hospital --
10 MS. DAILEY: Right.
11 MG STONE: -- in the combination of
12 Air Force and Army. It's a perfect
13 opportunity to talk about that care system,
14 what it's meant. The whole evolution, what
15 BRAC meant to the transition, how they
16 responded to it. It is the Center for Burn
17 Management. It's the Center for Regenerative
18 Medicine. The Center for the Intrepid was
19 started there. I mean, we've really failed to
20 capitalize at all on the care piece of this.
21 MS. DAILEY: Now, we were there all
22 last year. We had a full two days, sir, in

which we did do that piece. Yes, sir. That's why this is þ-

MG STONE: Okay.

MS. DAILEY: þ- light on that, frankly. We did the Center of the Intrepid. We got briefings for two full days on that process.

MG STONE: Okay.

MS. DAILEY: I apologize, I didn't make that clear. That's why you're seeing þ- yes, we keep telling BAMC we're not coming back because we did you last year.

CSM DeJONG: As comfortable as I could be without knowing what happened last year, but I þ- this is not the first time that you've briefed that, Suzanne, of why you þ-or, Denise, of why you were going down this route when we talked about it at the last business meeting of kind of what you were going to try to capture on this one.

MS. DAILEY: Yes.

MG STONE: How many of you

1 participated in that care portion?
2 MS. DAILEY: Who do I have here
3 who was at San Antonio last year? None of
4 you. You were there. You did. You did go to
5 the VA? Didn't you do the þ- yes, you also
6 did BAMC. Did you not do one of the focus
7 groups and the briefing? And we did the
8 Intrepid for lunch.
9 LTC KEANE: Yes.
10 MS. DAILEY: Okay. All right. So,
11 that's what San Antonio looks like right now.
12 That's what the business meeting at San
13 Antonio looks like right now. I'll make the
14 changes that we talked about, and I'll bring
15 in a panel of þ- we'll bring in members of the
16 þ- service members who have been through the
17 process, or who are in Polytrauma care right
18 now. Yes?
19 MR. CONSTANTINE: Real quick,
20 Denise. It looks like you have, if you scroll
21 up a little bit, the VSOs MSOs which is right
22 in line with what General Stone was talking

about. I wonder if they could go before we hear from management, so that we hear all the things they have to say about how everything went, and then we'll have better questions for the PowerPoint presenters.

MS. DAILEY: Okay. Okay. So, move the VSO MSO briefing up to earlier in the process. Okay. Okay, this tap dance might be going a little longer. Steven, would you pull up the þ-

CO-CHAIR CROCKETT-JONES: Are we waiting for the speaker?

MS. DAILEY: We are. He is on his way.

MG STONE: Denise, all of these are busy people.

MS. DAILEY: Yes, sir.

MG STONE: I'm sorry. I'm not sure that it's appropriate to keep þ-

MS. DAILEY: I þ-

MG STONE: Was there a miscommunication of the timing of this

speaker?

MS. DAILEY: No, sir. The only thing they have said to us is that he is running behind.

MG STONE: Okay. Maybe it would be appropriate to reschedule him. It's up to all of you. You all have flights, you all have things that you need to get to. What do you want to do?

MR. CONSTANTINE: I'm planning on finishing at 5:00 today. I really can't stay later than that. I have other things lined up for after this.

MR. DRACH: You know, with all due respect to him, he's 35 minutes late, and he's still not here.

CO-CHAIR CROCKETT-JONES: I think maybe we þ- if he's more than 10 minutes away, it might þ- it would have to be rescheduled, in my opinion. And even then he'll give us a pretty truncated presentation.

MG STONE: Denise, I recognize that

slump from my daughter.

(Laughter.)

MG STONE: I mean, it doesn't do very much.

MS. DAILEY: Well, sir, you're on. Let me introduce þ- and, ma'am, let me turn him over to you. You have the introductory comments. Please, sir, come on in.

MG STONE: We welcome Mr. Ortiz, Acting Assistant Secretary of Veterans Employment and Training Services. Mr. Ortiz, welcome.

MR. ORTIZ: General, ladies and gentlemen, first of all, I want to apologize. We had a logistical problem. We went to 2850 Eisenhower Avenue, which was out in Alexandria somewhere, and somebody turned around and said, no, we're supposed to be at the Hyatt Regency. Needless to say, going from one place to another during rush hour is not exactly the greatest gift in the world, especially on this glorious day. So, I

1 apologize profusely for not being here on
2 time. So, that being said, I want to thank
3 you all for inviting me to come over here and
4 kind of talk about our programs and things
5 like that.
6 What I would like to do þ- my
7 understanding is you'd like to kind of get an
8 overview of what we have, and what we're
9 doing, especially when it comes to our Wounded
10 Warriors.
11 I'd like to introduce to you
12 Gordon Burke, who's also my program manager
13 when it comes to all the specific programs at
14 Veterans Department of Labor, Veterans
15 Employment and Training Service.
16 The first thing I'd like to do is
17 þ- oh, there it is right there. All right.
18 I want to give you a little bit of oversight
19 just to kind of get you an idea of VETS.
20 First of all, is there anybody
21 here who doesn't not VETS is? I guess that's
22 the biggest question. Ron, you could probably

1 teach this course. I don't even know why I
2 showed up here. Ron Drach has been with us
3 for many years, so I appreciate you being
4 here, brother.
5 What I want to do is kind of give
6 you an overview of the different programs that
7 we have. Where is the slide person?
8 MS. DAILEY: We've got it, sir.
9 Just say next slide, and move on.
10 MR. ORTIZ: Okay. Next please, if
11 you don't mind. The þ- our mission,
12 basically, without having to go through all
13 the specific slides and stuff like that, ours
14 is þ- we have three major functions at the
15 VETS. One is to provide transitioning service
16 members and their spouses with a civilian
17 career as they leave the military.
18 The second piece is to provide
19 veterans with employment. And the third
20 piece, and probably one of the most important
21 pieces, is protect our Guard and Reserves
22 through the reintegration program USERRA. Can

1 you all hear me okay like this?
2 Again, we prepare them as they're
3 transitioning out. We provide them as much
4 information as we can in order to get them
5 ready for employment. And, of course, we
6 protect their rights. Next slide, please.
7 We have four major programs that
8 are under our charge. One is Jobs for Veteran
9 State Grants, and I'll go into each one of
10 them as we go along. The next one is
11 competitive grant programs. The next one is
12 a transition program. And last but not least
13 is compliance. Next, please.
14 JVSG is the specific grants that
15 we give to each one of the states. And it's
16 a formula grant. Basically, what that means
17 is a specific state may have þ- considering
18 how many veterans we have out there, is how
19 much funding they will get for each state.
20 Now, this is our extended Army, if
21 you will, our extended resources. VETS itself
22 has 243 individuals throughout the country.

1 Out of those 243 individuals, we have
2 Directors of Veteran State Grants þ- excuse
3 me, Directors of Veterans Employment and
4 Training, and they are the ones that are in
5 each one of the states, in 50 states plus
6 Puerto Rico, Hawaii, and Guam, and also D.C.
7 They, basically, are the extension of the
8 headquarters out in each one of the states.
9 The DVOPs and LVERs, which is who
10 these individuals are, are the ones that are
11 actually doing all the major services for our
12 veterans out there. DVOPs are Disabled
13 Veterans Outreach Program individuals, and
14 then the LVERs are Local Veterans Employment
15 Representatives.
16 The DVOPs, what they do is they
17 work þ- both of them work out of about 3,000
18 state þ- the state workforce agencies, and our
19 One-Stop areas. Our One-Stops are where we
20 provide all the transition as much information
21 as we can to these individuals that are going
22 out there working through the state workforce

1 program. The DVOPs and LVERs are specifically
2 mandated to take care of veterans as they walk
3 in.
4 We have approximately, I'd say
5 about 2,000, give or take, 2,500 DVOPs and
6 LVERs throughout the country. Again, DVOP
7 specialists, they are located within the state
8 workforce, and they're also providing specific
9 work as we can for individuals that have set
10 barriers. And when we say set barriers, we're
11 talking primarily about our warriors who
12 happen to be wounded.
13 Our LVERs are the ones that
14 actually go out there and try to find the
15 jobs. They go out to the different
16 organizations and find out what is available
17 in order to get our transitioning service
18 members and our veterans employed.
19 Priority of service. A priority
20 of service is more important than anything
21 else, is that a veteran is given priority over
22 a non-veteran when they come into the One-Stop

1 shop. In other words, as soon as an
2 individual comes in and they say, hey, I'm a
3 veteran, they go directly to our DVOPs and
4 LVERs.
5 Now, the biggest problem that
6 we're having right now, and this what we're
7 finding, is that ladies who are leaving þ-
8 women who are leaving the military are not
9 getting the services they need because they're
10 not actually saying that they're veterans. And
11 what we have found is that the reason why is
12 because a lot of the ladies are thinking,
13 well, a veteran is þ- it's three problems. One
14 is, a veteran is a person who's been in
15 combat. A veteran is a person who's old. I
16 can't be a veteran even though I was in the
17 service, although that's þ- we're trying to
18 change that mind set. In other words, so that
19 when they come into the One-Stop shop, instead
20 of saying are you a veteran, going up to them
21 and say to them have you served in the Armed
22 Services, or in the Armed Forces? And by

1 doing that, we're able to do þ- we're able to
2 push them in the right direction.
3 And the main reason for that is
4 because we have a high þ- we have found that
5 we're getting more ladies into the Armed
6 Services as we go along, and also a lot of
7 transitioning service members are leaving,
8 too. The females happen to be growing at a
9 considerable rate.
10 The next thing is just to kind of
11 give you an idea of some of the things that we
12 mentioned. The Veterans EER is the Entered
13 Employment Rate. In fiscal year '09, it shows
14 46 percent, I'm sorry, in program year.
15 Program year means instead of going fiscal, we
16 go program year from January to December. One
17 July, I'm sorry, to the following June.
18 This is just to kind of give you
19 an idea of what our Entered Employment Rate,
20 as well as the retention rate þ- and it shows
21 you how it is, and also how much earnings
22 these individuals are making.

1 Now, when you look at the earning
2 part, a lot of people will turn around and
3 say, hey, that's kind of low. The truth is,
4 this is not just full-time, but this is also
5 part-time employment. It's the average that
6 goes across.
7 We are one of the few agencies
8 that also measures the Entered Employment Rate
9 and the retention rate for disabled, for our
10 veterans who happen to be disabled, as you can
11 see on this slide.
12 The next area that I'd like to
13 talk to you about, our homeless veterans, are
14 actually competitive grants, which are the
15 HVRPs, Homeless Veterans Reintegration
16 Programs, our Workforce Investment Programs.
17 And we also have incarcerated
18 veterans. And one of the areas that we've
19 been concentrating on, last year was the first
20 time we had it, was, again, I told you about
21 the female population growing as they're
22 coming out. The homeless female veterans and

1 veterans with family grants.
2 We feel that it's very important
3 to get grantees to be able to take care of
4 them specifically, because it's a completely
5 different environment now, ladies and
6 gentlemen. More than anything else, we have
7 single warriors who happen to be þ- who have
8 families and things of that nature, and what's
9 happening is a lot of these individuals are
10 now coming back, and they're not finding the
11 jobs, the economy is not well. Not finding a
12 job, and actually are going into homelessness.
13 So, our job is try and help them in whatever
14 way we can, but at the same time we also need
15 to be able to take care of their families,
16 which is why this program was developed.
17 These are probably one of the
18 hardest pieces, because this is where we take
19 care of the ones that have the most
20 difficulties in not only reintegration, but
21 also the difficulties as far as not being able
22 to find a job. A lot of them, a lot of the

1 veterans that we're looking at þ- and we used
2 to say that it was the veterans back in the
3 Vietnam era and things of that, we're finding
4 younger and younger veterans coming back who
5 are going into homelessness. So, it's one of
6 our most important programs.
7 The VWIP Program is to take care
8 of green jobs, to get them trained into the
9 green job areas, and try to get them into
10 specific markets, giving them the skills that
11 they need in order to continue on.
12 CSM DeJONG: Sir, real quick.
13 MR. ORTIZ: Yes, sir?
14 CSM DeJONG: When we go back to the
15 homeless veterans.
16 MR. ORTIZ: Sure.
17 CSM DeJONG: That's been an ongoing
18 thing in the news, and ongoing highlight of
19 homeless veterans and why there are so many.
20 When you talked about your personnel on the
21 ground, your LVERs, are they actually going
22 out and seeking through homeless shelters and

1 other places, trying to locate what would be
2 a homeless veteran in some of the inner cities
3 and some of the other places where we do have
4 higher populations, or identified higher
5 populations of homeless veterans?
6 MR. ORTIZ: I tell you, sir, what
7 we have right now is we have actually
8 grantees, grants þ- we have programs out there
9 who actually do that. We give them a certain
10 amount of money to be able to find these
11 individuals that are out there.
12 Do we have the DVOP and LVERs that
13 actually go looking for the homeless? No, but
14 what we do have is we have DVOPs and LVERs
15 that are pretty much stationed with a lot of
16 these grantees, so that when they go through
17 the program, when they actually identify these
18 individuals that come in, the first thing
19 we've got to do is we've got to get rid of the
20 demons.
21 In other words, we have to be able
22 to kind of help them get into the program, if

they have substance abuse, if they have mental issues or things like, we have to be able to prepare them first before they can actually start going through the process and the program.

Once they're employment-ready, then we have the DVOPs and LVERs who actually work with them on a one-on-one basis. So, these guys þ- remember, the grantees are þ-the grants þ- the people that have all these grants also have VA grants, HUD, Department of Labor and things, so it's a concerted effort through all the different departments to try and do that sort of stuff.

To answer your question specifically, are DVOPs and LVERs going out under the bridges and looking for our guys and stuff like that, no, we don't do that.

CSM DeJONG: Okay.

MR. ORTIZ: The grantees actually do that.

CSM DeJONG: Okay. I mean, you

1 answered my question. You more than answered
2 it. Just you're dealing with a population
3 that is a high profile population, but also
4 one that is not going to have the
5 accessibility to go out and find these grants
6 to help themselves, also.
7 MR. ORTIZ: True. True. And
8 here's the other thing. I'm sorry, Major. One
9 of the things that they have also is DOL VETS
10 also gives a certain amount of money per year
11 to what we call stand-downs. And what stand-
12 downs are, basically, giving a certain amount
13 of money to different locations, non-profit
14 organizations and things like that who
15 actually throw þ- get a different room, get a
16 big place and bring in these homeless
17 individuals so they have a place to take care
18 of their dental, their health, some of the
19 things þ- clothes, take a shower, take a
20 haircut, things of that nature.
21 Those are some of our outreach
22 individuals that also work with our grantees

to try and identify and find some of those homeless individuals in order to make that work.

Unless we find them, unless we have the extended arm out there, we're not going to be able to help them directly. I hope that answers your question, sir.

Now, the transition program. For those of you who know, when you go through a transition, once you leave the service, you know, you've come into the service, you've done your time, and now it's time for you to go out.

The President has already pointed out that there are going to be different changes for these transitioning service members who are coming out, not only for the economic þ- what's happening in the economy right now, but also being able to get these young men and women prepared for employment.

Our program, which is the Employment Workshop, specifically handles

1 things like writing resumes, being able to get
2 information about the labor market, the
3 training opportunities, so on and so forth.
4 Unfortunately, the TAP Program was
5 over 20 years old, so imagine being in a
6 program where you go to get educated, and the
7 education that you're receiving is what you
8 would have received 20 years prior. You know,
9 death by PowerPoint. It's bad enough I have to
10 show you this. Could you imagine sitting here
11 and getting 180 to 200 PowerPoint slides to a
12 young man or a young woman who just came back
13 from combat, or has served their time and now
14 they're trying to get inundated with all sorts
15 of information.
16 Based on that, what we've done is
17 we've redesigned the program. Redesigned the
18 program to help an individual that's come in,
19 first of all to understand what they need in
20 order to transition out properly and get a
21 job. Secondly, to make sure that we give them
22 what training they need, or the things that

they need in order to be able to transition out effectively.

What we're doing þ- how we're doing that is, when we have three individuals þ- for example, Sergeant Major, you are a person that's been there 20 years. General, you've been there 10, and the young lady next to you has been there four years and she just came back from combat. She left in high school, did her thing, and now she's ready to get out. You've had the opportunity of being there for X amount of years. You've already kind of built a networking system. You understand what's going on. You have an idea of what you want to do after you finish.

Sergeant Major, you decide you know what, I already have everything I need. I'm just going to need a little job to take care of this. So, your employment ready piece is probably a lot higher than let's say them two.

More importantly, she is less

1 employment ready than any of you. So, the
2 idea is to take, from the beginning, assess
3 that information so that instead of putting
4 the three of you into a 180, 200 PowerPoint
5 slide and try to give you the same exact
6 information, because you might not get
7 anything out of it. You might get something
8 out of it. You definitely might, with
9 everything that's going on, you may need that.
10 So, the idea is to turn around and evaluate
11 that so that we put you all, all the people
12 that need the most help to transition out will
13 be put in that, and given that TAP class. The
14 second level the same thing, and then third
15 level the same thing, to be able to give them
16 that.
17 How do we do that? We do that
18 through Adult Learning Principles, making sure
19 that it's learning by doing, instead of just
20 learning be repetition.
21 The other piece is to make sure
22 that we have facilitators so that in Yokosuka,

1 Japan, what's being taught there is also being
2 taught in Camp Pendleton. So, the exact
3 things go across the board.
4 The next thing is making sure that
5 the Adult Learning Principles are carried out
6 in each area. In other words, being able to
7 teach them how to write a resume, how to
8 present yourself, the elevator speech, you
9 know that 60 seconds of when you're in the
10 elevator and you can basically sell yourself,
11 be able to do things like that.
12 The other piece is þ- a fourth
13 piece is to give them the opportunity to have
14 an eLearning platform. In other words, a
15 platform where they can actually go back, look
16 at what they have missed and be able to do it.
17 How do we do that? We want to make sure that
18 they have an individual transition plan, and
19 that transition plan, basically, what it is is
20 these are the things that I need in order to
21 be successful out there, by having that
22 eLearning tool, at least being able to go back

in there and look at what you're missing.

The next thing is support, being able to pick up the hook when you're out there and saying, you know what, I'm doing this in my individual transition plan. I've looked at what it is, however, I'm missing something. Can you help me out? And have a person literally be able to walk you through and help you through that.

And last but not least is the metric side. And the metrics is more important þ- is very important in the aspect of we don't want to go another 20 years and have to redesign it 20 years down the road. With the metrics at least we find out how people are understanding what's going on, is it helping them get a job, and so on.

That's the basic principle of the TAP Workshop that we're doing now. It's helping us. We deliver, as you can see, we deliver over 4,100 TAP Employment Workshops annually to over 130,000 individuals.

1 Now, let me also help you
2 understand that there is only one service that
3 has TAP as a mandatory thing, and that's the
4 Marines. All the other services are close but
5 not close enough. That may change in the
6 future, but for right now that's who it is.
7 Also, within the next year or two,
8 because of the draw down, because of
9 everything that's happening, we're going to
10 have a considerable amount of people going
11 through a transition program.
12 CSM DeJONG: Sir, what are your
13 thoughts about making it mandatory across all
14 forces?
15 MR. ORTIZ: You know what, Sergeant
16 Major, and I'm going to give you the party
17 line on this one, and I apologize. First of
18 all, I'm not a politician so I'm not going to
19 speculate on different things, but I think
20 that is a DoD recommendation. If you ask me
21 personally þ-
22 CSM DeJONG: Sure, I understand

that, but part of þ- I mean, with your position of being able to leverage that, one of the recommendations we made last year was to make TAP mandatory within the last 12 months of your time in service, whether you were being just ETSing, or however you were coming out of the service. And based off of how many people we can have behind that, I was just trying to get þ- not dig into anything too personal, or whatever, crossing lines þ-

MR. ORTIZ: No, no, no. Realistically, Sergeant Major, and I'll tell you my own feeling on that is, I think it's important that everybody should go through a TAP Program, whatever that TAP Program, whether it be in the ACAP side of the house or anything. Whether it be mandatory? I think it should only because the example I gave you right there.

You know, if you feel that that individual is such an asset to you that you're not going to let that individual go until the

1 last minute, and then at the last minute they
2 lose an opportunity to be able to do something
3 outside, you know, that's important.
4 In the Marine Corps, and I speak
5 for the Marine Corps because I happen to be
6 one of them, is we found, believe it or not,
7 that the TAP Program was a heck of a retention
8 tool. Because after you gave them all the
9 information and everything else, everybody is
10 like, ah, you know, maybe I might not want to
11 get out there as quickly as I want. As stupid
12 as that sounds, it's the truth.
13 However, at the same time, it also
14 gave them an opportunity to see what was going
15 on. And I think we owe that to our Soldiers,
16 Sailors, Marines, and Airmen and Coast
17 Guardmen. We need to at least give them the
18 opportunity to have that option, you know.
19 And we give them an opportunity to at least
20 get a resume going, prepare yourself, dress
21 for success, do whatever needs to be done. I
22 think that everybody should have that

1 opportunity.

2 Again, it's Junior RTs. Now, I do

3 have the, if you will þ- in the office that I

4 am presently serving in, I am, in fact,

5 talking with different individuals who have

6 the same þ- how do you say? They back what

7 you're saying right now, Sergeant Major. Yes,

8 sir?

9 MG STONE: So, we've taken the

10 position at our last report that everybody

11 should have TAP, but we also reference the

12 Hiring Heroes Act of 2011. Can you talk about

13 how that helps you, or hurts you, or how that

14 Act has either facilitated or hindered your

15 work?

16 MR. ORTIZ: Hiring our Heroes, sir,

17 as far as being able to team up with employers

18 out there to get the þ- we have gotten

19 together, we've partnered with Chamber of

20 Commerce, we're partnering with Society of

21 Human Resources, with the state workforce

22 agencies, and also -- the different areas.

1 The reason why þ- it has worked very well
2 because we are finally getting the
3 information. It's the outreach piece more
4 than anything else, General. And here's the
5 problem that arises, is that we have two basic
6 problems right now.
7 We have a lot of employers who say
8 we want to hire all the veterans we can, but
9 we don't know how. So, I can turn around and
10 talk to all the CEOs in the world, but that's
11 not going to get the job done. Why? Because
12 the ones that make the decisions on hiring is
13 not the CEO, but the hiring managers. So, we
14 have to educate them.
15 Now, the CEO can turn around and
16 say I want to hire X amount of people, make it
17 happen. But we have to educate them. The
18 Hiring Our Heroes has actually helped us
19 immensely because we brought them in, we
20 brought in CEOs and companies, and basically
21 have said look, you are not allowed to be at
22 this job fair, or career fair, or however you

1 want to put it unless you have a job. And
2 they've responded.
3 An example of that, sir, is we had
4 þ- we were in New Mexico, and we had 70
5 employers that came in, and they brought in
6 with them 3,000 jobs. And we had 1,000
7 veterans. So, it was a 3-1 ratio on it. Now,
8 did everybody get employed? Probably not.
9 However, the idea is at least it was there.
10 The second piece, and it goes to
11 the mandatory TAP piece is, we've got to
12 educate our young men and women what their
13 value is to these companies. We truly do.
14 And they have a tremendous value. If you talk
15 to an employer out there and you ask them
16 specifically what is it that you're looking
17 for? I want somebody that has team work, I
18 want somebody being able to work properly. I
19 want him to be able to do the thing under
20 stress. I want him to show up on time. I want
21 him to be clean. I want him to have integrity.
22 I want him to have honesty. I want him to have

loyalty.

Which one of our soldiers, or sailors, or marines, or airmen don't have those qualities? So, the Hiring Heroes has actually helped us in advancing that piece. And we've actually þ- we're doing quite well in it. I mean, I don't þ- I can't give you all the specific numbers on it, General, to this moment because we can only ask them to give us that information later on. We haven't been able to get all the specifics on it, but we're working on it. And they're working it as best as they can.

If you don't mind, I'm going to kind of walk through the other ones, and that way I can give you an idea of some of the other programs we have.

We have a program in REALifelines, and REALifelines, what it basically is, going into the hospitals and being able to help a warrior who happens to be wounded go through what they need in order to become eligible for

employment later on. However, the biggest problem that we had is þ-and Ron is probably one of the best that can tell you about this since he used to run the program a lot more, is the fact that when a warrior comes in and they're wounded, everybody and their mother decides to help them in any way they can. And they get inundated with all sorts of stuff.

What we try to do is þ- we're that last piece so that when they finally are in recovery and everything else being able to go in there and talk to them, and seeing where they are, and try to get them into the right programs.

We also have another piece for þ- another program that we use, that we have, it's called America's Heroes at Work. America's Heroes at Work is more for making sure that we have þ- that when an individual comes to a company, they have the proper equipment that they need in order to be able to do their job. Okay? Things like making

1 companies aware of what our Wounded Warriors
2 might need as they transition through their
3 company.
4 For example, something as simple
5 as if a person has been in combat, they don't
6 like somebody sneaking up behind them. Truth
7 is, the accommodations that we're talking
8 about are accommodations that could be for
9 anybody. You know, how many of you do not
10 like people sneaking up behind you, or how
11 many people don't like noises going off in
12 certain places. Those are the ways þ-
13 America's Heroes at Work helps to develop
14 that.
15 Ladies, am I speaking out of
16 school here? Am I doing all right so far?
17 The idea is to educate the employers on what
18 our Wounded Warriors need out there in order
19 to be part of that company.
20 The next area that I'm þ- please
21 go forward, if you don't mind, to compliance.
22 Keep going. Next, sir. Compliance.

1 Compliance is -- the most
2 important thing for us is the Uniformed
3 Services Employment and Reemployment Rights
4 Act, USERRA. This mainly is for our Guard and
5 Reserve. There's a lot of young men and women
6 who are leaving who are being called to
7 service, and when they go into service and
8 they come back, they don't have a job, or
9 their jobs have been released.
10 Our job is to make sure that they
11 get reinstated, that at least they do it.
12 Now, understand that USERRA only happens if an
13 individual requests it.
14 So, if they come back and they
15 said you know what, I used to be at this job
16 and now I'm being told that I'm not þ- I don't
17 have that job any more. As soon as they make
18 us aware of it, we investigate it and do what
19 needs to be done. We have 90 days to complete
20 the investigation, unless it's extended by the
21 individuals. And if the individual decides to
22 drop the case along the way, or if the

1 employer reinstates them, then it's done. But
2 this is more for our Guard and Reserve. And
3 let me tell you, ladies and gentlemen, this is
4 also available for active duty individuals,
5 and a lot of people don't know that, depending
6 on how long they've been in.
7 That is our biggest piece that we
8 try to take care of. We have a lot of
9 programs in the outreach side. We have
10 programs that are talking about the þ- please
11 go on to the last one -- we have a lot of
12 programs that we're working out there
13 specifically for the outreach portion only
14 because of the fact we need to make people
15 aware that our veterans, our transitioning
16 service members need þ- have the capabilities
17 to do what needs to be done for the bottom
18 line of a corporation.
19 I don't think there's anybody here
20 who would argue that our soldiers, sailors,
21 marines, airmen and coast guardmen have the
22 capability to improve the bottom line of any

1 corporation. So, my job, my Secretary's job,
2 and as the President has already said, is for
3 us to take care of our veterans and make sure
4 that they get the things that they need in
5 order to find meaningful employment.
6 I just want to tell you something
7 on a personal note, ladies and gentlemen. I
8 don't do this job simply because it's a job.
9 I don't do this job simply because it's þ- I
10 got appointed to this position.
11 I happen to have four children who
12 are military members. Between my sons I have
13 12 tours in Iraq and Afghanistan. It's
14 important to me to make sure they get taken
15 care of, so I treat any veteran or any kind of
16 service member that's transitioning out as if
17 it was my own. To have a certain disability,
18 or to have something come into your face and
19 be realistic about it, you have to be able to
20 understand what that feeling is like. I have
21 to be able to understand that in order to be
22 able to help that Wounded Warrior.

1 When my son calls me up at 6:00 in
2 the morning on a Saturday morning and tells
3 me, "Dad", or no, does not say dad, says,
4 "Colonel", I know I'm in trouble then because
5 now he's not addressing me as a parent. He
6 says, "Colonel, do you have nightmares? When
7 you walk down the street do you smell a
8 certain thing, and it gives you flashbacks,"
9 and spend the next three and a half hours
10 speaking to that young man, and all you say is
11 three words throughout the whole entire thing.
12 What you all are doing, and what
13 I'm trying to achieve here, it's not a job.
14 It's a calling for what we need. This is
15 something that I believe in, because I live it
16 everyday.
17 I've got a young sergeant who just
18 got out trying to find a job. Hell, I'm the
19 Acting Assistant Secretary and I can't get him
20 a job? So, what do I do? Go talk to the DVOP
21 and see if he can get you a job. So, this
22 isn't just something that I do simply because

I got appointed here. I do this because it means something to me, and every one of my staff members are all veterans. They understand what that's like.

Again, I apologize for my tardiness. I promise my logistics will get better.

I'm open to whatever questions you have.

CO-CHAIR CROCKETT-JONES: I have a question regarding the Jobs for Veterans State Grants.

MR. ORTIZ: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: They're state administered. The monies go to the states and they administrate the spending of those funds. Correct?

MR. ORTIZ: Yes, ma'am. Actually, yes, ma'am. We þ- here's the thing. These people are extended Army. We pay their salary, but they work for the governor.

CO-CHAIR CROCKETT-JONES: Okay.

1 So, is there any sort of system of score
2 carding their success rates versus their fund
3 þ- the way they allocate their budgets.
4 MR. ORTIZ: Yes, ma'am.
5 CO-CHAIR CROCKETT-JONES: Is that
6 tracked?
7 MR. ORTIZ: Gordon, do you want
8 toþ-
9 MR. BURKE: Yes. We have
10 performance measures for both the DVOP and
11 LVERs. Those measures are negotiated with the
12 state in an annual plan. We have the state do
13 a five-year strategic plan on how they're
14 actually going to take the populations of
15 those seeking employment and get them into
16 employment. And we þ- the language that we
17 use are targets. Of the numbers seeking
18 employment, how many will you have employed
19 within a year. Of that number employed, how
20 long will they remain in employment? And how
21 and what ways are you going to employ to
22 increase the average earnings?

1 So, that's translated to us in a
2 five-year plan. That five-year plan is
3 updated every year. And those measures, we
4 actually measure the DVOPs for that state and
5 the LVERs against those particular measures.
6 Now, if a state is falling behind,
7 we find out why with them. We may be able to
8 solve some of those problems with training and
9 with additional funding. And we do offer
10 incentives to the state to meet or exceed
11 their goals.
12 MR. ORTIZ: Does that answer your
13 question, ma'am?
14 CO-CHAIR CROCKETT-JONES: That
15 does. Thank you.
16 MR. ORTIZ: Sir?
17 CSM DeJONG: Along with that,
18 looking at þ- you explained it a lot better
19 that you leave it at the state level. Are you
20 influenced in any way by if you have a state
21 that has a 10 percent unemployment rate versus
22 a state that has a 3 percent, the state that

1 has 3 percent unemployment rate, are they
2 going to get more grant money than what would
3 be a state that has 10 percent unemployment
4 rate? Because, obviously, they've got
5 something þ- they probably have more
6 opportunities out there.
7 MR. BURKE: That's a good question.
8 Let me tell you something about the Job
9 Surveillance State Grant Program. Years ago
10 when the legislation was being written, there
11 were people on Capitol Hill who said
12 differently. They said, you know, if a state
13 is not doing þ- remember this, Ron. If a state
14 is not doing well, then we won't be able to
15 take money from them. And our position was
16 just the opposite. If they're not doing well,
17 for crying out loud, we need to find out why,
18 not by ourselves but together, explore that,
19 look at some best practices in other states,
20 and then maybe work with them on how to
21 provide services.
22 Let me give you an example. What

1 we learned in one state that helped another
2 one was a lot of the DVOP and LVERs, the staff
3 we were talking about, were at their desk. We
4 found a case in another state where their DVOP
5 and LVERs spend very little time at their
6 desk. They were swamped when they got back to
7 their desk, and that made a difference,
8 especially with reaching out to employers. So,
9 that's one way.
10 I guess -- but the ultimate
11 question is, if they don't continue to
12 improve, is there a way of pushing more
13 resources to them? Yes.
14 MR. ORTIZ: The other thing is,
15 too, Sergeant Major, is the fact that remember
16 this is based on the population of veterans in
17 that state. If a state is doing really well,
18 we want to also kind of capture what they're
19 doing so we can pass it on to some of the
20 other states, too. And that's part of also
21 the process.
22 We've been þ- there are times

when, as Gordon said, it all depends on how motivated that state is. It has nothing to do with the political landscape. It has a lot to do with those individual þ- remember those DVOPs and LVERs are also veterans. They're not just guys that they hired simply because they have to be by law.

MR. CONSTANTINE: How are you able to track how many veterans get jobs through your programs, and how long do they stay at those jobs?

MR. ORTIZ: Sir, it depends on what their needs are. It depends on what their needs are. As an example, I mean, each grantee þ- and I'll give you an example of what a grantee hears close by. We have a grantee up in Baltimore called MCVETS, and they run their program like a boot camp. And it's absolutely phenomenal. I mean, you walk in, the heads are þ- you can eat off the floor, and things like that.

The main reason they do that is

1 because they try to bring the individual back
2 into a place of known understanding. So,
3 depending on þ- for example, if Butch has been
4 out in the street and has been þ- has drug
5 problems, has social problems, and things of
6 that nature, it may take him more time to go
7 through the first piece, what I talked about
8 getting rid of the demons. Get through that
9 piece before they can get into okay, now that
10 I've cleaned you up, now you can at least
11 listen to me. And once you listen to me, now
12 I can educate on what needs to be done. So,
13 it all depends on the individual, sir.
14 MR. BURKE: There was a second part
15 of your question about how would we know if
16 they were retained on employment? How do we
17 know those numbers?
18 Let me give you an example. When a
19 person is employed, the employer has certain
20 responsibilities to report on that particular
21 person being employed. Now, that is captured
22 in what we call þ- translate into wage

1 records. So, for you and I who are employed,
2 the workforce system can pretty much tell if
3 we are employed by wage records. So, when a
4 person is not employed and they get a job,
5 they are counted as an entered employment.
6 That's kind of a little complicated process,
7 but suffice it to say they're counted as a
8 person placed in employment. Entered
9 employment.
10 That person is tracked to be
11 retained in employment by wage records,
12 because the employer when that person becomes
13 unemployed þ- I mean, they have a
14 responsibility in payments like the military
15 services do. When you have unemployed people
16 and they are seeking employment they claim UI,
17 you pay UCX. But this is not exactly the same
18 thing.
19 They will know when there's no
20 longer a record that this person is earning
21 wages. Then they know that they're not
22 employed.

1 MR. ORTIZ: And we track that, sir,
2 through other DOL agencies, through the tax
3 forms and things of that nature, sir.
4 MR. CONSTANTINE: So, you can tell
5 when someone starts and when they stop
6 working. So someone is running a list of
7 veterans' names to see if they're still in the
8 system, if they're working. I mean, you have
9 a list like that?
10 MR. BURKE: Well, the list by names
11 is really controlled by the states. Okay? But
12 they do have records, they have records. At
13 the national level, we don't have visibility
14 on those records because of the PII, and there
15 is þ- there aren't necessarily the agreements
16 in place that would allow the states þ- some
17 states by law can't transfer that kind of
18 information. However, there are mechanisms to
19 have identifiers for records that would have
20 the characteristics of that person, but
21 wouldn't have that name and social security
22 number.

1 MR. CONSTANTINE: Okay, I get that.
2 I just don't understand how you know how good
3 of a job you're doing in getting veterans
4 jobs, as opposed to veterans getting jobs on
5 their own.
6 MR. ORTIZ: Okay. You know what,
7 sir, I showed you a thing, the EER and the
8 ERR. That's how we find out þ- the only way
9 we really, truly find out how well a veteran
10 is doing is if they come through our One-Stop
11 Service.
12 MR. BURKE: They register.
13 MR. ORTIZ: In other words, they
14 register. So, if you decide to go find a job
15 þ- you get out of the service, and you decide
16 that you want to go find a job on your own,
17 and you get employed by somebody else, I will
18 never know that you're employed unless you
19 have actually come into the One-Stop or
20 registered with our DVOP and LVER.
21 MR. BURKE: And we don't get
22 credit.

1 MR. ORTIZ: And we don't credit for
2 you getting the job. You know what I'm
3 saying? I hope that answers your question.
4 MR. CONSTANTINE: It does. Thank
5 you.
6 MR. BURKE: Yes, just to give you
7 kind of a flavor for the kinds of numbers that
8 we're talking about. The DVOP and LVERs are
9 providing employment services to about over
10 600,000 per year.
11 MR. ORTIZ: Per year.
12 MR. BURKE: So, if you take that 46
13 percent number times that, that's how many of
14 that number got employed within that year.
15 Now, that doesn't mean that the remaining 54
16 percent don't get employed, it's just not
17 within the time frame that's captured for that
18 measure. Does that make sense?
19 MR. ORTIZ: Yes, sir?
20 DR. PHILLIPS: Yesterday we had a
21 briefing by VA Voc Rehab.
22 MR. ORTIZ: Yes, sir.

1 DR. PHILLIPS: And I may have these
2 numbers wrong, but we questioned that. They
3 said there were 8 million available jobs. Now,
4 if there are 8 million available jobs, I mean,
5 I'm just asking your opinion, where is the
6 disconnect? Why aren't we filling those jobs,
7 or a good portion of them?
8 MR. ORTIZ: I've got to tell you,
9 if there are 8 million jobs out there, which
10 they may be, they may be. Because remember,
11 I mean, if you're talking about the mom and
12 pop shops, and we're talking þ- there may be
13 8 million jobs. The disconnect is exactly what
14 I told the General a little while ago. Being
15 able to understand what the value of a veteran
16 is to those employers that are looking for
17 guys, and here's why.
18 I told you a story about my son.
19 My son is a major in the Marine Corps, flies
20 F-18s. I don't have any problems knowing that
21 he's going to be very successful. So, he has
22 PTSD, granted, so do I. However, we're able

1 to manage it.

2 A lot of our veterans are scared,

3 and I'll tell you straight up, to go and tell

4 an employer that they served in the service.

5 Why? Because it's been so sensationalized

6 that these individuals are going to go postal

7 on them any minute.

8 You asked the disconnect, sir.

9 Education, education, education. Until we're

10 able to educate our employers that these young

11 men and women have the capability to do

12 something for you and help you build your

13 company, you have to take a leap of faith.

14 Now, does that mean that every single

15 individual that comes back from combat or

16 leaves service is messed up in the head? Come

17 on, you know.

18 The other thing is, less than 1

19 percent, less than 1 percent of our population

20 serves in the military. If there are 8

21 million jobs out there, brother, then we

22 should be able to get a job for every single

1 person that walks through that door, and out
2 that damned door, excuse me.
3 DR. PHILLIPS: I know. Am I þ- did
4 I have the numbers wrong? We discussed that
5 yesterday, and they were specific. I mean, I
6 don't know whether they have a list.
7 MR. ORTIZ: And you know what,
8 sirþ-
9 CO-CHAIR CROCKETT-JONES: I think
10 that it may been in their speech. Okay, they
11 said they had 8 million job listings by
12 connecting several online agencies. We do not
13 have any idea how much of those are
14 redundancies.
15 MR. ORTIZ: It may be a true
16 statement. Because truthfully, again,
17 depending how we look at it, the mom and pop
18 shops þ- ladies and gentlemen, the majority of
19 employment that is being arranged on us, or
20 getting people employed are not the big
21 companies. They're the little ones.
22 And let me tell you how hard it is

1 for an individual to own a small company.
2 Let's say you have a small company and you
3 have 10 people. Some of them are reluctant to
4 hire a veteran or a reservist, or something
5 like that because the truth of the matter is,
6 you two are part of my company here, you two
7 were called to active duty. I just lost 10,
8 15, 20 percent of my company's capabilities.
9 So, it may be, it may be that there is a
10 possibility of having 8 million jobs out
11 there. I wish to God we did, because I tell
12 you what, I'd be a very happy camper right
13 now.
14 MR. BURKE: I think we would need
15 to look to look real hard at that, because
16 oftentimes what people will do is combine job
17 listing services, and you'll get some
18 duplication. And even if there were some
19 number close to that, I think there are
20 probably five other things that you would have
21 to look at. Where are these jobs would be
22 number one. Some people can't work in another

1 state. They need to work where they are.
2 The second thing is what Mr. Ortiz
3 talked about, skills gaps. They do exist.
4 Some of them really exist, some of them are
5 artificial. And we've talked about
6 transitioning service members, we believe that
7 a lot of those skills gaps are artificial.
8 And they're artificial because maybe the
9 service member doesn't know how to articulate
10 what they are worth in compelling terms. And
11 that's what Mr. Ortiz talked about taking on
12 in the TAP Program.
13 The other part is many of these
14 jobs are part-time jobs, and some of them are
15 seasonal jobs. So, there's some artificiality
16 built into this. And last but not least, not
17 everybody wants to sell. And I will tell you
18 that somebody out here on the street who will
19 come in here and offers a bunch of jobs to go
20 sell makeup door to door. So, yes, there is
21 some truth that there are a lot of jobs out
22 there, but we really need to peel that onion

1 back a couple of layers to really see what the
2 real story is.
3 MR. ORTIZ: Butch will sell makeup,
4 but I won't. I'm sorry.
5 MR. CONSTANTINE: You identified
6 that one of the biggest obstacles is educating
7 the employers. When do you think you will
8 have educated enough of these employers to
9 deal with this issue we have with the 19 and
10 24-year old veteran unemployment rate being so
11 high?
12 MR. ORTIZ: Sir, I think we're
13 doing a really good job of that right now. I
14 think having partnerships with something þ-
15 with, for example, the Society of Human
16 Resource Management, that is a very big deal
17 because of the fact they have over 3,000 þ- I
18 mean, they have 600 entities around, but they
19 have about 3,000 different little cells, if
20 you will.
21 They are the ones that are
22 actually making the difference in being able

1 to educate these other human resources
2 specialists on what needs to be seen. How do
3 you read a resume of a military individual?
4 How do you understand what þ- what questions
5 do you ask on that? So, that's one part.
6 The second part is, the services
7 are actually going out of their way to go and
8 talk to employers now. In the Reserve side of
9 the house, General Stultz, Jack Stultz, that's
10 his living. He goes out there and talks to
11 these companies and say you know what, I've
12 got a reservist over here who happens to be a
13 truck driver, who can probably do a damned
14 good job for you right now. So, we are doing
15 it.
16 How long is that going to take?
17 You know what, if I could tell you that, I'd
18 probably be somewhere else. But right now, I
19 think it's the þ- we need to be able to
20 articulate what our service members'
21 capabilities are, number one.
22 MR. CONSTANTINE: You can do that

in your sleep.

MR. ORTIZ: You can, but our own kids don't know how to do that. You understand? That's the problem. And on top of that, you also have to have employers that need to be receptive to understand what that is.

Again, the mom and pop shop, hey, I want to hire all the veterans that I can. But the moment that they get recalled, or the moment that they have to leave and my job, and my whole business goes down the drain because of that, do you really think I'm going to hire somebody again like that? Do you see what I'm saying? So, how long is that going to take? You know what, I can't answer that directly, but I've got to tell you, the bottom line is less than 1 percent of this population serves this country, less than 1 percent.

If we can't find them jobs, something is not right, especially when you're bringing young men and women out of the

service who may not be specifically trained in certain areas, but I've got to tell you, our kids have the capability of learning like that. Give them the opportunity, and they will þ- they excel.

We do this every day so, how long? I don't know, sir, but we're trying.

MR. CONSTANTINE: Yes, I'm not exactly for an exact date and hold you to it and say two years later you were wrong. I'm just þ- we've been at this for a while, and you're preaching to the choir here. Most of us have served in the military, so we know that less than 1 percent are, and we know how capable our young men and women are, but it's at all an all time high, and it's been at this level for quite a while.

MR. BURKE: Yes, you know, there is another side of the equation that we really can't talk about, but I'm going to assume that we all know what the other side of the equation is. We talked about the supply side,

which is people seeking employment. The other side is the number of jobs created.

Okay. Now, without going there, I would tell you that what we must do now þ- and here's the angle, the boss gave us this guidance, is look, I want you to prepare our veterans for their first failure because in this economy most people when they go to seek their first job are going to be told what? No. And we've got to somehow arm them with the skills and talent to be able to fight through that and go on.

What is plan two? What is your next group of people that you're supposed to network with? What is your call plan? When are you calling them? When are you going to eat and lunch with þ- I mean, all of that needs to be laid out like an execution plan. So, once they reach the point where somebody says no, they don't walk away with their head down, they've got more firing ability, the same kind that made them successful on active

1 duty and in combat.

2 So, that's our charge. We're

3 working with DoD to do that, because DoD will

4 have to cash in, will have to ante up on this.

5 You can't do it in two and a half days.

6 MR. ORTIZ: And I've got to tell

7 you, one of the biggest things that we found

8 with employers is þ- and I tell them this all

9 the time, good, bad, or indifferent, I say

10 what employee do you know of in your company

11 that is willing to give up their life for you

12 without even thinking about it? It stops them

13 dead in their tracks. Then they don't have any

14 excuses, then they could turn around and say

15 you know what, sir, what can I do? Sir?

16 CSM DeJONG: Sir, the last thing þ-

17 the last question I'm looking at is, we do

18 have kind of an interesting dynamic with this

19 TAP. With the Marine Corps making it

20 mandatory, and the other forces not, and with

21 this transition, I can't remember the exact

22 time line you said that this new TAP had come

1 out, but I would assume that you're taking
2 statistics versus how Marine Corps young men
3 and women are getting jobs versus how many
4 that are not mandatory and getting jobs. I'm
5 not asking for that answer now, because I know
6 it's a fairly new transition to this new TAP,
7 but in the future I'd like to see those
8 metrics, if we could.
9 MR. ORTIZ: And you know what,
10 Sergeant Major, let me þ- you're absolutely
11 correct. We've transitioned over 2 million
12 individuals in the past 20 years. Can I tell
13 you who has gotten a job because of TAP? No,
14 sir, I can't. That's the honest to God truth.
15 However, in this new system, just so that you
16 understand, Phase I, we awarded the contract
17 on 15th August. By the end of this month
18 we're going to be beta testing it in different
19 sites. Specifically, I can't say right off
20 the bat, but we're looking at possibility of
21 Fort Bragg, possibility of Norfolk, Camp
22 Lejeune, Andrews as a beta site. Why?

1 Because we write the curriculum, we test it,
2 we check different things, and we'll have our
3 DVOPs and LVERs doing this.
4 By 11/11/11, the magical number
5 everybody keeps throwing out there, we will
6 have a redesigned TAP Program curriculum. I
7 want you to understand that. We will have the
8 curriculum done. The implementation of this
9 program realistically is not going to be done
10 þ first boots on target will probably be
11 February, the first class. Actual
12 implementation of the program will probably
13 not happen until next January. But during
14 that time, we still need to be able to
15 transition individuals out. And during that
16 time, Sergeant Major, who knows? Next week
17 Senator Murray's bill may pass where it says
18 mandatory TAP for everybody. And if that's
19 the case, then we'll be able to put everybody
20 through that.
21 Now, the one kicker on that is, if
22 that happens tomorrow, I'm not going to be

able to come back and tell you how many people got jobs specifically. Why? Because I won't have a test bed. Those 80 percenters that I'm þ- the 80 percent that are going through a program, I know there's 20 percent off. I can at least tell you out of the 80 percent, these amount got jobs. But if everybody goes through the Transition Assistance Program, how am I going to answer that question for you, Sergeant Major? You see what I'm saying.

However, we're trying to build the metrics in so we can find out if the job þ- if the TAP is working, if it's moving the way it should, is the program doing what it's supposed to be doing, is it helping people get jobs? And if they do get a job, and they self-identify, how many of those translated back to what we've done on the TAP side.

CSM DeJONG: But at this point in time þ- how long has the Marine Corps been mandatory? Okay, it's a long time.

MR. ORTIZ: It's 20 years.

1 CSM DeJONG: Do we know the
2 percentage of marines, young men and women
3 that come out that do get employment?
4 MR. BURKE: Yes, can I go þ- I
5 think I have þ- I sit on the committee with
6 all of the service transition managers for
7 each one of the services. And being an army
8 guy, I'm going to talk from this end of the
9 table about army. I will tell you that the
10 Army has issued guidance on TAP, and the
11 guidance went from the Secretary of the Army
12 to field commanders, and his expectation is
13 for the transition process to begin for all
14 service members who are not retiring nine
15 months out, nine months out. So, I've seen
16 that guidance in writing.
17 I think what you're going to find
18 is the services are going to migrate toward
19 policy that makes it mandatory without being
20 told by Congress.
21 From the Marine Corps standpoint,
22 even though it's mandatory you need to

1 understand that 100 percent don't go through
2 TAP. It's about 88 percent, because even
3 though it's mandatory, the Marine Corps gets
4 about 88 percent. Army is doing it in the
5 high 70s right now, mid to high 70s without it
6 being mandatory. So, I think, first of all,
7 we're moving toward that end with or without
8 legislation. The services are doing that on
9 their own.
10 But I want to talk about TAP, when
11 you start to look at the Marine Corps
12 juxtaposed to the Army. The Marine Corps has
13 a lot of young first termers. I mean, they
14 let a lot of first termers go. And when you
15 look at that metric, it's really hard for
16 those first termers like that because their
17 high school classmates have four years up on
18 them out there in the job place. So, there's
19 a challenge getting the young men and women
20 into employment.
21 But I will say this about TAP,
22 when you look at the TAP Employment Workshop

1 and the redesigned curriculum, that is not the
2 panacea for this program. The reason is you
3 can have a redesigned TAP, a great curriculum,
4 great online tools and what have you, and you
5 go to a TAP Employment Workshop and you see
6 the workshop classroom is about this big with
7 150 soldiers sitting in it. And that won't
8 help.
9 We've got to get it down to a 25
10 to 35 class ratio, and then it could be
11 effective. That's going to be a challenge for
12 the military services. I know the Army will
13 have a shot. They'll get it done, but I think
14 it's going to be a challenge. They've already
15 said it.
16 So, the other thing when you look
17 at þ- look at the conditions. Is it þ- look
18 at not only how it's presented, but also look
19 at the conditions that þ- what's conducive to
20 learning here?
21 Another thing about the TAP
22 Workshop, there's going to be homework. It may

1 not be two and a half days contiguous. You
2 might come in for half a day or a day, and not
3 show up to your next part of TAP until next
4 week with the expectation that you've done
5 something between now and then. So, this thing
6 is kind of out of the box a little bit.
7 MR. ORTIZ: So, ladies and
8 gentlemen, I mean, it's very important for us
9 to make sure we take care of our transitioning
10 service members and our veterans. And we will
11 continue to do that.
12 I'm here to let you know that
13 we're working it. There are still some kinks,
14 but we're going to make it happen one way or
15 another. And with your help, hopefully, make
16 it worker a little quicker than it's been.
17 On that note, I think we've
18 overstayed our welcome.
19 CO-CHAIR CROCKETT-JONES: Well,
20 thank you very much.
21 MR. ORTIZ: Ma'am.
22 CO-CHAIR CROCKETT-JONES: It's

been very informative. Thank you for the information.

MR. ORTIZ: Thank you.

CO-CHAIR CROCKETT-JONES: And I believe that we have covered everything for this business meeting?

MS. DAILEY: Yes. I have no further business.

CO-CHAIR CROCKETT-JONES: Well, we're all looking forward to the installation visit job starting next week.

(Whereupon, the above-entitled matter went off the record at 4:43 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Care, Management and Transition of Recovering Wounded Task Force

Before: US DoD

Date: 10-05-11

Place: Arlington, VA

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter