DEPARTMENT OF DEFENSE

RECOVERING WARRIOR TASK FORCE MEETING

ST. ANTHONY RIVERWALK WYNDHAM HOTEL - PERAUX ROOM

300 EAST TRAVIS STREET

SAN ANTONIO, TEXAS

DECEMBER 8, 2011

08:33:03 1 LT GEN GREEN: Okay. Ladies and gentlemen,
08:33:11 2 it's good to have everybody together again,
08:33:12 3 although we don't have all our members and so I
08:33:12 4 apologize. I was talking with Suzanne Crockett
08:33:15 5 and she has some issues. Apparently she's -- that
08:33:18 6 preclude her being here and of course I missed our
08:33:20 7 meeting in October. So, we're kind of catching up
08:33:23 8 a little bit or at least I'm catching up a little
08:33:23 9 bit.
08:33:27 10 Ms. Dailey, thank you for bringing us
08:33:29 11 together. This is the second business meeting of
08:33:30 12 our second year of effort and our first meeting
08:33:33 13 outside of the Washington, D.C. area. So, we're
08:33:36 14 very excited to be here in San Antonio. I'm
08:33:38 15 really excited by this voice. Wow. And so before
08:33:44 16 we begin, I'd like to ask the members to introduce
08:33:47 17 themselves since we are in a new venue. So, if we
08:33:49 18 could start with you, Ron.
08:33:51 19 MR. DRACH: Yes. Okay. Good morning. I'm
08:33:56 20 Ron Drach. I'm one of the civilian members of the
08:33:59 21 task force. I was wounded in Vietnam in '67 and
08:34:03 22 have worked ever since I got back from Vietnam in
08:34:06 23 the area of veteran benefits, services and
08:34:08 24 programs.
08:34:09 25 CSM DEJONG: Good morning. Command Sergeant

08:34:09 1 Major Steve DeJong, DoD member of the National
08:34:12 2 Guard, wounded in 2004.
08:34:20 3 MR. REHBEIN: David Rehbein, one of the
08:34:23 4 civilian members of the task force. Past national
08:34:26 5 commander of the American Legion, research
08:34:29 6 scientist by profession and veterans advocate by
08:34:32 7 avocation.
08:34:33 8 DR. PHILLIPS: Morning. I'm Steve Phillips.
08:34:35 9 I'm a medical doctor. My war was Vietnam. 25
08:34:38 10 years in the reserves. I work at the National
08:34:41 11 Institute of Health and I'm a non-DoD civilian
08:34:44 12 member of the task force.
08:34:48 13 DR. TURNER: Good morning. I'm Russ Turner.
08:34:49 14 I'm also a physician and retired Air Force flight
08:34:53 15 surgeon and my war was the Gulf War.
08:34:56 16 MSGT MACKENZIE: Morning, sir. Master
08:35:00 17 Sergeant Christian MacKenzie, the -- one of the
08:35:03 18 military members on this task force. Also
08:35:05 19 occupying the seat as a SOCOM representative.
08:35:08 20 Wounded when shot down in Fallujah in 2004. Been
08:35:13 21 advocating for our wounded, ill and injured to
08:35:15 22 include working forces coalition as a liaison for
08:35:18 23 the last four and a half years.
08:35:22 24 LT COL KEANE: Lieutenant Colonel Sean
08:35:23 25 Keane, Marine Corps rep to the task force and

08:35:27 1 Marine Corps liaison to the VA.
08:35:30 2 LT GEN GREEN: And I'm Bruce Green. I'm
08:35:32 3 currently the Air Force surgeon general, the Air
08:35:35 4 Force rep to the task force and I don't know that
08:35:37 5 I have any other claims to fame. Okay. I am your
08:35:40 6 military co-chair on the task force. Okay. And
08:35:47 7 so, Steve, I understand you're going to be
08:35:48 8 stepping in for Suzanne.
08:35:50 9 DR. PHILLIPS: I will. I will.
08:35:51 10 LT GEN GREEN: Okay. Thank you, sir. All
08:35:54 11 right. So, I think that we're probably ready to
08:35:57 12 get on with business. I'm not certain where we're
08:36:03 13 going. Denise, help us out here.
08:36:06 14 MS. DAILEY: Yes, sir. We're going to spend
08:36:09 15 the next few hours, ladies and gentlemen, talking
08:36:12 16 about our installation visits. If you'll go to
08:36:14 17 tab B, I've briefly listed the installation visits
08:36:30 18 that we have attended in the last three months,
08:36:32 19 since October; and I'd like the members to
08:36:34 20 discuss, give us some of their outtakes, some of
08:36:38 21 their impressions, how we viewed the various
08:36:42 22 locations that we visited and the perceptions of
08:36:48 23 the service members that we talked to there. We
08:36:50 24 can start with Landstuhl.
08:37:05 25 LT GEN GREEN: Steve, you want to start us

08:37:08 1 off with your experience at Landstuhl.
08:37:09 2 CSM DEJONG: I know last year on the task
08:37:11 3 force a lot of -- one of the reasons that we had
08:37:12 4 chosen Landstuhl was because we were getting a lot
08:37:15 5 of feedback that a lot of decisions were made at
08:37:19 6 Landstuhl, a lot of different courses of action
08:37:21 7 were set up at Landstuhl. So, I know when we sat
08:37:24 8 down last year we talked about going there to get
08:37:26 9 the underground truth to see what happens, what
08:37:28 10 decisions are made and how soldiers, airmen,
08:37:31 11 marines end up at the locations that are chosen
08:37:35 12 for them back in the United States. One of the
08:37:38 13 good things that we did learn is that the only
08:37:40 14 real decisions that are made there as far as
08:37:41 15 destination -- because some of the feedback that
08:37:43 16 we'd been getting was that Landstuhl made the
08:37:46 17 decision to send my soldier to X and it's so far
08:37:50 18 away from home. So, the underground truth that we
08:37:54 19 did find there was that other than medical
08:37:57 20 decisions and medical treatment decisions, their
08:37:59 21 next choice of location was to send them as close
08:38:02 22 to their home of record as possible to be with
08:38:05 23 their family and they did fully believe in the
08:38:08 24 wholistic healing process of being close to family
08:38:12 25 where that's going to help them heal. A lot of

08:38:17 1 good information came out of that. I'll pass it
08:38:19 2 off to anyone else that wants to take that one.
08:38:22 3 MSGT MACKENZIE: Well, sir, the -- as a --
08:38:25 4 working over there as a liaison, as well as taking
08:38:28 5 care of the wounded, ill and injured coming out of
08:38:31 6 Landstuhl, I concur with the sergeant major that
08:38:34 7 it's -- that the decisions that are being made
08:38:35 8 over there are based on medical necessity, the
08:38:38 9 competency of the facilities that are provided.
08:38:41 10 However, the decision as to exactly where they end
08:38:45 11 up going is made by the individual service
08:38:47 12 branches.
08:38:47 13 Some of the things that we discovered that
08:38:49 14 we've all been talking about. In the Army
08:38:51 15 situation, you know, STARC is making the call.
08:38:54 16 You know, if they have a choice of facilities,
08:38:56 17 they're making the call. It's not actually the
08:38:58 18 medical team who's making the call. So, some of
08:39:00 19 the misunderstandings that were happening at the
08:39:02 20 site visit and other facilities, it's not my
08:39:04 21 decision, it's the hospital commander.
08:39:07 22 Number two, one of the things that we
08:39:08 23 discovered in the Navy reserve portion is that
08:39:12 24 they have -- that they are now sending them only
08:39:15 25 to two locations. They're either coming into Fort

08:39:19 1 Smith or they're coming into San Diego, with no
08:39:22 2 consideration given whatsoever by the Navy as far
08:39:25 3 as the family piece. So, you add that medical
08:39:27 4 piece and then these are the two entry points
08:39:29 5 they're coming in.
08:39:30 6 The -- sitting down with the hospital
08:39:32 7 command sergeant major, the -- although it was at
08:39:36 8 times hard to really describe what the service
08:39:40 9 liaisons do in Landstuhl, it was considered an
08:39:44 10 absolutely invaluable piece. You know, those
08:39:46 11 individuals -- those non-medical individuals that
08:39:48 12 run around putting hands on and working with these
08:39:51 13 people individually was an absolutely needed
08:39:55 14 program. However, it was certainly endorsed and
08:39:59 15 resounded not only by the liaisons; but by the
08:40:03 16 hospi -- medical command staff that a training
08:40:05 17 program needs to be in place to expose those
08:40:07 18 folks. USSOCOM does a training period before we
08:40:12 19 send any of our guys over there. However, at
08:40:15 20 times, some of the liaisons that are there, their
08:40:19 21 first exposure to what they're going to see as
08:40:21 22 they stand at the back of that bus is not briefed
08:40:25 23 to them at all.
08:40:26 24 So, we did identify a need for training for
08:40:29 25 those liaisons over there. The -- so that process

08:40:34 1 is unique to Landstuhl, but yet very, very
08:40:37 2 effective. So --
08:40:40 3 LT GEN GREEN: Is there service training for
08:40:43 4 the liaisons? In other words, is it all being
08:40:43 5 done -- you said USO?
08:40:45 6 MSGT MACKENZIE: No. No, sir. The -- we,
08:40:47 7 as SOCOM, train our guys before they go over.
08:40:51 8 That's part of what happens. The -- however,
08:40:55 9 across the board, there's no set training program.
08:40:57 10 It's normally done as on-the-job training. You
08:41:00 11 know, these folks are selected, normally hand
08:41:03 12 picked. With the exception of the Air Force, the
08:41:06 13 liaisons are hand picked and sent over and then
08:41:09 14 it's up to the folks in place in country to
08:41:12 15 actually do the training. So, it's -- it's all
08:41:14 16 done on the job. Word of mouth. And it was
08:41:19 17 definitely expressed to us not only by the command
08:41:22 18 sergeant major, but by some of the senior liaison
08:41:24 19 officers that a training program should be in
08:41:26 20 place because that -- the process itself, the
08:41:28 21 liaison, needs to continue; but there needs to be
08:41:32 22 a training program.
08:41:34 23 The -- and then the other -- the other
08:41:35 24 service specific thing that we discovered over
08:41:37 25 there is within the Air Force the two liaisons who

08:41:42 1 are sent over there are actually done as a request
08:41:45 2 for forces and they are not actually managed and
08:41:49 3 under the same chain of authority with the A-1 and
08:41:52 4 the -- you know, the responsible authority within
08:41:55 5 the Air Force for casualties. It's actually part
08:41:57 6 of an AEF rotation and the -- it's -- I haven't
08:42:01 7 been through the process with the Air Force; but
08:42:03 8 basically you submit the paperwork on a request
08:42:05 9 for forces, they say, yes, you're qualified and
08:42:09 10 you go. It's not an actual interview process and
08:42:11 11 a hand-picking process, which was a definite
08:42:13 12 challenge for the Air Force liaison we spoke to
08:42:16 13 over there.
08:42:23 14 DR. PHILLIPS: Let me just add. I support
08:42:26 15 what has been said. In general there's a common
08:42:29 16 theme that we've seen throughout many of the
08:42:31 17 visits that the training and the standards are not
08:42:34 18 really formalized. Something specific to Germany,
08:42:42 19 the rotation of the cadre. The time is somewhat
08:42:46 20 short. They've expressed that they would like to
08:42:49 21 have more time than one year.
08:42:53 22 The care and management of the acutely
08:42:58 23 injured soldier and their families is excellent.
08:43:00 24 Beyond reproach. We spent a little time in the
08:43:03 25 intensive care unit and had a chance to talk to

08:43:06 1 some of the doctors and see one of the patients
08:43:09 2 and I was very, very impressed, based on what I
08:43:12 3 used to do, that this is cutting edge treatment
08:43:14 4 and care and also the management and compassion
08:43:17 5 for the families. Some of the issues in Germany
08:43:22 6 that came up was some of the more chronic
08:43:27 7 management and care is somewhat decentralized.
08:43:29 8 It's a little difficult to get to some of the
08:43:31 9 services because they're outside of CONUS and they
08:43:36 10 have to depend on the local medical health care
08:43:40 11 facilities that they contract with to help out.
08:43:44 12 The other issue that we ran into is that
08:43:46 13 those who choose to retire directly from overseas
08:43:52 14 have some more administrative difficulties than
08:43:54 15 those that are in the US just because of distance,
08:43:59 16 communication, paperwork and so forth.
08:44:07 17 CSM DEJONG: Just to carry on with that
08:44:09 18 cadre. A lot of frustrations coming from the
08:44:12 19 senior chief of the Navy that was there was it was
08:44:14 20 a one-year tour. Most of their backfills for the
08:44:17 21 cadre is coming from the reserve forces on both
08:44:20 22 the Air Force and the Navy side and maybe some
08:44:22 23 military -- or some Army.
08:44:25 24 There is no -- so, when they looked at that
08:44:26 25 one year, by the time they actually get them

08:44:29 1 trained -- because there isn't a time period and
08:44:31 2 there isn't funding set up to allow them to be
08:44:33 3 trained prior to getting there. They spend the
08:44:36 4 first couple of weeks on a very short -- I
08:44:38 5 wouldn't even call it a left seat/right seat ride
08:44:42 6 -- to the point of -- they're kind of thrown in
08:44:44 7 and they've got about a week time and then they're
08:44:47 8 rotating out, their counterparts are rotating out
08:44:50 9 because there is no funding or time for overlap of
08:44:53 10 training.
08:44:54 11 Basically, the way they broke it down, sir,
08:44:57 12 was you've got a three week -- the first couple of
08:44:58 13 months of them learning their job, they've got
08:45:00 14 about a good four months of them having a good
08:45:03 15 handle on it and then they're -- so, they're only
08:45:06 16 getting about eight months -- out of the year,
08:45:08 17 they're only getting about eight months of good
08:45:10 18 quality work out of them, is what they would call
08:45:12 19 it, because they are finally comfortable with what
08:45:15 20 they have to do and then they're leaving again.
08:45:18 21 Most of them are requesting to stay. Requesting
08:45:20 22 to have an extension of orders. Most are being
08:45:22 23 denied based off of the -- how it's allocated, but
08:45:26 24 they would like to see that be about a two-year --
08:45:29 25 two-year billet. Both for the patient care side

08:45:32 1 because when you -- the focus groups and some
08:45:34 2 feedback is -- is -- I mean, it's the same as what
08:45:37 3 we heard last year. It's a lot of about the time
08:45:39 4 I get to know my non-medical case worker or my
08:45:44 5 cadre, they're rotating out and someone's starting
08:45:47 6 over and I feel like I'm starting out again from
08:45:50 7 the beginning.
08:45:57 8 LT GEN GREEN: So, did he have any
08:45:59 9 suggestions? I mean, two years is actually
08:46:01 10 almost -- you're almost better off assigning these
08:46:03 11 people and so the difficulty becomes how do you
08:46:05 12 identify folks. I mean -- so, on the medical side
08:46:09 13 we have assets that go into place that kind of
08:46:12 14 work the patient regulation and the aeromedical
08:46:16 15 staging. So, the movement on and off airplanes,
08:46:19 16 even the ticketing; but some of the things that
08:46:21 17 we're talking about in terms of liaison for
08:46:23 18 families that are coming through or those types of
08:46:26 19 activities are clearly something that's now new
08:46:29 20 with this war and so is he suggesting that we
08:46:36 21 should PCS the unit people and are there certain
08:46:38 22 units based on the flow of casualties that he
08:46:41 23 would try to have certain specialities? I'm
08:46:43 24 wondering if it fits into what's -- and I'll use
08:46:45 25 an example from the Air Force, but I think others

08:46:48 1 are using -- the DTC. So, deployment transition
08:46:53 2 center. So there are line people in certain
08:46:56 3 specialties that basically help people decompress
08:46:59 4 for a day or two before they come back to the
08:47:01 5 states.
08:47:01 6 Clearly if what you're talking about is
08:47:04 7 longer than a day or two, they'd be doing this
08:47:06 8 with multiple casualties who are now ingrained in
08:47:09 9 the hospital; but are you looking for something
08:47:11 10 where they're assigned along that manner.
08:47:14 11 CSM DEJONG: Somewhat. They're looking
08:47:16 12 for -- they would like to get them there trained.
08:47:18 13 They're looking at adding -- his suggestion was
08:47:20 14 increasing the amount of training that they're
08:47:22 15 doing and that's for liaisons especially. The
08:47:25 16 Navy mission over there is -- somebody's got to
08:47:29 17 correct me. I can't remember what that acronym
08:47:30 18 was. It started with D and I'm going to -- I'm
08:47:32 19 not going to put it on record because I'm going to
08:47:34 20 say something completely wrong; but, basically,
08:47:37 21 whatever their acronym stands for -- it will come
08:47:39 22 to me -- they move the patient movement in and out
08:47:42 23 of theater. They're receiving them -- and anybody
08:47:44 24 jump in if I start messing this up.
08:47:48 25 MSGT MACKENZIE: The Navy, sir, has been

08:47:50 1 there -- actually, they're the longest standing
08:47:51 2 that's been at Landstuhl and the Navy actually
08:47:54 3 does the medical case management for both Navy and
08:47:58 4 Marine Corps that come through there. So, they're
08:48:01 5 actually out of -- Naples I believe is the
08:48:04 6 headquarters and so they're -- they are the one
08:48:05 7 unique group because not only do they do the
08:48:08 8 liaison piece, but they're also the case managers
08:48:11 9 for Navy and Marine Corps personnel coming
08:48:16 10 through.
08:48:16 11 LT GEN GREEN: And are they also PCS or are
08:48:20 12 they just being given an alternative duty location
08:48:23 13 in Europe?
08:48:29 14 MSGT MACKENZIE: I'm trying to remember. I
08:48:30 15 don't believe the majority of them, no, sir,
08:48:32 16 they're not. They're -- I think within the Navy
08:48:36 17 piece there may be one or two that are PCS, but
08:48:39 18 the majority of it, no, sir, it's -- they're on a
08:48:42 19 temporary -- temporary duty status and some of the
08:48:45 20 additional folks that come in are -- in the same
08:48:48 21 way they follow the Navy deployment rotation.
08:48:53 22 Navy reserve deployment rotation coming in there.
08:48:56 23 LT GEN GREEN: One of the reasons I'm asking
08:48:57 24 so many questions is we're fairly fortunate to
08:49:00 25 have a fairly large logistics hub coming back

08:49:04 1 through Europe and therefore a large territory
08:49:07 2 hospital that's doing some of the stabilization.
08:49:09 3 In other areas of the world if we weren't coming
08:49:12 4 back through Europe, it's not quite as clear. In
08:49:14 5 the Pacific, for instance, where that large
08:49:16 6 hospital would be. Perhaps Tripler, but it's not
08:49:19 7 necessarily on the normal logistics routes and so
08:49:23 8 these kinds of things become even more imperative
08:49:26 9 if you're going to have to stand up a base
08:49:29 10 somewhere and do this on a rotational basis; and
08:49:31 11 so the length of the rotations, be they one year,
08:49:35 12 and that's really too short for the liaisons for
08:49:38 13 families, then the question is how do you pull
08:49:40 14 this together because it starts driving a whole
08:49:43 15 different concept in terms of support for people
08:49:45 16 coming back through these large logistics hubs.
08:49:50 17 MSGT MACKENZIE: Sir, USSOCOM actually PCS's
08:49:53 18 their liaisons in place. So, it's because of that
08:49:58 19 reason that continuity -- the continuation of
08:50:01 20 care. It is -- within the Army it is done based
08:50:05 21 on the rotation. So, these guys are in place
08:50:08 22 based on the division that they're supporting and
08:50:11 23 so those guys do rotate out; but in the case of
08:50:16 24 the Air Force and the Navy, these one-year
08:50:18 25 rotations -- you know, we heard one of the

08:50:22 1 corpsmen basically say, you know, I'm coming over
08:50:25 2 here for a year. You know, if it becomes my
08:50:27 3 choice, not to stay for two would be better than
08:50:30 4 not knowing if I can stay for two. In other
08:50:33 5 words, you go for one year, you're guaranteed that
08:50:35 6 if you want it, you meet the requirements, you're
08:50:38 7 actually going to be there for two years would
08:50:41 8 actually be better. I don't know how to do that.
08:50:43 9 It sounds kind of strange, but it's -- you know,
08:50:46 10 knowing that that second year exists and the --
08:50:49 11 some of these folks are -- you know, they're --
08:50:52 12 they're grabbing this mission. They're stepping
08:50:54 13 up to the plate going, "I want to be this person";
08:50:59 14 but yet they don't have any -- you know, the
08:51:01 15 dickens is -- in one particular case it was, you
08:51:04 16 know, you're at the end of your year, bye.
08:51:08 17 This guy's doing an outstanding job and it's
08:51:11 18 like it doesn't make sense to them. And that's
08:51:12 19 one of those frustrations and then there's that
08:51:15 20 lack of overlap and you start to see that stuff
08:51:18 21 happen; but --
08:51:19 22 LT GEN GREEN: Are all the liaisons military
08:51:21 23 members and is that the right answer?
08:51:23 24 MSGT MACKENZIE: Yes, sir, absolutely. And
08:51:25 25 the preponderance of experience is not necessarily

08:51:28 1 medical. This is a -- all the medical care is
08:51:32 2 happening. All that medical stuff is happening on
08:51:35 3 that facility. It's that non-medical coordinator
08:51:38 4 piece that -- that communication piece from the --
08:51:42 5 the combatant commands, from the units back in the
08:51:47 6 states, the families and that wounded warrior
08:51:50 7 who's laying in the bed and that's a lot of what
08:51:53 8 those liaisons are connecting those pieces on and
08:51:55 9 being able to make that stuff happen and that's
08:51:57 10 what was identified as being a very critical piece
08:52:00 11 to the mission there at Landstuhl.
08:52:04 12 DR. PHILLIPS: I would suggest that all of
08:52:06 13 these issues that have been discussed and some
08:52:08 14 that we haven't remembered, the short rotation,
08:52:11 15 the inability to overlap personnel for on-the-job
08:52:14 16 training, the lack of formalized training and on
08:52:17 17 and on and on, I think suggests an argument for
08:52:20 18 what we have been discussing. A more formal
08:52:26 19 program with perhaps an MOS or secondary MOS and
08:52:31 20 recognition that these folks are a critical
08:52:33 21 component to the whole system and not just kind of
08:52:37 22 picking them up based on division needs and so
08:52:42 23 forth.
08:52:47 24 CSM DEJONG: Sir, a lot of the
08:52:48 25 frustration -- it's kind of -- when you get into

08:52:50 1 reserve forces there's always that difficult time
08:52:53 2 period that they're only authorized so much time
08:52:56 3 and not given time to train up. The senior chief
08:52:59 4 that was there, she had asked for, you know, a
08:53:02 5 period of time. You're almost looking at a
08:53:04 6 two-and-a-half year set of orders. It'll be two
08:53:09 7 years at Landstuhl, but give them -- give them a
08:53:11 8 month or so -- give them some leeway to get
08:53:13 9 trained before they get there, allow some overlap
08:53:17 10 for a good two-week left seat/right seat and
08:53:21 11 then -- so, you're looking at a two-and-a-half
08:53:24 12 year commitment and then everything else that goes
08:53:27 13 into that with funding and allocations.
08:53:34 14 LT GEN GREEN: I guess -- let me ask just a
08:53:36 15 couple of other questions. Are the liaisons
08:53:38 16 principally working with active duty transients
08:53:41 17 and not family members at this point in terms of
08:53:44 18 the transit? Is it mostly active duty interface?
08:53:47 19 MSGT MACKENZIE: Sir, the preponderance of
08:53:49 20 the liaison duties is dealing with the service
08:53:51 21 member. However, when the need arises, they are
08:53:54 22 the go-to people with the family. The -- in the
08:53:58 23 case of the Marine Corps, in particular, the --
08:54:02 24 and USSOCOM does the same thing. When it is
08:54:04 25 critical enough to bring the family into Germany,

08:54:07 1 those guys never leave the family's side. They
08:54:09 2 are part of that whole process. The Marine Corps
08:54:12 3 especially. They assign one of their -- their
08:54:14 4 team members and that marine is with that family
08:54:17 5 the entire time they're on station there at
08:54:20 6 Landstuhl. So, when the need arises, that portion
08:54:24 7 is there. However, the preponderance is the
08:54:28 8 movement of service members through Landstuhl and
08:54:33 9 that's the majority of the job, working those
08:54:35 10 coordination pieces.
08:54:39 11 CSM DEJONG: But the Navy, in addition to,
08:54:41 12 is running pretty much the outpatient clinic
08:54:44 13 that's there. They're taking everybody in.
08:54:45 14 They're taking the non-critical ones that are not
08:54:48 15 going straight to a ward. They're in-processing
08:54:51 16 them. They've got the -- for the life of me -- I
08:54:54 17 wrote it down somewhere.
08:54:55 18 MS. DAILEY: DMWT.
08:54:57 19 CSM DEJONG: DMWT? I was going to say that,
08:55:00 20 ma'am; but I wasn't sure. Which is pretty much
08:55:03 21 their outpatient clinic which -- when the
08:55:06 22 non-severely wounded or very severely wounded come
08:55:09 23 in, they process them in, they start the
08:55:12 24 paperwork, they're seeing the Navy doc that's
08:55:14 25 there. They're going through and doing all of the

08:55:17 1 more routine injuries that -- for the patients
08:55:20 2 that are there, you know, 72 hours or less and
08:55:22 3 then moving somewhere else. So, they've got an
08:55:26 4 extreme workload with a very fluid staff that
08:55:29 5 they're trying to -- they're meeting the mission
08:55:31 6 and they're doing it. It's just very difficult
08:55:33 7 based off of the in -- the rotation of their folks
08:55:37 8 and having to retrain them along with dealing with
08:55:40 9 all the outpatient service members that are coming
08:55:43 10 through there.
08:55:49 11 LT GEN GREEN: So, let me just change the
08:55:51 12 subject just for a second. So, in terms of where
08:55:53 13 these folks are staying, so all these transient
08:55:56 14 folks, did you take a look at quarters and family
08:55:59 15 arrangements and all kinds of things in terms of
08:56:02 16 how we take care of people while they're there?
08:56:06 17 Did that look satisfactory?
08:56:07 18 CSM DEJONG: Yes, sir. It's outstanding and
08:56:11 19 even from going through there in 2004 and I don't
08:56:14 20 remember much about it. I was pretty much in ICU,
08:56:16 21 but in 2009 when I went back through there, it has
08:56:20 22 come leaps and bounds even above what was there.
08:56:23 23 Quarters are great. The family arrangements are
08:56:27 24 there for -- especially the critically wounded. I
08:56:32 25 had nothing bad to say. It was outstanding and

08:56:34 1 they're doing great things.
08:56:43 2 LT GEN GREEN: I guess the only thing --
08:56:44 3 coming back to the discussion. So, Steve, you
08:56:47 4 talked about the skills and training leading
08:56:49 5 towards a specialty to do this, trying to get the
08:56:52 6 right people; and yet it's something that we only
08:56:55 7 run into in terms of casualty flow with a war.
08:57:00 8 So, this is an unusual war for America because of
08:57:03 9 the length of time it's gone on. So, to actually
08:57:06 10 train people and sustain that for something that
08:57:08 11 would happen irregularly, it's kind of -- so, one
08:57:10 12 of the questions I had and asked whether or not
08:57:12 13 this was -- should be military or civilian is
08:57:15 14 could you use a family member? In other words,
08:57:18 15 can you -- could you train a spouse that was
08:57:20 16 assigned in Europe to become a liaison to do some
08:57:24 17 of these kinds of things? I'm just asking for
08:57:26 18 your take. I mean, you guys saw it.
08:57:28 19 MSGT MACKENZIE: Sir, multiple rotations
08:57:31 20 over there in Landstuhl as a liaison. It can't.
08:57:35 21 It does not work because the -- one of the things
08:57:37 22 about being a liaison at Landstuhl is that visual
08:57:40 23 connection between the wounded warrior and a
08:57:43 24 member of his unit, his command. That connection
08:57:47 25 right there. When you're -- you know, in my case

08:57:49 1 in 2004 when I was medevaced out of Iran, I was
08:57:53 2 completely blind. Couldn't see anything. Had no
08:57:56 3 one with me and the sound of the voice -- the
08:58:00 4 connection of someone saying, "Hey, I'm from
08:58:04 5 exactly where you're at. I'm your guy." That
08:58:06 6 connection helps to settle the unintended
08:58:12 7 consequence of being so good at medevacing
08:58:15 8 casualties out off the battlefield. You know, we
08:58:18 9 are so good at getting them to medical care that
08:58:20 10 that one piece that's missing is the fact that one
08:58:23 11 minute you're with your team, the catastrophic
08:58:27 12 incident happens, the next minute there's no one
08:58:29 13 around that you know, that you can connect with,
08:58:31 14 that provides that safety that -- that everything
08:58:35 15 is going to be okay, I can focus on what the
08:58:37 16 doctors are doing. And those liaisons -- you
08:58:41 17 know, in the Army situation, you know, having that
08:58:43 18 patch right there, you know, it's -- I saw it time
08:58:46 19 and time and time again where when you roll up to
08:58:49 20 that wounded warrior and say this is who I am and
08:58:53 21 this what I'm here for, it completely sets the
08:58:56 22 tone to initiate these guys' recovery and it's
08:59:00 23 very valuable.
08:59:03 24 DR. PHILLIPS: I think General Green makes
08:59:05 25 an excellent point of the peaks and valleys that

08:59:08 1 we face with these conflicts. In a perfect world
08:59:12 2 I would -- I would prefer to have a professional
08:59:16 3 component of the DoD doing this. In a perfect
08:59:21 4 world. But we're not in a perfect world and
08:59:25 5 perhaps a certain component of folks should be
08:59:29 6 trained and well-monitored contractors as we use
08:59:34 7 for other types of jobs to support the efforts
08:59:38 8 internationally. I would -- I would just guess as
08:59:42 9 an entrepreneurial nation, that we would find
08:59:47 10 agencies and companies that would be probably
08:59:49 11 interested in doing things like that. Retired,
08:59:54 12 you know, nurses or physicians or administrators
08:59:56 13 and so forth that under the DoD umbrella could
09:00:00 14 perhaps be mobilized when we need them.
09:00:07 15 LT GEN GREEN: Can I ask did they have any
09:00:09 16 experience with a liaison that didn't work out and
09:00:11 17 I'm asking not because I'm interested in the
09:00:14 18 specific circumstance, but wondering how they
09:00:16 19 oversee and make decisions on effective versus
09:00:19 20 non-effective. So, where are the liaisons
09:00:22 21 assigned? Are they assigned to a service lead of
09:00:24 22 some kind?
09:00:25 23 MSGT MACKENZIE: Each -- each individual
09:00:29 24 liaison there, the command and control is somewhat
09:00:34 25 different in each particular case. In SOCOM's

09:00:38 1 case, of course, they answer directly to
09:00:41 2 headquarters. However, we do a personal and
09:00:43 3 thorough hand-picking of these candidates. These
09:00:46 4 candidates are provided by the -- the special
09:00:50 5 operations units who say this is my guy that I
09:00:52 6 want to be there. Then we go through a whole
09:00:54 7 training process and review before we send them
09:00:57 8 over there. The -- I know the hospital command
09:01:00 9 sergeant major expressed the fact that sometimes
09:01:04 10 he looks at some of these guys and goes, "I wish I
09:01:06 11 had a connection to their command because we
09:01:08 12 probably need somebody new, it's not working out";
09:01:11 13 but with that -- with that being said, the things
09:01:15 14 that we are asking of our liaisons over there, it
09:01:18 15 has to be -- it's not a pass or fail. It has to
09:01:21 16 be -- we just need to get somebody else because
09:01:23 17 this isn't working out. It's nothing personal.
09:01:25 18 You know, until you're at the back of that bus,
09:01:28 19 you know, that's not a measurable -- that is not a
09:01:32 20 measurable requirement that you could tell
09:01:34 21 somebody they have to put up with or to be good at
09:01:37 22 dealing with. So, the -- it does propose a
09:01:41 23 challenge.
09:01:42 24 I think the command sergeant major at least
09:01:44 25 in the last year and a half has really gotten

09:01:46 1 heavily involved in interacting, at least on the
09:01:50 2 Army side, with that and done very well with it.
09:01:52 3 He just wishes at times they were more hand picked
09:01:55 4 and better trained before they arrived. So, it's
09:02:02 5 -- it's kind of difficult to answer; but it's when
09:02:05 6 we -- when we figure out what that recommendation
09:02:08 7 is, we have to keep in mind the fact that it's not
09:02:10 8 a pass or fail. It's just we need to get somebody
09:02:15 9 -- I don't know if I'm expressing that enough; but
09:02:17 10 sometimes you look at somebody and go, hey, this
09:02:19 11 job is just not for you. Not that there's
09:02:21 12 anything wrong with you, it's just that this is
09:02:23 13 more than you can handle and rotate that person
09:02:25 14 out; but the -- the only one I'm most experienced
09:02:31 15 with is the SOCOM piece and we're very, very
09:02:35 16 involved with what our guys are doing and making
09:02:36 17 sure that we have the right caliber of individuals
09:02:38 18 over there.
09:02:39 19 LT GEN GREEN: So, the other side of
09:02:40 20 continuity is burnout and so have they had any
09:02:43 21 experience with people -- since they're mostly on
09:02:45 22 one-year tours, with folks who really were
09:02:47 23 overwhelmed or were not able to deal with some of
09:02:50 24 the things that they found themselves having to
09:02:52 25 deal with with either the members or their

09:02:54 1 families?
09:02:55 2 CSM DEJONG: The burnout piece, sir, was
09:02:57 3 mentioned when we talked about lengthening the
09:03:00 4 tour over there. Two years seems to be, based on
09:03:04 5 what their experience is, what they're looking at
09:03:07 6 to be the right number based off of the number of
09:03:11 7 soldiers, airmen, sailors that have actually asked
09:03:14 8 for an extension of one year. They think anything
09:03:16 9 over two years probably would get to the point of
09:03:19 10 burnout. It also ends up looking at some sort of
09:03:23 11 formal -- I mean, they have a leadership -- a
09:03:27 12 chain of command there, but it -- there is a
09:03:29 13 portion of that to where they need to be monitored
09:03:32 14 and checked based off of the flow that's coming in
09:03:36 15 because you can see some of them -- it's kind of
09:03:39 16 personality driven also. You get the -- you get
09:03:42 17 the service members that are really out there,
09:03:44 18 they're there for the right reason and they want
09:03:47 19 to do the right thing and they will run 24/7/365
09:03:50 20 to do the right thing. There's other ones that --
09:03:53 21 based off of what the command sergeant major
09:03:56 22 said -- it's possibly leadership challenges that
09:03:59 23 it is a command selection of who they put in for
09:04:02 24 liaison that -- kind of like picking your rear
09:04:05 25 deck commander that's going to stay back with the

09:04:07 1 families. Sometimes it seems like they were hand
09:04:10 2 chosen to take that just to -- they didn't have to
09:04:14 3 deal with them in theater and that's -- that's
09:04:16 4 where you start getting the wrong answer for being
09:04:19 5 liaison because if you chose them there just
09:04:24 6 because -- the command chose them because they
09:04:26 7 don't want to deal with them and now you're asking
09:04:28 8 them to deal with all the families and the
09:04:30 9 wounded. So, it doesn't work out sometimes; but
09:04:34 10 two years seems to be what they feel would be the
09:04:37 11 right timeline.
09:04:41 12 MS. DAILEY: Sir.
09:04:42 13 MR. DRACH: If I could --
09:04:42 14 LT GEN GREEN: Go ahead.
09:04:45 15 MR. DRACH: -- just add a general comment.
09:04:48 16 I think -- I wasn't in Germany with the group, but
09:04:52 17 just listening to what I'm hearing and there's a
09:04:56 18 component that may be missing in this whole thing
09:04:59 19 and I don't know how you factor it in and I think
09:05:04 20 Mac touched on it a little bit. If, you know,
09:05:06 21 they screen their people, then train them.
09:05:07 22 Because one thing that you can't train people in
09:05:10 23 is passion for what they're doing and, you know,
09:05:13 24 you can give them all the training in the world;
09:05:16 25 but if this is a duty that I don't really want or

09:05:19 1 a duty that's corollary to what my main function
09:05:22 2 is and I don't have the passion -- you know, we --
09:05:26 3 back in the '70s when we started the DVOP
09:05:29 4 program -- I think you have one of the DVOPs
09:05:31 5 early -- you've got to have the fire in the belly.
09:05:33 6 You know, you don't need -- in some areas
09:05:36 7 you obviously do need an education, but you don't
09:05:39 8 necessarily need a Ph.D. You need the passion,
09:05:41 9 you need that fire in the belly and to just
09:05:45 10 randomly assign, you know, people without
09:05:47 11 screening them and trying to make sure that they
09:05:50 12 have that passion for what they're doing, the
09:05:53 13 training is -- I don't think is going to be very
09:05:56 14 effective.
09:05:58 15 MS. DAILEY: General Green, we also did talk
09:06:00 16 with them about capturing their lessons learned.
09:06:04 17 They've taken 10 years, they've built this whole
09:06:07 18 system, they've got a very good structure and back
09:06:09 19 to your comment in the beginning about can you
09:06:13 20 replicate it something else -- somewhere else, we
09:06:16 21 did talk with them about capturing lessons
09:06:18 22 learned. Maybe bringing over the Army historian
09:06:21 23 or the Army center for lessons learned to create a
09:06:25 24 -- a historical effort of how they did it, what's
09:06:31 25 its structure now, what does it look like now and

09:06:34 1 allow, you know, another operation to replicate it
09:06:38 2 if required.
09:06:43 3 MSGT MACKENZIE: Thank you, Denise. I was
09:06:44 4 trying to remember what it was they asked us most
09:06:46 5 importantly as a task force and that was on those
09:06:49 6 things. Is they do not have the time to assemble
09:06:50 7 something like that and having a group of experts
09:06:51 8 come over to do it would definitely capture it.
09:06:54 9 The only thing I want to mention on Dr.
09:06:57 10 Phillips' comments is this process over there is
09:06:59 11 incredibly fluid. You could not set up a group of
09:07:02 12 contractors because you can't identify the time.
09:07:05 13 You can't mathematically compute the time and how
09:07:08 14 long that process will last. However, I think we
09:07:11 15 need to get out of the paradigm of having to have
09:07:15 16 a MOS or AFSC and this whole rigid format. This
09:07:20 17 needs to be the ability of a, you know, temporary
09:07:24 18 assignment code that says you're going to go here
09:07:27 19 and this is the information and the training and
09:07:28 20 so forth that's required for this code for this
09:07:31 21 one-year period of time so if we ramp up into --
09:07:35 22 we continue this conflict and ramp into the next
09:07:38 23 war, commanders have the ability to stand this up
09:07:41 24 under a temporary or limited assignment code that
09:07:44 25 says here's my requirements. You know, we all

09:07:46 1 talk about this going on for 10 years; but part of
09:07:49 2 our process is also about how do we record this
09:07:51 3 back into a book on the shelf so our commanders
09:07:54 4 can open this book when we have to do this again
09:07:57 5 and I think that's -- that's really where it needs
09:08:00 6 to be looked at in that aspect.
09:08:06 7 LT GEN GREEN: So, I think that that's a
09:08:08 8 good summary, Mac; and we can probably go on to
09:08:11 9 the next site visit. This idea of really caring
09:08:14 10 about our own is kind of universal and the hard
09:08:18 11 part in this is how do you basically take lessons
09:08:23 12 so we don't have to learn these lessons again and
09:08:25 13 so I think that's part of what they're expecting
09:08:28 14 us to do in terms of the things that we catalog
09:08:31 15 and so clearly we have to figure out how we're
09:08:33 16 going to do this.
09:08:35 17 I mean, there's other lessons along these
09:08:38 18 lines in terms of -- I'll stay out of the
09:08:41 19 casualties for a minute, but in terms of how we
09:08:43 20 help countries rebuild after something like this
09:08:45 21 and some of the things that have been put into the
09:08:48 22 reserves and did we have enough when we went into
09:08:50 23 the war and so same kind of issue here. So, where
09:08:54 24 do you put these things if you don't use them
09:08:56 25 regularly, how do you train them and if you can't

09:08:59 1 train a whole MOS, which I suspect you're exactly
09:09:02 2 right, how do you have a professional cadre of
09:09:05 3 people whose job it is to make sure these programs
09:09:08 4 actually get put in place, knowing that we're
09:09:11 5 going to see this with any type of hostile
09:09:13 6 activity and flow of casualties. So, I think it's
09:09:17 7 a good discussion. How about we shift a little
09:09:20 8 bit and talk about Fort Knox. So, Ron, you want
09:09:23 9 to start us off? I'm sorry. Steve. Yes, Steve
09:09:26 10 was there. I'm sorry. Yeah, I was just thinking
09:09:30 11 about Ron's comments. So --
09:09:34 12 CSM DEJONG: Fort Knox, sir. Fort Knox has
09:09:39 13 come a long way. I was there in -- it was kind of
09:09:43 14 reliving two years of my life. I was there in
09:09:47 15 2004 and I was also there again in 2008, 2009.
09:09:51 16 They have -- a lot of the challenges that they
09:09:54 17 have is the same as every WTU that we've seen.
09:09:59 18 One of the added challenges was -- prior to our
09:10:02 19 site visit but about a year ago was they were one
09:10:05 20 of the WTUs that was staffed primarily by National
09:10:08 21 Guard soldiers and at that time it was probably --
09:10:11 22 I'd say about 12 months ago now is when the state
09:10:14 23 of Kentucky did a 100 percent title 10 recall of
09:10:18 24 all of their soldiers, which also decimated their
09:10:22 25 WTU. From command teams all the way down to

09:10:26 1 cadre. They lost about 75 to 80 percent of their
09:10:29 2 cadre within a 14-day period and I know that they
09:10:32 3 were reaching out across the -- all of the local
09:10:35 4 states trying to find anybody and everybody that
09:10:37 5 could actually add cadre to it because they were
09:10:41 6 overstaffed. They were running two companies at
09:10:45 7 the time and they were losing -- losing it all.
09:10:48 8 They're carrying forward. They are staffed well
09:10:53 9 now and looking at the model as far as manning,
09:10:57 10 they have more soldiers than what they actually
09:11:01 11 should be allocated and they're looking at
09:11:03 12 standing up a third company there and don't really
09:11:06 13 know how they're going to make that all happen
09:11:09 14 based off the allocations that they have.
09:11:22 15 DR. PHILLIPS: Just to add to that. They
09:11:24 16 were quite concerned about how they were going to
09:11:26 17 deal with the returning surge needs, as you
09:11:28 18 mentioned. The other issues were really, again,
09:11:34 19 common themes that we hear at other bases. It was
09:11:39 20 a difficulty to transfer into the WTU based on the
09:11:46 21 line unit's needs for manpower. We've heard that
09:11:50 22 repeatedly at the focus groups. How long it took
09:11:53 23 to get to the WTU. There were some personal
09:11:57 24 issues in one of the WTUs, I forget which one,
09:12:04 25 related to cadre and not being compassionate and

09:12:07 1 so forth; but that's just a one-time thing. And
09:12:11 2 then again the general issues related to the
09:12:15 3 transition process. If they were going to
09:12:19 4 transition to discharge, again, the process for
09:12:23 5 many was long and burdensome. I think it was Fort
09:12:28 6 Knox where -- and correct me -- where there was
09:12:30 7 one senior enlisted who was in the process for 800
09:12:40 8 days. I forget which -- whether it was Knox or
09:12:44 9 Carson; and, again, if they were transitioning to
09:12:47 10 discharge, they were concerned about having to
09:12:51 11 really be involved in the military activities over
09:12:57 12 the health care and rehab activities. A small
09:13:03 13 number wanted to transition back to active duty
09:13:06 14 and, again, there were some issues related to what
09:13:10 15 they could do based on their injuries and rehab.
09:13:18 16 At Fort Knox it was remote. It was
09:13:21 17 difficult to get outside care and support. Fort
09:13:26 18 Carson, which is obviously a lover facility and
09:13:30 19 community, they had no trouble finding people to
09:13:33 20 work there, as opposed to Fort Knox, which was a
09:13:38 21 little more difficult. There was one rule that we
09:13:42 22 could not really uncover the reason for. Do you
09:13:45 23 remember the two-hour rule? Do you remember that?
09:13:50 24 CSM DEJONG: It was --
09:13:53 25 DR. PHILLIPS: This was -- if they were in

09:13:54 1 the clinic for an appointment at 9:00 a.m., they
09:13:58 2 could not have the next appointment for two hours
09:14:01 3 and just basically had to sit there and wait. It
09:14:03 4 was related to credit for the physicians.
09:14:07 5 CSM DEJONG: Provider credit or something
09:14:09 6 like that. So, it didn't -- it did show a delay
09:14:12 7 in -- I wouldn't say delay in service. It just
09:14:16 8 seemed to be a -- a very organized way of doing
09:14:25 9 business.
09:14:25 10 DR. PHILLIPS: And a correctable --
09:14:27 11 potentially correctable issue.
09:14:32 12 LT GEN GREEN: So, really, you're saying
09:14:34 13 that they wouldn't book another appointment
09:14:36 14 because something about getting credit for the
09:14:38 15 workload?
09:14:39 16 DR. PHILLIPS: There was some, yeah,
09:14:40 17 administrative issue that you had to wait two
09:14:43 18 hours between appointments in the same clinic
09:14:46 19 facility. Whether you were seeing a neurologist
09:14:48 20 at one, an orthopod at the next, you had to wait
09:14:51 21 two hours and the staff seemed a little
09:14:53 22 frustrated. In fact, I think it was one of the
09:14:56 23 nurse colonels that brought that up.
09:14:59 24 CSM DEJONG: The case managers were -- it
09:15:00 25 made their job very difficult because they

09:15:02 1 couldn't schedule -- they couldn't send a service
09:15:04 2 member to the hospital and have them get all of
09:15:06 3 their appointments done in a short amount of time.
09:15:08 4 They had to separate all of their appointments by
09:15:11 5 no less than two hours and when you're juggling
09:15:14 6 a -- several hundred service members and trying to
09:15:19 7 separate each appointment by two hours, it just --
09:15:22 8 it added a level of chaos that seemed to be
09:15:25 9 unnecessary.
09:15:29 10 LT COL KEANE: Sergeant Major, was that
09:15:30 11 covered in the out briefing?
09:15:33 12 CSM DEJONG: It was -- yes, sir, it was.
09:15:35 13 Some of that has to do with just provider
09:15:37 14 contracts and provider -- it's levels above. It's
09:15:40 15 in the physician world of how they get credit for
09:15:43 16 what they -- the services they provide.
09:15:49 17 LT GEN GREEN: Have we seen that anywhere
09:15:51 18 else? That's the first time I've heard this.
09:15:53 19 CSM DEJONG: Yes, sir, it's -- it's wide.
09:15:58 20 DR. PHILLIPS: It's other places?
09:16:00 21 CSM DEJONG: Yes.
09:16:00 22 MSGT MACKENZIE: And it's -- especially with
09:16:02 23 the reserve component soldier it's an extreme
09:16:03 24 challenge. These folks are traveling trying to
09:16:06 25 get their stuff and it's that added level of

09:16:09 1 frustration where I'm going to the hospital to get
09:16:11 2 treatment; but I'm sitting around twiddling my
09:16:13 3 thumbs. You know, I want to come in, get what I
09:16:15 4 need to get and get out; but yet they're not --
09:16:18 5 there's no -- it's not being perceived as a
09:16:20 6 medical necessity to have those two hours. It's
09:16:23 7 perceived as a -- as bureaucracy. It doesn't help
09:16:28 8 them out at all.
09:16:30 9 CSM DEJONG: Fort Knox is constantly
09:16:33 10 evolving the services that they have there. Most
09:16:35 11 of -- when I was there several years back, all the
09:16:37 12 TBI screening, PTSD screening was all done in
09:16:43 13 Louisville off site. They're now building a new
09:16:47 14 clinic there that handles a lot of the TBI, PTSD.
09:16:52 15 It's not complete yet, sir. That is -- was it
09:16:53 16 complete? Was it up and running or was it going
09:16:55 17 to be running in a couple of weeks?
09:16:57 18 MS. DAILEY: It was not.
09:16:58 19 CSM DEJONG: It was not. Okay. They were
09:17:00 20 in the process of finishing it up and getting
09:17:02 21 services there under the same footprint or real
09:17:05 22 close to the same footprint as WTU to avoid some
09:17:10 23 of that travel and the outsourcing of services for
09:17:12 24 the service members.
09:17:19 25 DR. PHILLIPS: Again, I want to reemphasize

09:17:21 1 or at least bring up the issue of do the
09:17:23 2 recovering sick and ill and wounded have to
09:17:26 3 actively participate in any of the military
09:17:29 4 activities. For example, as they were cutting the
09:17:31 5 ribbon for the new facility and all the
09:17:34 6 dignitaries were seated and all of the recovering
09:17:37 7 warriors were standing at attention for the
09:17:37 8 service.
09:17:40 9 MSGT MACKENZIE: That was Fort Carson.
09:17:46 10 DR. PHILLIPS: Well, yeah, I was combining
09:17:48 11 both -- both comments.
09:17:50 12 CSM DEJONG: It seems -- it doesn't really
09:17:54 13 matter what WTU you go to or where you go, you're
09:17:57 14 going to have the conflict of perceptions of
09:18:01 15 trying to balance a command environment -- a
09:18:04 16 military command environment with an environment
09:18:09 17 established for healing and there's going to be
09:18:12 18 personality changes and -- personality differences
09:18:15 19 on each side of what they should be or what they
09:18:18 20 shouldn't be doing.
09:18:19 21 I constantly do see the challenges of
09:18:22 22 commanders coming in there and trying to still
09:18:27 23 maintain a military environment and sometimes
09:18:32 24 that -- that mindset of maintaining a military
09:18:35 25 environment doesn't always take into consideration

09:18:37 1 the needs of what someone truly does need for
09:18:41 2 healing. It's a difficult balance to make and
09:18:47 3 I've seen it all over and I don't really know what
09:18:49 4 the right answer is for it of how to -- because a
09:18:52 5 lot of it's personality driven and a lot of it is
09:18:56 6 sometimes command driven; but each -- I mean, one
09:19:01 7 of the recommendations that I had looked at or one
09:19:04 8 of the -- when I sat down and looked at it is, you
09:19:06 9 know, if this was my battalion or if this was my
09:19:10 10 company, how would I do different things.
09:19:12 11 Sometimes I think I'm looking at it across the
09:19:14 12 WTUs. Especially when we were in Kaiserslautern.
09:19:17 13 The resources that were available were so
09:19:20 14 far and few between. They had five different
09:19:21 15 locations in Germany trying to get soldiers healed
09:19:25 16 and I asked the sergeant major, I said, "You know,
09:19:27 17 have you ever thought about just kind of
09:19:29 18 concentrating your fires in each location?" If
09:19:31 19 you've got -- looking at five different companies
09:19:33 20 trying to get the limited resources out to each
09:19:36 21 company. Have you looked at making one -- you
09:19:40 22 know, if you can lump your service members into
09:19:42 23 return to duty in one location and then provide
09:19:45 24 the services for a return to duty in that location
09:19:48 25 and then if you've got ones that are going to be

09:19:50 1 PCS to home to medically retire, can you provide
09:19:53 2 those in one location. Just kind of match your
09:19:56 3 fires instead of trying to fire for effect all
09:19:59 4 over the battlefield and have people running all
09:20:01 5 over. I don't know if that's the right answer.
09:20:02 6 He did kind of consider it.
09:20:04 7 And even when we come back to CONUS, looking
09:20:07 8 at setting up companies within the WTUs that are
09:20:11 9 focused on what the needs and what the outcome of
09:20:13 10 that service member is going to be. If we know
09:20:16 11 we've got service members that are going to
09:20:19 12 ultimately be returning to civilian life, what I
09:20:23 13 talked to the sergeant major about was instead of
09:20:26 14 having these soldiers go to the training -- if I'm
09:20:29 15 a young staff sergeant, I don't need to -- and I'm
09:20:31 16 looking at trying to find my life in a civilian
09:20:35 17 world, I probably don't need to learn how to read
09:20:38 18 a map anymore. I don't need to do some of these
09:20:40 19 military trainings. I need to learn how to write
09:20:42 20 a resume, I need to learn how to become a
09:20:44 21 civilian, I need to learn how to become a father
09:20:48 22 and husband again. So, we almost need to look at
09:20:50 23 the WTUs and how -- and I don't even know how to
09:20:54 24 make a recommendation on it; but we need to look
09:20:57 25 at the outcome of our service members and where

09:20:59 1 they're going and provide the services and the
09:21:02 2 training for that outcome. Sometimes that's not
09:21:04 3 really being done. That's -- they're all lumped
09:21:06 4 into a company by assignment and Friday afternoon
09:21:11 5 training is going to be, you know, whatever it may
09:21:14 6 be and if I'm -- if that's not what I need, I'm
09:21:17 7 going to feel that I'm sitting here spinning my
09:21:19 8 wheels. And talking to the service members in the
09:21:22 9 focus groups, they said -- that was like a
09:21:24 10 resounding theme, where they wanted to learn how
09:21:29 11 to become a civilian and --
09:21:43 12 LT GEN GREEN: Is that complicated more by
09:21:45 13 the fact that the recovering warriors are a
09:21:50 14 mixture of folks with things associated with the
09:21:53 15 war and things that are just normal day-to-day
09:21:57 16 health care problems?
09:21:58 17 CSM DEJONG: Sir, I don't know if it's so
09:22:00 18 much complicated. There has to be a decision
09:22:02 19 point at some point in time and sergeant major
09:22:04 20 asked me, well, how would I make that decision
09:22:07 21 point; and I guess from my perspective of it is
09:22:09 22 once I have a -- once I had a service member that
09:22:13 23 I know was going down the MEB road -- and we've
09:22:16 24 got 300 and -- you know, 300 some days that
09:22:19 25 they're going to be on this road -- at that point

09:22:21 1 in time we know they're going to be medically
09:22:24 2 retired out of the military and that would be my
09:22:26 3 decision point as to, okay, you're going to go
09:22:28 4 into the company and we're going to -- into
09:22:31 5 whatever company it is and we are going to now --
09:22:33 6 your focus is writing resumes, looking at TAP,
09:22:37 7 looking at job opportunities or what can you do
09:22:40 8 based off the injuries and what you're going to be
09:22:43 9 leaving with, what can't you do and that your sole
09:22:45 10 focus in life is to work through the MEB process
09:22:48 11 and figure out where you're going to carry on as a
09:22:52 12 civilian in society.
09:22:56 13 DR. PHILLIPS: We heard that from family
09:22:58 14 members as well. Especially those that are living
09:23:02 15 off post and they are planning to transition back
09:23:05 16 into civilian life. Why does my husband have to
09:23:07 17 do this or that. And there's a certain amount of
09:23:11 18 military adherence that should be continued; but
09:23:17 19 why do they have to do certain things and, you
09:23:20 20 know, obviously we can list them. I don't have to
09:23:22 21 do that. We all know those things.
09:23:25 22 When I have children to take to school and I
09:23:28 23 have a job and yet I'm burdened with responding to
09:23:35 24 the requirements of the authorities for my husband
09:23:37 25 to do this when he's not going to be here in a

09:23:40 1 year or two.
09:23:43 2 LT GEN GREEN: And so this plays in pretty
09:23:47 3 well into some of the discussions that are going
09:23:50 4 to be coming up today, I think, as folks prepare
09:23:52 5 to talk to us about how we can better prepare
09:23:54 6 people for transition and so we'll hear more about
09:23:57 7 that, I think, as we go. And the folks who went
09:24:00 8 to Indiana.
09:24:01 9 MS. DAILEY: A real quick --
09:24:01 10 LT GEN GREEN: Oh, I'm sorry.
09:24:04 11 MS. DAILEY: Real quick. At Fort Knox we
09:24:08 12 did spend some time in Indianapolis at Roudebush
09:24:12 13 VA Hospital. It was a very good downward stream
09:24:18 14 look for the people coming out of Fort Knox. This
09:24:20 15 was also probably the first location where I think
09:24:23 16 we got a very good look at what's called the full
09:24:26 17 referral. What is the transition process from a
09:24:30 18 place like Fort Knox to a VA hospital in
09:24:34 19 Indianapolis, for example; and Fort Knox
09:24:38 20 demonstrated for us what the full referral was and
09:24:42 21 that process being where the case manager is
09:24:46 22 e-mailing, scanning, faxing a case to the VA
09:24:52 23 liaison there at Fort Knox and that VA liaison
09:24:56 24 then proceeds to set up appointments with
09:24:58 25 Roudebush Indianapolis at the VA hospital and they

09:25:03 1 were very efficient at showing us how that is
09:25:06 2 working and what that full referral means to the
09:25:09 3 veteran when they arrive at a VA hospital. So,
09:25:14 4 pulling that together was -- was very helpful for
09:25:17 5 us.
09:25:22 6 CSM DEJONG: Denise, do you want to mention
09:25:23 7 anything about the IDES facility at Knox?
09:25:27 8 MS. DAILEY: Yeah. Yes, sir. Brand-new
09:25:30 9 facility. Also a joint facility between the DoD
09:25:33 10 and the VA. They are -- they just stood up IDES
09:25:38 11 at Fort Knox on the 1st of October. So, I'm not
09:25:43 12 sure it's hit them. It would be better looked at
09:25:47 13 in process -- in its process in about a year.
09:25:51 14 The -- they have their joint facility. We talked
09:25:55 15 with the military service coordinators primarily
09:25:59 16 and they -- their piece is working well.
09:26:04 17 CSM DEJONG: I know one of the questions you
09:26:06 18 had, General Green, was -- and Ms. Dailey had
09:26:10 19 mentioned it -- was about rooms full of records
09:26:14 20 and they weren't shy about saying that, yes, they
09:26:17 21 still have rooms full of records that they're
09:26:18 22 trying to get through and trying to get scanned
09:26:21 23 into the system and they -- it's a monumental
09:26:24 24 task. They didn't really have a plan of how they
09:26:26 25 were going to get it done other than they were

09:26:27 1 nugging through it and trying to get it all done;
09:26:30 2 but there was still the -- and you had mentioned
09:26:32 3 something about it last year and it's still out
09:26:33 4 there. There's rooms full of records setting
09:26:36 5 there and they're trying to get them processed and
09:26:38 6 into the system.
09:26:41 7 LT GEN GREEN: Were you impressed? Did you
09:26:42 8 go visit the records room?
09:26:44 9 CSM DEJONG: We did not get a chance to see
09:26:46 10 the records room, sir; but -- I think they left us
09:26:49 11 purposely off of that site; but, yeah, IDES -- the
09:26:53 12 model that they have at Fort Knox, I don't know if
09:26:55 13 it's a true DoD model or if they're allowed to
09:26:59 14 kind of do their own thing. I think it's going to
09:27:01 15 work well. Didn't really get to see it in action,
09:27:03 16 other than there was a lot of briefings going on;
09:27:05 17 but everything is right across the hall from each
09:27:07 18 other. It seems like a service member can walk
09:27:08 19 back and forth and any questions that need to be
09:27:11 20 asked can be just across the hall. There seems to
09:27:14 21 be a good working network there. I'd be
09:27:16 22 interested in seeing it again when it was fully in
09:27:19 23 action and getting some feedback from some of the
09:27:21 24 service members that are going through it, see if
09:27:24 25 that is truly working.

09:27:26 1 LT GEN GREEN: Just from me to the members
09:27:29 2 as you go out on these visits. I ask that you do
09:27:32 3 take a look behind the scenes because it helps you
09:27:35 4 to understand what some of the folks are doing to
09:27:37 5 try and prepare the records for consideration by
09:27:40 6 the VA. This is beyond some of the work that's
09:27:43 7 going on just with recovering warriors; but it is
09:27:47 8 very impressive just to see the scope and how long
09:27:50 9 it takes to put the record together and so if we
09:27:53 10 can go back and see it, which is not something
09:27:55 11 that anyone is going to want to show you; but I
09:27:58 12 think that it's very enlightening.
09:28:02 13 DR. PHILLIPS: I probably should have jumped
09:28:03 14 on that, knowing how medical records work. One
09:28:06 15 area we didn't touch upon that perhaps we want to
09:28:10 16 just briefly discuss if we can is the
09:28:12 17 comprehensive transition plan and the issues with
09:28:14 18 that. Both the -- the soldiers and the cadre find
09:28:22 19 it a very burdensome and difficult system to use.
09:28:28 20 Complex downloading of the pages, lack of
09:28:32 21 response. Just checking the boxes and so forth.
09:28:35 22 I think Mac wants to comment.
09:28:37 23 MSGT MACKENZIE: The unique part about these
09:28:40 24 site visits so far this year is the fact that
09:28:43 25 the -- we're processing multiple locations and

09:28:46 1 we're starting to learn some of the nuances of
09:28:49 2 what's going on. The -- when we were at the WTU
09:28:54 3 in Kaiserslautern, one thing we learned in the
09:28:58 4 focus groups and then we began to see at the other
09:29:01 5 facilities was the fact that you talk to the squad
09:29:05 6 leader, you talk to the platoon sergeant, you talk
09:29:06 7 to the leadership and all that, yeah, the CTP
09:29:06 8 works. You talk to the service member and they
09:29:10 9 go, "It doesn't work." Well, besides the obvious
09:29:14 10 that everyone knows that the AKO interface on the
09:29:18 11 CTP is what causes the biggest problem with that,
09:29:22 12 what we found was the training on how to use the
09:29:25 13 CTP. These individuals are either not com -- not
09:29:32 14 understanding the training when it's first given
09:29:35 15 to them or there's no follow-up -- but there's no
09:29:37 16 follow-up training to make sure these guys
09:29:39 17 understand. Also what we found was when you
09:29:41 18 really think about it, as a -- as a warrior you're
09:29:45 19 sitting down, you are opening your heart and soul,
09:29:49 20 you are entering data that needs response on this
09:29:51 21 document. You're making a matter of official
09:29:53 22 record this transaction and what's happening at
09:29:57 23 times is these -- the soldiers are not connecting
09:30:01 24 that action with the one-on-one briefing with one
09:30:05 25 of the care providers or with the squad leader;

09:30:09 1 but what they are seeing -- why they say this
09:30:12 2 thing is junk is the providers are not -- what we
09:30:17 3 found out initially was they're not responding to
09:30:19 4 this. That soldier can't get on the CTP and go
09:30:23 5 this -- okay, I'm accountable to you to input this
09:30:26 6 information and I can visually see that you're
09:30:28 7 accountable to me and I see the responses to your
09:30:30 8 information. You know, that cross flow of action
09:30:35 9 was where it's actually missing. It's not that
09:30:38 10 the two processes are broke, it's actually
09:30:40 11 missing. So, to take that even a step further, at
09:30:43 12 another facility we found out that -- through one
09:30:46 13 of the focus groups. Unfortunately, Ms.
09:30:49 14 Crockett-Jones is not here. She's the one that
09:30:51 15 actually uncovered this. One of the individuals
09:30:53 16 she talked to said, "Well, what do you mean? I
09:30:56 17 know exactly where it is. Here it is right here."
09:31:00 18 Some of the -- the majority of the cadre, when we
09:31:02 19 went to another facility and asked the same
09:31:05 20 question, didn't know where it was. That actually
09:31:07 21 under my task is a tab where they can actually see
09:31:10 22 the comments of these medical professionals. And
09:31:12 23 we're sitting here with all these groups and stuff
09:31:15 24 we had with the CTP that that complaint was made.
09:31:18 25 The reality to it was nobody knew it existed or

09:31:22 1 did not remember that it existed or were not
09:31:24 2 trained properly that it existed, but the common
09:31:27 3 theme was if the CTP is going to work, it has to
09:31:30 4 be a two-way street; and that was where we were
09:31:33 5 able to nail down this problem that we keep seeing
09:31:36 6 over and over and over again where they say it
09:31:39 7 doesn't work. You know, through these multiple
09:31:41 8 visits when we started asking some of these
09:31:45 9 questions, you could ferret that out. Why do I
09:31:47 10 put this information in. You know, I put in this
09:31:51 11 comment -- this flagrant comment to see who's
09:31:54 12 listening to me. You know, the squad leader runs
09:31:56 13 across it and goes, okay, this thing is crap. You
09:31:59 14 know, greens the block, puts his information in,
09:32:02 15 the guy goes back home, pulls up the CTP and
09:32:04 16 doesn't see that the squad leader responded.
09:32:06 17 Thinks, okay, they don't care about me. Didn't
09:32:08 18 connect that interaction in the hallway with the
09:32:11 19 squad leader that said this guy is just messing
09:32:14 20 with us and can't see the response of the squad
09:32:16 21 leader. That's where I think we discovered a huge
09:32:20 22 disconnect in the user and the different levels of
09:32:25 23 user within that CTP.
09:32:30 24 DR. PHILLIPS: There was also some punitive
09:32:32 25 responses, as well. If someone honestly put in

09:32:35 1 that he was having or she was having some
09:32:37 2 psychological difficulties -- on occasion. This
09:32:40 3 is not universal, but on occasion we've heard
09:32:44 4 that. Well, you're confined to post then. You
09:32:46 5 cannot go out with the unit, as opposed to trying
09:32:49 6 to help them.
09:32:53 7 CSM DEJONG: It's the resounding PTSD mental
09:32:56 8 health stigma, sir, that keeps -- that we keep
09:32:59 9 beating up on every angle, every direction; but it
09:33:03 10 seems like the more service members are told that
09:33:05 11 there's going to be nothing punitive if they get
09:33:08 12 help and we're preaching that to all of our
09:33:10 13 soldiers from the highest levels down; but in
09:33:13 14 reality when a soldier does it, there is something
09:33:16 15 that they consider punitive. Whether they lose
09:33:19 16 a -- you know, they lose a weekend pass or they
09:33:21 17 lose a four-day pass, they're not allowed to go on
09:33:24 18 leave. Even going as far as to -- just the past
09:33:27 19 couple of days, to where your retainability is no
09:33:31 20 longer. We're finding over the -- every site
09:33:38 21 visit that the desire to hide mental health issues
09:33:41 22 or desire to -- it's not even a desire. It's that
09:33:43 23 they feel a need to hide it because they're --
09:33:47 24 what they're being told as far as non-punitive
09:33:51 25 actions, whether it's truly punitive or not, they

09:33:53 1 see it as a career stopper.
09:33:58 2 DR. TURNER: We were even actually told the
09:34:01 3 past few days that members were -- active duty
09:34:03 4 members were lying to their commanders to take
09:34:05 5 time off to go get treated for their PTSD.
09:34:09 6 LT GEN GREEN: Told by --
09:34:12 7 DR. TURNER: The members. No, by the
09:34:13 8 member.
09:34:19 9 LT GEN GREEN: -- commanders?
09:34:19 10 DR. TURNER: By members.
09:34:21 11 LT GEN GREEN: By members or -- I'm trying
09:34:22 12 to understand what your perspective is here.
09:34:25 13 MR. REHBEIN: By members of one of our focus
09:34:29 14 groups.
09:34:29 15 MSGT MACKENZIE: So, the individual
09:34:30 16 themselves worried about identifying themself as
09:34:33 17 needing it, so they were finding ways to take
09:34:34 18 leave or take time off to go see a civilian
09:34:36 19 provider so that the military didn't have to know
09:34:39 20 they had this problem.
09:34:45 21 LT GEN GREEN: I'm sorry. My head's about
09:34:47 22 to hit the desk in frustration here because we
09:34:50 23 have tried so hard not to make these things
09:34:53 24 happen. So -- yeah, I understand.
09:34:55 25 MSGT MACKENZIE: The other thing that the

09:34:57 1 sergeant major and I talked about a bit and some
09:34:59 2 of us that have been on these site visits have
09:35:02 3 started to see was the -- in a command climate
09:35:08 4 environment -- you know, I was brought up in a
09:35:10 5 whole different community; but as a senior NCO I'm
09:35:12 6 looking from a professional military standpoint at
09:35:17 7 what's going on and one of the things that I -- I
09:35:20 8 think we discovered and we kind of talked about we
09:35:21 9 started to see was we get concerned sometimes how
09:35:26 10 these issues end up popping up and if you really
09:35:29 11 break it down and go, okay, these people should be
09:35:31 12 self-advocating. You know, at what point do we
09:35:34 13 stop holding these guys' hands, where does this
09:35:37 14 advocacy come up; and as you look at it and start
09:35:40 15 to realize it, it's like are we training our young
09:35:43 16 warriors to self-advocate. When you think about
09:35:46 17 it, you bring an E2, an E3, you know, infantry
09:35:51 18 individual who was brought up in a very strict and
09:35:54 19 rigid climate within the Army and now you put them
09:36:00 20 into a situation of recovery from wounds and it's
09:36:02 21 the only way he knows how to operate. So, it's
09:36:07 22 not that -- I think sometimes we may be missing
09:36:10 23 the point. It's not that the care is not there
09:36:12 24 for this individual. They're waiting for this
09:36:15 25 individual to speak up and this individual does

09:36:16 1 not know that he can speak differently than the
09:36:19 2 way he is. And it was one of the things we talked
09:36:22 3 about with some of the cadre training was like at
09:36:23 4 what point do you go in as a squad leader or
09:36:28 5 platoon sergeant and say periodically I've got to
09:36:30 6 take this guy into another room so always good
09:36:31 7 order and discipline is maintained because we are
09:36:33 8 in the military, but at that point in time teach
09:36:36 9 this individual how to advocate for themselves and
09:36:42 10 we've had some -- we've had I think a lot better
09:36:44 11 turnout in a lot of these focus groups we've done
09:36:47 12 and I think we're really starting to see, at least
09:36:51 13 in the junior side, the younger side, this -- this
09:36:57 14 communication, this culture, this climate, we may
09:37:01 15 finally be seeing where this is now where this
09:37:04 16 barrier is with these guys that are going through
09:37:07 17 this process going -- and not knowing where
09:37:10 18 they're going and the reality is through no fault
09:37:13 19 of their own people are expecting them to speak
09:37:15 20 and they're standing there going I don't know how
09:37:17 21 to speak; but the connection is not being made.
09:37:21 22 So, that's another thing we discovered in this
09:37:23 23 throughout.
09:37:24 24 CSM DEJONG: I'll leave it in Indiana I
09:37:27 25 knew -- I was a little more comfortable there and

09:37:29 1 I can speak pretty intelligently about a lot of
09:37:33 2 what was happening based on the fact that it was
09:37:35 3 happening to a lot of my soldiers. Along the
09:37:38 4 mental health line, sir, looking at the post
09:37:42 5 deployment health reassessments and post
09:37:44 6 deployment health assessments in coming back, you
09:37:47 7 know, I remember my last deployment coming back
09:37:49 8 and they told everybody that you're not going
09:37:52 9 to -- nothing -- put down honest. Be honest. Put
09:37:55 10 down what you want to put down. If you want to
09:37:57 11 talk to somebody, talk to somebody; and within two
09:38:03 12 months my office was filled with phone calls based
09:38:05 13 off of the fact that as soon as they did say they
09:38:08 14 wanted to talk to somebody, under PDHAs they were
09:38:12 15 automatically coded a 3 in the mental health side
09:38:15 16 of this. So, now you've got soldiers that have
09:38:18 17 come back from 12 to 18 months on orders, they're
09:38:24 18 looking at trying to catch up in their
09:38:26 19 professional careers, whether that's go to school,
09:38:28 20 go to wherever; and most of them -- as far as from
09:38:31 21 a command side, I had a multitude of soldiers that
09:38:34 22 could no longer -- I couldn't even get them into
09:38:37 23 school because they were coded a 3 in mental
09:38:40 24 health until they had further evaluation. Now,
09:38:41 25 that's pushing their careers further and further

09:38:44 1 back. So, when you look at that as far as the
09:38:46 2 soldier sees it, it's punitive and it was
09:38:48 3 happening. Made some direct questions to the
09:38:51 4 Indiana joint force headquarters about that and
09:38:54 5 they did recognize and they did admit that that
09:38:56 6 was happening and they were going back and trying
09:38:59 7 to correct it. I don't believe across the board
09:39:00 8 that it is fully corrected because they are still
09:39:03 9 being coded until screened and that screening
09:39:08 10 process, based off the sheer numbers, is taking a
09:39:10 11 long time. So, when you're look at the young NCO
09:39:14 12 trying to further his career and I can no longer
09:39:15 13 get them into the schools that they need, they see
09:39:18 14 it as punitive and that is just -- probably a lot
09:39:21 15 of them, because I've had them in my office, are
09:39:24 16 simply soldiers that just want to talk through
09:39:26 17 some issues and some life changing and some
09:39:29 18 reintegration. I don't know what the answer is or
09:39:34 19 how to code that. I mean, a lot of times as
09:39:36 20 leaders we do things to try to protect them and
09:39:39 21 protect ourselves based off of the liabilities and
09:39:43 22 whatever else and trying to -- good initiative,
09:39:45 23 poor judgment I guess. I don't know what the
09:39:47 24 answer is to fix it, but it is still a chronic
09:39:52 25 issue.

09:39:57 1 LT GEN GREEN: So, is the current concern
09:39:59 2 regarding why they're actually given profiles to
09:40:01 3 make certain that -- are they considered risks in
09:40:05 4 some manner? I mean, is this happening at
09:40:08 5 individual unit -- medical units that are
09:40:11 6 basically coding them on the profile and they're
09:40:14 7 being coded before they see the mental health?
09:40:17 8 CSM DEJONG: Yes.
09:40:18 9 LT GEN GREEN: That's also a little unusual.
09:40:20 10 CSM DEJONG: As soon as it shows up on the
09:40:21 11 PDHRA -- as soon as that screening comes through,
09:40:22 12 then they have to talk to a provider. As soon as
09:40:25 13 they say that they want further treatment for any
09:40:29 14 type of counseling, they're coded until further
09:40:32 15 screened. Some of them -- and there's a lot of
09:40:39 16 schools -- especially in my squadron that we have,
09:40:41 17 you know, there's a lot of schools that I can't
09:40:43 18 get them into because -- the sniper school for
09:40:45 19 instance. You know, a lot of guys are wanting to
09:40:48 20 go there and just based off the screening that
09:40:48 21 they have to do to get in, as soon as that code is
09:40:51 22 there, it locks them out. And looking at the
09:40:54 23 OPTEMPO of where a lot of these units in a lot of
09:40:57 24 these states are going on the guard side, you have
09:40:59 25 a very short opportunity to try to get your

09:41:02 1 soldiers trained before you're ramping up for the
09:41:04 2 next deployment. So --
09:41:11 3 MSGT MACKENZIE: That was -- the thing that
09:41:12 4 got me was that there was no assessment of the
09:41:15 5 severity. Okay. You've got an individual
09:41:16 6 that's -- just wants to talk to somebody before he
09:41:20 7 goes home. Just wants to have that communication
09:41:22 8 to make sure he's okay. He or she is okay.
09:41:25 9 There's -- it's a flat out deal. You either are
09:41:29 10 or you're not and that's what -- that's what
09:41:32 11 really, really bothered me is that there was no
09:41:35 12 acuity or severity consideration in this -- this
09:41:39 13 documentation.
09:41:42 14 LT GEN GREEN: Can you tell me where the
09:41:44 15 profiling is being done? Is it by the home unit
09:41:46 16 or is it by the folks reviewing the PDHRA? I'm
09:41:50 17 just wondering if there's something we should
09:41:52 18 actually go after fairly quickly to eliminate that
09:41:55 19 particular problem, because I don't know why they
09:41:57 20 should be automatically coding just based on a
09:41:59 21 questionnaire response, until there's been some
09:42:03 22 type of screening. Whether that screening is done
09:42:05 23 by mental health or by a primary care provider.
09:42:08 24 You know, there really should be somebody who is
09:42:09 25 making an assessment before they actually do a

09:42:12 1 profile. So, that's my concern right now.
09:42:14 2 CSM DEJONG: I'm going to take a shot at
09:42:16 3 this. I'm not going to say it's going to be a
09:42:18 4 hundred percent accurate. A lot of the -- on the
09:42:21 5 National Guard side a lot of the providers that
09:42:23 6 come in are -- there's a contract organization of
09:42:24 7 providers that come in. Now, they are
09:42:27 8 generally -- from my understanding, sir, they are
09:42:29 9 briefed as to how to code different things based
09:42:34 10 off responses to that -- to the PDHRA and that is
09:42:39 11 even -- that was coming back -- I can validate
09:42:41 12 that from some of the providers that were there.
09:42:44 13 They're not allowing the physicians to make a
09:42:47 14 judgment -- a personal judgment from their
09:42:50 15 professional expertise on it. They're pretty much
09:42:53 16 coming into a room, being briefed. You're here on
09:42:57 17 a contract, we've got 3200 service members coming
09:43:01 18 through, you're going to be looking at these and
09:43:04 19 obviously productivity is part of it. They've got
09:43:08 20 a large workload and they can't spend a whole lot
09:43:12 21 of time. So, what they -- my understanding was
09:43:13 22 they are briefed that if this is checked like
09:43:16 23 this, this is the code that goes along with that.
09:43:19 24 Now, where those directives are coming from, sir,
09:43:22 25 I'm not sure if that's state surgeons or if that's

09:43:26 1 above the level of the state surgeon.
09:43:35 2 LT GEN GREEN: Have you shared any of this
09:43:37 3 with the Army representative? With General Stone
09:43:40 4 or -- in terms of the guidance that may be coming
09:43:42 5 from MEDCOM? I'm going to take this back and ask
09:43:44 6 questions within the Air Force. I'm not sure on
09:43:47 7 the Navy side. Do we have -- we don't have our
09:43:51 8 Navy rep here today either. So -- okay. I'll --
09:43:55 9 at my level I can actually ask that question.
09:43:58 10 So --
09:43:58 11 CSM DEJONG: Sir, General Stone and I have
09:44:00 12 talked briefly off line about it. I never -- I
09:44:03 13 kind of got a few more answers while we were in
09:44:05 14 Indiana of getting some honest feedback from the
09:44:08 15 state surgeon and the other flight surgeon that
09:44:13 16 was there. Got a -- kind of narrowed it down a
09:44:17 17 little bit more to be able to -- but I've never
09:44:19 18 spoke formally and on the record with General
09:44:22 19 Stone, no.
09:44:27 20 LT GEN GREEN: Okay. I'm going to take that
09:44:28 21 one and kind of see if I can do a little
09:44:30 22 investigation beyond. Sometimes we don't really
09:44:33 23 want to wait for a report in a year. Okay. Is
09:44:36 24 that -- any other thing we need to talk about with
09:44:37 25 the joint force headquarters?

09:44:42 1 MSGT MACKENZIE: Yes, sir. One of the
09:44:44 2 things that was mentioned while we were there was
09:44:47 3 the -- the accountability of National Guard
09:44:53 4 members being discharged out of the WTU and
09:44:56 5 returned to the state. There seemed to be -- they
09:45:00 6 were discovering these National Guard soldiers
09:45:03 7 actually being back in the state without any
09:45:05 8 formal notification and the -- that the
09:45:10 9 communication chain -- I haven't had enough time
09:45:13 10 to do enough research, but the communication chain
09:45:15 11 is completely broke. When the National Guard
09:45:19 12 soldiers are being -- you know, we're not talking
09:45:22 13 VSI, we're not talking even seriously injured.
09:45:26 14 Some of these guys that are -- had the situation
09:45:27 15 they're at WTU, they're getting their treatment.
09:45:29 16 Okay, you're ready for a med board, they discharge
09:45:33 17 them out of the WTU and they go back to the state.
09:45:36 18 There was no apparent requirement of the WTU to
09:45:39 19 communicate with the state saying we are sending
09:45:42 20 your soldier back and when we ask that question
09:45:49 21 it's -- and, you know, I asked it in multiple
09:45:51 22 different ways. There is -- you know, that
09:45:52 23 requirement does not -- from what I can understand
09:45:55 24 so far without doing further research, that
09:45:57 25 requirement does not exist and the -- it was

09:46:02 1 brought up to us by several members there at the
09:46:04 2 joint force headquarters on the Army National
09:46:06 3 Guard side. That was a concern. They were really
09:46:09 4 getting fed up with getting word that someone in
09:46:12 5 town ran across this guy at the local convenience
09:46:15 6 store going, "When did you get back"; and they've
09:46:18 7 been back in the state for two months and no one's
09:46:21 8 known about it and that's -- it doesn't take the
09:46:25 9 ownership of the soldier to report in, but the
09:46:28 10 reality of it is from an ownership and a command
09:46:31 11 responsibility that that's something that
09:46:33 12 really -- I'm a career active duty guy, but it
09:46:37 13 bothered the heck out of me to hear that that was
09:46:40 14 even possible to happen.
09:46:45 15 MR. REHBEIN: General, if I may for a
09:46:46 16 minute. We didn't run into that exact same
09:46:48 17 situation in Massachusetts, the joint forces
09:46:51 18 headquarters; but we did hear concerns about
09:46:53 19 communication between them and the WTU. They
09:46:57 20 didn't understand exactly what the criteria were
09:47:00 21 that their folks were being assigned to the WTU as
09:47:04 22 opposed to the community base and there were
09:47:07 23 concerns raised about people being locked into the
09:47:10 24 WTU while the med board was going on when they
09:47:15 25 felt they could provide as good a care back home

09:47:19 1 in the CBWTU. So, there -- there are other
09:47:22 2 communication issues there beyond just simply the
09:47:25 3 soldiers coming home and the joint forces
09:47:28 4 headquarters not being aware of it.
09:47:34 5 CSM DEJONG: It really becomes a National
09:47:37 6 Guard bureau issue to where -- looking at --
09:47:39 7 Indiana gave us a pretty good briefing and I'd
09:47:44 8 mentioned it last year about their canine concept
09:47:45 9 of how they take care of their wounded, ill and
09:47:49 10 injured and how they provided the same yellow
09:47:52 11 ribbon program to Long Island W -- CBWTU that they
09:47:55 12 provide to a unit that comes in and walks into
09:47:58 13 Indianapolis airport. Again, what we're looking
09:48:02 14 at is every state adjutant general has the
09:48:05 15 authority and -- to kind of build his own process.
09:48:10 16 There doesn't seem to be a standard model across
09:48:15 17 the United States and across the National Guard
09:48:17 18 bureau of how we do this. Funding is different,
09:48:20 19 it's named different things and that doesn't
09:48:22 20 really -- name doesn't matter; but we've got to
09:48:24 21 look at a model of how are we going to capture all
09:48:27 22 of our wounded, ill and injured. How are we going
09:48:31 23 to ensure that they're tracked. There's been a
09:48:33 24 lot of soldiers from the state of Indiana that --
09:48:37 25 99 percent will go to Fort Knox. Some haven't.

09:48:40 1 That was one of the questions that we had at
09:48:43 2 Landstuhl about, you know, why -- when I'm getting
09:48:46 3 a call in my office from a family member who lives
09:48:49 4 in southern Indiana and has to drive to Fort
09:48:52 5 Bragg, North Carolina to see their wounded
09:48:54 6 soldier, why can't they come to Fort Knox, what's
09:48:58 7 the allocation? Based off the fact this was an
09:49:01 8 ortho injury and there wasn't specific medical
09:49:04 9 conditions keeping them that far from home.
09:49:07 10 We've got to look at the strategy of the
09:49:10 11 National Guard bureau coming up with a model of how we
09:49:13 12 maintain communication between the states, how they're
09:49:18 13 tracked and how they're taken care of when they come
09:49:20 14 home, whether it's CBWTU or not. CBWTU is a great --
09:49:26 15 is a great option for our service members to get care
09:49:28 16 close to home, but a lot of them get lost in the mix
09:49:32 17 and the major -- their commands completely lose them
09:49:37 18 because they might be there for 12 months or more and
09:49:40 19 then they just kind of fall off the books and they get
09:49:43 20 out and they disappear.
09:49:45 21 LT GEN GREEN: So, let me just seek a little
09:49:49 22 clarification. Is it a problem at all levels?
09:49:53 23 So, first level. Someone is transferred out of
09:49:56 24 theater to come back as a casualty. Is the unit
09:49:59 25 notified?

09:50:02 1 CSM DEJONG: Yes and no.
09:50:04 2 LT GEN GREEN: Okay. If the unit is
09:50:06 3 notified that there's somebody who is now a
09:50:08 4 casualty, be it, you know, seriously injured or
09:50:12 5 minor injury, then when they come back -- when
09:50:15 6 they've decided where they're going to go, if
09:50:18 7 they're going to be retained on active duty or go
09:50:20 8 to a WTU, are they then notified of going to a
09:50:24 9 WTU?
09:50:26 10 CSM DEJONG: Generally, all of that is -- is
09:50:27 11 done, sir, yes. The rear deck commander would be
09:50:32 12 notified some way, somehow that they have a
09:50:33 13 casualty coming out of theater. Once they're
09:50:36 14 processed through Germany and through wherever
09:50:39 15 they end up, they should be assigned a WTU. How
09:50:43 16 that notification goes back as to where they're
09:50:47 17 going to be assigned -- I know the state of
09:50:48 18 Indiana has gone -- has changed their process
09:50:50 19 multiple times and they have a good handle on --
09:50:53 20 because the adjutant general was taking it very
09:50:55 21 personally, down to the name, and he is briefed I
09:50:58 22 believe four or five -- weekly by name of who is
09:51:01 23 where; but there was a process and a learning
09:51:03 24 curve of having service members end up somewhere
09:51:06 25 and fall off the roster because notifications

09:51:08 1 weren't done properly or there wasn't a good
09:51:11 2 process to track them. What Indiana has evolved
09:51:15 3 to has come from trial and error. And what was
09:51:17 4 the ramification between that trial and error and
09:51:19 5 the detriment that we have done to some of our
09:51:21 6 wounded we may never know.
09:51:24 7 LT GEN GREEN: And so if -- so, basically,
09:51:27 8 I'm getting notified of casualty status, yes;
09:51:31 9 notified of WTU assignment, not necessarily or at
09:51:35 10 least not a formal process?
09:51:36 11 CSM DEJONG: Correct. I don't know of any
09:51:38 12 formal process -- and I can tell you what
09:51:40 13 Indiana's process is; but I don't know if it is a
09:51:43 14 standard across the National Guard bureau to do.
09:51:46 15 LT GEN GREEN: Notified of release from a
09:51:48 16 WTU?
09:51:49 17 MSGT MACKENZIE: Actually, back up to the
09:51:50 18 other process, sir. Once they enter the WTU,
09:51:53 19 that's where the breakdown begins to happen. It
09:51:56 20 is in the National Guard -- what I saw in the
09:51:58 21 National -- in reserve component visits in
09:52:01 22 multiple states so far this year was once that
09:52:04 23 happens it is now the responsibility of the state
09:52:08 24 and the individual unit to try and stay in touch
09:52:11 25 with their service member. There is no

09:52:13 1 responsibility of the WTU or CBWTU to report the
09:52:16 2 status to that service member's command.
09:52:24 3 LT GEN GREEN: And so when they're -- so,
09:52:26 4 I'm just going to take that one step further. I
09:52:28 5 understand what you're saying. So, then, when
09:52:30 6 someone is released from a WTU return to duty, I
09:52:33 7 would assume there's something that puts them back
09:52:36 8 in the unit?
09:52:41 9 DR. PHILLIPS: Not necessarily.
09:52:42 10 CSM DEJONG: I'll use my example, sir. My
09:52:44 11 last time at Fort Knox was -- my DD-214 was
09:52:48 12 processed at Fort Knox. I was given a set of
09:52:48 13 orders to return back to traditional title --
09:52:51 14 title 32 status and it was up to me to report to
09:52:54 15 my unit. Now, I was the first sergeant at the
09:52:57 16 time, so -- I mean, it made it pretty easy for me
09:52:59 17 to understand what to do. I could image myself
09:53:01 18 being a private -- private first class and saying,
09:53:05 19 okay, I guess I got to go back at some point in
09:53:07 20 time and not really knowing when. There's not a
09:53:11 21 warm handoff. We're talking strategically about a
09:53:14 22 warm handoff from DoD to VA. Well, there's no
09:53:18 23 warm handoff from the WTU back to a reserve
09:53:20 24 component unit.
09:53:23 25 LT GEN GREEN: Okay. And if they're

09:53:25 1 separated, are they then notified?
09:53:29 2 CSM DEJONG: That's -- that's a whole other
09:53:34 3 issue. If they're separated and a med board is
09:53:36 4 done say at Fort Knox, Kentucky and they're
09:53:39 5 medically retired, they're basically walking out
09:53:43 6 on a terminal leave and they're done; but now if
09:53:47 7 you want to look at the ramifications back to the
09:53:50 8 parent unit in the states, that's where we're
09:53:52 9 starting to -- there is no formal out processing
09:53:55 10 then from the state. So, that's where you start
09:54:00 11 losing equipment and you start all the out
09:54:03 12 processing and all the logistical nightmare that
09:54:06 13 goes in logistically.
09:54:09 14 MSGT MACKENZIE: And, sir, this gets
09:54:10 15 exponentially exasperating when you're look at the
09:54:15 16 Army deployment cycle and these guys are gone for
09:54:18 17 12, 15 months. They have put their stuff in
09:54:20 18 storage or taken it to mom and dad's. They don't
09:54:24 19 have a home, they don't have a telephone. For the
09:54:26 20 individual unit to find this guy is by word of
09:54:30 21 mouth, not -- that any communication they have
09:54:33 22 documented no longer exists -- because they gave
09:54:36 23 all that up to go do a 12, 15-month rotation --
09:54:39 24 when they come back.
09:54:41 25 LT GEN GREEN: So, we don't have our Army

09:54:43 1 rep here, so we're kind of relying on you, Steve.
09:54:48 2 The -- I guess the question is, so are they
09:54:51 3 actually assigned by order to WTU? Does that
09:54:54 4 become their new unit?
09:54:56 5 CSM DEJONG: Yes, sir.
09:54:57 6 LT GEN GREEN: And so, therefore, when they
09:54:58 7 leave the WTU, regardless of status, there's not
09:55:02 8 another assignment? A set of orders that tells
09:55:05 9 them to report wherever?
09:55:10 10 CSM DEJONG: There is a set of orders.
09:55:12 11 There's a formal set of orders that is given to
09:55:15 12 them to tell them to go and report and that is for
09:55:17 13 the return to duty soldiers or the release from
09:55:19 14 active duty soldiers. Where we're losing them,
09:55:23 15 primarily -- and generally that's not a -- not a
09:55:26 16 problem. Those soldiers coming back. They're on
09:55:28 17 a roster somewhere. We can find them. It's the
09:55:31 18 ones that are released from active duty or
09:55:35 19 medically retired from a WTU that we're losing. I
09:55:38 20 had a soldier that was on my UMR that I spent four
09:55:41 21 months trying to find. He had no phone, he had no
09:55:44 22 -- when we did finally find him, he lived in a
09:55:47 23 small little town in Indiana. Didn't like --
09:55:50 24 didn't answer the door because he didn't like
09:55:51 25 answering the door. He didn't like telephones, so

09:55:52 1 he didn't have a phone. I had a four-man team out
09:55:54 2 and we finally did find him. I said, you know,
09:55:56 3 "Where have you been? You've been on my UMR for
09:55:58 4 six months and I didn't know where you were?" He
09:56:00 5 said, "Well, they told me I was medically retired.
09:56:02 6 The VA told me I was done or that I had a hundred
09:56:06 7 percent rating and I just left. No one told me I
09:56:10 8 had to go back and report to anybody." Okay.
09:56:14 9 Fair enough. Those are -- those are -- that's the
09:56:20 10 difficulty.
09:56:22 11 LT GEN GREEN: So -- let me take one step
09:56:24 12 back. So, because they are changed unit
09:56:28 13 assignment in terms of the guard unit and assigned
09:56:31 14 to an active duty billet at a WTU, it makes sense
09:56:35 15 that when they're separated from that they're
09:56:37 16 actually separating from the unit they've now been
09:56:39 17 assigned to. So, the real question is do they
09:56:44 18 come off your books when they're assigned to the
09:56:47 19 WTU? So, for instance, some of the logistics
09:56:49 20 questions you're asking about I would think title
09:56:52 21 32 issuance, etcetera, logistics type thing, are
09:56:55 22 they not done when they go to the WTU and then
09:56:59 23 reissued if they come back to you unit return to
09:57:01 24 duty?
09:57:02 25 CSM DEJONG: No, sir, that's where the

09:57:04 1 National Guard manning side becomes a lot more
09:57:07 2 complicated to where they are still carried on the
09:57:10 3 unit's books. They're still carrying a paragraph
09:57:13 4 and line number for that unit and they are
09:57:15 5 counting against them in strength. The issue
09:57:19 6 becomes after so many months it's a command level
09:57:23 7 issue -- a commander issue to track those soldiers
09:57:25 8 and figure out where they're at because they truly
09:57:27 9 are on your manning roster. I don't know how else
09:57:33 10 to explain it other than it's a command -- it's an
09:57:36 11 individual commander's responsibility to track
09:57:38 12 that soldier and they should. It's no different
09:57:40 13 than on the National Guard side when we have basic
09:57:43 14 training soldiers. They are assigned to the unit,
09:57:46 15 they carry a paragraph and line and they count
09:57:49 16 against their end strength. They have to track
09:57:51 17 them while they're in school. That differs from
09:57:53 18 activity duty to where training is completely
09:57:55 19 separate and they're not carried on your manning
09:57:57 20 roster until they're assigned to you. So, the way
09:58:00 21 we look at is it's kind of like a TDY assignment
09:58:05 22 on title 10 orders. There's multiple levels of
09:58:09 23 visibility -- there's multiple levels of failure
09:58:12 24 of how a soldier would leave or would get lost in
09:58:15 25 the system and some of it is truly command level

09:58:18 1 issues.
09:58:22 2 LT GEN GREEN: So, it's only a guard or
09:58:24 3 perhaps a reserve issue. We don't have someone to
09:58:28 4 talk to from the reserves. Because when they come
09:58:31 5 off active duty unit orders and they're assigned
09:58:34 6 to a WTU, it basically clears their books for them
09:58:37 7 to bring in a replacement; correct?
09:58:39 8 MSGT MACKENZIE: As far as our
09:58:40 9 understanding, sir, yes. And also when that
09:58:43 10 service member is released from the WTU to return
09:58:46 11 to that unit, the typical orders process applies.
09:58:51 12 You know, so that unit is receiving that order
09:58:54 13 saying this soldier is on the way to you with a
09:58:57 14 report no later than date of X. So, it -- the TCS
09:59:02 15 orders do happen that way. I don't know the
09:59:04 16 nuances. It's just my observation from working
09:59:07 17 with Army on my side of the program.
09:59:09 18 MR. REHBEIN: I don't know if this
09:59:10 19 gentleman's situation was unique or not, but in
09:59:13 20 Massachusetts at the CBWTU I met an active duty
09:59:18 21 soldier that was assigned to that CBWTU. He had
09:59:22 22 come home on R&R, they diagnosed stage 3 cancer,
09:59:27 23 put him in this CBWTU to receive cancer treatment.
09:59:30 24 He was PCS'd to that CBWTU. So, the unit he left,
09:59:36 25 he was no longer on their books. He was now a

09:59:39 1 member of that CBWTU until his treatment was
09:59:42 2 finished and then he would again be PCS'd into a
09:59:46 3 unit.
09:59:48 4 LT GEN GREEN: I think, Denise, this may be
09:59:50 5 worth getting something from the personnel side of
09:59:53 6 the services to see how they track the manpower.
09:59:56 7 Whether assigned to active component, reserve
09:59:59 8 component or the guard. Actually, reserve
10:00:03 9 component includes the guard; but essentially from
10:00:06 10 the components as to what their -- how they carry
10:00:08 11 their status because I suspect this is a manpower
10:00:11 12 issue. It becomes a spaces question in terms of
10:00:14 13 how they're tracking these in their personnel
10:00:17 14 system. So, in a guard unit that has someone
10:00:19 15 assigned to a WTU despite the continued
10:00:22 16 association back to the unit because of the way
10:00:24 17 you treat this, as you put it, as a TDY on title
10:00:30 18 10, there may be a problem in terms of how the
10:00:33 19 active component personnel system doesn't see the
10:00:36 20 difference between people who are on active duty
10:00:39 21 orders and so it would be worthwhile, I think,
10:00:43 22 making sure we have accountability, because the
10:00:45 23 worry -- and I think it started here -- is with
10:00:49 24 people who may be then coming out of the WTUs,
10:00:53 25 probably returning to duty, that's fairly well

10:00:56 1 positive controlled; but when they go out of the
10:00:59 2 WTU and are separated, especially if you're still
10:01:02 3 carrying them on your books, your books are going
10:01:06 4 to become more and more inaccurate over time. Am
10:01:09 5 I reading the problem right? Let alone the fact
10:01:11 6 that the unit who can offer support isn't
10:01:14 7 necessarily aware that the member is back in the
10:01:17 8 community, if they came back to the community.
10:01:19 9 CSM DEJONG: Absolutely. At a state level
10:01:21 10 it starts to -- a lot of times it's picked up at
10:01:25 11 battalion or higher levels, as to when you start
10:01:27 12 scrubbing -- when your S-1 sits down and you start
10:01:30 13 scrubbing rosters; and that's where we picked up
10:01:33 14 some of the stragglers that we had out there. And
10:01:37 15 truly it doesn't allow them to get all the
10:01:40 16 benefits that they need. If you're medically
10:01:42 17 retired or you're going to retire from the service
10:01:44 18 with 20 years in, there's a lot of benefits that
10:01:46 19 we owe you as a state -- each state owes you and
10:01:49 20 would like to provide you.
10:01:55 21 MSGT MACKENZIE: And the other -- the only
10:01:56 22 other situation I have without being at the CBWTU
10:01:59 23 is when they're covering multiple states and we
10:02:01 24 asked the question and it is actually different
10:02:05 25 from state to state. They could sit there and

10:02:08 1 tell you exactly which states were involved, which
10:02:10 2 states were not and which states were upset
10:02:13 3 because they wanted total control and didn't have
10:02:16 4 it and which states just didn't respond; and so we
10:02:19 5 asked -- as we have gone along and we've always
10:02:24 6 said within this task force, at every point we
10:02:26 7 begin to learn how to ask the right question to
10:02:29 8 get the real information and it's -- I'm very
10:02:32 9 impressed by what we've been able to ferret out in
10:02:36 10 these multiple locations this year.
10:02:39 11 LT GEN GREEN: Okay. We've kind of mixed a
10:02:41 12 little bit in terms of the Massachusetts CBWTU and
10:02:44 13 joint force headquarters and I've heard some
10:02:47 14 comments about Carson. I don't think we've talked
10:02:51 15 about joint base San Antonio. Do we want to talk
10:02:53 16 to some of those points?
10:02:55 17 DR. TURNER: Actually, if we have time. I
10:02:58 18 know we've gone a long time. I would like to make
10:03:00 19 about five objective things that I would --
10:03:03 20 that -- to report five objective things that I was
10:03:06 21 told and was -- and then make a subjective comment
10:03:10 22 at the end, if we've got some time.
10:03:13 23 Objectively, the things that we were -- we
10:03:15 24 heard is they said that -- and just to bring
10:03:19 25 everybody up to speed, the difference with the Air

10:03:22 1 Force process is that it's centralized and a lot
10:03:26 2 of it is done on the phone and you don't have the
10:03:28 3 face-to-face contact. While that may sound like
10:03:33 4 it might have some inherent problems, it
10:03:36 5 actually -- for those entered in the program, it
10:03:38 6 didn't do too bad, from what the people said,
10:03:41 7 which was a surprise to me. However, the problems
10:03:44 8 that they did voice was they felt that the
10:03:48 9 counselors got involved too late. AFW-2 people
10:03:52 10 got involved too late. Sometimes even after the
10:03:56 11 med board had gotten started and they felt that
10:03:59 12 they would have gotten better service from AFW-2
10:04:03 13 if the -- they had been involved earlier. We
10:04:07 14 talked about their identification processes and
10:04:11 15 felt that they probably could do a little bit
10:04:13 16 better job at getting involved earlier.
10:04:16 17 Second point. Talking to the members, they
10:04:21 18 felt that the return to duty option in reality was
10:04:28 19 nonexistent. That none of their commands pursued
10:04:31 20 the return to duty option. Which is once you were
10:04:33 21 identified as a wounded warrior, you should start
10:04:38 22 packing your bags because return to duty was
10:04:42 23 simply not an option. We chased this down a
10:04:45 24 little bit, which brings us to the next point; and
10:04:48 25 that was basically the command culture down in the

10:04:52 1 units and the command culture -- and I think Mac
10:05:00 2 would say especially in the SPs -- is that once
10:05:06 3 you're identified -- and I'm going to use one of
10:05:10 4 their words -- is you are ostracized from the
10:05:13 5 unit. Once you're identified as a wounded
10:05:16 6 warrior. And this came up -- this was not a
10:05:19 7 unique report, unfortunately. So, while they felt
10:05:24 8 they were being kicked under the bus once they
10:05:26 9 were identified, then they -- led them to these
10:05:30 10 behaviors we had spoken of earlier as trying to
10:05:33 11 hide, you know, their PTSD or being reluctant to
10:05:38 12 report it. So, they felt that -- when we tried to
10:05:44 13 pin it down where exactly in the unit that it came
10:05:47 14 from, the recurrent theme was the squadron
10:05:52 15 commander and someone would say, "Well, I was
10:05:55 16 treated very terribly by one squadron commander
10:05:58 17 and then after they changed, the next guy was
10:06:02 18 really good." So, it's on leadership and their
10:06:06 19 understanding and treatment of wounded warriors I
10:06:09 20 think could most accurately be characterized as
10:06:12 21 very inconsistent.
10:06:15 22 Next, staffing. At least for the staffing
10:06:19 23 of the agencies at Randolph. The DoD instruction
10:06:32 24 currently is 40 wounded warriors per counselor.
10:06:34 25 They currently operate at about 60 right now.

10:06:39 1 Something we discovered about the program is there
10:06:42 2 is no outflow to the program. Once you are in the
10:06:45 3 program, you are carried forever. You're carried
10:06:48 4 for life, rather. And so they are still adding 30
10:06:51 5 people per month. So, with no outflow and -- what
10:06:57 6 percent personnel cut were they taking?
10:07:00 7 MS. DAILEY: Six.
10:07:03 8 MR. DRACH: Six FTEs. As I recall, they
10:07:06 9 were going to lose six FTEs in the AFW-2.
10:07:11 10 DR. TURNER: So, they had decided to cut
10:07:12 11 people -- the wing decided to cut people. So,
10:07:15 12 with the increasing requirements and the
10:07:18 13 decreasing resources, mathematically they're
10:07:22 14 headed for failure.
10:07:25 15 MSGT MACKENZIE: Let me jump in real quick
10:07:26 16 on that.
10:07:27 17 DR. TURNER: Sure.
10:07:27 18 MSGT MACKENZIE: A couple of things to help
10:07:29 19 clarify, sir, was the fact that we were able to do
10:07:31 20 conference calls telephonically. So, we were
10:07:33 21 reaching out to multiple locations nationwide, as
10:07:36 22 we were doing these focus groups. That's how we
10:07:38 23 gathered some of this information. It's not
10:07:40 24 specifically here as much as it is how we can say
10:07:43 25 about the climate across the board.

10:07:46 1 Number two, the -- you know, get away from
10:07:49 2 all the formalities, the basic comment was the Air
10:07:52 3 Force was taking a, what, 15 percent cut or
10:07:55 4 whatever that percentage cut was and we're losing
10:07:58 5 six people and that's just the way it is. We're
10:08:01 6 going to have to figure out what services that
10:08:03 7 we're going to have to no longer provide because
10:08:05 8 we don't have the manpower to support what we're
10:08:08 9 about to face. So -- and the -- the -- that just
10:08:16 10 amazes me that it was just a blanket response to
10:08:18 11 this question. However, the personnel were very,
10:08:21 12 very concerned and said we're going to make it
10:08:24 13 work; but the reality to it is the AFW-2 program
10:08:28 14 is going to be cutting resources -- cutting
10:08:30 15 services because they don't have the manpower to
10:08:32 16 support it based on the latest cut.
10:08:35 17 DR. TURNER: So -- and kind of to summarize
10:08:39 18 the objective things. When you talk to all the
10:08:41 19 different people from around the country, you have
10:08:43 20 a lot of people saying they had very, very good
10:08:46 21 care once they were in the system and were very
10:08:50 22 happy and then you had -- I didn't do the numbers,
10:08:54 23 but my intuition says about half -- and half said
10:08:59 24 they didn't get any care at all; and to me,
10:09:02 25 anyway, it seemed more of a function of the units

10:09:05 1 than of the central organization, the central
10:09:08 2 care. The units seem to be the problem with the
10:09:11 3 inconsistent application of wounded warrior care.
10:09:17 4 That's the objective report of what they told us.
10:09:22 5 Subjectively there's some themes -- and this
10:09:27 6 seemed to continue. Some themes from last year
10:09:30 7 and all the guy -- all the trench people -- the
10:09:34 8 ones in the trenches are really working very hard
10:09:38 9 and I think once the wounded warriors access the
10:09:41 10 people that are providing the service, the system
10:09:45 11 works rather well. However, their numbers are
10:09:50 12 dwindling. What we have here is kind of a
10:09:52 13 Flanders Field thing where the people in the
10:09:55 14 trenches seem wholly unsupported by their
10:09:58 15 leadership and when the leadership is briefed
10:10:00 16 this, all leadership can do is point fingers at,
10:10:04 17 oh, this is I'm not getting this, I'm not getting
10:10:07 18 that; and no one seems willing to make a decision.
10:10:10 19 The other thing that the folks told us was they
10:10:14 20 preferred the Army model to the Air Force model.
10:10:20 21 CSM DEJONG: Sir, let me quantify a couple
10:10:23 22 of those points.
10:10:24 23 DR. TURNER: Sure. Please.
10:10:25 24 CSM DEJONG: Backing up to the gaining the
10:10:31 25 AFW-2 so late in the system. It seems to me the

10:10:36 1 AFW-2 program is designed for -- and they only
10:10:39 2 service the wounded warrior, sir. So, by the
10:10:42 3 time -- looking at the sheer numbers and the
10:10:44 4 majority of their population being PTSD, that is
10:10:48 5 why we're being briefed that they're being picked
10:10:51 6 up so late in the system because by the time they
10:10:53 7 finally identify it and then they work it all the
10:10:56 8 way back and realize that it was combat related,
10:11:02 9 so you -- now they've fallen into the wounded
10:11:06 10 warrior category, they're already into the med
10:11:09 11 board system, because what we found out is that --
10:11:12 12 I mean, based off Air Force requirements and
10:11:14 13 security clearances and the rest, I understand it.
10:11:18 14 There really is zero room in the Air Force for an
10:11:21 15 airman with PTSD. As soon as they've been
10:11:24 16 designated PTSD, about the only path that they
10:11:30 17 have is a med board. Looking at it -- it got kind
10:11:33 18 of -- there was a little bit of defensive
10:11:35 19 conversation going back and forth because we
10:11:37 20 talked about looking at manning cuts and looking
10:11:39 21 at other things and we had asked some hard
10:11:40 22 questions about, you know, is this -- who's making
10:11:43 23 the determination as to who can stay and who
10:11:45 24 can't; and they said, well, really, once you have
10:11:48 25 PTSD -- and they were quantifying it by levels of

10:11:51 1 PTSD, but the way -- what I carried away from it
10:11:53 2 was once you have PTSD, you're looking at a med
10:11:56 3 board and you're out.
10:12:03 4 DR. TURNER: I think one of the other,
10:12:05 5 identification. We talked a lot about --
10:12:06 6 LT GEN GREEN: If I can comment before you
10:12:09 7 go on.
10:12:09 8 DR. TURNER: Sure.
10:12:09 9 LT GEN GREEN: The actual statistics that I
10:12:11 10 see with regard to PTSD is that nearly 70 percent
10:12:15 11 stay in the Air Force and so are we only talking
10:12:19 12 to those who are hitting the disability boards?
10:12:22 13 In other words, are we only talking to the 30
10:12:24 14 percent that actually go out? If you see what I'm
10:12:27 15 saying.
10:12:28 16 CSM DEJONG: Based off of the focus groups
10:12:30 17 that we had, sir, most of them were already out.
10:12:32 18 So, it was kind of a unique situation where most
10:12:35 19 of them were on the post -- post side of all this.
10:12:39 20 We had very few that were actually working through
10:12:41 21 the system. With that small number, they had --
10:12:47 22 and what we were briefed on was -- we were also
10:12:50 23 briefed by the one focus group that that's -- that
10:12:54 24 was the majority of people that were hiding the
10:12:56 25 PTSD because there was very little numbers that

10:12:59 1 were briefed on -- I mean, they had -- 70 percent
10:13:01 2 of their wounded warrior population was PTSD. Out
10:13:06 3 of the 1325, I believe there was almost 800 of
10:13:09 4 them that were in the population of being tracked
10:13:11 5 and had an AFW-2 were PTSD cases; but what I
10:13:17 6 carried away from that was once you had PTSD, they
10:13:20 7 were -- there was very small chance that they were
10:13:23 8 going to stay in. So, there might be some
10:13:25 9 information that we didn't get.
10:13:27 10 DR. TURNER: The other thing that I was
10:13:29 11 going to bring up is identification. If you were
10:13:32 12 diagnosed with PTSD or a combat injury that
10:13:36 13 happened well after -- say, if you had been back
10:13:39 14 for six months and then they pick it up, you know,
10:13:42 15 late, there was certainly some trouble or it
10:13:46 16 seemed to be more a physician education or a
10:13:51 17 provider education problem as to whether or not
10:13:54 18 they notified AFW-2 that this indeed was a combat
10:13:59 19 person. So, for people that were not identified
10:14:02 20 in theater, identification to AFW-2 was a problem.
10:14:06 21 And, again, they weren't picked up until well
10:14:09 22 through the medical board and did not have legal
10:14:12 23 or counseling help to help them through the PEB or
10:14:18 24 MEB.
10:14:21 25 CSM DEJONG: Just to quantify. The question

10:14:22 1 that we asked specifically where the Army model
10:14:26 2 came up, sir, was we were briefed pretty -- that
10:14:32 3 the Air Force model that they -- the way we were
10:14:34 4 briefed by leadership was that it worked the best
10:14:37 5 because it allowed the airman to stay in their
10:14:39 6 line unit and be with their company and be with
10:14:42 7 their unit and that's where they felt the most
10:14:44 8 secure. The specific question that we asked
10:14:46 9 during the focus groups was is staying within your
10:14:50 10 line unit, within your command, is it helping your
10:14:54 11 healing process or is it hindering your healing
10:14:57 12 process; and the majority of the response was that
10:15:01 13 it made it more difficult. That we were in the
10:15:03 14 way, we were turned into maids, we were -- once we
10:15:06 15 were -- it was almost a command inconvenience and,
10:15:10 16 again, it goes into the command philosophy and it
10:15:13 17 goes into personalities. That we were in the way
10:15:15 18 and that we were holding a slot and we're holding
10:15:17 19 numbers. So, then we conversely asked what would
10:15:20 20 make it better; and they said if we could be in an
10:15:22 21 environment where we had support from other
10:15:24 22 wounded airmen and try to get some answers and try
10:15:27 23 to get some -- you know, talk through different
10:15:29 24 processes that are happening, similar to what the
10:15:31 25 Amy WTU process is, they felt that it would

10:15:35 1 probably help them in their process of -- and get
10:15:38 2 them out of an environment to where they feel in
10:15:44 3 the way.
10:15:44 4 DR. TURNER: We had a couple of people that
10:15:46 5 actually had been through both the Army and the
10:15:48 6 Air Force programs, due to their situation. So,
10:15:53 7 they had an opportunity to directly compare.
10:15:58 8 MR. DRACH: Also, sir, correct me if I'm
10:16:01 9 wrong on this. My understanding was if somebody
10:16:06 10 was identified as being wounded or injured and had
10:16:10 11 a PTSD diagnosis in addition to physical, they
10:16:16 12 were not a candidate for reclassification for
10:16:19 13 return to duty. Yet they were quick to point out
10:16:22 14 that they have many Air Force members that are
10:16:25 15 living with PTSD. I -- this is just my -- my
10:16:30 16 impression was that there was a double standard.
10:16:33 17 You know, that the fact that -- if I have a combat
10:16:37 18 wound and PTSD and can't be reclassified tells me
10:16:42 19 or tells my friend who's not combat wounded but
10:16:46 20 may have PTSD not to identify that they have PTSD
10:16:50 21 or as mentioned earlier they lie about going to
10:16:57 22 get treatment for their PTSD.
10:16:58 23 DR. TURNER: Something also -- I'd like the
10:17:01 24 two active duty members to comment about something
10:17:04 25 that was new to me -- was they talked about people

10:17:07 1 that were being dual tracked and a lot of wounded
10:17:10 2 warrior members were being administratively
10:17:11 3 separated at the same time they were undergoing
10:17:14 4 MEB and it was -- it seemed like whichever one
10:17:18 5 finished first was the one that happened. What
10:17:20 6 were you guys' impressions, Mac?
10:17:23 7 MSGT MACKENZIE: The -- that's actually not
10:17:26 8 a -- the terminology is different, but the process
10:17:29 9 is exactly the same. Anytime you process someone
10:17:32 10 who's in the Army and so forth it's the same deal
10:17:34 11 where you have -- you have a situation of -- and
10:17:36 12 unfortunately this case we see it a lot, which is
10:17:39 13 why Congress has put us out here. You know, when
10:17:42 14 you have individuals who find themselves in a
10:17:45 15 serious amount of trouble and then it is
10:17:48 16 discovered that potentially this unidentified PTSD
10:17:52 17 condition was probably why they were making the
10:17:54 18 decisions they were making. It is still handled
10:17:57 19 as the same track. There's the administrative
10:17:59 20 side and there's the medical side, because, you
10:18:01 21 know, the DoD says that we will evaluate this
10:18:04 22 medical piece before making the administrative
10:18:06 23 determination. So, it's just the terminology.
10:18:07 24 It's not -- the Air Force wasn't doing anything
10:18:10 25 different on that aspect; but what I find, sir,

10:18:12 1 from a -- from a -- you know, a fellow Air Force
10:18:16 2 guy, is that there is a severe lack of accountable
10:18:21 3 education at the lower command levels. Okay.
10:18:26 4 Whether the Air Force is putting this information
10:18:28 5 out, there's no accountability to make sure that
10:18:31 6 those commands have actually conducted that
10:18:33 7 training or are knowledgeable of that training and
10:18:35 8 communicate with clear guidelines as to when they
10:18:39 9 need that done. On top of that, when I use that
10:18:43 10 as a comparison, okay, with -- with the USSOCOM
10:18:50 11 process -- when a commander has to deal with a
10:18:54 12 casualty, he knows who to call. He picks up the
10:18:56 13 phone, these guys are the experts, I call them and
10:18:58 14 go, "Where do I go?" When I ask the AFW-2 folks
10:19:03 15 this, they are the folks that should be getting
10:19:06 16 called; but they are not getting called. When --
10:19:10 17 significantly in the NSI cases as well as the
10:19:15 18 later identified cases back at the line unit and
10:19:18 19 what we found, especially with -- even in the
10:19:20 20 senior ranking NCOs, some of the officers, was
10:19:24 21 they did not know who to call. When they realized
10:19:27 22 they had reached a problem with their medical
10:19:30 23 care, when they'd reached a problem with perceived
10:19:32 24 or knowledgeable treatment of what resources were
10:19:35 25 available to them, they don't know who to call.

10:19:37 1 And at that lower unit level, neither do they. Or
10:19:45 2 remember if they have been trained or accountable
10:19:49 3 to this whatsoever. So, in many instances it's --
10:19:55 4 the checklist of things that AFW-2 does for their
10:19:59 5 wounded population, we haven't seen yet. They're
10:20:02 6 going to get it to us, but it is apparently very
10:20:04 7 thorough. Unfortunately, the majority of cases
10:20:06 8 when they get a hold of these wounded warriors,
10:20:09 9 it's a crisis action checklist because they have a
10:20:11 10 short period of time to try to get this
10:20:13 11 information to these guys before they're out the
10:20:14 12 door because usually it's -- the decision's
10:20:16 13 already been made.
10:20:17 14 MS. DAILEY: One more comment. We've got to
10:20:19 15 wrap.
10:20:20 16 CSM DEJONG: Just wanted to throw in a quick
10:20:23 17 note on the Air Guard side, sir.
10:20:23 18 LT GEN GREEN: Yes.
10:20:27 19 CSM DEJONG: The Air Guard care once they're
10:20:29 20 picked up is outstanding and it is equal to that
10:20:32 21 of the active component. One thing that I think
10:20:34 22 the Air Guard is failing as far as what the Army
10:20:39 23 National Guard is doing is the LOD process is not
10:20:43 24 happening in trying to link those injuries back to
10:20:46 25 a title 10 injury and then that caveats into the

10:20:51 1 abuse of the end cap pay and what -- where to use
10:20:55 2 end cap pay and where not to. Right now
10:20:57 3 there's -- the end cap pay is being abused as far
10:21:00 4 as we're picking up soldiers because the LODs were
10:21:04 5 not done in theater, not carried forward and they
10:21:06 6 were not allowed to stay in title 10 orders. So,
10:21:09 7 going back and trying to put them on MEDCOM orders
10:21:14 8 prior to -- and prior to MEDCOM orders being
10:21:18 9 approved they have to have the LOD. So, if the
10:21:21 10 process was approved to where -- similar to what
10:21:23 11 the Army National Guard does and the Air Guard
10:21:24 12 side, if the LODs were processed prior to leaving
10:21:28 13 theater and they -- there was MEDCOM order, it
10:21:31 14 could then be approved at DEMOB and they could
10:21:35 15 carry forward the care, there would not be the
10:21:36 16 delays in the care and not be abuse of the end cap
10:21:39 17 pay that is going on.
10:21:41 18 MS. DAILEY: Ladies and gentlemen, we need
10:21:42 19 to wrap up. I'm going to put you on break and I'm
10:21:45 20 going to bring forward our 10:30 panel. So, I
10:21:49 21 need everyone back by 10:30, please.
10:21:59 22 (Recess taken between 10:21 and 10:32.)
10:32:26 23 LT GEN GREEN: Well.
10:32:29 24 DR. PHILLIPS: Well, I want to thank the
10:32:31 25 next panel for taking time out of their busy

10:32:34 1 schedules to report to us. We're going to hear
10:32:37 2 from non-DoD OEF/OIF case managers from the
10:32:42 3 Department of Veterans Affair and they will
10:32:44 4 present a panel on pre-separation challenges and
10:32:49 5 later in the day we'll hear from the veterans on
10:32:52 6 their views of pre-separation policies and
10:32:56 7 programs. And with us we have Ms. Yvonne
10:33:05 8 Santiago, Ms. Diane Jules, Ms. Linda Ray and Ms.
10:33:11 9 Tamara Alms-Chapa. Did I say that correctly?
10:33:15 10 MS. ALMS-CHAPA: Yes.
10:33:17 11 DR. PHILLIPS: Thank you. So, I will turn
10:33:17 12 it over to you all and if you would just please
10:33:20 13 introduce a little bit of your background. I have
10:33:22 14 it all here written out, but I think it would be
10:33:25 15 better if you just say a few words about yourself
10:33:27 16 and then we'll go to the conference.
10:33:29 17 MS. RAY: Okay. My name is Linda Ray. I'm
10:33:32 18 an OEF/OIF/OND program manager and I've been in
10:33:35 19 this current position for six months and before
10:33:39 20 that I was chief of social work services in the VA
10:33:43 21 hospital in West Texas. And then previously
10:33:47 22 before that I was in the private sector in a
10:33:51 23 mental health position and have done that for
10:33:53 24 many, many years. So, I've been in social work
10:33:56 25 services. I've been doing this for about 15, 16

10:34:02 1 years now. So, that's my background. Thank you.
10:34:08 2 MS. JULES: Hello. Good morning, everyone.
10:34:10 3 I'm Diane Jules. I am the social work supervisor
10:34:15 4 for the polytrauma rehabilitation center at the
10:34:18 5 VA. I too have been in the position for about six
10:34:23 6 months, but I've been with the VA since 2002 in
10:34:29 7 various capacities related to social work; and so
10:34:33 8 while this center is new and the program is new,
10:34:38 9 I'm not new to social work and -- or the VA. So,
10:34:42 10 thank you.
10:34:45 11 MS. SANTIAGO: Morning, everyone. I am
10:34:46 12 Yvonne Santiago. Prior to joining the VA I was in
10:34:54 13 the Air Force since 1986 and retired in 2006. I
10:34:56 14 joined the Air Force in -- I mean VA in 2007 and
10:35:00 15 I've been working for the VA since then. I've
10:35:03 16 been VA liaison with the VA for about three years
10:35:09 17 now.
10:35:10 18 MS. ALMS-CHAPA: Hi. My name's Tamara
10:35:13 19 Alms-Chapa and I'm an OEF/OIF/OND case manager for
10:35:16 20 the program here in South Texas. I've been with
10:35:18 21 the VA since November 2008 and began the OEF/OIF
10:35:24 22 program in November -- I'm sorry -- in February
10:35:26 23 2008 I was added to the program as a case manager.
10:35:31 24 My background is as a social worker in Child
10:35:35 25 Family Services and I chose to come to the VA in

10:35:38 1 November 2007 because of my husband who is now
10:35:41 2 medically retired Air Force. So, I'm an Air Force
10:35:45 3 dependent spouse.
10:35:47 4 DR. PHILLIPS: Thank you. And let's please
10:35:49 5 go ahead with the briefing.
10:35:54 6 MS. SANTIAGO: Okay. I am a VA liaison and
10:35:57 7 I am here and working with the VA and what I do is
10:36:01 8 currently I am stationed at San Antonio Military
10:36:05 9 Medical Center and my main role as a VA liaison is
10:36:09 10 to transfer the health care of all V -- both
10:36:14 11 inpatient and outpatient -- from the military
10:36:16 12 treatment facility out to the VA facility of the
10:36:21 13 service member's choice. And what I do is I
10:36:24 14 collaborate with the MTF staff for discharge
10:36:28 15 planning, I meet with the service member and I do
10:36:30 16 a biopsychosocial assessment. I provide that
10:36:34 17 referral to the receiving VA facility. In
10:36:37 18 particular the OEF/OIF program and then what I do
10:36:41 19 is assure that the service member has an initial
10:36:44 20 appointment before they leave that MTF at the VA
10:36:47 21 that they have selected.
10:36:51 22 Currently, the VA -- the VA liaison team and
10:36:56 23 case load, we are all located -- there are three
10:36:59 24 of us and we are located at San Antonio Military
10:37:02 25 Medical Center, which is considered SAMMC. Prior

10:37:07 1 to that it was called the Brooke Army Medical
10:37:09 2 Center and that was BAMC. We have three of us
10:37:14 3 located with -- within the warriors transition
10:37:18 4 unit. So, we're working side by side with the
10:37:21 5 military case managers. Two of us are social
10:37:26 6 workers and one of us is a nurse. There's also a
10:37:30 7 VA liaison at the Center for the Intrepid and they
10:37:34 8 deal with the majority of the amputees. SAMMC has
10:37:41 9 about 636 combined active National Guard and
10:37:44 10 reservists. That number fluctuates depending upon
10:37:48 11 who's leaving. All of those folks are in the
10:37:52 12 warriors transition unit.
10:37:53 13 MSGT MACKENZIE: Let me ask you real quick
10:37:55 14 there where you were going on that. You said the
10:37:58 15 three -- the three case managers are assigned to
10:38:01 16 the WTU?
10:38:02 17 MS. SANTIAGO: Yes.
10:38:03 18 MSGT MACKENZIE: Okay. Are you the only
10:38:04 19 three VA liaisons at SAMMC?
10:38:07 20 MS. SANTIAGO: Correct.
10:38:09 21 MSGT MACKENZIE: So, what are you doing
10:38:10 22 with -- or how are you interacting with the
10:38:13 23 population of other military personnel that are
10:38:16 24 not Army?
10:38:17 25 MS. SANTIAGO: What's happening currently is

10:38:20 1 that there are -- there is an Air Force case
10:38:24 2 manager and there is a military -- there is a
10:38:27 3 Navy/Marine case manager and those folks give us
10:38:33 4 referrals as well.
10:38:35 5 MSGT MACKENZIE: Thank you.
10:38:40 6 MR. DRACH: Excuse me. You say you
10:38:41 7 collaborate with the MTF staff on discharge
10:38:45 8 planning. Discharge planning from what? From the
10:38:46 9 military to civilian or from a hospital to your
10:38:51 10 hospital or what?
10:38:52 11 MS. SANTIAGO: It's -- what I mean by that
10:38:53 12 is that the service members that are in the WTU
10:38:55 13 that have met the IDES that are being separated
10:38:59 14 from the military via the WTU, those are the
10:39:03 15 service members that we are doing discharge
10:39:05 16 plannings for. There --
10:39:09 17 DR. TURNER: This -- go ahead.
10:39:10 18 MS. SANTIAGO: There are other service
10:39:12 19 members who are in the MEB but are not in the
10:39:14 20 warriors transition unit and those folks are being
10:39:17 21 referred to us via the military service
10:39:21 22 coordinator or they walk in and those service
10:39:24 23 members we will refer them, if they come to our
10:39:27 24 attention.
10:39:28 25 DR. TURNER: You have mentioned that to

10:39:31 1 access your services there's been a referral from
10:39:33 2 the case workers or the board. Can the -- can the
10:39:38 3 wounded warriors access you directly?
10:39:41 4 MS. SANTIAGO: Yes, they can; but whenever
10:39:44 5 we do a transition, we have to have medical
10:39:49 6 records and we have to have documentation and so
10:39:52 7 in order for us to make a complete referral, we do
10:39:55 8 have to have a military treatment facility case
10:39:58 9 manager provide us that information.
10:40:02 10 DR. TURNER: So, he can't -- the medical --
10:40:03 11 the member can't actually access you directly
10:40:06 12 without a referral?
10:40:08 13 MS. SANTIAGO: Well, they can and what we
10:40:10 14 will do is we will sit and we discuss their
10:40:13 15 situation and then what we will do is make contact
10:40:16 16 with whoever is taking care of their case. Oh,
10:40:28 17 I'm sorry. Next slide.
10:40:33 18 Okay. So, the 636 service members that are
10:40:39 19 in the WTU. The way that we divide that case load
10:40:44 20 is that each of these service members are divided
10:40:49 21 into three companies. Alpha, bravo and Charlie;
10:40:52 22 and so what the VA liaisons do is we have assigned
10:40:57 23 each other a company. The service members that
10:41:00 24 are not in the WTU, we divide that case load
10:41:05 25 alphabetically among the VA liaisons. This slide

10:41:13 1 shows the intra-agency communication between the
10:41:17 2 MTF and the military VA liaison. I mean the VA
10:41:23 3 liaison. Excuse me. What we do is that the
10:41:27 4 majority of our communication is done with that
10:41:30 5 military treatment facility case manager and she
10:41:33 6 will provide us a referral and the other folks
10:41:36 7 that we do consultation with is the federal
10:41:40 8 recovery coordinator, the Army wounded warrior
10:41:42 9 advocate and we get self-referrals or we get
10:41:47 10 referrals from the military service coordinators.
10:41:51 11 The VA liaisons, we sit at the triad
10:41:54 12 multidisciplinary weekly meetings and what happens
10:41:57 13 at these meetings is every Thursday the meetings
10:42:03 14 last about four hours and on this
10:42:06 15 multidisciplinary committee sits a psychiatrist,
10:42:10 16 sits a primary care physician, a supervisor, the
10:42:13 17 commander and us, the VA liaisons; and we will
10:42:16 18 discuss every case. We start off with the high
10:42:20 19 risk cases and then we'll go on to discuss any
10:42:23 20 issues that they're having currently. Substance
10:42:26 21 abuse, family issues. And they also discuss the
10:42:30 22 medical reconciliation and in addition to that
10:42:34 23 they talk about when this service member is going
10:42:36 24 to be leaving the military and if they have
10:42:38 25 received orders. If we have not seen that service

10:42:42 1 member at that particular time, we will let the
10:42:45 2 command know and we will let the unit know that
10:42:48 3 this service member has not seen the VA and we
10:42:51 4 need to see them. It also alerts the military
10:42:55 5 case managers that they need to send us a
10:42:59 6 referral. In order to send an appropriate
10:43:01 7 referral to the VA, you have to have medical
10:43:04 8 documentation.
10:43:07 9 LT GEN GREEN: So, can I get clarification.
10:43:09 10 Are you involved with all 636 from the time that
10:43:11 11 they arrive or are you getting involved at a
10:43:13 12 certain point in their evolving care?
10:43:17 13 MS. SANTIAGO: We get involved at a certain
10:43:20 14 point. So, the service members initially go into
10:43:22 15 the warriors transition unit and at that point in
10:43:27 16 time it has not been identified whether they're
10:43:30 17 going to be in a military evaluation board or if
10:43:32 18 they're going to hit the IDES. So, they are
10:43:36 19 medically stabilized, they are treated and then at
10:43:39 20 the point that the military decides that they are
10:43:41 21 going to put this person in a military evaluation
10:43:46 22 board to, you know, evaluate whether they are fit
10:43:50 23 for duty, at that point they go ahead and they do
10:43:54 24 that and then when the person hits the IDES and
10:43:59 25 they are being evaluated by the VA to determine

10:44:02 1 their service connection and when the service
10:44:05 2 member agrees that they are going to accept that
10:44:09 3 service connection and they want to be let out of
10:44:13 4 the military, at that point is that -- is when we
10:44:15 5 get the referral, because many service members
10:44:18 6 want to go on and do the COAD, continue on active
10:44:23 7 duty; and sometimes if they appeal the system,
10:44:27 8 then it's too soon for us to get the referral
10:44:31 9 because they can be at that MTF for another six
10:44:36 10 months and we -- it would be too early for them to
10:44:38 11 be transitioned.
10:44:39 12 LT GEN GREEN: So, the numbers that you're
10:44:41 13 getting involved with are those who have been
10:44:43 14 through the IDES and the member has agreed to the
10:44:46 15 disability rating?
10:44:48 16 MS. SANTIAGO: Correct.
10:44:49 17 LT GEN GREEN: And so can you give us an
10:44:50 18 idea of the numbers of people you actually worked
10:44:54 19 with out of the 636, that meet that criteria?
10:44:58 20 MS. SANTIAGO: I -- those numbers fluctuate.
10:45:01 21 We get about -- I can say that maybe in a month
10:45:05 22 between -- between the three of us we might get
10:45:08 23 about 60, 65 persons -- people that may transition
10:45:13 24 at that month and I think the -- and this is all
10:45:17 25 estimates. I believe that last year we may have

10:45:21 1 been in the 400s, but it just fluctuates.
10:45:26 2 LT GEN GREEN: I'm just trying to
10:45:28 3 understand. So, in essence, then, if it's roughly
10:45:31 4 60 a month, then because that's a shorter time as
10:45:34 5 they go on terminal leave and then come to the VA,
10:45:37 6 in essence you're staffing of three is roughly
10:45:40 7 working with 20 patients each month?
10:45:43 8 MS. SANTIAGO: We could be or more and that
10:45:46 9 number fluctuates. It just depends on the --
10:45:50 10 where the service members are. Sometimes they
10:45:53 11 don't -- they don't leave us and so it could be
10:45:56 12 about 20.
10:45:57 13 LT GEN GREEN: Okay. I'm trying to
10:45:58 14 understand how the VA decides how many to assign.
10:46:03 15 MS. SANTIAGO: Well, we just -- well, the
10:46:05 16 VA -- we just do it basically by the -- whatever
10:46:09 17 numbers we get and that number can fluctuate.
10:46:12 18 It's just the -- the numbers that we see that are
10:46:16 19 just the service members that are leaving. Like
10:46:18 20 in company C, if they have 20, 30 people that are
10:46:22 21 leaving that month, then I would be responsible
10:46:24 22 for transitioning 20, 30 people that particular
10:46:27 23 month.
10:46:27 24 LT GEN GREEN: And so if they had 200 that
10:46:29 25 were leaving that month, you would also take care

10:46:32 1 of 200?
10:46:34 2 MS. SANTIAGO: That is usually not likely to
10:46:37 3 happen, sir; but --
10:46:39 4 LT GEN GREEN: That's why I'm asking what
10:46:40 5 your staffing ratio --
10:46:41 6 MS. SANTIAGO: -- we would use the other VA
10:46:44 7 liaisons if that -- if I had to do 200.
10:46:46 8 LT GEN GREEN: But there's not a hard and
10:46:48 9 fast number that you would try to manage to -- if
10:46:50 10 you were handling a hundred a month, would it
10:46:52 11 be -- would you get additional help?
10:46:54 12 MS. SANTIAGO: Yes, we would get additional
10:46:56 13 help. We would definitely -- I would definitely
10:46:59 14 rely on my co-workers to assist me with that.
10:47:03 15 LT GEN GREEN: And then you -- you have kind
10:47:04 16 of an end point because they transition to the VA.
10:47:07 17 So, how long does it take? Once you start working
10:47:10 18 with someone who's agreed to the disability
10:47:12 19 rating, how long do you expect to work with that
10:47:14 20 particular individual?
10:47:15 21 MS. SANTIAGO: That could take anywhere from
10:47:18 22 two months to a month to a week. It all depends
10:47:23 23 on when the military is giving us the referral and
10:47:29 24 if the service member comes in and makes their
10:47:32 25 appointments. So, the preferable time for us to

10:47:35 1 transition that person is when they are four weeks
10:47:38 2 out or six weeks out because it gives us
10:47:42 3 sufficient time to collect the data and to send
10:47:44 4 him off to the VA, make contact with the VA and
10:47:47 5 get medical appointments and provide it for that
10:47:50 6 service member; but that time does fluctuate.
10:47:53 7 LT GEN GREEN: Okay. Thank you.
10:47:57 8 MS. SANTIAGO: So, at this triad
10:48:00 9 multidisciplinary meeting, pretty much when they
10:48:03 10 do let us know that the service member has orders,
10:48:06 11 if we have not already seen that service member,
10:48:08 12 then we will request support from the MTF, the
10:48:13 13 case manager, the commander, to have that service
10:48:17 14 member come in and see a VA liaison so that we can
10:48:21 15 transition them.
10:48:25 16 Support for the family caregiver. We always
10:48:29 17 have to obtain permission from the service member
10:48:33 18 to meet with the family caregiver. Many times
10:48:36 19 service members come in by themselves and they're
10:48:41 20 totally independent. We do provide them
10:48:45 21 information about the services that are available
10:48:46 22 at the VA. In addition, if the service member
10:48:50 23 does come in with a family member because the
10:48:53 24 family member is assisting them with remembering
10:48:57 25 things or just with getting around, pushing a

10:49:00 1 wheelchair, whatever the case may be, then we will
10:49:04 2 let that caregiver know the services that are
10:49:08 3 available to them and that is we'll let them know
10:49:11 4 about the new VA caregivers program and introduce
10:49:15 5 them to that and also what we will do is educate
10:49:19 6 them on the benefits that the service member is
10:49:22 7 entitled to and we will give them information,
10:49:27 8 provide them the name and number, to that family
10:49:30 9 caregiver coordinator. In addition to that, when
10:49:34 10 we transition the service member, we will alert
10:49:39 11 the OEF/OIF program manager of this service
10:49:44 12 member's need for the caregiver program so that a
10:49:47 13 referral is made to that program coordinator. In
10:49:52 14 addition to that, the service members generally
10:49:57 15 will -- if they don't want us to do an application
10:50:00 16 at that point, because a lot of times they have to
10:50:04 17 have a current physical exam by a primary care
10:50:07 18 doctor, then that can be done for them at the VA
10:50:10 19 as well.
10:50:16 20 MSGT MACKENZIE: So, based on that comment,
10:50:18 21 if the service member doesn't include his spouse
10:50:21 22 or his family member, then the person that's
10:50:25 23 going -- that that service member is going to be
10:50:28 24 residing with, relying on that caregiver, that
10:50:31 25 caregiver will not get any of this information or

10:50:34 1 training or enrollment because you rely on the
10:50:36 2 service member to say yes or no?
10:50:38 3 MS. SANTIAGO: We do rely on the service
10:50:41 4 member. Because we're dealing with medical
10:50:43 5 information, we do have to have the service
10:50:45 6 member's permission to talk to their family
10:50:47 7 member, spouse; and the reason that we do that is
10:50:50 8 because a lot of times we really don't know the
10:50:53 9 marital situation of the service members and
10:50:56 10 sometimes they do not want to include, you know,
10:51:01 11 their certain family members, etcetera. So, we do
10:51:04 12 rely on that service member to say, yes, please
10:51:07 13 include my family or no; and if they authorize
10:51:11 14 that, then we will make contact with them.
10:51:14 15 LT GEN GREEN: I'm guessing that there are
10:51:17 16 some exceptions. Aren't there some VA voc rehab
10:51:22 17 type activities that can go on prior to the time
10:51:25 18 when someone says yes to their disability rating?
10:51:29 19 I'm not sure OF the title for the program.
10:51:32 20 MS. SANTIAGO: The -- the service members --
10:51:34 21 the vocational rehab and a lot of those other
10:51:37 22 services are getting involved with the service
10:51:41 23 members way before, a lot of times, that we get
10:51:45 24 involved; and the reason being is because many of
10:51:47 25 these service members, especially the ones that

10:51:50 1 require any type of adaptive equipment; any type
10:51:54 2 of housing, you know, modifications, they are
10:52:00 3 getting in touch with the VA much sooner and that
10:52:02 4 would be vocational rehab. That would be the HISA
10:52:07 5 grant and those folks the family members are
10:52:10 6 involved way up front. So, the folks that I'm
10:52:12 7 referring to are the service members that are --
10:52:16 8 have not been involved in that part of the
10:52:18 9 program.
10:52:19 10 LT GEN GREEN: And so -- just to help me
10:52:22 11 understand. So, is there a time limit on that?
10:52:24 12 Because, for instance, from the time the MEB
10:52:27 13 starts -- whatever the DoD -- I think it's
10:52:30 14 supposed to be 45 days from the time they submit
10:52:32 15 the -- that and then the VA when it goes to the
10:52:36 16 IDES has 75 days. So, just within those two time
10:52:41 17 frames, you're talking nearly what, six months?
10:52:45 18 Am I doing the math right? Public math is never
10:52:48 19 good. So, is there a limit on how long they can
10:52:52 20 be involved in voc rehab before they finish the
10:52:56 21 disability process?
10:52:57 22 MS. SANTIAGO: I'm not sure about that. I
10:53:01 23 can't really answer that. I know that the service
10:53:04 24 members at -- here at SAMMC, they have -- majority
10:53:10 25 of them have been involved in the whole disability

10:53:12 1 process. It could take up to 12 months. It's
10:53:17 2 taken them a little longer. So, it varies. Some
10:53:20 3 of these service members have been at SAMMC for
10:53:23 4 two years. So, it varies.
10:53:25 5 LT GEN GREEN: What I'm trying -- for me,
10:53:26 6 and I'm not sure where Mac was going; but what I'm
10:53:29 7 trying to get at is to understand your workload.
10:53:32 8 And so as we -- you went through the numbers with
10:53:34 9 me and we kind of came up with somewhere around 20
10:53:38 10 or 30 that you're probably working with each
10:53:40 11 month, in an average month. I'm trying to
10:53:42 12 understand do you do any work with the people who
10:53:45 13 are in voc rehab? Does that increase your case
10:53:47 14 management work?
10:53:48 15 MS. SANTIAGO: The VA liaisons for health
10:53:50 16 care, we do not -- we do not do any work directly
10:53:53 17 with vocational rehab. Vocational rehab folks --
10:53:57 18 there are two folks -- one person that sits over
10:54:00 19 at the Center for the Intrepid and the service
10:54:04 20 member that I see will usually have touched base
10:54:08 21 with them -- with the vocational rehab up front
10:54:11 22 and then whatever they do there or decide and if
10:54:15 23 they take an application while they're active
10:54:18 24 duty, the vocational rehab person will monitor
10:54:21 25 that. So, I really don't get involved in that

10:54:23 1 part of it.
10:54:24 2 LT GEN GREEN: Okay. Thank you.
10:54:27 3 MSGT MACKENZIE: The benefits and health
10:54:28 4 care are two different tracks.
10:54:30 5 DR. PHILLIPS: Just related to the workload,
10:54:32 6 are there more difficulties with the non-medical
10:54:37 7 treatment facility referrals as opposed to the
10:54:41 8 medical treatment facility referrals? Is it more
10:54:45 9 burdensome for you to deal with those?
10:54:47 10 MS. SANTIAGO: When we get referrals from
10:54:49 11 the service members that are in the warrior
10:54:51 12 transition unit and that have case managers, that
10:54:55 13 is much easier for us. Although that still
10:55:01 14 presents a challenge sometimes. The folks that
10:55:04 15 are not in the warriors transition unit, yes, that
10:55:08 16 is a challenge and the reason being is because
10:55:12 17 it's difficult getting medical records for them;
10:55:16 18 it's difficult, you know, actually knowing if
10:55:21 19 they're high risk; and so therefore a lot of times
10:55:25 20 we have to track who is their primary care doc and
10:55:29 21 that type of thing. So, the folks that are not in
10:55:33 22 a warriors transition unit, there is some
10:55:35 23 difficulties with that.
10:55:36 24 DR. PHILLIPS: Do you have a feel of the
10:55:37 25 percentage of the differences, percentage wise?

10:55:41 1 MS. SANTIAGO: No, I do not have any idea
10:55:43 2 how many folks are not in the WTU unit.
10:55:48 3 DR. PHILLIPS: And just quickly, to extend
10:55:50 4 that. When you're making referrals to different
10:55:52 5 states and different state VAs, are you having
10:55:56 6 difficulty with the differences in the policies
10:55:58 7 for the local VAs, related to your workload?
10:56:02 8 MS. SANTIAGO: Not generally. Generally,
10:56:07 9 the VA has been responsive to getting us
10:56:14 10 appointments for these service members. I do have
10:56:17 11 to say that we have relied a lot on the national
10:56:21 12 program director because she sits in Washington,
10:56:27 13 D.C. and so a lot of times when we have
10:56:29 14 difficulties, we -- they're touching base with the
10:56:33 15 VISN level directors and things are getting
10:56:38 16 smoothed out. So, we -- that's -- without the
10:56:40 17 support, I think it would be very difficult.
10:56:45 18 LT GEN GREEN: Is there a clear tradeoff in
10:56:48 19 terms of the military case managers and the VA,
10:56:50 20 your liaison work? At what point do they actually
10:56:54 21 shift the management? So you say the patient
10:56:57 22 accepts a disability and it's much easier for you
10:57:01 23 to receive from someone who has a case manager.
10:57:04 24 At what point in the process as they move to the
10:57:06 25 VA does the military case manager I'll say --

10:57:11 1 won't -- disengage may be too strong; but when do
10:57:15 2 they take a secondary role to what you're doing?
10:57:18 3 MS. SANTIAGO: The military treatment
10:57:20 4 managers do not take a second role. They have to
10:57:26 5 manage this patient up until that patient
10:57:29 6 separates. So, if that patient goes on terminal
10:57:33 7 leave, that patient is still followed and the way
10:57:38 8 that that is done is that at that triad
10:57:43 9 multidisciplinary meeting that service member is
10:57:46 10 being tracked by the command and that is the way
10:57:48 11 that it's supposed to flow. So, they -- they'll
10:57:52 12 send them over to us and then we will go ahead and
10:57:55 13 talk to that service member and we start working
10:57:57 14 on giving them appointments and then if that
10:58:00 15 service member continues to need medication or if
10:58:03 16 that service member has any problems medically,
10:58:06 17 then that case manager is still responsible for
10:58:09 18 that service member.
10:58:13 19 LT GEN GREEN: And so the transition occurs
10:58:15 20 basically when they finish terminal leave?
10:58:18 21 MS. SANTIAGO: The transition starts before
10:58:22 22 that. So, what happens is once they sign that DES
10:58:28 23 process, they sign that they have accepted that
10:58:31 24 disability, we get a referral and then we start
10:58:34 25 transitioning them paper wise. We start sending

10:58:41 1 the paperwork, we start faxing, we start making
10:58:43 2 contact. However, that service member is still
10:58:46 3 active duty. He's still part of the warriors
10:58:51 4 transition unit and he still belongs to that
10:58:53 5 command. So, they have to track that service
10:58:55 6 member up until the last day that he is officially
10:58:59 7 retired. At that point then, that service member
10:59:03 8 would have VA appointments and then the VA -- he
10:59:07 9 would be going to the VA and the VA would pick him
10:59:10 10 up.
10:59:13 11 LT GEN GREEN: Okay. Thank you.
10:59:18 12 MS. SANTIAGO: So, in addition, when we get
10:59:22 13 with the family members, our goal is to assist the
10:59:28 14 -- assist the service member advocate for the
10:59:31 15 family and educate the service members about their
10:59:36 16 transition process and pretty much what the VA is
10:59:39 17 going to offer them and what does this transition
10:59:43 18 entail; and we let them know that as long as
10:59:47 19 they're active duty the MTF continues to be
10:59:52 20 responsible for their care and then we let them
10:59:55 21 know who their OEF/OIF program manager is going to
11:00:01 22 be and we can identify the case manager and the
11:00:04 23 main thing that we are focusing on is that the
11:00:07 24 service member has a warm handoff and that they
11:00:12 25 know who is going to be receiving them and where

11:00:15 1 to go and so we really focus on the OEF/OIF
11:00:20 2 program managers and the case managers. Our -- we
11:00:25 3 do have an outcome measure which has been sent
11:00:30 4 down to us from national headquarters and what
11:00:35 5 that performance measure is doing, it is looking
11:00:41 6 at whether the service members that we have
11:00:43 7 transitioned from the MTF have medical
11:00:47 8 appointments and --
11:00:48 9 LT GEN GREEN: Can I just get clarification?
11:00:51 10 The warm handoff you're talking about is from the
11:00:54 11 case manager to whoever is going to provide that
11:00:58 12 service in the VA?
11:01:03 13 MS. SANTIAGO: The warm handoff is from the
11:01:05 14 VA liaison -- well, it's actually from the MTF.
11:01:08 15 So, the MTF case manager gives the case -- refers
11:01:13 16 the case to us. They still continue to provide
11:01:16 17 care for that service member and then the warm
11:01:20 18 handoff is when we transition that person to the
11:01:24 19 OEF/OIF program managers office and we provide
11:01:28 20 them information so that when they enter the VA,
11:01:32 21 they know who there at the VA is going to assist
11:01:37 22 them in navigating through the VA. So, that's
11:01:41 23 really the warm handoff because the VA is very --
11:01:45 24 it's very comprehensive and there's a multitude of
11:01:49 25 agencies there. So, they have a point of contact.

11:01:52 1 They have a name and they have a phone number and
11:01:54 2 they have someone that they can make contact with.
11:01:57 3 And also the warm handoff is that person --
11:02:01 4 because I'm VA. If they have any problems, they
11:02:03 5 will make contact with me and then I will make
11:02:06 6 contact with that OEF/OIF program manager and ask
11:02:11 7 them what happened, if something goes wrong. So,
11:02:14 8 that's the warm handoff.
11:02:18 9 MSGT MACKENZIE: Does that warm handoff
11:02:20 10 include actually the service member being able to
11:02:22 11 have an initial communication with that OEF/OIF
11:02:27 12 coordinator prior to departure?
11:02:28 13 MS. SANTIAGO: Yes, they can. We can
11:02:30 14 make -- before we hand off that patient, we are
11:02:35 15 calling the program manager and we're saying we
11:02:38 16 have this person here, this is his name, this is
11:02:41 17 his information. We fax to them a complete
11:02:44 18 packet.
11:02:46 19 MSGT MACKENZIE: That's not what I was
11:02:47 20 referring to. The -- in the essence of the warm
11:02:52 21 handoff, it's that communication between the
11:02:54 22 service member and the receiving OEF/OIF
11:02:57 23 coordinator. Just the handing of information to a
11:02:59 24 service member to say this is who you call is not
11:03:01 25 actually a warm handoff. A warm handoff is that

11:03:05 1 connected communication.
11:03:06 2 MS. SANTIAGO: We sometimes have -- we will
11:03:08 3 call the OEF/OIF program manager. However, if the
11:03:11 4 service member's in our office and that program
11:03:15 5 manager is not available when we make that call,
11:03:18 6 then they cannot communicate; but if they are
11:03:21 7 there, then that communication can occur. That --
11:03:25 8 MSGT MACKENZIE: Okay. So, it's not a
11:03:26 9 requirement?
11:03:27 10 MS. SANTIAGO: Right.
11:03:28 11 MSGT MACKENZIE: It's just something that
11:03:28 12 sometimes you get the opportunity to do it?
11:03:30 13 MS. SANTIAGO: Correct.
11:03:31 14 MSGT MACKENZIE: Thank you.
11:03:31 15 LT GEN GREEN: And so just -- again --
11:03:36 16 forgive my vigilance, but -- so, you facilitate
11:03:37 17 that interaction between a VA coordinator of care
11:03:40 18 and the case manager that occurs at the end of
11:03:43 19 terminal leave and so VA benefits technically, if
11:03:46 20 I understand right, from the time the DD-214 --
11:03:50 21 that stuff all flows, but VA benefits don't start
11:03:53 22 until like 30 days after they separate; but the
11:03:56 23 health care starts immediately?
11:04:01 24 MS. SANTIAGO: The VA benefits I have to say
11:04:05 25 that I have to defer that question over to the

11:04:07 1 benefits because I'm not sure what their time
11:04:09 2 frame is. It has to do with a service member's
11:04:11 3 compensation, the financial part. The health
11:04:13 4 care, the service member can enter the VA once he
11:04:20 5 is retired. However, if that service member is
11:04:25 6 going on terminal leave and he is going to another
11:04:29 7 state, we will get Tricare authorization for that
11:04:33 8 service member to use the VA at another state
11:04:36 9 prior to him retiring; but because we are
11:04:39 10 locally -- the service member must use the
11:04:43 11 military treatment facility for any medical needs
11:04:46 12 that he needs while he's on terminal leave. So --
11:04:50 13 LT GEN GREEN: But upon terminal leave --
11:04:52 14 and many of these people will have continuing
11:04:55 15 Tricare benefits, so it may not be an issue. I'm
11:04:58 16 just trying to understand. Their health benefit
11:04:59 17 can start upon retirement. The next day they can
11:05:04 18 get VA health care?
11:05:07 19 MS. SANTIAGO: Yes, they can get -- yes,
11:05:08 20 they enroll for VA health care and they can start
11:05:11 21 getting health care benefits.
11:05:15 22 MS. DAILEY: And real quick. This -- when
11:05:17 23 we've -- we've -- this question has come up among
11:05:21 24 the members. What is the warm handoff? And the
11:05:23 25 warm handoff is a process, actually, and that's

11:05:27 1 what we're going through right now.
11:05:32 2 MS. SANTIAGO: So, our -- our performance
11:05:36 3 measure for making sure that the service members
11:05:40 4 are getting these medical appointments prior to
11:05:43 5 them leaving the MTF here at the local VISN has
11:05:50 6 been at 81 percent and meeting is 80 percent,
11:05:53 7 exceeding is 85 percent and in October we had 100
11:05:58 8 percent and that was based on a SOP, a standard op
11:06:04 9 policy, that we established.
11:06:14 10 MSGT MACKENZIE: Is that SOP -- is that SOP
11:06:16 11 nationwide or is that only here within this --
11:06:20 12 this region?
11:06:22 13 MS. SANTIAGO: The SOP that Linda Ray is
11:06:25 14 going to talk about is actually -- it is -- it has
11:06:30 15 been modified here for San Antonio, but it is
11:06:33 16 standard. The process is across the nation.
11:06:39 17 MSGT MACKENZIE: So, what is -- it's your
11:06:40 18 modification of the SOP that has allowed you to
11:06:43 19 exceed the standard, not necessarily meet the
11:06:46 20 standard SOP?
11:06:48 21 MS. ALMS-CHAPA: Correct. This is Tamara.
11:06:50 22 MSGT MACKENZIE: Thank you.
11:06:51 23 MS. SANTIAGO: VA liaison training. Every
11:06:56 24 18 months the VA liaisons meet for a VA liaison
11:07:00 25 conference in Washington, D.C. and we all talk

11:07:04 1 about the latest policies. We get information on
11:07:09 2 changes and also weekly we have national training
11:07:16 3 calls with our national director and we discuss
11:07:21 4 with her any issues, any obstacles, any problems
11:07:25 5 that we are having locally and they will intervene
11:07:29 6 and support us in that. And we also have on a
11:07:33 7 monthly basis a national coaching call where our
11:07:39 8 director from D.C. will talk to the individual
11:07:46 9 centers and we will talk about what are the
11:07:51 10 problems that we are having at a local level so
11:07:53 11 that they can address these issues. We also get
11:08:01 12 VISN, we also get local facilities training calls
11:08:04 13 and those occur on a weekly basis. We also get a
11:08:07 14 lot of pertinent information via e-mail on
11:08:10 15 policies that are coming down. We are provided
11:08:13 16 leave and reimbursement for the approved training
11:08:16 17 and at the Brooke Army Medical Center or SAMMC we
11:08:21 18 have professional and guest speakers that we can
11:08:24 19 attend their briefings on traumatic brain injury,
11:08:29 20 polytrauma issues and also any -- our program
11:08:33 21 manager provides us information that they receive
11:08:36 22 from the leadership.
11:08:42 23 And that concludes my briefing. The best
11:08:47 24 practice will be discussed by Linda Ray. Is there
11:08:50 25 any other questions?

11:08:52 1 MSGT MACKENZIE: Yes, I do. On the training
11:08:54 2 slide that you briefed, how much of that training
11:08:56 3 is actually mandatory and tracked or is it all
11:09:00 4 just training that's provided if you choose to
11:09:03 5 attend?
11:09:04 6 MS. SANTIAGO: The national VA liaison
11:09:06 7 conference, it is a mandatory training. The
11:09:09 8 weekly national training calls, it is a mandatory
11:09:13 9 training and we are required to attend. The
11:09:16 10 monthly national coaching call, it is a mandatory
11:09:20 11 training and we are required to attend. The rest
11:09:24 12 of the training that we get, the training between
11:09:28 13 the local VA and the VA liaisons, that is a
11:09:34 14 requirement because that's pretty much how we get
11:09:37 15 our supervision, as well as any discussion of
11:09:40 16 cases; and that is required. The rest of training
11:09:44 17 is optional. However, we are required to maintain
11:09:48 18 a license in the state of Texas. So, they are
11:09:51 19 also mandatory.
11:09:53 20 MSGT MACKENZIE: Okay. But -- I mean,
11:09:54 21 that's good. As we look at best practices and we
11:09:56 22 analyze across the deal, we get to look at one
11:10:00 23 facility. We were just wondering how that all
11:10:03 24 fits into play. The other question I had is just
11:10:06 25 being a liaison and being with these individuals

11:10:08 1 and their caregivers. There's a trend of just
11:10:12 2 relying on the family caregiver to provide
11:10:15 3 support. However, there's also a trend of not
11:10:17 4 communicating with the family caregiver unless the
11:10:21 5 service member gives permission. I find that to
11:10:26 6 be a conflict of interest because if we're relying
11:10:29 7 on this person to assist this person in their
11:10:31 8 recovery and day-to-day living, yet we don't
11:10:34 9 provide -- they're not treated in that fashion
11:10:37 10 where they're provided the information they need
11:10:39 11 to do the job that we're relying on them to do.
11:10:44 12 Do you find that your workload is increased when
11:10:47 13 you are faced with a service member who obviously
11:10:52 14 has a family member who is their caregiver but yet
11:10:56 15 you are not allowed to communicate with that
11:10:58 16 caregiver because of the fact the service member
11:11:01 17 said no on a piece of paper? Do you find that
11:11:03 18 increases your workload as you prepare that
11:11:05 19 service member to leave?
11:11:09 20 MS. SANTIAGO: It is -- it is difficult if
11:11:14 21 the service member -- if the service member is
11:11:18 22 medically injured, meaning he's an amputee, he has
11:11:22 23 wounds and he has difficulties with ADLs, his
11:11:26 24 activities of daily living, I would say the
11:11:29 25 majority of those folks their caregiver is right

11:11:32 1 there with them, whether it's their parent, their
11:11:35 2 brother, their sister. Whoever it is that they
11:11:38 3 have chosen is right there with them. The
11:11:40 4 difficulty that comes in is when -- and this is
11:11:45 5 difficult across the board, is when it is a mental
11:11:48 6 health patient, when it's a substance abuse
11:11:51 7 patient or those -- those or traumatic -- usually
11:11:55 8 the traumatic brain injury patients, they're very
11:11:59 9 forgetful and so they do allow us to make contact
11:12:01 10 with their family members or they will bring --
11:12:03 11 they'll say, yes, you can make contact. It's the
11:12:05 12 mental health patients and substance abuse
11:12:08 13 patients who if they -- if we know that they're
11:12:10 14 going out there and they are at high risk and they
11:12:15 15 don't want us to make contact with anybody about
11:12:18 16 their mental status, a family member, we cannot do
11:12:24 17 that; but we do make contact with the OEF/OIF
11:12:29 18 program manager and when we transition these
11:12:32 19 patients we let them know that this service member
11:12:32 20 is at high risk. So, the question is, yes, it can
11:12:37 21 become difficult when you have the mental health
11:12:40 22 and you have the substance abuse issues. That
11:12:43 23 really, because we have HIPAA, we cannot disclose
11:12:45 24 to a family member this person is an alcoholic,
11:12:48 25 etcetera and he's at high risk for risky behavior.

11:12:52 1 MSGT MACKENZIE: And that's -- forgive me.
11:12:54 2 Maybe I just -- I didn't deliver the question
11:12:56 3 properly. I mean, you guys have got an
11:12:59 4 outstanding program here. I've been here -- you
11:13:01 5 know, I've been here for a few months and I see
11:13:03 6 some of this stuff in action. There is a great
11:13:05 7 family climate where it seems to be the norm.
11:13:09 8 However, I do get to travel around quite a bit and
11:13:12 9 deal with these situations across the board and
11:13:15 10 this is not the norm. Okay. This -- what I'm
11:13:17 11 talking about is the caregiver. Okay. They're
11:13:19 12 either a family member or they're a family
11:13:21 13 caregiver. If they are providing assistance on a
11:13:23 14 day-to-day basis to that service member, but the
11:13:26 15 service member chooses on a piece of paper to say
11:13:29 16 no, do not contact my family, but you know this
11:13:32 17 person is a TBI patient, you know that he doesn't
11:13:36 18 remember things, that the individual doesn't have
11:13:38 19 this stuff, you can see where the problem lies --
11:13:40 20 MS. SANTIAGO: Yeah, exactly.
11:13:41 21 MSGT MACKENZIE: -- because that -- that
11:13:42 22 person -- the medical team is saying, okay, this
11:13:45 23 person is good to go, knowing this person is going
11:13:47 24 home with their spouse, going home with their mom
11:13:49 25 and dad; but at the end of the day this valuable

11:13:52 1 information and support to that mom, to that wife
11:13:58 2 to continue to take care of their son or daughter
11:14:02 3 is not being provided to them because of a simple
11:14:05 4 check the block "no" on a piece of paper. Do you
11:14:08 5 see what I'm saying?
11:14:10 6 MS. SANTIAGO: Yes.
11:14:10 7 MSGT MACKENZIE: Do you see where I'm
11:14:11 8 getting at?
11:14:12 9 MS. SANTIAGO: Yes.
11:14:14 10 MS. RAY: I do, sir; and I think -- I've had
11:14:15 11 cases like that myself that I've had to work with
11:14:18 12 and I think with those kind of patients, depending
11:14:20 13 on what it is, whether -- you know, on the type of
11:14:24 14 medical issue that's coming out or psychiatric
11:14:27 15 issue and the functioning level of the patient,
11:14:30 16 you have to work very strongly with the patient
11:14:32 17 and really my experience with that is encouraging
11:14:36 18 the patient to allow us to contact their family
11:14:41 19 member and work with them or encourage them to
11:14:43 20 bring that family member in with them and do a
11:14:47 21 family conference of some sort. I think that's
11:14:50 22 really where you have to go with a case like that.
11:14:54 23 And I think if it's a really strong medical issue,
11:14:58 24 you just really, really have to maybe work really
11:15:00 25 diligently with that patient and really help them

11:15:04 1 understand their medical needs and, you know, help
11:15:07 2 them comprehend that they're going to really need
11:15:11 3 this type of maybe a level of care at home.
11:15:14 4 That -- you know, help them understand that maybe
11:15:16 5 they're not going to be able to manage by
11:15:19 6 themselves and that we need that family member in
11:15:21 7 there. So, I would help them maybe comprehend
11:15:23 8 that.
11:15:24 9 MS. DAILEY: Do you all think -- and we run
11:15:25 10 across this. Do you all think that you could use
11:15:30 11 some legislative relief on this topic? Where it's
11:15:32 12 mandated that a family member be included? I
11:15:34 13 mean, it's not unprecedented. We've done it
11:15:36 14 before. Spouses have to come in to sign away
11:15:39 15 their SBP. So, it's not unprecedented; but we
11:15:44 16 hear this again. We have to work with the spouse,
11:15:46 17 we have to work with the spouse; but ultimately
11:15:47 18 you have no power and would it be better to
11:15:51 19 empower you to talk to spouses, with legislation?
11:15:58 20 MS. RAY: I think in our new model of
11:16:00 21 veteran center care that we've been rolling out
11:16:02 22 over the last year or so, couple of years, where
11:16:06 23 we're incorporating more the families into veteran
11:16:11 24 care and we're rolling that model out to veterans
11:16:14 25 and getting them to understand -- am I too close?

11:16:17 1 I'm sorry. Getting them to understand the
11:16:20 2 importance of including their families into their
11:16:24 3 care. I think as we start integrating that into
11:16:27 4 veterans and helping them understand that a little
11:16:29 5 bit more than what we have been in the past and
11:16:33 6 that we really want that in their care, as we
11:16:37 7 start I think doing that shift, that milieu and
11:16:41 8 getting that out there to veterans, I think that's
11:16:44 9 going to help a lot, without a doubt, in getting
11:16:47 10 veterans to understand. Because we have just been
11:16:50 11 focusing on veterans and getting this new
11:16:53 12 program -- the family caregiver support program
11:16:55 13 rolled out and getting veterans shifted in that
11:16:59 14 idea that we want their families involved. I
11:17:02 15 think that's definitely going to help. It's a
11:17:04 16 shift in thought process. I think that's going to
11:17:06 17 help. So, getting legislation, that would help us
11:17:09 18 too, especially in these difficult cases.
11:17:12 19 DR. PHILLIPS: You know, Ms. Dailey's
11:17:14 20 suggestion is very good and you can look at it
11:17:16 21 from the other point of view. We see this as a
11:17:18 22 policy that occurs across the board. You could
11:17:22 23 actually -- I mean, talk about HIPAA. You could
11:17:25 24 actually say that unless they sign no to having a
11:17:28 25 family member participate, it's automatic. I

11:17:33 1 mean -- and that's something that I think it's
11:17:35 2 palatable. One thing I was going to ask you or
11:17:38 3 ask anyone perhaps on your comments is would you
11:17:42 4 identify your problem areas and perhaps let us
11:17:44 5 know how we might be able to help you with those?
11:17:49 6 MS. SANTIAGO: I think for me as a VA
11:17:51 7 liaison, I think that it would be advantageous if
11:18:00 8 the leadership in the military could -- I think
11:18:08 9 it's educating and providing ongoing educating to
11:18:10 10 all levels of the military. Because a lot of
11:18:14 11 times when -- when these service members are in
11:18:18 12 the warriors transition unit, we have to do a lot
11:18:23 13 of advocating and a lot of following and a lot of
11:18:27 14 convincing of referrals to us. And a lot of times
11:18:32 15 I think it's because -- you know, I think the
11:18:36 16 focus a lot of times with the military is that
11:18:40 17 when the person -- when these service members are
11:18:43 18 in the MEB, they have to make all these
11:18:45 19 appointments, they have to go through the MEB
11:18:48 20 process, they have to go to that IDES process; but
11:18:51 21 I think it gets a little bit light when they're
11:18:54 22 getting transitioned out and so I think a big push
11:18:58 23 needs to be that the -- all the medical
11:19:02 24 appointments are tracked at the WTU. However, the
11:19:06 25 appointments with us are not tracked and when we

11:19:10 1 have these multidisciplinary meetings, discussion
11:19:13 2 about, okay, has that person gone to the VA and
11:19:17 3 what's that transition part about. It's really
11:19:19 4 not discussed at the multidisciplinary team
11:19:23 5 meeting.
11:19:24 6 DR. PHILLIPS: Do you notice a difference
11:19:25 7 between guard reserves and active duty and even
11:19:28 8 Army, Air Force, Marine and Navy, in this
11:19:31 9 educational role?
11:19:35 10 MS. SANTIAGO: I think a lot of times with
11:19:36 11 the folks that are National Guard or reservists,
11:19:39 12 if they have medical needs, they are referred to
11:19:43 13 us. Sometimes if they are in the REFRAG status
11:19:48 14 because they're returning back to a unit, they're
11:19:50 15 not always referred to us to be linked and a lot
11:19:55 16 of times these service members when they get back
11:19:57 17 and they get REFRAG'd, they are not necessarily
11:20:01 18 going to be within that unit for a long length of
11:20:04 19 time and so if they're not referred to us, then
11:20:06 20 that could be somebody that potentially is not
11:20:09 21 hitting the VA and their services have not been
11:20:12 22 linked. So, I think -- I really think that this
11:20:15 23 transition piece really needs to be emphasized,
11:20:18 24 that it needs to be tracked and you know --
11:20:25 25 MSGT MACKENZIE: Let me ask you to clarify

11:20:28 1 briefly here. Is that because the -- the DoD is
11:20:32 2 not recognizing those appointments or is that
11:20:35 3 because the VA appointment system does not talk to
11:20:38 4 the DoD system?
11:20:41 5 MS. SANTIAGO: I think it's -- I think it's
11:20:43 6 both. I think it's both. I think that a lot
11:20:46 7 of -- for me, what I see is that there needs to be
11:20:51 8 more communication and more handoff. I think
11:20:54 9 there needs to be a greater link getting medical
11:20:58 10 records. You know, we still struggle trying to
11:21:01 11 get a medical record for the service member that's
11:21:03 12 going to be seen at the VA and that should not
11:21:07 13 happen because the VA -- and being prior military
11:21:12 14 is the aftermath of the military and that's why
11:21:15 15 they're there. They're there to provide us when
11:21:18 16 we were active duty and now we're not active duty,
11:21:21 17 they should be there for us to deliver. They
11:21:23 18 should be delivering to us, but I don't think that
11:21:26 19 handoff in terms of getting medical records,
11:21:31 20 etcetera -- I think it just needs to continue to
11:21:34 21 be improved.
11:21:34 22 DR. PHILLIPS: I don't want to put words in
11:21:36 23 your mouth, but if you had identical IT systems
11:21:39 24 and they were all harmonized, wouldn't that make
11:21:42 25 it easier? You could just get online and look up

11:21:46 1 records and so forth?
11:21:48 2 MS. SANTIAGO: Correct. Yes, that's right.
11:21:50 3 MR. DRACH: On the medical record transfer
11:21:52 4 is there any discussion about the electronic
11:21:53 5 medical record transfer from what was there to you
11:21:55 6 all? In this area. I know there's talk of it
11:21:57 7 nationally, but I don't know what the current
11:21:59 8 status is.
11:22:00 9 MS. SANTIAGO: Yes, and it does exist; but
11:22:03 10 it doesn't exist consistently and whatever the VA
11:22:06 11 is looking at is not the whole record at the DoD.
11:22:09 12 We sit there and I have access to the DoD records
11:22:13 13 and I also have access to the VA record and I have
11:22:16 14 another computer that has solely VA. So, when I
11:22:19 15 look at this AHLTA note and I look in the VA, the
11:22:24 16 note may be in the VA but the detail of that note
11:22:26 17 is not in the VA and so when they're providing
11:22:29 18 care, it's not always there.
11:22:34 19 MS. RAY: Especially when we're talking
11:22:38 20 about relaxing an app in that area; and that's
11:22:39 21 been very difficult for the staff at the VA.
11:22:42 22 MSGT MACKENZIE: So, it's always the best
11:22:44 23 practice being the MTF having access to both
11:22:48 24 systems that assists you in doing your job better
11:22:48 25 than other locations where they don't have access

11:22:51 1 to both systems?
11:22:54 2 MS. SANTIAGO: Correct. That would be best
11:22:55 3 practice.
11:22:56 4 MS. DAILEY: We need to move on to the next
11:22:57 5 person you have.
11:22:59 6 MS. ALMS-CHAPA: Okay. Excellent. Again,
11:23:01 7 my name is Tamara. I'm one of the OEF/OIF case
11:23:01 8 managers. I'm actually one of three social worker
11:23:05 9 case managers for the South Texas area. Almost
11:23:09 10 forgot my slide there. We coordinate care and
11:23:11 11 services for OEF/OIF/OND veterans. It does state
11:23:17 12 seriously injured, but it's actually all service
11:23:19 13 members that come across our plate that we provide
11:23:22 14 services to, starting with looking at the
11:23:24 15 pre-separation for service members. The first
11:23:27 16 thing we're working at is coordinating care and
11:23:29 17 coordinating appointments for that pre-separated
11:23:32 18 service member. Treatment planning starts at the
11:23:34 19 first call. Completing our psychosocial
11:23:37 20 assessment starts at that first call, including
11:23:40 21 during that warm handoff if we're available to
11:23:43 22 speak with a service member, we speak with them.
11:23:45 23 If we are not, Linda will address our SOP where we
11:23:48 24 do have a plan of action of what we will do to
11:23:50 25 reach out to that service member to try to buy

11:23:52 1 them education about the VA health care service
11:23:55 2 and transitional services available through our
11:23:57 3 team; but, again, treatment planning starts at
11:23:59 4 that very first interaction. Assessing them for
11:24:01 5 their needs, caregiver, clothing allowance, making
11:24:05 6 sure they're aware of general benefits and health
11:24:07 7 care.
11:24:09 8 Our case loads -- this is a snapshot of the
11:24:12 9 last fiscal year of referrals, essentially. The
11:24:14 10 referrals, as you can see, have nearly doubled.
11:24:17 11 That's the yellow. From October of 2010 to
11:24:20 12 October of 2011. Our total case load at this
11:24:23 13 point hangs out around 426 service members and
11:24:27 14 veterans on our care management and tracking
11:24:29 15 application and our average case load is around
11:24:32 16 142 service members and veterans.
11:24:40 17 What we do to work with others, including
11:24:43 18 our liaisons, is -- it's phone calls and
11:24:45 19 interactions with anybody identified as a
11:24:48 20 coordinator with the service member. So, we're
11:24:49 21 asking questions from the get-go of who are you
11:24:52 22 working with, who's your risk case manager. I
11:24:54 23 have this name, is that still your case manager,
11:24:56 24 do you have -- if they're Army, I ask who's your
11:25:00 25 AW2, if you have one. Are you assigned to any

11:25:02 1 other people that contact you on a regular basis
11:25:04 2 and then try to clarify the roles between our
11:25:07 3 differences of functions, including the nurse case
11:25:10 4 manager versus my job. So, some of the people
11:25:14 5 that we work with in addition to the nurse case
11:25:16 6 managers and the liaisons are FRCs, PRCs and as I
11:25:20 7 mentioned the DoD advocates.
11:25:24 8 Support to the family caregivers. We do
11:25:26 9 want to address this a little bit more in detail.
11:25:29 10 That even if at first point in service they're not
11:25:32 11 open and willing to communicate approval for
11:25:35 12 talking to the caregivers, we still continue to
11:25:39 13 re-address that at every moment and opportunity.
11:25:41 14 Starting with our psychosocial simple questions
11:25:44 15 like who do you live with, who do you go visit for
11:25:46 16 the holidays. We're always asking about who
11:25:48 17 they're interacting with. Social interactions for
11:25:51 18 us is key in knowing how they're functioning and
11:25:53 19 how they reintegrating. So, at any given point
11:25:55 20 we're always asking about their family caregivers
11:25:56 21 and their spouses and permission to speak with
11:25:58 22 them and if they do not give us permission to
11:26:01 23 speak with them, we're in a little bit different
11:26:03 24 role.
11:26:04 25 So, she spoke to her role. Within my role,

11:26:05 1 even if they do not give me permission to speak to
11:26:08 2 them directly about the service member or the
11:26:10 3 veteran's health care, I still have the other
11:26:12 4 option of if the caregiver needs assistance or
11:26:14 5 guidance, they can call me directly and I can
11:26:17 6 speak to that caregiver as much as I want about
11:26:19 7 they're needs. Now, I identify that at the
11:26:21 8 beginning that I cannot communicate the veteran's
11:26:24 9 health care if the veteran has not given me
11:26:27 10 permission; but I can assist them in accessing
11:26:29 11 health care and support for themselves based on
11:26:31 12 their needs.
11:26:32 13 MSGT MACKENZIE: Now, let me drill into
11:26:33 14 that. If the caregiver has not been provided the
11:26:38 15 information because of the wall that has been put
11:26:40 16 up by the current process in place, how does a
11:26:43 17 caregiver know to call you?
11:26:46 18 MS. ALMS-CHAPA: One of the things we
11:26:48 19 utilize is making sure that our point of contacts
11:26:50 20 are current and accurate. So, if I have a veteran
11:26:53 21 who's resistant to treatment or noncompliant in
11:26:55 22 treatment or if I have any concerns for the
11:26:57 23 veteran and need to speak to a caregiver, again I
11:26:59 24 try to encourage them to give me permission and
11:27:01 25 talk about reasons. I call it my bag of tricks.

11:27:03 1 We pull out our bag of tricks and try to convince
11:27:07 2 the service member or veteran to agree to the best
11:27:09 3 treatment plan possible, which includes family.
11:27:12 4 And children, if necessary. If they still
11:27:13 5 continue not to agree, which I think within our
11:27:15 6 team isn't really happening because we're good;
11:27:20 7 but if that were to happen, we have a point of
11:27:23 8 contact. So, I have a chain -- kind of like a
11:27:26 9 chain of command. If I have phone numbers for the
11:27:28 10 service member and they don't pick up and I have
11:27:30 11 alternate phone numbers for next of kin emergency
11:27:32 12 contact, I am allowed within my code of ethics and
11:27:36 13 within the VA policies to contact the next of kin
11:27:38 14 or emergency contact to introduce myself and let
11:27:41 15 them know and leave a message on behalf, for the
11:27:43 16 veteran, stating I'm asking for a call back and
11:27:45 17 then if they engage me in a conversation about,
11:27:48 18 oh, who are you again and what do you do, then I
11:27:51 19 can continue the conversation from that point.
11:27:52 20 MSGT MACKENZIE: And you see that your
11:27:54 21 direct comment is our concern, which is the proper
11:28:00 22 level of care and support for the veteran and
11:28:03 23 their family across this nation. You guys are
11:28:07 24 good. You're doing a good job. You're making
11:28:10 25 strides that other people aren't making. How do

11:28:12 1 we reach a point where we can make a
11:28:14 2 recommendation so that that's across the board?
11:28:19 3 You know, if I don't come to -- if I don't get
11:28:21 4 medical treatment in San Antonio, I'm not going to
11:28:23 5 get this level of support. You know, nothing --
11:28:27 6 you guys are doing great. It's not a dig. You
11:28:30 7 see, what we see on a strategic level is that
11:28:32 8 unless you are at a specific location, the amount
11:28:35 9 of support you get is -- is not equal.
11:28:43 10 MS. RAY: I think what you suggested with
11:28:45 11 the release of information. Maybe changing our
11:28:49 12 release of information format, really, I think
11:28:52 13 might be a great idea. So, if we could do that
11:28:55 14 nationwide for the entire VA.
11:28:59 15 MS. ALMS-CHAPA: One of the -- well, I'll
11:29:00 16 mention the last point on family caregivers is
11:29:03 17 from the get-go when we identify that they might
11:29:06 18 need caregiver support is -- one of the bag of
11:29:07 19 tricks is inviting them to complete the 1010-CG
11:29:09 20 when they get off active duty status and we
11:29:09 21 discuss what comes with the caregiver stipend.
11:29:12 22 That if they're eligible for the caregiver
11:29:16 23 stipend, not only do they have resources within
11:29:17 24 the community; but there might be a stipend that
11:29:20 25 the service member's spouse or caregiver is

11:29:21 1 eligible for and sometimes that helps encourage
11:29:23 2 them to give us contact information and permission
11:29:25 3 to speak with them.
11:29:27 4 MSGT MACKENZIE: I think that issue --
11:29:31 5 MR. REHBEIN: If I may. Go ahead.
11:29:31 6 MSGT MACKENZIE: No, I feel as though that
11:29:35 7 VA bag of tricks ought to be issued at these 18
11:29:37 8 month conferences.
11:29:39 9 MR. REHBEIN: You've talked about the
11:29:41 10 treatment plan a couple of times. Within the
11:29:43 11 military, before they get to you, there is
11:29:45 12 something called the comprehensive transition
11:29:48 13 plan -- comprehensive recovery plan. Are you
11:29:50 14 given that to build on or are you starting over
11:29:53 15 from day one and developing a treatment plan?
11:29:58 16 MS. ALMS-CHAPA: Occasionally, in the packet
11:29:58 17 of pearls that we receive from our VA liaison, the
11:30:00 18 nurse case managers, I have had that on occasion.
11:30:02 19 I do not always get that, reliably.
11:30:04 20 MR. REHBEIN: But that's not a matter of
11:30:06 21 course that you're always given that?
11:30:08 22 MS. ALMS-CHAPA: No, sir.
11:30:10 23 MR. REHBEIN: Because its always suppose to
11:30:11 24 exist with every -- with every recovering warrior.
11:30:13 25 MS. ALMS-CHAPA: I'm sure it exists with

11:30:14 1 every service member; but we do not always have
11:30:16 2 access to it.
11:30:20 3 CSM DEJONG: If you would take that a step
11:30:23 4 further, was it beneficial or was it not? Would
11:30:25 5 you like to see that in the future?
11:30:27 6 MS. ALMS-CHAPA: It was beneficial. It
11:30:27 7 identifies -- you know, all treatment plans
11:30:29 8 identify what they're currently working on and
11:30:30 9 future goals and future expectations. It does
11:30:33 10 help me understand where they kind of stop their
11:30:35 11 care with the case manager. So, it is beneficial
11:30:38 12 and would be useful for all service members.
11:30:42 13 Moving on to my next slide to discuss
11:30:45 14 different services that we identify successful
11:30:48 15 case management or successful services. That is
11:30:52 16 so varied across the board, across each individual
11:30:56 17 veteran and service member, depending on who I'm
11:30:58 18 talking about. So, there's no real set rule.
11:31:01 19 These are a couple of ideas. One of the ones that
11:31:03 20 I like to focus on is case manager stabilization
11:31:06 21 and biopsychosocial factors. Is the -- are they
11:31:10 22 maintaining the same home, are they maintaining
11:31:12 23 the same relationships, are they active socially
11:31:15 24 in their communities. That's one of the signs I
11:31:17 25 have for a successful transition and successful

11:31:20 1 reintegration into community.
11:31:23 2 Our performance measures were already
11:31:26 3 mentioned. One of them is the bottom one about
11:31:27 4 the future appointments where in the last year we
11:31:30 5 were successful at meeting that at 81 percent,
11:31:33 6 with October 2011 an amazing 100 percent. Our two
11:31:37 7 other ones that the case managers are bound by is
11:31:40 8 severely injureds are all contacted within seven
11:31:44 9 days of referral, if they're not spoken to on that
11:31:46 10 day of referral; and for fiscal 2011 we're at 99
11:31:48 11 percent. Usual fallouts, if we have any, is more
11:31:51 12 of a documentation issue. At this point, in the
11:31:54 13 last -- well, I've been doing this now for four
11:31:56 14 years. I do not remember a single one in the last
11:31:59 15 four years that was not contacted within seven
11:32:01 16 days. Again, it was a systems issue of
11:32:03 17 documentation within two different systems. The
11:32:06 18 other performance measure is the veterans are
11:32:08 19 contacted per their patient care -- or patient
11:32:10 20 driven care plan, which is our contact plans.
11:32:13 21 Whether it's monthly, quarterly, semi-annually or
11:32:16 22 annually. We are monitoring how successful we are
11:32:19 23 at completing those and for fiscal year 2011 we're
11:32:21 24 at a hundred percent and we tend to maintain that
11:32:25 25 in the high 90s every year.

11:32:32 1 Our trainings. We have very similar
11:32:34 2 trainings between the liaisons and the case
11:32:37 3 managers with both central office, VISN and
11:32:42 4 facility training calls and they are expected and
11:32:45 5 mandatory with the exception of if we have veteran
11:32:48 6 care, that comes first and then our calls come
11:32:50 7 next. We also have our weekly meetings.
11:32:53 8 One of the things I'd like to address is --
11:32:55 9 you guys have had a chance to review this. One of
11:32:57 10 the things that's not on here that hit me while I
11:33:00 11 was sitting out there, the thing that is my
11:33:01 12 favorite type of training is the OJT. On-the-job
11:33:04 13 training which is on any given day I never know
11:33:06 14 who or what is going to walk through that door and
11:33:08 15 there are times on a pretty regular basis where it
11:33:10 16 kind of catches us by surprise and we kind of look
11:33:13 17 and go hmmmm, I'm not real sure what to do with
11:33:15 18 that; and one of the things I love about having a
11:33:17 19 team, especially the way our San Antonio team is
11:33:19 20 set up with the case management side, is that we
11:33:21 21 are all in one spot. We're all at the Audie
11:33:23 22 Murphy VA Hospital and I know there's been
11:33:25 23 discussion of, you know, putting us in other
11:33:26 24 places and some of the other VAs do split them up
11:33:30 25 into clinics. It has been so beneficial in the

11:33:32 1 last four years to have us all in one spot,
11:33:34 2 because when I run across something that I don't
11:33:36 3 know what to do or don't know how to do it or
11:33:37 4 there's such an intense event that needs multiple
11:33:40 5 people assisting, I have a program support, two
11:33:43 6 patient advocates and two other case managers
11:33:46 7 along with a program manager and a phone call away
11:33:48 8 is my liaisons, all ready to help and drop what
11:33:51 9 they're doing to assist. So, that's my favorite
11:33:54 10 type of training that we have. That is mandatory
11:33:56 11 of course because when it presents, you step up
11:33:58 12 and do your job.
11:34:00 13 MSGT MACKENZIE: I will say you have a good
11:34:02 14 argument on that because breaking this up into
11:34:04 15 individual locations creates a single point of
11:34:06 16 failure and the veteran doesn't come hang out.
11:34:09 17 The veteran comes because they have a need. If
11:34:11 18 you're not there, that need's not going to get
11:34:14 19 met. You can just imagine the myriad of choices
11:34:16 20 that member's going to make when they're not
11:34:19 21 getting the help they need. So, don't allow them
11:34:21 22 to do that to you.
11:34:23 23 MS. ALMS-CHAPA: My personal goal as far as
11:34:25 24 satisfaction in case management and one of the
11:34:27 25 ones that I know that it's okay for them to be

11:34:27 1 inactivated or discharged from case management is
11:34:30 2 that they call me just to say hi. They call me to
11:34:32 3 let me know they're not sure how to do this and
11:34:34 4 ask for a number, without me having to call them,
11:34:36 5 on the care contact plan. So, that is a sign of
11:34:40 6 success and we do have some that come just to
11:34:42 7 chitchat, as Linda knows. She'll catch us
11:34:47 8 regularly.
11:34:48 9 And I believe that was it for me. The next
11:34:50 10 part is our SOP that, like I said, is the sole
11:34:52 11 reason why we got to a hundred percent in October.
11:34:55 12 So, I'll pass it on to Linda Ray.
11:34:59 13 MSGT MACKENZIE: Thank you.
11:35:00 14 MS. RAY: Thank you very much, Yvonne and
11:35:02 15 Tamara. Good job. Okay. I think what I'm
11:35:04 16 hearing from everybody a lot is about our warm
11:35:07 17 handoff a lot. That you're very curious about
11:35:11 18 this. So, being new in this position -- when I
11:35:13 19 first came on, one of the things that I was
11:35:15 20 hearing from both teams was both of them -- both
11:35:19 21 teams were coming to me and they were saying --
11:35:23 22 the teams were a bit divided and what was
11:35:25 23 occurring with that was our service members
11:35:28 24 were -- at times were not able to get the future
11:35:33 25 appointments and what was happening here was the

11:35:36 1 case managers -- and not due to their -- not due
11:35:41 2 to them, but it was a systems issue is what I was
11:35:44 3 seeing and there were variables that were causing
11:35:48 4 this. We were not able to get some future
11:35:51 5 appointments for the service members and so what
11:35:53 6 was happening, the VA liaisons were having to
11:35:56 7 report the case managers up to their leadership
11:35:58 8 and so both teams were not feeling very good about
11:36:02 9 this. So, it was kind of a tattletale situation.
11:36:05 10 So, the VA liaisons were having to tattletale on
11:36:07 11 the case managers and so both teams were not
11:36:13 12 feeling good about this and so coming into this
11:36:15 13 situation I was like seeing this and I was
11:36:17 14 thinking what can we do to fix this situation. A,
11:36:21 15 to get the service members their appointments and
11:36:24 16 to make the team members -- you know, integrate
11:36:28 17 the teams better. So, I was looking at our best
11:36:31 18 practice with this or I was thinking let's develop
11:36:35 19 an SOP to make this better and fix this situation.
11:36:38 20 So, there are a number of factors at play here.
11:36:41 21 So, I started looking at our PSA also over at the
11:36:48 22 SAMMC system and how we can utilize her. So, I
11:36:50 23 was looking at the liaisons and they were not --
11:36:52 24 all of them were doing different things. You
11:36:55 25 know, they were busy. They were faxing their --

11:36:58 1 they were doing their own faxes and all of this.
11:37:01 2 So, I started getting them on the same system and
11:37:04 3 utilizing the PSA over there and trusting the PSA.
11:37:09 4 So, we started at that and then from there I
11:37:11 5 started this SOP and I'm very into using the team.
11:37:15 6 You know, I figure more brains are better than one
11:37:17 7 and so I started this and then I sent it out to
11:37:21 8 the team and got everybody's input and the first
11:38:08 9 part of this is kind of a standard process, which
11:38:08 10 Yvonne mentioned that earlier. And then this part
11:38:08 11 on the right-hand side is really our best
11:38:08 12 practice. This is what I started implementing as
11:38:08 13 a checks and balance system and this is what has
11:38:08 14 really gotten us up to a hundred percent; and so
11:38:08 15 whenever -- my goal here was to start looking at
11:38:08 16 how we could obtain the appointments for all the
11:38:08 17 veterans -- for the service members, integrate the
11:38:08 18 two teams and improve this system that we were
11:38:08 19 having. So, those were my goals. So, what I
11:38:09 20 started doing was -- as we get to this side over
11:38:09 21 here, when any liaison contacts me, whether it's
11:38:11 22 through the nation or through them, they contact
11:38:14 23 me, they usually call me and they provide a
11:38:19 24 referral for me and so let's just go with them
11:38:23 25 right here. With the VA -- with our VA liaisons.

11:38:26 1 So, they contact me and then I'm going to provide
11:38:29 2 them with -- with our PSA and with that our PSA
11:38:35 3 provides them with who the case manager is going
11:38:39 4 to be. Then, what happens with that is we follow
11:38:41 5 up with that with an e-mail and saying who the
11:38:44 6 case manager is going to be. If they're sitting
11:38:46 7 with the service member, then they can tell the
11:38:48 8 service member who their case manager is going to
11:38:51 9 be and we go from there. So, the service member
11:38:54 10 now has this contact. They know who their case
11:38:57 11 manager is going to be at the VA. So, from there
11:39:00 12 what's going to happen is now the case manager has
11:39:04 13 seven days to submit a consult.
11:39:08 14 LT GEN GREEN: Can I interrupt?
11:39:09 15 MS. RAY: Yes.
11:39:11 16 LT GEN GREEN: We're -- just the acronyms.
11:39:13 17 PSA stands for?
11:39:14 18 MS. RAY: Program support assistant.
11:39:18 19 MS. DAILEY: Admin support.
11:39:21 20 MS. RAY: And so from there -- so, then, the
11:39:22 21 program support assistant -- so, all that starts.
11:39:25 22 I'm sorry I got a little off there. Okay. So,
11:39:33 23 the program support assistant gets involved in
11:39:37 24 this process. I'm sorry. I got lost. All right.
11:39:44 25 So --

11:39:45 1 MS. ALMS-CHAPA: I believe you were talking
11:39:47 2 about how the packets are managed and what the PSA
11:39:49 3 does to help ensure that we meet seven-day
11:39:51 4 contact.
11:39:52 5 MS. RAY: Yeah. Okay. That's right. The
11:39:53 6 seven days. So, within that time frame, that
11:39:56 7 seven days -- this is what we started
11:39:58 8 implementing. Within that seven days they submit
11:40:01 9 the consult for the service member's appointment
11:40:04 10 and what was happening there was sometimes they
11:40:07 11 were not getting -- able to get that appointment
11:40:09 12 and some of the variables there that was causing
11:40:13 13 some problems there was scheduling. Some of the
11:40:20 14 schedulers didn't know that a service member could
11:40:22 15 get an appointment. They weren't educated to
11:40:26 16 that. Sometimes the consult would get closed out
11:40:29 17 and the appointment wasn't made. So, what I did
11:40:33 18 with that -- and the teams were coming to me and
11:40:35 19 the case managers were coming to me and saying,
11:40:37 20 "Linda, this is what's occurring here and we're
11:40:41 21 struggling with this." So, what I did is I went
11:40:43 22 to the supervisor over the schedulers and I -- he
11:40:46 23 was not aware of this problem and I said, "What
11:40:50 24 are we going to do? This is what's happening."
11:40:53 25 Well, he was very wonderful. He was quick to

11:40:56 1 respond to this and we got this resolved very,
11:40:58 2 very fast, which was wonderful. So, we are not
11:41:02 3 having these problems anymore at all. So, you
11:41:05 4 know, schedulers got educated to service members
11:41:08 5 that were able to -- you know, that they're able
11:41:10 6 to get their appointments. We resolved the
11:41:13 7 problem of consults getting closed out. All that
11:41:16 8 got resolved. So, now service members are getting
11:41:21 9 their appointments. When the case managers submit
11:41:23 10 their consults the appointments are getting made
11:41:26 11 and sometimes -- at times the VA liaisons will
11:41:31 12 send a consult or send a referral over to us and
11:41:34 13 it will be that day. The service member ETS is
11:41:38 14 like that day. We need to get an appointment that
11:41:40 15 day. So, we requested, you know, from Yvonne and
11:41:42 16 the team over there that if they could please get
11:41:45 17 that to us that morning so that we can have an
11:41:49 18 appointment by close of business that day. So,
11:41:50 19 that was another issue that was coming up for us.
11:41:54 20 So, you know, we were working all these out. Now,
11:41:57 21 the PSA over at SAMMC -- where our checks and
11:42:00 22 balances came into play here was we were having
11:42:04 23 her review our -- our charting system in the VA to
11:42:09 24 make sure that the service member had their
11:42:12 25 appointments and if they didn't, then what our

11:42:15 1 process was was she was to e-mail me, the case
11:42:19 2 manager and the -- and the -- and the liaison to
11:42:25 3 let us know that the appointment had not been made
11:42:28 4 and they had to do that on the sixth day, because
11:42:31 5 now remember we have seven days to get this
11:42:33 6 appointment; and that way it would notify us that
11:42:37 7 we -- you know, we're at risk at not having an
11:42:40 8 appointment made for the service member. So, it
11:42:42 9 took us a couple of months to get going in this
11:42:45 10 process and I have to say the last couple of
11:42:48 11 months we have not had any fallout in this
11:42:53 12 performance measure whatsoever and due to this new
11:42:56 13 process, as you can see, we're at 100 percent.
11:42:59 14 So, this has been working wonderful for us.
11:43:02 15 The other thing that we have also
11:43:04 16 implemented -- can you click to the next slide,
11:43:07 17 please.
11:43:08 18 MS. ALMS-CHAPA: Sure.
11:43:10 19 MS. RAY: They had in place already when I
11:43:12 20 came on board this Excel sheet and so one of the
11:43:17 21 things that we did -- it was a little difficult
11:43:20 22 and the team was struggling with this a little
11:43:23 23 bit. It's a daily referral log. So, what I did
11:43:25 24 with this was I implemented color to the daily
11:43:28 25 referral log. So -- for the really prime issues

11:43:32 1 that were things that we needed to look at and so
11:43:36 2 that has helped the team a lot too because we look
11:43:39 3 at this every single day and so now they know the
11:43:42 4 prime things that they need to be looking at of
11:43:45 5 things that are going to be due and so this has
11:43:48 6 helped a lot too. So, the team has been reporting
11:43:50 7 that they really like this, since we've been
11:43:53 8 adding color. So, it's a simple fix. This has
11:43:56 9 worked very well for us. So, due to these -- this
11:44:00 10 best practice, this has worked very well and the
11:44:04 11 team seems to be liking all of this. And, you
11:44:10 12 know, my experience has been when you have happy
11:44:14 13 team -- have a happy team, it goes back to
11:44:17 14 providing good care to service members and
11:44:21 15 veterans and we have a great team.
11:44:28 16 LT GEN GREEN: Go ahead.
11:44:29 17 DR. PHILLIPS: The issues that you describe
11:44:32 18 and the solutions that you came up with, are you
11:44:35 19 sort of recording that or is that going to be some
11:44:38 20 best practices for -- so other people that run
11:44:44 21 into the same situation can refer back to what
11:44:47 22 you've done?
11:44:49 23 MS. RAY: Yes, definitely. I mean, I would
11:44:52 24 be very happy to share this with anybody that
11:44:54 25 would need this or would like it.

11:44:56 1 MR. REHBEIN: I think the question there is
11:44:58 2 how do you know who needs it? How do you know who
11:45:00 3 to share it with? Is there a mechanism for you to
11:45:06 4 transmit it on up the line and make it available?
11:45:10 5 MS. RAY: Oh, yes. We have a national call
11:45:12 6 that we're on on a monthly basis and the last call
11:45:14 7 we were on they were seeing that there are some
11:45:19 8 programs that are struggling very -- very much
11:45:21 9 with getting the future appointments for
11:45:24 10 veterans -- for service members that are
11:45:26 11 separating. So, if anyone's willing or would like
11:45:30 12 this, I'd be very happy to share it with them.
11:45:35 13 LT GEN GREEN: So, can I just clarify. So,
11:45:37 14 does every VA have a PSA that's working at the WTU
11:45:42 15 or is that unique here?
11:45:45 16 MS. RAY: I believe -- I believe -- no, I
11:45:47 17 believe all the MTFs have PSAs. I believe so. Is
11:45:51 18 that correct, Yvonne?
11:45:53 19 MS. SANTIAGO: No, not every --
11:45:54 20 MS. RAY: No?
11:45:55 21 MS. SANTIAGO: -- not every WTU where
11:45:58 22 there's a liaison has a PSA.
11:46:01 23 LT GEN GREEN: So, what I'm kind of seeing
11:46:03 24 your best practice is is a combination of the PSA
11:46:06 25 and the check sheets -- the color-coded check

11:46:08 1 sheets; but my question to you is is it -- I mean,
11:46:11 2 clearly you hired -- is there only one person
11:46:14 3 that's that PSA or is there more than one?
11:46:17 4 MS. RAY: No, it's that PSA and also our PSA
11:46:20 5 over at the VA also and I think also the fact that
11:46:22 6 we did some education with the schedulers. That
11:46:24 7 was a big factor.
11:46:26 8 LT GEN GREEN: And that was my other part of
11:46:27 9 the question. So, is your PSA -- was she -- he or
11:46:30 10 she a prior scheduler?
11:46:32 11 MS. RAY: No.
11:46:33 12 LT GEN GREEN: So, it wasn't. So, it's not
11:46:34 13 an issue of -- I'm trying to make sure it's not
11:46:36 14 just we have an extremely talented person that now
11:46:40 15 knows all the right people to make this happen.
11:46:41 16 So, you actually educated your schedulers, hired
11:46:45 17 someone who's kind of double and triple checking
11:46:48 18 and doing the checklist against simple things like
11:46:50 19 verifying that an appointment was actually made in
11:46:53 20 the system and that's -- I mean, I'm glad to hear
11:46:57 21 it's happening because clearly you are at a
11:47:00 22 hundred percent and doing the warm -- I see your
11:47:02 23 warm handoff; but I'm trying to understand what
11:47:04 24 actually made the biggest difference. Was it the
11:47:06 25 check sheet, the education of the schedulers, the

11:47:09 1 PSA? I think it's PSA. Yeah, PSA.
11:47:13 2 MS. RAY: Yeah, that's correct.
11:47:14 3 LT GEN GREEN: And so I'm trying to
11:47:15 4 understand what you think had the biggest impact
11:47:17 5 or was it really the combination of all three?
11:47:20 6 MS. RAY: I think the combination of all
11:47:21 7 three and I think everyone -- I think just the
11:47:24 8 entire team pulling together. I think it was just
11:47:27 9 a combination of all of it. I think the
11:47:30 10 scheduling aspect. I think also the PSA reviewing
11:47:36 11 all the referrals, definitely. I think all of
11:47:40 12 that affected it.
11:47:42 13 DR. PHILLIPS: The mention of the 18 month
11:47:46 14 conference and the monthly calls and so forth. Do
11:47:49 15 you do anything above and beyond that? Like do
11:47:52 16 you have a list or a blog or an e-mail loop that
11:47:55 17 you can communicate with or is it just at that
11:47:59 18 level that you described?
11:48:01 19 MS. RAY: Well, we have it nationally and we
11:48:04 20 also have it at VISN level and we also have it
11:48:09 21 within the facility.
11:48:11 22 DR. PHILLIPS: Okay. I was just making a
11:48:13 23 suggestion. I mean, we have over 800 different
11:48:17 24 information specialists scattered around the US
11:48:20 25 and internationally and they communicate on a

11:48:22 1 Listserv every day asking certain questions, make
11:48:25 2 suggestions related to best practices, things they
11:48:28 3 identified like you have done and I was just
11:48:31 4 wondering if you were at that level?
11:48:33 5 MS. RAY: Oh, yes.
11:48:34 6 MS. SANTIAGO: We actually have an e-mail
11:48:36 7 group that we belong to, both program managers and
11:48:37 8 case managers and a liaison e-mail group and
11:48:41 9 regularly -- I'm not sure about the liaisons; but
11:48:41 10 I know for the program managers and case managers,
11:48:43 11 since I'm on both, Listservs. We regularly have
11:48:46 12 e-mails come through across the nation people
11:48:47 13 asking -- I believe Linda has even posted a
11:48:50 14 question out there to our cohorts across the
11:48:53 15 nation for assistance. Does somebody have this,
11:48:54 16 how do you all manage this and the response is
11:48:57 17 overwhelming. 20, 30 e-mails to that.
11:49:00 18 DR. PHILLIPS: That's what I meant. Thank
11:49:04 19 you.
11:49:04 20 MS. ALMS-CHAPA: Yes, we do have that.
11:49:06 21 MS. SANTIAGO: And community response. We
11:49:07 22 meet weekly and we exchange e-mails all the time.
11:49:09 23 So, we're always communicating, as well.
11:49:12 24 LT GEN GREEN: Some of the open press has
11:49:14 25 been critical recently because we have a lot of

11:49:17 1 help for the wounded warriors and their families
11:49:19 2 and people -- the quote was -- in the Washington
11:49:21 3 news at least was we need a liaison to handle all
11:49:25 4 the liaisons and kind of tell us -- and so as I've
11:49:28 5 been listening to you folks -- so, if I'm
11:49:32 6 understanding the different roles, the liaison is
11:49:34 7 someone who works with the military case managers
11:49:36 8 and gives the military members now the contact
11:49:40 9 numbers and how they would go ahead and get care
11:49:43 10 in the VA. The case manager that briefed,
11:49:47 11 yourself, essentially is the person who's going to
11:49:50 12 take over after they now start their VA health
11:49:54 13 care. So, your role is really more at the VA and
11:49:57 14 not as much in this case as SAMMC. Am I
11:49:59 15 understanding correct?
11:50:00 16 MS. ALMS-CHAPA: Correct. We do start as
11:50:02 17 soon as we get the referral, which sometimes is --
11:50:04 18 well, lately it's been actually 30 to 60 days out
11:50:08 19 we're calling service members; but our primary
11:50:10 20 role is once they're out, trying to get them VA
11:50:13 21 health care. If they identify any issues or
11:50:14 22 concerns while we're contacting them on active
11:50:16 23 duty, we do try to connect them back to our case
11:50:19 24 manager or any other appropriate resource.
11:50:20 25 LT GEN GREEN: And then behind the scenes,

11:50:23 1 not necessarily interfacing with the families or
11:50:26 2 the casualties, is the PSA who's really doing
11:50:28 3 support for you folks and yourself as a program
11:50:31 4 manager who's trying to bring the whole thing
11:50:33 5 together as a team approach?
11:50:35 6 MS. RAY: Yes.
11:50:35 7 LT GEN GREEN: Have I got this --
11:50:37 8 MS. RAY: Correct.
11:50:38 9 LT GEN GREEN: Okay. Thank you.
11:50:40 10 MS. RAY: One other thing that we're
11:50:41 11 starting to do that I implemented in the last
11:50:44 12 couple of months is groups. Support groups. So,
11:50:47 13 we're starting like transition groups and things.
11:50:49 14 That was another thing that I heard the team say
11:50:52 15 when I first came on. That a lot of the service
11:50:56 16 members are struggling with transitioning. Lots
11:50:59 17 of issues around that. So, we've started some
11:51:02 18 groups that we've implemented. So, that has just
11:51:06 19 started for us.
11:51:08 20 MS. DAILEY: And we do need to move on to
11:51:10 21 our next speaker.
11:51:13 22 MS. JULES: Hello. Again, my name is Diane
11:51:19 23 Jules and I'm the polytrauma social work case
11:51:23 24 manager supervisor and I'd like to just talk with
11:51:26 25 you briefly about our new polytrauma center. We

11:51:30 1 just recently had our grand opening in October of
11:51:35 2 this year and we have started to transition into
11:51:43 3 the new building. So, we're all excited about
11:51:46 4 that and we look forward to getting fully
11:51:50 5 operational. We currently have two case managers
11:51:55 6 in our polytrauma, along with myself as the social
11:51:59 7 work supervisor. Our inpatient case manager, the
11:52:05 8 ratio of patients to -- I guess case manager is --
11:52:12 9 is recommended to be one for every six polytrauma
11:52:17 10 inpatients and then the case load for our
11:52:20 11 outpatient social worker is recommended to be at
11:52:25 12 one for every 25 or every 30 polytrauma patients.
11:52:29 13 Right now our facility is currently operating at
11:52:33 14 eight bed capacity. Initially, when we started,
11:52:36 15 our inpatient unit -- we've been operational for
11:52:39 16 about 12 months. December actually makes it 12
11:52:42 17 months now. We started with six beds and we
11:52:45 18 increased to eight. We hope to transition to 12
11:52:49 19 beds, which will make us fully operational
11:52:52 20 sometime early next year. We currently have three
11:53:02 21 active duty soldiers in our unit that we're
11:53:06 22 providing care for and overall over the past six
11:53:13 23 months or so I think we've had a total of eight
11:53:16 24 active duty soldiers come through our unit. So,
11:53:20 25 we're very happy and pleased with that and we

11:53:23 1 expect those numbers to increase as the word
11:53:28 2 has -- it's spreading that, you know, we're fully
11:53:30 3 operational.
11:53:31 4 The polytrauma case managers are part of an
11:53:36 5 interdisciplinary team and we're there to address
11:53:43 6 the specific cognitive, behavioral and physical or
11:53:45 7 emotional difficulties that the patients may have.
11:53:49 8 On that team we have a physiatrist; we have PT,
11:53:55 9 physical therapy; occupational therapy; speech.
11:53:58 10 We have a neuropsychiatrist and also psychology on
11:54:04 11 board to help provide the care for our polytrauma
11:54:07 12 patients. We have a lifetime case management
11:54:11 13 model that we use to follow these patients
11:54:17 14 throughout their rehab phases and so in the
11:54:21 15 beginning, during the initial stages, we may have
11:54:26 16 contact with the patients daily, weekly just based
11:54:29 17 upon the clinical or psychosocial presentation of
11:54:36 18 the patient. So, again, talking about the
11:54:40 19 different phases of rehab, we may follow them
11:54:44 20 intensely or maybe for -- once a month maybe when
11:54:48 21 they're in an outpatient setting to -- the least
11:54:57 22 intensive phase I guess would be quarterly we
11:55:01 23 would follow these patient s. Once their recovery
11:55:05 24 needs stabilize and their -- the need for case
11:55:09 25 management decreases. And so most of these

11:55:13 1 patients have complex multiple injuries which can
11:55:17 2 include TBI or amputations.
11:55:23 3 The families are provided assistance. We
11:55:28 4 make sure that we include the family in our
11:55:32 5 coordination of services. Again, because most of
11:55:34 6 these injuries are complex and to manage them in
11:55:39 7 an outpatient setting or even while they're at the
11:55:43 8 -- our facility, it's important that the family
11:55:45 9 members are involved and are part of that team.
11:55:50 10 So, we can also assist the -- the team in terms of
11:55:59 11 evaluating their ongoing rehabilitation needs and
11:56:04 12 providing support services and assisting the
11:56:08 13 service member to reintegrate back into the
11:56:12 14 community.
11:56:16 15 Our VA liaison is a very important member of
11:56:21 16 our team and we so appreciate what they do. When
11:56:26 17 we get referrals to our polytrauma center,
11:56:29 18 typically they come through our VA liaison. And
11:56:36 19 this helps to streamline the process and get that
11:56:40 20 warm handoff from the military treatment facility
11:56:44 21 into our polytrauma center. There are some areas
11:56:51 22 across the nation that don't have a liaison
11:56:54 23 assigned to the area and so it makes it a little
11:56:57 24 more difficult to communicate with that unit or
11:56:59 25 that case manager. I think most of our challenges

11:57:03 1 come from situations where we're getting referrals
11:57:08 2 from a community hospital and there's no VA
11:57:14 3 liaison involved and we're trying to track down
11:57:16 4 the military to communicate with them as to what
11:57:21 5 we're trying to do with the service member. So,
11:57:23 6 we truly do appreciate the involvement of the VA
11:57:26 7 liaison and I'm not sure why everybody doesn't
11:57:29 8 have a liaison. I thought that was truly a best
11:57:35 9 practice. So, we communicate with our liaisons to
11:57:41 10 get these service members referred to our
11:57:45 11 facility. That communication can entail getting
11:57:48 12 the medical records so that our team can see what
11:57:54 13 has -- what treatments the service members have
11:57:58 14 received already, to help streamline or develop a
11:58:04 15 treatment plan at our facility. They also help
11:58:08 16 with getting the Tricare authorization. Our VA
11:58:13 17 liaisons are instrumental in also helping to put
11:58:21 18 us in contact with the family members to help with
11:58:27 19 that initial contact and that orientation, that
11:58:29 20 welcome, to say, okay, here's a team, this is what
11:58:32 21 we can provide. Where are you staying. You know,
11:58:37 22 what -- do you have issues with transportation,
11:58:40 23 lodging. All of these things are discussed with
11:58:43 24 our liaison when we're doing the handoff because
11:58:49 25 when they come to our rehab center, I think it's

11:58:51 1 enough just trying to deal with the rehab and the
11:58:55 2 medical care of that service member without having
11:58:57 3 to worry about some of these other issues like
11:59:01 4 where am I going to stay, how am I going to get
11:59:05 5 around. So, those are things that we look at.
11:59:07 6 Our team will make contact with the family. If
11:59:11 7 time allows, we like to have the family come and
11:59:13 8 visit our center and take a tour, meet the team;
11:59:16 9 and it's really up to the family to decide whether
11:59:20 10 they want to come to our center or go somewhere
11:59:26 11 else out in the community for rehab and I find
11:59:28 12 that once they meet our team, they're very pleased
11:59:32 13 with what we have to offer and most often they do
11:59:37 14 decide to -- to come to our facility.
11:59:41 15 MSGT MACKENZIE: So, let me ask you a
11:59:42 16 question --
11:59:43 17 MS. JULES: Yes.
11:59:43 18 MSGT MACKENZIE: -- on the same token. This
11:59:45 19 is only when you're allowed permission to talk to
11:59:47 20 the family or do you have a different set of rules
11:59:49 21 that allows you to talk to all the family members?
11:59:52 22 MS. JULES: Well, because of the complex
11:59:54 23 nature of the injuries that our patients have,
12:00:00 24 typically there's someone involved with the
12:00:04 25 family, whether it's a spouse, a parent or a

12:00:07 1 friend. There is someone and some of our patients
12:00:13 2 are not in a position to communicate a yes or a
12:00:18 3 no.
12:00:19 4 MSGT MACKENZIE: I totally un -- I totally
12:00:21 5 understand that. I spent a significant amount of
12:00:23 6 time with that. What I'm getting at is the one --
12:00:27 7 you know, is your contact with the family only
12:00:29 8 because you're in a good location, you've got the
12:00:33 9 family member, you've got the right caliber of
12:00:35 10 people or are there rules within your section that
12:00:40 11 allows you to talk to the family member whether or
12:00:42 12 not the service member has given you permission?
12:00:45 13 MS. SANTIAGO: I can answer that. The
12:00:46 14 patients that are going to Diane Jules, all of
12:00:50 15 those patients are inpatient. They're in an acute
12:00:53 16 setting because they have been significantly
12:00:53 17 injured. So, all of those patients will always,
12:00:59 18 always have, a hundred percent, a family member
12:01:01 19 with them.
12:01:01 20 MSGT MACKENZIE: Ma'am, I totally respect
12:01:03 21 that. However, I, personally, have been a liaison
12:01:06 22 for polytrauma cases who are able to communicate
12:01:10 23 on their own, who are in a polytrauma rehab
12:01:14 24 facility at the VA. So, that's not -- it happens
12:01:17 25 to always be the case; but it is not always the

12:01:20 1 case and so that's why I was asking what are your
12:01:23 2 guidelines when you don't -- when you're faced
12:01:26 3 with a patient where you don't have this level of
12:01:29 4 involvement?
12:01:30 5 MS. JULES: It absolutely makes it more
12:01:32 6 challenging if we do not have family involved and
12:01:36 7 so -- I understand your concern and I would like
12:01:41 8 for the task force to take away that I think it's
12:01:45 9 crucial. I think it should be mandatory that we
12:01:49 10 be allowed to include the family members in all
12:01:52 11 phases of this transition and leave it up to the
12:01:56 12 family member. If they don't want to be involved,
12:01:58 13 then they can choose to do so; but they should at
12:02:01 14 least be aware of what services are available to
12:02:05 15 them.
12:02:06 16 MSGT MACKENZIE: Thank you very much.
12:02:10 17 DR. TURNER: The question is you've got, you
12:02:11 18 know, difficult family members. Do you ever have
12:02:12 19 to go out and make contact with them to bring them
12:02:22 20 in?
12:02:23 21 MS. JULES: For my active duty patient, I do
12:02:25 22 not have to hunt down family members. Most often
12:02:30 23 when they come to us there is a family member
12:02:32 24 involved; but we do provide care to veterans at
12:02:36 25 the polytrauma center and, yes, it is difficult to

12:02:39 1 find family at times and it makes dispositioning
12:02:42 2 these patients even more challenging. Especially
12:02:45 3 if the patient doesn't have capacity and they've
12:02:49 4 reached their maximum benefit for rehab.
12:02:52 5 DR. TURNER: Do you ever see homeless
12:02:53 6 patients?
12:02:54 7 MS. JULES: Absolutely.
12:02:56 8 DR. TURNER: Could you comment about them?
12:02:58 9 MS. JULES: It goes in line with what I have
12:03:01 10 said before. With the homeless patient there are
12:03:10 11 challenges on several levels. If there are no
12:03:13 12 resources -- if the patient has no resources, it
12:03:17 13 makes it difficult to move them on to the next
12:03:22 14 level of care. If there isn't family involvement,
12:03:28 15 even something as simple as if we want to maybe
12:03:32 16 place them in a nursing home that would be the
12:03:34 17 most appropriate setting for them, it makes it
12:03:37 18 more difficult to do so because there isn't family
12:03:39 19 involvement. We may not be aware of resources the
12:03:43 20 patient may have because he can't communicate that
12:03:45 21 to us and so we have challenges across the board.
12:03:51 22 We do have a wonderful homeless program there with
12:03:55 23 our -- with our VA and so we will tap into them to
12:04:01 24 see if they can offer any assistance in terms of
12:04:05 25 helping us to disposition these patients; but

12:04:09 1 those are some of our most challenging cases.
12:04:12 2 DR. TURNER: I guess, curiously, you
12:04:14 3 wouldn't discharge someone to the street, knowing
12:04:17 4 they're homeless?
12:04:18 5 MS. JULES: We could not do that. We could
12:04:20 6 not do that.
12:04:23 7 DR. TURNER: There is -- there is --
12:04:25 8 MS. JULES: And I say that because --
12:04:27 9 depending on the level of functioning of this
12:04:32 10 patient. If physically he -- and cognitively he
12:04:37 11 were able to make his own decisions and he did
12:04:39 12 want to return to the streets and this would not
12:04:44 13 pose a risk to him and his health, as providers
12:04:48 14 we -- we have to allow the patient choice and
12:04:51 15 he -- a patient could return to the streets in a
12:04:56 16 situation like that; but we're there to help them
12:04:58 17 to locate the most safe environment for them
12:05:05 18 within their means, of course, and within the
12:05:07 19 means of VA.
12:05:10 20 LT GEN GREEN: So, just to be clear. So,
12:05:12 21 the issue regarding advising family members --
12:05:17 22 Mac, you brought it up twice now -- on available
12:05:20 23 services. Is that a privacy act problem?
12:05:20 24 MS. JULES: I think --
12:05:23 25 LT GEN GREEN: It doesn't sound like a HIPAA

12:05:25 1 problem.
12:05:25 2 MS. JULES: No, I --
12:05:25 3 LT GEN GREEN: So, is it a policy issue
12:05:27 4 within the VA or is it actually a legal challenge
12:05:30 5 because of the privacy act?
12:05:32 6 MS. JULES: I see that issue very separately
12:05:35 7 from discussing health care. I think that family
12:05:40 8 members should be involved just to be educated on
12:05:44 9 what's available and that is separate. That
12:05:47 10 doesn't include talking about the service member's
12:05:52 11 issues or violating HIPAA. And I will talk with a
12:05:58 12 family just about VA benefits or what's available
12:06:02 13 to them through the VA, without disclosing any
12:06:06 14 patient sensitive information; and I do that
12:06:09 15 routinely throughout my practice.
12:06:13 16 LT GEN GREEN: I'm getting the impression
12:06:15 17 there's some barrier. Mac, what is it you're --
12:06:18 18 MSGT MACKENZIE: The -- you know, we hear it
12:06:22 19 from Congress, we hear it around the country,
12:06:24 20 about people not being aware of services available
12:06:26 21 to them and as we've gone on our site visits and
12:06:29 22 we've gone to these different locations, we see
12:06:32 23 this barrier that's being imposed on communicating
12:06:36 24 with the families and it's all being wrapped under
12:06:42 25 privacy or HIPAA and the reality to it is that

12:06:45 1 that's not correct. Now, when you go to different
12:06:48 2 facilities and you see different people do
12:06:50 3 different things that they do, they do great
12:06:51 4 stuff. What I -- I mean, I don't ever have a
12:06:53 5 problem talking to my family members about what's
12:06:55 6 available to them; but then again I don't ask the
12:06:57 7 service member to talk to them because I'm not
12:07:00 8 talking about the service member. I'm talking
12:07:01 9 about this. But when you go to these different
12:07:03 10 areas, these individuals say we do not reach out
12:07:07 11 to the family members because we're not allowed to
12:07:09 12 unless the family -- the service member says you
12:07:14 13 can call my family member. So, it's -- when we're
12:07:19 14 in a location where people have a very great
12:07:22 15 success in talking to family members, it is very
12:07:24 16 difficult to bring this topic up; but what you --
12:07:26 17 what I was trying to gather from the panel, sir,
12:07:30 18 was their acknowledgment of the fact that, yes,
12:07:32 19 they should be talking to the family members. And
12:07:35 20 although they do a very good job here, it is not
12:07:39 21 the standard across the country and we need to
12:07:41 22 make sure that is -- I believe that is a
12:07:44 23 recommendation that we need to make sure gets out
12:07:47 24 there, that these folks are spoken to; and it's --
12:07:50 25 you know, there's case study after case study

12:07:53 1 after case study where it's the spouse who
12:07:54 2 actually saves the service member or the mom who
12:07:56 3 actually saves the service member that's spiraling
12:07:59 4 out of control and it's the same per -- this same
12:08:02 5 spouse is the one who's not being communicated
12:08:04 6 with by either DoD and -- in that aspect. So,
12:08:09 7 it's -- I look at the family unit -- the immediate
12:08:13 8 family unit as the entire team. This is the
12:08:16 9 entire team. You know, when you -- you dig even
12:08:20 10 further, when we as DoD bring a family member, a
12:08:23 11 spouse, a mom or dad to the bedside on official
12:08:26 12 military orders. You know, I've seen this at the
12:08:30 13 hospitals. They're in official military capacity
12:08:33 14 to be at the bedside of their loved one, yet
12:08:37 15 they're asked to leave the room when a
12:08:39 16 communication happens, you know, between the
12:08:41 17 service member and the medical team and you're
12:08:43 18 scratching your head going, we're relying on them
12:08:46 19 to be here when the nurse and the doctor and
12:08:47 20 everybody else is out being busy; but as soon as
12:08:50 21 we want to talk about something, the family has to
12:08:53 22 leave the room. It gets -- to me that just does
12:08:56 23 not make sense and so those who actually are
12:09:00 24 responsible for seeing to our veterans and that
12:09:01 25 our service members are taken care of, I ask that

12:09:04 1 question to see their -- how they view the input
12:09:08 2 of the family and what they would like to see
12:09:10 3 changed as well.
12:09:11 4 LT GEN GREEN: So, from my perspective there
12:09:13 5 should be, I agree. With these family members
12:09:15 6 there's really nothing in HIPAA or the privacy act
12:09:18 7 that would restrict briefing them on available
12:09:23 8 services. However, in a hospital room, it may be
12:09:25 9 that you want consent from the patient to share
12:09:27 10 with the broader family and that's what -- so,
12:09:29 11 there is a mixture of what goes on in terms of
12:09:31 12 conditions or what's going on with the individual
12:09:33 13 and the services; and so the tricky part there
12:09:37 14 would be simply to have the consent on file saying
12:09:40 15 that they want information shared, because I think
12:09:42 16 what you're talking about when you say hospital
12:09:45 17 room and they ask them to step out is really about
12:09:48 18 because you have an amputation or this is what
12:09:50 19 you're experiencing with your limb pain or
12:09:54 20 whatever the condition may be, these are
12:09:55 21 the services. And so it's -- the first preface on
12:09:58 22 that basically becomes a problem and it shouldn't
12:10:00 23 be a problem with simple consenting.
12:10:03 24 MSGT MACKENZIE: And that's very true.
12:10:05 25 That's a lot of why we're -- I think we're getting

12:10:08 1 into this as we go to -- even in the outpatient
12:10:11 2 care, you know, especially where you're dealing
12:10:13 3 with a TBI patient or in some of these cases where
12:10:18 4 the decisions to allow this person to leave the
12:10:21 5 hospital and go home is not because the person is
12:10:24 6 a hundred percent, but because there's a family
12:10:27 7 member there to assist them.
12:10:29 8 LT GEN GREEN: So, we have a training
12:10:31 9 problem in terms of making certain people
12:10:34 10 understand services are different than health
12:10:35 11 care. I got it.
12:10:36 12 MSGT MACKENZIE: Correct.
12:10:37 13 MS. DAILEY: Yes, sir, it is ubiquitous.
12:10:40 14 Every time we ask what the Army, Air Force, Navy,
12:10:44 15 Marine Corps are doing for family members, the
12:10:46 16 first thing they say to us is we ask the service
12:10:50 17 member if we can communicate with the family. It
12:10:53 18 is -- everyone says the same thing. We go through
12:10:57 19 the service member. But the distinction is
12:10:59 20 they're going through the service member even to
12:11:01 21 deliver the most basic of information the family
12:11:03 22 needs to take care of their own needs and it's a
12:11:07 23 big roadblock.
12:11:10 24 MSGT MACKENZIE: We -- when we first started
12:11:12 25 the task force, our very first site visited at

12:11:15 1 Fort Campbell, we saw it from day one, which was
12:11:17 2 the service member was allowed to live at home
12:11:20 3 with his spouse and children. The service member
12:11:23 4 had to be on post at 6:00 a.m. and the WTU relied
12:11:27 5 on the spouse to get that service member to post
12:11:30 6 for the 6:00 a.m. formation. Yet the WTU would
12:11:34 7 not communicate with that spouse as to what the
12:11:37 8 schedule was she had to meet. This individual has
12:11:40 9 a TBI, memory problems, cognitive issues. They
12:11:42 10 would hand him the information and then he would
12:11:45 11 get -- he would get counseled and in trouble for
12:11:51 12 not making formation; but they weren't telling the
12:11:54 13 one person who was the only one that could ensure
12:11:57 14 that this individual got to the post because we
12:12:01 15 gave it to the service member, but yet you're
12:12:04 16 relying on that spouse as a caregiver for him to
12:12:08 17 be at his medical appointments. You see where --
12:12:11 18 this is where that -- and we see different
12:12:14 19 variances across the services.
12:12:17 20 MS. RAY: Can I just interject and say
12:12:19 21 something here? In holding our focus group -- we
12:12:22 22 held a big focus group on caregivers and one of
12:12:25 23 the things that came up for the caregivers was
12:12:29 24 they did feel maybe not important or not -- what
12:12:34 25 would be the word here -- not recognized enough

12:12:37 1 and so maybe one of the suggestions here, since
12:12:41 2 we're here at this today, is maybe to develop a
12:12:44 3 national recognition day for caregivers and that
12:12:48 4 might also start something to start this whole
12:12:53 5 getting them so involved in the patient's care.
12:12:55 6 That might help too. So, just a recommendation.
12:13:01 7 MS. ALMS-CHAPA: And as a military spouse
12:13:02 8 who's gone through the medical retirement system
12:13:04 9 and now as a VA employee working with my service
12:13:06 10 members and veterans, one thing that I notice that
12:13:09 11 never happened for my transition is information.
12:13:13 12 Simple things as mailouts. All mailouts from the
12:13:16 13 military -- I'm a dependent and there is a very
12:13:20 14 clear definition amongst the military of status
12:13:23 15 and -- on the totem pole of active duty, retired
12:13:26 16 and then dependents. Something as simple as
12:13:30 17 mailouts to the spouses would be very beneficial,
12:13:33 18 even across the VA, DoD. Military service members
12:13:37 19 have TAPS and ATAPS, it's named different things;
12:13:39 20 but the transitional program out of the military,
12:13:42 21 all service members have a checklist that they
12:13:43 22 must go through. Something as simple as a
12:13:45 23 spouse's checklist would be assistive. I know one
12:13:48 24 of our biggest -- one of my biggest difficulties
12:13:51 25 in -- talking about -- you mentioned earlier about

12:13:53 1 identifying problems -- areas for us to improve
12:13:55 2 on. One of the biggest difficulties is I have
12:13:59 3 VBA, VHA, VRE, all these benefits, community
12:14:03 4 resources out there to keep track of. So, I think
12:14:05 5 something as simple as -- I seriously put post-it
12:14:08 6 notes identifying don't forget to tell them about
12:14:09 7 travel compensation, don't forget to ask them if
12:14:11 8 they need caregiver support. Doing mailouts to
12:14:13 9 the family members informing the family members
12:14:15 10 what's out there is additional. Even the DAV and
12:14:18 11 the VSOs out there -- I didn't even mention DAV;
12:14:21 12 but the VSOs, veteran service organizations, do
12:14:25 13 mailouts to the service members. Something
12:14:26 14 including opening up information given to the
12:14:28 15 spouses would be beneficial.
12:14:30 16 MSGT MACKENZIE: And one more -- one more
12:14:32 17 fact.
12:14:33 18 MS. DAILEY: We need to wrap here. It's
12:14:36 19 well over our polytrauma guy. Ma'am, why don't
12:14:40 20 you wrap this and we need to break for lunch.
12:14:44 21 MS. JULES: Okay. I'd like to just talk
12:14:48 22 then about the supports that we have in place for
12:14:55 23 the family. At the polytrauma center we -- we
12:15:00 24 consider the family to be an important part of the
12:15:04 25 treatment team because we recognize and understand

12:15:09 1 that, you know, this family member is going to be
12:15:11 2 the person who takes -- who goes home. That
12:15:17 3 quickly. Okay. Who will provide care in the home
12:15:25 4 for the patient. And so we try to help the family
12:15:31 5 member while they're there to help them through
12:15:37 6 their grief, adjusting to the new situation that
12:15:43 7 they find themselves in, coordinate the family
12:15:45 8 meetings with the teams. Also link them with
12:15:48 9 community resources that are available to help
12:15:52 10 them adjust; and, again, put them in touch with
12:15:56 11 our caregiver support coordinator there at the VA.
12:15:58 12 I -- I'm going to end there and ask if anyone has
12:16:03 13 any questions for me. My time is up.
12:16:10 14 LT COL KEANE: I don't have a question, but
12:16:11 15 I do need to make a comment. I'm Lieutenant
12:16:13 16 Colonel Keane. I'm the Marine Corps liaison to
12:16:14 17 the VA and I work with Ms. Anderson in response to
12:16:16 18 my position, I work with Pete Kennedy and Jennifer
12:16:20 19 Perez and I just want to say -- this needs to be
12:16:22 20 said in a public forum, documented, that the
12:16:25 21 OEF/OIF team are the super heroes of the VA. If
12:16:29 22 we could clone that hiring process for the rest of
12:16:31 23 the VA, we wouldn't have any VA problems. They go
12:16:34 24 above and beyond what they need to do all the
12:16:35 25 time. That's my daily interaction with the VA. I

12:16:38 1 don't talk to people locally. I talk to all the
12:16:40 2 businesses and ask them what -- how they can --
12:16:43 3 ask them how they can help our marines. So, if we
12:16:46 4 could clone what you all do -- you're the force
12:16:49 5 recon of the VA. Thanks very much.
12:16:51 6 MS. ALMS-CHAPA: Thank you.
12:16:52 7 MS. JULES: Thank you.
12:16:57 8 MS. RAY: Thank you.
12:16:57 9 DR. PHILLIPS: No other questions. Thank
12:16:58 10 you all very much. It was very helpful and please
12:17:01 11 keep in touch with us as things come up that you
12:17:06 12 haven't had a chance to discuss and we'll respond.
12:17:11 13 MS. JULES: Thank you.
12:17:11 14 DR. PHILLIPS: Take a break for lunch.
12:17:11 15 MS. DAILEY: We have a panel starting at
12:17:11 16 1:00 o'clock. Lunch for the members is in the
12:17:11 17 room immediately to your left and we will return
12:17:23 18 at 1:00 o'clock. Thank you.
12:17:23 19 (Recess taken between 12:17 and 1:05.)
12:17:23 20 MS. DAILEY: Ladies and gentlemen, if I can
12:17:23 21 get you to take your seats, we'll start our 1:00
01:05:27 22 o'clock panel.
01:05:27 23 LT GEN GREEN: Okay. Ladies and gentlemen,
01:05:29 24 thank you and welcome back. As we earlier had a
01:05:31 25 panel with the VA representatives on

01:05:33 1 pre-separation case management, we now have a
01:05:36 2 panel of veterans that are going to express their
01:05:38 3 views on post-separation policies and programs,
01:05:40 4 followed by another panel of service providers
01:05:42 5 expressing their views on post DD-214 challenges;
01:05:47 6 and so with us -- I think we have all three, but
01:05:50 7 I'll see if I can introduce folks. We have Andrew
01:05:53 8 Johnson, US Navy retired. Okay. Thank you. We
01:05:57 9 have Staff Sergeant Jon E. Arnold. Okay. US Army
01:06:01 10 retired. Thank you. And I believe there's a
01:06:06 11 Master Sergeant Joseph Briscoe, too. Is Sergeant
01:06:08 12 Briscoe in the audience?
01:06:10 13 MS. DAILEY: No, sir, we don't have him.
01:06:12 14 Sorry. If he gets here, we'll run him up there.
01:06:16 15 LT GEN GREEN: So, gentlemen, I'm going to
01:06:17 16 pass it over to you. I've got no rank for you,
01:06:19 17 Andrew, and so I'm sorry.
01:06:25 18 PO1 JOHNSON: Petty officer first class.
01:06:26 19 I'm still currently on active duty and in the med
01:06:29 20 board process. Trying to figure my way and how to
01:06:33 21 get through that.
01:06:33 22 LT GEN GREEN: Okay. I was just going to
01:06:34 23 apologize for not addressing you by rank. I'm
01:06:39 24 sorry, sir.
01:06:42 25 SSG ARNOLD: Good afternoon, everyone. I

01:06:44 1 went through the med board process in 2007, so
01:06:48 2 it's been awhile and I wasn't exactly sure what I
01:06:52 3 went through and how that's going to be relevant
01:06:54 4 to you guys' topic today. So, instead of
01:06:57 5 preparing a speech, I just figured I would be open
01:07:00 6 for questions so I can adequately address what's
01:07:04 7 on the panel's mind.
01:07:06 8 LT GEN GREEN: Okay. And so before we open
01:07:10 9 up just for questions in general, why don't we --
01:07:12 10 did you have anything you wanted to share with us?
01:07:17 11 PO1 JOHNSON: No, I figured the same, that
01:07:19 12 I'd -- got a couple of, you know, prep questions
01:07:22 13 that I, you know, kind of, you know, got
01:07:26 14 pre-answers to; but my understanding was that it
01:07:28 15 would be more towards, you know -- you know, like
01:07:31 16 what have you seen; what could you do -- you know,
01:07:34 17 what could be done differently; what could be put
01:07:36 18 in place, you know, for, you know, the guys that
01:07:38 19 might have fallen through; or, you know, that sort
01:07:40 20 of thing. So, I -- you know, I prepped myself;
01:07:44 21 but I haven't -- I don't have a speech, no, sir.
01:07:49 22 DR. TURNER: Well, why don't we start with
01:07:51 23 that question then for both of you. What in your
01:07:53 24 experience -- if you were king for a day, what
01:07:56 25 would be the first thing you would change about

01:07:58 1 your experience going through it?
01:08:02 2 SSG ARNOLD: I think I might have been king
01:08:03 3 for a day because my biggest concern when I was
01:08:06 4 going through the process was the -- the time it
01:08:10 5 took and the discrepancy between the med board
01:08:15 6 military side and getting that translated to the
01:08:17 7 VA side and I went through the Center for the
01:08:19 8 Intrepid here in San Antonio and I had access to
01:08:24 9 the full gambit of VA services right there in the
01:08:29 10 hospital and it was a smooth transition for me at
01:08:31 11 that time. Even smoother than most people and
01:08:33 12 still some gaps and hiccups; but in talking to
01:08:36 13 veterans who have come through now, I've heard
01:08:39 14 that that's been pretty streamlined. I'm not sure
01:08:42 15 if that's correct or not, but I've -- from what
01:08:43 16 I've heard, it's gotten a lot better.
01:08:45 17 MS. DAILEY: Yeah, he's talking about the
01:08:48 18 IDES. He's talking about the IDES. You went
01:08:50 19 through what we call the Legacy --
01:08:53 20 SSG ARNOLD: Yes.
01:08:54 21 MS. DAILEY: -- disability evaluation system
01:08:56 22 where you were released from active duty and then
01:08:58 23 you submitted your package for VA benefits.
01:09:02 24 SSG ARNOLD: Correct.
01:09:05 25 MS. DAILEY: Good. Good. And ladies and

01:09:05 1 gentlemen, if you run out of questions to ask our
01:09:07 2 panel, at the top of page 3 are questions that tie
01:09:11 3 back to our research questions; but please go
01:09:18 4 ahead.
01:09:18 5 PO1 JOHNSON: Just to pick up on what he was
01:09:20 6 saying. Yes, there was is a new -- the IDES
01:09:23 7 process is in place. I am very familiar with it
01:09:27 8 in terms of I know it exists and I know how the
01:09:30 9 guys are going through it right now. The only
01:09:33 10 hiccup there is I am the last person at BAMC to go
01:09:37 11 through the Legacy system. So, I am -- you know,
01:09:39 12 I am the cutoff, basically. There might be, you
01:09:44 13 know, two or three guys left after me; but
01:09:46 14 they're -- you know, I'm it. The differences that
01:09:49 15 I've seen is I have some lag time between right
01:09:53 16 now and between when my board comes back and when
01:09:56 17 I get off active duty; and, unfortunately, right
01:09:59 18 now with not having a definite end date, I can't
01:10:02 19 go to the VA and say I need to start my -- my
01:10:05 20 appointments, my process, my, you know, way to get
01:10:08 21 out, because I don't have a separation date. I
01:10:12 22 don't know how the IDES or the DTS -- IDES system
01:10:17 23 completely ties that in; but I have at least two
01:10:20 24 or three months right now while I'm waiting for
01:10:22 25 the board to come back from DC where -- I mean,

01:10:25 1 I'm still going to the hospital, I'll still going
01:10:28 2 to -- getting my appointments, you know, but I
01:10:29 3 could drive over to the VA on one of the slow days
01:10:32 4 or off days and I could still get that stuff done.
01:10:36 5 So, with these guys being able to do the process
01:10:38 6 at the same time I would think would severely cut
01:10:43 7 down the wait time after they get off -- or
01:10:45 8 separate from active duty, because that's when
01:10:47 9 I'm -- I've got months right now where I can wait
01:10:50 10 and do things, but the -- the hiccup is you don't
01:10:55 11 have a separation date, so we can't start anything
01:10:57 12 right now, you know, and that's where -- that's
01:11:00 13 where I'm at. I've been actually barking at the
01:11:04 14 tree trying to get in; but it's -- that's just the
01:11:07 15 way it is because of the rules that I'm under
01:11:10 16 right now.
01:11:10 17 LT GEN GREEN: So, Staff Sergeant Arnold,
01:11:12 18 how long was it from the time you separated from
01:11:14 19 the military to the time you received VA benefits?
01:11:18 20 SSG ARNOLD: My -- I separated December
01:11:22 21 12th. I was in the system December 13th because I
01:11:25 22 had already started the process and it was at BAMC
01:11:27 23 waiting to transfer; but once it -- once I was
01:11:30 24 technically in the VA system, I started all of my
01:11:33 25 appointments, which became a pretty long,

01:11:38 1 drawn-out process as far as the compensation side
01:11:40 2 and then getting into the VA health care system,
01:11:44 3 getting a primary care doctor and getting the
01:11:47 4 specialty appointments that I needed.
01:11:52 5 MSGT MACKENZIE: What was the timeline?
01:11:54 6 What was the --
01:11:54 7 SSGT ARNOLD: From the -- from my actual
01:11:58 8 military separation date until my very first
01:12:03 9 specialty appointment was -- like I said, I got
01:12:05 10 out December 12th. My first specialty appointment
01:12:08 11 was middle of February. So, we're looking at
01:12:10 12 two -- two and a half months.
01:12:13 13 MR. REHBEIN: How far apart had those
01:12:16 14 specialty appointments been when you were being
01:12:19 15 seen in the military? Was that twice as long as
01:12:21 16 normal?
01:12:22 17 SSGT ARNOLD: It was -- at BAMC the
01:12:23 18 specialty appointments were relatively quick.
01:12:26 19 Especially during the med board process. It
01:12:29 20 was -- once I saw my primary care physician and
01:12:31 21 they evaluated what I needed, an ENT appointment
01:12:35 22 was maybe a week after it was identified that I
01:12:38 23 needed one. MRI scheduling was maybe a week and a
01:12:40 24 half. I didn't -- I think the longest wait time I
01:12:44 25 had in the military was three weeks for a

01:12:48 1 specialty appointment.
01:12:49 2 LT GEN GREEN: And so were you able to fill
01:12:51 3 that gap of two and a half months? You still had
01:12:54 4 Tricare benefits. Were you able to still get care
01:12:56 5 at the military institution then?
01:12:58 6 SSGT ARNOLD: Yes, I was still able to go to
01:13:01 7 BAMC for whatever care I needed; but in order to
01:13:03 8 get it populated, I guess is the best word for it,
01:13:06 9 in the VA system and for them to get everything
01:13:09 10 documented and everything, it required me to go to
01:13:13 11 Audie Murphy here in San Antonio.
01:13:15 12 LT GEN GREEN: And when you say February,
01:13:16 13 you're talking about February of last year or of
01:13:18 14 this year.
01:13:20 15 SSGT ARNOLD: No, no. This is February -- I
01:13:21 16 got out in 2007. So, this would have been
01:13:25 17 February 2008.
01:13:26 18 LT GEN GREEN: So, how long after that
01:13:28 19 before you received the VA benefits?
01:13:32 20 SSGT ARNOLD: Which --
01:13:35 21 LT GEN GREEN: Not health care. Are there
01:13:37 22 any other VA benefits that you're receiving?
01:13:40 23 SSGT ARNOLD: I received vocational
01:13:41 24 rehabilitation which started immediately because I
01:13:44 25 was working with my counselor when I was still in

01:13:47 1 the service. The compensation packet had been
01:13:49 2 filed; but, like I said, I had to go through the
01:13:51 3 medical process.
01:13:57 4 MSGT MACKENZIE: So, when did you receive
01:13:58 5 your first compensation -- part of the
01:13:59 6 compensation package?
01:14:02 7 SSGT ARNOLD: It was -- I would say
01:14:04 8 February, sir. Air Force rank. I'm not exactly
01:14:07 9 sure what that is.
01:14:11 10 DR. PHILLIPS: Did you --
01:14:14 11 MR. DRACH: Did you go through a DTAP,
01:14:15 12 disability transition assistance program?
01:14:18 13 SSGT ARNOLD: I believe so, yes.
01:14:19 14 MR. DRACH: Did you find it helpful?
01:14:19 15 SSGT ARNOLD: The -- oh, I know what you're
01:14:20 16 --
01:14:20 17 MR. DRACH: The four hour --
01:14:27 18 SSGT ARNOLD: The classes. We call it -- we
01:14:28 19 have another acronym for it. Yes, it was actually
01:14:31 20 very --
01:14:33 21 CSM DEJONG: ATAP.
01:14:34 22 SSGT ARNOLD: ATAP. Thank you. It was very
01:14:36 23 beneficial, very helpful. Especially in -- one of
01:14:39 24 the biggest challenges I found in the transition
01:14:42 25 was sitting in front of an employer and trying to

01:14:44 1 explain to them what all the stuff -- what I did
01:14:46 2 in the service, what that translated to and the
01:14:49 3 ATAP or DTAP class actually -- they walk you
01:14:52 4 through step by step. This is kind of how the
01:14:55 5 civilian corporate employer is going to look at
01:14:58 6 that. So, that gave me a heads up and I actually
01:15:00 7 got to start teaching some of my former soldiers
01:15:04 8 how to translate their military service into
01:15:06 9 something that a corporate employer could look at
01:15:08 10 and understand.
01:15:13 11 DR. PHILLIPS: It sounds like both your
01:15:14 12 experiences were pretty smooth. I mean, there
01:15:17 13 weren't really any stumbling blocks. Can you
01:15:21 14 comment on any of your fellow soldiers that went
01:15:25 15 through the same process that may have had
01:15:27 16 difficulties or are you aware of any?
01:15:32 17 PO1 JOHNSON: No, the only thing that I am
01:15:36 18 aware of is that it seemed to take different
01:15:38 19 people different times and what that is and how
01:15:40 20 that completely translates out to -- you know, I
01:15:46 21 don't know. A lot of it is self-motivation. You
01:15:49 22 can't complain if you can't get out of bed, you
01:15:52 23 know, and that sort of thing; but as far as I've
01:15:55 24 seen, as far as what services are available -- he
01:15:59 25 went through a couple of years ago. The buildings

01:16:01 1 that are there now, the -- the outlets that are
01:16:04 2 there. I mean, you've got a whole trailer full of
01:16:08 3 social services that you can go take advantage of.
01:16:11 4 Social Security, VA. You know, all that kind of
01:16:13 5 stuff that they can get some of the preparatory
01:16:15 6 stuff done or get you qualified for benefits
01:16:17 7 before you get out. Social Security was one of
01:16:20 8 them and I went through the education prep course
01:16:26 9 there at the family service center and also the
01:16:31 10 wounded warrior center now has all kinds of
01:16:34 11 classes. You know, Microsoft Word classes.
01:16:37 12 Anything that you want to -- if you think you
01:16:39 13 might need, available to you there that, you know,
01:16:43 14 the guys just separating don't -- don't have
01:16:47 15 available to them, you know; and that's --
01:16:49 16 that's -- it's one of the step ups, for sure, that
01:16:52 17 you get, you know, as you go through that medical
01:16:55 18 process and, you know, things like that. That
01:16:59 19 there are a whole bunch of people out there, you
01:17:00 20 know, looking to try to help you out and bring you
01:17:03 21 up and help you recover over, you know, whatever
01:17:07 22 might be, you know, out in front of you.
01:17:12 23 SSGT ARNOLD: When I went through the
01:17:14 24 transition I was lucky. That's kind of crazy to
01:17:17 25 say. I'm lucky that I'm an amputee at BAMC

01:17:21 1 because the amputee patients and the burn patients
01:17:22 2 were the first ones run through the services that
01:17:24 3 he was talking about. So, Social Security just
01:17:27 4 came online being co-located with us at BAMC when
01:17:31 5 I was there. The VA health benefits and
01:17:35 6 compensation just started getting co-located at
01:17:39 7 BAMC when I was there. So, a lot of it my peer
01:17:42 8 group so to speak, as far as amputees going
01:17:45 9 through the separation process, we all had access
01:17:47 10 to all the different facets of separating. So, we
01:17:52 11 had the VA, we had Social Security, we had access
01:17:54 12 to the ATAPs and it was a pretty smooth process
01:17:59 13 all around. There were one or two just minor
01:18:02 14 hiccups here and there. Just large systems
01:18:04 15 there's going to be a couple, but nothing major.
01:18:06 16 Nothing that really stands out, no, sir.
01:18:09 17 LT GEN GREEN: Can I ask both to answer.
01:18:11 18 How long were you actually in the transition unit?
01:18:16 19 SSGT ARNOLD: I went through -- and it had
01:18:18 20 many different names while I was there. It
01:18:20 21 started as the warrior transition something and
01:18:23 22 then it became -- it had at least three different
01:18:28 23 names while I was there; but I was there from May
01:18:32 24 of 2006 until December of 2007, sir.
01:18:39 25 PO1 JOHNSON: I've been at BAMC since July

01:18:42 1 '09 and I don't have a retirement date yet. So,
01:18:45 2 almost two years.
01:18:47 3 MSGT MACKENZIE: Let me ask you. The term
01:18:50 4 "access" is at times defined differently. At
01:18:57 5 times it's given credit differently. You guys
01:19:00 6 have both stated the fact that you have access to
01:19:02 7 all these resources. Is it the access to the
01:19:06 8 resources or is it the fact that these
01:19:09 9 professionals are within a couple of hundred feet
01:19:13 10 of where you spend your day and they are walking
01:19:15 11 the halls, interfacing with you on a daily basis?
01:19:21 12 SSGT ARNOLD: I think you just hit on --
01:19:22 13 that's a crucial part; and at the center that I
01:19:25 14 was at, they were co-located within the same
01:19:29 15 building. So, to me that's access. I go in and I
01:19:32 16 do my physical therapy and I have a question, I
01:19:35 17 can pop in somebody's office and say, "Hey, do you
01:19:37 18 have a minute? Help me go through -- what is
01:19:39 19 this, what does this mean?" That's -- to me, it's
01:19:42 20 direct access. It's facilitating the
01:19:44 21 relationship. I don't have to call and make an
01:19:47 22 appointment and say it was -- and I think that
01:19:49 23 helped smooth out my process.
01:19:52 24 PO1 JOHNSON: Yeah, I would say even if you
01:19:55 25 have to call and make an appointment, they're

01:19:56 1 literally across the parking lot. You know, you
01:19:58 2 don't have to drive across town or plan, you know,
01:20:01 3 all this into your day. If you have two hours in
01:20:04 4 between PT and OT, that you -- hey, I can shoot
01:20:07 5 over there, I can ask them a question, I can
01:20:09 6 apply, I can turn in my packet, I can do these
01:20:12 7 sorts of things and we're talking, you know, on --
01:20:14 8 you know, on the same post, you know. They're not
01:20:17 9 in the same building anymore, but they're just
01:20:19 10 right down the road. They're not far at all and
01:20:21 11 they're all right there. So, if you walk into one
01:20:25 12 person's office and maybe it's not really their
01:20:27 13 area of expertise, they'll say, you know, go see,
01:20:29 14 you know, Johnny on the other side; and the next
01:20:31 15 people down that's what he does or that sort of
01:20:34 16 thing. So, it really -- it shortens the process
01:20:38 17 in terms of -- you know, if I walk -- if I spent
01:20:40 18 all day going gown to the Social Security office
01:20:42 19 and I went to the wrong office -- she goes, "No,
01:20:43 20 you need to go across town to, you know, the VA
01:20:46 21 benefits. That's where you need to go," that --
01:20:48 22 that's how it -- it's all right there. I mean,
01:20:50 23 it's really a streamlined process and you get --
01:20:53 24 you can take advantage of more programs and get
01:20:56 25 more benefits and be aware of more things that are

01:20:59 1 out there because that's one of the biggest things
01:21:01 2 why -- they say, you know, is you just don't know.
01:21:05 3 You know, if you don't know about it, you don't
01:21:07 4 know to take advantage of the program or the
01:21:09 5 service and that's the biggest thing. That -- you
01:21:12 6 know, getting that information to the service
01:21:14 7 member, you know, in the hospital or to the family
01:21:17 8 member of the service member and then that can --
01:21:19 9 that can start -- that starts the process, you
01:21:22 10 know, and that's -- that would be the biggest
01:21:25 11 thing by having all those people there is
01:21:28 12 everyone's aware. They might not know a hundred
01:21:30 13 percent what they do; but, you know, hey, go talk
01:21:32 14 to someone over there in the family service center
01:21:35 15 or in the soldier family assistance center, you
01:21:37 16 know; and then, you know, you just poke your head
01:21:39 17 in there and things start to roll and you start
01:21:41 18 getting stuff, being able to take advantage of
01:21:43 19 those things.
01:21:46 20 SSGT ARNOLD: One more thing I would say to
01:21:48 21 that. Having everything right there in one
01:21:49 22 facility, depending on -- regardless of how many
01:21:52 23 buildings it is -- with them all right there, when
01:21:55 24 we're coming through the process, we have a
01:21:56 25 million things on our mind. Family issues,

01:21:59 1 education, what am I going to do when I'm out.
01:22:02 2 We're usually on medication. So, there's a
01:22:04 3 million things going on and you walk by and you
01:22:06 4 see VA disability and it triggers something. Hey,
01:22:11 5 I do need to go in there and talk to them. Or
01:22:14 6 having your family there, your family can say,
01:22:16 7 "Hey, have you thought about going and talking to
01:22:18 8 so and so in this office." So, I think just
01:22:21 9 constantly being surrounded by it, it also
01:22:23 10 increases your access to it and it makes people
01:22:26 11 seek out things. That, like you were saying, just
01:22:29 12 going across town or if you drive by the building
01:22:31 13 it doesn't -- it's not at the forefront of your
01:22:33 14 mind.
01:22:34 15 LT GEN GREEN: So, each of you had roughly
01:22:36 16 two years and I know that yours is still an
01:22:38 17 ongoing thing?
01:22:40 18 PO1 JOHNSON: Yes, sir.
01:22:41 19 LT GEN GREEN: But when did you personally
01:22:43 20 feel that you had started the process for leaving
01:22:45 21 the service? So, was there an event during the
01:22:48 22 hospitalization? Is there someone -- we heard
01:22:52 23 from the VA this morning that it's when people
01:22:55 24 accept what comes back from the VA in terms of
01:22:59 25 disability. When do you really feel that you made

01:23:01 1 the transition that you were going to be getting
01:23:03 2 out of the service?
01:23:07 3 PO1 JOHNSON: You want to take this one
01:23:09 4 first?
01:23:10 5 SSGT ARNOLD: I'm trying to figure out
01:23:12 6 exactly when it was. I think -- and for a lot of
01:23:16 7 us the first -- we get back and the first thing
01:23:18 8 you have to deal with is whatever your injury is.
01:23:20 9 So, mine was figuring out. Okay, what was the
01:23:23 10 level of my injury and then when I decided to go
01:23:27 11 ahead with the amputation, it was getting up and
01:23:30 12 walking, what is it going to be and then I think
01:23:32 13 once I got to the functional stage of my recovery
01:23:36 14 where I could put on a limb and function at about
01:23:41 15 60 percent, it was time to think of, okay, what is
01:23:43 16 my life going to be after -- after the limb; and I
01:23:47 17 think somewhere in there is where the actual
01:23:49 18 decision was made, okay, I'm going to -- do I want
01:23:52 19 to stay in, do I want to separate. I'm going to
01:23:55 20 separate and then the acceptance and the pursuing
01:23:59 21 that avenue came in, sir.
01:24:02 22 LT GEN GREEN: So, is that in the first
01:24:03 23 year, in the second year?
01:24:05 24 SSGT ARNOLD: That was in the first year.
01:24:07 25 Probably about eight -- eight months into it; but

01:24:10 1 with everybody it's going to be dependent on the
01:24:13 2 severity of their injury and when they're through
01:24:15 3 the initial healing phase.
01:24:17 4 LT GEN GREEN: And so that means that you
01:24:18 5 then spent another 14 months waiting for what you
01:24:22 6 thought was going to probably be your future?
01:24:27 7 SSGT ARNOLD: Yes and no. I had some
01:24:29 8 more -- once that decision was made, I had to have
01:24:32 9 a revision level to my surgery, I had to have some
01:24:35 10 knee surgery and some other things that were
01:24:38 11 uncovered during the physical therapy process; but
01:24:41 12 once -- once the actual initial paperwork and
01:24:46 13 everything was filed, it would have been in --
01:24:50 14 December, March -- probably May, June and I didn't
01:24:55 15 actually fully transition out until December.
01:24:59 16 Although two months of that was -- was ETS leave.
01:25:05 17 So, we're looking at maybe June through
01:25:10 18 Octoberish.
01:25:15 19 MSGT MACKENZIE: One of the things that
01:25:16 20 we've been asking or that's been proposed to us
01:25:18 21 and it's the -- maybe a cultural attitude.
01:25:21 22 However, that may be -- a significant number of
01:25:24 23 things have changed since you went through the
01:25:26 24 process. This all has changed. I myself was a
01:25:29 25 liaison for SOCOM for three and a half years up in

01:25:32 1 DC, so I know what you're talking about with those
01:25:34 2 changes and how things cycle. The question that
01:25:39 3 gets posed to us or the recommendation that gets
01:25:41 4 posed to us at times is, you know, when that
01:25:43 5 decision is made that my end state is medical
01:25:47 6 retirement or separation -- not the med board, not
01:25:50 7 that point; but it's like, hey, I've accepted
01:25:53 8 where I'm at, I've accepted now the challenge of
01:25:55 9 where I need to go, I know I'm going transition.
01:25:58 10 Did you see it to be or did you experience this
01:26:01 11 challenge of I'm not going back to the Army, why
01:26:06 12 can't I focus on just the transition part?
01:26:09 13 SSGT ARNOLD: Yes.
01:26:11 14 MSGT MACKENZIE: And how did that impact
01:26:12 15 you?
01:26:13 16 SSGT ARNOLD: What am I -- once I made that
01:26:16 17 decision, I was solid in it, I'm not going back to
01:26:20 18 the Army, my focus was career advancement. I
01:26:23 19 wanted to go back to school. And the command here
01:26:26 20 did a really good job working with me. They
01:26:29 21 allowed me to go to school in between my
01:26:33 22 appointments and everything. So, I spent almost
01:26:36 23 an entire semester that June through December
01:26:39 24 period. I was able to -- I think I took 12 -- 12
01:26:45 25 hours that semester while I was still on active

01:26:48 1 duty. I had my appointments in the morning and
01:26:50 2 then I did school in the afternoon. So, yes, it
01:26:53 3 was a challenge and I was able. If I'm going to
01:26:56 4 get out anyway and the command knows that I'm
01:26:58 5 going to get out, why can't I do this; but my
01:27:01 6 command was very good at working with me to allow
01:27:03 7 me to do that. I don't know if that's something
01:27:05 8 that's offered to a lot of people in the
01:27:07 9 transition process. I wish it -- if it's not, I
01:27:10 10 wish it would be offered more.
01:27:12 11 PO1 JOHNSON: It's -- I've seen it be very
01:27:14 12 hit or miss. It depends on what battalion you're
01:27:17 13 in. Especially with the guys in the Army. The
01:27:19 14 Marines and Navy that are out there, they're such
01:27:23 15 a small group that it's not, you know, that -- the
01:27:28 16 leash that's put on us is a little more liberal;
01:27:32 17 but the Army guys, they have, you know, definite
01:27:34 18 times and things they have to do every day. So,
01:27:36 19 they have to plan around that, you know, in terms
01:27:38 20 of morning formations and mandatory PT and things
01:27:41 21 like that; and, you know, when you're talking to
01:27:43 22 somebody who's going to stay in, that's something
01:27:45 23 that they need. That's something that they want.
01:27:47 24 They want to get up in the morning and go to the
01:27:50 25 command PTs and do that sort of thing; but the

01:27:52 1 guys that are getting out, they have a different
01:27:54 2 focus and to make these guys get up and then go PT
01:27:57 3 when they could be doing something else is -- in
01:28:01 4 my view, is not as fair to them; but at the same
01:28:04 5 time, I do understand that, you know, you have to
01:28:07 6 treat everybody the same with uniform, you know,
01:28:10 7 justice. So, it kind of plays out, you know, in
01:28:14 8 that sort of thing where -- to me, I've been very
01:28:17 9 blessed with who the -- my commanders are and my
01:28:23 10 people -- the people who want to work with me and
01:28:26 11 we've had the same, you know, vision. Since I got
01:28:28 12 to BAMC it was -- it was like a month when I
01:28:32 13 realized that I'm not going to be the same person
01:28:34 14 I was before the surgery and therefore I need to
01:28:38 15 start focusing on other things. I mean, I've been
01:28:40 16 a mechanic for 13 years and I don't know if I want
01:28:43 17 to work on airplanes anymore. Only because I
01:28:47 18 can't remember everything all the time. You know,
01:28:48 19 my injury was my brain and I'm still pretty, you
01:28:52 20 know, up there and good; but if I don't put the
01:28:54 21 screw on right and the plane crashes and, you
01:28:57 22 know, I caused crew members, you know, their
01:29:00 23 lives, that's something that kind of weighs real
01:29:05 24 heavy on me and that's one of the things that I --
01:29:06 25 I can't say, hey, I'm going to jump right back

01:29:09 1 into airplane mechanics. You know, I just don't
01:29:11 2 know. I don't know if I feel -- if I have the
01:29:13 3 comfort level, you know, because I forget weird
01:29:16 4 things now and I just don't want to forget that
01:29:19 5 wrench inside that wing and, you know, have
01:29:21 6 somebody -- someone's life, you know, because of
01:29:23 7 my forgetfulness or because of my injuries right
01:29:26 8 now or my challenges you should say. You know, so
01:29:30 9 that's why I was like all I'm going to do -- all I
01:29:34 10 know how to do is be a mechanic, so what am I
01:29:37 11 going to do next. You know, what other -- what
01:29:39 12 other traits do I have that are marketable that I
01:29:41 13 can get a position to where I can support myself;
01:29:44 14 and they were also considered with the fact that I
01:29:47 15 might need, you know, extended medical care at
01:29:49 16 some point in time. You know, that's where --
01:29:51 17 that's been my biggest challenge and my biggest
01:29:54 18 fear is just walking forward and getting out and
01:29:56 19 then taking a job, you know, with, you know, any
01:30:00 20 company and then all of a sudden having problems,
01:30:03 21 you know, because of my injury or realizing that
01:30:05 22 there's certain things that I can't do anymore
01:30:07 23 and, you know, how do I work through that at that
01:30:10 24 point in time. You know, will they work with me
01:30:13 25 at that point. You know, that's what I don't know

01:30:15 1 and I don't understand and that's where I'm very
01:30:17 2 nervous at the certain point that I'm at right
01:30:20 3 now.
01:30:21 4 LT GEN GREEN: So, Petty Officer Johnson,
01:30:23 5 how do you fill your days? Have you actually had
01:30:26 6 the VA disability exam now?
01:30:31 7 PO1 JOHNSON: No, sir. I'm trying to get
01:30:32 8 that worked out. I'm working with the VA
01:30:35 9 coordinators at the CFI right now and I've run
01:30:39 10 into -- I don't have a definite retirement date.
01:30:41 11 When I get that, they say we can start the
01:30:43 12 paperwork. We can start stuff. But the VA right
01:30:46 13 now, because I'm in the Legacy system, won't -- I
01:30:51 14 can't kick over into the other system because I've
01:30:53 15 already started down this path, I guess. So, I
01:30:55 16 can't go down there and say, "Hey, you know, get
01:30:58 17 my stuff going." So, what I do, I have a couple
01:31:01 18 of nonprofit organizations that I volunteer for
01:31:05 19 and I go out and try to do -- try to do those.
01:31:09 20 One of my biggest things that I've gotten over --
01:31:14 21 not fully, but I've still got -- is public
01:31:16 22 speaking. When I go out to those events with them
01:31:19 23 and they ask me if I would like to say something.
01:31:21 24 I've never been the guy to get in front of the
01:31:23 25 crowd; but, you know, I'm getting better and

01:31:26 1 things like that. So, I'm finding that doing
01:31:29 2 those things with those organizations is helping
01:31:31 3 me develop a new skill that I was not very -- not
01:31:33 4 developed in to begin with and, you know, I'm
01:31:37 5 getting introduced to people who want to help who,
01:31:40 6 you know, accept me for who I am and understand
01:31:42 7 that I'm going to have challenges. So, therefore,
01:31:44 8 when I get out I can maybe call on them as
01:31:47 9 resources to, you know, help me, you know, get
01:31:49 10 where I need to go throughout the rest of my life.
01:31:52 11 MS. DAILEY: And ladies and gentlemen, we
01:31:54 12 need to wrap this up. I only had 30 minutes for
01:31:57 13 our distinguished gentlemen here. So, if there's
01:32:00 14 anything else we could say to close.
01:32:05 15 LT GEN GREEN: I guess the one question I
01:32:08 16 would have. So, it sounds like you filled your
01:32:11 17 time, were able to take a full semester, when I
01:32:15 18 talked with our Army colleague, and that you're
01:32:18 19 filling up your time with things that you enjoy.
01:32:20 20 So, it's not really a sense of limbo. You
01:32:23 21 actually feel like you're being productive and
01:32:25 22 that there's still motion in terms of your
01:32:27 23 recovery?
01:32:29 24 PO1 JOHNSON: Yes. And I would say that as
01:32:30 25 a cross section we probably represent, I would

01:32:32 1 say, the upper 50 percent. There are -- and I do
01:32:35 2 see the guys that fall into the black hole of
01:32:40 3 depression and don't do anything beside, you know,
01:32:43 4 what is required of them and helping those guys is
01:32:49 5 one of the things that would really benefit.
01:32:52 6 Figuring out -- you know, I know that social
01:32:56 7 services like -- you know, have mandatory
01:32:58 8 appointments, you know, once every month and
01:33:01 9 things like that to try to locate guys that are,
01:33:03 10 you know, getting depressed and, you know, not
01:33:06 11 doing everything that's totally beneficial for
01:33:08 12 them; but once again it's that whole you can lead
01:33:11 13 a horse to water thing; but, you know, you can't
01:33:13 14 force them to drink. So, that's where I see that
01:33:18 15 I have, you know, concern, you know, I guess; and
01:33:22 16 I have feelings for these guys that -- you know, I
01:33:25 17 understand that they're going through stuff and,
01:33:28 18 you know, I was lucky enough not to be in their
01:33:31 19 shoes; but, you know, I can't really relate to
01:33:35 20 some of the combat injuries that -- that come back
01:33:39 21 and how they feel and, you know, those sorts of
01:33:44 22 things. So, that's where, you know, I see that --
01:33:47 23 there are guys out there that are going right back
01:33:50 24 in. There are other guys out there that are
01:33:52 25 getting -- you know, doing what they need to to

01:33:55 1 get out and there are -- there is a sizeable
01:33:56 2 amount of guys that kind of just go through the
01:33:59 3 process and, you know, don't push and don't do
01:34:01 4 anything more than what, you know, they see
01:34:05 5 necessary.
01:34:06 6 SSGT ARNOLD: For the limbo question, sir.
01:34:07 7 I was an anomaly when I was transitioning out of
01:34:10 8 the Army because, one, it was crucial for me that
01:34:12 9 I went to school; but, two, I came to them and I
01:34:14 10 brought them a plan. I said, "This is the classes
01:34:16 11 I'm going to take; this is where -- when it is.
01:34:18 12 It's not going to interfere with this. I can make
01:34:21 13 formation, do whatever"; and because I was
01:34:23 14 proactive about it I think I kind of circumvented
01:34:26 15 the normal, traditional system. I saw the
01:34:28 16 majority of my peers. They had -- they would go
01:34:31 17 to formation, they would do their physical
01:34:33 18 training or rehabilitation and then they were
01:34:37 19 stuck in minimal tasks. Working for the hospital
01:34:43 20 doing -- it was -- they had a term for it. It was
01:34:48 21 basically a menial job to occupy them during the
01:34:52 22 day when they were not going -- actively going to
01:34:55 23 appointments. I do not know if that is still
01:34:58 24 going on or if that has been fixed, but I know a
01:35:01 25 lot of guys that spent time in limbo in that where

01:35:04 1 I was lucky enough to go to school.
01:35:06 2 MS. DAILEY: Gentleman, thank you very much.
01:35:09 3 SSGT ARNOLD: Thank you, ma'am.
01:35:10 4 MS. DAILEY: We have another panel that I'd
01:35:12 5 like to bring up to the table, please. I'm going
01:35:14 6 to call off everyone's name. Staff Sergeant
01:35:17 7 Gallardo, Master Sergeant Schiller, please.
01:35:20 8 Lieutenant Commander Cole, Mr. David Pennington,
01:35:25 9 Mr. James Burbach, Ms. Jane Baskerville, Dr. Mary
01:35:34 10 Ramos and Mr. Ignacio Garcia. So, ladies and
01:35:39 11 gentlemen, we have a very large panel here. I
01:35:41 12 have eight people and we have -- we have a very
01:35:45 13 large panel here and we will be -- we have an hour
01:35:49 14 and 15 minutes to talk with them. So, we're going
01:35:49 15 to get everyone seated and get their microphones
01:35:49 16 over to them so that they can start some of their
01:36:35 17 briefings.
01:36:35 18 DR. PHILLIPS: Welcome and thank you all.
01:36:37 19 To continue our discussion on post-separation
01:36:40 20 policies and programs we have you all here and
01:36:45 21 thank you for coming. We will be discussing
01:36:48 22 primarily the post-separation challenges facing
01:36:52 23 the recovering warriors and their families. Ms.
01:36:58 24 Dailey was nice enough to introduce you all. So,
01:37:01 25 I really don't have to go through that again.

01:37:06 1 There are a list of questions. I don't know if
01:37:08 2 you got those questions. So, why don't we just
01:37:14 3 begin, if we could and -- okay. One more. Great.
01:37:31 4 So, basically, if I can go through just the first
01:37:38 5 question to jump start this. What is your current
01:37:41 6 recovering warrior case load and how many have
01:37:45 7 separated from the military?
01:37:55 8 LCDR COLE: Are we going in order or do you
01:37:57 9 just want us to --
01:37:57 10 MS. DAILEY: Yeah, let's -- we do have an
01:37:58 11 order here. I do have the US Marine Corps DISCs
01:38:00 12 that -- our first staff would actually have some
01:38:02 13 briefing slides where they are answering these
01:38:04 14 questions, I believe; but they lend themselves to
01:38:07 15 discussion and this is kind of our first
01:38:12 16 opportunity with DISCs, ladies and gentlemen. I
01:38:15 17 haven't had any DISCs brief. We've got debriefing
01:38:19 18 from the wounded warrior regiment, but this is the
01:38:22 19 first time we've had the opportunity to see real
01:38:25 20 live DISCs. So, take advantage of the opportunity
01:38:28 21 to ask them about their population of separated
01:38:30 22 marines and their duties in supporting them.
01:38:30 23 MSGT SCHILLER: I'll begin. My name is
01:38:42 24 Master Sergeant Brian Schiller. This is Staff
01:38:43 25 Sergeant Mateo Gallardo. We represent the two

01:38:44 1 DISCs in the state of Texas as USMC district
01:38:47 2 injured support coordinators. The staff
01:38:50 3 sergeant's been on site here in San Antonio and
01:38:54 4 southern Texas since October 1st. Myself, I came
01:38:58 5 on December 1st. However, I spent the last four
01:39:01 6 years as the senior enlisted advisor for our
01:39:05 7 wounded marines at Brooke Army Medical Center.
01:39:09 8 Slide, please.
01:39:14 9 We'll explain the DISCs mission as well as
01:39:15 10 our command structure and provide some locations
01:39:18 11 and points of contact for you and explain what it
01:39:21 12 is that we generally do on a daily basis. Slide,
01:39:24 13 please.
01:39:26 14 Wounded warrior regiment mission, which we
01:39:29 15 fall under, which also includes the two battalions
01:39:31 16 on the east coast and west coast that take care of
01:39:35 17 the active duty marines which include reservists
01:39:38 18 that have been mobilized as well as active duty
01:39:40 19 marines of the wounded, ill and injured and it's
01:39:43 20 to provide and facilitate assistance to wounded,
01:39:46 21 ill and injured marines or sailors attached to or
01:39:49 22 in support of marine units, along with their
01:39:52 23 families, in order to assist them as they return
01:39:54 24 to duty or transition to civilian life. Slide,
01:39:54 25 please.

01:39:58 1 The phases of recovery are obviously the
01:40:01 2 recovery, as we heard the petty officer speaking
01:40:04 3 to earlier, and then working on the
01:40:07 4 rehabilitation. That's what the great majority of
01:40:13 5 the wounded warrior regiment concentrates on. The
01:40:15 6 reintegration part is twofold. From the active
01:40:19 7 duty and those mobilized reservists and what I
01:40:23 8 like to term our tertiary stage of recovery and
01:40:27 9 reintegration and the assistance that the DISCs
01:40:31 10 provide specifically. As we move to the
01:40:35 11 reintegration, we will work with the RCCs or the
01:40:39 12 FRCs at the military treatment facilities so there
01:40:42 13 is what we like to call a warm handoff from that
01:40:46 14 marine or sailor serving on active duty and as the
01:40:50 15 colonel refers to, left of the DD-214 to the right
01:40:55 16 of the DD-214 where the DISCs will then come in.
01:41:01 17 Slide, please. I'm sorry. Hit it again.
01:41:05 18 The roles and responsibilities of the DISCs
01:41:09 19 are -- we are the commanding officer's
01:41:12 20 representatives. Commanding officer of wounded
01:41:15 21 warrior regiment representatives in the civilian
01:41:18 22 community, which I'm sure that you can all imagine
01:41:20 23 how important that is. Especially if you take a
01:41:23 24 drive in any direction away from Brooke Army
01:41:27 25 Medical Center or any major military treatment

01:41:29 1 facility. We facilitate the successful transition
01:41:32 2 of post 9/11 wounded, ill and injured marines from
01:41:36 3 the active or reserve components to veteran
01:41:38 4 status. This mission is accomplished by providing
01:41:43 5 needs-based support and problem resolution to
01:41:45 6 include the non-medical care management to those
01:41:48 7 post 9/11 wounded, ill and injured marines, as
01:41:53 8 well as their families. So, the mission statement
01:41:55 9 isn't very different from what we do for our
01:41:57 10 active duty marines and sailors that have been
01:42:03 11 injured, but now we take them back to the
01:42:06 12 community where that amputee is not one of many.
01:42:14 13 They turn out to be one of very few in their
01:42:17 14 community and the comfort that they've had as they
01:42:20 15 have been recovering and rehabilitating at a
01:42:23 16 military treatment facility amongst others that
01:42:26 17 have had similar injuries, have had similar
01:42:30 18 experiences and the troubles that they run into,
01:42:34 19 the challenges that they run into, they have
01:42:36 20 someone that they can go to on their left and
01:42:39 21 right. You put them back in that community in
01:42:42 22 anytown USA, it can become very burdensome, very
01:42:45 23 challenging not know ing where to go and those are
01:42:48 24 the services that we will then provide to those
01:42:50 25 marines that have been separated that are on the

01:42:53 1 temporary retired list or the marines that have
01:42:57 2 been separated and are within that 90-day window;
01:43:01 3 and give them that opportunity to help them
01:43:04 4 transition to the VA structure and to the points
01:43:07 5 of contact that they need, as well as disseminate
01:43:11 6 information. As we know, laws are changing,
01:43:15 7 awards bases are changing and as those continue to
01:43:19 8 change you have all service members that may have
01:43:22 9 been separated three, four, five years ago and
01:43:25 10 just now based on congressional change rate
01:43:30 11 certain benefits or certain awards that would then
01:43:32 12 rate them further benefits; and just getting the
01:43:35 13 word out to those individuals that have served
01:43:39 14 honorably and deserve those benefits is extremely
01:43:42 15 important. Next slide, please.
01:43:45 16 Who do we assist. I'm sure -- I've already
01:43:49 17 touched on that. With the -- we assist with the
01:43:52 18 transition of the active duty marines to that
01:43:55 19 veteran status, at which time they are then
01:43:58 20 transferring over to the VA system; but as we all
01:44:01 21 know, the VA system is -- is a huge organization
01:44:04 22 and sometimes navigating that, especially for
01:44:08 23 somebody with TBI, somebody with PTSD, can be
01:44:12 24 quite intimidating to them. We are that marine in
01:44:15 25 uniform assisting them with that and we do that

01:44:18 1 with the wonderful relationships that we've built
01:44:21 2 across the country with the VA representatives,
01:44:23 3 with the hometown representatives from different
01:44:26 4 service organizations that can help us provide
01:44:28 5 those answers to these recovering national heroes.
01:44:36 6 We also -- it's important that the point is made
01:44:39 7 that we do not differentiate between our active
01:44:43 8 duty marines and reserve marines. As our
01:44:49 9 commandant has said, we are all marines. We are
01:44:52 10 no longer former marines. We're either marines in
01:44:56 11 uniform or we're in civilian clothes and that
01:44:58 12 stands true with the reservists. Those reservists
01:45:01 13 have been mobilized and have served their country
01:45:04 14 honorably. So, we really don't -- we don't
01:45:06 15 differentiate in the manner in which we provide
01:45:08 16 the care. We certainly abide by the different
01:45:11 17 laws and rules and regulations. However, we're
01:45:13 18 still going to give those individuals all of our
01:45:15 19 attention as we would give anyone else and they
01:45:18 20 fall into our case load without -- without any
01:45:22 21 question.
01:45:23 22 Active duty marines or reserve marines that
01:45:26 23 have separated in those remote locations. Right
01:45:29 24 now we have 30 DISCs throughout the country. We
01:45:33 25 have over 25 00 marines just on the temporary

01:45:38 1 disabled retired list. Now, if you do the math,
01:45:41 2 that's about 85 per DISC. Not all will need that
01:45:46 3 assistance. However, we are out there to provide
01:45:48 4 that to them. So, one of your questions -- next
01:45:52 5 slide, please. I'm sorry. A little out of order.
01:45:58 6 Our desired end state, which is very
01:46:01 7 important to us. We provide that wounded, ill or
01:46:06 8 injured marine to be financially, emotionally and
01:46:10 9 socially reintegrated into the civilian society
01:46:15 10 and moving forward with his or her personal goals.
01:46:17 11 The integrated wounded, ill or injured marine will
01:46:21 12 have the knowledge and skills to self-advocate.
01:46:24 13 That's the biggest part of this statement here.
01:46:26 14 To be able to self-advocate and to be able to have
01:46:29 15 that point of contact that can enlighten them on
01:46:33 16 where they can go and find the answers themselves
01:46:37 17 and then to inform other wounded, ill and injured
01:46:41 18 marines about support services available from the
01:46:45 19 regiment and that -- we have a 1-800 number which
01:46:48 20 will be on the last slide, which addresses our
01:46:50 21 call center that any marine at any time if they
01:46:53 22 have any questions as to their status or need
01:46:57 23 assistance or need crisis management, we are
01:47:01 24 publicizing that number nationwide, worldwide.
01:47:03 25 So, they have a single point of contact to go to

01:47:06 1 if they have not had the ability or the knowledge
01:47:10 2 to run into their local area DISC. Next slide,
01:47:16 3 please.
01:47:17 4 So, right now we have 30 DISCs throughout
01:47:20 5 the nation. We have populated, obviously, major
01:47:23 6 metropolitan areas and we are moving on to some of
01:47:27 7 the not so major population areas. In Texas
01:47:31 8 there's only two of us. Yet, there's two in a
01:47:35 9 matter of five states in the north central region,
01:47:40 10 in the midwest. So, as we are finding places to
01:47:43 11 be able to assist marines, where they are going
01:47:46 12 back home is where we hope to continue to place
01:47:50 13 our DISCs so we can be there for them. That means
01:47:54 14 that there's one person that's driving five or six
01:47:57 15 states right now. He's on -- he or she is on the
01:48:00 16 phone 24/7 because we understand the importance of
01:48:04 17 this role. Excuse me. Next slide, please.
01:48:09 18 The question says -- and I can answer these
01:48:12 19 and then I'll let everyone else -- they'll be
01:48:16 20 answering them. Right now our DISCs have an
01:48:19 21 average case load of between 25 and 40. 40 being
01:48:22 22 the max. Again, if you do the simple numbers,
01:48:26 23 that can obviously go over, which is why we are
01:48:29 24 continuing to try and expand this program and
01:48:32 25 we -- and the efforts that we're putting forth to

01:48:37 1 enlighten and educate our former marine -- I'm
01:48:41 2 sorry -- our marines that make the transition is
01:48:43 3 going to continue to have our case load grow.
01:48:47 4 Both reserve and active marine components face
01:48:50 5 similar challenges and therefore they're treated
01:48:53 6 the same. And then the biggest challenge that we
01:48:55 7 have encountered as wounded warrior regiment and
01:49:00 8 DISCs is as I stated earlier. When these marines
01:49:03 9 go back to anytown USA and they're separated from
01:49:06 10 those major military treatment facilities or bases
01:49:11 11 or support services, sometimes they just don't
01:49:13 12 know where to turn to. And if anyone has ever
01:49:17 13 picked up that VA phone, it can be very difficult
01:49:20 14 if you don't know the direct area that you want to
01:49:24 15 go to. And if you're that individual especially,
01:49:26 16 as I stated, with the TBI or the PTSD, along with
01:49:33 17 the stubbornness of a marine, not wanting to ask
01:49:37 18 for help, you may cut yourself off from that
01:49:39 19 opportunity before it ever comes to you. And by
01:49:42 20 us being out -- by the DISCs being out in the
01:49:47 21 communities, making ourselves known, we hope to be
01:49:51 22 able to help overcome any of the challenges that
01:49:54 23 are out there. Last slide, please. That's all I
01:50:02 24 have.
01:50:02 25 CSM DEJONG: Master Sergeant, I've got two

01:50:04 1 quick questions. Is this an additional duty for
01:50:07 2 the DISCs that are assigned there or is this your
01:50:10 3 primary duty?
01:50:13 4 MSGT SCHILLER: Every DISC this is primary
01:50:15 5 duty, sir.
01:50:17 6 CSM DEJONG: Okay. So, as you're talking
01:50:18 7 about wanting to expand the program, that's going
01:50:19 8 to require the Marine Corps to facilitate those
01:50:21 9 billets and fill them with a body?
01:50:26 10 MSGT SCHILLER: That's correct. That's
01:50:28 11 correct.
01:50:28 12 CSM DEJONG: And along a completely
01:50:30 13 different line, how do -- do you reach out to them
01:50:32 14 or how do the wounded marines know that you're
01:50:35 15 there? Do you reach them before they reach their
01:50:39 16 community or are you handed an area of vocation?
01:50:42 17 How do you know that you're reaching all of them?
01:50:45 18 MSGT SCHILLER: Well, several different
01:50:47 19 answers to that, Sergeant Major. As I stated
01:50:50 20 before, having that good relationship with the RCC
01:50:53 21 or the FRC that that individual marine has while
01:50:56 22 they are going through their active duty care,
01:50:58 23 that is one way to where there can be a clean
01:51:00 24 handoff. We have marines that are on the
01:51:03 25 temporary disabled and the permanently disabled

01:51:07 1 retired list that we physically reach out to. We
01:51:09 2 do that as DISCs, as well as our call center
01:51:14 3 reaching out and just saying, "Hey, this is who we
01:51:16 4 are, this is what we can help provide. If we can
01:51:19 5 help you here, we'd like to." On the medical
01:51:21 6 side, because that's often staffed by a myriad of
01:51:25 7 medical professionals and if it is community
01:51:29 8 based, they allow -- or they'll pass on our
01:51:32 9 information for contact and they will also then
01:51:35 10 pass on the individual marine's information to us
01:51:38 11 so we can reach out as well. And then the third
01:51:40 12 stage is really by word of mouth. By getting into
01:51:44 13 the areas and the facilities -- the VA facilities,
01:51:48 14 meeting with all those individuals. Oftentimes we
01:51:51 15 can walk into a VA and it's the first time they've
01:51:54 16 seen a DISC in North Dakota and he says, "You know
01:51:58 17 what, I have a stack this high of marines that
01:52:01 18 have come to me and I've been working on trying to
01:52:03 19 find answers. Can you help me out? Yes." And
01:52:05 20 the team work really comes through that way.
01:52:07 21 CSM DEJONG: Okay. My last question -- I
01:52:09 22 know we've got a rather large panel here -- how
01:52:12 23 long does this care continue?
01:52:13 24 MSGT SCHILLER: The care continues
01:52:14 25 through -- the temporary disabled, they have that

01:52:17 1 five-year window; and, obviously, in going through
01:52:22 2 their process, could be switched over to the
01:52:24 3 permanent retired list at any time and then we
01:52:27 4 will continue that for 90 days, to where it allows
01:52:31 5 them to transfer into the VA system. Oftentimes
01:52:35 6 they're already working in that VA system. The 90
01:52:40 7 days, if an individual has been separated and just
01:52:43 8 wanted to see Twentynine Palms in their rearview
01:52:48 9 mirror and didn't want to admit -- or say that
01:52:51 10 anything was wrong and then they get out there and
01:52:53 11 they find that there is something wrong, we can
01:52:55 12 help advocate for them. We're not going to turn
01:52:58 13 our back on any marine. And through our knowledge
01:53:01 14 base, we'll be able to put them in touch with the
01:53:03 15 right people or help facilitate the paperwork
01:53:05 16 that's necessary in coordination with the VA.
01:53:10 17 CSM DEJONG: Outstanding. Thank you.
01:53:14 18 MSGT SCHILLER: Thanks.
01:53:15 19 LT GEN GREEN: Just a very simple question.
01:53:19 20 What does DISC stand for?
01:53:21 21 MSGT SCHILLER: District injured support
01:53:23 22 coordinator, sir.
01:53:24 23 LT GEN GREEN: And where do you house these
01:53:25 24 folks, usually? Do you put them in the VA
01:53:28 25 hospital?

01:53:28 1 MSGT SCHILLER: The actual -- the actual
01:53:29 2 DISC, sir, the majority of us work from our home
01:53:32 3 because we're on the road constantly. There is
01:53:37 4 certain -- or I shouldn't say certain because
01:53:40 5 they're not particular. Dependent upon that DISC
01:53:44 6 and that relationship with a VA authority or their
01:53:50 7 OIF/OEF coordinator, have been able to use some of
01:53:55 8 the facilities in the VA or in the outreach
01:53:59 9 centers and that's become a place of gathering, so
01:54:05 10 to speak.
01:54:06 11 LT GEN GREEN: And are you giving them any
01:54:07 12 technology to do the outreach?
01:54:09 13 MSGT SCHILLER: I'm sorry, sir?
01:54:10 14 LT GEN GREEN: Are you issuing any
01:54:11 15 technology for them to do the outreach?
01:54:14 16 MSGT SCHILLER: Absolutely. All of us are
01:54:17 17 provided cell phones, as well as computers; and
01:54:20 18 that's the one thing that has made it difficult.
01:54:24 19 There are many VA facilities that are willing to
01:54:27 20 allow us a small office space to have a central
01:54:30 21 location. However, we can't talk to -- we don't
01:54:34 22 have an MCI reciprocate if necessary. Yet the
01:54:41 23 office space is very valuable when we are in
01:54:44 24 there.
01:54:46 25 DR. PHILLIPS: What is your chain of

01:54:48 1 command? I mean, who do you report to?
01:54:50 2 MSGT SCHILLER: All of the DISCs -- we have
01:54:52 3 our regional officers in charge, OICs, that, as it
01:54:57 4 states, is region. So, I believe we have five or
01:55:00 5 six regional OICs. However, our direct chain of
01:55:04 6 command is the commanding officer of wounded
01:55:09 7 warrior regiment, Colonel John Mayer, who's
01:55:11 8 located in Quantico, Virginia, sir.
01:55:16 9 DR. TURNER: Master Sergeant Schiller.
01:55:16 10 MSGT SCHILLER: Yes, sir.
01:55:16 11 DR. TURNER: We've seen some of the other
01:55:18 12 support agencies use social media. Have you all
01:55:20 13 used that at all?
01:55:22 14 MSGT SCHILLER: Social media is very
01:55:24 15 prevalent within the wounded warrior regiment, as
01:55:27 16 a whole. And, again, knowing marines, we were
01:55:30 17 maybe the last ones to pick up on that; but it's
01:55:35 18 certainly proven to be -- certainly proven to be
01:55:38 19 beneficial because the call center uses it and --
01:55:41 20 as well as local DISCs.
01:55:43 21 DR. TURNER: Could you give us an example?
01:55:47 22 MSGT SCHILLER: An example? Well, there's
01:55:49 23 chat rooms. People tend to like on Facebook. If
01:55:51 24 they go on and they like the wounded warrior
01:55:53 25 regiment and -- they can like it and then they

01:55:56 1 will get updates. Changes in law, changes in
01:55:59 2 policies. And as they're checking that, that made
01:56:03 3 them say, okay, thanks for the change, now what;
01:56:06 4 and then we come back and respond to them here's
01:56:10 5 your DISC, contact your DISC.
01:56:15 6 MSGT MACKENZIE: Master Sergeant, as we get
01:56:17 7 better at the care of our wounded, ill and injured
01:56:20 8 as a whole, across the board, some of the core
01:56:22 9 tasks that you listed on that slide are core tasks
01:56:25 10 of other groups and organizations directly
01:56:27 11 assigned that they have pass or fail grades on
01:56:31 12 completing those tasks. The -- it lends me to
01:56:36 13 believe, I think, without further clarification,
01:56:37 14 that -- or it makes me ask the question what is it
01:56:41 15 that -- about the marines that requires this
01:56:43 16 position that the other services don't require or
01:56:46 17 are the other services not taking advantage of
01:56:49 18 this process like the Marine Corps is?
01:56:51 19 MSGT SCHILLER: I can't speak specifically
01:56:54 20 about the other services. The colonel --
01:57:00 21 LT COL KEANE: It's the commandant's issue.
01:57:03 22 Commandant of the Marine Corps has said we'll do
01:57:07 23 this. It's pretty easy.
01:57:09 24 MSGT SCHILLER: And we're doing it and
01:57:10 25 frankly hoping that the other services may follow

01:57:14 1 the task.
01:57:15 2 MSGT MACKENZIE: And the other question I
01:57:16 3 have for you is working here at BAMC in the
01:57:18 4 position you were in and now being a DISC, --
01:57:21 5 MSGT SCHILLER: Yes, sir.
01:57:22 6 MSGT MACKENZIE: -- do you see with the
01:57:22 7 marines that you're working with an increased
01:57:27 8 level of -- correction. Different word. Do you
01:57:31 9 see the marines being better prepared for
01:57:33 10 civilian -- to integrate into the civilian
01:57:35 11 community through your tenure -- and you can
01:57:37 12 answer as well, Staff Sergeant -- as you've done
01:57:39 13 this -- you worked this DISC process or from the
01:57:42 14 other bases that you've interfaced with that said
01:57:44 15 you should just early transition over to it?
01:57:47 16 MSGT SCHILLER: If I understand the
01:57:48 17 correction -- or the question correctly, I can't
01:57:51 18 compare other services. What I can do is I can --
01:57:54 19 is I can speak to the continuity of care, which,
01:57:59 20 again, many of these terms, many of these tasks,
01:58:01 21 many of our missions are overlapping and what the
01:58:08 22 commandant -- through the commandant's initiative
01:58:10 23 we have realized that, okay, when somebody has --
01:58:13 24 has their base, their hospital, in their rearview
01:58:16 25 mirror and they get back to anytown USA, that is

01:58:21 1 where we are running into many issues and once all
01:58:25 2 the dust is settled and that burn patient from
01:58:27 3 BAMC that's been around hundreds of other burn
01:58:31 4 patients, fully accepted in the wonderful
01:58:33 5 community of San Antonio, is then the outcast in
01:58:36 6 Tulsa, Oklahoma because they're alone. So, again,
01:58:41 7 that continuity of care and also the fact that we
01:58:44 8 remain in uniform and I am that master sergeant
01:58:48 9 sitting in front of that lance corporal or that
01:58:51 10 sergeant. Regardless if they are retired or
01:58:54 11 separated or completely out and they have a full
01:58:59 12 beard, what we teach our marines in boot camp
01:59:02 13 still snaps in and then we are able to get back on
01:59:05 14 task and be able to assist them with moving ahead.
01:59:09 15 MSGT MACKENZIE: And my apology, Master
01:59:12 16 Sergeant. I had my question in my head and it
01:59:13 17 came out my mouth the wrong way.
01:59:15 18 MSGT SCHILLER: I -- it must be a master
01:59:16 19 sergeant thing.
01:59:17 20 MSGT MACKENZIE: You know, that or brain
01:59:18 21 injury or many other things that I deal with on a
01:59:22 22 day-to-day basis just being who I am. The
01:59:25 23 question I guess I had was through the life cycle
01:59:27 24 of the DISC program, have you seen marines better
01:59:29 25 prepared to be in the civilian community as DoD

01:59:33 1 and VA has tried to improve their processes to
01:59:36 2 take care of our wounded, ill and injured?
01:59:40 3 MSGT SCHILLER: What I can answer to is --
01:59:42 4 well, yes, I have. Through my -- through having
01:59:45 5 been here for four years and seeing many stages
01:59:48 6 from -- from the active duty side, it -- I have
01:59:53 7 seen it grow leaps and bounds from the marine that
01:59:57 8 was separated -- you know, in '04 or '05 they just
02:00:01 9 got their DD-214 and was gone, to now that whole
02:00:04 10 continuum of care. The addition of RCCs and FRCs
02:00:08 11 and throughout that whole process we are -- we are
02:00:14 12 running into less challenges with those marines
02:00:17 13 that have been separated from an MTF that have had
02:00:24 14 these assets available to them, as opposed to the
02:00:26 15 marines that may not have recognized that TBI or
02:00:31 16 PTSD and separated and were not exposed to it.
02:00:36 17 So, it -- does that help?
02:00:39 18 MSGT MACKENZIE: That's what we're charged
02:00:41 19 to do. See where these programs and improvements
02:00:43 20 and directives have gone and are we really helping
02:00:46 21 the guys out there in the community.
02:00:48 22 MSGT SCHILLER: Unquestionably.
02:00:50 23 MSGT MACKENZIE: And, you know, that's what
02:00:51 24 we're charged to look at and so I wanted someone
02:00:53 25 like yourself, boots on the ground, saying it's --

02:00:56 1 not saying that your job is not required, but that
02:00:58 2 there is certainly improvement in that process and
02:01:01 3 we are seeing a better product.
02:01:03 4 MSGT SCHILLER: Without question. Without
02:01:04 5 question.
02:01:04 6 MSGT MACKENZIE: Thank you, Sergeant.
02:01:06 7 MS. DAILEY: And --
02:01:06 8 LT GEN GREEN: Let me ask one more question
02:01:08 9 just to understand. Do you have a travel budget?
02:01:10 10 So, do you get to go and visit them in the various
02:01:12 11 places where they live?
02:01:13 12 MSGT SCHILLER: Yes, sir. We work through
02:01:16 13 DTS and our budget for the regiment has a specific
02:01:21 14 allocation for DISCs. So, we have to be prudent
02:01:26 15 and we have to be conscious of the budgetary
02:01:33 16 restraints as we're all under; but, again, through
02:01:37 17 word of mouth and having that great team at any
02:01:42 18 individual location throughout someone's region,
02:01:47 19 we'll be able to provide that assistance
02:01:49 20 oftentimes by telephone.
02:01:53 21 LT GEN GREEN: And so are you expected --
02:01:55 22 and so -- I realize you try to do it by telephone
02:01:57 23 and e-mail; but as you -- and so you're kind of a
02:02:00 24 distant support; but I look at some of the
02:02:02 25 districts and you've got fairly wide areas and so

02:02:05 1 there's not a requirement, then, for a home visit?
02:02:08 2 It's one of those things where that would be an
02:02:11 3 unusual thing?
02:02:12 4 MSGT SCHILLER: Home visits are certainly
02:02:14 5 the optimal way. At least once. And getting
02:02:17 6 as -- you know, we get kneecap to kneecap with
02:02:20 7 that marine, because there's also many things that
02:02:22 8 the home visits can tell us that we may not be
02:02:25 9 able to understand on the phone. Such as the
02:02:27 10 family support, the family situation and
02:02:30 11 oftentimes that significant other is where you're
02:02:33 12 going to get a great deal of your information from
02:02:35 13 and oftentimes a little bit more accurate. So --
02:02:40 14 I mean, budgetary restraints certainly affect all
02:02:45 15 of us and --
02:02:47 16 LT GEN GREEN: I understand. I understand
02:02:48 17 where you're going. So, the only other question
02:02:51 18 and then I'll end, is do you ever find -- have you
02:02:55 19 found anybody who feels it's intrusive,
02:02:59 20 particularly from a TDRL?
02:03:02 21 MSGT SCHILLER: There have been.
02:03:03 22 Absolutely. That's occurred. Whether it be from
02:03:05 23 that phone call -- we won't go to the house
02:03:08 24 unannounced, as recruiters may do, because that
02:03:12 25 could be startling. There's many things that we

02:03:15 1 would want to avoid with that. But there's many
02:03:17 2 that say, "Hey, I'm perfectly fine. I know I got
02:03:20 3 this, but I'm moving on in life. I'm doing well";
02:03:24 4 and we accept that, sir.
02:03:26 5 MS. DAILEY: Thank you very much, gentlemen.
02:03:28 6 We do need to move on and I would like to
02:03:33 7 introduce Lieutenant Commander Cole. She's with
02:03:37 8 the Navy Safe Harbor program and she's a
02:03:40 9 non-medical case manager.
02:03:43 10 LCDR COLE: Good afternoon. I've been at
02:03:48 11 SAMMC about four years and two months. I'm a
02:03:51 12 reservist, so I was working for the Army WTU at
02:03:56 13 CFI and then I've worked here at Navy Safe Harbor
02:03:59 14 as a regional non-medical care manager for three
02:04:02 15 and a half years.
02:04:07 16 FORCM PENNINGTON: And my name's Dave
02:04:09 17 Pennington and I want to thank recovering warrior
02:04:10 18 task force for the invitation to come down from
02:04:11 19 Washington, D.C. I'm the transition lead for Navy
02:04:15 20 Safe Harbor and basically what I do is collaborate
02:04:18 21 with these great non-medical care managers across
02:04:20 22 the country and assist our sailors and guardsmen
02:04:24 23 as they transition from active duty or reserve
02:04:28 24 life into life after the military on a medical
02:04:30 25 retirement.

02:04:32 1 A couple of answers to the questions that
02:04:33 2 were posed. As an organization, Navy Safe Harbor,
02:04:38 3 the wounded warrior program for Navy/Coast Guard,
02:04:42 4 has 759 enrollees and that's over a five-year
02:04:47 5 window of time from the conception of the program.
02:04:50 6 Of those 759, 391 have transitioned. If you could
02:04:56 7 hit slide, please.
02:04:59 8 Similar to the Marine Corps -- and many of
02:05:01 9 the other discussions this morning that I've heard
02:05:03 10 from both recovering service members and members
02:05:08 11 related to -- through the VA and various other
02:05:11 12 venues, I think there's a common theme. We didn't
02:05:15 13 write a lot of verbiage, but we summarized. The
02:05:17 14 biggest issue is coming out of that comfort zone
02:05:20 15 when you transition and leaving those things that
02:05:22 16 you know. It's that continuity. It's the
02:05:25 17 military support structure. I think Petty Officer
02:05:28 18 Johnson talked about just being able to walk down
02:05:30 19 the street. We're in the checklist, we have
02:05:34 20 people that tell us where to go and who to see and
02:05:36 21 what to do; and when you transition there's that
02:05:38 22 fear of the unknown and just not having that
02:05:41 23 structure and that continuity that you would have
02:05:44 24 under the military umbrella and in that comfort
02:05:47 25 zone that you have and even knowledgeable

02:05:49 1 representation in many cases. There's no doubt
02:05:53 2 the VA is there and has made incredible
02:05:56 3 improvements. We were talking about this at
02:05:58 4 lunch. But it is different and it is sometimes
02:06:01 5 often a challenge for our recovering service
02:06:04 6 members to really get where they need to go and
02:06:07 7 get the information they need. So, that -- that
02:06:10 8 really is a summary of some of the major
02:06:12 9 challenges that our recovering service members
02:06:15 10 face and their families when they leave that --
02:06:17 11 that cocoon of military support.
02:06:19 12 The challenges for the reserve component and
02:06:23 13 the active component. One Navy -- I love the
02:06:27 14 Marine Corps one -- Marine for life, one Marine.
02:06:28 15 Same thing in the Navy and Coast Guard. However,
02:06:31 16 once a reserve component sailor leaves the DEMOB
02:06:36 17 process, if they're identified as a wounded
02:06:39 18 warrior or if their injury is identified while
02:06:40 19 they're transitioning out, then basically they
02:06:45 20 have the same benefits, they have the same
02:06:47 21 support; but often our reserve component sailors
02:06:53 22 end up coming through the DEMOB process, end up
02:06:56 23 going home and then re -- you know, realize that
02:06:59 24 they've got some issues, they've got some
02:07:00 25 problems; and it's at that point where sometimes

02:07:04 1 it can be a challenge. So, quite honestly, some
02:07:06 2 of the policies and processes are still not
02:07:09 3 aligned. And especially when folks go home it's
02:07:12 4 tough sometimes to get people connected with the
02:07:14 5 right folks in the reserve force to get the right
02:07:17 6 answers. So, prior to separation, it's not as
02:07:22 7 much an issue; but it is sometimes a challenge for
02:07:25 8 our reserve component sailors once they're
02:07:28 9 processed and transferred out and then realize
02:07:31 10 that there's some medical issues that need
02:07:33 11 attention. Often we'll have to recall them back
02:07:36 12 on active duty, bring them back to MTF and get
02:07:40 13 them back in the mix to get what they need. Many
02:07:42 14 times, quite honestly, the policy is it's just a
02:07:46 15 fast track to the VA for a reserve component
02:07:50 16 guy -- sailor or guardsmen -- guy or gal, whereas
02:07:52 17 for the active duty component it's under that --
02:07:56 18 again, that safe zone of military medical support.
02:07:59 19 It's just sometimes different.
02:08:01 20 DoD services, quite honestly, are just
02:08:04 21 different and the dynamics change depending on
02:08:07 22 locations and that's just a real bullet. You
02:08:10 23 know, as we talk to our care managers, quite
02:08:13 24 honestly, you hear different stories and different
02:08:15 25 programs and different things. I work adaptive

02:08:20 1 athletics as well as my transition job and, quite
02:08:24 2 honestly, I hear sailors talk about, "Hey, I got a
02:08:27 3 handcycle from the VA. Oh, gosh, I wish I knew
02:08:31 4 about that. I'd like a handcycle." And, you
02:08:34 5 know, they weren't tied into the same kind of
02:08:36 6 networking to get the same kind of benefits in one
02:08:39 7 area that was available in another area. So,
02:08:42 8 basically, that's some of the things that we
02:08:45 9 summarized with regards to DoD support. It
02:08:49 10 just -- I know many of the policies and processes
02:08:52 11 and benefits are there, but sometimes the
02:08:55 12 effective communication of those and the
02:08:57 13 availability is different, depending on where they
02:08:59 14 are. I want to talk just briefly -- if you can
02:09:04 15 hit slide for me.
02:09:04 16 CSM DEJONG: Sir, before we go on to the
02:09:06 17 next slide, I want to -- if we can back up to
02:09:06 18 reserve component, I've got a couple of
02:09:08 19 different -- we face the same thing on the Army
02:09:12 20 side and National Guard and air side. One of the
02:09:15 21 frustrations that we have had expressed from -- on
02:09:18 22 the Navy side -- and this is -- compounds the
02:09:20 23 problem. You can confirm or deny this. Is that
02:09:23 24 you only have two locations. You have east or
02:09:26 25 west.

02:09:27 1 FORCM PENNINGTON: True.
02:09:29 2 CSM DEJONG: So, if you're a soldier from
02:09:31 3 the midwest, are they -- would you think they'd be
02:09:33 4 more likely to check the block during DEMOB and
02:09:37 5 say everything's fine so they can go home?
02:09:40 6 FORCM PENNINGTON: Yeah.
02:09:42 7 CSM DEJONG: And we also talk about the
02:09:43 8 continuum of care being -- and having family
02:09:45 9 support throughout the recovery process.
02:09:45 10 FORCM PENNINGTON: Yeah.
02:09:47 11 CSM DEJONG: And that's not offered in the
02:09:49 12 Navy. So, it seems to compound the problem and
02:09:52 13 the feedback that we're getting is -- is I want to
02:09:54 14 go home, I want to be close to my family. I
02:09:57 15 haven't seen them in a year.
02:09:59 16 FORCM PENNINGTON: No doubt.
02:10:00 17 CSM DEJONG: And if I check yes or no -- if
02:10:01 18 I check yes that I have a problem, I'm going east
02:10:03 19 or I'm going west and my family can't afford to
02:10:06 20 come and see me and I won't have my family
02:10:08 21 throughout the entire treatment process.
02:10:11 22 FORCM PENNINGTON: Well, there's no doubt,
02:10:12 23 Sergeant Major, that -- our two processing centers
02:10:15 24 are in San Diego and Norfolk. So, when sailors
02:10:19 25 are DEMOB'd after doing deployment, they are going

02:10:23 1 to go one of those locations to go through the
02:10:25 2 DEMOB process. Now, you're right. Many of those,
02:10:29 3 if they're not catastrophically injured, will
02:10:32 4 probably just kind of go through the motions to
02:10:33 5 get back to Kansas. They want to get with their
02:10:36 6 family. One of the things we're trying to improve
02:10:39 7 on is the briefing and the knowledge that if we
02:10:41 8 have to retain them and keep them at a major
02:10:43 9 medical treatment facility, we're going to move
02:10:45 10 them where we need to. If not, we'll try to get
02:10:48 11 some family there to get around them during that
02:10:51 12 time. So, we're still getting better; but, again,
02:10:53 13 a lot of what drives that -- and Sandy's jumping
02:10:55 14 at the bit because she works at that; but, you
02:10:57 15 know, we've just got to get better at
02:11:00 16 communicating that care, that support and it's
02:11:02 17 okay. Identify -- because if you go home, it gets
02:11:07 18 really hard to address it after the fact. I
02:11:09 19 mean -- and, Sandy, I don't know if you want to
02:11:11 20 add to that.
02:11:12 21 CSM DEJONG: Okay. I realize -- and from
02:11:14 22 what we've been told over the last couple of
02:11:15 23 months is this -- the east or west locations is
02:11:17 24 fairly new.
02:11:19 25 FORCM PENNINGTON: No, sir. We've been

02:11:20 1 actually DEMOB'ing our reserve component sailors
02:11:24 2 at those two processing stations since the
02:11:27 3 beginning of the war.
02:11:29 4 CSM DEJONG: Okay.
02:11:31 5 FORCM PENNINGTON: Since we've been
02:11:33 6 mobilizing reserves, they've come through those
02:11:34 7 two locations.
02:11:34 8 MSGT MACKENZIE: What's new was about the
02:11:36 9 fact that we were briefed and the -- what we were
02:11:38 10 seeing over at Landstuhl was that -- the medical
02:11:41 11 piece. Okay. But you had VSI patients going
02:11:46 12 through a major facility. Naval reserve personnel
02:11:51 13 that are injured or, you know, take a fall or
02:11:54 14 illness, whatever, they're coming through the
02:11:57 15 medical evacuation system, they are going to Fort
02:12:01 16 Smith or --
02:12:06 17 FORCM PENNINGTON: San Diego. Balboa.
02:12:09 18 LCDR COLE: Balboa.
02:12:10 19 MSGT MACKENZIE: Thank you. And there's no
02:12:12 20 exception to the rule. And this is information we
02:12:14 21 just picked up a couple of months ago and it
02:12:16 22 really, really surprises me because the other
02:12:19 23 services are going how do I get this warrior close
02:12:23 24 to their family, close to their unit, with the
02:12:25 25 appropriate medical care; and it seems as though

02:12:28 1 the Navy has gone the exact opposite direction and
02:12:31 2 says you're going right here.
02:12:34 3 FORCM PENNINGTON: Yeah.
02:12:35 4 MSGT MACKENZIE: And oh, by the way, if
02:12:37 5 you're familiar enough with JFTR, you realize that
02:12:40 6 you just put a Navy personnel in Fort Smith and
02:12:43 7 they don't qualify for family member travel.
02:12:46 8 So --
02:12:46 9 LCDR COLE: We're seeing more of a push -- I
02:12:48 10 think that -- to answer your question, there --
02:12:50 11 here recently there is more of a push for the
02:12:54 12 reservists to go to the two sites. So, that's
02:12:59 13 what's happening.
02:13:00 14 CSM DEJONG: And, really, the way that I was
02:13:02 15 briefed on it was it was too hard to control any
02:13:03 16 other way, so this was an easy fix to it and there
02:13:07 17 was very little consideration for location or
02:13:09 18 desire to be close to any family.
02:13:12 19 LCDR COLE: Right. So, they're not able to
02:13:14 20 be with their family in the locale. Say they're
02:13:17 21 from San Antonio, Texas. They're not -- their
02:13:19 22 family support is not with them when they go to
02:13:22 23 the DEMOB site for medical care.
02:13:25 24 CSM DEJONG: Correct me if I'm -- for what
02:13:26 25 could be potentially long-term medical care?

02:13:30 1 LCDR COLE: Yes. Yes. I had an example
02:13:33 2 of -- for the question on reserve component as
02:13:35 3 opposed to the active duty, I had a reservist that
02:13:39 4 was brought to me, frankly, by the Air Force and
02:13:42 5 telling me that he was falling through the cracks.
02:13:44 6 And what had happened, he was a 50 sailor and he
02:13:49 7 had been mobilized three times. He was DEMOB'd at
02:13:54 8 the -- Gulfport, Mississippi and he had had a
02:13:58 9 chassis of a car fall on his head when he was in
02:14:01 10 Afghanistan. An IED went off. And somehow the
02:14:06 11 TBI -- later on the PTSD surfaced six months later
02:14:11 12 after the DEMOB; and, you know, when you're a
02:14:15 13 reservist and you are getting ready for
02:14:18 14 mobilization, I don't know that the teaching or
02:14:21 15 the VA or what's going on at the VA is ever
02:14:24 16 taught. So, when the fellow went to the VA -- to
02:14:27 17 the DEMOB site, they told him, "Well, you're all
02:14:31 18 right. Just go to the VA." But he was so injured
02:14:35 19 that he wasn't sure what to do, how to get into
02:14:39 20 the VA system and he started to show -- you know,
02:14:43 21 acting out.
02:14:45 22 FORCM PENNINGTON: Let me bring up a few
02:14:46 23 things for clarification, Command Sergeant Major.
02:14:49 24 Petty Officer Johnson who spoke today is a
02:14:52 25 reservist. He's in San Antonio receiving care.

02:14:55 1 Okay. So, these DEMOB sites doesn't mean that's
02:14:58 2 where you stay forever. I think the point is you
02:15:00 3 go through the demobilization process and then
02:15:02 4 you're taken wherever you need to go to get the
02:15:06 5 medical care you need. There is a little bit of a
02:15:09 6 difference in the support structure in the Navy
02:15:11 7 with regards to heartland America and let's face
02:15:13 8 it, that's where reserve components are from.
02:15:17 9 It's really -- it's a real benefit in the Army,
02:15:20 10 for example, to have major commands and bases
02:15:23 11 across the heartland of America. Whereas the Navy
02:15:26 12 don't have that convenience. There's not a Navy
02:15:29 13 base in Kansas, to my knowledge. So, the bottom
02:15:32 14 line is if the recovering service member and his
02:15:36 15 family live in Kansas, then what we're going to do
02:15:38 16 is either try to get the family to where they are
02:15:40 17 or move them to wherever they can that's closest
02:15:44 18 for the medical care.
02:15:49 19 DR. TURNER: Just a quick question and
02:15:52 20 perhaps maybe I missed this. Could -- two things.
02:15:54 21 Number one, could you characterize your long-term
02:15:56 22 care as a non-medical care manager? How long do
02:16:01 23 you hang on to the --
02:16:03 24 LCDR COLE: Until death.
02:16:04 25 DR. TURNER: Until death?

02:16:06 1 LCDR COLE: Yes, sir. Basically, the
02:16:09 2 disease process or actual injury -- and it's for
02:16:13 3 the severely ill and injured Coast Guard and Navy.
02:16:17 4 So, we follow them through -- we get the rest of
02:16:20 5 the story after they are retired and we see a lot
02:16:23 6 of things that you go, "Oh, my Lord."
02:16:25 7 DR. TURNER: Perhaps this is not a large
02:16:28 8 demographic of yours, but it's been my experience
02:16:31 9 in the Navy that you have a lot of folks retire
02:16:35 10 OCONUS and I was wondering if you had run into
02:16:39 11 that as a challenge?
02:16:41 12 LCDR COLE: Well, I have the southern
02:16:43 13 states -- southern district, so I don't have any
02:16:45 14 OCONUS.
02:16:47 15 DR. TURNER: That would be southern Manila,
02:16:51 16 I guess. I was just curious if y'all had seen --
02:16:53 17 because, like I say, there is a demographic in the
02:16:55 18 Navy of people that are OCONUS and I was wondering
02:16:58 19 if you had seen that or had addressed that at all.
02:17:02 20 FORCM PENNINGTON: Great questions on the
02:17:04 21 reserve component. We'll definitely take that
02:17:06 22 back to the staff. I know we're constantly
02:17:08 23 working to try to improve the support and that is
02:17:10 24 definitely, you know, one of the things we want to
02:17:13 25 talk about. The policies and processes are

02:17:15 1 constantly being reviewed, but I guess the summary
02:17:19 2 of that is the two demobilization sites are
02:17:23 3 Norfolk and Balboa in San Diego and if they're
02:17:26 4 identified with a medical issue at that time, then
02:17:29 5 we try to get the family there initially.
02:17:31 6 Especially if it's catastrophic. And then
02:17:34 7 ultimately get them to a facility that's close to
02:17:37 8 their home where we can meet their needs and have
02:17:40 9 family close by. It is, often cases, depending on
02:17:44 10 the injury. So, there's a lot of variables there;
02:17:47 11 but it often is a VA -- VA facility. So, that's
02:17:50 12 where I mention that fast track to the VA through
02:17:54 13 -- through heartland America because that's
02:17:56 14 usually the closest place to home; but -- yeah.
02:18:02 15 CSM DEJONG: I can't remember what they told
02:18:03 16 me. Great Lakes no longer has a medical facility?
02:18:07 17 FORCM PENNINGTON: They do.
02:18:08 18 CSM DEJONG: They do?
02:18:09 19 FORCM PENNINGTON: Yes, sir. So -- and that
02:18:10 20 is middle of the country and, you know, I know
02:18:12 21 there's been discussion about that, as well. So,
02:18:14 22 again, the reserve force piece for the Navy honed
02:18:17 23 right in on it.
02:18:18 24 CSM DEJONG: Because I asked about that
02:18:19 25 knowing that there's a lot of units -- I come from

02:18:21 1 the Midwest myself. So, knowing there's a lot of
02:18:23 2 units out there. The Seabees in Nebraska may say,
02:18:24 3 well, there is no option. And I'm glad that you'd
02:18:27 4 said that there is some looking into moving family
02:18:31 5 or moving the sailor, because the way it was
02:18:34 6 briefed to us was there is no allocation to get a
02:18:35 7 family out there and their choice is east or west.
02:18:38 8 No matter where they DEMOB through, it's going to
02:18:41 9 be east or west closest to home; but we can't
02:18:43 10 guarantee you. So, thank you.
02:18:46 11 MSGT MACKENZIE: And that's just when -- you
02:18:47 12 bring up the conversation, sir. We're not talking
02:18:49 13 about the DEMOB process. We're talking about the
02:18:52 14 medical evaluation process of the reserve
02:18:54 15 component sailor.
02:18:56 16 FORCM PENNINGTON: Right.
02:18:56 17 MSGT MACKENZIE: And we're also talking
02:19:00 18 about the challenges of an active duty and reserve
02:19:00 19 component sailor getting treated differently for
02:19:03 20 the same injuries. Okay. And what we're also
02:19:06 21 talking about is you have an entire cell of
02:19:09 22 corpsmen at Landstuhl who are willing to hold on
02:19:12 23 to these folks an extra day or two days to
02:19:14 24 complete the coordination piece to put that person
02:19:17 25 in the medical facility that's closer to home; and

02:19:20 1 every time they put in that request trying to do
02:19:22 2 the right thing for the reserve component sailor,
02:19:25 3 they're promptly told, no, they will go east or
02:19:28 4 west. So, as you bring that up, sir, please keep
02:19:30 5 that in mind, that that is out there.
02:19:33 6 FORCM PENNINGTON: Yes, sir. We'll do it,
02:19:34 7 Chief. I know other people are going to speak
02:19:36 8 here, so I just want to summarize very quickly.
02:19:38 9 With the anchor program we try to match up every
02:19:42 10 sailor or guardsman that's medically retired with
02:19:46 11 somebody near their home town, within a 50 mile
02:19:49 12 radius; and that's the mentoring program that we
02:19:53 13 have. We work through the community and veterans.
02:19:55 14 We also work through the reserve component
02:19:59 15 commands, the NOSC. Ironically, we were just
02:20:02 16 talking about the operational support command.
02:20:04 17 So, it's a really cool program that has really
02:20:07 18 proven to be a great benefit for our recovering
02:20:09 19 service members. To date we have 67 recovering
02:20:14 20 service members across the country and we have 63
02:20:18 21 mentors assigned who contact them once a month for
02:20:21 22 a year after their medical retirement. Check up
02:20:24 23 on them, see how they're doing and notify the care
02:20:27 24 manager if there are issues and concerns. So,
02:20:30 25 it's a real boots on the ground, eyes on target

02:20:33 1 sailor that's involved with this recovering
02:20:36 2 service member and their family. We also involve
02:20:38 3 mentors from the senior community. Specifically,
02:20:42 4 American Legion, Fleet Reserve Association, Navy
02:20:45 5 League and these folks really do good things. A
02:20:48 6 lot of goodness in the anchor program and we
02:20:53 7 really bolster that up with support.
02:20:56 8 I want to close with this. I had this idea.
02:20:58 9 Wouldn't it be cool if all the services could come
02:21:03 10 together and collaborate on a mentoring program
02:21:05 11 where instead of, you know, just healthy sailors
02:21:08 12 who live in heartland America who are contacting
02:21:11 13 these folks to make sure they're doing okay,
02:21:14 14 wouldn't it be cool to match them up with somebody
02:21:17 15 that has a like injury in heartland America. If
02:21:20 16 somebody had an ampu -- is an amputee and we can
02:21:23 17 match them up and we put an Air Force or a soldier
02:21:26 18 with a sailor to say, "Hey, you know what, I live
02:21:28 19 this, I know the wickets at the VA, I would love
02:21:31 20 to be able to help you out." Now, that's real
02:21:34 21 mentoring and if we could ever collaborate
02:21:37 22 together in all the services and get a list of
02:21:39 23 injuries and compare them and match them up across
02:21:43 24 the country, there could be some real value to
02:21:46 25 that. Thank you for your time.

02:21:49 1 MR. REHBEIN: Just if I may -- go ahead.
02:21:49 2 LT GEN GREEN: I was just going to ask how
02:21:51 3 do you pick the 67 that get that program?
02:21:54 4 FORCM PENNINGTON: Okay. These are all
02:21:56 5 volunteer. Any -- we offer this to every sailor
02:21:58 6 that is medically retired. So, every sailor and
02:22:02 7 guardsman that is transitioned out, we offer them
02:22:05 8 the anchor program opportunity and let them know
02:22:08 9 what it is and tell them that we're going to match
02:22:10 10 them up with somebody near their hometown that can
02:22:13 11 help them out and they can either accept or
02:22:15 12 decline. If they accept, we immediately start
02:22:18 13 trying to find somebody out in the community to
02:22:19 14 help them.
02:22:21 15 MR. REHBEIN: Yeah, that was going to be one
02:22:23 16 part of my question. How do you qualify mentors
02:22:24 17 and what kind of -- do they get any training?
02:22:27 18 FORCM PENNINGTON: Yeah, good question.
02:22:29 19 What we do on this is basically -- you know, throw
02:22:31 20 out the net. Cast out the net for volunteers at
02:22:35 21 hometown USA as well. A lot of people out there
02:22:38 22 that are willing to stand up and assist. They
02:22:41 23 fill out, basically, a data information sheet with
02:22:44 24 their background information; we interview them,
02:22:46 25 the care managers get involved and then,

02:22:48 1 basically, what we do is we have an orientation
02:22:51 2 process where we let them know what the
02:22:53 3 expectations are, a brochure. We're not asking
02:22:57 4 them to be legal experts. We're not looking for
02:23:00 5 them to be medical experts. We just want them to
02:23:04 6 be caring folks that will give these recovering
02:23:06 7 service members a call, give them a visit and have
02:23:09 8 their antennas up on how things are going and then
02:23:13 9 basically get in touch with the pros whenever
02:23:16 10 there are issues.
02:23:19 11 LCDR COLE: I have a service member in
02:23:20 12 Houston that has been very successful. He has
02:23:23 13 PTSD and TBI and we have a couple of retired --
02:23:27 14 one retired chief and another chief that's taking
02:23:30 15 care of him and things that he forgets -- a lot of
02:23:33 16 times my guys that have PTSD or TBI are divorced.
02:23:37 17 So, they've lost their -- you know, first of all,
02:23:39 18 the injury and then the wife or the husband is
02:23:42 19 gone. So, these boots on the ground set them up
02:23:46 20 with social services in that city. Because I have
02:23:50 21 eight states. So, to have those boots on the
02:23:52 22 ground is in coordination with the VA and it's a
02:23:55 23 marvelous program.
02:23:57 24 MS. DAILEY: Thank you. Thank you, ladies
02:23:59 25 and gentlemen. I would like to introduce our two

02:24:03 1 SOCOM care coalition representatives. Ms. Jane
02:24:08 2 Baskerville and Mr. James Burach.
02:24:08 3 MS. BASKERVILLE: Burbach.
02:24:08 4 MS. DAILEY: Burbach.
02:24:19 5 MS. BASKERVILLE: Well, I'll just go over
02:24:21 6 the notes. You can see who we are and where we're
02:24:24 7 from. When they told us that we needed to get a
02:24:28 8 briefing together -- tell me if you can't hear me
02:24:30 9 through this -- I didn't think it was telling you
02:24:33 10 what we -- what exactly we do. Moreso what could
02:24:39 11 we improve on. So, I just have some comments to
02:24:44 12 make about certain things that we hope that this
02:24:47 13 panel is going to try to change in the future. As
02:24:51 14 it says, we are -- we have the longest name.
02:24:54 15 Special operations command care coalition recovery
02:24:59 16 program advocate. That's my title and Jim's title
02:25:03 17 is special operations command care coalition
02:25:06 18 recovery care coordinator. Now, what Jim does
02:25:10 19 that's different from me is he is boots on the
02:25:14 20 ground. Guy medevacs from Landstuhl, he's at
02:25:18 21 BAMC, he meets the person right there at BAMC.
02:25:20 22 Coordinates all the travel for the family to get
02:25:23 23 there. What I do as an advocate, I pick up -- and
02:25:26 24 we deal with very seriously injured and seriously
02:25:29 25 injured and the SOCOM care coalition. Very

02:25:36 1 seriously injured, there's not a definite
02:25:39 2 definition, but it's if you have to rehab more
02:25:41 3 than six months or more than 30 days inpatient in
02:25:45 4 a facility. Now, that could change; but with care
02:25:48 5 coalition it's very seriously injured and
02:25:51 6 seriously injured and you're in the program for
02:25:54 7 life. Now, when you're first inpatient, we see
02:25:55 8 you every day. When you're outpatient, we see you
02:25:58 9 weekly and that's how we establish a relationship.
02:26:01 10 After that it depends on what you need, how
02:26:05 11 seriously are your injuries and how long you're
02:26:07 12 going to be rehabbing. We could be seeing you for
02:26:10 13 the next year every week. It just depends. As an
02:26:14 14 advocate, I'm more concerned with reintegration
02:26:17 15 and everybody's talked about mentorship.
02:26:20 16 Reintegration, mentorship and wellness. And let
02:26:22 17 me talk about wellness first. You -- you are at a
02:26:26 18 military treatment facility. Things aren't going
02:26:29 19 as well as we would like. There are other
02:26:32 20 civilian treatment facilities that have very good
02:26:36 21 success records doing some type of treatment. Me,
02:26:40 22 in my job, I could research that for them and then
02:26:44 23 try to set it up so we could get that military
02:26:48 24 person into that civilian treatment facility just
02:26:50 25 to try to get them a little bit better. That's on

02:26:54 1 the wellness side. On reintegration I'm a SOCOM
02:26:59 2 advocate. I have not had a SOCOM service member
02:27:02 3 come to BAMC or in my program that when they first
02:27:05 4 hit the ground didn't want to go back to their
02:27:07 5 unit. Every one of them, I want to go back to my
02:27:09 6 ODA, I want to go back to whatever I was doing, I
02:27:12 7 want to go back to ARSOC. Every one of them
02:27:16 8 wanted to do that. Three months into the rehab
02:27:18 9 process they've changed a little bit on what
02:27:21 10 they're thinking. You know, maybe I can't jump
02:27:23 11 out of airplanes anymore. They came to this
02:27:26 12 realization. When they first got there, I want to
02:27:28 13 go back to my unit, Jane. Okay, no problem, I'll
02:27:31 14 do whatever I can to get you back to the unit.
02:27:33 15 Three months later, maybe I can't go back and be
02:27:36 16 in charge of an ODA. Okay. Well, you -- when you
02:27:38 17 decide what you want to do -- because in SOCOM
02:27:41 18 there's a policy that you can continue on active
02:27:44 19 duty. Might not be in the same role, but you have
02:27:47 20 that choice. Six months later, you know what, I
02:27:51 21 really can't do what I used to do. I don't want
02:27:54 22 to sit behind a desk. Maybe I'll think about
02:27:57 23 getting out of the military. So, the
02:28:00 24 reintegration is whatever you want to do. If you
02:28:02 25 want to go back on active duty, I'm going to help

02:28:05 1 you do that. If you want to get out of the
02:28:06 2 military, we're going to assist you in doing that
02:28:10 3 also.
02:28:10 4 Mentorship. One of the biggest things that
02:28:13 5 we do in the SOCOM care coalition. You just get
02:28:15 6 to BAMC, you're a bilateral amputee. What do I
02:28:19 7 want to do? I want to get another bilateral
02:28:22 8 amputee walking into that room and start that
02:28:25 9 conversation with you as a mentor. That's -- we
02:28:28 10 have had so much success with pairing folks and it
02:28:31 11 doesn't matter if you're MARSOC, ARSOC, an Army
02:28:36 12 Ranger or Green Beret. Let me not forget the Navy
02:28:39 13 Seals. It doesn't matter. If you walk in with
02:28:42 14 the same injuries and you have family members that
02:28:44 15 have been through this too and then you go in that
02:28:47 16 room, your credibility is a hundred times more
02:28:51 17 than anybody else's credibility. Okay. I'm going
02:28:54 18 to try to talk quick because she told me 10
02:28:57 19 minutes and there's just no way I can do this in
02:28:59 20 10 minutes.
02:29:00 21 Transitioning service members. I had a
02:29:02 22 service member out of Fort Campbell transition off
02:29:05 23 of active duty. These are just notes. It's not
02:29:09 24 on my slide. You can see how long we've been
02:29:11 25 here. Service member transitioned off of active

02:29:13 1 duty out of Fort Campbell. Severe PTSD, severe
02:29:18 2 depression. He was inpatient twice for suicidal
02:29:22 3 tendencies. He is now a medically retired person.
02:29:25 4 He went into the VA system. When he went into the
02:29:28 5 VA system, he has those appointments where, you
02:29:31 6 know, okay, I've got to set you up with pain
02:29:34 7 management, I've got to set you up with this and
02:29:36 8 that. I wish there was some type of bell or alarm
02:29:42 9 that went off saying, look at this guy's record,
02:29:45 10 he's severely depressed, we need to get him in to
02:29:49 11 see a counselor on mental health today, tomorrow,
02:29:51 12 the next day. Well, it went on for some months
02:29:55 13 and he -- they just said, "Well, we're going to
02:29:55 14 set you up for an appointment." This is a
02:29:58 15 documented seriously depressed person. So, that's
02:30:01 16 where I came in. Wait a minute. You haven't seen
02:30:03 17 a counselor yet, you're not back in mental health.
02:30:06 18 That's where we come in. That's my job. To get
02:30:08 19 in touch with the case manager wherever it is that
02:30:11 20 they are to get him better. That's one of the
02:30:14 21 things that I would like to see. I didn't do the
02:30:18 22 disclaimer up front about the VA. I'm not bashing
02:30:21 23 the VA. It's just that medically retired service
02:30:23 24 members for the most part go into the VA system
02:30:26 25 and that's what -- that's what we deal with.

02:30:29 1 I got off a plane last night from Omaha. I
02:30:32 2 was up at QLI seeing a very seriously injured
02:30:36 3 MARSOC service member. This person came -- he was
02:30:41 4 at QLI up in Omaha. Before that he was at Craig,
02:30:44 5 before that he was at Tampa polytrauma. I wasn't
02:30:48 6 going to name the VAs, but I have. The polytrauma
02:30:51 7 in Tampa and he started here at the burn unit.
02:30:54 8 Very seriously injured. Triple amputee, burned
02:30:57 9 over 90 percent of his body. He had to transition
02:31:00 10 somewhere from BAMC -- excuse me -- SAMMC,
02:31:02 11 formerly known as BAMC. So, he went -- the
02:31:05 12 polytrauma here wasn't open. He went to the
02:31:08 13 polytrauma in Tampa and I hope there's nobody from
02:31:12 14 there. It was horrendous. It was horrendous, the
02:31:15 15 care that this person got; and the wife was there,
02:31:19 16 the spouse, the daughter. They moved there with
02:31:22 17 him. We're trying to get the guy better and he's
02:31:24 18 getting worse. Okay. So, the guy's getting
02:31:28 19 worse. He's sick every day, he's now having to
02:31:31 20 have tube feeds. So, care coalition stepped in
02:31:36 21 and said wait a minute, let's call these other
02:31:39 22 facilities and see if we can get him transitioned
02:31:43 23 to a place that's going to try to get him better.
02:31:44 24 The quality -- he went to Craig in Englewood,
02:31:47 25 Colorado. That's where the care coalition steps

02:31:51 1 up and tries to get all the -- the moving widgets
02:31:54 2 together so we can get this seriously injured
02:31:57 3 MARSOC service member somewhere where we can try
02:32:01 4 and get him a little bit better, because he wasn't
02:32:03 5 at the end of his treatment; but they kind of
02:32:05 6 wrote him off like that was the end. That wasn't
02:32:08 7 the end. Anyway -- it got worse at the end. A
02:32:11 8 week before he was scheduled to fly from Tampa to
02:32:16 9 Craig, they somehow dropped him and they broke his
02:32:20 10 arm and they broke his hip and this is -- this is
02:32:24 11 a hero and that's in the VA system and I'm not --
02:32:28 12 they're not all bad, but this was horrendous.
02:32:31 13 Anyway, he's up at QLI. He's doing really well.
02:32:35 14 But we're going to have to transition him back.
02:32:37 15 The family wants to come back down here and we're
02:32:39 16 going to make sure the family gets back down here
02:32:42 17 and I'm going to help them navigate the VA system
02:32:45 18 because the spouse didn't know where to turn. She
02:32:48 19 was in Tampa with her service member and she was
02:32:52 20 clueless. I'm here at a VA, what am I supposed to
02:32:57 21 do. That's where we step in. God, I have a
02:33:02 22 horror story -- I don't mean to do the horror
02:33:04 23 stories; but I just -- I -- if we're going to
02:33:05 24 change a system, let's try to change a system.
02:33:09 25 CSM DEJONG: The one question I remember,

02:33:10 1 ma'am, if you would real quick. One of the
02:33:12 2 reasons that we talked last year and wanted you to
02:33:15 3 brief is you guys have an outstanding system. How
02:33:17 4 do we take that and apply it to big Army, apply it
02:33:20 5 to Navy, apply it to -- how do we take some of
02:33:24 6 those lessons learned and apply them?
02:33:25 7 MS. BASKERVILLE: You know, I -- and I
02:33:25 8 didn't want to come here with just bad stuff and
02:33:34 9 not have a solution. It's almost like you have to
02:33:36 10 have a degree to navigate the VA system or a
02:33:39 11 medical system or IDES or an MEB system. SOCOM is
02:33:42 12 blessed with having resources and personnel to
02:33:45 13 personally reach out and touch these people. I
02:33:47 14 only have no more than 25 people on my watch and I
02:33:51 15 have an unlimited bu -- not an unlimited budget,
02:33:54 16 but I can fly to wherever I need to fly to go see
02:33:58 17 these people and it's getting face to face with
02:34:01 18 them that's the most important thing. I don't
02:34:01 19 have an answer on the big Army because the
02:34:03 20 numbers -- excuse me -- the big DoD because of the
02:34:05 21 num -- sheer numbers and the cost to have a single
02:34:11 22 person helping you and your family navigate the
02:34:14 23 system through forever. Forever. I don't have an
02:34:18 24 answer to that.
02:34:19 25 CSM DEJONG: And we realize that there's a

02:34:21 1 difference in -- personnel difference in that; but
02:34:25 2 what we're hearing is there's two soldiers. The
02:34:28 3 average mother sees two soldiers and a mom from
02:34:34 4 big Army can sit there and say how come this other
02:34:37 5 soldier is getting all this, when my soldier
02:34:39 6 can't. So, how do we get -- how do we equalize
02:34:42 7 that? How do we get it? I can sit here and tell
02:34:44 8 you I understand certain -- the differences
02:34:46 9 between SOCOM and the Army; but the people that
02:34:50 10 are reporting to Congress, the people that are
02:34:53 11 doing the congressional -- the reason this task
02:34:55 12 force was stood up is seeing a difference in care
02:34:58 13 and how do we equalize that.
02:35:02 14 MS. BASKERVILLE: Well, if -- in a perfect
02:35:02 15 world and if it was the world according to Jane
02:35:02 16 Baskerville, I would have enough personnel so that
02:35:05 17 big Army or big military could do the same thing
02:35:08 18 that I do, based on a ratio of one to 25. I don't
02:35:11 19 know -- and I don't know if that's what you --
02:35:13 20 they consider what the case manager or the
02:35:15 21 non-case managers do; but I'm an advocate and I'm
02:35:19 22 only there to make sure whatever you need, it
02:35:23 23 happens and this is not what right looks like.
02:35:26 24 This one person over here at the MEB is telling
02:35:29 25 you this and that's not what right looks like.

02:35:31 1 That's not correct. Wish I had a better answer
02:35:35 2 for you.
02:35:37 3 MS. DAILEY: Okay. I need to kind of close.
02:35:40 4 I'd like to move on to --
02:35:43 5 LT GEN GREEN: Denise, can I ask a --
02:35:45 6 MS. DAILEY: Yes, sir, you all can.
02:35:47 7 LT GEN GREEN: So, we don't have anyone in
02:35:49 8 the public session this afternoon; is that
02:35:50 9 correct?
02:35:50 10 MS. DAILEY: Correct.
02:35:51 11 LT GEN GREEN: And so we do have some time
02:35:53 12 at the end?
02:35:54 13 MS. DAILEY: Correct. I have another panel
02:35:56 14 starting at 3:00, though, sir.
02:35:58 15 LT GEN GREEN: Right. I'd like to not cut
02:36:00 16 these folks short.
02:36:00 17 MS. DAILEY: Okay.
02:36:01 18 LT GEN GREEN: They've kind of waited
02:36:01 19 awhile. So, let's add another 10 or 15 minutes.
02:36:06 20 Continue, please.
02:36:11 21 MS. BASKERVILLE: Okay. I have a retired --
02:36:12 22 and I'll just give examples of certain service
02:36:15 23 members. I have a retired ASOC service member
02:36:19 24 that's in Texas -- north Texas and he's a
02:36:23 25 quadriplegic. He's on a sip-and-puff. When the

02:36:26 1 family first got to -- they live very, very
02:36:31 2 rurally, out there in the boondocks. Their case
02:36:36 3 manager from the VA would not return phone calls.
02:36:39 4 The case manager from the VA would not try to get
02:36:42 5 them authorized for bowel and bladder. This is
02:36:47 6 not what right looks like. So, that's where the
02:36:49 7 advocates came in and the people -- unfortunately,
02:36:53 8 we had to go to the top. We had to fight, we had
02:36:56 9 to argue. When is a spouse the caregiver or the
02:37:00 10 primary caregiver? The spouse was asking me, "I'm
02:37:03 11 the spouse. I shouldn't be the caregiver also
02:37:06 12 because I can't do both." So, the very seriously
02:37:09 13 injured, the quadriplegics, the ones that are not
02:37:14 14 cognizant and the spouses can't just be the wife,
02:37:18 15 they have to be the caregivers also, they're
02:37:23 16 becoming overwhelmed and lo -- this is, you know,
02:37:26 17 a year post injury, two years post injury. What
02:37:29 18 happens 10 years down the road? They're going to
02:37:31 19 be overwhelmed. They're not going to be the wife
02:37:34 20 anymore. They're going to be some very depressed
02:37:37 21 caregivers and that's what we're seeing. They --
02:37:39 22 the ones that stay together. I mean, that's a
02:37:42 23 reality, because they already -- and that's
02:37:44 24 another thing. They reach out to me because I've
02:37:47 25 established this relationship. So, when they do

02:37:49 1 have these -- I'm getting depressed, my service
02:37:51 2 member's getting depressed, they'll call and tell
02:37:53 3 me because we have an established relationship.
02:37:55 4 Well, what's -- she's asking me, "What's going to
02:37:57 5 happen five years or 10 years down the road when
02:37:59 6 I'm fighting for bowel and bladder care or
02:38:03 7 reimbursement or I can't get any help on the
02:38:07 8 weekends because that's not in the regulation
02:38:10 9 where they can fund that"; and that's a good
02:38:12 10 question that I couldn't answer. What is going to
02:38:14 11 happen 10 years from now as far as giving that
02:38:16 12 person any type of -- of help. She needed to go
02:38:20 13 somewhere for two weeks and the answer to her for
02:38:24 14 her husband was to put him in a long-term care
02:38:28 15 facility so they could -- as opposed to getting
02:38:31 16 more home health, because I guess that was the
02:38:33 17 cheaper route. I don't know. Of course, we went
02:38:35 18 a different way and we had to get money from other
02:38:38 19 resources; but I didn't know what to tell her. I
02:38:41 20 did not know what to tell her. I can get the
02:38:44 21 resources, I can get the mental health help; but
02:38:47 22 10 years from now, if things don't change, it's
02:38:50 23 not going to be a good situation and he's going to
02:38:53 24 be -- he doesn't have any other family. He's
02:38:54 25 going to be in a long-term facility and that's not

02:38:57 1 what I want to see with these heroes.
02:39:03 2 DR. PHILLIPS: Let's just continue the
02:39:05 3 discussion about SOCOM and big Army or big DoD and
02:39:11 4 the scalability or lack of scalability and you did
02:39:14 5 mention, well, you had a one to 25 ratio; but
02:39:17 6 perhaps you can share with us your thoughts. Are
02:39:19 7 there other ways of achieving that same or similar
02:39:23 8 goal of an education of the infrastructure across
02:39:27 9 the board? Is -- is it simplifying the navigation
02:39:35 10 of the system? I mean, obviously, we cannot have
02:39:39 11 one to 25 throughout the whole US; but maybe there
02:39:43 12 are alternative ways that -- if you can't think of
02:39:45 13 things now, maybe you can just catch up with us on
02:39:52 14 that.
02:40:00 15 MS. BASKERVILLE: Okay.
02:40:00 16 DR. PHILLIPS: Is there more than one way of
02:40:00 17 doing the same thing?
02:40:00 18 MS. BASKERVILLE: Well -- and I'm wondering
02:40:00 19 when somebody gets out of the service -- and, Jim,
02:40:01 20 I'm going to let you jump in if you need to. When
02:40:04 21 someone is medically retired, what is the standard
02:40:07 22 as far as contact from anybody from -- a VA
02:40:10 23 representative, from a case manager, from anybody
02:40:13 24 that's now in their retired realm? What's the
02:40:17 25 frequency that they even contact anybody that is

02:40:21 1 medically retired or seriously injured or very
02:40:24 2 seriously injured? Is it a month, is it a week?
02:40:28 3 CSM DEJONG: It seems to differ from VA to
02:40:30 4 VA. The VAs are obviously -- I'm from the state
02:40:34 5 of Indiana. The Indianapolis VA, based on your
02:40:37 6 care your case manager -- and based on your case,
02:40:40 7 they will contact you a minimum of once a month.
02:40:45 8 MS. BASKERVILLE: Maybe enforcing that
02:40:46 9 standard, because I don't see that happening
02:40:48 10 everywhere and maybe it's -- you know, from state
02:40:50 11 to state it might differ; but maybe enforcing some
02:40:54 12 of those things that are already in place. I'm a
02:40:56 13 contractor. If I don't do my job, if I don't have
02:40:59 14 good customer service, if I don't have good
02:41:01 15 feedback, I don't have my job anymore. I wish
02:41:03 16 that in some of the other agencies, if you're
02:41:08 17 substandard, you don't have customer service, that
02:41:10 18 you didn't have your job either. That's just -- I
02:41:16 19 mean, I know that's not going to happen; but that
02:41:18 20 was just the world according to Baskerville.
02:41:22 21 LCDR COLE: We -- monthly we check on our
02:41:23 22 retirees.
02:41:25 23 DR. PHILLIPS: Again, what I -- correct me
02:41:28 24 if I'm wrong. What I hear you saying is
02:41:30 25 education, training, accountability as broad

02:41:35 1 policies?
02:41:39 2 MS. BASKERVILLE: Yes.
02:41:45 3 MSGT SCHILLER: If I could answer that, sir.
02:41:46 4 What we see in the DISC realm, which is after
02:41:47 5 retiring, we are continually making the contacts
02:41:49 6 to help provide that conduit, as all the VAs have
02:41:54 7 done. They have the OEF/OIF representatives
02:41:58 8 there. There's no way that that one or two people
02:42:02 9 are going to be able to do it. Comes done to
02:42:05 10 brass tax. That's what it is, sir. The folks
02:42:08 11 that are there are wonderful. There's 24 hours in
02:42:11 12 a day and seven days in a week and those that I've
02:42:15 13 run into do everything they can; but they possibly
02:42:19 14 could not hold a five-minute conversation once a
02:42:23 15 month, if they worked 24/7 for 30 days, with
02:42:26 16 everyone that falls under their guise, which is
02:42:32 17 why the commandant of the Marine Corps saw that
02:42:38 18 there was a greater need. There was a greater
02:42:40 19 need for the Marine Corps to assist with those
02:42:43 20 separated, retired, TDRL, PDRL marines; and even
02:42:47 21 if what we were doing is working hand in hand with
02:42:49 22 that OEF/OIF coordinator, that's three minutes
02:42:54 23 more in their day that they have to service
02:42:56 24 someone, because we can also assist and begin on
02:42:59 25 the paperwork or begin to meet what the

02:43:03 1 expectations are of the wounded -- of that hero's
02:43:06 2 new normal and being able to spread that out.
02:43:10 3 However, with 30 DISCs, we could easily double our
02:43:17 4 forces out there and still not reach the level
02:43:20 5 that we would all like it to be at.
02:43:22 6 LT GEN GREEN: I have to interrupt for just
02:43:25 7 a second. So, we've had two or three people
02:43:26 8 talking about this and yet I haven't heard a
02:43:28 9 definition of who you're doing this for. Yours
02:43:32 10 says VSI/SI.
02:43:36 11 MS. BASKERVILLE: Very seriously injured and
02:43:36 12 seriously injured. Special operations command
02:43:39 13 service words.
02:43:39 14 LT GEN GREEN: So, you're talking about
02:43:41 15 catastrophically injured and then when they --
02:43:42 16 because VSI/SI is something the medics use and
02:43:46 17 typically it's used for hopefully a relatively
02:43:48 18 short time. So, do these people maintain VSI/SI
02:43:54 19 in terms of --
02:43:55 20 MS. BASKERVILLE: No, sir.
02:43:56 21 LT GEN GREEN: So, it's only while they're
02:43:58 22 VSI/SI? I mean, it's a fairly narrow range for
02:44:01 23 VSI/SI. I mean, it's something that's going to
02:44:04 24 somebody that's critically injured or in an ICU or
02:44:08 25 once they come out of the ICU or rehabilitation

02:44:09 1 phase, it's not something that's traditionally
02:44:11 2 used in terms of the -- by the medics, at least.
02:44:16 3 MSGT SCHILLER: Sir, it's based upon that
02:44:19 4 original -- original diagnosis. Just because
02:44:22 5 someone is stabilized, yet they don't have two
02:44:24 6 legs or two arms and they are no longer in
02:44:28 7 immediate -- which -- immediate danger of loss of
02:44:31 8 life, limb --
02:44:32 9 LT GEN GREEN: Which is why I was trying to
02:44:35 10 restrict it to catastrophically injured.
02:44:37 11 MSGT SCHILLER: Yes, sir.
02:44:37 12 LT GEN GREEN: I'm trying to understand how
02:44:41 13 you target --
02:44:41 14 MSGT MACKENZIE: What we found very quickly,
02:44:43 15 sir, is that the target set up by the medical
02:44:46 16 community of VSI and SI became a very easy
02:44:49 17 identifier for the length of care that a patient
02:44:51 18 was going to need in following up with that
02:44:54 19 advocate role and that's why the terminology
02:44:58 20 remains the same; but it doesn't -- we don't use
02:45:00 21 the terminology like the medical folks do that
02:45:02 22 puts that patient in a category which let's us
02:45:04 23 know --
02:45:05 24 LT GEN GREEN: So, I talked to a triple
02:45:06 25 amputee at Walter Reed the other day that probably

02:45:09 1 walked as well as I did and I was very -- I mean,
02:45:12 2 incredible in terms of how he had come back and
02:45:15 3 wonderful for him and I was very pleased to see
02:45:18 4 it; but he would fall into your program.
02:45:20 5 MR. BURBACH: Yes, sir. It's more equated
02:45:21 6 to the time of treatment that's involved
02:45:23 7 necessary, not the criteria of an evacuation
02:45:26 8 category. So, VSI, SI and individuals that get
02:45:29 9 evacuated via nonstandard ways. Combat issue,
02:45:33 10 thorn in the side, got infected, evacuated, went
02:45:36 11 back with his unit, not medevaced or medically
02:45:40 12 evacuated, they all fall underneath us. So, this
02:45:43 13 is just a category of precedence for evacuation
02:45:45 14 back to CONUS or AS -- from ASEV. We follow these
02:45:48 15 individuals for life.
02:45:49 16 LT GEN GREEN: And you -- okay. And I
02:45:52 17 appreciate that. Following them for life is a
02:45:54 18 different issue. What I'm kind of trying to get
02:45:57 19 at is the home visits and the ability to intervene
02:45:59 20 and use alternate care after they've separated
02:46:03 21 requires you to kind of target people who are
02:46:06 22 get -- who you think are going to have ongoing
02:46:08 23 problems and that's -- I'm trying to get at how do
02:46:11 24 you target those people that you think are going
02:46:13 25 to have ongoing problems. Your TDRL is actually a

02:46:17 1 very different entity, which is an interesting
02:46:21 2 marine only right now I've heard; but some of the
02:46:23 3 things you're doing I'm kind of going, okay, how
02:46:25 4 do you make decisions on who do you case manage at
02:46:27 5 that level?
02:46:28 6 MR. BURBACH: It's -- I've only been on
02:46:31 7 station for four months. Just retired recently, 1
02:46:33 8 October, as first sergeant; and it's a tiered
02:46:35 9 approach. With the advocates at Tampa, they make
02:46:37 10 a hundred percent contact with every individual
02:46:39 11 that comes through, whether it's -- so, it's based
02:46:42 12 on a time hack per se. Hundred percent contact.
02:46:45 13 Whether it's monthly -- in my case I do the daily,
02:46:48 14 hourly, whatever. Meet them at the plane, bring
02:46:51 15 them in. So, it's based upon a time hack. The
02:46:53 16 advocate at Tampa determines that the individual
02:46:55 17 now is self-sufficient, no issues, you know, they
02:46:58 18 call every day or once a year.
02:47:00 19 LT GEN GREEN: And see I'm not having any
02:47:02 20 problem with what you do. I love the system, Mac.
02:47:05 21 I've seen it work firsthand; but the examples that
02:47:07 22 you're using infer that same kind of coverage and
02:47:11 23 now you're saying lifelong and that's fine; but
02:47:14 24 obviously beyond separation and so for someone
02:47:18 25 who -- in the case you brought up I think with the

02:47:21 1 triple amputee, he's probably still on active
02:47:23 2 duty. Probably has not gone through the
02:47:26 3 disability system.
02:47:27 4 MR. BURBACH: Okay, sir.
02:47:28 5 LT GEN GREEN: But if he had gone through
02:47:29 6 the disability system -- because we're now back
02:47:31 7 over to you guys. So, somebody who has a double
02:47:33 8 or triple amputee, gone through the disability
02:47:35 9 system, is out functioning in the community,
02:47:37 10 you're following up with those folks once a month?
02:47:44 11 MSGT SCHILLER: Yes, sir. We're following
02:47:45 12 up -- we're reaching out, making the initial
02:47:46 13 contact, addressing any needs and then if after --
02:47:49 14 if initial contact is I'm fine, we would still put
02:47:52 15 them in a tickler and contact them 90 days later.
02:47:56 16 If it still remains to be that, we would put them
02:47:59 17 in an inactive state.
02:48:01 18 LT GEN GREEN: But you're ending at 90 days
02:48:04 19 if they basically go out and you don't contact
02:48:06 20 them after that?
02:48:06 21 MS. BASKERVILLE: And ours is based on need,
02:48:08 22 sir.
02:48:08 23 MSGT SCHILLER: Correct, sir.
02:48:09 24 MS. BASKERVILLE: It's based on need.
02:48:10 25 LT GEN GREEN: Okay. So, I think it's time

02:48:11 1 to go to the RRC because you've kind of wrapped
02:48:14 2 this all together. So, why don't we hear from you
02:48:17 3 guys in terms of how you see it. Go ahead.
02:48:23 4 DR. RAMOS: I was just going to comment.
02:48:24 5 It's a little bit like a R&T developing. You know
02:48:27 6 it when you see it. And with a triple amputee you
02:48:30 7 know that into perpetuity that retired service
02:48:36 8 member is going to need to be in active
02:48:40 9 interaction with either the VA or a prosthetic
02:48:44 10 center because they're going to need maintenance
02:48:46 11 for the residual -- they're going to need care for
02:48:49 12 their residual limbs, they're going to need
02:48:52 13 maintenance for their prosthetics, they're going
02:48:54 14 to need new prostheses as they change in functions
02:48:57 15 and as they age and, you know, on into the night.
02:49:00 16 So, I think the question as far as our program
02:49:05 17 goes which is how long -- how will you know it
02:49:06 18 when you see it or how long do you stay with them
02:49:09 19 has a lot to do with knowing that person
02:49:12 20 intimately and what kind of resources are -- do
02:49:16 21 you project, as a professional, they're going to
02:49:19 22 need into the future and so with a patient with a
02:49:22 23 TBI, we'll have to watch them for dementia or a
02:49:27 24 patient with PTSD we're going to have to figure
02:49:30 25 out school and -- you know, you kind of know it

02:49:33 1 when you see it and you can kind of sense when
02:49:36 2 they're ready to go on their own; but you always
02:49:39 3 hold it back. That they can get a hold of you
02:49:42 4 anytime they want to. Even if you're not
02:49:44 5 contacting them, they can contact you, which is
02:49:47 6 kind of key to the way we usually close an acute
02:49:53 7 relationship with a patient.
02:49:57 8 MSGT SCHILLER: As -- and one final thought
02:49:58 9 on that, sir. If you recall, the Marine Corps'
02:50:01 10 DISC end state is to provide all those things
02:50:04 11 initially, as well as periodically, as they
02:50:07 12 request. In the meantime, educating them and
02:50:12 13 allowing them to be their own self-advocate; and
02:50:16 14 that's truly -- that's truly our end state. Can
02:50:19 15 that be done with all? No, many won't have that
02:50:22 16 capacity; but -- so, those that are
02:50:25 17 self-advocating would become inactive on our
02:50:29 18 rolls.
02:50:30 19 LT GEN GREEN: So, back to the SOCOM. So,
02:50:32 20 at some point where they become their own
02:50:35 21 self-advocate, then you put them into an annual
02:50:37 22 follow-up or where you touch base periodically?
02:50:37 23 MSGT SCHILLER: No.
02:50:44 24 LT GEN GREEN: So, the self-advocacy becomes
02:50:46 25 the real key here? That's what I'm looking for,

02:50:49 1 is how do you differentiate. I think we're
02:50:51 2 getting well beyond our time. I don't want to
02:50:53 3 leave out the FRCs. Mary, do you want to take
02:50:55 4 that one quickly, if you can.
02:50:58 5 DR. RAMOS: Sure. I can talk about the FRC
02:51:01 6 program fairly briefly because you probably have a
02:51:03 7 good knowledge of it. My name, as everyone
02:51:07 8 probably knows by this time, is Mary Ramos. I've
02:51:10 9 been a federal recovery coordinator since June of
02:51:13 10 2008. So, about three and a half years. I came
02:51:15 11 in five months after the beginning of the program.
02:51:18 12 Next slide.
02:51:21 13 Everybody knows in this room the federal
02:51:23 14 recovery coordination program was developed at the
02:51:25 15 recommendation of the Dole-Shalala commission
02:51:29 16 during the summer of 2007. The program became
02:51:32 17 active in January of 2008 and we facilitate care
02:51:36 18 and transitions for the most seriously wounded,
02:51:39 19 ill and injured based upon federal recovery plans
02:51:44 20 that we formulate with the service member and/or
02:51:47 21 the family, in partnership. Next slide.
02:51:51 22 The potential clients are referred to the
02:51:54 23 program from many sources. I can certainly answer
02:51:57 24 questions about that, if you have them; and our
02:52:00 25 referral numbers are steadily rising over time

02:52:02 1 from a mean of 28 per month now to a mean of
02:52:06 2 almost 50 per month. If they're -- patients are
02:52:09 3 referred directly to the local FRCs, we will
02:52:13 4 interview them, talk to the families, discuss it
02:52:18 5 with our supervisory personnel and we'll either
02:52:20 6 redirect them to their current care team or we
02:52:24 7 will activate them into our program if they agree
02:52:26 8 that they want to be activated into the program.
02:52:30 9 To answer one of the questions that came up
02:52:32 10 fairly recently or fairly frequently this morning,
02:52:37 11 we usually talk to the family together. Make it
02:52:42 12 very clear that our care is based on the family as
02:52:47 13 a unit. I added a patient yesterday who is a new
02:52:52 14 triple amputee. I talked to his wife and didn't
02:52:55 15 bother him because he's sick in the ICU. So, I
02:52:58 16 initiated the FRC program for this patient and his
02:53:01 17 wife. She is 30 weeks pregnant, will need to be
02:53:07 18 set up with OB care. You know, looking at the
02:53:09 19 entire family. And I will talk to the actual
02:53:12 20 service member later, assuming that he will want
02:53:16 21 to be participating in care; but we make it very
02:53:19 22 clear very early that families and service members
02:53:23 23 are a unit to us and that -- we talk to the
02:53:28 24 service members at some length about getting
02:53:30 25 permission and understanding that talking to the

02:53:33 1 spouse or the parent will give us a new
02:53:36 2 perspective on exactly what they need and it will
02:53:39 3 enrich our ability to care for them. So, that's
02:53:42 4 what we do for that.
02:53:44 5 MR. DRACH: Excuse me. What's your total
02:53:47 6 client population? How many?
02:53:49 7 DR. RAMOS: Our total client population at
02:53:51 8 this time -- there we go. 785 active clients at
02:53:58 9 this point in time. 431 of those are active duty.
02:54:02 10 354 are veterans. We continually run about 55/45
02:54:08 11 veteran to active duty in our population. Right
02:54:12 12 now there are 63 in evaluate status. For me -- if
02:54:17 13 you ask specifically for me, I have 56. This was
02:54:20 14 Monday. It's no longer true. I now have 58. I
02:54:25 15 had 56 patients on Monday. 31 were active duty,
02:54:28 16 25 were veteran. I inactivated one client on
02:54:34 17 Tuesday who -- SOCOM, who wanted to go back to
02:54:37 18 active duty and he did. So, I inactivated him;
02:54:42 19 but then I added three more patients. One veteran
02:54:45 20 and two active duty. So, I run in the high 50s.
02:54:48 21 The mean for an FRC is about 35. We really don't
02:54:57 22 know what our optimal case load is right now.
02:55:00 23 We're working with an acuity tool to see how much
02:55:03 24 time there is in a day, how many days in a week;
02:55:06 25 but the demand for our services is so acute right

02:55:10 1 now, all of us are working as hard as we can to
02:55:13 2 give optimal service to as many as we can.
02:55:16 3 Luckily there are other partners who are helping
02:55:19 4 to take care of many of these patients and we're
02:55:21 5 in a matrix of Marines, Navy, Army and everybody
02:55:25 6 to help us so that we can sit back and watch Jane
02:55:30 7 do a wonderful job with our mutual client, because
02:55:33 8 I can see what's going on and I want her and don't
02:55:39 9 send her enough e-mails telling her that; and I
02:55:43 10 feel like my function is to assure that everything
02:55:47 11 will get done and make sure it gets done, but not
02:55:50 12 necessarily having to do everything myself, which
02:55:52 13 is fairly important when you have a fairly high
02:55:56 14 case load. If you could go to the next slide.
02:56:02 15 This is where we set. There are currently
02:56:04 16 only 23 of us in the country. Two are in hiring
02:56:07 17 actions right now. We have -- in the past have
02:56:12 18 had five at BAMC, which was very -- very nice. We
02:56:15 19 now have four and we're going to be replacing the
02:57:28 20 FRC who was at Navy Safe Harbor and we have a new
02:57:28 21 one at SOCOM who's working through all the
02:57:28 22 security issues and computer systems.
02:57:28 23 LT GEN GREEN: Let me interrupt you, Mary.
02:57:28 24 Just -- I have one final question and I'll see if
02:57:28 25 the panel has any and we'll try to get back closer

02:57:28 1 to being on time.
02:57:28 2 DR. RAMOS: Perfect.
02:57:28 3 LT GEN GREEN: And my question is how do you
02:57:28 4 work deconfliction between the various programs,
02:57:28 5 because clearly you're all involved with some of
02:57:28 6 the same casualties? Obviously, some service --
02:57:28 7 SOCOM issues; but even there, SOCOM with the
02:57:28 8 marine. Deconflicting in terms of who owns what
02:57:29 9 at the time? How do you deconflict?
02:57:29 10 DR. RAMOS: Well, personally, I haven't
02:57:29 11 found any conflict. I have not been looking for
02:57:29 12 conflict. We have made it -- I have enough
02:57:29 13 conflict in my life. I go to Brian and say I have
02:57:29 14 enough conflict, what are we doing. I really --
02:57:29 15 and Brian can speak to this. I think from the
02:57:29 16 first day I started as a recovery coordinator I
02:57:29 17 saw it as my job to focus only on the wounded, ill
02:57:29 18 and injured and make it my business to learn what
02:57:29 19 the Marines do, what the Navy does. I think that
02:57:30 20 all of us have tried to build very strong
02:57:31 21 partnerships with everybody so that we didn't
02:57:35 22 worry about who had responsibility for what.
02:57:38 23 There are certain natural divisions in that the
02:57:41 24 federal recovery coordinators are all master's
02:57:44 25 prepared health care professionals and I probably

02:57:48 1 have a little more expertise in some of the
02:57:51 2 physiological stuff than Brian does; but if it
02:57:54 3 comes to, you know, knowing anything about the
02:57:56 4 Marines, I don't even presume to know anything
02:57:59 5 about the Marines and we work together, hand in
02:58:04 6 glove, and try to figure out, okay, what's going
02:58:07 7 on. If we've got -- if I've got a mutual client
02:58:09 8 with Nacho and I have an Army issue, I was never
02:58:13 9 active duty. You know, how am I going to get this
02:58:16 10 Purple Heart, how are we going to work about the
02:58:19 11 Army board of correction, how are we going to do
02:58:21 12 this with the JAG office. So, a lot of it is
02:58:27 13 assessing what exists for this particular client
02:58:30 14 and who is the best person to address that and how
02:58:33 15 can we communicate optimally so that nobody's
02:58:37 16 feelings get hurt, nobody's feeling territorial
02:58:40 17 and all of the needs get met, which is what I kind
02:58:43 18 of see is my ultimate function, is making sure
02:58:46 19 that whoever does it, it gets done.
02:58:50 20 MSGT SCHILLER: And most importantly, along
02:58:52 21 with that, originally when the FRC program came
02:58:55 22 into place, they were -- the FRCs themselves were
02:58:58 23 very knowledgeable, ready, willing and able and us
02:59:00 24 on the street or those in the MTFs were unaware
02:59:03 25 that they were coming in and then we were told

02:59:06 1 that our -- by our patients that they were
02:59:09 2 contacted by an FRC and then they were a little
02:59:12 3 confused as to where the team all came into play
02:59:15 4 and that was able to be ironed out very, very
02:59:18 5 quickly and with those understandings it is just
02:59:20 6 an extension of a team, be it from the Marine
02:59:24 7 Corps, Air Force, the Navy or any of the other
02:59:25 8 services. We're all fighting the same fight and
02:59:28 9 we're all moving in the same direction.
02:59:30 10 LT GEN GREEN: So, Mr. Garcia, you're kind
02:59:33 11 of at the tail end of this thing.
02:59:35 12 DR. RAMOS: Poor Nacho.
02:59:37 13 LT GEN GREEN: Is there anything that you
02:59:39 14 want to add or talk about?
02:59:40 15 MR. GARCIA: Sir, the key thing I would like
02:59:41 16 to add is the partnership that we have with all
02:59:41 17 these folks that are available out there and as
02:59:45 18 long as we maintain communication and I think that
02:59:48 19 becomes a very effective tool in utilizing the
02:59:51 20 resources to assist the soldier. That's become a
02:59:59 21 very effective tool. As long as we maintain the
03:00:02 22 communication and we work hand in hand for the
03:00:04 23 betterment of the soldier and the family member.
03:00:07 24 I've been working as an advocate since November of
03:00:10 25 '06. I'm a retired Army veteran. I currently

03:00:13 1 have one son who's in Afghanistan and he's on his
03:00:17 2 third tour. He's been wounded in 2004, but he's
03:00:21 3 really progressing really well. So, I'm going to
03:00:24 4 get a chance to see him again in December.
03:00:27 5 LT GEN GREEN: So, to the Washington Posts
03:00:29 6 of the world who say we have so many care
03:00:32 7 coordinators and case managers and they need
03:00:34 8 another person to just manage all the case
03:00:36 9 managers, you would say?
03:00:42 10 MR. GARCIA: I'm non-medical. My job is as
03:00:46 11 a non-medical advocate for the service members and
03:00:48 12 the families and -- in comparison to Mary and
03:00:51 13 everyone else. She's more in the clinician field
03:00:54 14 than I am.
03:00:55 15 LCDR COLE: I --
03:00:55 16 LT GEN GREEN: And each of you -- go ahead.
03:00:57 17 LCDR COLE: I'm sorry, sir. I can answer
03:00:59 18 that. I thought -- I've heard that many, many a
03:01:01 19 time, sir; and when you have a service member that
03:01:04 20 is -- they're doing all right and then all of a
03:01:09 21 sudden they're getting very sick and maybe passing
03:01:12 22 or they're very ill, then it takes -- I'm
03:01:14 23 non-medical even though I'm a nurse. So, you're
03:01:17 24 talking about the non-medical, which is finances.
03:01:19 25 Finances for a family. Then I have the VA, Mary.

03:01:23 1 I don't really -- VA. I don't understand VA. I
03:01:26 2 don't have a VA computer and there's where Mary
03:01:30 3 steps in and then I have a medical case manager
03:01:33 4 that is working on the medical side. So, when you
03:01:36 5 are actually a team player and you're working this
03:01:39 6 team together, it fits very smoothly. Like a
03:01:42 7 puzzle, sir.
03:01:46 8 DR. RAMOS: May I just give one example?
03:01:48 9 You had asked as a last question how does the DoD
03:01:52 10 contribute after the DD-214 and I have a great
03:01:56 11 example. I've been gifted with being able to work
03:01:59 12 with the burn patients at -- at BAMC and we are
03:02:03 13 finding now that there were several people who
03:02:06 14 were severely burned in 2004, 2005, 2006 who have
03:02:12 15 been retired and are doing well; but now they're
03:02:15 16 coming to a spot where they are developing
03:02:18 17 contractures in their fingers or their eyes are
03:02:22 18 not doing as well as they could because of the
03:02:25 19 skin around the eyes or they need -- some scar
03:02:27 20 problem needs to be fixed; and they have started
03:02:29 21 approaching Dr. Renz, who told them they -- the
03:02:32 22 head of the ISR, the burn unit -- once you're my
03:02:35 23 patient, you're always my patient. So, they have
03:02:37 24 called back to Dr. Renz and said, "I would like to
03:02:40 25 come back and have you evaluate my eye because I

03:02:44 1 can't see because my eyelid's turning in"; and a
03:02:50 2 social worker on burn, a utilization manager, AW2,
03:02:55 3 all of us have come together and said how do we
03:02:58 4 make this work? How do we go to the VA and get
03:03:01 5 them to pay transportation for the patient to come
03:03:04 6 down, we get Tricare to pay for the surgery and we
03:03:07 7 get everything to work with Fisher House and
03:03:10 8 everything else, because we're a team and we're
03:03:12 9 all focused on that patient. And I think that
03:03:16 10 there are bumps in the road. We have times when
03:03:18 11 we're not communicating properly, but that's never
03:03:21 12 the fault of the service member. It's always us
03:03:25 13 individuals who are either overlooking
03:03:27 14 communications or we're just not doing the best
03:03:31 15 job we could and we fix that and it all works for
03:03:35 16 the patient, because that's who we love.
03:03:40 17 MR. GARCIA: And, sir, one thing I would
03:03:41 18 like to add. My interpretation of team is
03:03:43 19 everyone accomplish the mission and that's what
03:03:45 20 it's all about.
03:03:46 21 LT COL KEANE: Dr. Ramos, I have a question.
03:03:48 22 How are you?
03:03:49 23 DR. RAMOS: I'm fine, thanks. How are you?
03:03:52 24 LT COL KEANE: Good. Not until today did I
03:03:53 25 realize that there was a VA polytrauma care

03:03:56 1 program. How does the FRC program -- what does
03:03:56 2 the FRC program do that the poly --
03:03:59 3 DR. RAMOS: The polytrauma case managers?
03:03:59 4 LT COL KEANE: Yes.
03:04:02 5 DR. RAMOS: The polytrauma case managers are
03:04:03 6 attached to the polytrauma centers in the VA. One
03:04:06 7 of the five of them. And when the patients are
03:04:10 8 inpatient in the -- in the polytrauma center or
03:04:15 9 located within the area seeking care at that VA,
03:04:18 10 they have a polytrauma case manager. If they're
03:04:23 11 not in the polytrauma center, they have an OEF/OIF
03:04:26 12 case manager. So, we co-manage the patients
03:04:29 13 either with the polytrauma case manager or the
03:04:33 14 OEF/OIF case manager, however we need to do that.
03:04:36 15 The patients will sometimes ask me a question
03:04:38 16 like, "I've asked about my wheelchair 17 times and
03:04:42 17 I can't get an answer." So, I e-mail the case
03:04:44 18 manager, say, "What's the deal, how can I help";
03:04:46 19 and they give me a couple of phone calls to make
03:04:49 20 and I make it and it's -- we co-manage the
03:04:53 21 patient. It takes a village. And the polytrauma
03:04:58 22 case managers and the OEF case managers are
03:05:02 23 wonderful partners. They have a lot of patients,
03:05:06 24 but they're wonderful partners.
03:05:07 25 LT GEN GREEN: Okay. Ladies and gentlemen,

03:05:08 1 we've kept you for an additional 20 minutes. We
03:05:11 2 thank you for you patience in your working. Your
03:05:14 3 passion comes through loud and clear and we
03:05:16 4 appreciate what you're doing for these folks. Our
03:05:18 5 job is to try and help codify some of the
03:05:20 6 wonderful things you're doing so that everybody
03:05:23 7 else can find ways to do it similarly. And so we
03:05:26 8 will let you go and take about 10 minutes to get
03:05:28 9 the new panel stood up and so we'll reconvene at
03:05:31 10 3:15. Thank you, everybody.
03:05:37 11 (Recess taken between 3:05 and 3:15.)
03:15:28 12 LT GEN GREEN: We're getting closer. Be
03:15:31 13 patient. I'm sorry. I was personally responsible
03:15:33 14 for making you folks start a little late and I do
03:15:36 15 apologize. Okay. I think we can go ahead and get
03:15:50 16 started and let you folks go. This is a panel on
03:15:53 17 VA IDES support. So, we have three members with
03:15:59 18 us. Okay. We have Ms. Ramirez, Mr. Santos and
03:16:03 19 Ms. Long and I'm going to let you folks introduce
03:16:06 20 yourself in terms of your background and I don't
03:16:08 21 know who wants to go first; but I'll let you folks
03:16:11 22 kind of -- is there something in the slides saying
03:16:13 23 who's going to go first or --
03:16:16 24 MS. RAMIREZ: I think we actually do.
03:16:20 25 What's -- a couple of slides, but my name is

03:16:23 1 Marcie Ramirez. I'm one of the military service
03:16:27 2 coordinators assigned to SAMMC, but I'm
03:16:29 3 specifically assigned to the Center for the
03:16:34 4 Intrepid. I'm the one MSC locally. The rest of
03:16:34 5 us are co-located at SAMMC with WHMC. My
03:16:38 6 background is prior to Air Force I've been with
03:16:41 7 the VA for 22 years and an MSC for two years and
03:16:46 8 six months, I think. We all started at the same
03:16:49 9 time.
03:16:51 10 MR. SANTOS: Sir, my name is Rick Santos and
03:16:53 11 I'm also a military service coordinator. I work
03:16:57 12 out at Wilford Hall. We just stood up the Air
03:17:01 13 Force there about six months ago or so. My
03:17:04 14 background is retired Navy about five years ago.
03:17:06 15 So, I've got 20 years in myself. I understand the
03:17:10 16 veteran perspective. Been within the VA about
03:17:14 17 four years in various roles. So, I kind of have
03:17:17 18 an idea of how the whole claim process works and
03:17:21 19 transition into the military service coordinator
03:17:24 20 role was pretty smooth. So, that's my background.
03:17:28 21 MS. LONG: Sir, my name is Jennifer Long and
03:17:31 22 like the rest of my colleagues, I'm a military
03:17:34 23 service coordinator. I am a retired Army medic.
03:17:38 24 After my retirement I actually worked for a couple
03:17:41 25 of years for an ombudsman with the wounded warrior

03:17:44 1 hotline. So, I really understand what's going on.
03:17:47 2 I'm out at SAMMC as well, with four other MSCs;
03:17:52 3 and, you know, we're just trying to improve IDES
03:17:56 4 every day.
03:17:57 5 LT GEN GREEN: Okay. And please go ahead
03:17:58 6 and brief.
03:18:00 7 MS. RAMIREZ: Well, our role as MSCs is to
03:18:04 8 guide our military service members that are going
03:18:06 9 through a medical evaluation board and just make
03:18:10 10 their way through this VA process as well, since
03:18:12 11 we're a joint assignment, with one -- one
03:18:16 12 examination and one VA decision. A comprehensive
03:18:21 13 rating decision for both entities. We talk about
03:18:26 14 every single aspect of the VA. A little bit
03:18:32 15 further background. Myself, I've been out at Fort
03:18:35 16 Sam at the Center for the Intrepid since it
03:18:40 17 opened. So, I have been there four years already,
03:18:42 18 but integrated within the WTU system. They know
03:18:45 19 about the VA because we are integrated with the
03:18:49 20 WTU. They have in-processing briefings for all
03:18:52 21 incoming warriors weekly. Every Tuesday we will
03:18:56 22 go to a designated conference room and we brief
03:18:59 23 these new incoming warriors about the VA while
03:19:02 24 we're at that installation. How we can assist
03:19:06 25 them with any process throughout their stay there.

03:19:09 1 It's one of those first we reach out and touch you
03:19:12 2 and let you know. We're not here to interfere
03:19:14 3 with your treatment, we're here to just inform you
03:19:17 4 of what we do. If there are certain benefits that
03:19:20 5 they want to apply for, we can help facilitate
03:19:22 6 that request. Certain members -- you know,
03:19:24 7 throughout this discussion I've heard about
03:19:26 8 whether or not they want to go to school or maybe
03:19:28 9 they want to buy a home. We facilitate those.
03:19:32 10 You've asked how early on can they start applying
03:19:35 11 for benefits. At a certain point, typically six
03:19:40 12 months prior to a known separation. That's kind
03:19:42 13 of standard, if you're going to come out of the
03:19:46 14 military; but with specific service members who
03:19:50 15 have been categorized as seriously ill and
03:19:54 16 injured, we kind of touch them way early on in
03:19:57 17 their care process. Once they get to a certain
03:20:00 18 point where they want to get more information
03:20:00 19 about that, we will guide them to the appropriate
03:20:03 20 personnel that are there at the Center for the
03:20:06 21 Intrepid for education benefits and they might go
03:20:09 22 ahead and start an evaluation process and most
03:20:11 23 likely start a program if they have approval from
03:20:14 24 their department, whether or not it's -- you know,
03:20:18 25 whichever branch of service they belong to. If

03:20:20 1 they give them approval to go ahead and start some
03:20:23 2 kind of class or course work, then the VA will be
03:20:25 3 there to help facilitate that aspect. So, it's
03:20:29 4 not just six months. Sometimes they're in a
03:20:32 5 program a year prior to them getting out.
03:20:35 6 Previous speaker, Mr. Jon Arnold, has been
03:20:38 7 one of our clients and he started going to school
03:20:41 8 a year prior to his release from active duty, from
03:20:44 9 his retirement. So, we're embedded there. We do
03:20:47 10 tons of briefings. So, it's not like we only
03:20:49 11 visit with them when they start the med board
03:20:53 12 process. I'm actually there years before they
03:20:56 13 even get to that point. So, they have information
03:20:58 14 to them. We also do TAP briefings every month for
03:21:03 15 them. So, there's more in depth information
03:21:06 16 that's given to them at different stages of their
03:21:10 17 stay. So, once they get into the IDES program,
03:21:16 18 we're going to guide them through that whole
03:21:18 19 process.
03:21:19 20 The single disability exam, the
03:21:25 21 comprehensive rating and the payments of VA
03:21:29 22 benefits within 30 days after member separation
03:21:31 23 from service, that's all part of our process.
03:21:40 24 Currently -- this is our active case load as of I
03:21:43 25 think Monday.

03:21:47 1 MS. LONG: Yes.
03:21:48 2 MS. RAMIREZ: With all our members here at
03:21:52 3 SAMMC -- the six located here at SAMMC. Myself, I
03:21:58 4 have an active case load of 188; but I also
03:22:02 5 specifically handle the seriously ill and injured,
03:22:05 6 the amputee population along with the SOCOM
03:22:08 7 population. We have a lot of special forces that
03:22:10 8 are injured and there for treatment. I am that
03:22:13 9 designated military service coordinator. I handle
03:22:16 10 their med board process if they're going to go
03:22:20 11 through the med process here at SAMMC. So, they
03:22:21 12 have one specific person to go to. I see them
03:22:21 13 there, they have their treatment there. I see
03:22:26 14 them daily. I'm located on the third floor of the
03:22:28 15 Center for the Intrepid where they have their
03:22:31 16 physical therapy. So, they see me a lot. It's
03:22:34 17 not like they see me once a month. I see them on
03:22:37 18 a daily basis. So, they're familiar with me and
03:22:39 19 they know who to go to for any VA questions. So,
03:22:43 20 my population is a little bit higher just because
03:22:46 21 we have that -- that scope of clientele there at
03:22:50 22 that facility. And this is our case load for our
03:22:54 23 MSCs that are located at Wilford Hall, which just
03:22:59 24 stood up I believe in June.
03:23:02 25 MR. SANTOS: May.

03:23:05 1 MS. RAMIREZ: May. We all started basically
03:23:08 2 at the same time. Two years, six months
03:23:10 3 experience with our newest MSC -- Ms. Cole has
03:23:14 4 been onboard for five months and Mr. Santos here
03:23:18 5 has been onboard for eight months and Ms.
03:23:22 6 Blackburn for four. We just talked about all
03:23:31 7 that.
03:23:32 8 MR. SANTOS: Next one.
03:23:41 9 MS. RAMIREZ: The two VA military service
03:23:43 10 coordinators assigned in April were Mr. Santos and
03:23:47 11 we had a different employee who helped out and
03:23:50 12 then was replaced by Ms. Blackburn; but so far
03:23:54 13 they've processed 14 claims completely, to date,
03:23:56 14 and that's just at the Wilford Hall location.
03:24:04 15 Okay. Our overall process actions. Medical
03:24:09 16 provider refers service members to the medical
03:24:10 17 board, which then in turn that information is
03:24:12 18 given to the PEBLO for them to gather all the
03:24:15 19 medical information and put all their packet
03:24:18 20 together to transfer all the paperwork to the VA
03:24:21 21 representative, the MSC themselves. Where we will
03:24:26 22 in turn review all of their service medical
03:24:28 23 records and attain any additional claims they
03:24:32 24 might want to claim and we will call that service
03:24:33 25 member in for an additional interview to discuss

03:24:36 1 all of the different conditions that we have seen
03:24:38 2 so far and if there's anything else that they're
03:24:41 3 wanting to claim. We'll completely finish
03:24:44 4 processing the paperwork and go ahead and schedule
03:24:47 5 their medical appointments at our military -- at
03:24:51 6 our medical facility. When we put in a request,
03:24:54 7 usually we have our appointment dates the
03:24:57 8 following day. It's picked up a lot lately.
03:25:00 9 There's been a lot of administrative change, more
03:25:03 10 staffing at the hospital to help facilitate the
03:25:08 11 process for making these appointments for the
03:25:09 12 service members. It's not a long delay any more.
03:25:24 13 We have a requirement of --
03:25:26 14 LT GEN GREEN: Can I interrupt and ask a
03:25:28 15 question. We're back. The -- has there been any
03:25:36 16 change in the VA disability exam as you went to a
03:25:38 17 single physical? Is it the same exam that it was
03:25:42 18 prior to the decision back in '07 to go to a
03:25:46 19 single exam?
03:25:48 20 MS. RAMIREZ: As far as I'm aware, there's
03:25:50 21 been no change.
03:25:51 22 LT GEN GREEN: And so this -- can you
03:25:52 23 describe what the VA physical is? And so you say
03:25:56 24 in the forms that you presented that it's
03:25:58 25 basically things they were referred for and things

03:26:03 1 that are claimed?
03:26:04 2 MS. RAMIREZ: Correct.
03:26:05 3 LT GEN GREEN: So, is there -- so, after the
03:26:05 4 DoD submits their paperwork, then the patient also
03:26:09 5 fills out the things that they feel may be of
03:26:11 6 interest and then the exam is done by the VA
03:26:15 7 physician; is that correct?
03:26:15 8 MS. RAMIREZ: Yes, sir.
03:26:19 9 LT GEN GREEN: And yet I hear through the
03:26:21 10 different medical systems that there's a lot of
03:26:23 11 back and forth going on in terms of someone who
03:26:26 12 goes for a VA exam with a now referred record as
03:26:29 13 well as the entire record and the patient's
03:26:31 14 history and then that there are activities that
03:26:35 15 drive it back to the service to get more
03:26:39 16 information. Is that accurate, in your
03:26:42 17 experience? I'm just trying to get a sense of the
03:26:45 18 folks who work within this system. Do you see it
03:26:47 19 go over and then come back for more workup by
03:26:50 20 the -- I'll say Army just because you're working
03:26:53 21 here and been here at Brooke Army, now SAMMC. Do
03:26:58 22 you see it come back and forth where they'll do an
03:27:00 23 eval and say they need more information on this
03:27:03 24 and then it comes back and the service will
03:27:05 25 actually do more evaluation?

03:27:07 1 MS. LONG: Sir, the only time that we really
03:27:11 2 see it come back and forth is if the DoD actually
03:27:14 3 adds an additional concur condition. There was
03:27:18 4 something that happened or occurred with the
03:27:20 5 service member that now the DoD feels is medically
03:27:23 6 unacceptable, then they will send it back to us
03:27:26 7 for an additional exam; but in our experience
03:27:28 8 there's never been a true back and forth.
03:27:31 9 LT GEN GREEN: Okay. And so in your
03:27:33 10 experience down here, then, there's just a single
03:27:36 11 exam that establishes disability with the
03:27:38 12 information that's in the record presented by the
03:27:40 13 patient and that's what's presented back to DoD?
03:27:44 14 MS. LONG: Yes, sir.
03:27:45 15 MS. RAMIREZ: Correct.
03:27:46 16 LT GEN GREEN: That's a little different
03:27:47 17 than I'm being told, but that's fine.
03:27:49 18 MS. LONG: When you say a single exam --
03:27:51 19 when we say single exam, we mean that we request
03:27:54 20 one exam; but there are multiple exams in -- under
03:27:57 21 that examination. It's more than just a general
03:28:01 22 med. You know, if they have a neuro psycho eval
03:28:03 23 or joints or anything, there are specific
03:28:06 24 examinations that's done; but it's completed as
03:28:09 25 one exam.

03:28:09 1 LT GEN GREEN: And are those exams then done
03:28:12 2 by the VA? All the sub exams, all the --
03:28:15 3 MS. RAMIREZ: Yes, sir.
03:28:16 4 LT GEN GREEN: -- specialty exams?
03:28:17 5 MS. RAMIREZ: Yes, sir.
03:28:18 6 LT GEN GREEN: And so they're all done by
03:28:20 7 different specialists within the VA and the length
03:28:22 8 of time to complete an exam, at least in the IDES
03:28:26 9 program, is listed as 75 days. Is the reason for
03:28:29 10 taking 75 days because of all the subspecialty
03:28:33 11 evaluations?
03:28:34 12 MS. RAMIREZ: No, sir, it's not that any
03:28:35 13 longer. Not at our facility. Our facility --
03:28:38 14 MS. DAILEY: Please talk into the --
03:28:41 15 MS. RAMIREZ: We did have a delay in the
03:28:43 16 reports -- our scheduling of exams back in the
03:28:46 17 past. Not so much anymore. Like I said, they
03:28:48 18 hired personnel, added more doctors, were able to
03:28:51 19 open more appointments for a quicker turnaround
03:28:54 20 time. So, if we put in an exam request today,
03:28:58 21 I'll have the appointment scheduled tomorrow and
03:29:00 22 the service member might have the appointment
03:29:02 23 scheduled for next week. Some as early as two
03:29:05 24 days from now. It just depends what type of exams
03:29:08 25 are required. If they have some kind -- everybody

03:29:11 1 gets a general medical examination. If they have
03:29:14 2 any type of mental health issue, they're going to
03:29:16 3 get a mental health examination. Any type of
03:29:19 4 orthopedic examination, they're going to have an
03:29:21 5 orthopedic doctor evaluate that situation. If
03:29:24 6 they have cancer, maybe they'll have a specialist
03:29:27 7 from oncology come in to take a look at that. It
03:29:31 8 just depends on what kind of specific examinations
03:29:34 9 they're requiring and we request those based upon
03:29:36 10 the list of all the conditions that they're
03:29:38 11 claiming.
03:29:41 12 DR. PHILLIPS: And this is just for your
03:29:42 13 facility. You're not aware of what's going on
03:29:45 14 nationally or --
03:29:46 15 MS. RAMIREZ: I can't answer for somewhere
03:29:47 16 else, yes, sir.
03:29:50 17 LT GEN GREEN: Am I mistaken? Is it 75 days
03:29:53 18 in the IDES process for the --
03:29:58 19 MS. RAMIREZ: That's the --
03:29:58 20 LT GEN GREEN: How is the standard set up?
03:29:59 21 MS. RAMIREZ: -- average.
03:30:00 22 MS. DAILEY: What standard do you have to
03:30:02 23 meet for your exams?
03:30:04 24 MS. RAMIREZ: 45 days, ma'am.
03:30:07 25 MS. DAILEY: 45 days, sir. That's the

03:30:08 1 standard.
03:30:09 2 MS. RAMIREZ: We can have our exams
03:30:11 3 completed and done and the reports completed
03:30:14 4 usually within two weeks. It is a very quick
03:30:16 5 turnaround time.
03:30:17 6 MS. DAILEY: That is -- we started out the
03:30:18 7 beginning of the year we wanted to talk with the
03:30:22 8 MSCs. We talked a lot last year with the PEBLOs,
03:30:26 9 but in fact this phase of the IDES process is
03:30:30 10 going very smoothly.
03:30:32 11 LT GEN GREEN: Okay.
03:30:51 12 MS. RAMIREZ: I don't know if this
03:30:57 13 information -- we do have two additional MSCs
03:31:01 14 located at our main facility here in San Antonio
03:31:05 15 as kind of a backfill if we get too much of a case
03:31:08 16 load and we don't want to delay the process. We
03:31:10 17 do have a time frame of 10 days from the date that
03:31:13 18 we receive the referral with the medical records
03:31:15 19 to see the service member, to do their initial
03:31:18 20 interview. If for whatever reason we just get an
03:31:21 21 abundance of cases coming in, we might call on
03:31:24 22 their assistance to help us review the records and
03:31:26 23 interview that service member so we don't exceed
03:31:28 24 the 10-day standard that we have. Typically we're
03:31:31 25 seeing our service members within three days of

03:31:33 1 receipt of that referral. And higher utilization
03:31:44 2 of our MSCs is limited primarily because of the
03:31:48 3 space available at the MTFs. I know that our
03:31:51 4 PEBLOs are currently hiring more PEBLOs for their
03:31:53 5 facilitation. I'm not aware that we're hiring any
03:31:57 6 more MSCs to help facilitate the influx of new
03:32:00 7 cases; but there is limitation with the space that
03:32:03 8 we have available right now. I know they're in
03:32:06 9 the process of trying to relocate where the PEBLOs
03:32:08 10 and the MSCs are at SAMMC right now. I'm not sure
03:32:12 11 where they're going to be located at, at this
03:32:14 12 time. They haven't come up with a decision of
03:32:16 13 where they're being relocated to.
03:32:20 14 MR. DRACH: What kind of transportation
03:32:21 15 issues are you facing?
03:32:31 16 MS. LONG: One of the unique things that our
03:32:33 17 structure has that's different, maybe that you've
03:32:35 18 seen across the country, like at Fort Hood where
03:32:39 19 everyone's co-located, may be the providers are on
03:32:42 20 site. Where we are now at SAMMC, unfortunately,
03:32:46 21 when a service member from IDES has to get an
03:32:49 22 examination, they have to travel 20, 25 minutes to
03:32:52 23 the Frank Tejeda Outpatient Clinic and that has
03:32:57 24 caused some issues. The warrior transition
03:32:59 25 battalion does have a transportation cell that --

03:33:02 1 you know, if a service member has difficulty
03:33:04 2 getting there because their spouse or parent
03:33:07 3 cannot drive them, then they'll go; but we have
03:33:10 4 had some issues where individuals although
03:33:12 5 provided a strip map are late for the appointment
03:33:15 6 and hence there's a no show. So, the hope is that
03:33:20 7 co-locating our providers on the installation with
03:33:23 8 us will eliminate some of that.
03:33:43 9 CSM DEJONG: One quick question. Active
03:33:44 10 case load. Okay. Active cases. What would be --
03:34:15 11 you guys are looking at a little over a hundred --
03:34:17 12 between a hundred and some or close to 200 cases.
03:34:20 13 What's going to max you out? What would be the --
03:34:24 14 what would be the optimum range of case load
03:34:26 15 you're looking at and what would be -- at what
03:34:29 16 point are you mission ineffective?
03:34:32 17 MS. RAMIREZ: Well, the way things are right
03:34:34 18 now we don't see them just at the initial
03:34:37 19 interview. Technically, we're like case managers
03:34:40 20 for VA purposes for the benefit aspect. Like I
03:34:43 21 said, I see them on a weekly basis, so they come
03:34:47 22 in all the time asking questions. So, they can
03:34:51 23 have injuries that they don't remember or they
03:34:53 24 want to bring their spouse in, can you please
03:34:56 25 repeat this. I mean, we're case managing

03:34:58 1 throughout the entire process, not just the
03:35:01 2 initial interview and not just at the exit
03:35:03 3 interview when we're supposed to meet with them
03:35:05 4 and discuss all these problems or the ratings. We
03:35:08 5 see them throughout the entire process because
03:35:11 6 they do come back and they ask questions or they
03:35:14 7 want to know about a different benefit. So, it's
03:35:19 8 an actual working case load that we follow every
03:35:22 9 day. What was our ratio supposed to be?
03:35:29 10 MS. LONG: One to 30.
03:35:31 11 MS. RAMIREZ: One to 30?
03:35:33 12 MS. LONG: One to 30 active cases. Active,
03:35:35 13 you know, means we have the cases. We have not
03:35:38 14 interviewed the person. We are in the process of
03:35:41 15 interviewing. The number that you see of active
03:35:43 16 cases listed on here are people that we've already
03:35:45 17 seen. They may have already had their
03:35:48 18 examination, but they need to bring us DD-214s,
03:35:52 19 they need to bring us dependent information, they
03:35:54 20 have questions about both rehabs. Just a myriad
03:35:57 21 of things that they need answers to. So, they
03:35:59 22 call us and even when they're retired and done
03:36:02 23 with IDES, they have our numbers. So, instead of
03:36:05 24 calling the 1-800 number, they come to someone
03:36:08 25 they trust. But from an active perspective, one

03:36:11 1 to 30.
03:36:13 2 MS. RAMIREZ: So, we're a little over that.
03:36:15 3 CSM DEJONG: Right.
03:36:18 4 MSGT MACKENZIE: I've been asking several
03:36:19 5 folks just because running around you guys'
03:36:22 6 facility and to me it's painfully evident, the
03:36:26 7 difference. Do you find the success of your
03:36:29 8 program directly in correlation to your location
03:36:32 9 of the recovering warrior?
03:36:35 10 MS. RAMIREZ: Yes, sir, I do. It's
03:36:38 11 co-located, it's easy access. What is very
03:36:41 12 beneficial is that we all have different
03:36:43 13 backgrounds. Ms. Long, like I said, is retired
03:36:46 14 Army. She knows the Army workings. Retired Navy,
03:36:51 15 he knows those workings. We have Air Force
03:36:55 16 personnel also. We just know who to go to. We
03:36:59 17 find out shortcuts. We know who to go to. If
03:37:03 18 there's a problem, we know exactly who to go to to
03:37:06 19 get this documentation. I'm very fortunate to
03:37:09 20 have access to the medical record system, both
03:37:12 21 inpatient and outpatient. So, I don't have to do
03:37:14 22 a release of information to send it over to BAMC
03:37:16 23 to get a specific document, I can look it up
03:37:19 24 myself. So, it -- it speeds up the time. So, our
03:37:24 25 background and having access to military records

03:37:28 1 is extremely beneficial.
03:37:33 2 MSGT MACKENZIE: So, you mean having access
03:37:34 3 to the information you need actually helps you do
03:37:37 4 your job correctly? How about that.
03:37:39 5 MS. RAMIREZ: Absolutely. Absolutely.
03:37:41 6 DR. PHILLIPS: What barriers are you
03:37:43 7 identifying and facing and how can this task force
03:37:47 8 perhaps help you?
03:37:49 9 MS. RAMIREZ: One of the barriers is getting
03:37:51 10 entrance physicals. Not -- you know, it depends
03:37:54 11 on what branch of service. I know we've had a
03:37:57 12 little bit more difficult time getting entrance
03:37:59 13 exams for our Marine Corps and Navy personnel. To
03:38:05 14 accept a claim, we have to have a complete copy of
03:38:08 15 their medical records and that is including the
03:38:10 16 entrance physical. If we don't receive this
03:38:13 17 entrance physical along with all the medical
03:38:15 18 records, technically it's an incomplete claim and
03:38:18 19 we would have to turn this back into the PEBLO to
03:38:21 20 have them search for this record and if they
03:38:24 21 cannot find it, they have to annotate where they
03:38:27 22 went to to try to find this document and if they
03:38:29 23 can't find it, they will do a memorandum letting
03:38:32 24 us know that they've gone to X, Y, Z and we have
03:38:36 25 been unsuccessful in trying to locate this record

03:38:38 1 and we're going to have to proceed without it and
03:38:40 2 they'll return that to us.
03:38:44 3 DR. PHILLIPS: When you get these records --
03:38:45 4 the entrance physicals, when you've located them,
03:38:46 5 are they paper or electronic, are they faxed?
03:38:49 6 MS. RAMIREZ: They're paper, sir. We go
03:38:50 7 through forests.
03:38:52 8 DR. PHILLIPS: Would it be more helpful if
03:38:54 9 it were electronic that you could access? I mean,
03:38:57 10 if you can get on your computer and you had an
03:38:59 11 identification number -- last four digits of the
03:39:01 12 social or something -- you can --
03:39:04 13 MS. RAMIREZ: Probably so, but people like
03:39:07 14 looking through a record and being able to access
03:39:09 15 that paperwork right then and there. Because all
03:39:12 16 the medical records are actually transferred to
03:39:14 17 the medical facility and they're available to the
03:39:17 18 doctor. So, they will actually have that. I know
03:39:19 19 there's ways that we can look at -- through our VA
03:39:22 20 health care system to look at DoD information. I
03:39:25 21 remember earlier one of the health care liaisons
03:39:28 22 compared the two and there's missing information.
03:39:30 23 Not everything is available to be seen.
03:39:35 24 MR. DRACH: How much training have you had
03:39:37 25 on the VA rating schedule and do you have an

03:39:40 1 opportunity to review the draft decision before
03:39:44 2 the rating is actually finalized; and if you have
03:39:47 3 an opportunity to review it, do you have any
03:39:50 4 opportunity to give feedback saying we think you
03:39:52 5 missed something?
03:39:56 6 MS. RAMIREZ: Well, yes, we do. When
03:39:57 7 that -- the proposed rating is completed, it is
03:40:01 8 actually sent to the military service coordinator
03:40:04 9 and it's also sent directly to the PEB. So, I do
03:40:07 10 get to see that rating. You know, it's not really
03:40:10 11 in our lane to review it and let them know because
03:40:14 12 according to our guidance the PEBLO is supposed to
03:40:18 13 release that information to the service member
03:40:21 14 once the PEB has gone through and looked at
03:40:27 15 everything and put their information on their form
03:40:28 16 to present to that service member.
03:40:30 17 MR. DRACH: What if there's something
03:40:30 18 blatantly -- not intentionally, necessarily; but,
03:40:33 19 you know, I made a claim for hypertension and
03:40:38 20 there's no rating coming back on hypertension?
03:40:40 21 Can you take that back and say --
03:40:42 22 MS. RAMIREZ: Yes, sir, I've done that on
03:40:43 23 several occasions. If I see something that's left
03:40:48 24 out, yes, sir. We'll contact the rating
03:40:50 25 specialist that there's a condition that was not

03:40:52 1 addressed and they'll go back and do it, yes, sir.
03:40:57 2 MS. LONG: And to add, sir. A great thing
03:40:59 3 about being here is that we also have our own
03:41:01 4 group of raters at our San Antonio office. So,
03:41:06 5 although we may not be specifically trained, so to
03:41:08 6 say, in ratings, I can call a rater at my office
03:41:11 7 and say, "Hey, I want you to look at this rating.
03:41:13 8 Tell me what you think." And they provide us the
03:41:15 9 guidance to give us to go back to the DRAS and
03:41:18 10 say, "Hey, can you re-look, you know, at this
03:41:21 11 individual's rating for us."
03:41:22 12 MR. DRACH: Well, who's actually -- the VA
03:41:23 13 is doing the rating, but it's not your regional
03:41:26 14 office rating board. You have a separate rating
03:41:28 15 board?
03:41:29 16 MS. LONG: Correct. It's going -- our
03:41:31 17 particular ratings for SAMMC, it's going to
03:41:33 18 Seattle and then we have some going to Baltimore
03:41:36 19 and then we have another service going to
03:41:38 20 Providence; but because rating specialists get
03:41:41 21 that specialized training, you know, it saves a
03:41:44 22 lot of headache.
03:41:46 23 MR. DRACH: And are they on detail from the
03:41:48 24 Houston regional office or where do they come
03:41:50 25 from, the ratings specialists here on the IDES?

03:41:54 1 MS. LONG: Oh, they belong to the Houston
03:41:56 2 regional office with the San -- we have a San
03:41:58 3 Antonio base and they are in San Antonio. So,
03:42:00 4 that's a benefit to us.
03:42:01 5 MS. RAMIREZ: They don't make the decision
03:42:03 6 for the IDES process.
03:42:05 7 MR. DRACH: Who makes it?
03:42:07 8 MS. RAMIREZ: The DRAS. The disability
03:42:07 9 rating activity site in Seattle makes that
03:42:11 10 decision.
03:42:14 11 MR. SANTOS: For the Army.
03:42:15 12 MS. RAMIREZ: For the Army.
03:42:15 13 MR. SANTOS: For the Air Force it's -- those
03:42:20 14 regional offices have been identified.
03:42:25 15 MS. RAMIREZ: So, we have our go-to guys.
03:42:30 16 LT GEN GREEN: So, there was a policy at the
03:42:32 17 VA that you didn't accept the electronic and
03:42:35 18 everything had to be printed. That you only would
03:42:37 19 look at a paper record. Is that still true?
03:42:43 20 MS. LONG: Yes, sir. I mean, that's what we
03:42:46 21 are getting now. Obviously, if we were provided
03:42:50 22 electronic records, I personally don't know what
03:42:53 23 the implications are to get it up to Seattle and
03:42:56 24 get all these things done; but as an MSC, clearly
03:43:00 25 having that paper record allows me to go through

03:43:05 1 it with a fine tooth comb; but whatever -- by
03:43:09 2 whatever means we get the record, we'll still get
03:43:12 3 to the same end; but right now we are getting
03:43:15 4 paper records, sir.
03:43:16 5 LT GEN GREEN: But by VA policy you don't
03:43:18 6 accept an electronic record at this point in time,
03:43:21 7 from what I understand, which is why they make
03:43:23 8 three copies; correct? One for the member and two
03:43:25 9 that come to you folks?
03:43:27 10 MS. RAMIREZ: Yes, sir, that's correct.
03:43:34 11 MR. SANTOS: I have one more comment about
03:43:36 12 the hurdles the doctor there asked about. One of
03:43:39 13 the problems we have or run into is dealing with
03:43:43 14 IT. All the kinks haven't been worked out. I
03:43:47 15 know it's a new program, but we run on an
03:43:50 16 application called Syntrix. We have to go
03:43:52 17 through -- through each hospital, MTF, and then if
03:43:57 18 that goes down for us, then that slows us down to
03:44:00 19 a standstill. We can't do our job, which delays,
03:44:03 20 you know, other timelines. So, I just wanted to
03:44:07 21 bring that up, since, you know, it was brought up,
03:44:10 22 what hurdles we're looking at.
03:44:12 23 MR. DRACH: If a service member is going
03:44:14 24 through this process and he or she selects a
03:44:17 25 veteran service organization representative to

03:44:20 1 represent him or her in the claim process, what
03:44:24 2 relationship do you all have with the VSO in terms
03:44:27 3 of allowing them to see the draft rating and
03:44:30 4 everything?
03:44:32 5 MR. SANTOS: As far as I know, that's not an
03:44:34 6 option right now. We have -- we're the one
03:44:37 7 reviewing the service records with the service
03:44:39 8 member. So, we're kind of taking the role of the
03:44:41 9 VSO, as well.
03:44:43 10 MR. DRACH: Even if the service member
03:44:44 11 designates a VSO?
03:44:46 12 MR. SANTOS: We haven't been given that
03:44:48 13 guidance, that I know of. Do you?
03:44:51 14 MS. RAMIREZ: No.
03:44:51 15 MS. LONG: No, and even though those who
03:44:53 16 already have a VSO, like our National Guard
03:44:57 17 reserve members, they may already have a VSO; but
03:45:00 18 they're not integrated into this process.
03:45:05 19 MR. DRACH: It'll be interesting to hear
03:45:07 20 from the VSOs tomorrow as to their take on this.
03:45:11 21 MS. RAMIREZ: They've been asking us that
03:45:13 22 question, how can we help. As far as we know, in
03:45:16 23 our guidelines implementation they're not allowed
03:45:19 24 to participate in this IDES --
03:45:20 25 MS. DAILEY: I need y'all on the microphone.

03:45:20 1 MS. RAMIREZ: I'm sorry.
03:45:20 2 MS. DAILEY: If you want to put that on the
03:45:20 3 record, you've got to talk into that microphone.
03:45:20 4 MS. RAMRIEZ: In our implementation guide
03:45:25 5 the VSOs are not allowed to participate in this
03:45:29 6 IDES process. They were in the Legacy program,
03:45:31 7 but not in this IDES process.
03:45:37 8 MR. REHBEIN: I think that might be stating
03:45:39 9 it a little bit too strongly. They may not be
03:45:42 10 officially involved, but I believe the service
03:45:44 11 member with the -- with his or her copy of the
03:45:49 12 reports is allowed to go to anybody they want for
03:45:51 13 advice.
03:45:52 14 MS. RAMIREZ: Yes, sir.
03:45:54 15 MR. REHBEIN: And I believe VSOs are being
03:45:56 16 included informally in that -- in that process.
03:45:59 17 It has to be done at the service -- at the service
03:46:01 18 member's initiative.
03:46:02 19 MS. RAMIREZ: Not at the initial interview
03:46:04 20 when we take the claims. They're not taking the
03:46:08 21 information --
03:46:09 22 MR. REHBEIN: True, yes; but the report --
03:46:11 23 MS. RAMIREZ: After the fact we --
03:46:11 24 MR. REHBEIN: The results -- the results,
03:46:13 25 particularly -- particularly the PEB.

03:46:17 1 MS. RAMIREZ: Yes, sir.
03:46:19 2 MR. REHBEIN: Right.
03:46:21 3 MS. DAILEY: Essentially, at your stage,
03:46:23 4 you're collecting all their paperwork, getting it
03:46:26 5 all in one place, making sure it's complete and
03:46:28 6 then you are aligning them up with every one of
03:46:31 7 their appointments?
03:46:33 8 MS. RAMIREZ: Yes, ma'am.
03:46:34 9 MS. DAILEY: And you're doing that well
03:46:36 10 within the current guidelines for the physical?
03:46:42 11 MS. RAMIREZ: Yes, ma'am.
03:46:50 12 LT GEN GREEN: I think that deserves some
03:46:53 13 clarification.
03:46:53 14 MS. RAMIREZ: Good.
03:46:53 15 LT GEN GREEN: One of the reasons that I
03:46:54 16 asked you guys to visit the paperwork mills that
03:46:57 17 are behind the -- these various sections is
03:47:00 18 because you folks are just verifying that you
03:47:04 19 received everything. It's others that are
03:47:07 20 actually making the copy, putting it together,
03:47:09 21 sending it to you so that you have a full record
03:47:12 22 for evaluation; correct?
03:47:13 23 MS. RAMIREZ: Yes, sir.
03:47:24 24 MS. DAILEY: Currently, the processing time
03:47:27 25 at this phase is 21 days. It's a good piece for

03:47:33 1 us to understand because this is the -- this is
03:47:37 2 new. There's never been an MSC before in the
03:47:41 3 desig -- in the disability evaluation system. So,
03:47:45 4 we wanted to take a look at it. However, it has
03:47:48 5 unfolded at this point in time to not be the
03:47:52 6 problem area in the IDES process, as farther down
03:47:57 7 the line is where we are seeing the backups. To
03:48:00 8 date we are not seeing them in this phase. So,
03:48:05 9 get to know your MSCs; but, gentlemen, I
03:48:08 10 apologize, this is not the problem area.
03:48:11 11 LT GEN GREEN: I have to ask a couple of
03:48:12 12 more questions on interface. So, what happens
03:48:17 13 when they send you paperwork that's not complete?
03:48:19 14 So, let's say they don't have the physical -- the
03:48:22 15 induction physical from DODMERB. So, what
03:48:25 16 happens? Do you send the record back?
03:48:27 17 MS. RAMIREZ: Yes, sir, we send it back to
03:48:30 18 the PEBLO and let them know this information is
03:48:32 19 missing.
03:48:32 20 LT GEN GREEN: And so then your timing ends
03:48:33 21 and it's back to the DoD side; right?
03:48:36 22 MS. RAMIREZ: Yes, sir. Also, along -- when
03:48:37 23 we review these records, sometimes the service
03:48:39 24 member doesn't inform that PEBLO that they had
03:48:42 25 treatment at a private facility and throughout

03:48:45 1 reading the records we find out that they were
03:48:47 2 sent to an off-site location, locally, in town;
03:48:50 3 and those records aren't attached. We have to
03:48:53 4 notify that PEBLO that he had treatment at another
03:48:56 5 facility and they need to provide those records.
03:48:58 6 And typically they're going to have -- the case
03:49:01 7 manager will have them and they just forgot to
03:49:03 8 forward it on to the PEBLO to include it in their
03:49:06 9 medical package; but as we read through those
03:49:09 10 records, we can find out that they've been to
03:49:11 11 other places.
03:49:17 12 LT GEN GREEN: Okay. And I'm sorry that
03:49:20 13 Rich Stone or someone from the Army isn't here,
03:49:22 14 because they're the ones that -- the Army keeps
03:49:25 15 talking about the IDES being broken at several
03:49:28 16 different levels; but one of them in terms of the
03:49:31 17 single physical is the back and forth that goes
03:49:33 18 on. So, do we have -- probably you're not the
03:49:36 19 right ones to ask; but I'll ask anyway. So, when
03:49:38 20 you identify -- so, let's take an easy system.
03:49:42 21 So, you get the records, you go to the first thing
03:49:45 22 you expect to see in the record, you look in the
03:49:47 23 physical exams, you don't have the induction
03:49:50 24 physical. Do you stop there and send it back?
03:49:53 25 MS. RAMIREZ: Yes, sir.

03:49:54 1 LT GEN GREEN: Okay. And on average how
03:49:56 2 long before it comes back to you?
03:49:58 3 MS. RAMIREZ: It varies.
03:50:00 4 LT GEN GREEN: Give me an idea.
03:50:02 5 MS. RAMIREZ: Sometimes it could take a few
03:50:05 6 days because they know that they've already
03:50:07 7 researched, they just forgot to do the memo to let
03:50:11 8 us know that they've tried to track this
03:50:13 9 documentation down; and we can have it back within
03:50:15 10 a few days. Sometimes it might be a month before
03:50:17 11 we get it back. It just depends.
03:50:19 12 LT GEN GREEN: Okay. And so let's say the
03:50:20 13 induction physical was in there, but you're
03:50:23 14 looking and you see something where the patient
03:50:25 15 had a referral. You don't know whether they kept
03:50:26 16 it or not, but they had a referral to downtown.
03:50:30 17 Does it go back for them to go and research and
03:50:32 18 find out whether there's a referral or not?
03:50:35 19 Whether they were actually seen downtown?
03:50:37 20 MS. LONG: No. I don't, sir. When I see
03:50:40 21 that service member, we can request those records
03:50:43 22 ourselves. All we need is the name and the
03:50:45 23 address of the facility and we will get them
03:50:48 24 ourselves. That is not a show stopper for us.
03:50:51 25 LT GEN GREEN: Is that part of your 20 --

03:50:53 1 how many days is it? 21 days at risk, if you do
03:50:56 2 that?
03:50:57 3 MS. RAMIREZ: Our 10 days.
03:50:59 4 MS. LONG: Well, we've already seen the
03:51:00 5 service member and we're going to request that
03:51:02 6 exam. However, those records -- those civilian
03:51:04 7 records from a civilian provider are absolutely
03:51:07 8 crucial during the adjudication phase, which is
03:51:10 9 months down the road. So, I'm not going to let,
03:51:13 10 you know, some records from a civilian facility
03:51:15 11 stop me. I'm going to move the train forward and
03:51:18 12 request them and when they come in, then they will
03:51:21 13 be consolidated with the person's file.
03:51:23 14 LT GEN GREEN: Okay. And that's better.
03:51:24 15 I'm trying to figure out how many times it goes
03:51:26 16 back and forth before it actually gets processed.
03:51:30 17 MS. LONG: Honestly, sir, the -- you know,
03:51:31 18 for me, I'm retired Army. I work at an Army
03:51:33 19 facility. So, for me, if there's no entrance
03:51:36 20 exam, I'm going to go through every channel that I
03:51:39 21 can to get it, first, before I give that case
03:51:41 22 back. I mean, because for me, I can get it. I
03:51:45 23 know FRCs, you know, case managers, this person.
03:51:49 24 There are so many people at BAMC and if they can't
03:51:52 25 find it, it's missing and it doesn't exist and the

03:51:56 1 PEBLO can give me a memo saying they've exhausted
03:51:59 2 all efforts to find it and they don't have it. We
03:52:02 3 cannot just stop a person's board because they
03:52:03 4 don't have it. If a service member comes in to
03:52:06 5 see me, I say, "Where is your entrance physical.
03:52:08 6 Oh, I have it at home. Okay. Bring it in." Done
03:52:11 7 deal.
03:52:13 8 LT GEN GREEN: How many times has that
03:52:15 9 happened? I'd be pretty impressed if a service
03:52:17 10 member had it at home.
03:52:19 11 MS. LONG: Oh, trust me.
03:52:21 12 LT GEN GREEN: My exam from '74 would be
03:52:23 13 hard to find.
03:52:24 14 MS. LONG: Sir, you would be surprised.
03:52:26 15 CSM DEJONG: You're doing that and I think
03:52:28 16 that's admirable and I would hope that everyone
03:52:31 17 did that; but what truly is the standard? Is
03:52:33 18 there a standard out there of how -- when to
03:52:36 19 return a record and when not to return a record?
03:52:40 20 We can hear from people that are going above and
03:52:42 21 beyond all the time; but what truly is the answer
03:52:45 22 for if -- if you get a new hire and you tell --
03:52:50 23 you -- and you tell them that this is missing --
03:52:56 24 X, Y or Z is missing, then the file goes back;
03:52:59 25 right? I mean, what's the true answer? What are

03:53:01 1 others doing?
03:53:02 2 MS. LONG: I don't know what others are
03:53:04 3 doing. I've got to be honest with you, Sergeant
03:53:06 4 Major; but I think for our facility as a whole, if
03:53:09 5 it's five to seven years missing, that's a
03:53:11 6 problem; and we have that with more senior people.
03:53:15 7 E7s, E8s, E9s going through the board, they're
03:53:19 8 missing those -- you know, the records before
03:53:23 9 AHLTA and CHCS. They're missing those and that
03:53:27 10 becomes a problem; but once the PEBLO informs us
03:53:30 11 that they have exhausted all efforts to get the
03:53:32 12 records, we just have to work with the soldier to
03:53:35 13 see if there's any alternate evidence that he or
03:53:39 14 she may have that can assist us in getting him
03:53:42 15 through this process.
03:53:52 16 LT GEN GREEN: I think you answered our
03:53:53 17 questions. Okay. Do I hear anything else from
03:53:54 18 the folks?
03:53:55 19 DR. PHILLIPS: I've got one.
03:53:57 20 LT GEN GREEN: Go ahead.
03:53:58 21 DR. PHILLIPS: Just real quick. Do you have
03:53:59 22 an estimate of what percentage of records come to
03:54:02 23 you that are incomplete? 5, 30?
03:54:10 24 MS. LONG: I would say less than 5 percent.
03:54:15 25 MR. SANTOS: Yeah, it's not that high.

03:54:18 1 MS. LONG: It's really not as high as -- you
03:54:19 2 know, it's the actions you take when they're
03:54:21 3 missing that's really, you know, what's going to
03:54:23 4 solve the problem. It's what you do. Okay.
03:54:25 5 They're missing, there's nothing you can do about
03:54:27 6 it. You just have to drive on and get the soldier
03:54:31 7 or, you know, the military member through the
03:54:33 8 process.
03:54:38 9 MSGT MACKENZIE: I don't want to put words
03:54:40 10 in people's mouth; but this is what I see day
03:54:41 11 after day after day. Who is the one willing to
03:54:43 12 put the effort in to do the work and that
03:54:45 13 environment creates that rapid effortless deal.
03:54:49 14 However, the standards that are out there don't
03:54:53 15 drive that level of people in those seats. So,
03:54:56 16 how do we get that across the board? You know,
03:54:58 17 when I'm -- when I've got an Air Force guy I'm
03:55:02 18 sending to San Antonio because I know that through
03:55:04 19 that system he is going to get this level of care,
03:55:09 20 why wouldn't I? You know, I find out how he
03:55:11 21 qualifies to do down there, put him down there, he
03:55:14 22 meets his medical board and rolls through because
03:55:15 23 I know that it's going to happen. So, is the
03:55:19 24 question -- I think the bigger question here is
03:55:21 25 not always -- we see how they do it and the

03:55:24 1 success; but the question is is the standard
03:55:26 2 actually meeting what should be done on a
03:55:28 3 day-to-day basis and I don't think the standard
03:55:33 4 comes anywhere close to the quality of personnel
03:55:35 5 that we have in this area doing the job. So --
03:55:42 6 MS. DAILEY: And, sir, I think that the back
03:55:43 7 and forth that the Army is talking about is during
03:55:48 8 the physical exam portion. He goes into a
03:55:51 9 cardiac -- he's got a cardiac appointment and he
03:55:55 10 goes in for a cardiac evaluation with the VA and
03:55:58 11 the VA doc sees something else possibly during
03:56:01 12 that cardiac exam. So, if he sees a show stopper
03:56:05 13 at the VA during that appointment and it goes back
03:56:08 14 to the Army and they say either fix it or you do
03:56:11 15 the rest of the tests or treatment and then
03:56:15 16 they've got to go back to the VA and I think --
03:56:18 17 can you talk about how it might play out in that
03:56:22 18 situation or have you seen it or can you talk
03:56:26 19 about it?
03:56:26 20 MS. RAMIREZ: I've seen a couple of cases
03:56:28 21 where a service member has been diagnosed by -- a
03:56:30 22 new condition by the VA doctor. It's put into the
03:56:34 23 records, that service member is informed that he
03:56:36 24 needs to go back and see his military doctor and
03:56:40 25 when all these exams are completed, a copy of that

03:56:42 1 examination is given to the PEBLO. He can
03:56:47 2 probably request a copy of that evaluation to take
03:56:49 3 it to his primary care doctor and let them see
03:56:52 4 what the VA found and they can continue on with
03:56:54 5 treatment. If at that point they think that that
03:56:57 6 new condition that has been diagnosed is an
03:57:00 7 unfitting condition, then they're going to give us
03:57:02 8 that additional condition to put onto their claim.
03:57:07 9 We've already done an evaluation, we've already
03:57:10 10 found there's no additional exam that would be
03:57:12 11 required. It's just an additional condition that
03:57:14 12 would have to be added to his claim.
03:57:18 13 MR. DRACH: Let me go back to your -- one of
03:57:20 14 your slides where you talk about the case loads
03:57:21 15 and I just thought about it. There's quite a
03:57:23 16 discrepancy. Some of you -- I think you have a
03:57:26 17 122 or something like that?
03:57:29 18 MS. LONG: 110 active.
03:57:31 19 MR. DRACH: And some have --
03:57:31 20 MS. RAMIREZ: I have 188.
03:57:32 21 MR. DRACH: -- have quite a few more. How
03:57:34 22 do you determine the distribution of the cases?
03:57:36 23 MS. RAMIREZ: I have specific cases assigned
03:57:38 24 to me because I work in the Center for the
03:57:44 25 Intrepid and I have the amputee population I head

03:57:46 1 up.
03:57:46 2 MR. DRACH: What about the rest of you, do
03:57:50 3 you have specific --
03:57:50 4 MS. RAMIREZ: Next in line.
03:57:51 5 MR. DRACH: I'm sorry?
03:57:53 6 MS. RAMIREZ: Next in line. A case comes
03:57:54 7 in, Jennifer just got one, the next one is going
03:57:57 8 to go to Ric, the next one's going to go to Omar.
03:57:58 9 MS. LONG: We deal it like a deck of cards.
03:58:01 10 MR. DRACH: Okay. So -- okay. So, it comes
03:58:03 11 in, you're next, you get it and the fact remains
03:58:06 12 that your case load keeps growing because you're
03:58:09 13 not closing them as fast as somebody else might
03:58:11 14 be. And that's fine. It's just because they're
03:58:15 15 not ready to be closed.
03:58:17 16 MS. LONG: Right. And closing means that
03:58:18 17 the person has already left the military and they
03:58:20 18 are in receipt of benefits or return to active
03:58:22 19 duty or whatever. That's what closing means. So,
03:58:25 20 I have about 30 people since June 2009 who have
03:58:29 21 been returned to duty or chaptered, that didn't
03:58:32 22 even go through the entire process. So, my
03:58:34 23 numbers may look a little different because I've
03:58:36 24 had a significant amount that were fit for duty.
03:58:40 25 LT GEN GREEN: So, I asked earlier whether

03:58:42 1 or not there was any difference in the disability
03:58:44 2 physical before they became the single physical
03:58:47 3 for DES and so Denise's question just a minute ago
03:58:53 4 inferred that if you find a new condition, that
03:58:55 5 you'd actually send them back to DoD for DoD to
03:58:59 6 evaluate that condition, which is really not a
03:59:01 7 single physical then. Is there a reason that you
03:59:04 8 don't simply rate what you find? In other words,
03:59:06 9 by the time they get to you you have what the
03:59:08 10 patient claimed, you have what DoD has treated
03:59:12 11 them for for their entire career and now if you
03:59:14 12 find something else, because they're still on
03:59:16 13 active duty, technically you could rate that as
03:59:19 14 well, why do you send them back?
03:59:22 15 MS. RAMIREZ: Well, if they need to receive
03:59:23 16 treatment for this new condition that DoD has not
03:59:26 17 treated them for, they need to continue on with
03:59:28 18 treatment.
03:59:28 19 LT GEN GREEN: But you can still send them
03:59:31 20 back for treatment with a rating based on --
03:59:33 21 MS. RAMIREZ: The process will continue on,
03:59:35 22 sir. It's just that informing the military doctor
03:59:37 23 that there's a new condition this service member
03:59:39 24 has. We're not going to stop our process for this
03:59:43 25 IDES program. It'll continue. I've seen a

03:59:46 1 scenario where the rater will go ahead and rate
03:59:48 2 that condition in it. Even though, you know, he
03:59:52 3 didn't claim it initially, they will go ahead and
03:59:54 4 rate it because a doctor has already given his
03:59:57 5 diagnosis on this condition; but I've also seen it
03:59:59 6 where the rater says the VA doctor has found this
04:00:04 7 condition, but you did not claim it. You need to
04:00:06 8 go to the VA and formally claim this condition.
04:00:10 9 I've seen it go both ways. It just depends on
04:00:12 10 who's rating the information.
04:00:17 11 LT GEN GREEN: So, the one that I'm told --
04:00:19 12 again, unfortunately, our Army counterparts aren't
04:00:23 13 here today; but the one that I'm told is one of
04:00:26 14 the more common ones is PTSD and so, in essence,
04:00:30 15 they've been evaluated and thought to have PTS,
04:00:34 16 but not the disorder. Come to the VA, the VA
04:00:36 17 feels it is disorder and then it basically goes
04:00:40 18 back and forth. And so the question that I'm
04:00:42 19 asking is under a normal disability evaluation you
04:00:46 20 would simply rate the person based on where they
04:00:49 21 are at the time you see them for that, get
04:00:51 22 whatever specialty information you need; but it
04:00:54 23 would still be a single evaluation that
04:00:56 24 essentially is an aggregated multispecialty to get
04:01:00 25 to a final word. It really wouldn't come back for

04:01:03 1 treatment for something at the point where they're
04:01:06 2 getting a disability eval. I mean, yes, whatever
04:01:08 3 they find may well need treatment, but the
04:01:11 4 disability evaluation, since they found it, would
04:01:13 5 continue. So, I'm trying to figure out -- because
04:01:15 6 it seems that the process has changed if you're
04:01:18 7 sending people back to DoD. Now, if your
04:01:22 8 disability system proceeds, then I have no
04:01:25 9 heartburn with this; but if your disability system
04:01:28 10 stops until the new condition is treated, that's
04:01:31 11 an interesting dynamic.
04:01:33 12 MS. RAMIREZ: As far as I know, it won't
04:01:35 13 stop, sir. I haven't -- I have not seen it stop
04:01:36 14 when there's a new condition diagnosed. And I had
04:01:40 15 a gentleman who they took lab work and his sugar
04:01:45 16 level was through the roof and he actually needed
04:01:47 17 to go to the ER. The doctor got the information
04:01:50 18 after his interview with that service member was
04:01:53 19 over and immediately contacted me and said you
04:01:55 20 need to get in touch with the service member, he
04:01:58 21 needs to go to the ER immediately.
04:02:01 22 LT GEN GREEN: Clearly needs to be treated.
04:02:03 23 That's not the question.
04:02:04 24 MS. RAMIREZ: Exactly. But for the most
04:02:05 25 part I don't see that the board will stop because

04:02:07 1 of a new condition that's been diagnosed. It
04:02:10 2 could be unfitting, it could not be unfitting.
04:02:13 3 Just the fact the VA doctor has found this
04:02:16 4 condition upon his examination.
04:02:20 5 MS. DAILEY: The D -- is it the DoD member
04:02:23 6 wants to be rated on the -- well, that couldn't be
04:02:26 7 it either because if you rated 30 percent or
04:02:29 8 above, he would still be eligible for the DoD
04:02:34 9 cutoff or disability retirement and its Tricare
04:02:38 10 benefits. Okay.
04:02:43 11 LT GEN GREEN: Right. Essentially -- yeah,
04:02:45 12 that would be part of the question. If the
04:02:47 13 disability process stops because something is
04:02:51 14 found, then the other question is is it -- can --
04:02:54 15 but it should be taken care of based on the
04:02:56 16 patient's claim. So, if the patient claims PTSD,
04:03:00 17 then that would be dealt with at the time of the
04:03:02 18 disability evaluation.
04:03:03 19 MS. RAMIREZ: Correct.
04:03:05 20 MS. LONG: Exactly.
04:03:06 21 LT GEN GREEN: So, that shouldn't be a
04:03:07 22 problem.
04:03:08 23 MS. RAMIREZ: If initially the service
04:03:09 24 member claimed anxiety and the doctor evaluated
04:03:12 25 him and said, well, it's not really anxiety, I

04:03:15 1 think it's posttraumatic stress disorder, he --
04:03:17 2 our raters are going to see that and say PTSD
04:03:20 3 claimed as anxiety, because that's what was on the
04:03:23 4 documentation. So, we have to refer to all the
04:03:25 5 conditions that were initially listed; but if the
04:03:28 6 diagnosis was changed upon that evaluation, it's
04:03:31 7 going to be written as such. We have that all the
04:03:35 8 time. I'll have anxiety disorder or depression
04:03:40 9 disorder and it will be PTSD claimed as. So, that
04:03:45 10 way we know that this is what they initially
04:03:48 11 claimed; but it's not that, it's this condition.
04:03:57 12 LT GEN GREEN: I'm trying to represent my
04:03:59 13 Army colleagues and they're not here to help me
04:04:01 14 with this. So -- and you folks obviously have a
04:04:04 15 good system down here. It's the best timing that
04:04:07 16 I've heard of. And so I do know that it takes
04:04:09 17 considerable effort to bring the paperwork
04:04:11 18 together, whether it's for the DES based on the
04:04:14 19 recovering warriors and also just for separating
04:04:16 20 service members. It's a fairly intense effort to
04:04:19 21 try and get all the paperwork together so that we
04:04:22 22 can get it to the VA so that then the baton can be
04:04:25 23 passed, if you will; but there seems to be some
04:04:28 24 places where it kind of bounces back and forth and
04:04:30 25 that's what we're trying to get from you folks.

04:04:33 1 If there are things that clearly cause the system
04:04:35 2 to gyrate where now it bounces back and forth and
04:04:39 3 it sounds like incomplete records is one of those
04:04:41 4 things that has a potential for doing that,
04:04:44 5 although you're giving us statistics that say
04:04:47 6 that's a very small percentage; and then the other
04:04:50 7 question would be new items and you're saying
04:04:50 8 that's also a fairly small occurrence.
04:04:55 9 Differences in diagnoses, but you're saying the
04:04:57 10 disability system continues, it doesn't bounce
04:05:00 11 back or cease, to go back and get further
04:05:02 12 evaluation. It basically proceeds. And so I
04:05:07 13 don't know another way that it would bounce back
04:05:09 14 and forth. And your folks have the experience.
04:05:11 15 But that's what I'm looking for. Is there
04:05:13 16 anything else in terms of opportunities where this
04:05:15 17 would go back and forth between the two
04:05:18 18 departments?
04:05:22 19 MR. SANTOS: I can't think of anything.
04:05:24 20 MS. LONG: No, sir. Additional referred
04:05:29 21 conditions. That's our experience.
04:05:32 22 LT GEN GREEN: And the additional referred
04:05:33 23 conditions that come to you after someone has
04:05:34 24 submitted is also an interesting thing because
04:05:36 25 technically they should come to you only once.

04:05:39 1 So, I'll use an Air Force static that I know. I
04:05:42 2 was a little concerned when I saw that our return
04:05:46 3 to duty rate after an IDES evaluation by the VA
04:05:50 4 was around 14 percent I think. Somewhere in that
04:05:54 5 neighborhood. Meaning that there were
04:05:57 6 opportunities in the MEB where you could have
04:06:00 7 chosen to retain that person, whether you're going
04:06:03 8 to retain them or put them back in their
04:06:07 9 original -- in our world AFSC and Army world
04:06:10 10 MOS -- and then -- but you still chose to put them
04:06:12 11 through the IDES and when you put them through the
04:06:14 12 IDES -- and essentially for 14 percent of the
04:06:16 13 people that were being referred, you folks were
04:06:18 14 doing work, but they were going to stay on active
04:06:21 15 duty, which means you were wasting your time, from
04:06:24 16 my perspective. So, we're working real hard to
04:06:26 17 see if we can't make sure that our MEB is making
04:06:28 18 solid decisions and I chalked it up to things
04:06:32 19 being made by relatively junior physicians at some
04:06:37 20 of our facilities and so we've centralized the
04:06:40 21 decision regarding retraining and so we'll see
04:06:42 22 whether it makes a difference in terms of the
04:06:44 23 numbers. Do you know the other services return to
04:06:46 24 duty? And by the way, I realize that there are
04:06:49 25 some people -- so, for instance, for the

04:06:51 1 recovering warrior that's blind or some of the
04:06:54 2 SOCOM rules where everybody can stay active,
04:06:56 3 that's different. Okay. That's not what I'm
04:06:58 4 talking about here. But do you have any idea what
04:07:00 5 the percentages are that come to you that are
04:07:03 6 retained on active duty?
04:07:04 7 MS. RAMIREZ: Like I say, SOCOM is a
04:07:07 8 different monster.
04:07:09 9 LT GEN GREEN: Correct.
04:07:10 10 MS. RAMIREZ: They'll make exceptions for
04:07:13 11 their members, but I cannot tell you --
04:07:14 12 LT GEN GREEN: So do all the services.
04:07:15 13 Okay. Each service has some that -- you know,
04:07:18 14 whether amputees or blind. Actually, each of the
04:07:21 15 services have different cases where they've kept
04:07:23 16 people on active duty. Our chief has a letter to
04:07:26 17 the personnel board -- personnel council telling
04:07:29 18 them that we will keep anybody that's possible and
04:07:31 19 if there's no way possible, that we'll find them
04:07:34 20 GS jobs. So, how that's implemented exactly at
04:07:37 21 AFPC I don't know; but each service kind of does
04:07:40 22 something to try and take care of their own; but
04:07:42 23 that's not what I'm referring to. That's not the
04:07:44 24 14 percent.
04:07:47 25 MS. RAMIREZ: I couldn't give you a number.

04:07:48 1 I know some that have chosen to stay on and
04:07:51 2 request a COAD or a COAR and a year and a half
04:07:55 3 later they're notifying me again, I want to get
04:07:58 4 out, what do I need to do. I had a service member
04:08:01 5 send me an e-mail the other day. He went through
04:08:04 6 the whole process and decided he was going to stay
04:08:06 7 in. He's now at Fort Bragg and now he wants to
04:08:09 8 get out and he would probably have to initiate a
04:08:12 9 medical board process all over again.
04:08:15 10 MS. LONG: Sir, I'd just like to add that
04:08:17 11 one of the things that can, you know, reduce that
04:08:21 12 number is being cognizant of how the military
04:08:25 13 works. There have been a number of times that I
04:08:29 14 received a packet on someone who has over 20
04:08:32 15 years -- I had a CW4 over 20 years. He had one
04:08:36 16 referred condition. So, he sits down in my
04:08:38 17 office. I'm like, "Chief, why are you going
04:08:41 18 through the board." He's like, "I don't know.
04:08:42 19 They told me I had to because of my profile or
04:08:45 20 because of AR 40-501." You know, it's a
04:08:50 21 regulatory requirement. I'm like, "You're
04:08:51 22 eligible to retire. There are other pre discharge
04:08:54 23 programs that we can put you in." And we sent his
04:08:59 24 stuff up to the MEB doc and he said okay. It's
04:09:01 25 just making sure everyone knows that there are

04:09:05 1 other things out there that they can do besides
04:09:08 2 going through IDES, where they get the same
04:09:11 3 benefit.
04:09:16 4 LT GEN GREEN: All right. I think I've
04:09:18 5 gotten what I need and I'll be able to talk with
04:09:21 6 Rich Stone and tell him I asked all the right
04:09:24 7 questions. So -- because I asked the best -- it
04:09:27 8 sounds like the best -- do you guys have the best
04:09:29 9 statistics in the VA?
04:09:31 10 MS. LONG: I hope so.
04:09:34 11 LT GEN GREEN: That's what I thought. It's
04:09:35 12 good to talk with the best. Any other questions,
04:09:38 13 folks? Thank you so much.
04:09:40 14 MS. LONG: Thank you, sir.
04:09:41 15 LT GEN GREEN: We really appreciate your
04:09:43 16 answers and thank you for taking such good care of
04:09:46 17 our service members.
04:09:47 18 MS. DAILEY: Sir, we do have two individuals
04:09:49 19 who would like to present in public forum format
04:09:52 20 to the task force.
04:09:58 21 LT GEN GREEN: Yeah, let's take five and let
04:10:01 22 people take a bathroom break.
04:10:03 23 MS. DAILEY: Five minutes, John, and we can
04:10:05 24 have them ready to go.
04:10:08 25 (Recess taken between 4:10 and 4:22.)

04:22:17 1 MS. DAILEY: Ladies and gentlemen, can I get
04:22:18 2 the task force members to return to their seats.
04:22:18 3 We have a public forum -- we have two public forum
04:22:20 4 presentations at this time and we'll let Mr.
04:22:22 5 Robert Felth speak first. Thank you, sir, for
04:22:25 6 coming today.
04:22:26 7 MR. FELTH: I want to thank the committee
04:22:28 8 and the board for allowing me to make a few
04:22:30 9 comments today. Real quick, within the two
04:22:33 10 minutes I'm allowed initially, a couple of things
04:22:35 11 that I wanted to address was that, first, I do
04:22:38 12 need to speak praise of an organization that I
04:22:43 13 have worked with recently that has certainly
04:22:45 14 helped me personally and I've seen some of the
04:22:47 15 work they've done with some other individuals; and
04:22:49 16 that is the Texas Veterans Commission.
04:22:52 17 Specifically the clinic or the office that I
04:22:55 18 worked with that is located over at the Frank
04:22:58 19 Tejeda Building. They were able to take some
04:23:02 20 unresolved service connection issues that I'd been
04:23:05 21 dealing with since retirement in '96 and actually
04:23:10 22 resolve them when no one or no other organization
04:23:13 23 could; and that was no small task, considering
04:23:18 24 that they were dealing with service rec -- medical
04:23:20 25 records from multiple branches of the service and

04:23:23 1 ones that have probably been gathering dust in
04:23:28 2 archives long forgotten. So, I definitely have to
04:23:31 3 thank them for -- you know, for the job they're
04:23:33 4 doing.
04:23:33 5 One of the questions I have -- I know a lot
04:23:35 6 of what's been addressed is different branches of
04:23:38 7 the service certainly starting the ball rolling
04:23:40 8 and helping their individual members. My
04:23:43 9 situation, having been in two different branches,
04:23:45 10 I have a spouse still on active duty, who has
04:23:49 11 actually been in three branches with service
04:23:52 12 dating back to '75; and what I'm concerned with
04:23:54 13 is -- when it comes time for her to retire is how
04:23:57 14 well the system is prepared to handle dealing with
04:24:02 15 pre electronic records, archive records and
04:24:05 16 gathering records from multiple branches when it's
04:24:08 17 going to come time to bring this all together for
04:24:11 18 an MEB or for VA consideration upon, you know,
04:24:15 19 determination of connected or not connected
04:24:18 20 service conditions upon her retirement. And
04:24:21 21 that's kind of where I want to leave it because I
04:24:24 22 know -- you know, it may not seem like -- you
04:24:25 23 know, a lot of our warriors, unfortunately, coming
04:24:27 24 back are very young; but there are a few of us
04:24:31 25 dinosaurs out there, who, again, like I said,

04:24:32 1 we're going to be challenging folks with paper
04:24:35 2 records as well as the electronic system that we
04:24:39 3 have in place now. Thank you.
04:24:42 4 LT GEN GREEN: Just one comment, just so you
04:24:47 5 know. We have not had electronic records until
04:24:50 6 about 2004. So, even many young people are going
04:24:54 7 to be dealing with a mixture of paper and
04:24:56 8 electronic records for years to come and so DoD
04:25:00 9 and VA are working through that. If you heard the
04:25:02 10 last session, then you know that the VA today
04:25:05 11 looks only at paper records and so everything is
04:25:08 12 printed for the actual disability evaluation. So,
04:25:11 13 they bring all paper records, print all of the
04:25:14 14 electronic records. That may get easier when we
04:25:17 15 get to a combined record for VA and DoD; but we
04:25:21 16 will still have to deal with paper records prior
04:25:23 17 to 2004.
04:25:24 18 MR. FELTH: So, the electronic is brought
04:25:26 19 back to paper form for that consolidation purpose
04:25:29 20 then?
04:25:30 21 LT GEN GREEN: Today that's true.
04:25:32 22 MR. FELTH: Okay, sir. Thank you.
04:25:33 23 DR. PHILLIPS: I don't have a specific
04:25:34 24 answer for you, but I can tell you what I did and
04:25:36 25 I had to go back through microfiche in the '60s.

04:25:39 1 I -- it took me about six months, but I was able
04:25:41 2 to collect all my own records and maybe that's
04:25:44 3 something you should be trying to do.
04:25:47 4 MR. FELTH: So, the service member -- and
04:25:48 5 certainly not all the service members; but, you
04:25:50 6 know, their responsibility or motivation to start
04:25:52 7 doing some gathering on their own as well then.
04:25:54 8 Okay, sir. Thank you very much.
04:25:57 9 DR. TURNER: I would also like to echo what
04:25:58 10 you said about the Texas vets. They are terrific
04:26:01 11 and, you know, we see that a lot. Just a
04:26:04 12 wonderful group of folks.
04:26:06 13 MR. FELTH: And like I say, certainly not to
04:26:07 14 fault any other organization, you know, that I
04:26:08 15 dealt with over the years; but, like I say -- for
04:26:12 16 example -- not knocking the Corps, but -- well, it
04:26:16 17 wasn't the Corps that lost -- why my records were
04:26:18 18 hidden; but it took four years and a congressional
04:26:21 19 inquiry to find health records that, you know,
04:26:24 20 with private request had, you know, not been found
04:26:28 21 or recoverable; and, you know, like I say,
04:26:31 22 anything -- you know, that was -- that's the kind
04:26:32 23 of thing that in my case delayed me; but in other
04:26:35 24 cases I could certainly see it taking someone to
04:26:38 25 the point of giving up. You know, you can only

04:26:42 1 persevere for so long before you realize, okay,
04:26:44 2 maybe these records never will be found, maybe I
04:26:47 3 don't have any recourse, that type of thing. So,
04:26:49 4 you know, like I say, in their case to be able to
04:26:52 5 pull something like that off, I look upon it as
04:26:54 6 nothing short of, you know, a small miracle.
04:26:56 7 So --
04:26:58 8 MSGT MACKENZIE: A couple of questions for
04:26:59 9 you, sir. What branch of the service is your
04:27:01 10 spouse in?
04:27:02 11 MR. FELTH: She's currently in the Air
04:27:04 12 Force, sir.
04:27:04 13 MSGT MACKENZIE: Okay. And has she filed
04:27:06 14 her retirement paperwork or anything at this time?
04:27:09 15 MR. FELTH: No, sir. She still has
04:27:11 16 approximately two years to go to retire.
04:27:14 17 MSGT MACKENZIE: With that being said, this
04:27:15 18 is the time for her to begin and what I advise you
04:27:17 19 based on -- the rules continue to change; but most
04:27:20 20 important for your spouse would be to have that
04:27:22 21 stuff in hand prior to submitting that paperwork,
04:27:25 22 because the last thing you want to add to that
04:27:27 23 process of digging up old records is dealing with,
04:27:32 24 you know, proving service connected after you've
04:27:35 25 already decided to get out. The days of I'm going

04:27:38 1 to work, work, work until I've got to draw up my
04:27:41 2 paperwork and then I'm going to tell everybody
04:27:44 3 what's wrong with me are over and it's not all
04:27:45 4 clearly delineated or explained to the service
04:27:50 5 member to get that stuff in place prior to getting
04:27:52 6 that paperwork in. So, if she has two years left,
04:27:56 7 this is the time and -- is she here in the local
04:27:57 8 San Antonio area?
04:27:58 9 MR. FELTH: Yes, sir, she is.
04:28:00 10 MSGT MACKENZIE: You've heard some of the
04:28:01 11 people briefing today. These are the people that
04:28:03 12 will provide that guidance to assist her in
04:28:05 13 discovering that stuff.
04:28:06 14 MR. FELTH: Yes, sir. What -- what you said
04:28:07 15 was my mistake. It was the way it was done when I
04:28:10 16 retired and actually, again, goes to Texas Vets
04:28:14 17 because they were very specific. They told her
04:28:15 18 through me 186 days. For some reason that's the
04:28:18 19 number prior to. 180 days, approximately, prior
04:28:21 20 to she needs to get over there and even they will
04:28:24 21 begin to facilitate and help her put stuff
04:28:27 22 together so that, you're right, on the last day
04:28:30 23 you're not left hanging.
04:28:32 24 DR. TURNER: Three copies. One for you, one
04:28:34 25 for them and one to replace the one they're going

04:28:36 1 to lose.
04:28:37 2 MR. FELTH: Yes, sir.
04:28:40 3 MSGT MACKENZIE: Thank you, sir.
04:28:46 4 MR. SAMPSON: Members of the panel, I'm Jim
04:28:48 5 Sampson. I'm retired Air Force. I'm also the
04:28:50 6 area supervisor for the Texas Veterans Commission,
04:28:53 7 claims and compensation. I thought I'd sit in the
04:28:56 8 back and be good today; but now I'm up here with a
04:29:00 9 mic in my hand. I did just have a few comments
04:29:03 10 about some of the topics that have come up this
04:29:04 11 afternoon.
04:29:05 12 Number one. About the back and forth during
04:29:07 13 the MEB process. I think the majority of the back
04:29:12 14 and forth is when the service member appeals the
04:29:16 15 initial decision. They get one shot to appeal
04:29:18 16 what the VA doctors have found. And it goes back
04:29:21 17 to the issue that was addressed. There's a huge
04:29:24 18 difference between being medically separated and
04:29:26 19 medically retired and it's my understanding that
04:29:29 20 there's a 10-day turnaround on that and that's
04:29:31 21 really the last appeal the service member can make
04:29:33 22 of the medical determination.
04:29:39 23 Dead right, none of the service
04:29:41 24 organizations have any involvement in the IDES
04:29:44 25 process. Nonetheless, the majority of the service

04:29:48 1 members leaving active duty are one way or another
04:29:51 2 ill, injured or otherwise beat up. None of us are
04:29:55 3 19 years old anymore when we leave active duty.
04:29:58 4 So, we probably help 3 or 4,000 soon-to-be
04:30:04 5 veterans here in the San Antonio area every year
04:30:06 6 do their initial claims. Overall we see about
04:30:08 7 30,000 veterans and their families here in San
04:30:12 8 Antonio. With regard to psychological claims, the
04:30:14 9 case law is pretty clear. A veteran does not have
04:30:17 10 to be a medical expert. If you claim a
04:30:19 11 psychological condition, the VA has to consider
04:30:23 12 any psychological condition. If you claim a sore
04:30:25 13 knee, they have to consider any sore knee
04:30:28 14 pathology that there might be. So, they're really
04:30:31 15 very liberal on that and I think pretty good on
04:30:33 16 that. VA ratings versus DoD ratings. The VA's
04:30:37 17 kinder or more generous, however you want to see
04:30:40 18 it. The proof of that is with the physical
04:30:43 19 disability board of review where they're taking
04:30:46 20 all of the military determinations from 9/11
04:30:49 21 through December of '09. The rate that is being
04:30:52 22 overturned, based on the VA exam, is over 60
04:30:55 23 percent. That's pretty high. Now, not a lot of
04:31:00 24 people have applied. There have only been about
04:31:02 25 4,000 applications and two-thirds of those people

04:31:04 1 that were medically separated during that period
04:31:06 2 are now being medically retired.
04:31:10 3 Although we're not part of the IDES process,
04:31:13 4 we're sure a big part of the appeal process and we
04:31:17 5 do I think a very good job on that. And as was
04:31:21 6 mentioned, we informally talk to all sorts of men
04:31:24 7 and women that are going to meet a PEB. The MEB
04:31:29 8 is done, the recommendation's that they not be
04:31:32 9 retained on active duty. So, they're going to
04:31:35 10 meet a PEB, informal or formal. Two of our staff
04:31:39 11 were actually PEB board members before they
04:31:41 12 retired. We talk to folks just about every day
04:31:43 13 about that and if they're really determined, we'll
04:31:45 14 actually go over to the board and represent them.
04:31:48 15 Frankly, the JAG officers do a very good job; but
04:31:51 16 they'd like a second opinion, preferably someone
04:31:53 17 that's not in the service at this time. So, we do
04:31:56 18 that.
04:31:59 19 Electronic records versus paper records. We
04:32:02 20 of course see both because all of the BBD claims
04:32:05 21 now are electronic. To transmit, to safeguard, to
04:32:08 22 make a copy and put in safe deposit box, I'm all
04:32:11 23 for electronic. To analyze the case file, get
04:32:14 24 them ready for a hearing, it drives you crazy when
04:32:17 25 you've got to go screen by screen through it. We

04:32:20 1 still have paper documents from Pearl Harbor that
04:32:23 2 we're using in our office and you put a sticky
04:32:26 3 here and a paper clip here and a pencil there and
04:32:28 4 it's far, far more efficient than -- particularly
04:32:31 5 with the speed of our computers -- to go through
04:32:34 6 1700 pages on a computer screen. So, I feel
04:32:37 7 strongly both ways.
04:32:42 8 Finally, Sergeant MacKenzie, you gave our
04:32:44 9 pre separation briefing. We go out to all the
04:32:48 10 installations. Pre separation. It's prior to the
04:32:51 11 TAP briefing. You don't even have to have a date
04:32:53 12 of separation, you're just thinking about it. And
04:32:55 13 part of the sermon is get your medical records in
04:32:59 14 shape now. Be straight with your doctor, your
04:33:03 15 commander, your flight surgeon and, you know, most
04:33:06 16 of us didn't do that, frankly. No one wanted to
04:33:08 17 meet that board or be grounded or get a profile.
04:33:12 18 We see that in the yellow ribbons with the
04:33:15 19 soldiers, sailors and airmen coming back
04:33:18 20 demobilizing. They're not going to file a claim
04:33:21 21 because they're going to do what the lady said.
04:33:23 22 They want to go back to their outfit. The claim
04:33:26 23 could get in their way.
04:33:27 24 So, there's a bunch of random comments from
04:33:28 25 what I've heard over the last few hours. I'd be

04:33:29 1 glad to answer any questions that any of you have.
04:33:35 2 LT GEN GREEN: We want to thank you for
04:33:37 3 supporting the veterans. Okay.
04:33:39 4 MR. SAMPSON: Thank you, General.
04:33:40 5 LT GEN GREEN: Actually, many of us either
04:33:42 6 are veterans or soon to be veterans and we
04:33:45 7 appreciate your help.
04:33:46 8 MR. SAMPSON: Come on by.
04:33:48 9 DR. TURNER: I'd like to -- as a satisfied
04:33:50 10 customer -- one of your satisfied customers, I'd
04:33:52 11 like to thank you, especially.
04:33:54 12 MR. SAMPSON: Thank you, Doctor.
04:33:55 13 MSGT MACKENZIE: I just -- this is a gee
04:33:57 14 whiz question, but I just -- I'm curious because
04:33:59 15 some of what we're here to do is based on this
04:34:02 16 comment. Do you see a difference between the
04:34:05 17 Legacy MEB system and those veterans that you
04:34:08 18 support and those veterans that are going through
04:34:12 19 the IDES process? Whether that be in fairness or
04:34:15 20 amount of involvement or -- you know, do you see a
04:34:18 21 difference?
04:34:19 22 MR. SAMPSON: Two differences. The VA
04:34:21 23 examination is more fair. You probably know the
04:34:26 24 background where for a number of years the Army
04:34:28 25 instruction regarding the evaluation said you will

04:34:30 1 not compensate for painful motion, even though
04:34:33 2 that's not what title 38 says in chapter 4.
04:34:37 3 That's why there is the physical disability board
04:34:39 4 review. So, the first comment is the VA
04:34:41 5 examination is more appropriate, in my opinion.
04:34:44 6 The second is -- is that the people in the IDES
04:34:48 7 program get their answers a whole lot sooner, in
04:34:51 8 all honesty. Right now, if you've been out of the
04:34:55 9 service 30 days and you come in and file a claim,
04:34:58 10 our best opinion is 18 months and none of us
04:35:03 11 should be treated that way. They deserve a
04:35:05 12 straight answer and that's why they're screaming
04:35:07 13 now.
04:35:09 14 MSGT MACKENZIE: Thank you, sir.
04:35:12 15 LT GEN GREEN: We thank you for coming
04:35:15 16 forward. Thank you.
04:35:16 17 MR. SAMPSON: Thank you, sir.
04:35:17 18 MS. DAILEY: All right, ladies and
04:35:20 19 gentlemen, that concludes today's activities. We
04:35:23 20 will start again tomorrow morning at 8:30. If you
04:35:27 21 want to talk to the staff or if the staff needs
04:35:30 22 anything or if you need anything from the staff,
04:35:31 23 please let us know.
04:35:35 24 LT GEN GREEN: Okay. Thanks everybody. See
04:35:37 25 you first thing in the morning.

04:35:39 (Meeting adjourned at 4:35.)

1 THE STATE OF TEXAS *
2 COUNTY OF BEXAR *
3 I, SHAN MORRIS BLANCHARD, Certified Shorthand
4 Reporter in and for the State of Texas, do hereby
5 certify that I was employed to and did report in
6 shorthand the proceedings at the meeting of the
7 Recovering Warrior Task Force and that the foregoing
8 pages of typewriting were prepared under my direction
9 and contain and constitute a full, true, and correct
10 transcript of my shorthand notes taken at said time and
11 place and reflect to the best of my skill and ability
12 an accurate record of the subject proceedings.
13 WITNESS MY HAND AND SEAL OF OFFICE this
14 the _____ day of _____, A.D. 2011.
15
16
17
18
19 mjc _____
SHAN MORRIS BLANCHARD
20 Certified Shorthand Reporter
in and for the State of Texas
Certificate No. 3863
21 Exp. Date: 12/31/12
22 **EDDIE MORRIS COURT REPORTERS**
Firm Registration No. 74
23 Exp. Date: 12/31/11
24
25