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DEPARTMENT OF DEFENSE
RECOVERING WARRIOR TASK FORCE MEETING
ST. ANTHONY RIVERWALK WYNDHAM HOTEL - PERAUX ROOM
300 EAST TRAVIS STREET
SAN ANTONIO, TEXAS
DECEMBER 9, 2011

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08:30:51 1 MS. DAILEY: We can start early, but I would
08:30:54 2 like to do a little bit of administration, please.
08:30:57 3 I know I have my briefers lined up here and we can
08:30:59 4 rock and roll with them. Thank you very much for
08:31:00 5 being prompt and available to us. I do want to
08:31:04 6 talk to the task force members just a little bit
08:31:07 7 about upcoming installation visits. We are --
08:31:16 8 we're halfway through our installation visits,
08:31:20 9 ladies and gentlemen; and -- of course I'm
08:31:24 10 stumbling over this because I thought we were
08:31:27 11 farther along; but we are halfway through and our
08:31:30 12 next one is going to be in January and it's going
08:31:34 13 to be Camp Lejeune. And currently I have three
08:31:39 14 people going. I have Mr. Rehbein, Ms.
08:31:44 15 Crockett-Jones and Master Sergeant MacKenzie. Is
08:31:48 16 there anyone else interested or -- interested in
08:31:52 17 going to -- I'll send out another e-mail to the
08:31:54 18 rest of the members. But three is a good crowd.
08:31:58 19 If someone drops out I'm going to be --

08:31:58 20 LT GEN GREEN: What are the dates?

08:32:03 21 MS. DAILEY: The Camp Lejeune, sir, is 11
08:32:08 22 and 12 January. Keep that one in mind. Our next
08:32:12 23 one after that is Iowa, joint forces headquarters.
08:32:16 24 I've got Dr. Phillips, Ms. Crockett-Jones, Master
08:32:21 25 Sergeant MacKenzie and Mr. Rehbein going to that.

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08:32:24 1 Four is generally a pretty good crowd. Yes.

08:32:26 2 MSGT MACKENZIE: You have me on Iowa?

08:32:31 3 CSM DEJONG: Where was that?

08:32:33 4 MS. DAILEY: Iowa.

08:32:33 5 CSM DEJONG: Iowa.

08:32:33 6 MS. DAILEY: Dates are 24, 25 January. It

08:32:37 7 is at joint forces headquarters.

08:32:40 8 CSM DEJONG: I had that on my calendar.

08:32:43 9 MS. DAILEY: All right. Well, this is what

08:32:45 10 I want to do. So, you're programmed into it.

08:32:48 11 DR. PHILLIPS: As much as I'd like to go

08:32:50 12 back to my hometown, I'll be in the Middle East. I

08:32:55 13 won't be back.

08:32:55 14 MS. DAILEY: Okay. I -- we got it. You

08:32:57 15 won't be on that one, Dr. Phillips, and you do want

08:33:01 16 to be on it --

08:33:02 17 CSM DEJONG: Yes, ma'am.

08:33:05 18 MS. DAILEY: Okay. And Master Sergeant

08:33:06 19 MacKenzie, you can't be on it?

08:33:08 20 MSGT MACKENZIE: It was not originally on my

08:33:10 21 calendar; --

08:33:10 22 MS. DAILEY: Okay. I can --

08:33:11 23 MSGT MACKENZIE: -- but if it's needed, I

08:33:13 24 think I can probably get it coordinated.

08:33:15 25 MS. DAILEY: Okay. No, if you haven't

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08:33:18 1 programmed it, let me take it off. Let me take you
08:33:21 2 off. So, I have on that Ms. Crockett-Jones, Mr.
08:33:24 3 Rehbein and Command Sergeant Major DeJong. Rock
08:33:30 4 Island is the next installation visit and it's 31
08:33:36 5 January and 1 February. I have Lieutenant Colonel
08:33:41 6 Keane, Ms. Crockett-Jones, Command Sergeant Major
08:33:44 7 DeJong and Mr. Rehbein. Okay. Anyone else? Fort
08:33:51 8 Smith and Langley. Ladies and gentlemen, let me
08:33:53 9 just make sure you have situational awareness on
08:33:58 10 this. This is a con -- this is a con --
08:34:05 11 DR. TURNER: Concurrent.
08:34:06 12 MS. DAILEY: -- concurrent site visit. I'm
08:34:08 13 going to have part of the task force at Fort Smith
08:34:10 14 for a Navy review and I'm going to have part of the
08:34:13 15 task force at Langley for -- for an Air Force site
08:34:18 16 visit. So, there's a lot of moving parts here.
08:34:21 17 For Fort Smith I have Doctor -- Dr. Turner, you
08:34:30 18 wanted to go to Langley; right?
08:34:33 19 DR. TURNER: Langley.
08:34:34 20 MS. DAILEY: Langley. Okay. Good. So, for
08:34:37 21 Fort Smith, the Navy piece, I've got Command
08:34:41 22 Sergeant Major DeJong, Master Sergeant MacKenzie
08:34:45 23 and Mr. Rehbein. So, I have three people going to
08:34:52 24 Fort Smith. Anyone else interested in going to
08:34:54 25 Fort Smith? That is, again, the 7th and 8th of

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08:35:50 16
08:35:55 17
08:35:58 18
08:36:02 19
08:36:03 20
08:36:05 21
08:36:07 22
08:36:07 23
08:36:11 24
08:36:14 25

February.

MR. REHBEIN: Denise, I think that one's going to give me some problems.

MS. DAILEY: Okay. All right. That's good to know. It's better I know now than the week or day before. So, I have Command Sergeant Major DeJong and Master Sergeant MacKenzie on that one. So, I only have two people. I will advertise that one a little bit more.

DR. PHILLIPS: I have to check my schedule; but when I call it up, I'll -- I'll look at it and I'll let you know this week.

MS. DAILEY: Okay. So, Dr. Phillips is a follow-up. Okay. Going to Langley I have Dr. Turner, Justin Constantine and Ms. Crockett-Jones, Mr. Drach and General Green. We're putting that on your schedule, sir; or you asked for it to be put on your schedule, to go to Langley. Okay. So, I have one, two --

LT GEN GREEN: Or Fort Smith, by the way. I can go either way.

MS. DAILEY: Okay. All right. So, I can -- I might -- anyone have a particular tie? I have -- I'm a little heavy on Langley. Is anyone interested in going to Fort Smith? Would you be

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08:36:16 1 flexible enough if I moved you to the left?

08:36:20 2 LT GEN GREEN: I can do that.

08:36:23 3 MSGT MACKENZIE: Okay. And then Fort
08:36:25 4 Stewart. Currently I have Dr. Turner, Lieutenant
08:36:33 5 Colonel Keane, Mr. Rehbein and Dr. Phillips. Fort
08:36:40 6 Stewart is the 15th and 16th of February. Getting
08:36:47 7 a little too far out there I would --

08:36:51 8 DR. TURNER: When's the business meeting in
08:36:54 9 February?

08:36:54 10 MS. DAILEY: The business meeting in
08:36:55 11 February is 21, 22 and 23 February. Okay. So, for
08:37:08 12 Stewart I have, again, Turner, Keane, Rehbein and
08:37:14 13 Phillips. All right. And the last one is
08:37:23 14 Twentynine Palms the last week in February, 28 and
08:37:29 15 29 February. Ms. Crockett-Jones, General Stone,
08:37:33 16 Command Sergeant Major DeJong, Master Sergeant
08:37:38 17 MacKenzie and Dr. Phillips.

08:37:43 18 DR. PHILLIPS: As much as I want to go back,
08:37:45 19 I can't make that one. I'm out of the country
08:37:49 20 again.

08:37:49 21 MS. DAILEY: Okay. All right. Okay. Quick
08:37:52 22 review on that. I know that schedules will change
08:37:55 23 and you're going to check your schedule, Dr.
08:37:59 24 Phillips, for Fort Smith on 7, 8.

08:38:03 25 DR. PHILLIPS: Yes, ma'am.

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08:38:05 1 MS. DAILEY: Okay. So, that's my only
08:38:06 2 follow-up. I get -- I know schedules fall out,
08:38:10 3 ladies and gentlemen. I will continue to follow up
08:38:13 4 with you on these. Thank you very much.

08:38:18 5 DR. PHILLIPS: Well, good morning. Good
08:38:20 6 morning. Thank you for being so patient. Welcome
08:38:24 7 to the second day of our task force meeting and we
08:38:27 8 will begin the day with a briefing on the Army WTU
08:38:33 9 cadre training. The task force was interested in
08:38:37 10 learning more about the training provided to Army
08:38:40 11 cadre and those who serve as non-medical case
08:38:44 12 managers. With us this morning -- and correct me
08:38:48 13 if I mispronounce, please -- Ms. Cheryl -- Sherri
08:38:53 14 Emerich. Is that --

08:38:58 15 MS. EMERICH: Correct, sir.

08:39:00 16 DR. PHILLIPS: Okay. Thank you. Colonel
08:39:03 17 Dave Blair.

08:39:03 18 COL BAIR: Bair, sir.

08:39:06 19 DR. PHILLIPS: Bair.

08:39:06 20 COL BAIR: Bair, yes, sir.

08:39:06 21 DR. PHILLIPS: I'm zero for two so far.

08:39:08 22 Colonel Suzanne Scott and Lieutenant Colonel Andrew
08:39:12 23 Grantham. Thank you very much and I'll turn the
08:39:15 24 floor over to you.

08:39:16 25 MS. EMERICH: Thank you, sir. Good morning.

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08:39:19 1 Lieutenant General Green, members of the committee,
08:39:21 2 we'd like to thank you for inviting us down here to
08:39:23 3 share with you some of the details of the Army WTU
08:39:27 4 cadre training. My name is Sherri Emerich and I'm
08:39:29 5 the program director of the cadre training program.
08:39:32 6 We are based out of the Academy of Health Sciences
08:39:36 7 on Fort Sam Houston, under the umbrella of the Army
08:39:40 8 Medical Department Center & School. With me is
08:39:43 9 Colonel Bair, Colonel Scott and Colonel Grantham
08:39:45 10 from the warrior transition command. At this time
08:39:48 11 I'd like to let them introduce themselves.

08:39:51 12 COL BAIR: For the third time my name is
08:39:53 13 Dave Bair. I'm the G-3/5/7 division chief for the
08:39:58 14 warrior transition command.

08:39:59 15 COL SCOTT: Good morning. I'm Colonel Suzie
08:40:01 16 Scott. I'm the chief nurse for warrior transition
08:40:04 17 command and the consultant to the surgeon general
08:40:06 18 for case management.

08:40:07 19 LT COL GRANTHAM: I'm Lieutenant Colonel
08:40:09 20 Andy Grantham. I am the training officer, work for
08:40:12 21 Colonel Dave Bair. Have been since April. Prior
08:40:14 22 to that I was the deputy battalion commander at
08:40:14 23 Fort Carson.

08:40:20 24 MS. EMERICH: This is the agenda, the areas
08:40:22 25 that we'll be covering throughout the brief.

08:40:24 1 Colonel Bair will start the brief, followed by me
08:40:29 2 talking about some of the details and answering
08:40:32 3 some of your questions specifically about cadre
08:40:34 4 training; and then followed by Colonel Scott
08:40:37 5 talking more on the details of case management.
08:40:40 6 And we'll begin with Colonel Bair.

08:40:42 7 COL BAIR: Good morning again. When I
08:40:43 8 learned that the task force was coming down here to
08:40:47 9 San Antonio to talk to the cadre training course, I
08:40:52 10 quickly contacted Ms. Emerich and really just asked
08:40:57 11 for about five or 10 minutes up front to be able to
08:41:00 12 lay out for you the training program at the macro
08:41:03 13 level. I think it's important to put into context
08:41:05 14 that while the cadre course is certainly an
08:41:07 15 invaluable training program, especially for the
08:41:10 16 initial training at the inculcation of our new
08:41:13 17 cadre, it's not the only program. In fact, it's
08:41:16 18 part of a larger training framework to ensure that
08:41:21 19 our cadres are adequately prepared not only when
08:41:24 20 they begin their job, but throughout the duration
08:41:26 21 of their duties. So, it's my intent, really, just
08:41:28 22 to take a few minutes up front, not to take any
08:41:30 23 time away from Sherri; but to establish a broader
08:41:33 24 training framework for which the course we're going
08:41:37 25 to discuss in detail fits.

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08:41:39 1 I wanted to show this slide just to refresh
08:41:41 2 your memory. I just wanted to show this slide to
08:41:49 3 refresh the task force's memories of what the
08:41:52 4 mission statement for the WTC is and I just want to
08:41:56 5 draw your attention to the bold and underlined
08:41:58 6 words. We are the component for centralized
08:42:02 7 oversight, guidance and advocacy for all soldiers,
08:42:05 8 active, guard and reserve, for veterans and their
08:42:09 9 family, as they heal and reintegrate either back
08:42:11 10 into the force or into the community; and the
08:42:14 11 process which we use to do that is the
08:42:16 12 comprehensive transition plan.

08:42:23 13 We are generally grateful for the numerous
08:42:25 14 visits and probes we have into our program yearly
08:42:28 15 and I just highlighted a very few over the last 12
08:42:31 16 months that have really helped us to see ourselves.
08:42:36 17 And just for -- so everybody understands the
08:42:38 18 acronyms -- and I apologize -- the Department of
08:42:38 19 Army IG, Department of Defense IG and of course
08:42:42 20 your own annual report. And then we have our own
08:42:44 21 program within the warrior transition command in
08:42:47 22 which we have organizational inspection programs.
08:42:49 23 That's an internal audit that we run about 12 to 15
08:42:54 24 times a year for about four -- about three to five
08:42:57 25 days at select locations. That we go and conduct

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08:43:04 1 our own inquiries into programs to help see
08:43:07 2 ourselves. On the right-hand side you'll see some
08:43:10 3 of the common themes that we pulled from these
08:43:12 4 reports. Specific, really, to the training aspect
08:43:14 5 or what we're here to talk about today. But they
08:43:20 6 have been truly the drivers that have fed our
08:43:22 7 training revision process that we really started in
08:43:24 8 the August time frame. So, it really helped us to
08:43:27 9 figure out the direction that we need to go. Quite
08:43:34 10 honestly, though, my challenge in laying out that
08:43:36 11 vision for the commander is not to make changes to
08:43:38 12 programs that are -- are already in place and
08:43:45 13 fruitful. So, for example, we often dwell on those
08:43:48 14 that are highlighted on the right; but truth be
08:43:51 15 told, we have about an 80 plus percentage
08:43:57 16 satisfaction rate of recovering warriors over the
08:44:00 17 last two years based on a series of surveys of
08:44:05 18 thousands of recovering warriors. Now, 80 percent
08:44:09 19 is pretty good; but it certainly is not where we
08:44:12 20 want to be as an organization and so we identified
08:44:15 21 the gaps between the optimal, the hundred percent,
08:44:19 22 and where we are right now; and that's really what
08:44:21 23 we're attacking. And as I mentioned, you can see
08:44:23 24 many of them there on the right-hand side.
08:44:27 25 I -- just briefly -- this is a very busy

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08:44:30 1 slide and I don't want to get into the weeds; but I
08:44:33 2 do just want to remind and highlight that the CTP
08:44:35 3 remains the core of our program. It is what we
08:44:38 4 use, as I mentioned, to help transition and
08:44:40 5 reintegrate. That has not changed since we last
08:44:43 6 briefed you in February. However, there are
08:44:45 7 several things within the CTP that have changed
08:44:48 8 that I do think are noteworthy and I just want to
08:44:51 9 express to you quickly. At the policy level -- in
08:44:55 10 February when we last briefed you, although we had
08:44:57 11 a surgeon general signed policy, what we didn't
08:45:00 12 have was implementing guidance. Not signed
08:45:04 13 implementing guidance. So, this past August we
08:45:08 14 started a comprehensive revision, rewrite of the
08:45:12 15 CTP. We pulled in all cadres, all members from the
08:45:18 16 multidis -- interdisciplinary teams for a series of
08:45:21 17 workshops and IPRs over an extended period of time.
08:45:24 18 We completely, in many cases, reworked the CTP and
08:45:29 19 in other cases went into much greater detail than
08:45:33 20 what the guidance -- the unsigned guidance
08:45:37 21 previously had. At the policy level then we rolled
08:45:40 22 it out. We used the vice chief of staff of the
08:45:46 23 Army CTP to brief all senior mission commanders on
08:45:46 24 the CTP -- the new CTP and the changes. We also
08:45:49 25 held two DTCs with all WTU commanders at the

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08:45:54 1 separate -- through brigade -- separate company
08:45:58 2 through brigade level, to brief them on it and then
08:46:00 3 we staffed it not only through MEDCOM, but through
08:46:02 4 the Army. And so through the participation of the
08:46:04 5 field and the input, I think for the first time the
08:46:09 6 program has a codified and formalized guidance for
08:46:14 7 implementation. Something that we didn't have in
08:46:14 8 the past.

08:46:17 9 Some of the things that the CTP kind of
08:46:20 10 rectified is -- you'll see on the previous slide
08:46:25 11 roles and responsibilities of the interdisciplinary
08:46:27 12 team and how they work with one another. We took
08:46:30 13 great measures to get their input to lay out more
08:46:35 14 clearly not only for the new, say, commander or the
08:46:38 15 new case manager, to show how they fit; but so that
08:46:41 16 each of the team members understands how they play
08:46:44 17 in this process. So, we went into a little bit
08:46:46 18 more detail. We also eliminated some of the
08:46:50 19 confusions that -- we had asked in the old guidance
08:46:54 20 of CBWTUs -- which we knew they couldn't execute
08:46:59 21 because they were either underresourced or didn't
08:47:02 22 have the time to do it; and so we took those
08:47:04 23 demands off them and aligned the requirements which
08:47:07 24 they are required to perform within their
08:47:09 25 capabilities. But the revision was just a small

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08:47:13 1 piece of it. Once you revise you have to educate
08:47:16 2 and I think as Ms. Emerich is going to show you,
08:47:19 3 that starts here at the cadre course for our new
08:47:22 4 cadre; but we also have a couple of other
08:47:24 5 initiatives that we use to educate the force. I'll
08:47:28 6 show you later on we have a senior leader
08:47:30 7 orientation course that we run for our battalion
08:47:34 8 commanders and battalion level, brigade level
08:47:37 9 leadership, to include primary care providers; and
08:47:40 10 we go over the CTP there.

08:47:42 11 My team briefs the IG monthly. All the new
08:47:45 12 IGs that come into the Army. We brief them on the
08:47:50 13 CTP process so we all have a common understanding
08:47:53 14 of what it is and we also go to the AW2 advocates,
08:47:56 15 who I think might have spoke to you yesterday. We
08:47:59 16 go to their new hires training program monthly as
08:48:03 17 well and brief them on the CTP. So, education is
08:48:07 18 the next step and then we have to inspect. And I
08:48:12 19 know there will be no shortage of outside looks, I
08:48:16 20 hope, in the upcoming year because it will really
08:48:18 21 help to see us and make improvements on this
08:48:20 22 version; but will also focus and adjust our own
08:48:23 23 internal OIP inspection checklist to make sure
08:48:26 24 compliance at the unit level -- standardization
08:48:28 25 where applicable at the unit level and also to

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08:48:31 1 identify any deficiencies that we need to work on
08:48:33 2 in the future.

08:48:34 3 And then finally, once you educate and
08:48:37 4 inspect, you've got to know if it's successful or
08:48:40 5 not; and we are internally reworking our own
08:48:42 6 metrics to try to find measures of effectiveness to
08:48:46 7 know if in a year from now what we've put in place
08:48:51 8 vice what we had in place is moving us in the right
08:48:54 9 direction. So, pretty exciting. It's a wholistic
08:48:57 10 approach to the CTP. Another busy slide and again
08:49:00 11 I apologize.

08:49:00 12 LT GEN GREEN: Can I ask --

08:49:02 13 COL BAIR: This slide is intended to
08:49:04 14 highlight our whole system.

08:49:04 15 LT GEN GREEN: Excuse me. Just real quick.
08:49:05 16 When you rewrote the program, were there any
08:49:08 17 changes to who goes to your WTUs? In other words,
08:49:12 18 did they make any -- they made a change in -- a
08:49:15 19 year ago or maybe a little over a year ago which
08:49:19 20 changed the eligibility criteria for who went to
08:49:22 21 WTU. Have they made any changes in who's going to
08:49:24 22 WTU?

08:49:25 23 COL BAIR: As far as the entrance criteria,
08:49:27 24 no, sir.

08:49:29 25 LT GEN GREEN: Okay.

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08:49:29 1 CSM DEJONG: Sir, real quick while we're on
08:49:29 2 the CPT, if we can kind of take these
08:49:30 3 independently. Looking through your slides it
08:49:32 4 looks like things are pretty well organized in
08:49:35 5 here. So, if we can take a few minutes on the CTP,
08:49:38 6 I'd like to give you the underground truth of the
08:49:41 7 feedback that we're getting from the end user of
08:49:44 8 it, being the wounded warrior. A lot of it is
08:49:48 9 difficult. It's not so much difficult. Bottom
08:49:51 10 line up front is the part that's missing is -- the
08:49:54 11 CTP is out there. Leaders are using it. Leaders
08:49:56 12 are -- commanders are checking it. The wounded
08:50:03 13 warriors feel that it is a check the block, the
08:50:05 14 commanders can go in and make sure everything is
08:50:07 15 green and then they're done. They don't feel that
08:50:10 16 they're getting an accurate response to what
08:50:15 17 they're inputting on their CTP and when we started
08:50:19 18 beating this up and really digging down into it,
08:50:22 19 what's lacking is the interaction between the CTP
08:50:27 20 and -- between the leader, the cadre and the
08:50:29 21 wounded warrior. What the wounded warrior's
08:50:31 22 looking for is basically to take that CTP out and
08:50:34 23 use it as a counseling tool. Face-to-face
08:50:37 24 counseling and say this is what I wrote, how can we
08:50:40 25 move this forward. They don't like the -- the

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08:50:45 1 virtual -- the internet world of responses. Some
08:50:48 2 of it is also lack of knowledge of where the
08:50:50 3 responses are; but they really want that
08:50:52 4 face-to-face interaction between their cadre, the
08:50:55 5 CTP being the counseling tool and then being able
08:50:59 6 to talk through what their plan is.

08:51:08 7 DR. PHILLIPS: May I just add a bit to that.
08:51:10 8 As the command sergeant major said, we've heard
08:51:12 9 this repeatedly, that the CTP should really just be
08:51:16 10 the bridge that will stimulate the face-to-face
08:51:19 11 discussion. Some of the comments we heard from the
08:51:25 12 cadre were related to technical, which I think can
08:51:28 13 be fixed. It took a long time to upload a page.
08:51:33 14 Up to two minutes sometimes. Because of the
08:51:36 15 complexity of the program the computer would freeze
08:51:39 16 and they were getting frustrated. So, I think
08:51:42 17 you've heard these things before.

08:51:45 18 DR. TURNER: I would be curious just what do
08:51:47 19 you hear from your folks in the field about the CTP
08:51:49 20 and its effectiveness?

08:51:52 21 COL SCOTT: We've heard very similar
08:51:54 22 feedback from members of the cadre, from warriors
08:51:57 23 in transition; and I think as we go back and look
08:52:00 24 at what we had done in the past, one of the root
08:52:06 25 cause factors that contributed to this lack of use

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08:52:18 1 of the -- of the CTP as a process and more of as a
08:52:24 2 tool was the fact that when we -- when we educated
08:52:28 3 our cadre members on the CTP, we educated them on
08:52:34 4 the CTP process and the tool as one. So, we -- we
08:52:41 5 didn't impart a level of understanding that the CTP
08:52:44 6 is a process. Is a mechanism for coaching,
08:52:49 7 teaching and mentoring soldiers through the
08:52:51 8 transition process as opposed to an electronic tool
08:52:55 9 where we document. So, with this last round of
08:52:59 10 instruction that we just started a week ago, we
08:53:03 11 began to separate those two and addressed the
08:53:06 12 comprehensive transition plan as a process and
08:53:09 13 that's written in the new CTP guidance, as well,
08:53:12 14 that we just distributed to the field and we're
08:53:15 15 separating that from the automation tool and then
08:53:20 16 using -- training the cadre that the automation
08:53:24 17 tool that we have is merely that. It's a tool to
08:53:27 18 be able to document, but that the process as a
08:53:29 19 whole is how you're going to help transition
08:53:32 20 warriors from point of illness or injury to
08:53:36 21 becoming a self-determined veteran or recover ing
08:53:39 22 warrior that's back on duty.

08:53:41 23 DR. TURNER: And when did that process
08:53:43 24 start? That training process start?

08:53:46 25 COL SCOTT: The beginning of the week with

08:53:48 1 this last -- with this ca -- we just rolled out the
08:53:51 2 new guidance on the 1st.

08:53:52 3 DR. TURNER: So, it's a bit soon for
08:53:55 4 feedback and follow-up.

08:53:57 5 COL SCOTT: Pardon?

08:53:59 6 DR. TURNER: A bit soon for feedback.

08:54:02 7 COL SCOTT: Just a bit, yes.

08:54:04 8 DR. TURNER: Do you have a plan -- is
08:54:05 9 there -- do you any in-place plan for tracking the
08:54:06 10 effectiveness of this new program?

08:54:09 11 MS. EMERICH: Sir, if I can add to that and
08:54:11 12 just address -- this is -- our plan in the training
08:54:12 13 arena is that -- as Colonel Scott said, we want to
08:54:17 14 better separate the process from use of the
08:54:20 15 automated tool. So, the intent in the training
08:54:23 16 program is we would first train on the process and
08:54:28 17 fully ensure a good understanding of the process
08:54:31 18 and the wholistic approach to comprehensive
08:54:35 19 transition planning and setting up this road map
08:54:38 20 for success for the soldier; and once we -- we see
08:54:43 21 that we have a clear understanding of that, the
08:54:45 22 next piece of the training then would move to now
08:54:48 23 here's how we document the process and show the
08:54:51 24 automated tool; but with the Army -- the warrior
08:54:55 25 care and transition new system that's coming out,

08:54:59 1 we'll be able in that system to set up an area for
08:55:02 2 training that won't allow our students or our
08:55:06 3 attendees to go into any HIPAA related data. So,
08:55:10 4 the intent is now to put computers in front of them
08:55:13 5 and have them work either individually or in teams,
08:55:16 6 given a case study, and actually go through and
08:55:18 7 document the CTP and understand what they need to
08:55:21 8 do with that as they do that and the soldier's role
08:55:25 9 in that and their roles and responsibilities in
08:55:27 10 that.

08:55:28 11 COL SCOTT: To further answer your question,
08:55:29 12 our plan to ensure that we have effectively trained
08:55:34 13 the individual is to monitor this with our OIP
08:55:39 14 inspections that we do on a routine basis. We also
08:55:43 15 ask for feedback from our warriors on other visits
08:55:48 16 as well and we also seek feedback from DAIG, DoDIG
08:55:53 17 and you all as you go out as well. We incorporate
08:55:57 18 that feedback immediately so we can continue to
08:55:59 19 adjust and make changes as we go forward.

08:56:02 20 CSM DEJONG: Just one more quick note on the
08:56:05 21 CTP. One of the questions that we specifically ask
08:56:07 22 during our focus groups to the families is do
08:56:10 23 you -- have you ever heard of the term CTP or CRP
08:56:13 24 and across the board generally they give us a blank
08:56:15 25 look that they have no idea; and one of the

08:56:17 1 resounding issues over the last year and a half
08:56:21 2 have been that the families -- spouses, especially,
08:56:24 3 don't feel they're included into their warrior's
08:56:27 4 transition plan. And we understand that there's
08:56:29 5 the dynamics of that where some don't even want to
08:56:33 6 be involved. The ones that do want to be involved
08:56:36 7 want to be involved. So, if you're taking this to
08:56:39 8 a new -- my only suggestion would be if you're
08:56:41 9 kicking off a new program here and you're kicking
08:56:45 10 off a new training program, the leaders have to try
08:56:48 11 to include the families into the transition plan
08:56:51 12 for that wholistic healing process.

08:56:54 13 MS. EMERICH: Yes, and -- and that's
08:56:56 14 disappointing to hear that the families are not
08:56:59 15 being engaged. When we train -- from the training
08:57:02 16 perspective, when we train we do -- we do emphasize
08:57:05 17 the importance of engaging the family in
08:57:08 18 comprehensive transition planning and their value
08:57:11 19 and we actually have a family that talks on day one
08:57:16 20 that provides testimony to the importance of
08:57:18 21 engaging the family. Not only the spouse, but even
08:57:20 22 the children and the effects on the children.

08:57:24 23 CSM DEJONG: We understand the difficulties.
08:57:25 24 It's an automated system now. Back when I went
08:57:27 25 through it it was still paper. So, there's --

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08:57:30 1 there's connectivity issues and access issues. We
08:57:33 2 understand that. I think they just want to be
08:57:36 3 involved in -- in the face-to-face counseling part
08:57:40 4 of it. So --

08:57:42 5 DR. PHILLIPS: I want to share with you just
08:57:44 6 one other comment that we've heard repeatedly from
08:57:46 7 some of the warriors and their family related to
08:57:49 8 responses, which you might address. With all good
08:57:54 9 intentions, when they're asked about perhaps
08:57:57 10 anxiety and if they check yes, I have a high
08:58:00 11 anxiety level, there seems to be a response from
08:58:04 12 whoever is reviewing it, "Well, your weekend pass
08:58:07 13 is canceled. You're going to stay on post and
08:58:11 14 we'll get you an appointment to see somebody"; and
08:58:15 15 that appointment may be two -- two weeks down the
08:58:18 16 road and that doesn't set well with some of the
08:58:20 17 warriors and because of that they seem to be
08:58:22 18 fudging answers or responses.

08:58:24 19 MS. EMERICH: Well, thank you for that
08:58:26 20 feedback as well, sir. We teach an area through
08:58:30 21 the CTP in risk mitigation and one of the things
08:58:34 22 that we emphasize is -- is that being coded as red
08:58:40 23 or high risk doesn't mean that all privileges go
08:58:44 24 away, doesn't mean that -- it's on a case-by-case
08:58:47 25 basis and the soldier should be evaluated as to

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08:58:50 1 whether they can go on pass for the weekend or go
08:58:54 2 home for the weekend or whatever it is; but hearing
08:58:57 3 that from you -- thank you. We need to look at
08:59:00 4 that and see if we can do that better.

08:59:03 5 MSGT MACKENZIE: I would just like to add
08:59:05 6 one more thing before we jump off the CTP. The --
08:59:07 7 and unfortunately the question popped into my head
08:59:10 8 without time to do research. So, I'm just going to
08:59:13 9 ask you guys as the experts. When we were at one
08:59:16 10 particular battalion speaking with the battalion
08:59:18 11 commander and one of the company commanders, one of
08:59:20 12 the things that we saw after focus groups and other
08:59:23 13 discussions was the tool of the commander to be
08:59:25 14 able to review that things are green or red as a
08:59:29 15 measurement device and the question that came up
08:59:32 16 was, you know, is there an effort to create a
08:59:36 17 measurement device where the command can actually
08:59:39 18 go and look at the quality of the responses. You
08:59:42 19 know, are you really evaluating your troops and
08:59:45 20 your cadre just by a color of button or are you
08:59:48 21 actually getting the opportunity to evaluate your
08:59:51 22 troops based on the quality of responses; and it
08:59:54 23 seemed to be at both the battalion and company
08:59:58 24 command level that that was very intriguing for
08:59:59 25 them and they were -- maybe there's a way we can

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09:00:03 1 figure that out and my curiosity in that fact is is
09:00:05 2 that part of the new process or have you guys
09:00:10 3 started looking at that yet?

09:00:12 4 MS. EMERICH: From the -- just within the
09:00:15 5 cadre training itself, approximately six months
09:00:18 6 ago -- I'm not sure of the exact amount of time --
09:00:21 7 we added a block of instruction specifically for
09:00:24 8 the company level leaders. First sergeants, XO's,
09:00:28 9 company commanders, where the CTP instructor just
09:00:30 10 sits down with that group and shows them how to use
09:00:33 11 the reporting portion of the automated CTP so that
09:00:37 12 they can go in and view the effectiveness of the
09:00:40 13 overall program by -- and what types of reports can
09:00:45 14 be pulled out of the program.

09:00:47 15 LTC GRANTHAM: Can I say something? As a
09:00:49 16 prior commander, though, I understand what your
09:00:51 17 point is; but the bigger point to this is that
09:00:53 18 should only be an indicator for the leader of that
09:00:56 19 particular soldier. Squad leader, nurse case
09:00:59 20 manager, PCM, battalion commander. Just an
09:01:02 21 indicator. If we're going to put the quality into
09:01:05 22 the automation, then it's going to get to all
09:01:07 23 automation. We don't want that. We just want to
09:01:10 24 have a quick snapshot that that commander, that
09:01:13 25 squad leader can go back and say -- sit down with

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09:01:14 1 them and say face to face what's really going on.
09:01:16 2 What's going on at home. What's happening in your
09:01:19 3 life and let me make it better. So, in some
09:01:22 4 regards I don't know that we want to go totally
09:01:24 5 that direction. I think it's more of an indicator
09:01:28 6 for the commanders and the squad leaders and
09:01:30 7 interns to actually go out there and say, "Hey, let
09:01:32 8 me put my arm around you, what's really going on
09:01:34 9 with you."

09:01:35 10 MSGT MACKENZIE: This was a unique situation
09:01:37 11 because you've got companies scattered over a large
09:01:40 12 territory with a battalion commander. I think it
09:01:43 13 was unique the way that was brought up and I was
09:01:46 14 just -- it was just curiosity on that aspect.
09:01:49 15 Also, because I didn't have time to do research,
09:01:51 16 the -- when we were at a CBWTU one of those things
09:01:57 17 was has this soldier actually received all the
09:02:00 18 training in the CPT. You know, one of the things
09:02:02 19 the squad leaders were having a hard -- or the
09:02:04 20 platoon sergeants were having a hard time with was,
09:02:06 21 you know, they thought everything was fine and then
09:02:08 22 they realized this guy didn't get all the training
09:02:10 23 prior to leaving a WTU and now he's in a CBWTU and
09:02:15 24 now we're going to have to -- the assumptions were
09:02:18 25 made some of the responses were incorrect and they

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09:02:20 1 were going to have to jump back and, you know,
09:02:21 2 that -- you know, what training has this soldier
09:02:23 3 received prior to me -- him arriving to the CBWTU.
09:02:27 4 So, I was just curious if that was also involved?

09:02:30 5 COL BAIR: In the old guidance it never
09:02:32 6 stipulated what requirements had to be met to
09:02:35 7 transition out of the program and so I think
09:02:37 8 commanders developed their own checklist. Some
09:02:40 9 great in length and some not so much. And so we --
09:02:43 10 from a policy standpoint we did try to define that.
09:02:46 11 So, we have two measures. One is transition
09:02:48 12 eligible, which is an objective measure; and then
09:02:52 13 one is transition ready, which is subjective. And
09:02:54 14 so we've put rigor between those tasks associated
09:02:59 15 with being transition eligible. There's currently
09:03:02 16 seven tasks that we'll track through the CTP. Some
09:03:07 17 have numerous tasks associated with them, like ATAP
09:03:12 18 for example; but -- that he cannot become -- the
09:03:15 19 recovering warrior is ineligible for transition
09:03:18 20 until that point; and then it comes down to
09:03:20 21 transition ready, asking -- that's a subjective
09:03:23 22 evaluation by the chain of command of that
09:03:27 23 recovering warrior. Are you -- do you feel ready
09:03:29 24 to transition. I mentioned a little bit earlier
09:03:32 25 about the metrics piece. So -- because truly

09:03:34 1 successful transition is the goal of the CTP, we're
09:03:37 2 focusing our metrics -- the metrics that I look at,
09:03:42 3 on trying to qualify that over time to see if the
09:03:46 4 subjective and the objective view are the same.

09:03:51 5 And to follow --

09:03:51 6 DR. TURNER: And -- just quickly. And who
09:03:53 7 has the final say whether this guy is ready or not?

09:03:57 8 COL BAIR: It -- truth be -- it's really --
09:04:01 9 well, medical will always take precedence,
09:04:04 10 obviously; and then I think it's going to be a
09:04:07 11 shared responsibility of both the recovering
09:04:10 12 warrior and his cadre, if there is a disconnect;
09:04:14 13 and I don't know how often that will or will not
09:04:16 14 occur, but if someone says they're ready and the
09:04:19 15 other says they're not, I think that will be one of
09:04:21 16 those sit-down discussions at the chain of command
09:04:26 17 that the recovering warrior and hopefully the
09:04:28 18 family have together.

09:04:29 19 DR. TURNER: Because there is a chain of
09:04:32 20 command, it's my impression that if it comes to an
09:04:34 21 impasse, the unit commander has the call?

09:04:41 22 COL SCOTT: Between the unit commander and?

09:04:43 23 DR. TURNER: Medical.

09:04:45 24 COL SCOTT: Medical drives.

09:04:46 25 DR. TURNER: Medical drives.

09:04:48 1 COL SCOTT: Medical drives the decision and
09:04:50 2 we've written that in the CTP guidance.

09:04:52 3 DR. TURNER: That's what I want to hear.
09:04:54 4 Thank you.

09:04:54 5 MSGT MACKENZIE: Thank you for addressing
09:04:55 6 that because that was brought up by a platoon
09:04:58 7 sergeant and the -- facilitating him being -- we
09:05:00 8 all have manning issues and with budget cutbacks
09:05:03 9 and so forth, the amount of time having to be spent
09:05:06 10 to try to figure out what happened at the WTU and
09:05:10 11 seeing him in my department now and that's -- it's
09:05:12 12 good to see that that's already happening when
09:05:14 13 someone brings up that point. So, thank you.

09:05:20 14 MR. REHBEIN: Colonel, before you go on, if
09:05:22 15 I may for just a moment, I'm going to go back to
09:05:24 16 the cadre. Providing the right training is
09:05:26 17 essential, but equally essential is training the
09:05:29 18 right people and I would like -- maybe you will be
09:05:31 19 talking about it later on, but the selection and
09:05:34 20 the qualification process for the cadre; and,
09:05:37 21 frankly, I would like to know what percentage of
09:05:42 22 the people that would like to be cadre don't
09:05:45 23 actually make it. Aren't assigned as cadre.

09:05:53 24 COL BAIR: Colonel Grantham, with his
09:05:55 25 experience as a commander, can probably give you a

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better --

LTC GRANTHAM: I think what you're asking is how do we get the guys -- how do we get the soldiers into the -- into the cadre or how do we select the --

MR. REHBEIN: Yes, sir, and if you could, just focus -- just focus on the squad leader position because that's really where the hands-on between the cadre and the recovering warrior is.

LTC GRANTHAM: Informally, as -- as we go through this process -- and Sherri can step in on this -- but I would say probably 85 to 90 percent of the soldiers that are in the cadre course raise their hand when we ask them, "Hey, would you volunteer for this." They raise their hands. Some of the soldiers are -- you know, this is going to be your next duty assignment; but I would say the majority of the soldiers that come into those assignments are -- they volunteer to come in. They -- excuse me. They want to be -- they want to be that particular source and they have to have a certain background. They have to be -- depending on what their rank is, they have to have certain qualifications, certain schooling already, certain background. The -- I'm losing my thought on that

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09:07:04 1 one. Maybe it's on the next slide. The warrior
09:07:07 2 leader course for squad leaders you have to be
09:07:11 3 warrior leader course qualified. Certain
09:07:13 4 background. But we have -- through our ranks, as
09:07:17 5 you know, we have a multitude of various soldiers
09:07:21 6 from active duty, guard and reserve with various
09:07:24 7 experiences. Very difficult if you -- to be
09:07:28 8 honest, to know if a soldier squad leader is going
09:07:34 9 to be that right guy. You may not know and to be
09:07:38 10 honest with you we don't have a set process that
09:07:40 11 says, you know what, if we pick this guy from this
09:07:43 12 background, he's going to be absolutely successful.
09:07:45 13 He's going to be able to answer everything that he
09:07:47 14 needs to know on a moment's basis to be the
09:07:50 15 perfect squad leader. We won't know that. There
09:07:53 16 are checks and balances through the entire process.
09:07:56 17 A soldier comes in and we know that he's not doing
09:07:58 18 the things that he needs to do in the cadre course,
09:08:01 19 we're going to pick up on that. He comes in and
09:08:03 20 he's not doing the things he needs to do from a
09:08:06 21 squad leaders perspective once he gets to the unit,
09:08:09 22 the unit's going to pick up on that because they
09:08:11 23 know right away, from having the experience there,
09:08:14 24 that this guy is going to make it or he's not.
09:08:17 25 Couseled, etcetera. And I know as a battalion

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09:08:19 1 commander I had to remove individuals all the way
09:08:23 2 through company commander level because they were
09:08:25 3 not cutting the muster. They were not getting the
09:08:28 4 point of the mission, they didn't have what it took
09:08:30 5 and so we moved them out and found somebody that
09:08:34 6 could. Would it be fantastic to have a -- some
09:08:37 7 kind of magic wand that said, "Hey, we know you're
09:08:40 8 going to make it"? That would be great, but it
09:08:42 9 doesn't work that way.

09:08:43 10 MR. REHBEIN: You're not necessarily feeling
09:08:46 11 pressure then because of -- as a commander you're
09:08:48 12 not necessarily feeling pressure then that we can't
09:08:51 13 get enough people who want to be cadre, I have to
09:08:53 14 keep someone that's borderline because borderline
09:08:57 15 is better than an empty slot?

09:09:00 16 LTC GRANTHAM: No, sir. Great question
09:09:01 17 though. But no, sir. The units at the
09:09:04 18 installations, through a multitude of educational
09:09:09 19 processes, VDC -- the vice chief of staff having
09:09:12 20 this intimate relationship with the senior mission
09:09:14 21 commanders taking on the responsibility of really
09:09:17 22 overseeing the progress that we're making in these
09:09:20 23 programs. Through that education process the
09:09:23 24 senior mission commanders and the senior NCOs at
09:09:26 25 those installations understand the responsibility

09:09:29 1 and so -- I can speak for Fort Carson. My sergeant
09:09:34 2 major, the garrison sergeant major, the MTF
09:09:37 3 sergeant major and the 4ID division sergeant majors
09:09:41 4 will meet on a regular basis and talk about our
09:09:43 5 needs for cadre. Quality cadre, but cadre, to come
09:09:47 6 into the program and backfill those soldiers that
09:09:51 7 were leaving. So, it was -- it was being worked at
09:09:55 8 all levels to make sure that we had cadre coming
09:09:57 9 in.

09:09:58 10 DR. TURNER: Lieutenant Colonel Grantham,
09:10:01 11 while you're speaking to this, could you comment on
09:10:04 12 where -- the time the soldier is in cadre, how does
09:10:07 13 that fit into his overall career? Does he come in
09:10:10 14 just for a while as cadre and then go back to his
09:10:13 15 original MOS or, you know, is it a career enhancer,
09:10:17 16 is it a sideline? Just -- could you comment on
09:10:20 17 that?

09:10:21 18 LTC GRANTHAM: I can speak to that typically
09:10:23 19 a soldier will come in and spend no more than two
09:10:27 20 years. A year to two years is what we typically
09:10:30 21 look at and according to our records, that the
09:10:35 22 soldier -- the soldier is -- is -- they're on the
09:10:42 23 same progression for promotion, etcetera, as
09:10:44 24 everyone else; and I will tell you this. Talking
09:10:47 25 to some of the soldiers that were cadre members of

09:10:50 1 mine and had gone back into say 4ID, the learning
09:10:55 2 experiences that they get, the variations, the
09:10:57 3 training, the new or varied techniques of how to
09:11:04 4 handle various situations has actually made them a
09:11:06 5 better soldier. Made them a better leader.

09:11:08 6 DR. TURNER: Does big Army view this time as
09:11:10 7 a career enhancer or is it neutral?

09:11:13 8 LTC GRANTHAM: Sir, I really can't speak on
09:11:15 9 what big Army thinks. I honestly can't answer that
09:11:18 10 question.

09:11:19 11 CSM DEJONG: If you're looking for --
09:11:20 12 especially for NCO advancement. It is supposed to
09:11:23 13 be considered for -- for promotion points based off
09:11:26 14 of other equal recruiting duty, other equal tasks
09:11:30 15 that you've performed. What we're seeing across
09:11:33 16 the board is -- and it's coming leaps and bounds.
09:11:35 17 A lot -- a lot better. You're still going to get
09:11:38 18 the ones that -- we get some feedback that -- and I
09:11:43 19 want -- I don't want to take up too much time. I
09:11:45 20 want to go through the training program. I want
09:11:47 21 you to run with it. We do get some feedback that
09:11:49 22 two weeks is not enough time to train guys to be an
09:11:51 23 expert in Tricare, to be an expert in medical, to
09:11:54 24 be an expert in -- you know, somewhat of a
09:11:57 25 pharmacologist, somewhat -- I mean, there's so much

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09:11:59 1 and it's very -- it's a huge, overwhelming task.
09:12:03 2 We're getting feedback from different -- different
09:12:05 3 areas. 82nd airborne for instance. You know, the
09:12:09 4 high level of command sergeant majors. Post
09:12:11 5 command sergeant major and division sergeant majors
09:12:13 6 have a lot of input on who they selected for their
09:12:16 7 cadre. That's not equal across the board as far as
09:12:18 8 from the NCO side. There's other cadres -- my
09:12:21 9 cadre when I was at Fort Knox, I asked the staff
09:12:24 10 sergeant, "How did you get here? I was the first
09:12:26 11 sergeant selected." I said, "What does that mean?"
09:12:28 12 He said, "Well, I was the first behind in pitching
09:12:30 13 my module --" he was going to be an instructor --
09:12:33 14 "and I was selected." I -- from my perspective, I
09:12:37 15 think I would take some of these leaders that truly
09:12:40 16 like it because we are creating a leader that
09:12:42 17 has -- instead of the 90/10 scenario of -- you
09:12:45 18 know, 10 percent -- 90 percent or 10 percent of
09:12:48 19 your people, you've got a hundred percent of your
09:12:51 20 soldiers that have issues and you're learning
09:12:53 21 things that the average squad leader or platoon
09:12:56 22 sergeants don't learn.

09:12:58 23 The other issue that I see is we're not
09:13:00 24 building this -- it's not a long-term assignment.
09:13:02 25 So, it's not -- it's not like an infantry unit

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09:13:06 1 where by the time you make platoon sergeant you're
09:13:09 2 that subject matter expert that you can keep
09:13:11 3 handing knowledge down. I understand with burnout
09:13:13 4 and lows that you can't do more than a two-year
09:13:15 5 assignment; but we haven't truly grasped how do we
09:13:18 6 keep these subject matter experts in the position
09:13:20 7 to take the new cadre that are coming in and help
09:13:23 8 them work through the challenges of trying to learn
09:13:25 9 this on the run. I don't want to take up any more
09:13:29 10 of your time. I want you to have it to go through
09:13:32 11 the training program.

09:13:32 12 LT GEN GREEN: Yeah, I think we need to let
09:13:34 13 you guys go ahead. If I can get us back -- moving
09:13:37 14 on the schedule and if I can let us -- take us down
09:13:39 15 a little bit and we can come back to some of those
09:13:42 16 questions. Okay. Go ahead, Colonel.

09:13:44 17 COL BAIR: Sergeant major, that's a great
09:13:45 18 segue really into this slide. I agree that two
09:13:48 19 weeks is not nearly enough time to -- nowhere near
09:13:52 20 enough time to train our cadre in everything that
09:13:53 21 they do and so we're in the process, again, of
09:13:55 22 revising how they receive training from the
09:13:58 23 beginning, through sustainment, throughout the
09:14:01 24 duration of their duties. And so just a little
09:14:03 25 slideology here. A very busy slide. The pictures

09:14:07 1 on the left depict various stages in time of where
09:14:12 2 a cadre member gets his training. Down there on
09:14:16 3 the lower left-hand corner with the distributive
09:14:19 4 learning prerequisite, which Sherri will talk to in
09:14:21 5 a little bit more detail when she gets to her
09:14:25 6 piece; and the classroom phase down here in San
09:14:25 7 Antonio.

09:14:28 8 We've also started, and you're probably
09:14:30 9 aware, we have a four and a half day senior leaders
09:14:32 10 course that we recently revised to make more
09:14:35 11 current and we've added doctors to that program as
09:14:37 12 well. That's quarterly in Alexandria, for that
09:14:42 13 level of leadership.

09:14:43 14 At home station training. I think that's
09:14:45 15 hit and miss and so what we've done for the first
09:14:47 16 time is we've produced in conjunction with the
09:14:51 17 surgeon general's training -- annual training
09:14:53 18 guidance specified training. Not only for cadre
09:14:57 19 members in the upcoming year, but for recovering
09:15:01 20 warriors as well. Part of that training is your
09:15:05 21 typical 350-1 type things, which isn't really what
09:15:09 22 we're after. We're after more the competen --
09:15:12 23 sustaining some of the competencies that they
09:15:14 24 learned earlier. So, for example, in conjunction
09:15:18 25 with CSF, the Army's comprehensive soldier fitness

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09:15:23 1 program, CSF prep, we've resourced and directed
09:15:24 2 resiliency training each quarter not only for the
09:15:26 3 cadre -- and that's in response to the burnout that
09:15:30 4 we've talked about, but also for the recovering
09:15:33 5 warrior and his family, if that's what they desire.
09:15:37 6 So, we've made that possible.

09:15:40 7 We also hold our annual training conference,
09:15:43 8 which last year was about a thousand members of the
09:15:45 9 interdisciplinary team down in Florida, where we
09:15:50 10 spent a week going through the nuances of the CTP,
09:15:54 11 which is where, quite honestly, a lot of the gaps
09:15:57 12 that we addressed this past fall and winter came
09:16:00 13 from. We listened to the field and made that a
09:16:03 14 better product; but we'll sustain their training
09:16:07 15 through that not only at the macro level but then
09:16:09 16 we break down into individual tracks for social
09:16:12 17 workers, squad leader, command commander and
09:16:15 18 whatnot, where they come together and receive
09:16:17 19 training in, by the way, a forum where they can
09:16:19 20 talk their challenges and best practices.

09:16:21 21 The dotted line really is the future
09:16:24 22 initiatives that we're working on right now and one
09:16:27 23 of the things that we started in the distributive
09:16:30 24 learning piece down here in the lower left this
09:16:32 25 fall was to address the prerequisite training for

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09:16:35 1 the cadre course. We think that's going to produce
09:16:39 2 an awful lot of fallout training that we're going
09:16:42 3 to identify as things that cadre members need to
09:16:45 4 sustain over the course of their duration. So, we
09:16:48 5 foresee in the future a program -- a series of
09:16:51 6 modules that a cadre member is required to conduct
09:16:55 7 to maintain his currency on those competencies and
09:16:59 8 stay abreast of any changes that are afoot. That
09:17:03 9 is still a work in progress and I'll show you some
09:17:05 10 milestones that we have towards that.

09:17:08 11 We're also looking at getting all of our
09:17:11 12 cadre, ideally, master resiliency trained. We have
09:17:16 13 a pilot course that we're going to do this spring
09:17:19 14 in conjunction with the cadre course down here to
09:17:21 15 see how that works and the benefits that the cadre
09:17:25 16 are going to receive from it. We think from the
09:17:30 17 master -- from the resiliency training feedback we
09:17:34 18 get from others that have gone through, that this
09:17:36 19 will be a big boost to the cadre. This is just a
09:17:45 20 segue slide from the macro to the micro, which Ms.
09:17:49 21 Emerich will take you through.

09:17:50 22 My -- what I want to convey to you is that
09:17:52 23 we have a path mapped out. Again, it's part of the
09:17:55 24 revision that we underwent this fall. We have a
09:17:59 25 vision that -- along with AMEDD Center & School.

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09:18:02 1 We share that common vision. More interactive, get
09:18:06 2 away from the PowerPoints, more role playing. You
09:18:08 3 want to flip. Bring in, ideally, family members to
09:18:11 4 be participants in the role playing of those
09:18:14 5 scenario-based training in the future course; and
09:18:20 6 so we've laid out a timeline to make sure that
09:18:23 7 we're en route to accomplishing those goals within
09:18:25 8 the next -- really, 12 to 15 months; and you can
09:18:29 9 see some of them here. I just want to highlight
09:18:31 10 the two that I mentioned briefly. This fall -- not
09:18:36 11 sure which one is the pointer. This fall we
09:18:39 12 established a contract with LSI to help us
09:18:41 13 revitalize our distributive learning piece. The
09:18:45 14 prerequisites of coming into the cadre course.
09:18:47 15 You're absolutely right, Sergeant Major. Again, it
09:18:50 16 goes back to how much stuff can you get in two
09:18:54 17 weeks; but if we establish a baseline for those
09:18:56 18 cadre to come in ahead of time, one, we expand
09:18:58 19 their knowledge; but, two, we also facilitate more
09:19:01 20 efficient training during the two weeks that
09:19:03 21 they're there and so we're working with LSI to
09:19:06 22 completely redo that program and we think we'll
09:19:09 23 have a pilot out mid to late summer and full
09:19:12 24 implementation by this fall. So, that's an
09:19:12 25 example.

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09:19:18 1 And then I mentioned the master resiliency
09:19:21 2 course that we're going to add on to the cadre
09:19:23 3 course, again, this spring; and based on the
09:19:25 4 feedback that we get and the resources that we're
09:19:27 5 able to get from CSF-PREP long term, ideally that
09:19:32 6 becomes part of the new training that the cadre get
09:19:36 7 as they begin their duties.

09:19:37 8 So, at the macro level that's our timeline
09:19:40 9 and we're on track -- early on -- to meet that.
09:19:43 10 I'll turn it over to Ms. Emerich right now, who
09:19:45 11 then will take you down I think a little bit more
09:19:48 12 into the weeds of the questions that you had set
09:19:51 13 forth.

09:19:51 14 LT GEN GREEN: Before you jump briefers, can
09:19:53 15 I just ask. So, very extensive in terms of your
09:19:56 16 training program. On the previous slide, just
09:19:57 17 looking at the training, I count almost 45 days,
09:20:01 18 not inclusive of CME and other recurring training;
09:20:04 19 and so is that a one-time thing to get them ready?
09:20:08 20 So, I'm counting 15 days for the NCMs, 10 day
09:20:13 21 resident cadre, four and a half days senior leader,
09:20:15 22 six days resiliency training per quarter. I'm kind
09:20:20 23 of going -- that's a significant amount of
09:20:23 24 training. Is it sustainable?

09:20:27 25 COL BAIR: I think it is. Right now we're

09:20:28 1 currently doing the cadre course and we're
09:20:30 2 currently doing the senior leader and clinician
09:20:32 3 course and so no disruption to the training or the
09:20:35 4 performance of the duties there. The training that
09:20:38 5 we specified in the annual training guidance, we
09:20:42 6 worked very closely with the commanders to see if
09:20:45 7 they were able to support. Before we directed them
09:20:47 8 to do it, we needed to do two things. One, was the
09:20:50 9 training necessary or wanted and the answer was
09:20:53 10 yes. Two, did we have the resources. At the time
09:20:56 11 we didn't have the resources to conduct that
09:20:58 12 training; but working with CFS-PREP we were able to
09:21:01 13 align performance enhancing specialists at each
09:21:05 14 location that can resource the commanders training
09:21:08 15 program. So, to answer your question, I do think
09:21:10 16 it's a very sustainable module that the units are
09:21:15 17 able to conduct on their own. Either with our
09:21:17 18 assistance or on their own at their home station.

09:21:20 19 LT GEN GREEN: So, just roughly, I would say
09:21:21 20 that one in eight of your cadre are probably in
09:21:24 21 some kind of training course on any given day.
09:21:27 22 Does it change your manpower standards?

09:21:29 23 COL SCOTT: General Green, those 10 -- 10,
09:21:31 24 15 and 4.5 day are separate courses. So, squad
09:21:37 25 leaders, platoon sergeants, company level leaders

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09:21:39 1 attend the 10-day program, not all 45. Case
09:21:43 2 managers attend the 15 day. Our supervisor nurse
09:21:47 3 case managers also attend that 4.5 day. So,
09:21:50 4 they've got about 20 days. The physicians and
09:21:53 5 senior leaders, the brigade, battalion commanders
09:21:57 6 and command sergeants major only attend the 4.5
09:21:59 7 day. So, it's not a total of 45 days, which is why
09:22:02 8 it's sustainable. Otherwise we would have a third
09:22:04 9 of our cadre in training all the time.

09:22:06 10 LT GEN GREEN: Right. That's what I was
09:22:08 11 wondering. Okay.

09:22:12 12 MS. EMERICH: Okay. As I mentioned, the
09:22:15 13 program complies with the Army Medical Department
09:22:18 14 Center & Schools. Specifically in the Academy of
09:22:21 15 Health Sciences. Also the chief of the department
09:22:23 16 of warrior transition that was recently stood up as
09:22:26 17 a training department in the Academy of Health
09:22:29 18 Sciences. So, the school also stands as a
09:22:32 19 proponent for that training. But I would note that
09:22:36 20 while our desks are in two separate subordinate
09:22:41 21 commands of the Army Medical Command, warrior
09:22:43 22 transition command and AMEDD Center & School, we --
09:22:47 23 we have a great collaborative effort towards -- we
09:22:50 24 work very closely together all the time in ensuring
09:22:54 25 that we are trying to move in the right

09:22:56 1 direction -- in the same direction to assist our
09:23:00 2 cadre in what's best for their training program and
09:23:04 3 ultimately taking care of soldiers.

09:23:10 4 Just a little bit of background on the
09:23:12 5 program -- I won't spend too much time on that --
09:23:14 6 is that right now the current training solution for
09:23:17 7 the cadre is a blended learning solution. They
09:23:20 8 have an online distributive learning course that
09:23:23 9 they are required to take within 30 days of
09:23:25 10 assignment to a WTU or CBWTU, followed by the
09:23:29 11 attendance to the two-week resident training
09:23:32 12 program and as Colonel Bair mentioned, that current
09:23:37 13 distributive learning product desperately needs
09:23:40 14 updated and also needs improved and there is a
09:23:44 15 contract in place and that is -- has now been
09:23:47 16 initiated. Colonel Grantham and I both serve as
09:23:51 17 approvers on many of the products that will be
09:23:54 18 produced by them along the way and we think that
09:23:57 19 that new distributive learning product will be a
09:24:01 20 whole lot better. Not only will it be current and
09:24:04 21 relevant, but we plan to increase the level of
09:24:07 22 interactivity of just the online program itself.
09:24:11 23 So, it should be more informative and more engaging
09:24:15 24 to the learner as they go through the program. It
09:24:19 25 will also allow us to take some of the briefs that

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09:24:24 1 are in the current resident course that have now
09:24:27 2 become fairly standardized and hopefully migrate
09:24:30 3 them into the online distributive learning product,
09:24:33 4 giving us a little bit more time for some more
09:24:36 5 hands-on type training in the resident program.

09:24:39 6 So, we have three courses. We have one
09:24:42 7 that -- and they run concurrent. We have one
09:24:44 8 specifically geared toward the squad leaders and
09:24:47 9 platoon sergeants and in HR Army training
09:24:51 10 requirement resource system the number is 300-F39.
09:24:57 11 As mentioned, the course is two weeks long. We run
09:24:59 12 that about nine to 10 times a year. We do our best
09:25:01 13 to schedule as many classes as we can and keep them
09:25:04 14 out of the area of holidays. The class size is
09:25:09 15 about -- approximately 80, but that varies. And it
09:25:12 16 really varies according to demand. We do our best
09:25:16 17 to get -- every requesting squad leader and platoon
09:25:21 18 sergeant requesting the training, we get them into
09:25:24 19 the first course -- the next course. The next
09:25:26 20 course. So, if it means that we only have 60, we
09:25:29 21 do 60. If it means we have a demand for 90, we do
09:25:32 22 90. We've actually gone up even higher than that
09:25:35 23 and it's really -- it's really limited by the size
09:25:39 24 of the facility. How many people we can bring in
09:25:42 25 and be able to provide seats for them to go through

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09:25:45 1 the training. But we do not want soldiers to have
09:25:47 2 to roll over into the next -- the next class
09:25:50 3 iteration and we get them as quickly as possible.

09:25:54 4 The other --

09:25:55 5 LT GEN GREEN: Can I ask you just -- you say
09:25:57 6 class size of roughly 80?

09:26:00 7 MS. EMERICH: Yes, sir.

09:26:01 8 LT GEN GREEN: So, what is the cadre size in
09:26:02 9 terms of the squad leaders, platoon sergeants?
09:26:05 10 Where you have nearly 600, if I understand -- I
09:26:08 11 think a little over 600 in your WTU. You have 600
09:26:11 12 casualties. What is the rough cadre size?

09:26:14 13 COL BAIR: I don't know that number off the
09:26:15 14 top of my head, sir. I --

09:26:17 15 MS. EMERICH: It's actually a bit higher
09:26:17 16 than that.

09:26:19 17 COL BAIR: -- want to say around 900; but --

09:26:19 18 LT GEN GREEN: So, you think you have 900
09:26:22 19 wounded -- wounded, ill and injured that are in the
09:26:25 20 WTU. I'm just trying to understand how much cadre
09:26:27 21 you assign to --

09:26:30 22 COL BAIR: Our population -- our recovering
09:26:31 23 warrior population is just under 10,000, sir.

09:26:34 24 LT GEN GREEN: No, you're talking -- I
09:26:36 25 understand at the larger level. So, let's talk

09:26:40 1 Brooke Army for a second. And so the WTU that's
09:26:42 2 here at Fort Sam Houston, how many people -- how
09:26:47 3 many WIIs are currently here? I understood there
09:26:49 4 were -- I think it's roughly 600 something.

09:26:54 5 COL SCOTT: A little over 600.

09:26:56 6 LT GEN GREEN: Right. A little over 600.
09:26:58 7 So, how much staff does it take to manage roughly
09:27:02 8 600? Do you have an idea? And I don't mean
09:27:02 9 medical staff. I'm talking your squad leaders,
09:27:09 10 your platoon sergeants.

09:27:09 11 MS. EMERICH: Well, I believe it's a one to
09:27:14 12 10 ratio.

09:27:15 13 LT GEN GREEN: So, 60.

09:27:17 14 MS. EMERICH: 60. I believe it -- on the
09:27:20 15 TBA it's -- I believe it's actually a little over a
09:27:21 16 thousand -- close to a thousand -- around a
09:27:22 17 thousand. Somewhere around there, actually, slots
09:27:24 18 for squad leaders and platoon sergeants.

09:27:28 19 COL SCOTT: Across the --

09:27:30 20 LT GEN GREEN: Okay. I'm just -- so, when
09:27:32 21 you say class size of 80, these are essentially
09:27:35 22 then courses for all the WTUs; is that what we're
09:27:37 23 talking about?

09:27:38 24 MS. EMERICH: Yes, sir.

09:27:39 25 LT GEN GREEN: Now I'm starting to

09:27:40 1 understand.

09:27:40 2 MS. EMERICH: Yes, sir. This cadre training
09:27:42 3 that they come here for is required for the squad
09:27:46 4 leaders and platoon sergeants across all the Army
09:27:48 5 WTUs and CBWTUs, as well.

09:27:52 6 MR. DRACH: Real quickly. Can we get a copy
09:27:54 7 of your training syllabus?

09:27:57 8 MS. DAILEY: I have it, sir.

09:27:59 9 MS. EMERICH: Yes, sir. Okay. Also, just
09:28:02 10 to note on this with the squad leaders. For the
09:28:04 11 squad leaders and platoon sergeants in the Army,
09:28:07 12 they also get an additional skill identifier now,
09:28:10 13 which talking about career and enhancement, I
09:28:13 14 believe that probably contributes when the board is
09:28:16 15 looking at their records. That they have an
09:28:19 16 additional skill identifier, specifically Y9. The
09:28:22 17 qualifications are noted for that and the squad
09:28:27 18 leaders and platoon sergeants also get special duty
09:28:29 19 assignment pay just due to the increased challenges
09:28:33 20 of this position.

09:28:36 21 The other group that runs with them are, as
09:28:39 22 mentioned before, the company level leaders. First
09:28:42 23 sergeants, X0s, company commanders. That's a
09:28:45 24 smaller group. Optimum class size about 50.
09:28:50 25 Again, that varies according to the demand.

09:28:53 1 Previously we had included in that two-week course
09:28:55 2 was a nurse case -- a WTU nurse case manager course
09:28:58 3 also ran at the same time, the two weeks. Colonel
09:29:01 4 Scott will talk a little bit later about the
09:29:03 5 details of changes we made to that, being replaced
09:29:07 6 by an Army nurse case manager course being extended
09:29:13 7 now to not just case managers -- training for not
09:29:16 8 just case managers in WTU, but all Army nurse case
09:29:20 9 managers. That course has increased. It is now
09:29:23 10 three weeks long, but it will always run concurrent
09:29:27 11 with our WTU course because there's still a need
09:29:29 12 for a lot of the same training to be extended to
09:29:33 13 nurse case managers.

09:29:36 14 Occasionally we have others on a volunteer
09:29:39 15 basis that do request and providing seats are
09:29:43 16 available, we welcome them to come to the training
09:29:46 17 because for whatever reason they feel a need to
09:29:48 18 also orient to the WTU environment, since it is
09:29:54 19 such a unique environment.

09:29:55 20 CSM DEJONG: Just a quick question there.
09:29:56 21 You say they run concurrent. Is there any
09:29:58 22 interaction between the two course syllabuses?

09:30:02 23 MS. EMERICH: Absolutely. Absolutely. And
09:30:03 24 that's intentional. And actually could -- that
09:30:09 25 last statement pretty much points to that, is we do

09:30:13 1 want them to run together because this is a unique
09:30:16 2 environment. We do have -- you have non-medical
09:30:19 3 squad leaders that -- enlisted squad leaders
09:30:22 4 working with medical officers and -- as well as
09:30:25 5 commanders. So, they don't -- it's pretty rare
09:30:28 6 that they would ever be in a training class
09:30:30 7 together; but because it's so important to have
09:30:33 8 that team effort in taking care of the soldier,
09:30:35 9 it's important I think that they train together and
09:30:38 10 start building that team and collaborating with
09:30:41 11 each other.

09:30:42 12 LT GEN GREEN: Are the courses taught at the
09:30:45 13 AMEDD school or do you have a separate cadre of
09:30:48 14 people that teach these courses as part of WTU? I
09:30:51 15 shouldn't say WTU. The larger entity.

09:30:54 16 MS. EMERICH: Yes, sir. Actually, we have
09:30:57 17 probably between -- at least -- the two programs,
09:30:59 18 probably at least 30 subject matter expert
09:31:02 19 instructors that come in. Some of them do come
09:31:05 20 from within the schoolhouse itself where the
09:31:07 21 expertise lies. There's expertise that we rely on
09:31:10 22 from the warrior transition command. Also reaching
09:31:14 23 out to Brooke Army Medical Center and an
09:31:20 24 individual -- I'll talk a little bit about a
09:31:22 25 communication individual from the public health

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09:31:24 1 command that comes every time. So -- but as far
09:31:27 2 as -- the training is actually not conducted in the
09:31:29 3 schoolhouse due to the large size. There's not
09:31:33 4 really classroom size available. So, we train off
09:31:35 5 site at a hotel in the area. The courses are
09:31:44 6 conducted concurrent. That does help us with
09:31:46 7 resourcing and in cutting down on the number of
09:31:50 8 instructor requirements or the number of times that
09:31:52 9 they have to teach. Cutting down on the TDY for
09:31:56 10 folks like the public health command or warrior
09:31:59 11 transition command.

09:32:01 12 Okay. One of the questions about -- just
09:32:04 13 talking about case management. And this slide
09:32:06 14 really -- really focuses on the non-medical case
09:32:09 15 manager. All the different classes and lessons
09:32:11 16 that are provided in non-medical case management.
09:32:16 17 The next slide I will talk a little bit more about
09:32:20 18 CTP itself. Exactly what is trained in CTP.

09:32:23 19 CSM DEJONG: Ma'am, on your last slide you
09:32:25 20 had the other groups that were training on a
09:32:28 21 volunteer basis. Is there any consideration across
09:32:31 22 WTC and -- down to the other line units, that the
09:32:34 23 liaisons need some sort of training? The liaisons
09:32:37 24 that we're putting at the hospitals are -- is there
09:32:39 25 any consideration of that for the future?

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09:32:44 1 MS. EMERICH: There's -- you can't tell from
09:32:45 2 WTC, but I will tell you that I just spoke with a
09:32:51 3 sergeant major from -- a new sergeant major at
09:32:52 4 Brooke Army Medical Center WTB. She's new there.
09:32:54 5 And we talked just about that. About possibly
09:32:57 6 including them in the training.

09:33:00 7 COL BAIR: Sergeant major, prior to your --
09:33:01 8 we sat in yesterday and prior to the discussion
09:33:03 9 that took place, I was not aware of that training
09:33:06 10 deficiency. Since then, since your topic
09:33:08 11 yesterday, I have inquired through your and my
09:33:14 12 deputy to figure out what, if any, training they
09:33:17 13 receive and I don't know. I think you guys
09:33:20 14 probably know better than I do. But that is
09:33:22 15 something based on the conversation that I heard
09:33:24 16 yesterday that I'm going to -- that I took back as
09:33:26 17 a note that we need to look at.

09:33:29 18 MSGT MACKENZIE: I will say, sir, from my
09:33:30 19 interaction with the Army liaisons at Landstuhl,
09:33:33 20 there is no training. It's all done when they show
09:33:35 21 up. So --

09:33:40 22 MS. EMERICH: And educationally we would do
09:33:43 23 the proper analysis to see exactly what training is
09:33:47 24 required and if the current training we're doing
09:33:49 25 meets -- or any portion of it would meet those

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demands.

So, families of the -- some of the areas in non-medical case management, some of the classes that squad leaders and platoon sergeants go through. It -- really important in classes noted on this list is risk communication. We have a risk communication specialist from the public health command that provides a full eight-hour block of instruction in training in risk communication and we think this is a really critical lesson because so many other things that we're going to train them in, no matter what their knowledge base is or their skill base is in those other things, if they can't communicate it effectively to their soldiers, it's not effective. So, they go through some extensive training on -- on really how to communicate and we perceive this as a high risk/low trust environment. Basically, because the soldiers come in to -- this is not their typical Army team. They're in a very unfamiliar environment. Therefore, initially, feel very little control over how their life is going to go or their daily activities and haven't quite seen the benefits of how warrior transition unit versus their other Army unit is going to help them. So, it's really important for them to learn some of the

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09:35:13 1 skills and effective communication as well as risk
09:35:17 2 communication and how to establish credibility and
09:35:21 3 trust with their soldiers. Sort of raise that
09:35:23 4 trust and lower that risk so that they can better
09:35:26 5 assist them in a successful transition in whichever
09:35:31 6 track they go down.

09:35:39 7 Talking about the comprehensive transition
09:35:41 8 plan. The details of -- on the left you can see
09:35:44 9 some of the areas that we go over and we've already
09:35:47 10 talked a little bit about what we're doing with
09:35:50 11 that and some of the changes that we're making in
09:35:52 12 our approach to covering these pieces of the CTP
09:35:57 13 and that will be done in conjunction, of course,
09:36:00 14 under the new CTP guidance; and on the right I list
09:36:04 15 supporting lessons. Basically because -- the note
09:36:06 16 that I put at the bottom. Because the
09:36:08 17 comprehensive transition plan is really that
09:36:11 18 wholistic approach to helping the soldier with
09:36:14 19 successful transition, I believe that every single
09:36:17 20 thing we teach in that training is part of
09:36:20 21 comprehensive transition planning or supports it
09:36:22 22 because it's understanding that they need, in that
09:36:25 23 wholistic approach to help their soldiers, whether
09:36:27 24 it's -- it's not just medical, but it's maybe
09:36:29 25 assisting with their family or maybe it's assisting

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09:36:33 1 in their emotional needs or their career. What
09:36:36 2 direction will they go in their career and it's all
09:36:40 3 about setting up that plan for success and we
09:36:42 4 emphasize that on day one and the last day again,
09:36:46 5 that it's all about going from A to Z and how do we
09:36:49 6 establish a plan. That a soldier is going to be
09:36:51 7 more comfortable with their transition if they have
09:36:53 8 a good plan. If they have good goal setting. And
09:36:56 9 how to do that. The comprehensive soldier fitness
09:36:59 10 group actually provides a specific block of
09:37:02 11 instruction on goal setting. So, how to help their
09:37:05 12 soldier in goal setting; but also to do better goal
09:37:07 13 setting for themselves because that will make them
09:37:10 14 better at time management and more efficient in
09:37:12 15 doing their job as well.

09:37:22 16 Here -- talking about performance and
09:37:26 17 accountability standards from the training program
09:37:30 18 itself. How do we evaluate -- how do we evaluate
09:37:34 19 success in the training program. For the course
09:37:37 20 attendees there are two exams that they take.
09:37:41 21 We -- there is a -- there is a standard POI. They
09:37:45 22 take exams. There's a student evaluation plan that
09:37:48 23 defines what are -- what are the terms of
09:37:51 24 successful completion in this course; and that's
09:37:54 25 defined for them. But also looking a little

09:37:59 1 broader than that, we do end-of-course surveys.
09:38:04 2 So, after every single class iteration, every
09:38:09 3 person is actually required to do a course survey
09:38:14 4 and I look at all of those and one of the questions
09:38:19 5 on there is do you feel that this course has better
09:38:24 6 prepared you for your job as a cadre in a WTU; and
09:38:27 7 we have 90 percent or above either agree or
09:38:33 8 strongly agree that, you know, they feel that that
09:38:35 9 course has really helped them; but bigger than
09:38:40 10 that, then we look at feedback from the warrior
09:38:43 11 transition command. We're able to see the results
09:38:46 12 of the OIP feedback that maybe comes from DAIG or
09:38:50 13 committees such as yourself; and we listen to
09:38:54 14 everything. We take it very seriously and we look
09:38:56 15 at -- constantly look at how can we improve the
09:39:00 16 program and we are constantly looking at new things
09:39:02 17 to do. There have been -- from the very first
09:39:05 18 iteration of the course to the current iteration of
09:39:08 19 the course, there have been many changes and a lot
09:39:10 20 of them were initially effected just by the
09:39:12 21 students and course attendee feedback themselves,
09:39:15 22 on making those changes to make it better and more
09:39:17 23 engaging to the learner. And AMEDD Center &
09:39:21 24 School, you know, formally has a quality assurance
09:39:24 25 program that also comes out and reviews.

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09:39:30 1 MS. DAILEY: Ms. Emerich, surveys at the end
09:39:34 2 of the resident course and 60 days post resident.
09:39:38 3 So, they're out in the field now for 60 days and
09:39:42 4 you send out surveys. Probably by mail or e-mail?

09:39:46 5 MS. EMERICH: I'm glad you brought that up.
09:39:49 6 Actually, we're just now initiating that and we've
09:39:53 7 met with the survey branch at the schoolhouse and
09:39:55 8 developed the survey. That we will now implement
09:39:59 9 an aggressive postgraduate -- we call them
09:40:02 10 postgraduate surveys. Just started bringing
09:40:04 11 feedback from the field that way as well.

09:40:06 12 MS. DAILEY: Yeah. It'd be interesting
09:40:08 13 to -- I mean, you don't know what you don't know.
09:40:09 14 You're very impressed with all the knowledge when
09:40:12 15 you walk out of the school, but when you stand up
09:40:15 16 to a warrior in transition and you try to answer
09:40:17 17 his questions and you go, "Oh, my God, I don't
09:40:20 18 know," then you really get a feel for how much you
09:40:22 19 know and don't know and how valuable the course
09:40:25 20 was. Okay. Thank you.

09:40:25 21 MS. EMERICH: I would fully agree with that
09:40:27 22 and we've relied on other aspects of getting that
09:40:30 23 feedback from the field, but I think this is -- is
09:40:34 24 going to provide better data for us.

09:40:37 25 CSM DEJONG: First thing -- is there any --

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09:40:38 1 and I don't know how it all works, so maybe you
09:40:41 2 can -- is there any exposure to the cadre prior to
09:40:43 3 them coming to the course? Are they assigned there
09:40:45 4 for any period of time? I think back to the early
09:40:47 5 days of drill sergeants when they were exposed to a
09:40:50 6 period of time and the commanders were allowed to
09:40:52 7 pick them before they actually went to the course.
09:40:54 8 They figure out, wow, I really -- this is what I
09:40:55 9 have to really know and this is what I don't know.
09:40:58 10 Is that happening out in the field?

09:41:00 11 MS. EMERICH: Most of them are and I -- I
09:41:04 12 guess Colonel Grantham can talk more from the
09:41:06 13 command perspective. I just know from asking those
09:41:09 14 questions inside the classroom when they start.
09:41:12 15 The majority of people have been there 60 days or
09:41:16 16 less. There's a -- we try -- we want them to get
09:41:20 17 the training as soon as possible. I think there is
09:41:23 18 a little benefit to having a little exposure and
09:41:27 19 knowing, oh, yeah that's what that -- what that is;
09:41:31 20 but most of them are within 60 days, that are
09:41:34 21 attending the course.

09:41:36 22 LTC GRANTHAM: That's true. They are --
09:41:38 23 right now I think even this class going on right
09:41:42 24 now, like 30 days. We're trying to get it down.
09:41:45 25 General Williams, the commander of the WTC

09:41:48 1 division, has highly recommended they go TDY en
09:41:51 2 route. He wants -- it will help him on a lot of
09:41:54 3 realms because when the soldiers hit the ground for
09:41:57 4 that commander, there is an overlap -- a higher
09:42:03 5 level of overlap potential with the outgoing -- the
09:42:07 6 squad leader, platoon sergeant. They have basic
09:42:11 7 familiarity and are really good to go; but what
09:42:15 8 really impacts -- and I think you can understand
09:42:17 9 this, Sergeant Major -- is with the guard and
09:42:18 10 reserve, bringing those guys in, getting them
09:42:22 11 engaged right away so that they're not having to
09:42:24 12 wait to get into the class, they go TDY en route.
09:42:28 13 As soon as they come in, that's the first thing
09:42:30 14 that they do. A lot of benefits to that, we
09:42:32 15 believe; and as we continue to make the course even
09:42:37 16 stronger, as we get the input from the field, I
09:42:44 17 think it's going to be even more beneficial that
09:42:46 18 they go to the course before they ever show up at
09:42:49 19 the unit.

09:42:51 20 CSM DEJONG: Okay.

09:42:54 21 MS. EMERICH: There was also a question on
09:42:57 22 how does the training the WTU -- CBWTU cadre differ
09:43:03 23 and I would say that we train -- the standards are
09:43:06 24 the same, what we train; but the execution of those
09:43:09 25 standards is what differs. So, you have -- and you

09:43:13 1 can see we have -- you know, a CBWTU we have
09:43:17 2 platoon sergeant versus squad leader and -- there
09:43:19 3 are no squad leaders in a CBWTU. Then, in risk
09:43:23 4 communication they talk about the challenges of
09:43:27 5 accountability, the telephonic versus face to face
09:43:30 6 and the challenges of remote care, remote case
09:43:33 7 management and those things. So, we do get into
09:43:36 8 that. The CBW -- there is a separate brief on the
09:43:43 9 CBWTU itself to fully explain its structure and how
09:43:47 10 it works and we're making -- we're currently
09:43:50 11 developing changes to our current command and
09:43:53 12 control lesson to possibly pull the CBWTU
09:43:57 13 personnel -- at some point track out of that lesson
09:44:00 14 and get into some more specifics in command and
09:44:04 15 control like how to organize a muster and things
09:44:06 16 like that for the CBWTU personnel. And now we want
09:44:12 17 to move into some details on case management.
09:44:15 18 Colonel Scott.

09:44:18 19 MSGT MACKENZIE: One thing before you get
09:44:19 20 started, Colonel Scott. The -- I found it very
09:44:22 21 intriguing at one location where the -- the senior
09:44:26 22 enlisted leadership of battalion had made a
09:44:32 23 decision that in any line unit you spent time as a
09:44:33 24 squad leader before becoming platoon sergeant.
09:44:37 25 Master the obvious here. However, in his unit he

09:44:40 1 would take those new platoon sergeants and they had
09:44:43 2 to do time as a squad leader before full assumption
09:44:46 3 of duties. Is that something that's being looked
09:44:49 4 at by the WTU as best practice and how do we -- you
09:44:56 5 know, is that something that's being seen as a
09:44:58 6 valuable tool?

09:45:04 7 LTC GRANTHAM: Yes, actually. We are
09:45:05 8 looking at -- based on some of the things that the
09:45:07 9 nurse case management team is doing now. She calls
09:45:11 10 it preceptorship; but I wouldn't know how to -- how
09:45:13 11 to spell that. So -- but, really, it's basically
09:45:16 12 what you just said. Doing phases. We've got the
09:45:19 13 distance learning. Setting the cadre members up
09:45:22 14 for success before they come to the residence
09:45:24 15 course. Going through the residence course and
09:45:26 16 doing all the things that we do here and now and
09:45:29 17 then when they get on the ground -- and, Sergeant
09:45:32 18 Major, this helps address your question I think as
09:45:34 19 well -- that they do have a period of time where
09:45:37 20 they are looked at, evaluated, to make sure that
09:45:40 21 they truly understand what the ins and outs of that
09:45:43 22 particular job is, that particular position is,
09:45:45 23 before someone signs off; and we're looking at
09:45:48 24 various ways to do that to make it truly effective.
09:45:52 25 And, yes. Bottom line to your question is, yes, we

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09:45:55 1 are looking at that as a best practice.

09:46:02 2 COL SCOTT: Okay. To this point we've
09:46:04 3 really focused on the non-medical case management
09:46:07 4 of recovering warriors. I'd like to look a little
09:46:13 5 bit with you at the medical case management aspect
09:46:16 6 of cadre training for our service -- for our
09:46:22 7 service members. Again, the comprehensive
09:46:26 8 transition plan is a process that applies to all of
09:46:34 9 our cadre members. So, we have incorporated that
09:46:36 10 into all of our training. So, by way of some
09:46:38 11 background information, when you're considering
09:46:41 12 what to train and how to train WTU cadre on
09:46:45 13 recovering warrior case management, we have to
09:46:49 14 consider the DoD uses the Case Management Society
09:46:52 15 of America definition of case management and that
09:46:58 16 the standards of practice and the core components
09:47:01 17 of the case management program have to be based on
09:47:03 18 these CMSA standards of practice. In addition, the
09:47:07 19 fundamentals of case management for the military
09:47:10 20 health system are outlined in the medical
09:47:12 21 management guide that's -- that was published in
09:47:15 22 2009 by Tricare management activities. So, this is
09:47:18 23 really the foundation of where we've gone in terms
09:47:22 24 of the core content of what we're teaching.

09:47:26 25 As Ms. Emerich noted, we've restructured the

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09:47:29 1 resident nurse case management training program.
09:47:32 2 I'm going to detail the changes for you in a moment
09:47:35 3 and you're already aware that the Department of
09:47:37 4 Defense mandates 10 online case management courses
09:47:42 5 for nurse case management -- for Army case managers
09:47:46 6 and all of our Army case managers are required to
09:47:49 7 complete these within 30 days of assignment to a
09:47:51 8 WTU. We track this both at the DoD level and Army
09:47:56 9 level; but then additionally on our OIP inspections
09:47:59 10 we go and double-check that to make sure that they
09:48:02 11 have indeed completed that training and understand
09:48:04 12 what it is that they've accomplished. We have had
09:48:07 13 and continue to maintain an 80-hour distance
09:48:11 14 education course for case managers. However, the
09:48:14 15 seats in this course are very limited. We only
09:48:16 16 have 94 seats per year for this course, which is
09:48:20 17 not adequate to train all of our population of case
09:48:24 18 managers. We have roughly 535 at any given time
09:48:29 19 within our warrior transition units, given the
09:48:35 20 transition in and out of the -- of that population.

09:48:40 21 DR. TURNER: Is there recurrency training,
09:48:42 22 as well, every year?

09:48:44 23 COL SCOTT: We have -- we have built that
09:48:45 24 into the WTU annual training guidance for online
09:48:51 25 training. In addition, Department of Defense,

09:48:54 1 Tricare management activity also provides
09:48:56 2 additional requirements for us for recurrent
09:48:59 3 training as well. We just added a new module for
09:49:03 4 integrated disability evaluation system which is
09:49:06 5 published on MHS Learn. There are frequent updates
09:49:11 6 to the training that are available to keep us up to
09:49:13 7 date in our practices on that.

09:49:16 8 The core competencies that drive our
09:49:21 9 training on case management for all cadre, again,
09:49:24 10 are derived from the CMSA standards of practice and
09:49:28 11 incorporate the unique aspects of soldier care and
09:49:31 12 patient care in the military health system. The
09:49:34 13 six essential domains are outlined here and then
09:49:36 14 the specific competencies are detailed on a later
09:49:41 15 slide for your reference. I won't go into detail
09:49:46 16 on those unless you ask me to; but we have put
09:49:49 17 those in the briefing for you.

09:49:51 18 Ms. Emerich already noted that case
09:49:54 19 management standards are included in cadre training
09:49:57 20 in one of her earlier slides, as one of the core
09:50:00 21 components of recovering warrior cadre training.
09:50:03 22 Our WTU company commanders and first sergeants
09:50:06 23 participate in a 90-minute block of instruction on
09:50:10 24 the case management standards that are outlined by
09:50:13 25 CMSA and how we demonstrate those in our WTUs and

09:50:18 1 CBWTUs. And then we also discuss the role of the
09:50:20 2 case manager and the interdisciplinary team across
09:50:24 3 those six domains of practice. So, they get some
09:50:26 4 idea of the interrelationship that the team plays
09:50:29 5 and how we meet those standards of care for case
09:50:33 6 management. And we also talk about the role of the
09:50:35 7 nurse case manager in our warrior transition units
09:50:38 8 and CBWTUs starting on day one with the
09:50:42 9 introduction of our WTU and WTC and then we
09:50:48 10 continue to discuss that role as part of the
09:50:50 11 interdisciplinary team throughout the rest of the
09:50:52 12 course.

09:50:52 13 DR. TURNER: And the selection criteria for
09:50:54 14 your nurse case manager is?

09:50:56 15 COL SCOTT: All of our nurse case managers
09:50:58 16 are registered nurses. Baccalaureate in nursing is
09:51:02 17 preferred but not required. Our military nurse
09:51:06 18 case managers are selected by -- centrally by human
09:51:11 19 resources command based on the leadership
09:51:15 20 attributes, clinical skills and level of autonomy
09:51:20 21 that they've demonstrated in previous assignments
09:51:23 22 and then those selections are reviewed by the
09:51:28 23 brigade battalion commander or MTF commanders for
09:51:32 24 those separate companies to ensure that they've got
09:51:35 25 the right nurse. In addition to that, I'll

09:51:36 1 detail -- with this new cadre course we have added
09:51:42 2 a preceptorship to validate those competencies and
09:51:46 3 they don't graduate until after that and I'll
09:51:48 4 detail that a little bit more.

09:51:51 5 DR. TURNER: GS contract?

09:51:53 6 COL SCOTT: GS nursing staff have a set job
09:51:57 7 description. They are interviewed by the local MTF
09:52:00 8 and oftentimes the supervisor nurse case manager --
09:52:04 9 most often the supervisor nurse case manager is
09:52:07 10 engaged in that selection process for those nurses
09:52:09 11 as well.

09:52:12 12 DR. TURNER: GS-11?

09:52:14 13 COL SCOTT: Oh, I'm sorry. Yes, the GS-11
09:52:16 14 for the WTU nurse case manager and the supervisor
09:52:20 15 nurse case manages are GS-12. There are a couple
09:52:25 16 of locations such as Walter Reed that do have a
09:52:28 17 higher GS level because of the hiring needs in that
09:52:32 18 locale; but the job description is written as a
09:52:35 19 GS-11 job description.

09:52:45 20 You asked us to dive into discussing how we
09:52:51 21 reach out to family caregivers and incorporate that
09:52:55 22 in -- that support into our cadre training. We --
09:52:58 23 as Ms. Emerich noted, we emphasize the importance
09:53:02 24 and value of including and supporting family
09:53:06 25 caregivers throughout the cadre training. We

09:53:08 1 discuss the value. We need to include the family
09:53:10 2 in developing and achieving CTP goals. We
09:53:14 3 specifically discuss the role of the non-medical
09:53:16 4 attendant and then as Ms. Emerich noted, on day one
09:53:21 5 we bring in an Army wounded warrior program -- AW2
09:53:26 6 program advocate who is also the spouse of a
09:53:28 7 severely wounded soldier and then that sever -- her
09:53:32 8 husband, the severely wounded soldier, comes and
09:53:35 9 they present as a team. So, they tell their story
09:53:38 10 and they talk about the value of the team. They
09:53:40 11 talk about the value of including the family in
09:53:44 12 that process of recovery and transition. So,
09:53:48 13 that -- because that's on day one of the course,
09:53:50 14 that actually sticks with them and is maintained
09:53:53 15 throughout the rest of the instruction and is a
09:53:56 16 basis for us to be able to refer back to.

09:53:59 17 DR. TURNER: What is officially considered a
09:54:01 18 family member?

09:54:04 19 COL SCOTT: It's the person -- individual
09:54:06 20 that that soldier identifies as their support
09:54:11 21 network. It does not have to be -- we have had
09:54:17 22 best friends serve as non-medical attendants, as
09:54:20 23 support systems. We've had spouses, we've had
09:54:23 24 brothers, sisters, mothers. It's not limited to
09:54:28 25 immediate family. Absolutely not.

09:54:30 1 MSGT MACKENZIE: This may not be the
09:54:32 2 right -- necessarily the right forum for the
09:54:34 3 question; but by bringing it up it triggered the
09:54:37 4 question. You know, as we look at incorporating
09:54:39 5 the family and finding ways to authorize your
09:54:42 6 interaction with the families, other than what's
09:54:44 7 currently laid out, this is one of the things that
09:54:47 8 we looked at and it's -- you know, you bring that
09:54:50 9 family in on non-medical attendant orders, they're
09:54:53 10 in an official capacity. It changes the
09:54:55 11 requirement of a yes or no from the service member.
09:54:59 12 Have you looked at that when you're looking at
09:55:02 13 involving the CTP? I mean, is that starting to
09:55:05 14 spark interest in you, as well, knowing, you know,
09:55:07 15 we're bringing them in on official orders, they're
09:55:09 16 signing up a non-medical attendant the service
09:55:12 17 member already knows, now I've got a perfect hand,
09:55:15 18 I don't have to worry about it because this person
09:55:17 19 is performing duties?

09:55:18 20 COL SCOTT: You know, we talked about this
09:55:19 21 yesterday after listening to the discussion about
09:55:22 22 this and listening to the thoughts about
09:55:26 23 legislation to be able to mandate that we can allow
09:55:29 24 discussion with family members; and the line there
09:55:34 25 is really gray and fuzzy between keeping the family

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09:55:38 1 member, whoever that is, whether they -- whether
09:55:41 2 they're on orders officially or not, informed and
09:55:47 3 protecting the desires and wishes of that
09:55:51 4 individual soldier. We -- and we were talking
09:55:57 5 about personal experiences of having family members
09:55:59 6 who are there on official, non-medical attendant
09:56:03 7 orders who unofficially the soldier themself
09:56:06 8 doesn't want to have anything to do with. So, it's
09:56:12 9 a -- it's a fine balance and you really have to
09:56:16 10 weigh the needs of that soldier and the desires of
09:56:19 11 that soldier and their best interest individually,
09:56:23 12 because they're at the center of this.

09:56:24 13 MSGT MACKENZIE: It is a concept that I know
09:56:27 14 is running around because, you know, you as a nurse
09:56:29 15 many a times looks at a liaison like me and goes
09:56:33 16 why is this on non-medical attendant orders,
09:56:35 17 they're not doing anything or vice versa, they're
09:56:37 18 doing too much; and it's just -- it's only a
09:56:39 19 thought right now until we can figure it out; but
09:56:42 20 is that part of that briefing both between service
09:56:45 21 member and that family member getting on
09:56:48 22 non-medical attendant orders clearly laying out
09:56:51 23 what that role and responsibilities are and
09:56:53 24 endorsed to be as a non-medical attendant? It's
09:56:56 25 not just a way of keeping them there on orders

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09:56:59 1 because the ITOs have run out. There's
09:57:02 2 actually any --

09:57:03 3 COL SCOTT: It's their job.

09:57:04 4 MSGT MACKENZIE: -- military task involved
09:57:06 5 and, you know, across the DoD it's something to
09:57:09 6 look at. We then create an open door, at that
09:57:11 7 point, to where we make sure that this stuff is
09:57:15 8 happening the right way and the right people at the
09:57:17 9 bedside while you guys are trying to do their care.
09:57:20 10 So --

09:57:20 11 COL SCOTT: We've got to look into that
09:57:22 12 deeper and we've got to balance that to make sure
09:57:25 13 that that soldier's desires and needs are met as we
09:57:29 14 go through, because it is their care.

09:57:31 15 MSGT MACKENZIE: Right.

09:57:32 16 COL SCOTT: However, sometimes they don't
09:57:34 17 have the capacity or capability of making those
09:57:37 18 decisions. So, we really have to balance that.

09:57:41 19 Next week we are -- as you know, we are
09:57:46 20 currently conducting our first nurse case
09:57:48 21 management -- new nurse case management course.
09:57:52 22 Next week those nurses will receive a briefing on
09:57:55 23 SCAADL and they will receive a briefing on the VA
09:57:57 24 caregivers compensation as a part of that course
09:58:01 25 curriculum and that will continue to be included in

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09:58:04 1 that course curriculum. We have also -- within WTC
09:58:08 2 have initiated weekly video teleconferences with
09:58:14 3 our WTU commanders and command teams on SCAADL and
09:58:18 4 then during our last WTU commanders meeting that
09:58:23 5 was held I believe in October with the last AMEDD
09:58:29 6 medical symposium, we provided them a briefing on
09:58:33 7 VA caregivers compensation; and, additionally, all
09:58:37 8 of our facilities that have VHA LNOs, those VHA
09:58:42 9 LNOs have been tasked by their central office to
09:58:45 10 provide training to the WTU cadre and then we've
09:58:49 11 asked that WTU cadre to schedule time on their
09:58:52 12 training calendars to make sure that they receive
09:58:54 13 training on VA caregivers compensation. So, we're
09:58:57 14 making sure that in addition to teaching the cadre
09:58:59 15 about the need to have that family member included
09:59:01 16 in the support network, we've also tried to begin
09:59:05 17 teaching them about what other support services are
09:59:07 18 available for those family members, because they
09:59:10 19 have -- they don't come to us always -- they always
09:59:15 20 come to us with needs of their own, in addition to
09:59:17 21 having to deal with the needs of that family member
09:59:19 22 who's had a devastating illness or injury.

09:59:26 23 You asked us to address training regarding
09:59:28 24 working with the numerous other case managers
09:59:31 25 working with recovering warriors. And to be very

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09:59:35 1 candid with you, we have a long way to go with
09:59:40 2 this. It's something that we continue to struggle
09:59:42 3 with on a daily basis. As we look at ourselves, we
09:59:46 4 see that we've got a well-rounded interdisciplinary
09:59:50 5 team that surrounds the soldier as a triad and
09:59:54 6 provides the link with all of the other case
09:59:57 7 managers, medical and non-medical, that interact
10:00:00 8 with that soldier; and you saw this yesterday. And
10:00:02 9 we understand this as an interdisciplinary team and
10:00:05 10 you saw this yesterday with the VHA LNOs when they
10:00:09 11 provided their brief and they showed you that
10:00:12 12 pictorial of the -- the circle with the triad in
10:00:15 13 the middle and then the VHA LNO on the periphery as
10:00:18 14 one of the touch points to that triad who's then
10:00:21 15 surrounding that soldier. That's how we see
10:00:26 16 ourselves and that's how we train internally. What
10:00:29 17 our soldiers see and what our recovering warriors
10:00:36 18 often see is a hundred case managers and members of
10:00:40 19 the interdisciplinary team helping them with their
10:00:43 20 comprehensive transition planning with that
10:00:45 21 recovery plan. So, we've got to get better and
10:00:48 22 find a way to better message how we're delivering
10:00:53 23 that interdisciplinary care model to our recovering
10:00:56 24 warriors and their family members.
10:00:58 25 CSM DEJONG: Ma'am, across the board, case

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10:01:00 1 managers -- this recipe is correct. Boots on the
10:01:05 2 ground, case managers have always been regarded as
10:01:08 3 the number one player in their team for their care.
10:01:10 4 So, whatever this is -- whatever you're doing is
10:01:14 5 right. Whatever you can improve on, outstanding.
10:01:16 6 They -- consistently, across the board, that is the
10:01:18 7 number one person that is mentioned. Where they're
10:01:21 8 starting to feel lost is at that transition point
10:01:24 9 out and what we're seeing now is a better -- is a
10:01:26 10 better coordination between the Army case manager
10:01:29 11 and what's going to be their VA case manager; and
10:01:32 12 when that handoff is -- what some of the VAs are
10:01:36 13 doing, when they have that warm handoff and there's
10:01:38 14 that case manager to case manager interaction and
10:01:40 15 they know -- they've got a face and a name that
10:01:43 16 they're going in with, that comfort level has gone
10:01:46 17 up twofold.

10:01:48 18 COL SCOTT: And, Sergeant Major, you are --
10:01:52 19 you're hitting right on target with where we are
10:01:56 20 going with our case management training. That
10:01:59 21 transition point is the most critical time, whether
10:02:02 22 it's transitioning a soldier from our WTU to
10:02:07 23 veteran status and making that handoff with the VA
10:02:11 24 or transitioning our soldiers that are returning to
10:02:15 25 duty to their health care team as they go back to

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10:02:18 1 duty. You know, particularly for our COAD/COAR
10:02:22 2 soldiers who probably still need case management
10:02:26 3 services, making sure that we've done that warm
10:02:29 4 handoff with the receiving facility so that that
10:02:32 5 continuity of care continues and we continue to
10:02:35 6 manage that care plan. With the -- I will show you
10:02:39 7 a slide of all the knowledge skills and tasks and
10:02:43 8 within that transitions and handoff is a key
10:02:46 9 component of that. We are actually spending quite
10:02:49 10 a bit of time with the new case management course
10:02:52 11 to make sure that we've got it right. We're
10:02:55 12 teaching team steps as a process for managing those
10:02:59 13 handoffs. We're having -- we've got briefings from
10:03:02 14 VHA and VBA to talk about those handoffs and then
10:03:07 15 we're spending two hours just talking about the
10:03:09 16 transition process and case closure so that we
10:03:12 17 ensure that our nurse case managers understand how
10:03:15 18 that works and the importance of that and keeping
10:03:18 19 the soldier at the center of that as we work
10:03:20 20 through.

10:03:20 21 MR. DRACH: Real quick. I don't see the RCC
10:03:22 22 in your --

10:03:23 23 COL SCOTT: This was just a -- I ran out of
10:03:25 24 space. I just picked -- this is not all inclusive.
10:03:28 25 This is just a snapshot of -- circles I picked as I

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10:03:31 1 was drawing them. So --

10:03:38 2 LT COL KEANE: Ma'am, to add to what the
10:03:38 3 sergeant major just mentioned --

10:03:38 4 COL SCOTT: Yes.

10:03:40 5 LT COL KEANE: -- regarding transition.
10:03:40 6 Yesterday we heard from the VA the goodness if they
10:03:43 7 would be able to receive the CTP. Do you agree
10:03:46 8 with that?

10:03:46 9 COL SCOTT: Say that again.

10:03:48 10 LT COL KEANE: The CTP. The VA reps
10:03:49 11 yesterday mentioned that there would be goodness in
10:03:52 12 getting the CTP.

10:03:54 13 COL SCOTT: The VA representatives felt that
10:03:56 14 it would be good for them to receive training on
10:03:57 15 the CTP?

10:03:57 16 LT COL KEANE: To receive a copy of it in
10:03:59 17 transition.

10:04:01 18 MR. REHBEIN: What they told us yesterday --
10:04:03 19 we asked a question because they're building a
10:04:05 20 recovery plan too when that warrior moves to the
10:04:08 21 VA. Most of the time they've had no access to the
10:04:11 22 CTP.

10:04:11 23 COL SCOTT: And --

10:04:12 24 MR. REHBEIN: So, they're having to build a
10:04:13 25 whole brand-new foundation.

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10:04:15 1 COL SCOTT: And you bring up a good point.
10:04:18 2 If you ask a soldier for their CTP -- and I imagine
10:04:22 3 that you've asked this as you've gone out on your
10:04:25 4 visits -- the soldiers give you the blank look like
10:04:28 5 I don't know what that is. Ask them for their goal
10:04:31 6 setting book and their -- and their scrimmage
10:04:38 7 results because those are the actual outputs from
10:04:41 8 the CTP process that they receive as copies of
10:04:46 9 that. As we move forward with AWCTS, our future
10:04:51 10 system, we should be able to print out a historical
10:04:55 11 record of all of the self-assessments, scrimmage
10:04:59 12 results, the goal setting -- the goal changes that
10:05:00 13 have taken place; but that soldier should have a
10:05:03 14 hard copy of that care plan -- of that CT plan and
10:05:06 15 the goals that they've set that we've validated and
10:05:10 16 helped them manage through that. In addition, the
10:05:14 17 case managers should have included those goals in
10:05:19 18 their notes in AHLTA as part of their comprehensive
10:05:22 19 care plan that they're developing -- that they
10:05:24 20 developed for that soldier. So, those should be
10:05:27 21 available in AHLTA for those -- for the VHA LNOs.
10:05:32 22 I think what -- probably what we need to do is do
10:05:36 23 some additional education with the OEF/OIF/OND
10:05:40 24 program coordinators and with the VHA LNOs about
10:05:44 25 the CTP process and what the outputs of that are

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10:05:46 1 with our next round of training and I'll talk to
10:05:48 2 Ms. Kennedy and Ms. Perez to make sure that we're
10:05:51 3 on the docket for their agenda. We actually do
10:05:55 4 present on that. With each iteration of the
10:05:58 5 training that they noted yesterday, we actually do
10:06:00 6 have some time to present at that training each
10:06:04 7 time they have it. So, we'll make sure that we're
10:06:06 8 on the docket for that.

10:06:09 9 MR. REHBEIN: We have recovering warriors in
10:06:12 10 four separate military services, all with the same
10:06:15 11 goal. Recovery. Do you ever get a chance to sit
10:06:19 12 down with your counterparts in the other military
10:06:22 13 services to exchange best practices, to talk about
10:06:25 14 who's doing what better than I am, pick up ideas,
10:06:30 15 as the colonel said you did here yesterday?

10:06:34 16 COL SCOTT: We do. We -- the service --
10:06:38 17 case management service leads meet monthly and we
10:06:45 18 do a -- mostly via video teleconference; but often
10:06:49 19 in person, to be able to collaborate and share
10:06:52 20 ideas. That monthly meeting is chaired by the
10:06:56 21 chief of medical management for TMA, so we are able
10:07:00 22 to -- to be able to communicate. In addition to
10:07:04 23 that, as an example of the outputs of that, we have
10:07:08 24 an Air Force nurse who is auditing our nurse case
10:07:11 25 management course this week to look at what it is

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10:07:14 1 that we're doing for our nurses, to look at other
10:07:17 2 aspects of this that would be valuable to them as
10:07:20 3 training that we can collaborate on in the future
10:07:24 4 to have a tri-service course or other aspects of
10:07:27 5 this that they want to take away for their Air
10:07:30 6 Force case managers.

10:07:32 7 MR. REHBEIN: Actually, when I asked if you
10:07:33 8 have the chance to do that, I intended that for the
10:07:37 9 entire panel.

10:07:37 10 COL SCOTT: Okay. I'll step back and let --

10:07:37 11 MR. REHBEIN: That was a broader question
10:07:39 12 than just the case -- I appreciate your answer, but
10:07:41 13 that was a broader question --

10:07:42 14 COL SCOTT: Got my 6 inch wide --

10:07:46 15 MR. REHBEIN: -- than just the case
10:07:47 16 managers.

10:07:47 17 MS. DAILEY: We should go on.

10:07:47 18 MR. REHBEIN: But I appreciate your answer.
10:07:49 19 Thank you.

10:07:49 20 COL BAIR: That's an initiative, sir, that
10:07:51 21 I'm very much looking into. I think there is
10:07:53 22 goodness for that cross talk. I envision inviting
10:07:58 23 some of their leaders to our senior leader course
10:08:02 24 and talking just ideas at the policy level. I have
10:08:06 25 not done that to this point yet, but it is on my

10:08:08 1 list of things to do. Now that our plan -- our
10:08:11 2 policy is now formalized, it is part of the
10:08:15 3 outreach that I plan on doing.

10:08:19 4 MS. EMERICH: In reference to training
10:08:21 5 programs, I have on occasion spoken to a few other
10:08:26 6 people in the past; but only by accident. It's not
10:08:30 7 been coordinated or collaborated.

10:08:33 8 LT GEN GREEN: Just for your knowledge so --
10:08:36 9 we're a little over our timing right now, so if you
10:08:39 10 could think about how you want to wrap up. And
10:08:42 11 it's our fault. We ask lots of questions. So, we
10:08:44 12 thank you for answering all of our questions; but
10:08:47 13 I'm not sure how you want to kind of wrap up your
10:08:49 14 presentation.

10:08:50 15 MS. DAILEY: How about if we go to -- how
10:08:53 16 about if we go to slide 32. Will you go to best
10:08:58 17 practices, innovation and sharing. And you have --
10:09:10 18 that leaves you with what, just three more slides?
10:09:15 19 Five more slides.

10:09:17 20 MS. EMERICH: Okay. Some of the things to
10:09:20 21 note on -- some of these things we've actually
10:09:22 22 already talked about it, with the team training,
10:09:25 23 incorporating results from the field, improvements
10:09:27 24 in doing postgraduate surveys. One thing I'd like
10:09:31 25 to note on here that I'm particularly excited about

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10:09:33 1 as an educator is we have just purchased and are
10:09:37 2 incorporating a response technology to the training
10:09:40 3 program and we foresee every attendee actually
10:09:44 4 being issued a response card. It's an electronic
10:09:47 5 response card. And training our instructors how to
10:09:50 6 incorporate this in their training where they get
10:09:54 7 feedback in the classroom. Asking questions and
10:09:58 8 the students have to select the responses or put
10:10:01 9 things in order or whatever. Do some pretesting.
10:10:04 10 Things like that. That is a way of taking the
10:10:10 11 lectures or briefings and making them more engaging
10:10:13 12 to the learner and by making them more engaging to
10:10:17 13 the learner, then hopefully they're listening
10:10:19 14 better and they're learning more and ultimately
10:10:21 15 performing better. Also, it will provide very good
10:10:24 16 feedback for the instructors as they go through and
10:10:28 17 they get those responses. So, for example, if they
10:10:30 18 see a varied -- a varied response to a particular
10:10:34 19 question that should be pinpoint A, B, C or D, they
10:10:38 20 would know, hey, here's -- I need to immediately go
10:10:41 21 back and probably re-teach that concept because the
10:10:44 22 students didn't -- didn't grasp it. So, we're
10:10:46 23 really looking forward to that. We've just
10:10:49 24 purchased some Smart Boards, as well. We already
10:10:52 25 talked about that we are -- have a contract to

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10:10:54 1 update the DL product. The new Army nurse case
10:10:58 2 manager is I think going to be great.

10:11:02 3 A best practice is we don't just have one
10:11:06 4 person that knows a little bit about everything.
10:11:08 5 We do bring in the subject matter experts from the
10:11:11 6 schoolhouse and outside the schoolhouse to always
10:11:15 7 ensure that training is current and relevant. A
10:11:18 8 simple example. We've talked about CTP. The new
10:11:21 9 CTP guidance got signed on Thursday evening, I
10:11:24 10 believe, and on Monday we were teaching it, because
10:11:27 11 we have the right person teaching that.

10:11:31 12 We've added -- we've added -- in some of our
10:11:34 13 training we've added more role playing. In risk
10:11:37 14 communication they have now exercises where they
10:11:40 15 actually go through role playing as if they are
10:11:43 16 talking to a hostile soldier, an upset family
10:11:47 17 member. Just, you know, challenges that they go
10:11:52 18 through that we've added role playing. We've
10:11:55 19 incorporated some real interactive videos like at
10:11:59 20 PTSD and leadership where they actually go through
10:12:03 21 decision points and have to respond. The student
10:12:05 22 survey, site visits and we're undergoing a manpower
10:12:09 23 review to hopefully better staff our department
10:12:13 24 within the Academy of Health Sciences.

10:12:22 25 COL BAIR: What I'd just like to leave the

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10:12:23 1 task force with is some of the examples that Ms.
10:12:27 2 Emerich just showed for the cadre course, what I
10:12:29 3 call the tactical level, are indicative of the
10:12:33 4 changes that are occurring at the policy level; and
10:12:35 5 I tried to highlight some of those through our
10:12:38 6 programs just laid out along that chart. We
10:12:41 7 appreciate the feedback that we get from groups
10:12:43 8 like yours because it helps us see ourselves and
10:12:48 9 then figure out how to improve those areas. And so
10:12:50 10 I look forward to come -- we all do. We look
10:12:53 11 forward to coming back here whenever and telling --
10:12:56 12 and reporting on hopefully the metrics that are in
10:12:59 13 place to measure the changes that occur starting 1
10:13:02 14 December with the new CTP; but as a result of many
10:13:07 15 of the other initiatives that we're putting in
10:13:09 16 place.

10:13:09 17 I want to thank the sergeant major for
10:13:12 18 pointing out the LNO piece. Every time we think we
10:13:15 19 have just about all the right areas addressed or
10:13:18 20 focused on, another one pops up and certainly is
10:13:21 21 something that we'll take a look at. So, we never
10:13:23 22 stop.

10:13:24 23 CSM DEJONG: Sir, one quick note and
10:13:26 24 something we've looked at. Is there a plan -- and
10:13:29 25 I don't even know the details. Is there a plan in

10:13:31 1 the future to capture this so we can keep this
10:13:33 2 level of knowledge across the forces and can expand
10:13:38 3 and contract this as needed, based on whether we're
10:13:41 4 in war or whether we're not in war, so we don't
10:13:43 5 lose this? Is there a plan in place at the higher
10:13:45 6 level to maintain this level of training across our
10:13:49 7 forces?

10:13:50 8 COL BAIR: We were discussing how to do that
10:13:52 9 just recently, Sergeant Major.

10:13:54 10 DR. PHILLIPS: Any areas of concern or
10:13:56 11 impedence that you face that this task force might
10:13:59 12 be able to help you with?

10:14:06 13 COL BAIR: We feel that this is an enduring
10:14:10 14 pro -- the program itself is an enduring program
10:14:13 15 and I know conditions, resources are changing and
10:14:18 16 will probably continue to change that certainly
10:14:20 17 would affect our population and so whatever
10:14:26 18 advocacy you could do on the part of the program
10:14:30 19 for shielding resources I think would be
10:14:33 20 challenging but appreciated.

10:14:35 21 MS. EMERICH: Absolutely.

10:14:39 22 DR. TURNER: Just to follow up on that. The
10:14:41 23 pencil neck geek question. Can you tell me your
10:14:44 24 funding stream? Are you PALM 4 and who competes
10:14:49 25 for you at the PALM?

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10:14:52 1 COL BAIR: I wish I had a GA representative
10:14:54 2 right here to answer that question for you, sir.

10:14:57 3 DR. TURNER: Where does your money come
10:14:58 4 from?

10:14:59 5 MS. EMERICH: I can tell you that right now
10:15:01 6 the training program itself is funded under AMAP
10:15:04 7 dollars. Army medical action plan dollars. But we
10:15:08 8 are undergoing a manpower review to hopefully
10:15:11 9 establish a permanent TDA to hire permanent staff
10:15:15 10 to, you know, conduct operations in the training
10:15:19 11 department; but that's just the training program
10:15:23 12 itself. The course attendees are funded each at
10:15:27 13 the unit level and --

10:15:32 14 LT GEN GREEN: One of the questions that I
10:15:33 15 think would help because -- I understand what
10:15:35 16 you're saying, but do you know if the funding is --
10:15:37 17 is it DHP coming through the AMEDD, is it OCO, a
10:15:43 18 mix -- or perhaps a mix of those dollars, or is it
10:15:47 19 a line funding? Do you know? Is it a mix of all
10:15:51 20 three?

10:15:51 21 COL BAIR: I would rule out the OCO, sir.

10:15:57 22 LT GEN GREEN: So, it's not OCO.

10:15:57 23 COL BAIR: Which leaves us two and --

10:15:58 24 LT GEN GREEN: So, probably DHP funding.

10:16:00 25 MS. EMERICH: I think that's correct, sir;

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10:16:02 1 but I -- I can't swear to that, but I think -- I
10:16:04 2 think you're correct, it is DHP; and, yes, it is
10:16:07 3 not OCO.

10:16:07 4 DR. TURNER: Are you subject to any of the
10:16:11 5 current manning cuts?

10:16:17 6 MS. EMERICH: Honestly, our TDA -- the
10:16:19 7 training department's TDA, we're still undergoing
10:16:22 8 a -- we're in the process of a manpower review just
10:16:24 9 to establish that permanent TDA.

10:16:27 10 DR. TURNER: So, you're establishing what
10:16:29 11 your model is right now, the manning standard?

10:16:32 12 MS. EMERICH: Yes, sir, that's correct.
10:16:33 13 We're currently supported by mobilized sergeants
10:16:36 14 and contractors. I'm the only person that's
10:16:40 15 actually permanent.

10:16:42 16 LT GEN GREEN: So, basically, it is a mix of
10:16:44 17 DHP and line because all the squad leaders are
10:16:48 18 probably line funded military positions, is my
10:16:53 19 guess.

10:16:53 20 COL SCOTT: Can we come back to you with
10:16:55 21 confirmed answers to that? It's a little bit
10:16:58 22 beyond our scope. That's why we're looking at each
10:17:00 23 other. We can confirm that we've had discussions
10:17:02 24 of this in our staff meetings, but without a GA rep
10:17:06 25 here to make sure that we're saying the smart

10:17:08 1 answer --

10:17:09 2 DR. TURNER: The main thing I -- I just want
10:17:10 3 to make sure that you're -- you're a permanent
10:17:13 4 program and you're -- you've got good roots and a
10:17:17 5 good solid foundation.

10:17:19 6 MS. EMERICH: We would like that.

10:17:21 7 LTC GRANTHAM: Appreciate that.

10:17:22 8 LT GEN GREEN: A good first step is not
10:17:23 9 being OCO funded. That would obviously be a
10:17:26 10 problem. The only other thing that I'm curious
10:17:29 11 about is your mix right now between wounded
10:17:32 12 warriors and -- with us now out of Iraq, as of this
10:17:36 13 month, are you seeing a change in your mix between
10:17:38 14 the ill and injured versus the wounded?

10:17:44 15 COL BAIR: No, sir.

10:17:46 16 LT GEN GREEN: Still roughly 10 to 20
10:17:48 17 percent that are wounded?

10:17:50 18 COL BAIR: Yes, sir.

10:17:50 19 LT GEN GREEN: Okay. And for the 80 percent
10:17:52 20 that are ill and injured, do you know what the
10:17:54 21 average time is? Is it shorter? Obviously because
10:17:58 22 of the rehab time for some of it, but do you have
10:18:01 23 any idea of the ill and injured whether or not your
10:18:04 24 timing is shorter or longer in terms of how long
10:18:07 25 they're in the transition unit? I'm trying to get

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10:18:09 1 a sense because those are people who normally would
10:18:12 2 have been done within the units and basically gone
10:18:14 3 through their medical board elsewhere and so does
10:18:16 4 that centralization actually help with getting them
10:18:20 5 through the process or is it just another location?

10:18:24 6 COL SCOTT: We've looked at length of stay
10:18:27 7 based on individual type of injury. The orthopedic
10:18:33 8 versus PTSD. We've also looked at average length
10:18:38 9 of stay based on COMPO; but we have not separated
10:18:41 10 wounded from ill and injured to look at length of
10:18:45 11 stay. So, we haven't -- that's something that we
10:18:46 12 can go back and take a look at to see if there is a
10:18:50 13 difference in that.

10:18:50 14 LT GEN GREEN: My only reason for asking is
10:18:52 15 to try to understand if the centralization into a
10:18:55 16 WTU actually helped with the processing. Because
10:18:58 17 of the skill sets that you're building, are you
10:19:01 18 actually able to get people through the process and
10:19:04 19 either return to duty or in the disability process
10:19:07 20 earlier. It would be nice to understand.

10:19:10 21 COL SCOTT: Because we also -- we also track
10:19:12 22 return to -- return to force rates for those. So,
10:19:15 23 we'll go back and ask the question.

10:19:17 24 LT GEN GREEN: Do you know what your return
10:19:18 25 to force rate is for the ill and injured?

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10:19:22 1 COL SCOTT: It's a little -- well, wounded,
10:19:25 2 ill and injured together. We have not separated
10:19:28 3 out wounded versus ill and injured return to force
10:19:30 4 rate. We've done it by COMPO and we've done it for
10:19:34 5 individual injury types. Again, orthopedic versus
10:19:38 6 PTSD. As an aggregate whole, it's a little over 50
10:19:41 7 percent right now.

10:19:42 8 COL BAIR: Which is an upward trend over the
10:19:47 9 last, say, 12 months. We were just at or a little
10:19:49 10 below 50 percent.

10:19:50 11 LT GEN GREEN: I'm interested in process.
10:19:51 12 So, if it does help to centralize it is something
10:19:54 13 that -- you know, obviously the Navy and the Army
10:19:57 14 have centralized theirs. We have not. And so I'm
10:20:00 15 curious to see your numbers to know whether or not
10:20:02 16 we can get people back to duty quicker or if it
10:20:04 17 actually takes longer when you put them into a
10:20:06 18 central location.

10:20:08 19 COL SCOTT: We can ask -- we can certainly
10:20:09 20 look at breaking that out for you. I can show you
10:20:12 21 individual -- based on the individual condition and
10:20:14 22 we can break it out that way too.

10:20:16 23 MS. DAILEY: Sir, I can -- I can also get
10:20:22 24 a -- I can also ask WTC to present that data at our
10:20:27 25 February meeting.

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10:20:27 1 LT GEN GREEN: Okay. That'd be great.

10:20:29 2 That'd be great.

10:20:29 3 MS. DAILEY: Yeah. So, we can get someone
10:20:32 4 in who really nugs down on those numbers and
10:20:34 5 they'll get time to prepare something that will
10:20:37 6 answer all of your questions. I'm very happy to do
10:20:39 7 that, ladies and gentlemen. So, I won't put that
10:20:41 8 task on these guys. I'll go to Colonel Pasick and
10:20:44 9 my POCs up there and we'll work out something that
10:20:47 10 will answer all your questions.

10:20:49 11 LT GEN GREEN: Okay. Outstanding.

10:20:50 12 MS. DAILEY: Great. Thank you.

10:20:51 13 LT GEN GREEN: I think that we're going to
10:20:52 14 let you off the hook. Okay. You've been very
10:20:55 15 tolerant with us. Okay. Thank you for answering
10:20:57 16 all our questions so thoroughly. We're sorry to
10:20:59 17 keep you a little later than we planned. For the
10:21:01 18 task force members, let's take a 10-minute break
10:21:04 19 and come back at half past the hour. Thank you,
10:21:08 20 folks.

10:21:11 21 (Recess taken between 10:21 and
10:39:47 22 10:39.)

10:39:48 23 LT GEN GREEN: Okay, folks. They're trying
10:39:49 24 to get us back on track. I think that -- thank you
10:39:51 25 for taking a little shorter break and welcome back.

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10:39:54 1 The task force was interested in learning more
10:39:57 2 regarding the family liaison officers, their role
10:39:59 3 as non-medical case managers and the support they
10:40:01 4 provide to the family caregiver; and so with us is
10:40:03 5 Master Sergeant Timothy Eichman. Is that correct?

10:40:03 6 MSGT EICHMAN: Yes, sir.

10:40:09 7 LT GEN GREEN: Okay. US Air Force 802nd CES
10:40:12 8 explosive ordnance disposal. And so we really
10:40:14 9 appreciate you coming to visit with us and
10:40:16 10 hopefully you have a few things to share with us
10:40:18 11 and then we'll ask a few questions. We're just
10:40:20 12 trying to understand the things that you do. Thank
10:40:23 13 you.

10:40:23 14 MSGT EICHMAN: I'm Master Sergeant Eichman.
10:40:27 15 I'm from the EOD program. When I started --

10:40:32 16 LT GEN GREEN: You can relax. If you want
10:40:33 17 to sit down, that's fine. Thank you.

10:40:33 18 MSGT EICHMAN: When I started this I was
10:40:34 19 actually working at headquarters ATC, which from my
10:40:37 20 point of view being a FLO, that made it actually a
10:40:39 21 little easier because my duties weren't as
10:40:42 22 constrained as say a person that was working at a
10:40:44 23 flight. One of the questions that was asked of me
10:40:52 24 was what exactly is the FLO program. To this day
10:40:56 25 the Air Force mortuary affairs definition actually

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10:41:00 1 still has it as working with the family of a
10:41:03 2 deceased or a KIA member. The program as it is
10:41:06 3 right now kind of grew with working with wounded
10:41:10 4 warriors out of that definition. Whenever I first
10:41:15 5 did this, there was no video, there was no
10:41:17 6 checklist or anything else like that; and a lot of
10:41:20 7 the things that we learned as we went along, as
10:41:23 8 Sergeant MacKenzie can probably testify to, has
10:41:28 9 gotten better and we've gone on; but I will take
10:41:30 10 you -- again, my viewpoint is from an EOD
10:41:33 11 viewpoint. I do understand that not all programs
10:41:37 12 and a number of the FLOs are not necessarily the
10:41:39 13 way we do it. With our particular AFSC we tend to,
10:41:45 14 quote, unquote, "take care of our own." The RCCs
10:41:50 15 will actually call our unit whenever we have a
10:41:53 16 wounded EOD airman coming out of -- coming out of
10:41:55 17 the AOR or from anywhere. A good example was we
10:41:59 18 took care of the family somewhat unofficially of an
10:42:02 19 instructor that was actually on leave and had an
10:42:05 20 aneurysm and died. They happened to be in Oregon.
10:42:08 21 We sent a person from the nearest EOD flight to
10:42:10 22 make arrangements for that family and to care for
10:42:13 23 that family. A lot of the times with wounded
10:42:16 24 warriors that are coming out of Afghanistan, I know
10:42:19 25 they're coming before even Mr. Beckett knows

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10:42:21 1 they're coming because my chief that is working
10:42:24 2 that particular AOR will contact us and say, hey,
10:42:29 3 we have a person coming to BAMC; or if that person
10:42:31 4 happens to be going to Walter Reed, Dover or one of
10:42:35 5 the units in that area will actually pick him up or
10:42:40 6 her up when she is coming in or he's coming in.

10:42:43 7 Probably the hardest part using that system
10:42:45 8 is tracking the person as they're moving from the
10:42:49 9 AOR to whatever location they're going to for
10:42:53 10 medical care. I guess if there's one improvement
10:42:56 11 that I would ask is that the FLOs are actually more
10:42:58 12 incorporated into the movement of a wounded person.
10:43:03 13 Specifically -- I mean, with my system I know where
10:43:04 14 they're going. I know whenever they're going to
10:43:07 15 Landstuhl because we have a unit on Ramstein. I
10:43:09 16 know when they're coming in to Andrews because we
10:43:12 17 have a unit setting either at Andrews or at Dover;
10:43:15 18 and I know when they're coming to San Antonio. But
10:43:17 19 for the average person that gets, quote, unquote,
10:43:20 20 "tasked" to be a FLO, trying to track the member is
10:43:24 21 not an easy thing.

10:43:32 22 What is my current case load? We had two
10:43:35 23 airmen actually at BAMC. One of them was Sergeant
10:43:42 24 Fye. He's going to be with us for a while. He's
10:43:45 25 been here roughly about 90 days, maybe a little

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10:43:48 1 longer; and he actually still has his halo on his
10:43:52 2 leg. He hasn't been, quote, "really PCS'd" into
10:43:55 3 the San Antonio area; but he is going to be here
10:43:58 4 for some time. Master Sergeant Prowell, whenever
10:44:03 5 he came in, it was more of a come in and seen,
10:44:05 6 check you out before we send you back out. He is
10:44:08 7 actually back in his unit working very hard to get
10:44:11 8 off of his codes so he can go back to doing what he
10:44:15 9 wants to do.

10:44:22 10 This was actually kind of a -- I took this
10:44:25 11 as how long have I been doing this. I've actually
10:44:29 12 been the FLO or the alternate FLO for every wounded
10:44:34 13 EOD warrior that's come into the San Antonio area
10:44:36 14 starting 2004, which is when I got to the ATC. It
10:44:40 15 just happened that way. Mainly because the unit
10:44:42 16 that was on Lackland -- I mean, yes. Would we
10:44:44 17 allow somebody else to be a FLO for one of our
10:44:47 18 airmen, absolutely. Could I go and be a FLO for
10:44:49 19 somebody else, absolutely; but from our point of
10:44:52 20 view I pretty much know how this person got hurt,
10:44:54 21 one way or the other. Whether they got shot, blown
10:44:57 22 up, hit while in the bomb suit or whatever. So, I
10:45:01 23 have kind of an insight on how their mind is
10:45:03 24 working at that point. Sergeant Prowell is a good
10:45:06 25 example. Sergeant Prowell came down here and he

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10:45:08 1 just could not relate to the people that he was
10:45:10 2 seeing in the hospital. The only thing he wanted
10:45:12 3 to do was get a cast on his arm so they'd put him
10:45:15 4 back on an airplane and send him back to the AOR.
10:45:18 5 Well, I had to -- me and another master that was in
10:45:21 6 the shop actually had to sit him down and counsel
10:45:24 7 him, for lack of a better word, and say the only
10:45:26 8 way you're going to go back is if you're better.
10:45:29 9 The other part of it is that some of the people
10:45:31 10 that come back are going just down the wrong road.
10:45:35 11 You know, they came back and they've -- Master
10:45:38 12 Sergeant -- or Tech Sergeant Chris Slaydon or Matt
10:45:43 13 Slaydon, depending on how you know him -- is a
10:45:45 14 prime example. He desperately wanted to go back to
10:45:48 15 the AOR. When he got to me he was blind in both
10:45:51 16 eyes, lost part of his arm, lost part of his leg,
10:45:54 17 burned over about 35 percent of his body. The odds
10:45:57 18 of Chris making it back to Iraq were dismal. It
10:46:01 19 just isn't going to happen. They said unless
10:46:03 20 you're going back to speak to them about what
10:46:05 21 happened to you, it's just not going to happen.
10:46:07 22 Chris had an RCC, he had a social worker, his wife
10:46:12 23 was there. Good example of working with his wife,
10:46:15 24 Annette never got into the military. Okay. She
10:46:18 25 was a paralegal. The only contact she had with the

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10:46:22 1 military was her husband. So, whenever we called
10:46:25 2 her in the middle of the night out in Phoenix and
10:46:28 3 said, "Matt has been hurt badly. He is going to
10:46:31 4 Germany. This is what's happening," she had no
10:46:35 5 concept of how that -- what happened, how it
10:46:36 6 happened and what was going to happen now. So,
10:46:39 7 between myself and Staff Sergeant Winger, we tried
10:46:42 8 to relate to her what actually happened to Matt,
10:46:47 9 what is going on with him. Matt was not conscious
10:46:49 10 until he actually got to BAMC. So, signing up the
10:46:52 11 order to -- who was going to take care of him was
10:46:55 12 not going to happen also. They went down the line
10:46:58 13 of next of kin. We met him in Landstuhl. We
10:47:01 14 brought him all the way back and from the time that
10:47:03 15 he got here to the time that he was released from
10:47:05 16 the Air Force, it was -- I was his supervisor, I
10:47:10 17 was his friend, I was his social worker and I was
10:47:12 18 his psychiatrist. He was seeing all these other
10:47:15 19 people, but the way his brain was working, they --
10:47:18 20 he just couldn't take anything they were saying
10:47:21 21 because they had no viewpoint on what he -- what
10:47:24 22 happened to him, how it happened to him and what he
10:47:27 23 did for a living. So, you know, the family liaison
10:47:31 24 position is you're everything. You're the paper
10:47:35 25 pusher, you're the counselor, you're the taxi

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10:47:39 1 driver, you're everything and that's how -- that's
10:47:44 2 how the program has evolved from what it was.

10:47:46 3 Whenever Chris Ramakka first got here and he
10:47:49 4 lost his leg, he was determined to go back on
10:47:52 5 active duty and I ended up being his supervisor
10:47:54 6 until he actually became a member of the school and
10:47:57 7 that was in 2004. Chris is now embarrassing me
10:48:00 8 because he runs faster than I do; but he's actually
10:48:03 9 over in Ramstein and he's a flight chief over
10:48:05 10 there. I have deployed him once and he's been on
10:48:09 11 another deployment since.

10:48:11 12 So, again, it's all frame of mind and you
10:48:13 13 have to help them with that frame of mind because
10:48:15 14 you are their contact. RCCs have a case load that
10:48:19 15 is enormous sometimes. A lot of RCCs are taking
10:48:23 16 care of seven, eight, nine, 10, 11 people. They
10:48:25 17 get to spend this much time with each one of those
10:48:28 18 patients depending on what's happening with that
10:48:30 19 patient. As a FLO, you are with them 24 -- almost
10:48:33 20 24/7 for the first four or five days and then as
10:48:36 21 needed thereafter. So, you have to be able to
10:48:39 22 relate what is happening with the person you're
10:48:42 23 taking care of to everybody else that is also
10:48:44 24 seeing them. The social worker, the docs, the
10:48:47 25 nurses on the ward, the RCC, whatever.

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10:49:01 1 Again, Senior Airman -- at the time Senior
10:49:04 2 Airman Acosta and now Master Sergeant Ramakka came
10:49:10 3 in at exactly the same time. Senior Airman -- or
10:49:13 4 Staff Sergeant Acosta had the same framework of
10:49:17 5 mind that Master Sergeant Ramakka did at the time.
10:49:20 6 They both wanted to go on duty. The difference was
10:49:24 7 Chris was missing the lower part of his leg and Dan
10:49:26 8 was missing his left arm. So, because of what was
10:49:31 9 going on at that time, I never spoke with an RCC
10:49:35 10 with that case back in 2004, I never saw a social
10:49:39 11 worker. I dealt with the nurses and the docs that
10:49:41 12 were on the ward at Wilford Hall. Myself and
10:49:45 13 Senior Master Sergeant Hepner became their
10:49:48 14 supervisors because nobody really knew what to do
10:49:50 15 with them. This was kind of like -- this was a new
10:49:54 16 thing. These two -- these weren't the first losses
10:49:56 17 that we had, but it was the first ones that had
10:49:59 18 come back. So, it seems like the process was being
10:50:02 19 learned. So, we -- they ended up being part of the
10:50:07 20 patient squadron, which at the time the patient
10:50:12 21 squadron went from, you know, guys that had hurt
10:50:13 22 their foot or sprained something or something along
10:50:16 23 those lines to having guys that were missing body
10:50:18 24 parts or whatever and they were even learning their
10:50:21 25 job. So, we kind of took over the care and

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10:50:23 1 maintenance of this -- the whole thing. Dan's wife
10:50:27 2 was kind of like Annette. She had no contact with
10:50:30 3 the military. So, whenever they were coming asking
10:50:32 4 her questions about orders and vouchers and all
10:50:36 5 these interesting things -- because he was from
10:50:38 6 Hill Air Force Base and they were going to have to
10:50:40 7 move here; and she was doing it by herself. So, we
10:50:43 8 ended up helping her do that. Do her TMO, do her
10:50:46 9 travel orders, do the PCS, how do they get paid,
10:50:49 10 where are they going to get paid. And Chris' wife
10:50:51 11 was a little bit more into it. She spent more time
10:50:56 12 with the unit where Chris was coming from, so she
10:50:59 13 was a little bit more prepared; but at the same
10:51:02 14 time she had her husband sitting in a hospital room
10:51:05 15 missing his leg. So, we ended up doing a lot of
10:51:08 16 the same for her. At one point I was even -- had
10:51:11 17 power of attorney for Dan and Chris, just because I
10:51:14 18 was more mobile.

10:51:19 19 Again, today it is almost a completely
10:51:21 20 different experience and the only thing I've had to
10:51:23 21 do as a FLO is work with the family and console
10:51:28 22 them and do what I -- the best I can to -- all they
10:51:32 23 have to do is concentrate on the wounded person.
10:51:35 24 You know, that is their job because the point of
10:51:38 25 the matter is that if family and friends can

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10:51:41 1 concentrate on them and help them get better -- the
10:51:44 2 faster they get out of the hospital, the faster
10:51:47 3 they get better. I mean, that's the primary goal
10:51:48 4 for us, is how fast can we get them out of the
10:51:51 5 medical facility and if they don't have to do
10:51:54 6 anything other than -- "Hey, somebody came by and
10:51:55 7 dropped this off today. What do you think it is?"
10:51:57 8 You explain it to them and you go take care of it.
10:51:59 9 The biggest thing is -- with at least my unit at
10:52:03 10 the time or the one that's setting at Lackland
10:52:05 11 right now is we actually have 11 people now instead
10:52:08 12 of four. So, detailing somebody out to take care
10:52:11 13 of somebody 24 hours a day, seven days a week for
10:52:14 14 as long as they want you there. And this is an
10:52:17 15 important thing. You know, one day they may say,
10:52:20 16 "Hey, can you stop darkening our door? We'd like
10:52:25 17 to go to dinner now." Okay. So, you know, you go
10:52:28 18 away; but you have to be on the other end of the
10:52:30 19 cell phone in case it goes back the other
10:52:32 20 direction.

10:52:44 21 From my point of view, again, the -- your
10:52:47 22 job is to translate because not everybody and most
10:52:52 23 family members are not fluent in jargon and -- I
10:52:56 24 mean, I -- I'm married to a doctor and I can't tell
10:52:58 25 you half the things I hear whenever I'm up at BAMC.

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10:53:01 1 So, you have to be able to track down somebody that
10:53:04 2 can interpret that, too. Matt Slaydon was sitting
10:53:07 3 in a bed with more tubes, machines and vials of
10:53:10 4 whatever, skin grafts and everything else going on,
10:53:14 5 that -- I mean, we didn't -- the first thing out of
10:53:16 6 Annette's mouth was, "What is that," because it
10:53:20 7 didn't look like her husband and she had no idea
10:53:23 8 what was going on. At the time, nobody had really
10:53:26 9 explained it to her and then whenever they
10:53:28 10 explained to her about debriding, that got even
10:53:31 11 more interesting because Dan was burned over quite
10:53:33 12 a bit of his body and she had to go in and help
10:53:36 13 that happen. So, she was -- she is an extremely
10:53:39 14 strong woman. The next person that came in that
10:53:42 15 was burned was actually Senior Airman Gogan. Well,
10:53:46 16 Senior Airman Gogan -- you know, we -- y'all talked
10:53:49 17 about the order for the family caregivers whenever
10:53:52 18 they get there. Gogan was more or less conscious
10:53:56 19 whenever he came through Andrews and that's where
10:53:58 20 they signed up this order. Well, he wasn't able to
10:54:02 21 make that decision. So, they went down the line to
10:54:04 22 next of kin. Whenever he got to BAMC, he said he
10:54:07 23 didn't want his parents there. He wanted his
10:54:10 24 girlfriend. Okay. Well, initially, she didn't
10:54:12 25 want to come. So, somebody had to make decisions

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10:54:17 1 for him because he was not always coherent and his
10:54:21 2 mother and father we got out of Connecticut at the
10:54:24 3 last minute came down and made those decisions
10:54:26 4 until his girlfriend decided to show up. Another
10:54:29 5 instance we had was a non-EOD person; but at the
10:54:33 6 time they wanted -- the parents were coming and
10:54:36 7 they flat said, no, I do not want them here, I
10:54:39 8 don't want them making any decisions for me and I
10:54:41 9 don't even want to talk to them. I want this
10:54:44 10 person. Well, that person at the other end of that
10:54:46 11 phone said, no, I don't want to go down there,
10:54:50 12 don't want to see it, I don't like anything about
10:54:52 13 the military. So, at that point you're making --
10:54:57 14 you're trying to help them understand that somebody
10:55:00 15 has to be here in case something bad happens and he
10:55:03 16 relented and allowed his brother to come here; but,
10:55:07 17 you know, you find out all kind of interesting
10:55:10 18 things about family once you became a family
10:55:13 19 liaison officer. So, you also find out interesting
10:55:16 20 things about other folks that are in your service
10:55:19 21 that are doing this job so they can check something
10:55:21 22 off of their EPR, but they don't actually show up.
10:55:25 23 There's a number of folks that have been at BAMC --
10:55:29 24 as a senior airman security forces person, the only
10:55:32 25 person that they have heard, seen or talked to

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10:55:35 1 since they got there because their particular
10:55:38 2 family didn't want to come here either, was the
10:55:40 3 nurses and doctors. Nobody wanted to be his FLO.
10:55:44 4 The security forces academy sets over on Lackland
10:55:47 5 Air Force Base. So, we arranged something for them
10:55:49 6 and we got somebody down there that could relate to
10:55:53 7 him and help him out because this does -- this --
10:55:57 8 any FLO will tell you this is going to occupy your
10:56:01 9 time. I don't know what plans you had for the next
10:56:04 10 month or whatever, but you might as well just scrap
10:56:07 11 all that because this is your job and it's going to
10:56:11 12 be your job until the family tells you otherwise,
10:56:13 13 not you. You know, if for some reason you get
10:56:17 14 tagged for deployment or whatever, there -- you are
10:56:21 15 on order as a FLO. They actually generate an
10:56:24 16 order. It's not -- you don't get paid TDY or
10:56:27 17 anything else like that, but they generate an order
10:56:29 18 that this is what you're going to do for a while.
10:56:31 19 Well, if you get tagged for deployment, that kind
10:56:33 20 of supercedes it or if you get PCS of course that
10:56:37 21 will; but you have to be able to transition the
10:56:39 22 family to another person that they get along with.
10:56:41 23 Not just randomly pick somebody that's going to go
10:56:44 24 down, because, again, it's your job.
10:57:01 25 The first few cases that I worked I wasn't

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10:57:03 1 really, quote, unquote, "trained." That came later
10:57:06 2 whenever a lot of the lessons learned were learned
10:57:09 3 and they were put into a cognitive format that you
10:57:12 4 go and you -- now, the last time I did this, I went
10:57:15 5 and watched a video, I had a checklist of things
10:57:18 6 that I had to check off and initial saying I
10:57:21 7 understand this and this and this; and I had a list
10:57:23 8 of contact numbers for the RCC that would be
10:57:27 9 working that case, I had their number, the number
10:57:28 10 of the social worker, I knew who the person was.
10:57:31 11 There's a lot more, as opposed to making it up as
10:57:36 12 you go along. Again, in the beginning it boiled
10:57:39 13 down to just being an effective supervisor and
10:57:41 14 supervising everything from the airman that was
10:57:45 15 sitting in the bed to his family, you know, believe
10:57:49 16 it or not, to, you know, being an effective day
10:57:52 17 care center because there's kids that show up here
10:57:55 18 too. You know, just because that person is coming
10:57:58 19 to BAMC -- the wife is coming, well, if their kids
10:58:01 20 are between the ages of six months and three years
10:58:04 21 old, they're not going to be sitting back at home
10:58:06 22 by themselves and a lot of these members, they're
10:58:09 23 not stationed anywhere near family. So,
10:58:11 24 everybody's coming. And whenever you work with the
10:58:13 25 Fisher House, you have to make sure you understand

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10:58:15 1 the components of the family whenever it shows up
10:58:18 2 and you have to be able to -- you know, you don't
10:58:20 3 want a two-year old going in and seeing dad wired
10:58:23 4 to a transformer. You know, you need to be able to
10:58:27 5 take care of them and work with them too. So, you
10:58:30 6 become a day care person also and I've had the -- I
10:58:35 7 probably have some potential EOD recruits by now
10:58:38 8 because they all went down to the shop and we train
10:58:40 9 them too.

10:58:43 10 Again, I did not or I have not been through
10:58:45 11 RCC training. I wasn't even aware of the Army's
10:58:49 12 program, which to be honest with you, some of the
10:58:51 13 things that they're doing, even if it's distance
10:58:54 14 learning, might help be able to at least relate to
10:58:58 15 the RCC.

10:58:59 16 MR. DRACH: Master Sergeant, have you
10:59:02 17 requested training?

10:59:05 18 MSGT EICHMAN: No, sir, I have not. The
10:59:06 19 RCCs that I've worked with, Chief Master Sergeant
10:59:09 20 Page, the first that comes to mind, coordinates a
10:59:12 21 lot of the RCC or retired -- coordinates the RCCs
10:59:17 22 over at BAMC and Wilford Hall. He's hired a lot of
10:59:22 23 good people. So, I haven't really -- I don't
10:59:25 24 really get into their business per se, unless I
10:59:27 25 have to. The biggest problem I had with one RCC is

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10:59:32 1 he seemed to be inviting everybody and their
10:59:34 2 brother to come see the wounded guy on the other
10:59:37 3 side of the glass and I had to -- ended up having
10:59:40 4 to step on him a little bit and say, "Look, you
10:59:42 5 know, he's here to get better, not be the dog and
10:59:44 6 pony show for whoever wants to show up." So, you
10:59:47 7 end up being a little bit of a gatekeeper, too.
10:59:50 8 So, I had a problem. Gogan was a good example. I
10:59:52 9 had generals coming from everywhere that wanted to
10:59:54 10 see him because of where he had gotten hurt and,
10:59:57 11 you know, eventually I had to turn off the spigot
11:00:00 12 for a while because the man wasn't getting any
11:00:02 13 sleep. So -- but that was -- I found out later
11:00:05 14 that it was because the RCC that he had was a
11:00:07 15 retired chief that knew all these folks in NAVSOC
11:00:11 16 and he was calling them and telling them and so on
11:00:14 17 and so forth. It ended up I guess kind of being a
11:00:16 18 good thing because SOCCENT has a huge back office
11:00:22 19 program for their wounded that come back and, you
11:00:25 20 know, that helped Senior Airman Gogan along the
11:00:29 21 way; but, you know, again, whenever they're in the
11:00:31 22 beginning of their care and they're being seen and
11:00:34 23 being treated for abrasions and burns -- Gogan had
11:00:36 24 been sand blasted, literally, from the top of his
11:00:39 25 shoulders to the back of his heels. So, there was

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11:00:42 1 a lot of skin grafting and all those interesting
11:00:45 2 things going on and they would -- folks would show
11:00:47 3 up out of the blue with no forethought and a lot of
11:00:51 4 times we had to tell them -- even if they were only
11:00:54 5 going to be there for a few hours, we had to have
11:00:56 6 the wherewithal to say, "Sorry, sir, but he's going
11:00:59 7 to be occupied for the next couple of days."

11:01:01 8 CSM DEJONG: Master Sergeant, you've
11:01:03 9 mentioned that you've captured some of your lessons
11:01:06 10 learned. Is it in a trainable format? I mean,
11:01:09 11 what's going on from you forward. You learned this
11:01:11 12 by trial by fire.

11:01:13 13 MSGT EICHMAN: Yes, sir.

11:01:14 14 CSM DEJONG: What are you doing for the new
11:01:15 15 ones now?

11:01:16 16 MSGT EICHMAN: One of the things -- I think
11:01:18 17 it's on one of the slides. We are -- one of the
11:01:21 18 things that came out of that, I guess, and one of
11:01:23 19 the things that you have to learn whenever you're a
11:01:25 20 FLO now is you have to keep a log. Senior Master
11:01:28 21 Sergeant Hepner and I started a log with Staff
11:01:34 22 Sergeant Acosta and Staff Sergeant Ramakka and
11:01:36 23 detailed literally almost hour by hour what they
11:01:38 24 were going through every day, what we were
11:01:40 25 experiencing every day; and within our community,

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11:01:41 1 unfortunately, we shared that all the way up to our
11:01:44 2 pentagon representative that's up there. Those
11:01:48 3 logs initially came forth to -- I can't remember
11:01:53 4 his name. A master sergeant that was on Dover
11:01:55 5 that -- he recently retired; but he had taken all
11:01:58 6 that information and whenever he did the video for
11:02:00 7 the FLO training, he went over a lot of those
11:02:03 8 things. So, a lot of the things that we had
11:02:05 9 captured from our first two wounded to that point
11:02:08 10 went into the checklist that I was seeing because
11:02:11 11 it was like -- it was like deja vu because I was
11:02:14 12 going down and saying, oh, yeah, you know, need
11:02:16 13 that, keep going. The only thing that really
11:02:18 14 hasn't happened and it boils down to you asking
11:02:22 15 about it. It is available, but I'll -- and I'll
11:02:24 16 tell you, the -- your best friend as a FLO is a
11:02:32 17 cell phone; and, you know, before the age of
11:02:34 18 unlimited whatever, whenever I was working with
11:02:38 19 Ramakka, at the end of my first month my cell phone
11:02:42 20 bill was \$437.46; and that was just making calls,
11:02:47 21 text messages and whatever. And you know, yeah,
11:02:50 22 that hurt a little bit; but it was what it was.
11:02:55 23 Whenever I was working with Gogan, I showed up and
11:02:58 24 at the time Stef Page who had worked with us with
11:03:03 25 Senior Airman Acosta handed me a cell phone and

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11:03:06 1 said, "Here, use this"; but that was just Randolph,
11:03:09 2 you know, being nice and they gave me one; but --
11:03:12 3 and that's one of the few lessons learned that we
11:03:15 4 have put forth that I have yet to see happen with
11:03:17 5 the FLO program. Not necessarily just with the EOD
11:03:21 6 FLO program or what happens on Randolph Air Force
11:03:24 7 Base; but the ability to have transportation
11:03:26 8 available to you that's a GOV. That helped a
11:03:29 9 little bit, but I ran into a guy down in trans who
11:03:33 10 said, "Well, who are they?" I said, "Well, that's
11:03:34 11 the family member. I'm transporting them from the
11:03:36 12 airport downtown." He said, "No, you can't put
11:03:39 13 civilians in a GOV." I was like really? Watch.
11:03:44 14 And I put them in the car and I drove off. You
11:03:47 15 know, what were they going to do, really. But, you
11:03:50 16 know, you run into that and that would have been a
11:03:55 17 nice caveat for a wounded warrior, you know. Yeah,
11:03:58 18 you've been designated this and as part of your
11:04:01 19 orders you can transport whoever and whatever from
11:04:03 20 point A to point B using a GOV unless -- or you end
11:04:08 21 up doing it in your own vehicle and -- I mean, I
11:04:11 22 drive a 2010 Silverado and it gets -- and I live in
11:04:14 23 Lytle and driving from Lytle to BAMC to Randolph
11:04:18 24 and back again, that was starting to get pretty
11:04:20 25 serious.

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11:04:26 1 But, again, the -- a lot of the things --
11:04:29 2 this is what came from a lot of that. I mean,
11:04:31 3 there was folks getting hurt and one of the things
11:04:33 4 that I see in my -- I put in my suggestions is
11:04:36 5 that, you know, the wounded warrior, you know,
11:04:41 6 bubble is for guys who got shot at, blown up, was
11:04:44 7 in the AOR. To be classified as a wounded warrior
11:04:47 8 you had to be -- the last time I saw it, you had to
11:04:51 9 be injured as a result of enemy action or something
11:04:55 10 thereof. Well, I ended up being the FLO for a
11:05:00 11 guardsman that was on his annual tour working on a
11:05:03 12 base in Montana that had a truck dropped on him and
11:05:07 13 he was going -- he was going to be at BAMC for a
11:05:10 14 very, very, very long time because the Center for
11:05:13 15 Intrepid -- I don't know if you folks have been
11:05:16 16 there; but it is God's gift to anybody who needs a
11:05:20 17 prosthetic. Well, he was going to be down there
11:05:21 18 for a long time. I had to go through and move a
11:05:24 19 few mountains just so I could get him on active
11:05:27 20 duty orders so he could be seen. He was hurt when
11:05:30 21 he was on active duty; but they were going to drop
11:05:32 22 him off his orders because he wasn't going to be --
11:05:35 23 and they didn't want me to be his FLO because he
11:05:37 24 wasn't a wounded warrior, he was a wounded airman;
11:05:42 25 and, you know, my point being is that if you're

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11:05:45 1 wearing a uniform and you get hurt in the service,
11:05:47 2 then you need to be able to experience all the
11:05:50 3 benefits that come in that. You know, you get
11:05:53 4 assigned somebody that's going to help you move you
11:05:55 5 and your family from point A to point B. That was
11:05:58 6 his other deficit, he didn't have a family. So,
11:06:00 7 who are you going to liaison for except him.

11:06:04 8 So, you know, it needs to be -- all these
11:06:08 9 things need to happen for a person that is -- you
11:06:12 10 know, if you're seriously injured, you need to be
11:06:15 11 able to get all the benefits or -- and care that
11:06:18 12 that entails. The man lost his leg while working
11:06:22 13 on a government vehicle. So, you know, he needs --
11:06:25 14 he needs help. And being in the guard and/or
11:06:28 15 reserve now days, unless you're a wounded warrior
11:06:31 16 over in the AOR, you're going to get dropped like a
11:06:34 17 rock when you get back on your orders.

11:06:38 18 CSM DEJONG: Who do you officially report to
11:06:40 19 as far as the FLO duty?

11:06:42 20 MSGT EICHMAN: I'm sorry, sir?

11:06:43 21 CSM DEJONG: Who do you report to? Who is
11:06:45 22 your command when you're on this FLO duty? How
11:06:47 23 does that go?

11:06:48 24 MSGT EICHMAN: I work for -- at the time,
11:06:49 25 the person who wrote my order and the person I

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11:06:52 1 reported back to was a captain that was in mortuary
11:06:55 2 affairs at the 802nd.

11:06:57 3 CSM DEJONG: So, it went back to
11:06:59 4 basically -- it wasn't hospital command, it
11:07:01 5 wasn't --

11:07:01 6 MSGT EICHMAN: It went back to mortuary
11:07:04 7 affairs. They were handling the program at the
11:07:07 8 time and the other part of that was casualty
11:07:10 9 matters, who is the folks that are over in the Air
11:07:13 10 Force personnel center that dealt with a lot of the
11:07:17 11 movements and whatnot; but as far as -- if I ran
11:07:19 12 into a problem that by force of personality I
11:07:22 13 couldn't take care of, I started actually going up
11:07:25 14 my own chain and as high as I needed to go before I
11:07:29 15 could get it fixed, because a lot of times I would
11:07:31 16 go back to the captain and I was lucky if he
11:07:35 17 remembered me. You know, he was getting my logs
11:07:36 18 and whatnot, he was forwarding those up to Mr.
11:07:39 19 Beckett and disseminating that information and for
11:07:41 20 that he was great; but, you know, again, this case
11:07:45 21 load is this big and if I was having an issue with
11:07:50 22 whatever -- trans or anything else or personnel or,
11:07:52 23 you know, the MPF or whoever and I couldn't get it
11:07:55 24 fixed, then I started moving up my chain until I
11:07:59 25 got to somebody who could fix it; and a lot of

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11:08:02 1 times that might be the chief that sits in my
11:08:04 2 office, who is now Chief Ayers, or it might be our
11:08:08 3 colonel; but, you know, one of the things that was
11:08:11 4 an interesting side benefit to being a FLO is that
11:08:14 5 I had the names of more people that I never thought
11:08:16 6 I would have in my phone and every single one of
11:08:20 7 them came to me and said, "Hey, if you have a
11:08:22 8 problem, you call me." Okay. And, you know, I did
11:08:25 9 and it would happen. It started with General Fox
11:08:29 10 back in the day, the two star that was the CE up at
11:08:33 11 A7. And, you know, Acosta was having issues and he
11:08:35 12 wanted to stay in the Air Force. His only problem
11:08:38 13 was he wanted to stay in the EOD. He wasn't going
11:08:41 14 to accept anything else. General Fox was going to
11:08:43 15 plant him somewhere, even if it meant being a PME
11:08:45 16 instructor over at the airman leadership school;
11:08:48 17 and same thing with Ramakka. Ramakka wanted to
11:08:51 18 stay in the Air Force. I found him a job. I
11:08:53 19 needed to put him over at the school. There wasn't
11:08:55 20 a position at the school. The next thing I know
11:08:57 21 something showed up on the UMD and they said put
11:09:00 22 him there, you know. So, there's people that I
11:09:03 23 would call; but as far as direct management and
11:09:06 24 somebody that's going to ask me a question, it was
11:09:09 25 the captain in mortuary affairs.

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11:09:12 1 MSGT MACKENZIE: Did you find that the
11:09:14 2 assigned leadership to you was more of a figurehead
11:09:18 3 than somebody who actually had power to do anything
11:09:21 4 for you?

11:09:22 5 MSGT EICHMAN: As far as the mortuary
11:09:24 6 affairs person or --

11:09:26 7 MSGT MACKENZIE: Across the board. I mean,
11:09:28 8 it's -- we're all in a military organization.

11:09:30 9 MSGT EICHMAN: Right.

11:09:31 10 MSGT MACKENZIE: If -- your calling in
11:09:32 11 favors on a cell phone doesn't sound to me like a
11:09:35 12 very good chain of command and if the person that
11:09:37 13 you're supposed to call doesn't have the ability to
11:09:40 14 respond to your needs, then it doesn't sound like
11:09:42 15 you really had any chain of command at all.

11:09:45 16 MSGT EICHMAN: For me, the very first people
11:09:46 17 that I found out who their -- what their name was,
11:09:48 18 what their phone number was, was the airman's chain
11:09:50 19 of command. You know, starting with the first
11:09:53 20 sergeant. I mean, you would be amazed what those
11:09:56 21 folks can get done. So, the very first -- I would
11:09:58 22 call that person's supervisor because chances are I
11:10:02 23 knew them anyway; and said, "Okay. Well, who's
11:10:04 24 your first sergeant, who's your commander, who's
11:10:06 25 your MS -- your mission support commander and who

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11:10:09 1 is your wing commander and are they coming,"
11:10:12 2 because that's something I needed to know also.
11:10:14 3 And those -- because they actually had a vested
11:10:17 4 interest in the airman that I was being the FLO
11:10:19 5 for, they would start making things happen; and if
11:10:23 6 it went beyond their scope, nine times out of 10
11:10:28 7 those folks would tell me, "You need to contact
11:10:31 8 these people"; and if that didn't work, that's
11:10:33 9 never -- I started going up to -- we have a fellow
11:10:37 10 that runs all the EOD -- what's called the Air
11:10:39 11 Force civil engineer support unit. He sits down on
11:10:42 12 Tinker Air Force Base. Our career field manager
11:10:44 13 that sits down there is a chief master sergeant.
11:10:48 14 Well, that person has a direct line to the chief
11:10:51 15 master sergeant of the Air Force, who, for lack of
11:10:52 16 a better word, is like the super first sergeant;
11:10:55 17 and I would go down that road and -- but I -- and
11:10:59 18 after awhile, I'd start to figure out who it is
11:11:01 19 that's telling you call me because it's just
11:11:04 20 something they need to say and the people who are
11:11:06 21 saying call me if you've got a problem and you
11:11:09 22 just -- you just know; and if not, you just keep
11:11:12 23 going down the phone list until you get -- until
11:11:14 24 you make it happen.
11:11:16 25 MSGT MACKENZIE: The -- one of the things

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11:11:18 1 that you mentioned that I want to highlight for the
11:11:20 2 record is you were actually on an official order in
11:11:24 3 this capacity to be the FLO. From what I'm
11:11:27 4 gathering from your conversation, that the expenses
11:11:29 5 incurred while doing this job are not reimbursed?

11:11:34 6 MSGT EICHMAN: Not by that order. That
11:11:35 7 order is nothing more than to get you out of work
11:11:38 8 at your shop. That's it. You can't file a voucher
11:11:42 9 against it, you can't recoup any expenses for it.
11:11:44 10 That order is just so you can go to your -- if you
11:11:47 11 happen to be a staff sergeant or senior airman as a
11:11:51 12 FLO, which -- something else I need to bring up is
11:11:53 13 I don't know where it's written that it has to be a
11:11:55 14 senior NCO that's a FLO. I assume they went down
11:11:58 15 that line because the senior NCO has some more
11:12:01 16 capacity to make things happen; but what I found
11:12:06 17 for younger airman that I've worked with, from
11:12:08 18 senior airman, staff sergeant and tech sergeant,
11:12:11 19 there's a lot of times that they look at you as
11:12:13 20 dad; and I don't know if y'all remember being a
11:12:15 21 teenager; but there's some things you just don't
11:12:18 22 want to tell dad. Okay. So, I would send a staff
11:12:20 23 sergeant or senior airman, say, "Can you go talk to
11:12:22 24 this person, because they're not talking to me.
11:12:24 25 You know, I'm happy with dealing with the family;

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11:12:26 1 but there's something on their mind." They'll tell
11:12:30 2 it to their compatriots before they tell it to the
11:12:34 3 master sergeant. So, I think aligning that way and
11:12:37 4 then giving that person who happens to be a senior
11:12:41 5 airman or staff sergeant FLO somebody they can go
11:12:41 6 to -- and that's what I started doing. I started
11:12:46 7 getting senior airmen and staff sergeants and tech
11:12:48 8 sergeants to go do this job and I'm their
11:12:51 9 alternate. And if they run into an issue, they
11:12:53 10 will -- I tell them, "I don't care where I'm at.
11:12:55 11 You can call me at home." You know, I will go fix
11:12:57 12 it and if I can't, I'll find somebody who will; but
11:13:00 13 right now there's no program to -- unless you
11:13:02 14 actually get to use the car trans or somebody gives
11:13:07 15 you a BlackBerry or something along those lines --
11:13:09 16 to reimburse a FLO for any experiences that they
11:13:12 17 may put out.

11:13:20 18 Again, these are all the things that you end
11:13:22 19 up being for a recovering person. I use -- I mean,
11:13:28 20 warrior is a great term. That's exactly what
11:13:31 21 they're doing whenever they're over there and they
11:13:33 22 happen to get injured; but at the same time it's
11:13:35 23 not the only people who get injured. So, a lot of
11:13:38 24 the times I will substitute just airman. You know,
11:13:42 25 I don't really care where you came from, how you

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11:13:44 1 got hurt, how -- I don't care. You know, if you
11:13:46 2 show up at BAMC or if you show up at Wilford Hall
11:13:50 3 and -- you know, I guess it's kind of snobbish;
11:13:53 4 but -- and you're EOD, whoever, and you're
11:13:56 5 supervisor calls, "Hey, my guy's down there. Can
11:13:59 6 you go look at him," I own you until you leave here
11:14:02 7 and I'll do whatever it takes to get you out of
11:14:05 8 here as fast as I possibly can. So, it's
11:14:07 9 recovering airmen or marine or sailor or soldier, I
11:14:12 10 think is a better road to go down than classifying
11:14:14 11 them all as they happen to get hurt in AOR. Just
11:14:20 12 my viewpoint.

11:14:21 13 MR. DRACH: Master Sergeant, you
11:14:23 14 mentioned -- up there you mentioned driver, which
11:14:25 15 means transportation. You mentioned on an earlier
11:14:27 16 slide about transportation. I know that the state
11:14:31 17 of Texas -- a lot of the counties and communities
11:14:33 18 in the state of Texas have various levels of
11:14:35 19 support for needs of disabled veterans, so forth.
11:14:41 20 Have you ever reached out to the community to see
11:14:43 21 if there's any assistance for transportation needs?

11:14:47 22 MSGT EICHMAN: Only as by-product and
11:14:51 23 I'll -- I'll plug them. Enterprise Rent-A-Car.
11:14:51 24 I -- you know, there's a reason those people have
11:14:53 25 colors of green, you know. I went down there

11:14:56 1 with -- with a mom and dad that came in. They
11:15:00 2 weren't well funded but they needed -- you know,
11:15:02 3 they didn't -- they were starting to feel dependent
11:15:05 4 and it made them feel weird. So, they wanted some
11:15:08 5 transportation. They were going to go down and
11:15:11 6 rent a car for the weekend so that they could go
11:15:14 7 out and -- you know, take them out and just be on
11:15:16 8 their own for once instead of having me drag along
11:15:19 9 with them as a fifth wheel. So, I took them down
11:15:21 10 to Enterprise. I was going to use my little VIP
11:15:23 11 card or whatever to get them a discount. We
11:15:25 12 explained the situation to them and Enterprise
11:15:26 13 said, "I'll tell you what. We don't need that car.
11:15:28 14 So, why don't you just keep it for a week, give us
11:15:31 15 50 bucks, life is good," you know, and they -- that
11:15:34 16 was on them. That's no program that's out there
11:15:37 17 that got them reimbursed or anything. That was
11:15:39 18 just something that they did; but, no, sir, I'm not
11:15:41 19 aware that -- of any programs. Sometimes it helps
11:15:50 20 whenever they -- you know, Staff Sergeant Hendrick
11:15:53 21 was here and he had a halo from -- and that's
11:15:55 22 probably the best thing in the world if you want to
11:15:58 23 go get something done -- but he had a halo that
11:16:01 24 went from his shoulder down to his wrist. I took
11:16:03 25 them down to, you know, rent a car and the girl on

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11:16:05 1 the other side of the counter was in tears before
11:16:07 2 we left and upgraded them to like -- I think it was
11:16:10 3 a Cadillac or something like that. I said, "You
11:16:12 4 know, that's great; but he's got like four dozen
11:16:15 5 kids, we need something boxier." So, they gave
11:16:19 6 them a large van for the duration that they were
11:16:21 7 here and that was three months. So, you know --
11:16:26 8 CSM DEJONG: Again, I can't -- we can't
11:16:27 9 present anything that's not documented as far as --
11:16:30 10 and I know you've got some documentation and
11:16:32 11 some -- if these lessons learned aren't captured
11:16:35 12 and aren't continually updated with the good, bad
11:16:38 13 and the ugly, it's hard to present anything. Even
11:16:41 14 at the level of the Air Force --
11:16:43 15 MSGT EICHMAN: Right.
11:16:43 16 CSM DEJONG: -- you have to make some
11:16:46 17 movement on it.
11:16:47 18 MSGT EICHMAN: I know that our logs -- my
11:16:49 19 log, Staff Sergeant Cunningham's log, Staff
11:16:54 20 Sergeant Nells and Master Sergeant Siegler, mine
11:16:56 21 and the folks that have been in -- that I've had
11:17:00 22 contact with, all of ours ended up with Mr.
11:17:04 23 Beckett.
11:17:08 24 CSM DEJONG: Do you know how many airmen in
11:17:10 25 your position are out there across the board?

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11:17:11 1 MSGT EICHMAN: As far as being a FLO?

11:17:15 2 CSM DEJONG: Yes.

11:17:16 3 MSGT EICHMAN: There are three at Ramstein,
11:17:18 4 there is my entire shop that's currently -- not
11:17:20 5 currently working, but have done the job. There
11:17:23 6 was three at Ramstein because that's where
11:17:25 7 Landstuhl is and they just pick up -- in case the
11:19:29 8 family comes in or to -- just to see if the airman
11:19:29 9 needs anything; and that's actually Sergeant
11:19:29 10 Ramakka and two folks that work for him. At my
11:19:29 11 shop, there's 11 folks that work there that's
11:19:29 12 actually assigned to the shop and we take turns,
11:19:29 13 depending on who comes in and when they come in;
11:19:29 14 and there was at least seven at Dover. Currently
11:19:29 15 actually working with somebody there's -- as far as
11:19:29 16 I know, there's only the -- the one airman that's
11:19:29 17 left here is Staff Sergeant Fye and I think there
11:19:29 18 was one left at Dover. We still look in on
11:19:29 19 Sergeant Frost and we still look in on Sergeant
11:19:30 20 Flowers; but they're actually working in the
11:19:30 21 military right now and they're back on active duty.
11:19:30 22 So, it's kind of really dropped off from the way it
11:19:30 23 was.

11:19:30 24 MSGT MACKENZIE: One of the things I -- when
11:19:30 25 I looked at Master Sergeant Eichman's slide, it

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11:19:30 1 gave us an insight of somebody who actually does
11:19:30 2 the work and I recommended to the task force that
11:19:30 3 we get some time with the person who actually is
11:19:30 4 required to be managing this program to come in and
11:19:30 5 brief us. You know, what they're doing versus
11:19:30 6 what's actually happening on the ground. One of
11:19:30 7 the things that I hear quite a bit and it's this --
11:19:31 8 how this whole -- a lot of how this program got
11:19:31 9 started, but quite obviously never finished, was
11:19:31 10 because of the individual commitment of the
11:19:31 11 specialized units who do -- who did this stuff just
11:19:31 12 out of need and the reality to it was the Air Force
11:19:31 13 across the board didn't have this level of support
11:19:31 14 because the program didn't exist until 2007 when it
11:19:31 15 was started. However, the initiatives that were
11:19:31 16 brought up in 2007 were obviously not fulfilled as
11:19:31 17 here we are in 2011 and the same concerns I had in
11:19:31 18 '07 are still the same concerns that Master
11:19:31 19 Sergeant Eichman has expressed.

11:19:31 20 LT GEN GREEN: So, this is clearly on the
11:19:31 21 DA-1 shop up there. The people at Dover you talked
11:19:31 22 with are services. Mr. Beckett I think is up at
11:19:34 23 the air staff. Is he still in charge of the
11:19:36 24 program?

11:19:37 25 MSGT EICHMAN: As far as I know, sir, he's

11:19:39 1 still with the wounded warrior program. I
11:19:41 2 personally have not spoken with him in some time,
11:19:44 3 but I still do get e-mails from him. A long time
11:19:47 4 though.

11:19:47 5 LT GEN GREEN: Denise, do you know?

11:19:48 6 MS. DAILEY: No, sir. He has left. There's
11:19:50 7 a Major Wyatt in the A-1 who is the program manager
11:19:55 8 and, yes, I found Master Sergeant Eichman through
11:19:59 9 the Dover connection. There's a GS -- I don't
11:20:02 10 remember his name -- who I talked with and gave me
11:20:05 11 Master Sergeant Eichman's name.

11:20:08 12 MSGT EICHMAN: The person that threw the
11:20:12 13 rock at me was -- Stef Page is who I got the e-mail
11:20:17 14 from concerning this right here.

11:20:18 15 MS. DAILEY: Yeah, it was Mr. Page that I
11:20:20 16 chatted with to find someone like Master Sergeant
11:20:24 17 Eichman.

11:20:25 18 LT GEN GREEN: So, we clearly had a briefing
11:20:27 19 last year in the task force talking to what the Air
11:20:29 20 Force was going -- was envisioning their program to
11:20:32 21 do. As we come down and talk to people who are
11:20:34 22 actually doing this at the FLO level, it would be
11:20:36 23 interesting -- I mean, to hear that there's a
11:20:39 24 checklist being developed is a good thing.

11:20:42 25 MSGT EICHMAN: Yes, sir.

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11:20:42 1 LT GEN GREEN: Although it's a little late
11:20:44 2 in terms of getting us there; but I'm glad we're
11:20:47 3 capturing some of your knowledge. And so we'll see
11:20:49 4 if we can't get Major Wyatt to come and talk with
11:20:52 5 us and share some of the things we're seeing.
11:20:57 6 Thanks.

11:20:57 7 MSGT EICHMAN: I think I probably touched
11:20:59 8 this more than once, but what it boils down to is
11:21:02 9 if the person is cognizant or they hit Dover or
11:21:05 10 even at Landstuhl and they delineate who is going
11:21:09 11 to -- up to three people who can be on the order.
11:21:11 12 Those are the people I -- I personally end up
11:21:15 13 working with. We've had -- you know, you say
11:21:19 14 spouse. We've had them go down the next of kin,
11:21:23 15 but they didn't know because the person deployed
11:21:27 16 and what did not get updated was the spouse was
11:21:30 17 about to be an ex-spouse and they woke up and --
11:21:33 18 that was way interesting and we ended up getting a
11:21:38 19 social worker to work that out; but he -- that
11:21:42 20 particular airman said, no, my sister and my mom
11:21:45 21 and that's who we brought in as fast as we could
11:21:49 22 possibly get them there; and at that point it
11:21:52 23 doesn't really matter. You know, it's the person
11:21:54 24 that is going to be the caregiver for that airman,
11:21:57 25 regardless of their status. Whether it's, you

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11:21:59 1 know, boyfriend, girlfriend, wife, mother, whoever
11:22:05 2 that shows up and that's who we are going to assist
11:22:09 3 in doing their job.

11:22:16 4 MSGT MACKENZIE: Sir, let me ask you a
11:22:17 5 question. Up in the national capital region the
11:22:19 6 Air Force has assigned two patient liaisons that
11:22:26 7 are actually in the hospital and then the airmen
11:22:28 8 that are actually coming in are assigned FLOs; but
11:22:31 9 from what I'm hearing, it seems as though that
11:22:35 10 doesn't exist here in this major medical center.
11:22:38 11 Do you see that to be a shortfall that you don't
11:22:40 12 have an understanding why the Air Force hasn't
11:22:42 13 produced?

11:22:43 14 MSGT EICHMAN: Well, I mean, I don't live
11:22:44 15 with them while they're here. They're -- they stay
11:22:48 16 either in -- in the case of BAMC they're at the
11:22:51 17 Fisher House or they're in the palace guest house
11:22:55 18 or in some cases there is actually corporate
11:22:57 19 apartments if that gets full; and I don't -- like I
11:23:01 20 said, I don't live with them. I will get text from
11:23:04 21 them in the middle of the night or they'll call me
11:23:06 22 or something like that; but if they had somebody
11:23:09 23 that sat actually at the medical center, you know,
11:23:12 24 that whenever I'm not there and it's an immediate
11:23:16 25 need, that they could go to, absolutely, because,

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11:23:19 1 again, the RCC is not -- you know, I guess there's
11:23:23 2 a down side to that because that person that
11:23:26 3 actually sits at the medical center, again, is
11:23:28 4 going to be farmed out to many, many people. The
11:23:31 5 same that happens with the RCCs, the same that
11:23:35 6 happens with the social workers that are there.
11:23:37 7 They have a case load. I have a case that I work.
11:23:40 8 So -- but having somebody actually there that they
11:23:44 9 could walk down the hall and/or call them on the
11:23:46 10 phone and get the same -- the same feeling that
11:23:50 11 they get from their FLO, yes, that would be a great
11:23:52 12 thing, as long as that person is available as often
11:23:55 13 as say I am. I mean, I've had calls and I've gone
11:23:59 14 from my house at 2:00 o'clock in the morning to the
11:24:02 15 Fisher Center because they were told by the Fisher
11:24:04 16 House that they had to leave. I was like, "Really?
11:24:07 17 You know, the guy is still sitting over in the
11:24:09 18 hospital, where are they supposed to go? Well, we
11:24:11 19 need this room. Well, put them in another one or
11:24:14 20 find them an apartment or --" you know, I've
11:24:16 21 actually had them living at my house because there
11:24:19 22 was no place else for them to go at the time and
11:24:22 23 funds were short. So, they stayed in my guest room
11:24:27 24 until we could get them something else. So, you
11:24:32 25 know, you have to be available and you have to be

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11:24:34 1 able to make things happen and, you know, possibly
11:24:37 2 if a liaison would have been at BAMC at the time or
11:24:40 3 even the social worker at 2:00 o'clock in the
11:24:43 4 morning would have been available at the time that
11:24:45 5 could have been headed off and -- because the next
11:24:48 6 day -- well, the day after that we ended up getting
11:24:51 7 them in a corporate apartment for the next two
11:24:55 8 months that they were here. So -- but, you know,
11:24:58 9 again, cell phones. It works.

11:25:03 10 DR. PHILLIPS: Did you have to pay this cell
11:25:06 11 phone bill yourself?

11:25:08 12 MSGT EICHMAN: Yes, sir, I do; but, again,
11:25:09 13 you know, Verizon changed their plan, so it's
11:25:16 14 fairly inexpensive. I think we've -- again, you
11:25:33 15 know, cell phones are cell phones. The milestone
11:25:36 16 was the log being tracked and actually making it
11:25:39 17 somebody who could actually do something with it.
11:25:41 18 You know, having a path that it needed to go down.
11:25:44 19 There's a lot of folks that get our log. I mean, I
11:25:46 20 share my log with the airmen's supervisor who
11:25:51 21 shares it with their chain and then the log goes
11:25:53 22 through mortuary affairs up the channels that way
11:25:56 23 and I share it with our overall leadership, General
11:26:00 24 Byers, whenever it's -- because obviously he wants
11:26:03 25 to know. I mean, there -- but the first person on

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11:26:07 1 that list is always up the mortuary affairs line
11:26:11 2 because that is the line that's going to take it up
11:26:13 3 to the wounded warrior folks that are sitting at
11:26:17 4 the pentagon. You know, General Byers can read
11:26:19 5 something that he wants to take issue with and walk
11:26:22 6 down the hall and take care of it or General Reno
11:26:25 7 or, you know, any of those other folks that are in
11:26:29 8 my chain of command, you know, or the wing
11:26:30 9 commander that sits out -- whichever wing this
11:26:34 10 person came from; but these are the folks that A-1
11:26:36 11 staff and I'll give them a plug too. That I've --
11:26:40 12 if I have called somebody that is on the checklist
11:26:42 13 that I have, if I don't get them that -- you know,
11:26:47 14 right then and there, they have never failed to
11:26:50 15 call me back before the end of the day. You know,
11:26:52 16 at least that's my experience and that goes from,
11:26:56 17 you know, Stef Page to, at the time, Mr. Beckett,
11:27:00 18 to whoever. They have always called me back and
11:27:04 19 other than that, I -- it's whoever needs the
11:27:09 20 information. I've seen some of the results of
11:27:11 21 those logs, as I said, in the checklist. The last
11:27:14 22 one I filled out whenever I was getting retrained.
11:27:29 23 As I said, every case is unique. Each
11:27:29 24 family will have its own needs. A lot of the
11:27:32 25 families that I've dealt with over the years, I

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11:27:34 1 actually still have contact with. One of them
11:27:37 2 wanted me to come to Connecticut for some reason in
11:27:39 3 the middle of November and that just wasn't going
11:27:42 4 to happen; but he -- I still talk with them, they
11:27:45 5 still send me e-mails. I give every single
11:27:49 6 person -- every family member, every son, daughter,
11:27:54 7 mom, dad, whoever shows up -- they have the contact
11:27:58 8 information for myself and anybody who can yell at
11:28:00 9 me. So, if I'm not doing my job and they don't
11:28:06 10 feel comfortable telling me that, they have the
11:28:09 11 phone numbers to the people who have no problem
11:28:11 12 whatsoever telling me that I am screwing up and in
11:28:16 13 my opinion that's what keeps me straight. You
11:28:18 14 know, I may wonder off into the back 40 because
11:28:23 15 something happened at work or whatever and if I
11:28:26 16 forget to contact them for some reason because I
11:28:28 17 get too deep in my own woe, they can call me or
11:28:33 18 they can call my boss and he can walk into my
11:28:36 19 office and say, "Hey, have you talked to him in the
11:28:38 20 last couple of days"; and I'd be -- "Oh, crap. No,
11:28:42 21 I haven't."

11:28:47 22 Some of the suggestions that I've continued
11:28:50 23 and probably beat the horse to death with. You
11:28:53 24 know, cell phone, beautiful thing. You know,
11:28:56 25 having the Air Force give the FLOs one, regardless

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11:28:59 1 of who they are, for the duration of their duty.
11:29:02 2 You know, we're -- everybody, conceivably, that is
11:29:06 3 in the Air Force is an adult and hopefully they
11:29:09 4 will figure out, you know, this is -- the reason
11:29:10 5 why you're getting this is so you can take care of
11:29:13 6 this wounded person, not to call whoever in
11:29:16 7 California.

11:29:18 8 Same thing with the you-drive-it. Having a
11:29:24 9 part of your order saying you can transport
11:29:27 10 non-government entities in your you-drive-it would
11:29:30 11 be great because it would prompt a lot more people
11:29:33 12 to go down there and get one and use it. And
11:29:35 13 having the ability to have it assigned to you for
11:29:38 14 longer than 30 days at a time is even better. You
11:29:41 15 know, yes, you'll park it at your work center every
11:29:44 16 evening and pick it up every morning. You're not
11:29:47 17 going to take it to your house. But having it
11:29:49 18 there where you don't have to go through the
11:29:51 19 process every day, because that's an hour and a
11:29:55 20 half, getting a you-drive-it.

11:29:59 21 Again, not everybody who's wounded was in
11:30:03 22 Afghanistan or Iraq or Jabuti or Egypt or wherever.
11:30:10 23 Some of them were wounded in Wisconsin. And
11:30:13 24 they're wounded seriously. So, being able to
11:30:16 25 classify them into a wounded airman program to

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11:30:20 1 where they get some of the same support that we're
11:30:24 2 giving the guys who got shot, I think that would be
11:30:27 3 a bonus because, you know, if it's serious enough
11:30:34 4 and their installation doesn't have the medical
11:30:37 5 facility to deal with what's wrong with them,
11:30:39 6 they're going to be sent to one of the major
11:30:41 7 medical centers and that is away from home and that
11:30:44 8 is mom and, you know, the wife and whoever else is
11:30:47 9 going to come down and take care of them. So,
11:30:49 10 being able to put those folks on orders and get
11:30:52 11 them down here so that they can see to the needs,
11:30:56 12 that would be a beautiful thing.

11:31:00 13 MSGT MACKENZIE: And, actually, that does
11:31:02 14 exist. I encourage you it's not to put them under
11:31:05 15 one categorical name, but to expand the program to
11:31:09 16 wounded, ill and injured; but the VSI and SI is not
11:31:13 17 a combat process. It is actually an injury process
11:31:18 18 which should be connected within that order to make
11:31:20 19 sure they get that availability.

11:31:23 20 MSGT EICHMAN: Well, the folks at casualty
11:31:25 21 matters don't necessarily agree with you because
11:31:27 22 I've had that -- I had that discussion and I said,
11:31:30 23 "Well --" they said, "Well, he has to be VSI." I
11:31:33 24 said, "The truck landed on his knee, man. I mean,
11:31:36 25 he's missing his leg. That's pretty serious." And

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11:31:40 1 we went around and finally they relented and I got
11:31:42 2 his mom down here, because he wasn't married; but
11:31:45 3 it took some effort.

11:31:49 4 DR. TURNER: Sergeant Eichman, could you
11:31:51 5 comment a little bit about differences you've seen
11:31:53 6 in a company versus single airman and how they're
11:31:57 7 treated?

11:31:58 8 MSGT EICHMAN: Well -- and that person was a
11:32:00 9 good example. Like I said, he was -- not only was
11:32:03 10 he not married, but he was a guard/reservist and
11:32:09 11 whenever they got -- he didn't denote anybody until
11:32:14 12 we poked him in the forehead a couple of times.
11:32:16 13 Said, "You need somebody down here. You know, I
11:32:18 14 love you to death; but I'm not going to live with
11:32:21 15 you"; and finally he said -- he brought his mother
11:32:23 16 down here and his mother had her own issues,
11:32:26 17 because this man was 44 years old. You know, mom
11:32:28 18 was in her 60s, approaching 70. She wasn't really
11:32:32 19 hip to it, but she came down and she stayed with
11:32:34 20 him for some of the time that he was here; but
11:32:37 21 whenever they are younger airmen or soldiers, in
11:32:40 22 the case of BAMC they actually get put into a dorm
11:32:44 23 setting over on Fort Sam Houston. Well, in the
11:32:46 24 beginning those dorms were fairly close to BAMC,
11:32:53 25 right behind the CFI, over on the left-hand side,

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11:32:54 1 until they got full; and then they had to go in and
11:32:58 2 start using dorms elsewhere. The fact that they
11:33:00 3 did that I thought was amazing, because the palace
11:33:04 4 guest house -- I mean, it's a guest house and it's
11:33:05 5 designed for, you know, family type of environment
11:33:07 6 per se; but they -- I haven't really seen -- I
11:33:12 7 mean, from the standpoint of them being single or
11:33:15 8 married or anything like that, you know, it's
11:33:17 9 whoever gets -- whoever they decide to put on the
11:33:19 10 order. You know, so from that point of view, at
11:33:22 11 least from the FLO and even from the RCCs that I
11:33:24 12 dealt with, it didn't really -- that didn't really
11:33:27 13 play in, as far as what their marital status was.
11:33:30 14 Their status and whether they're active duty, guard
11:33:34 15 or reserve, that's a little bit different because
11:33:36 16 reserve orders end and, you know, it's -- even
11:33:40 17 that's gotten better where you have continuing
11:33:42 18 medical orders; but even those will end and the
11:33:46 19 magic day for that is September 30th, regardless;
11:33:49 20 and why, it's the FY. And when they're put on CMD
11:33:54 21 orders, those CMD orders are for this long and this
11:33:58 22 FY. And whenever they're getting mandates to be on
11:34:00 23 continuing medical orders, again, it's done on
11:34:03 24 mandate s and it's done within an FY. So, there's
11:34:06 25 a time in there whenever they can actually drop

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11:34:09 1 into being a civilian for about 24 hours before you
11:34:12 2 get them back on orders. Most of the time that's
11:34:15 3 not a big issue, but it could be.

11:34:20 4 MSGT MACKENZIE: Now, the FLO program is
11:34:24 5 actually an immediate tasking for a specific period
11:34:28 6 of time and then it's over?

11:34:30 7 MSGT EICHMAN: Yeah.

11:34:33 8 MSGT MACKENZIE: Obviously, our airmen have
11:34:35 9 had a lot of luck with having you and some of your
11:34:36 10 work center being right here in the San Antonio
11:34:38 11 area. Do you find that the -- the training and
11:34:43 12 equipping of a FLO that was tasked perhaps at San
11:34:46 13 Antonio and went UPCS or in any other location
11:34:50 14 where this is required, is adequate enough for them
11:34:53 15 to be able to do the job at the level at which that
11:34:56 16 job is required?

11:34:56 17 MSGT EICHMAN: No, I actually -- I mean, I'm
11:34:59 18 contemplating becoming a farmer next year and I
11:35:01 19 still have airmen sitting in Afghanistan and I
11:35:06 20 still have folks getting injured. I'll still --
11:35:08 21 you know, I mean, I say we've had a dry spell
11:35:12 22 there, thank God, that we -- Staff Sergeant Fye is
11:35:16 23 the only person we have sitting right now in San
11:35:18 24 Antonio; but, you know, I have a wealth of
11:35:21 25 experience in this program. I've tried to pass

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11:35:24 1 that off to Master Sergeant Siegler or somebody who
11:35:28 2 will be here and, you know, I was extremely happy
11:35:31 3 whenever Stef Page told me that this was happening
11:35:34 4 and that it was for the recovery of somebody who
11:35:37 5 had been injured, because I honestly -- I mean,
11:35:40 6 other than going back up the A-1 chain, I had no
11:35:44 7 idea, other than leaving it with the flight, how to
11:35:46 8 pass on and keep the level of commitment. I mean,
11:35:50 9 it will stay in ours because it's just who we are.
11:35:54 10 You know, PJ, CCT and all that; but for security
11:35:58 11 forces or the cook that was sitting in his mobile
11:36:02 12 kitchen and got covered in hot grease, you know,
11:36:05 13 those folks, it's not the same for them and it
11:36:10 14 should be and occasionally you have to like jump
11:36:14 15 start that program. Well, I'm hoping that
11:36:16 16 everything that y'all learn here and that you pass
11:36:18 17 forward will make that happen, because in addition
11:36:23 18 to all of this that we do, we still take care of
11:36:29 19 these folks and we still -- you know, regardless of
11:36:33 20 where their family is at, we have somebody that's
11:36:35 21 not on orders but they are a family person that has
11:36:39 22 to -- if they call and say, "Hey, you know, I need
11:36:42 23 to get onto the base and I have to do this thing
11:36:44 24 because, you know, I'm having an issue," then
11:36:48 25 somebody from one of our flights will go down there

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11:36:50 1 and take care of the family, you know. And we're
11:36:53 2 hoping we don't add to the list; but, you know, it
11:36:56 3 could happen.

11:36:58 4 Chief Ayers recently went to New Orleans
11:37:01 5 because that's where Sergeant Douville was from;
11:37:03 6 and there is no -- the closest base for them to be
11:37:07 7 seen and where they're seeing them is in Keesler.
11:37:10 8 So, he drove the family over to Keesler and got
11:37:13 9 them -- more paperwork done for them because they
11:37:15 10 didn't know what to do or where to go. His wife
11:37:18 11 had no contact with the military and -- other than
11:37:21 12 PNUTS, and she didn't know the process. So, he
11:37:24 13 went over there and did it. It's what you do.
11:37:31 14 That's all I have for y'all.

11:37:33 15 LT GEN GREEN: So, a couple of questions.
11:37:36 16 The -- clearly you're representing non-medical case
11:37:40 17 management in a way because the Air Force uses the
11:37:43 18 RCC and the FLOs?

11:37:44 19 MSGT EICHMAN: Yes, sir.

11:37:45 20 LT GEN GREEN: And so you've been doing this
11:37:47 21 for a number of years. Has there been any change
11:37:50 22 in the interface between the -- you talked about at
11:37:53 23 Andrews the patient liaisons. So, do you have
11:37:57 24 representatives that work with you from the
11:37:58 25 hospital in terms of what's going on?

11:38:02 1 MSGT EICHMAN: I think the Brooke Army
11:38:06 2 version of the patient liaison, whenever -- say
11:38:10 3 whenever Matt Slaydon was here, was his social
11:38:13 4 worker. He was assigned -- there's a vast number
11:38:16 5 of social workers at BAMC. In addition to the RCC,
11:38:20 6 she would come over and speak with him and we would
11:38:25 7 go as a family liaison and probably at least once a
11:38:31 8 week during the first stages until Matt got out and
11:38:35 9 was actually traveling between the palace and the
11:38:38 10 CFI, we would meet once a week and they would ask
11:38:41 11 me if -- you know, can he do this and I would tell
11:38:45 12 them things that Annette, his wife, had seen with
11:38:49 13 his care that she may not have discussed with them;
11:38:52 14 and then anything that was not either medical or
11:38:56 15 dealt directly with family, the social worker was
11:38:58 16 also coordinating with the medical staff. The
11:39:00 17 doctors, the nurses. The warrior center that's now
11:39:05 18 on BAMC is another great resource; but I have
11:39:08 19 never -- or recently I have not seen somebody who
11:39:11 20 has been designated as a patient liaison. It
11:39:16 21 was -- to me, that job was being attributed to the
11:39:20 22 social worker.

11:39:26 23 LT GEN GREEN: The other question that I
11:39:27 24 have is with the amount of time you've done this,
11:39:31 25 has it adversely affected your career progression?

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11:39:34 1 MSGT EICHMAN: Oh, no, sir. I'm a master
11:39:35 2 sergeant because if I make senior master sergeant,
11:39:38 3 my wife will sue me. So, I -- you know, if
11:39:40 4 anything -- I mean, I have met a vast number of
11:39:43 5 people that I have seen in all colors and stripes.
11:39:46 6 From, you know, general officers that have come
11:39:48 7 down and they truly, truly want to be involved and
11:39:51 8 chiefs and everybody else. So, I mean -- not me
11:39:56 9 personally, no, sir; and a lot of the times -- you
11:39:59 10 know, like I said, there's -- there's a lot of -- I
11:40:03 11 won't say a lot. There are a few FLOs that the
11:40:06 12 reason why they signed up for it and they got that
11:40:09 13 order and they got a date is so they could check
11:40:12 14 something on their EPR and say I did this, because
11:40:14 15 it was -- they considered it community service.
11:40:17 16 You know, obviously, it's not the real reason you
11:40:19 17 need to sign up to do this job; but it's not going
11:40:23 18 to be a hindrance to do this job. The staff
11:40:26 19 sergeants and the senior airmen that I have asked
11:40:29 20 them, "Hey, would you like to volunteer to do this"
11:40:31 21 and they step up and say absolutely, you know,
11:40:35 22 they -- I cut them loose and this is what they do
11:40:39 23 and if they come back and say, "You know, I was
11:40:41 24 down there all weekend or whatever. I'd like to
11:40:44 25 spend some quality time with my wife," you know,

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11:40:46 1 then I cut them loose some more and give them two
11:40:49 2 days off, if they were down there all weekend. You
11:40:51 3 know, they'll take -- or, you know, they'll gather
11:40:54 4 up their family and meet up with the warrior's
11:40:57 5 family and take them out to eat or take them to a
11:41:00 6 movie or something like that because sometimes the
11:41:02 7 best thing to do is get away from the hospital.
11:41:05 8 You know, so -- no, I don't foresee it in any way
11:41:09 9 whatsoever that this could hamper somebody's
11:41:12 10 career.

11:41:12 11 Now, the other side of that is that -- and
11:41:16 12 it was amazing because we just had our EOD safety
11:41:19 13 day and we had a psychologist and a psychiatrist
11:41:22 14 come over and talked to us about PTSD and all this
11:41:25 15 other good stuff. If you spend enough time as a
11:41:28 16 FLO and you're at a medical center a lot and you
11:41:32 17 see folks that have been melted and holes blown in
11:41:37 18 them, missing limbs and all these other good
11:41:40 19 things, if anything is of a concern, it is
11:41:43 20 secondary. PTSD. Seeing that every day and
11:41:47 21 dealing with it and helping these folks because --
11:41:51 22 Staff Sergeant Ellis is a prime example. She is
11:41:54 23 probably the most empathetic person I know and she
11:41:56 24 will just take in anybody else's emotions and make
11:42:00 25 them her own. I had to sit her down a couple of

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11:42:03 1 times and say, you know, "Hey, it's not you and you
11:42:05 2 need to -- you know, if you need to talk about it,
11:42:07 3 talk about it; and if not, I know some folks you
11:42:10 4 can go see that you can go talk to about it"; but,
11:42:13 5 you know, being a continuous FLO for seven years --
11:42:17 6 you know, I sent a lot of these guys over to the
11:42:20 7 desert and they came back in pieces. So, that's
11:42:22 8 probably the only concern that I really had. I
11:42:25 9 wasn't getting empathetic to it, I was getting dead
11:42:28 10 to it. So, I started letting other people do this
11:42:32 11 job.

11:42:36 12 LT GEN GREEN: Caregiver fatigue is a true
11:42:39 13 entity and so hopefully we found some people for
11:42:42 14 you to be talking with, whether peers or
11:42:45 15 professionals, either way.

11:42:49 16 DR. PHILLIPS: All right. Sergeant, thank
11:42:51 17 you very much for your commitment and your
11:42:53 18 compassion and this very insightful report.

11:42:57 19 MSGT EICHMAN: Thank you.

11:43:02 20 DR. PHILLIPS: Shall we continue?

11:43:04 21 MS. DAILEY: We do have another briefer.

11:43:06 22 DR. PHILLIPS: Yes, I was just going to
11:43:08 23 introduce -- the task force, as you know, is very
11:43:10 24 interested in the issues related to transition of
11:43:15 25 the wounded warriors and their families to the VA

11:43:20 1 and to that end we've asked the veterans affairs
11:43:26 2 vet center counselors to brief us more about the
11:43:30 3 transition process and their role and I want to
11:43:35 4 thank retired Lieutenant Colonel John Uriarte.

11:43:35 5 LT COL URIARTE: Uriarte.

11:43:35 6 DR. PHILLIPS: Uriarte. I'm getting better
11:44:11 7 with names. For the next briefing. Thank you.

11:44:11 8 LT COL URIARTE: Well, morning, and thank
11:44:12 9 you for allowing me to come here today to tell you
11:44:14 10 about the vet center. I think it's sort of
11:44:16 11 important just to sort of introduce myself and what
11:44:19 12 I bring to the table. I'm -- as you can see, I'm a
11:44:21 13 retired US Army lieutenant colonel and I'm a
11:44:28 14 Vietnam era vet. I spent four years in the
11:44:31 15 infantry back in the '70s and when I re-entered
11:44:34 16 active duty with my social work degree, for the
11:44:37 17 last 20 years I did all kinds of jobs as a social
11:44:40 18 work officer, going back to the Persian Gulf War up
11:44:45 19 to 2008. When I left active duty I was a clinical
11:44:52 20 professor of social work at Texas State University
11:44:54 21 and shortly after that I ended up going to the vet
11:44:56 22 center.

11:45:04 23 So, the vet center basically is one of those
11:45:07 24 entities that is extremely important and offers a
11:45:11 25 service that the VA cannot offer anywhere else.

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11:45:18 1 Going back to Abraham Lincoln, the whole premise is
11:45:21 2 to help the family and the children and that is
11:45:24 3 exactly one of the things that the vet center does
11:45:26 4 is that we've opened our doors to spouses, to their
11:45:29 5 kids, to parents, to siblings. Especially in the
11:45:35 6 areas where we -- the family's experienced a loss.
11:45:38 7 And so we pull out all the stops in allowing them
11:45:42 8 to come in and give them as much time as they need
11:45:45 9 to get the care and services that they want. Our
11:45:56 10 whole goal is about making readjustment. Everyone
11:45:59 11 who's ever served in the military, no long matter
11:46:02 12 how long or how short, has had a -- has had an
11:46:05 13 impact on their lives that for better or for worse
11:46:08 14 it's going to be a part of them. They have to put
11:46:13 15 it in some sort of perspective so they can move on
11:46:16 16 with their lives. The vet centers were born out of
11:46:18 17 the Vietnam era and originally they were called the
11:46:22 18 Vietnam vet centers; and so as such there were a
11:46:25 19 lot of issues with the Vietnam experience that the
11:46:28 20 soldiers coming back -- there were issues with
11:46:30 21 trust with the government, with the VA. They
11:46:32 22 didn't want the care and basically with a lot of
11:46:35 23 the Vietnam vets it took 10 years for them to come
11:46:38 24 to a full realization that there were issues going
11:46:40 25 on and they needed help. Around the early '80s the

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11:46:47 1 vet centers started to come up. The first one was
11:46:50 2 in California. In San Antonio we had one and then
11:46:52 3 as the Vietnam vet population started to increase,
11:46:55 4 it grew into two. The whole thing about this was
11:46:58 5 the vet centers were originally meant to be store
11:47:01 6 front counseling centers. Away from the hospital,
11:47:03 7 away from any feeling that they were in a
11:47:06 8 government agency. So, a vet could walk in the
11:47:09 9 door, sit down, talk, have coffee. Maybe they
11:47:13 10 didn't want to talk to anyone, but it was a place
11:47:16 11 just to get away to hang out. Today, some 40 plus
11:47:20 12 years later, we have Vietnam vets who have been
11:47:24 13 coming to my vet center for 20 years once a month
11:47:28 14 to have a support group where they just need that
11:47:31 15 contact. Not to deal with therapy or issues that
11:47:35 16 happened in Vietnam, but as a way of maintaining
11:47:37 17 that connection with their identity. They don't
11:47:40 18 want to lose that and we see that also with a lot
11:47:40 19 of OIF/OEF vets.

11:47:42 20 Originally, if you were just a veteran,
11:47:50 21 anyone could come to the vet center. What has
11:47:52 22 happened is with the OIF/OEF conflict, once that
11:47:55 23 started up, we started -- our numbers were
11:47:57 24 increasing. We started seeing more and more people
11:48:00 25 asking for services. So, we had to limit our

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11:48:03 1 service provision for those who served in combat.
11:48:12 2 We -- any vet can come in. If they're a non-combat
11:48:16 3 vet, we'll see them up to three times; but our goal
11:48:16 4 is to do -- identify what resources they need and
11:48:20 5 get them referred and do a handoff where we're
11:48:22 6 actually making phone contact with someone, letting
11:48:23 7 them know the vet's information, what they need and
11:48:26 8 making sure that they get connected.

11:48:36 9 Other areas that people are seeing us are
11:48:38 10 reserve and national guard. About a month ago we
11:48:39 11 got a request to do a PDHRA and a SRP for an entire
11:48:42 12 medical battalion and we had about 500 soldiers
11:48:45 13 coming through and they asked the vet center to
11:48:49 14 provide the mental health screening. Now, this was
11:48:51 15 a first. Normally we -- on active duty we did
11:48:55 16 those things when a unit re-deployed. I was up in
11:48:59 17 Alaska when the Stryker brigade got extended six
11:49:02 18 months and the secretary of defense came to Alaska
11:49:04 19 to talk to a lot of angry spouses because they
11:49:07 20 weren't coming home for Christmas and Thanksgiving.
11:49:12 21 The mental health role, though, when the soldiers
11:49:14 22 came back, was we had to screen all these folks to
11:49:17 23 make sure that they were okay to go home and this
11:49:21 24 unit had just re-deployed. A lot of the commanders
11:49:26 25 and the -- and this combat support hospital saw

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11:49:29 1 soldiers that were having numbers of problems.
11:49:32 2 They didn't know how to approach them, they didn't
11:49:34 3 know how to address them. All they knew was that
11:49:37 4 their soldiers were -- they were getting calls
11:49:39 5 they'd been arrested, there were DUIs. We had a
11:49:42 6 couple of cases of domestic violence that came up
11:49:45 7 and so they asked us to come by and to screen that
11:49:49 8 unit. We identified out of 500 folks almost 70
11:49:57 9 that either had mental health intervention in the
11:50:00 10 past or were requiring some sort of intervention;
11:50:03 11 and so because this was a drill weekend, we had
11:50:05 12 them scheduled with appointments by the following
11:50:09 13 day and over the next two weeks we were able to get
11:50:11 14 those people in and to go through whatever
11:50:14 15 screening they needed and to provide them with the
11:50:16 16 resources.

11:50:22 17 Of course, currently these are the -- the
11:50:23 18 current campaigns; but we also see soldiers who
11:50:31 19 have served in any one of these campaigns over the
11:50:35 20 years. Primarily, there's two vet centers in San
11:50:42 21 Antonio. We're located in different parts of the
11:50:44 22 city. My vet center is the largest vet center in
11:50:48 23 the entire country and so we are located in a newer
11:50:52 24 building; but we're located in an older part of
11:50:55 25 town. It's a very well established Vietnam veteran

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11:50:58 1 community. So, what ended up happening is we get a
11:51:01 2 lot of Vietnam vets coming in, but we see fewer
11:51:06 3 numbers of OIF/OEFs. The other vet center is
11:51:09 4 located on the northeast part of town. That's a
11:51:11 5 newer part of San Antonio. There's new
11:51:13 6 developments going on. Housing is more affordable
11:51:16 7 and so we see a lot of OIF/OEF veterans moving out
11:51:19 8 there and so that vet center is set up to take care
11:51:22 9 of those vets.

11:51:27 10 These are basically a list of most of the
11:51:29 11 services that we offer. The one unique thing about
11:51:38 12 the vet center, though, is we have no psychiatrists
11:51:41 13 and we have no psychologists. We don't diagnose.
11:51:45 14 Our whole goal -- even though we're all -- I'm a
11:51:47 15 clinical social worker and I'm state licensed.
11:51:50 16 Although we're all trained to diagnose -- and when
11:51:54 17 we staff cases and talk about the issues that the
11:51:57 18 veterans present to us, we look at that with a
11:52:00 19 clinical eye; but when we're actually helping the
11:52:03 20 veteran, we're more focused on normalizing their
11:52:07 21 experience and getting them to deal with their
11:52:09 22 symptoms and what they went through and just get
11:52:12 23 them on with their life. If they're looking to
11:52:14 24 increase their disability rating, if they're
11:52:16 25 looking for someone to say that they have PTSD, we

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11:52:19 1 refer them over to the outpatient mental health
11:52:22 2 clinic of the VA and there they need to get a
11:52:25 3 psychiatrist to sign off on that. More often than
11:52:28 4 not what happens is the psychiatrist will request
11:52:30 5 our records, use our records, our interviews, our
11:52:33 6 treatment notes; and then come up with their own
11:52:36 7 interview and make their own assessment. And
11:52:39 8 generally that, you know, helps the vets a lot.
11:52:41 9 But one of the things that makes us more
11:52:45 10 approachable is that they see us as not being part
11:52:47 11 of the system.

11:52:48 12 The readjustment counseling service is the
11:52:51 13 umbrella organization for all of the vet centers in
11:52:55 14 the country, which is -- there are about 300 of
11:52:59 15 them. So, what makes us unique is my chain of
11:53:02 16 command is not part of the medical center. My
11:53:04 17 chain of command goes straight to Dallas and then
11:53:07 18 from Dallas, Texas goes straight to Washington,
11:53:09 19 D.C. So, the chief of the readjustment counseling
11:53:12 20 service is the consultant in all vet centers to the
11:53:18 21 director of the VA. So, it makes things more
11:53:21 22 streamlined for us. One of the nice things about
11:53:25 23 it is that we have our own budget. We have our
11:53:28 24 separate line item budget from the president and
11:53:30 25 so -- the VA medical centers, they have their

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11:53:33 1 budget. Our money comes from a separate pot. So,
11:53:36 2 when I get my budget at the -- for the new fiscal
11:53:40 3 year, I have the freedom to look at what kinds of
11:53:44 4 services I can provide, identify new training for
11:53:48 5 the staff, creating and identifying community
11:53:51 6 resources to hook up that make up existing
11:53:56 7 programs. Yesterday we had -- I'm trying to do a
11:54:01 8 staffing with the chaplains at the VA because the
11:54:04 9 chaplains are trying to redefine what they do and
11:54:08 10 trying to emphasize less about seeing folks with
11:54:12 11 religious and spiritual issues and more about being
11:54:16 12 an ancillary service to mental health; and so by
11:54:19 13 having programs and workshops and retreats that
11:54:24 14 they set up for soldiers, if the vet center gets
11:54:27 15 hooked up with those kind of initiatives, it just
11:54:29 16 sort of expands our ability to outreach and to
11:54:33 17 touch more soldiers to bring them in.

11:54:35 18 When it comes to drug and alcohol,
11:54:36 19 employment, referral, etcetera, we don't do any
11:54:41 20 drug and alcohol treatment. We'll do assessments
11:54:45 21 and we'll get the veteran set up to go wherever it
11:54:49 22 is they need to go to get the help that they need.
11:54:52 23 Employment guidance. I have a veteran right now
11:54:55 24 who's a former naval pilot -- naval aviator, and
11:55:00 25 he's been out of work since he left the Navy and so

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11:55:03 1 he's been struggling just dealing with the
11:55:06 2 frustration of how hard it is to find a job.
11:55:09 3 That's -- we're not -- I'm not in the job finding
11:55:12 4 business, but just trying to preserve his marriage
11:55:15 5 and keep things going for him, keep him motivated,
11:55:18 6 trying to help him out whatever ways we can.
11:55:21 7 That's about the extent that we do on employment
11:55:23 8 counseling.

11:55:31 9 This is another big area at the time, is
11:55:34 10 military sexual trauma or MST. With this category
11:55:42 11 of population the veteran, male or female, does not
11:55:45 12 have to have had a MST experience over in Iraq or
11:55:51 13 Afghanistan or while deployed. They could have an
11:55:54 14 experience just while they were serving in the
11:55:56 15 peace time military and it just traumatized them to
11:56:00 16 the point that they need counseling or they want to
11:56:02 17 come in and talk to someone. That automatically
11:56:04 18 makes them eligible for care. And so -- of course,
11:56:08 19 predominantly we see mostly female service members;
11:56:12 20 but we are finding a larger proportion of male
11:56:16 21 soldiers who are coming in within -- I mean
11:56:19 22 veterans, not so much soldiers; but vets who have
11:56:22 23 been coming in seeking counseling. So, this has
11:56:25 24 been a big area within the readjustment counseling
11:56:29 25 service, to get more people trained and qualified

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11:56:31 1 to provide military sexual trauma counseling. So,
11:56:34 2 right now there's a mandate that every single vet
11:56:37 3 center should have at least one military sexual
11:56:40 4 trauma counselor and one counselor who is trained
11:56:43 5 in marriage and family therapy.

11:56:49 6 MR. DRACH: When you say traumatized, that
11:56:51 7 includes harassment; is that correct?

11:56:54 8 LTC URIARTE: Correct. Correct. The
11:57:01 9 bereavement service -- this is probably one of the
11:57:04 10 more difficult things that we have to do and
11:57:07 11 fortunately we don't -- I haven't seen a lot since
11:57:09 12 the year and a half that I've been at the San
11:57:12 13 Antonio vet center. The bereavement services --
11:57:14 14 this is one of the few times where we can actually
11:57:18 15 go out and go to the home of the family. Not long
11:57:22 16 ago we had a gentleman whose daughter passed away.
11:57:25 17 She got a disease and she died at BAMC and it
11:57:29 18 wasn't -- she didn't die in combat or anything like
11:57:32 19 that; but she had been sick for a long time. He
11:57:35 20 lived out in the middle of nowhere, didn't have any
11:57:38 21 transportation to go to the hospital to visit his
11:57:41 22 daughter and so once she passed away, we get word
11:57:43 23 of that from my main office in Dallas, that we made
11:57:48 24 contact with the father and we actually had two
11:57:50 25 counselors drive out to his house and we did that

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11:57:53 1 several times over the next several weeks until the
11:57:56 2 father decided, you know, "Hey, thanks for coming
11:57:59 3 by. You know, I think I'm doing okay"; and we
11:58:01 4 terminated the services that way. A lot of times
11:58:04 5 we'll have the mother come in and bring her
11:58:08 6 children and we have counselors. I'm also trained
11:58:11 7 in marriage and family therapy and family practice
11:58:15 8 and so we have people set aside. We'll see the
11:58:19 9 kids separately, we'll see the kids individually,
11:58:22 10 we'll see mom separately. If the parents or
11:58:25 11 grandparents are there, they're grieving too about
11:58:28 12 the loss, we'll see them and if it's a friend or a
11:58:31 13 fiance, we'll see them also. Even a girlfriend.
11:58:34 14 We'll see them. So, we're not turning anybody away
11:58:37 15 and we don't limit this to any number of sessions.
11:58:40 16 A lot of times, you know, we would send -- one of
11:58:43 17 the things I would hate when I was on active duty
11:58:46 18 is when you're at a small installation, a small
11:58:49 19 military hospital, resources, especially in mental
11:58:53 20 health, are very limited. You don't always have a
11:58:56 21 child psychiatrist, you don't always have a
11:58:58 22 developmental pediatrician or something along those
11:59:01 23 lines and you refer to the outside and they go to
11:59:04 24 Tricare, they get hooked up and they say, "Well, we
11:59:07 25 can only see you for six sessions" or "We can see

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11:59:10 1 you eight times and then we have to see if we can
11:59:12 2 see you again." A lot of times what ends up
11:59:16 3 happening is these families will sometimes feel
11:59:20 4 abandoned because, you know, they're looking for a
11:59:22 5 service that they feel the military should provide.
11:59:24 6 And one of the things about the vet center is we
11:59:27 7 make sure that if you are impacted in any way,
11:59:30 8 direct or indirect way, by a loss, we will provide
11:59:33 9 that service for that individual and we don't say,
11:59:37 10 "Well, we can see you three times." We all grieve
11:59:40 11 differently and we all have our different
11:59:42 12 timeliness or how we express that grief; and so
11:59:46 13 many times what ends up happening is they might not
11:59:51 14 come in for six to nine months. The casualty
11:59:54 15 affairs officer will provide information to the
11:59:56 16 spouse that -- in part of that information packet
11:59:59 17 there's the vet center from where it is they're
12:00:02 18 going to move to and then if they decide to make
12:00:05 19 contact, I get a call from my regional office in
12:00:09 20 Dallas to make contact with the spouse and family
12:00:12 21 and then that's how we reach out. So, it doesn't
12:00:15 22 usually happen the soldier passes away and then
12:00:18 23 we're on the case. That's probably the worse thing
12:00:22 24 that can happen. And I remember in Alaska the
12:00:28 25 general did not like all the unhappy spouses when

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12:00:31 1 the Stryker brigade was extended and my suggestion
12:00:35 2 was, you know, spouses are very resilient, we just
12:00:38 3 need to let them be upset. They'll get over it,
12:00:41 4 they'll get it together and they're going to
12:00:43 5 regroup. Well, of course, you know, when you're in
12:00:46 6 a system where, you know, we don't want spouses
12:00:49 7 going to the news complaining about the system, the
12:00:52 8 radios, he thought it would work out best if mental
12:00:56 9 health would intervene and contact every single
12:00:59 10 spouse and provide mental health counseling. That
12:01:02 11 would have made things so much worse. So, I think
12:01:07 12 by, you know, taking off all the stops and making
12:01:10 13 ourselves available to the family and extended
12:01:12 14 family has been a big help.

12:01:18 15 The other big thing that we have is we have
12:01:21 16 a national combat call center and the military --
12:01:26 17 the mobile med center. The combat call center is a
12:01:30 18 place -- I think they're located in Colorado. They
12:01:32 19 operate 24/7. And so any veteran at any time day
12:01:36 20 or night can call this phone number up and talk
12:01:40 21 about -- you know, I need help, I need to talk to
12:01:43 22 someone. They'll talk to them, they'll identify
12:01:45 23 where do you live, they'll give them the name of
12:01:48 24 someone. The closest vet center that's near them.
12:01:51 25 Tell them, you know, that they need to come in and

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12:01:54 1 bring their 214 to verify eligibility; but get them
12:01:57 2 set up. The other thing -- what happens is we have
12:02:00 3 this network where they'll call -- they might be in
12:02:05 4 a vet center somewhere back east, they're PCS'ing
12:02:10 5 to San Antonio for their home of record when they
12:02:12 6 ETS out of the military. We get a heads up call
12:02:16 7 from the vet center back east, expect this person,
12:02:22 8 this is when they'll arrive, we get their name,
12:02:23 9 their phone number, we'll make contact. The one
12:02:25 10 thing we want to avoid is we don't want anyone to
12:02:29 11 be lost in the system or to fall between the
12:02:31 12 cracks; and so we work very hard to make those
12:02:33 13 things happen.

12:02:35 14 The other thing that we have is the mobile
12:02:37 15 vet center and the mobile vet center is basically
12:02:41 16 an RV. About the size of a regular RV. Probably a
12:02:48 17 little bit bigger. The difference is that what it
12:02:50 18 lacks in luxury on the inside, it has in high tech.
12:02:53 19 We have satellite communications, a satellite dish
12:02:56 20 on top. We have secure communications. We have
12:02:59 21 the ability to do video teleconferencing inside the
12:03:03 22 mobile vet center. We have two separate counseling
12:03:08 23 rooms inside. In addition, we have a surgical
12:03:11 24 suite in the back. So that if we're called to do
12:03:13 25 humanitarian missions, stretchers can be put in the

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12:03:17 1 back of the mobile vet center. We can have a
12:03:19 2 doctor and a nurse and they can perform minor
12:03:21 3 procedures back there if called upon to do so. So,
12:03:26 4 it's totally secure. The nice thing about the
12:03:30 5 mobile vet center is its ability to go to rural
12:03:34 6 areas and get in touch with those veterans who
12:03:37 7 might not otherwise have the ability to come to San
12:03:40 8 Antonio to get help at the medical center; and so
12:03:42 9 what we do is we -- we'll contact the veteran
12:03:46 10 service officer in their local communities, let
12:03:49 11 them know when we are going to be there and then
12:03:52 12 they will let their veterans know that the mobile
12:03:55 13 vet center will come and we have a licensed
12:03:58 14 clinician on board and so if they need to come,
12:04:02 15 they need to talk, we're there and we can provide
12:04:05 16 that service.

12:04:10 17 In regards to our hours, we have very, very
12:04:14 18 flexible hours. Every night of the week, probably
12:04:18 19 with the exception of Friday, we work into the
12:04:21 20 evenings doing groups, seeing individuals.
12:04:24 21 Probably two weekends out of every month I have my
12:04:28 22 staff working where we're providing outreach
12:04:31 23 services, going to the communities, as well as we
12:04:35 24 provide services to soldiers and their family
12:04:38 25 members. A lot of the OIF/OEFs don't have time

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12:04:44 1 during the day to come in. Their spouses go to
12:04:48 2 school at night, they have young children and yet
12:04:51 3 they still need the counseling. So, what we do is
12:04:54 4 we provide those weekend services on request. So,
12:04:56 5 if the soldier says, you know, "It's more
12:04:58 6 convenient for me to come in at 9:00 o'clock on a
12:05:01 7 Saturday," we can make that happen.

12:05:07 8 So, these are just some of the things that
12:05:12 9 we're seeing all the time. These problems aren't
12:05:19 10 any different than any soldier I would have seen on
12:05:22 11 active duty. The difference is -- between going to
12:05:26 12 a mental health clinic let's say in Fort
12:05:31 13 Wainwright, Alaska and to my vet center -- is I
12:05:34 14 have more resources available to provide the
12:05:36 15 services that we need. In the area, I'm the only
12:05:40 16 one that does clinical hypnosis. A lot of times
12:05:43 17 veterans don't want -- don't care about
12:05:46 18 understanding why a problem is a problem, they just
12:05:48 19 want it to go away. So, if someone comes in and
12:05:52 20 they're complaining of sleep, one session of
12:05:54 21 hypnosis, I can get them off their medicine. We
12:05:58 22 can deal with anxiety. All of these issues can be
12:06:01 23 dealt with in very few sessions; but, in addition,
12:06:04 24 we provide the education. We have the staff, we
12:06:06 25 have the resources to do whatever it is we need to

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12:06:10 1 do to help the veteran and/or their family.

12:06:14 2 MR. REHBEIN: Sir, can I ask a question --

12:06:14 3 LTC URIARTE: Yes.

12:06:15 4 MR. REHBEIN: -- about a situation you've

12:06:16 5 kind of alluded to a couple or three times. By the

12:06:20 6 time someone in the military is on their second

12:06:25 7 enlistment, they probably have sufficient paperwork

12:06:27 8 to satisfy your eligibility requirements. Do you

12:06:30 9 suspect that you're seeing very many currently

12:06:34 10 serving soldiers that have a DD-214 from their

12:06:40 11 first enlistment but they're on their second? We

12:06:43 12 all know about -- and we hear about it in our focus

12:06:46 13 group. The stigma still exists. The reason that

12:06:48 14 the vet centers were formed. Having those vet

12:06:51 15 centers out there with currently serving people in

12:06:56 16 the community, do you think you see many?

12:06:58 17 MS. DAILEY: Sure. With the population that

12:06:59 18 I see -- and I didn't know this until after I left

12:07:01 19 active duty. Is that every time a reservist or a

12:07:05 20 guard gets deployed and they come back, they get a

12:07:08 21 DD-214. And so initially for me that was a little

12:07:12 22 confusing. Well, why do you have so many. But as

12:07:16 23 long as they -- on that 214 it says that they have

12:07:20 24 a campaign medal, that they served in Afghanistan

12:07:27 25 or Iraq, they're eligible. The other criteria,

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12:07:30 1 however, which is somewhat difficult is that a
12:07:32 2 soldier might have three 214s. Two of them are
12:07:35 3 what we call good paper. He has an honorable
12:07:38 4 discharge. The third one, because of some of his
12:07:42 5 post-deployment issues and the trauma he
12:07:45 6 experienced, he might have gotten into trouble.
12:07:47 7 So, maybe he got a general unhonorable discharge.
12:07:51 8 Well, according to -- the current policy within the
12:07:53 9 readjustment counseling service is they're not
12:07:56 10 eligible and that would be something that
12:08:00 11 definitely we'd probably need to look at. We
12:08:03 12 definitely don't see people with dishonorable
12:08:05 13 discharges.

12:08:06 14 MR. REHBEIN: Well, the question I'm trying
12:08:08 15 to ask and not doing a very good job of it I guess,
12:08:13 16 do you see many folks that you suspect may be
12:08:16 17 currently serving soldiers that are avoiding going
12:08:21 18 to their base mental health clinic, but yet getting
12:08:25 19 help by coming to you?

12:08:27 20 LTC URIARTE: None that I'm aware of,
12:08:29 21 because we -- we go out right now to Lackland,
12:08:34 22 Randolph, Fort Sam, BAMC and we're providing these
12:08:38 23 services to soldiers who are within 90 days of
12:08:42 24 getting out and they can come and we'll make
12:08:44 25 contact and we want to reach out to them so that we

12:08:47 1 have that seamless transition; but my experience
12:08:52 2 has been when we've gone out and done these
12:08:54 3 transitional assistance briefings, a lot of folks
12:08:58 4 have never heard of the vet centers. They just
12:09:01 5 don't know we're there. The ones who really know
12:09:04 6 about us, of course, are the Vietnam guys; but
12:09:07 7 we're sort of this new entity. And I agree. I
12:09:10 8 think that the term "mental health clinic" has a
12:09:17 9 very negative connotation to it. You put that word
12:09:21 10 out there and it sort of keeps people away. So, we
12:09:24 11 don't describe ourselves as being a mental health
12:09:27 12 clinic. Not even as a clinic. We talk -- we
12:09:29 13 rather refer to it as just a counseling center;
12:09:32 14 but -- but the whole issue about that is we really
12:09:38 15 want to portray to these veterans that they are our
12:09:42 16 number one priority. Not putting a label on them,
12:09:46 17 you know, or anything else. That's the least of
12:09:49 18 our concerns. But they come in, they get the help
12:09:51 19 they need so that they can get on with their lives.

12:09:56 20 MR. DRACH: Are you seeing many or any
12:09:57 21 caregivers and if the caregiver is not a family
12:10:01 22 member, are you permitted to see them?

12:10:06 23 LTC URIARTE: If the -- once again, please.

12:10:08 24 MR. DRACH: Are you seeing many caregivers
12:10:11 25 and are you able to see caregivers who are not

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12:10:14 1 family members?

12:10:15 2 LTC URIARTE: We don't see a whole lot of
12:10:17 3 caregivers. The -- if a caregiver -- again, they
12:10:22 4 would have to be a vet and they would have to have
12:10:24 5 served in combat in order to come to get our
12:10:27 6 services. There are a lot of vets who get jobs at
12:10:34 7 Fort Sam or at BAMC who definitely would qualify;
12:10:38 8 but as much as we network with them and they know
12:10:41 9 about our services, we just don't see them come our
12:10:43 10 way. And it does present an issue and this is an
12:10:46 11 area that's not so much talked about. I was in
12:10:48 12 Iraq from 2003 to 2004 and yet if I needed services
12:10:52 13 to talk to someone, I'm at a loss because I'm in
12:10:56 14 the business of providing mental health care and I
12:10:59 15 have -- I can't go anywhere within the system that
12:11:02 16 we have all these services available because I
12:11:05 17 can't get care from the very people that I work
12:11:07 18 with. So, you know, we're sort of having to go
12:11:10 19 farther out. And it's not that much of a dilemma.
12:11:14 20 I mean, it's not such an unusual problem. In the
12:11:18 21 medical community it's a big problem. One thing,
12:11:21 22 medical providers want to avoid being labeled as
12:11:24 23 a -- I'm sorry. The word escapes me. As being a
12:11:33 24 provider who's not being able to provide those
12:11:36 25 services that they need. So, what they do is the

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12:11:38 1 doctors, the nurses, the counselors, the
12:11:39 2 therapists, they all go outside, off post, and keep
12:11:43 3 it quiet and they get the counseling on their own.

12:11:57 4 MS. DAILEY: Colonel, you've covered most of
12:11:58 5 these remaining slides. Can I get the task force
12:12:02 6 to ask any questions --

12:12:06 7 LTC URIARTE: Sure.

12:12:06 8 MS. DAILEY: -- they want to focus on for
12:12:10 9 your services and what would be helpful? For them
12:12:11 10 to ask you some questions.

12:12:12 11 LT GEN GREEN: Can I just ask what's your
12:12:14 12 business model? Are you -- how do you receive --
12:12:16 13 how do you receive funding? Does it come from the
12:12:20 14 federal government? Is it a congressional funded
12:12:23 15 program or is it -- do you charge for any of the
12:12:25 16 services that you're offering?

12:12:28 17 LTC URIARTE: No, sir. The money comes
12:12:30 18 straight from the federal government. So, the
12:12:31 19 readjustment counseling service gets their one lump
12:12:35 20 sum budget and then it's doled out throughout the
12:12:40 21 vet centers; but like anything else -- you know,
12:12:40 22 we're all bean counters in the medical field. So,
12:12:43 23 any increases in funding is going to come by the
12:12:45 24 number of veterans that we see and increase in our
12:12:49 25 population. So, my only hope of getting more staff

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12:12:52 1 to provide more services is I have to see more
12:12:54 2 veterans. So -- but that is something that has
12:12:58 3 been a huge, huge benefit, is to be able to have
12:13:01 4 that money available when we need it. We do have
12:13:05 5 certain defense funds that we use for contracts if
12:13:08 6 we need to have any; but all of our services are
12:13:13 7 free. And to give you an example, the Vietnam vets
12:13:19 8 right now have taken a very big interest in wanting
12:13:23 9 to learn tai chi. They're through with their
12:13:27 10 second retirement, their kids are gone, many of
12:13:30 11 them their spouses have passed away, they're in
12:13:34 12 their 70s now, they don't move around as much. And
12:13:37 13 we identified a tai chi instructor who wants to
12:13:42 14 give back to the community and he's willing to
12:13:45 15 provide free tai chi classes to the veterans, if
12:13:48 16 they just want to come once a week just to get
12:13:51 17 moving again; and so there's some ethical things
12:13:56 18 that we have to work out in that; but we're always
12:13:58 19 open to those kinds of ideas, but we would never
12:14:01 20 use our money to pay someone to come in and provide
12:14:05 21 a service. It's always going to be that -- pro
12:14:10 22 bono. That they want to find a way to contribute
12:14:13 23 and to give back.

12:14:15 24 DR. PHILLIPS: A difficult area for perhaps
12:14:18 25 you to deal with are homeless veterans because they

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12:14:21 1 don't carry their DD-214s with them; but are you
12:14:26 2 affiliated with any of the programs that support
12:14:28 3 that or do you have any programs for the homeless
12:14:31 4 vets?

12:14:34 5 LTC URIARTE: That -- the medical center at
12:14:37 6 Audie Murphy does and they have -- matter of fact,
12:14:40 7 they have a retired Army social work colonel who's
12:14:43 8 in charge of that very program. And so they have
12:14:45 9 their own separate counselors and social workers
12:14:48 10 and clinical providers working within the various
12:14:52 11 homeless programs. So, we don't see them per se in
12:14:57 12 our clinic; but what we do do is we establish a
12:15:03 13 collaborative relationship with them. So, if we
12:15:05 14 have homeless vets who have anger issues, we can go
12:15:10 15 ahead and send one of our counselors over there and
12:15:13 16 once a week do an anger support group and provide
12:15:16 17 education about stress management or something
12:15:18 18 along those lines. There may be issues that are
12:15:22 19 keeping them from getting employed and so we can
12:15:26 20 send someone over there to help them recognize what
12:15:29 21 those -- those issues are; but if we're going to
12:15:32 22 provide those services, we definitely have to go
12:15:35 23 there to do that. They wouldn't be able to reach
12:15:37 24 us.

12:15:38 25 MR. DRACH: An interesting point on that.

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12:15:39 1 Several years ago -- probably 30 years ago -- data
12:15:43 2 came out showing that Vietnam veterans came forth
12:15:47 3 approximately 10 to 12 years post discharge with
12:15:50 4 PTSD. On average, Vietnam veterans became homeless
12:15:55 5 12 years after discharge. Very close relationship.

12:16:01 6 LTC URIARTE: Uh-huh. My own -- and this is
12:16:03 7 not based on any statistics. This is just my own
12:16:06 8 experience. Is if it took the Vietnam vets 10 to
12:16:11 9 12 years, I think it's going to take the OIF/OEF
12:16:13 10 vets anywhere from five to seven years to come to
12:16:16 11 that same realization and that's going to change
12:16:18 12 the whole scope and how vet centers operate.
12:16:23 13 The -- having the small store front counseling kind
12:16:27 14 of vet centers, they're going to find themselves
12:16:30 15 overwhelmed with the number of veterans coming in.
12:16:33 16 They're not going to have room to expand to
12:16:35 17 increase their staffing and so my particular vet
12:16:39 18 center, we're the second -- we're in a three story
12:16:41 19 office building and we occupy most of the entire
12:16:44 20 second floor; and so I can see that becoming more
12:16:47 21 of a model down the road in order to expand to get
12:16:51 22 the increased number of vets coming through. I
12:16:54 23 don't see any reason -- any way that we can avoid
12:16:57 24 that possibility from happening.

12:17:05 25 MS. DAILEY: Task force members, do you have

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12:17:07 1 any questions? Are you -- yeah. Because we've
12:17:12 2 covered a lot of these. If not in your briefing,
12:17:15 3 we've covered them in many of our other briefings.
12:17:18 4 So --

12:17:19 5 LTC URIARTE: What I would like to do is to
12:17:21 6 show you a picture of the mobile vet center. Right
12:17:27 7 now Texas has three of these and the goal is to
12:17:31 8 have one -- at least one in every single state.
12:17:33 9 So, this serves two functions. One, it -- it goes
12:17:38 10 out more as a public relations thing where we
12:17:42 11 provide a booth, hand out information. This
12:17:44 12 particular vet center -- we got invited to go to
12:17:48 13 the World Series and so we had a number of
12:17:50 14 counselors who would rotate. They would go to the
12:17:53 15 game and then rotate for their shift at the vet
12:17:55 16 center. They would travel all over, especially in
12:17:59 17 the rural areas, making contact with vets, letting
12:18:03 18 them know about who we are and what we do. The
12:18:05 19 flip side, though, inside is the communications
12:18:09 20 clinical part of it and the whole idea is to be
12:18:12 21 able to reach those vets who can't get to the
12:18:15 22 services that they need. Ideally, if a vet needs
12:18:17 23 to see their doctor, they've run out of their
12:18:20 24 medication, but they can't get to San Antonio, we
12:18:23 25 can dial up their doctor right here inside this MVC

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12:18:28 1 and the vet and the doc can talk to one another and
12:18:30 2 write a script for his meds and he can get it
12:18:33 3 filled at the local store.

12:18:39 4 LT GEN GREEN: Okay. We want to say thank
12:18:42 5 you to you.

12:18:43 6 LTC URIARTE: Thank you.

12:18:44 7 LT GEN GREEN: Appreciate you coming out and
12:18:45 8 sharing the story. It's great to have these
12:18:47 9 services for our veterans and some of us may take
12:18:49 10 advantage of them one of these days. So, thank you
12:18:51 11 very much.

12:18:52 12 LTC URIARTE: Thank you very much.

12:18:53 13 LT GEN GREEN: For all the members, I think
12:18:55 14 we're adjourned for lunch and we'll have to be back
12:18:57 15 in the room here at 1:15.

12:19:02 16 (Recess taken between 12:19 and 1:18.)

01:18:06 17 MS. DAILEY: Okay, ladies and gentlemen, we
01:18:08 18 will be starting.

01:18:09 19 LT GEN GREEN: Okay, everybody. Welcome
01:18:11 20 back from lunch. So, last year we were given a
01:18:13 21 briefing on the hearing center of excellence and
01:18:15 22 today we're got Lieutenant Colonel Mark Packer.
01:18:18 23 Welcome, Mark.

01:18:20 24 LT COL PACKER: Thank you.

01:18:21 25 LT GEN GREEN: Okay. Who's the interim

01:18:22 1 director for the HCE. I'm not sure why they're
01:18:23 2 still calling you an interim director, but I do
01:18:26 3 understand the politics of that. You're going to
01:18:28 4 give us an update on where we are. So, thanks,
01:18:29 5 Mark. Take it away.

01:18:31 6 LT COL PACKER: It's my pleasure. Thank
01:18:32 7 you, sir. Today -- I think I've got control of
01:18:36 8 this, so I'll move right along. Yeah, it is my
01:18:39 9 distinct pleasure to present the hearing center of
01:18:41 10 excellence to you all and if you'd allow me a brief
01:18:46 11 second to wax philosophical just up front. I just
01:18:50 12 finished a week of trauma call at SAMMC and had a
01:18:54 13 very interesting contrast in combat warrior and
01:18:59 14 medical care in comparison to a lot of the troops
01:19:02 15 that are coming back. We have been taking care of
01:19:06 16 quite a few of the -- I guess the home sprung
01:19:11 17 combat warriors in town and down south and there's
01:19:15 18 a distinct difference in contrast between the care
01:19:18 19 of these individuals and it's very much a pleasure
01:19:21 20 to help contribute to their care and to take care
01:19:24 21 of their needs and it's a very hopeful, grateful
01:19:33 22 crowd that comes through and it's nice to see them
01:19:36 23 interact with their peers and their families. So,
01:19:39 24 this project has been very rewarding in that
01:19:42 25 aspect, looking at the primary customer and the

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01:19:46 1 ultimate investor that we take care of. So, today
01:19:49 2 I hope to cover some of the questions that were
01:19:52 3 posed to us.

01:19:53 4 The introduction and purpose of the hearing
01:19:55 5 center of excellence and the status of several
01:19:59 6 different fields within. And in way of
01:20:02 7 introduction, hearing is extremely important. As
01:20:05 8 you know, combat is chaotic and the ability to hear
01:20:09 9 and communicate is a critical aspect of safety for
01:20:14 10 the warrior, central to effective command and
01:20:17 11 control and mission accomplishment and key
01:20:20 12 consideration given the scope of our problem to
01:20:24 13 force management, the attrition retraining,
01:20:27 14 replacement rates. Not only that, but it's also
01:20:30 15 extremely important to the warrior as they
01:20:33 16 transition home. It's a key element of integrating
01:20:36 17 into society and communication allows that
01:20:39 18 individual to interact with his caregivers, with
01:20:42 19 his work relations and with his family; and so it's
01:20:45 20 a very crucial aspect of full multidisciplinary
01:20:52 21 recovery. Our executive mandate, as you're aware,
01:20:57 22 came out in 2009. We're to establish to
01:21:01 23 collaborate to the maximum extent practicable with
01:21:05 24 veterans affairs to develop a registry with
01:21:08 25 bi-directional data exchange between the agencies

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01:21:11 1 and to utilize that registry to encourage and
01:21:13 2 facilitate research and to develop clinical tools
01:21:16 3 to help our providers.

01:21:21 4 As far as the mission and overview, our
01:21:23 5 mission comes from that mandate and our intent is
01:21:27 6 to heighten readiness, improve health and quality
01:21:31 7 of life of our members in all aspects of
01:21:34 8 auditory-vestibular system injuries. As an
01:21:37 9 overview then, the establishment of the
01:21:40 10 auditory-vestibular centered collaborative network
01:21:43 11 is really developing a hearing health improvement
01:21:47 12 network. It's establishing relationships and ties
01:21:51 13 that will facilitate and act as force multipliers
01:21:55 14 to the care of these individuals. We intend to
01:21:57 15 provide efficiency and coordination of care and
01:22:00 16 research in all aspects of auditory care and
01:22:05 17 research and to establish a longitudinal
01:22:08 18 platform -- a repository system to manage the data.

01:22:13 19 Our organizational chart flows through the
01:22:17 20 lead component of the Air Force, through General
01:22:21 21 Green. We have set this up as a virtual concept
01:22:24 22 and we'll talk about this in a little bit. With
01:22:27 23 five direct -- directorates. Prevention,
01:22:29 24 surveillance, clinical care and rehabilitation,
01:22:31 25 research coordination, global outreach and

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01:22:34 1 information management. And at our full operating
01:22:38 2 capability this info graphic shows that by December
01:22:43 3 2013 we hope to have these readiness issues along
01:22:47 4 the left-hand side established that aims the
01:22:49 5 auditory injury module that has been developed
01:22:52 6 within the joint trauma theater registry to have a
01:22:57 7 strategic communication plan online as web -- and
01:23:02 8 accessible by the web which will coordinate
01:23:06 9 clinicians, researchers, integrate teams and
01:23:09 10 provide clinical practice guidelines and tools for
01:23:12 11 providers. The -- the DOEHS or defense
01:23:17 12 occupational environmental health and readiness
01:23:20 13 system, which is the repository system for the
01:23:23 14 hearing conservation program. The electronic
01:23:27 15 network then that we hope to establish will provide
01:23:31 16 through the registry that we are developing linked
01:23:36 17 with the occupational data that flows, as well as
01:23:39 18 the clinical audiograms, audiometric data from
01:23:42 19 clinical care will all circulate in this joint
01:23:46 20 hearing loss and auditory system injury registry
01:23:50 21 system and provide a longitudinal look at hearing
01:23:54 22 loss and auditory injuries. The -- the research
01:23:59 23 facilitation ties into that full operating
01:24:03 24 capability. The direct link and connection between
01:24:05 25 the DoD and the VA for the smooth transition of

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01:24:08 1 care. And on this slide I'd also like to mention
01:24:13 2 that along with looking at our specific injury
01:24:17 3 patterns, the hearing loss and auditory system
01:24:20 4 injuries, no individual is injured in a vacuum and
01:24:25 5 we understand that hearing oftentimes, if not most
01:24:29 6 of the time, is associated with multiple other
01:24:32 7 injuries and it's the relationship of that hearing
01:24:35 8 loss to the amputation or the visual deficit or the
01:24:39 9 TBI or PTSD that we also hope to link and establish
01:24:45 10 ties with the other centers of excellence and with
01:24:48 11 other disciplines of care.

01:24:52 12 Slide 10 shows our initial operating
01:24:54 13 capability and full operating capability
01:24:57 14 definitions. Right now we feel that we are
01:24:59 15 operating at initial operating capability and have
01:25:03 16 been since May. We have appointed five directorate
01:25:08 17 chiefs as leveraged bodies through different
01:25:11 18 service lines. We have a hub support that is
01:25:16 19 operationalizing the concept of operations to
01:25:19 20 develop the registry that we discussed. The
01:25:22 21 registry is developing in concert with the vision
01:25:27 22 and eye injury registry. So, the vision center of
01:25:31 23 excellence. The framework will enable us to
01:25:37 24 integrate impairment data and to look at the close
01:25:42 25 ties between those -- not only the injury rates and

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01:25:45 1 incidences, but also the care that will point to
01:25:49 2 best practice guidelines and establishment of
01:25:52 3 changes in the way that we do business clinically.
01:25:55 4 We are also currently trying to capture the
01:25:59 5 clinical audiographic data that is obtained through
01:26:05 6 the DOEHR system. The defense occupational and
01:26:09 7 environmental health record system -- registry
01:26:12 8 system. The occupational data in the surveillance
01:26:15 9 and the year-to-year testing -- readiness testing
01:26:19 10 is available through that system; but when somebody
01:26:22 11 falls out of that system because of a hearing
01:26:24 12 impairment or a change in their thresholds, they
01:26:28 13 are evaluated by an audiologist who then does a
01:26:31 14 clinical audiogram that is lost to that system and
01:26:34 15 so we are developing -- or we're looking at current
01:26:37 16 off-the-shelf technology that will allow us to
01:26:40 17 capture that electronic data and integrate it into
01:26:44 18 our registry system.

01:26:44 19 The communications/prevention campaign is
01:26:47 20 under way. We had a strategic planning session
01:26:52 21 where the communications within our network as well
01:26:55 22 as prevention campaign was published in August and
01:27:00 23 we are operationalizing that plan currently; and if
01:27:04 24 I might point out -- Estella, can you wave your
01:27:07 25 hand. We are a couple of months away from having

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01:27:10 1 our website up and operational, which is very
01:27:13 2 exciting. It will be an interactive website that
01:27:17 3 reaches out to the clinical world, to the injured
01:27:20 4 and their families, to the researchers and tie --
01:27:24 5 as well as to the line commanders in offering
01:27:28 6 standardization and guidelines within the hearing
01:27:30 7 community.

01:27:31 8 MSGT MACKENZIE: Excuse me. The -- did I
01:27:34 9 just hear you correctly -- and no pun intended --
01:27:38 10 that the -- this website is also going to connect
01:27:40 11 the injured, the wounded? They're going to be able
01:27:43 12 to access this too for information?

01:27:47 13 LT COL PACKER: Yes, they will. It will
01:27:48 14 be -- provide an excellent source of information
01:27:50 15 for them. It will be a way we can reach out
01:27:52 16 through educational products and awareness
01:27:55 17 initiatives to develop their personal
01:27:59 18 accountability for hearing and utilization of
01:28:01 19 hearing protection and tools and downloadable
01:28:04 20 applications, as well as -- they can access this as
01:28:08 21 well as their families. Hopefully to -- there are
01:28:12 22 in the works models or simulations of hearing loss
01:28:16 23 to experience what hearing loss means to the
01:28:19 24 individual and how that affects the family and so
01:28:22 25 on.

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01:28:24 1 MR. DRACH: Colonel, you mentioned on the
01:28:26 2 previous slide that the VA is currently developing
01:28:28 3 a registry. Who is eligible and how are they
01:28:32 4 identifying -- how are they developing this
01:28:34 5 registry?

01:28:37 6 LT COL PACKER: Good question. We -- and I
01:28:40 7 might add too that throughout this course, this has
01:28:44 8 been an integrated effort of all of the services
01:28:47 9 and the VA and the VA has their own repository
01:28:52 10 system for capturing audiometric data and they have
01:28:57 11 a problem with accessing information from the
01:28:59 12 service member as they transition and that's been
01:29:02 13 an issue for quite awhile and -- so, this registry
01:29:07 14 effort is developing along the common framework of
01:29:14 15 division injury registry a collection of data based
01:29:19 16 on ICD coding that every case of hearing loss and
01:29:23 17 auditory injury will be sorted out and applied and
01:29:27 18 be captured within the registry, which will include
01:29:30 19 the hearing conservation network, the clinical care
01:29:34 20 network and then follow these patients through
01:29:39 21 their course of treatment, surgery, rehabilitation
01:29:43 22 and so through this system -- and will be
01:29:47 23 bi-directional with the VA so that they can access
01:29:51 24 and determine service connection and continuity of
01:29:56 25 care for the -- for the injured.

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01:29:59 1 MR. DRACH: Are you doing any pre discharge
01:30:02 2 screening for hearing loss, particularly for those
01:30:04 3 coming back from combat and those that were
01:30:06 4 wounded, to see about getting them into the
01:30:09 5 registry?

01:30:10 6 LT COL PACKER: We are. And I might add --
01:30:12 7 and this goes along with the concept of operations
01:30:16 8 that while we are kind of an integrating,
01:30:20 9 collaborative, facilitating function, we are not
01:30:23 10 taking on clinical care or the hearing conservation
01:30:27 11 programs; but we work with these entities within
01:30:32 12 the services to identify best standards, elevate
01:30:35 13 and try to standardize best practices and so we --
01:30:43 14 some of the issues -- the initiatives that we're
01:30:46 15 dealing with right now answer to the
01:30:49 16 recommendations of the government audit that just
01:30:52 17 came out in January that took us -- a look at the
01:30:55 18 hearing conservation programs and identified and
01:30:58 19 recommended different ways of doing business. One
01:31:02 20 of the -- one of the recommendations was to provide
01:31:06 21 more streamlined, more systematic identification of
01:31:10 22 injury. So, the recommendations not only of the
01:31:17 23 GAO audit, but also the Institute of Medicine study
01:31:20 24 was put out in 2005 that was a VA-backed study
01:31:25 25 looked at capturing the data on entry into the

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01:31:29 1 services, pre and post deployment and exit of the
01:31:33 2 military at a minimum; and so we are looking at
01:31:37 3 ways to standardize this and to capture and
01:31:41 4 maintain that information, pass it along to the VA.

01:31:46 5 LT GEN GREEN: Ron, just so you know, the
01:31:47 6 Army went to annual hearing exams based on their
01:31:51 7 deployments, etcetera. So, they re-instituted
01:31:55 8 annual hearing exams. The Air Force has had it in
01:31:58 9 their PHA program, but it varies based on age
01:32:02 10 requirements unless there's a reported problem.
01:32:04 11 So, we're moving back towards where there would be
01:32:07 12 annual exams because of the threat from the
01:32:11 13 deployments.

01:32:13 14 LT COL PACKER: Yeah. Thank you, sir. That
01:32:15 15 brings up a point that now days people are deployed
01:32:18 16 in different job specifications and they have more
01:32:22 17 global threat based on IED exposure and so due to
01:32:27 18 this the Army system of making hearing a readiness
01:32:33 19 issue has been a model that's being looked at.

01:32:38 20 MSGT MACKENZIE: I've got a quick question.
01:32:39 21 Is there any changes as far as of those mustered
01:32:43 22 with hearing damage from blast injuries? Is that
01:32:45 23 going to create a flag or cause somebody to
01:32:46 24 actually take a look at you?

01:32:49 25 LT COL PACKER: That's another interesting

01:32:50 1 question. There was a recent study that came out
01:32:53 2 in the medical surveillance monthly report that --
01:32:58 3 that showed tinnitus as number one and hearing loss
01:33:03 4 as number three most diagnosed injury or most --
01:33:08 5 most commonly diagnosed code within six months of
01:33:13 6 separation. And so I think that for a couple of
01:33:17 7 reasons that holds true. One is that oftentimes
01:33:20 8 hearing loss is something that people put up with
01:33:22 9 and make do with and don't necessarily realize
01:33:25 10 until it hits at a certain threshold; and so it's
01:33:30 11 not uncommon. It's an invisible injury. It's
01:33:33 12 something that otherwise you look healthy and well
01:33:37 13 and job capable and so it's put off for -- until
01:33:41 14 you separate. Other reasons are threat to jobs and
01:33:47 15 duties. Folks may hold that off. But it's -- it's
01:33:52 16 also something that we hope that establishing
01:33:59 17 awareness will create the ability to -- to initiate
01:34:03 18 the diagnostic workup for a significant injury.

01:34:06 19 So --

01:34:06 20 MSGT MACKENZIE: And I guess the reason I'm
01:34:08 21 asking is I'm one of those strange cases, but -- no
01:34:11 22 surprise to this task force. The diagnosed hearing
01:34:16 23 damage from a blast injury; but, you know, baseline
01:34:22 24 has been readjusted.

01:34:23 25 LT COL PACKER: Right.

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01:34:25 1 MSGT MACKENZIE: So, if I go in for a
01:34:27 2 hearing test, it doesn't show anything. Like you
01:34:28 3 said, you don't always notice your hearing going
01:34:30 4 bad until you finally can't hear anything. So, my
01:34:33 5 question is more toward those that are diagnosed
01:34:35 6 with minor or major hearing injuries, is there a
01:34:40 7 means or a direction to follow up or create a
01:34:42 8 requirement where they have to get another exam in
01:34:45 9 order to help them deal with any degrading issues
01:34:48 10 or potential follow-on problems due to that damage?
01:34:51 11 LT COL PACKER: Yes, there is and it varies
01:34:54 12 by service, but within the conservation programs
01:34:56 13 there is a means to capture and track that and
01:34:59 14 follow it along. The -- the resetting of a
01:35:06 15 baseline is a means to an end, I guess, of
01:35:11 16 identifying and tracking; but it doesn't
01:35:13 17 necessarily contribute to the rehabilitation.
01:35:17 18 The -- there is an initiative we have under way
01:35:21 19 that is looking for fitness for duty requirements
01:35:24 20 that will validate and show necessary function --
01:35:28 21 or hearing capabilities required for certain
01:35:32 22 mission performance within certain job duties, as
01:35:39 23 well as looking at the twofold risk or the risk to
01:35:42 24 the individual that hearing creates, risk to the
01:35:45 25 mission performance that hearing loss creates and

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01:35:48 1 so standardizing loss rather than just resetting a
01:35:52 2 baseline will be important to -- to show that
01:35:57 3 certain function may be reintegrated to certain
01:36:02 4 positions and so forth.

01:36:08 5 Let's see. So, our goal, again, for full
01:36:10 6 operating capability is expected to be December
01:36:14 7 2013. Moving on to slide 11, our staffing issues.
01:36:18 8 Currently we have 37 planned for our staff. The
01:36:25 9 accomplishments to date. Our leadership positions
01:36:28 10 have been described and are undergoing
01:36:31 11 classification. Currently we have contracted
01:36:35 12 support to run several of these initiatives that
01:36:40 13 we've been discussing. The registry requirements,
01:36:42 14 the strategic and communication and the prevention
01:36:46 15 plans. The director -- the directorate chiefs have
01:36:51 16 been appointed through military uniform personnel
01:36:55 17 and we have three senior military audiologist
01:36:59 18 billets that will be repositioned to the
01:37:02 19 headquarters to act as action officers and look at
01:37:05 20 policy development standardization. The next steps
01:37:09 21 then are to staff the augmentation intended to
01:37:13 22 be --

01:37:13 23 LT GEN GREEN: Is there a VA tie in? You
01:37:16 24 say three services, but I don't see a VA here.
01:37:18 25 What's the VA representation?

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01:37:20 1 LT COL PACKER: The VA representation --
01:37:21 2 they have sent off an executive decision memo to
01:37:25 3 their leadership that will include a deputy
01:37:29 4 director for the center and three directorate leads
01:37:34 5 to run side by side with the DoD uniformed members.
01:37:41 6 CON -- so, moving on to slide 12, CONOPS highlights
01:37:45 7 are --

01:37:45 8 MR. REHBEIN: Sir, if I could for a minute.
01:37:48 9 And maybe this is just lack of my knowledge and
01:37:50 10 definitions I don't know, but full operating
01:37:53 11 capability expected in December of 2013 but not
01:37:56 12 fully staffed until sometime in '15 or '16?

01:38:02 13 LT COL PACKER: Correct. And --

01:38:04 14 MR. REHBEIN: There seems to be some
01:38:05 15 discrepancy there.

01:38:07 16 LT COL PACKER: Right. What our definition
01:38:08 17 of full operating capability is is to have a
01:38:11 18 functional registry to be able to identify, track
01:38:14 19 injury and to make that smooth transition with the
01:38:16 20 VA, to have the senior staff in place in the
01:38:20 21 headquarters; and the bulk of our staffing diagram
01:38:25 22 will be implemented in a step by step fashion over
01:38:29 23 the next four to five years, which will identify
01:38:32 24 key positions in regional centers that would
01:38:35 25 benefit from coordination efforts. Right now we

01:38:39 1 have identified six of the chief medical centers
01:38:44 2 and six research labs that do auditory research and
01:38:49 3 the coordination will start with those and move on.

01:38:53 4 As --

01:38:55 5 MR. REHBEIN: What you define as full
01:38:57 6 operational capability then, full operating
01:38:59 7 capability, is strictly the registry?

01:39:01 8 LT COL PACKER: Correct. The registry is
01:39:03 9 the baseline -- the framework for the system, I
01:39:07 10 believe.

01:39:08 11 MR. REHBEIN: Thank you.

01:39:10 12 LT COL PACKER: Thank you. So, let's see.
01:39:17 13 Let's move on to slide 13, the strategic
01:39:20 14 communications plan. This we talked about and I
01:39:22 15 mentioned briefly the key to our system in this
01:39:26 16 virtual leveraged concept is to communicate. To
01:39:30 17 provide transparency and communication throughout
01:39:33 18 the system. The communication plan links those key
01:39:38 19 sites that we had mentioned. It ties research
01:39:41 20 interest with clinical practice to promote
01:39:44 21 translation of industry products, it provides the
01:39:48 22 outreach to industry, to academia and to
01:39:54 23 international allies as dictated by the NDAA.
01:40:01 24 The -- to date the communication plan was
01:40:05 25 established based on stakeholder interviews across

01:40:09 1 the Department of Defense and within the VA and an
01:40:13 2 extensive literature review, campaign review and
01:40:15 3 media scan that was published in August and the
01:40:21 4 steps to initiate that plan are under way, which
01:40:25 5 will culminate in the establishment of the website
01:40:30 6 with the multifunctional interface with the
01:40:34 7 web-based program. The next steps show that the
01:40:40 8 launch will be 22nd of February 2012. We're on
01:40:44 9 target for that right now.

01:40:46 10 The following page, the prevention campaign
01:40:48 11 is also running in parallel with this communication
01:40:52 12 plan and is based on the messaging that the
01:40:55 13 strategic communication will provide. It was also
01:40:59 14 initiated and conducted through stakeholder
01:41:03 15 interviews and research to identify the -- and
01:41:10 16 operationalize some of the recommendations within
01:41:15 17 the GAO audit and Institute of Medicine study we
01:41:16 18 mentioned earlier. Next steps involved here are
01:41:20 19 to -- to establish the communications network and
01:41:24 20 to promote the messaging, again, that will provide
01:41:27 21 the personal accountability and outreach to the end
01:41:31 22 users.

01:41:32 23 Slide 15 shows the hearing aid and implant
01:41:36 24 purchase standardization. Along the way we have
01:41:39 25 identified that the -- our field is very device

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01:41:46 1 oriented as far as rehabilitation with the hearing
01:41:48 2 aids and the implants and whatnot; and there's --
01:41:50 3 there was a large discrepancy across the Department
01:41:53 4 of Defense on how these implants were obtained.
01:41:57 5 Implants and hearing aids. And through
01:42:01 6 standardized ordering process that is based off of
01:42:06 7 a web-based ordering option that the VA has to
01:42:11 8 offer through their -- their Denver acquisition
01:42:16 9 logistic center we can do away with purchase orders
01:42:19 10 and credit card fees across the board and provide
01:42:21 11 accountability for the hearing aids that are
01:42:24 12 dispensed and the implants that are implanted.
01:42:28 13 Right now this is a Herculean task to go to
01:42:32 14 different military treatment facilities and pull
01:42:35 15 records to identify who has been rehabilitated and
01:42:39 16 in what way. So, this provides immediate feedback
01:42:42 17 to us, it cuts down cost and standardizes a problem
01:42:47 18 that -- or it standardizes a purchase order
01:42:51 19 technique that will save money, as well as provide
01:42:55 20 accountability.

01:42:58 21 Slide 16 shows the defense occupational and
01:43:01 22 environmental health readiness system for hearing
01:43:04 23 conservation that we discussed. This is the
01:43:06 24 hearing conservation program database. Over the
01:43:13 25 last few years the DOEHRS-HC system has been

01:43:19 1 defunded and undermanned and it has had a -- some
01:43:26 2 issue with obtaining authoritative demographic
01:43:30 3 data. This -- this is -- this has been identified
01:43:37 4 and money to be put towards the software program
01:43:41 5 that -- or the link that will establish that
01:43:44 6 authority will create modularity within the system
01:43:47 7 so that we can look at each service specifically
01:43:49 8 and it will provide an interface with the VA so
01:43:53 9 that they can access data. We've had pilots out so
01:43:57 10 that the VA can, in a limited capacity, look into
01:44:01 11 the DOEHR system and look into extend that on a
01:44:05 12 more universal framework. Next step, then, is the
01:44:14 13 execution of that plan, which should be complete by
01:44:19 14 June 2012.

01:44:21 15 And slide 17 talks about a centralized IRB.
01:44:25 16 This is something that has been of interest to not
01:44:28 17 only us, but all of the centers of excellence.
01:44:32 18 There is a working model that the infectious
01:44:38 19 disease program worked up. The ID-IRB, as they
01:44:42 20 call it. This was, as I said, set up through USUHS
01:44:45 21 and established under the authority of the surgeon
01:44:48 22 general and the assistant secretary of defense.
01:44:52 23 The progress to date in this has been an MOU has
01:44:57 24 been created based on that model -- the previous
01:44:59 25 model, the ID-IRB. A system has been looked at

01:45:05 1 within MRMC'S centralized IRB system and the
01:45:09 2 centers of excellence have met and agreed on the
01:45:15 3 utility of the centralized system, as well as the
01:45:18 4 location -- a favorable location of the MRMC. Next
01:45:24 5 steps on that are outlined on page 18, showing that
01:45:27 6 over the course of the next 15 months authority
01:45:32 7 could be obtained and a central system in place so
01:45:35 8 that multisite studies can proceed more efficiently
01:45:40 9 and, honestly, more safely. When you look at a
01:45:45 10 specialty specific IRB where there are review
01:45:49 11 boards that are -- that are especially based to
01:45:53 12 review potential studies, then the -- the specialty
01:46:00 13 knowledge can translate into safety as well as the
01:46:04 14 efficiency of approving multisite projects rather
01:46:07 15 than waiting for 24 months, which has been the case
01:46:11 16 in some situations.

01:46:12 17 Slide 19 just shows the facilities. Right
01:46:15 18 now we're located in an interim space in Wilford
01:46:20 19 Hall Ambulatory Surgery Center -- Wilford Hall
01:46:25 20 Medical Center, transitioned to Wilford Hall
01:46:28 21 Ambulatory Surgery Center, which should be phase
01:46:32 22 complete in 2015.

01:46:34 23 Slide 20 passing on through the next steps
01:46:37 24 to 21. So, accomplishments to date just show the
01:46:43 25 networking and the -- and the communication network

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01:46:47 1 that we wish to establish. Primary priority is
01:46:51 2 working on registry and the functional requirements
01:46:54 3 were reviewed and approved last March. We're
01:46:58 4 working in concert with division registry for
01:47:01 5 economies and for crossover looks within that
01:47:04 6 framework. The joint trauma -- or joint theater
01:47:08 7 trauma system has added in their auditory injury
01:47:11 8 module and we should be able to develop some pilot
01:47:16 9 data within this upcoming year. Strategic
01:47:19 10 communications plan and the prevention plan, as we
01:47:21 11 discussed, is online and working forward. The
01:47:26 12 network clinical care and research partners has
01:47:30 13 been a theme. February 2010 there was a state of
01:47:34 14 the science meeting. March 2011 a follow-on
01:47:37 15 scientific meeting looking at the fitness for duty
01:47:40 16 initiative; and we just held a state of the science
01:47:45 17 blast tinnitus meeting last month. We've
01:47:48 18 contributed to the VA research guidebook which is
01:47:51 19 an outstanding product that points to collaboration
01:47:55 20 as a way of the future. The -- we've worked to
01:48:00 21 facilitate our integration into MRMC as far as
01:48:06 22 research goes, to sit on their steering committees,
01:48:09 23 to sit on their review boards and to develop a road
01:48:15 24 map for auditory research. The -- working with the
01:48:19 25 human systems integration teams, the hearing

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01:48:23 1 conservation working group has -- again, we don't
01:48:28 2 intend to take over prevention; but we intend to
01:48:31 3 stand side by side with the hearing conservation
01:48:34 4 folks and be the unified voice to elevate standards
01:48:38 5 and promote this transparency and unity. We've
01:48:44 6 held otology consortiums to look at emerging
01:48:50 7 technologies and to establish a way ahead for
01:48:52 8 rehabilitation. We have led a NATO project. An
01:48:57 9 exploratory team looking at rehabilitation and
01:49:01 10 reintegration of the auditory injured, which looks
01:49:05 11 promising to -- to develop into a full research
01:49:09 12 team effort that should kick off this March. Next
01:49:15 13 steps. We're still --

01:49:17 14 LT GEN GREEN: Mark, let me interrupt for
01:49:19 15 just a second. So, just to make sure everybody
01:49:21 16 kind of understands. When we heard about this last
01:49:23 17 May, one of the things that was in progress was the
01:49:26 18 realignment to get things -- to get the centers of
01:49:28 19 excellence basically to stop aligning directly with
01:49:32 20 health affairs and get them aligned up to MRMC
01:49:36 21 where there could be common services. So, a lot of
01:49:39 22 the work that's going on is now MRMC trying to
01:49:42 23 establish the right relationships so they can
01:49:45 24 provide conference support and research support,
01:49:47 25 the common IRB oversight, all of those kind of

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01:49:51 1 things. So, I guess -- brass tax, Mark -- so, the
01:49:55 2 first year, in '10, when we brought this over -- or
01:49:58 3 was it '09? I don't remember. But --

01:50:01 4 LT COL PACKER: '10.

01:50:02 5 LT GEN GREEN: Okay. When it came into the
01:50:04 6 Air Force, they didn't quite release the dollars.
01:50:06 7 So, we gave some dollars to really get things
01:50:07 8 started because of these ongoing questions about
01:50:10 9 final alignment. With the final alignment
01:50:12 10 decision, have you seen a release of dollars? Did
01:50:15 11 you actually get -- it was roughly a budget of
01:50:18 12 what, \$9 million?

01:50:20 13 LT COL PACKER: Yes, sir, it was -- the
01:50:22 14 baseline was about 5 million and we were able to
01:50:25 15 execute that last year.

01:50:26 16 LT GEN GREEN: So, you did get it in '11,
01:50:29 17 then, or in '10?

01:50:31 18 LT COL PACKER: That was in '10. Yeah, we
01:50:32 19 got it late in the year in '10; but we were able to
01:50:34 20 place that out on contract to run some of these
01:50:36 21 initiatives and we have similar -- last year was
01:50:40 22 4.5 million, this year \$5 million. A lot of that
01:50:44 23 is geared towards the purchasing of the
01:50:48 24 off-the-shelf software for the registry effort to
01:50:52 25 come in and for hiring actions which haven't taken

01:50:55 1 place yet, which are in the works. We have courses
01:51:00 2 developed in --

01:51:01 3 LT GEN GREEN: So, the money is flowing?

01:51:02 4 LT COL PACKER: Correct.

01:51:03 5 LT GEN GREEN: That was one of the things we
01:51:05 6 were kind of worried about last year. So, you got
01:51:07 7 the money. You just got it late in the year again.

01:51:11 8 LT COL PACKER: Right.

01:51:11 9 LT GEN GREEN: But this year because of the
01:51:13 10 CRs, continuing resolutions, are you also -- is the
01:51:14 11 money late again or is it programmed money and
01:51:17 12 you're getting it now incrementally?

01:51:19 13 LT COL PACKER: No, we do have program money
01:51:20 14 and we -- we haven't tested it yet this year.
01:51:23 15 We're still waiting for those hiring actions to be
01:51:25 16 graded.

01:51:26 17 LT GEN GREEN: Okay. Thanks.

01:51:27 18 LT COL PACKER: Thank you. So, it's an
01:51:31 19 exciting field. I appreciate your audience and I
01:51:35 20 am happy to take any questions. This is, again,
01:51:40 21 very much a collaborative effort and I think a
01:51:47 22 paradigm shift in the way of managing hearing
01:51:51 23 injuries, really.

01:51:53 24 CSM DEJONG: Sir, real quick. With the IDES
01:51:55 25 system coming in and the VA going to be doing the

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01:51:58 1 rating -- and maybe it varies from VA facility to
01:52:04 2 VA facility; but it seems that they get a much more
01:52:08 3 elaborate hearing test when they claim on the VA
01:52:10 4 side -- when they go over the VA claim to start
01:52:13 5 looking at their comprehension, the hearing test --
01:52:15 6 I mean, personally, the one that I had, was far
01:52:17 7 more expansive than what I had when I was in the
01:52:21 8 Army, before my last mobilization. Is there
01:52:24 9 efforts to equalize those tests, especially if the
01:52:26 10 VA's going to be doing the rating, to make sure
01:52:29 11 that the services aren't doing one test and the VA
01:52:32 12 is doing a far more elaborate test and it possibly
01:52:36 13 lowering the rating for the veteran?

01:52:38 14 LT COL PACKER: Yeah. No, you're absolutely
01:52:40 15 right. There's a couple of answers along that
01:52:42 16 line. Some of that deals with differences between
01:52:45 17 services; but a lot of -- I think what you're
01:52:48 18 hitting at is that the hearing conservation
01:52:50 19 programs develop a baseline test and as long as
01:52:53 20 your hearing is within normal limits on that, then
01:52:59 21 the rest of the clinical audiogram that you've
01:53:01 22 experienced in the VA system is irrelevant. So,
01:53:05 23 they -- the question that needs to be answered for
01:53:10 24 that transparent flow of information is we need to
01:53:13 25 develop a baseline test for every individual as

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01:53:16 1 they enter the service or else the VA has no -- no
01:53:22 2 leg to stand on as far as claims. They don't know
01:53:27 3 if it's service connected or not. They can't prove
01:53:30 4 that. So, the baseline training -- baseline
01:53:33 5 testing of each individual has been in question and
01:53:36 6 the winds are blowing to standardize that process.

01:53:40 7 CSM DEJONG: Would that standardization be
01:53:42 8 across the forces then?

01:53:45 9 LT COL PACKER: Yes, that is what we are
01:53:46 10 hoping to achieve.

01:53:49 11 CSM DEJONG: Thank you, sir.

01:53:54 12 DR. PHILLIPS: Scientifically, how
01:53:56 13 interactive are you with the academic health
01:53:59 14 centers or NIH or some of the other centers?

01:54:02 15 LT COL PACKER: We have, within the
01:54:03 16 military, a very unique research world when it
01:54:10 17 comes to the ears and there are world class
01:54:13 18 auditory research labs within each of the services
01:54:17 19 that really investigate lines that are very
01:54:23 20 characteristic of military and don't have
01:54:25 21 application outside of the military. The research
01:54:28 22 world is very integrated to include a lot of the
01:54:32 23 academic centers. Right now a lot of that
01:54:35 24 collaboration happens locally and regionally. With
01:54:38 25 the development of this center we hope to have a

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01:54:42 1 platform that will establish a practice space
01:54:44 2 research network with resource allocation and
01:54:48 3 identification of study populations to look more at
01:54:52 4 auditory protection medications, to look at
01:54:55 5 communication devices and protective devices and so
01:54:58 6 forth.

01:54:58 7 DR. PHILLIPS: The reason I ask, and I'm not
01:55:00 8 being facetious, is the whole population of younger
01:55:03 9 people who have been exposed to these rock bands.
01:55:06 10 You know, 80 to 120 decibels, and all of the music
01:55:11 11 that people listen to and -- if you're on a metro,
01:55:14 12 you can hear the music from someone sitting three
01:55:18 13 seats away and I'm just wondering what's going on
01:55:21 14 on the civilian side with this?

01:55:23 15 LT COL PACKER: You're absolutely right.
01:55:25 16 There's several initiatives. A lot of the hearing
01:55:28 17 aid companies develop product lines. The NIDCD,
01:55:31 18 NIOSH have initiatives that are geared towards
01:55:34 19 prevention and hearing health. Big issue within
01:55:37 20 the military, too. We have young teenage kids that
01:55:42 21 are carrying rifles exposed to loud noises and also
01:55:45 22 putting their iPod buds in. So, it's a hard task
01:55:50 23 for us to ferret that out and, you know, how do we
01:55:52 24 call something service related when it's
01:55:56 25 self-inflicted. Right now, if it happens within

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01:55:58 1 the military -- we do have blast and auditory
01:56:01 2 injuries that is a little bit of a different beast
01:56:04 3 than the standard hearing loss and there are
01:56:06 4 several academic centers that are looking at the
01:56:09 5 typical determination of audiograms to look at the
01:56:13 6 specific slopes of the audiogram to determine, you
01:56:16 7 know, if this is metabolic, if it's hearing
01:56:18 8 related, if it's age related and so forth; and
01:56:21 9 genetic testing that may be of some use. So, we
01:56:26 10 need to create the awareness and the
01:56:28 11 accountability, the educational efforts; and that's
01:56:31 12 part of the GAO recommendations that we captured
01:56:34 13 early. We teach and train early and often. And so
01:56:37 14 we need to take advantage of every touch point
01:56:40 15 along the way to drum in that you are your own
01:56:45 16 protector of your future hearing.

01:56:47 17 DR. PHILLIPS: The reason I ask is from the
01:56:49 18 point of view of the task force, we could possibly
01:56:52 19 make recommendations related to legislation on
01:56:55 20 education. I probably shouldn't go there. Even
01:56:58 21 legislation of maximum decibel emission from music
01:57:03 22 devices and, you know, even rifle suppression.
01:57:08 23 I -- you know, that whole spectrum. I don't know
01:57:11 24 if you have a thought about that.

01:57:13 25 LT COL PACKER: No. That's a great thought.

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01:57:15 1 We -- you know, along with accountability -- I
01:57:21 2 guess accountability is a way we're addressing it
01:57:25 3 without taking away agency or freewill; but there
01:57:31 4 is a potential problem. There was a recent article
01:57:34 5 out that talked about iPod users or MP3 users
01:57:39 6 versus non-users having six times more frequent
01:57:44 7 rate of hearing loss and so it's a problem.

01:57:46 8 DR. PHILLIPS: I mean, we amazingly restrict
01:57:49 9 smoking and things like that. So, prevention
01:57:51 10 rather than --

01:57:53 11 LT COL PACKER: Yeah, exactly. That's a
01:57:54 12 good thought.

01:57:55 13 LT GEN GREEN: At a recent conference -- one
01:57:57 14 of the reasons I brought -- I suggested the hearing
01:57:59 15 center liaisons be down here in San Antonio is
01:58:02 16 because of the work I knew you both were doing in
01:58:04 17 the auditory center with Coker implants and stuff
01:58:09 18 like that. At a recent conference I saw some new
01:58:11 19 technologies that are actually being made available
01:58:14 20 based on some of the inner ear injuries when you
01:58:17 21 have dislocation of the small bones that transmit
01:58:19 22 hearing. Are you folks using those things and
01:58:22 23 tracking that and especially in regards to some of
01:58:25 24 the blast injuries where you may have dislocation
01:58:27 25 of some of the auditory canal?

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01:58:30 1 LT COL PACKER: Right. Yeah, we are looking
01:58:31 2 at several of those. We just finished a phase 2
01:58:35 3 trial with a completely implantable middle ear
01:58:39 4 device. We have an ongoing multisite study that is
01:58:44 5 looking at -- at another device implanted into the
01:58:49 6 round window so you -- bypassing the ossicles
01:58:52 7 completely and placing the vibrational device at
01:58:56 8 the round window. There's a new device that we --
01:58:59 9 we had a meeting two weeks ago to look at that
01:59:03 10 rather than an implanted device to restore
01:59:07 11 single-sided deafness, it's a prosthetic. It's a
01:59:10 12 dental appliance that you can snap in and it has a
01:59:14 13 short relay transmission that vibrates your tooth
01:59:20 14 and you hear it on the good side. So, there are
01:59:23 15 several -- there are two other implantable devices.
01:59:27 16 Right. Two other implantable devices that have
01:59:31 17 unique potential military relevance in that all of
01:59:35 18 these devices so far have had external components
01:59:39 19 that wouldn't do well in the battle zone; but a
01:59:41 20 couple of these -- and I think the one that you
01:59:43 21 mentioned is out of Houston and they -- everything
01:59:47 22 is -- is implanted behind an intact ear drum. So,
01:59:53 23 yeah, we're looking strongly at that. The DoD
01:59:56 24 otologists are meeting in February to be trained on
01:59:59 25 that and to start an internal look. It's pretty

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02:00:11 1 fascinating.

02:00:12 2 DR. PHILLIPS: Well, no other questions?

02:00:14 3 MSGT MACKENZIE: I do have one, actually;

02:00:16 4 and hopefully I'm not going the wrong angle with

02:00:19 5 this; but this whole registry and this whole

02:00:21 6 process, is this going to help in the particular

02:00:23 7 case with an individual that's got hearing damage,

02:00:26 8 gets a hearing aid, has no idea, really, if it's

02:00:30 9 working at a hundred percent, doesn't really

02:00:33 10 understand the whole process? Several years later

02:00:35 11 goes in for a totally different treatment deal, you

02:00:40 12 know, and in my case it was vestibular. When they

02:00:45 13 started working with my traumatic brain injury,

02:00:48 14 they were like, you know, what are you doing with

02:00:50 15 that hearing aid? That's totally the wrong hearing

02:00:53 16 aid. You need this one. Right. And so -- and

02:00:55 17 then several years later I just -- it was brought

02:00:58 18 up by me looking at your slides, when I realized

02:01:01 19 you were coming here. It's like -- you know, that

02:01:02 20 question I asked earlier was very poignant because,

02:01:06 21 you know, what's the process for following up with

02:01:08 22 this injury of mine or anybody else in my position

02:01:12 23 where it's a minor injury, but yet requires a

02:01:15 24 hearing aid when your baseline has been shifted and

02:01:20 25 nobody has any reason to do another look?

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02:01:25 1 LT COL PACKER: No, you're absolutely right
02:01:26 2 there. That is one of the sole -- well, I can't
02:01:30 3 say the sole source, but it -- that ongoing gap
02:01:35 4 analysis and the look to standardize the practice
02:01:39 5 of medicine and elevate the best standards is what
02:01:42 6 the longitudinal registry is all about. So we can
02:01:46 7 take a look at individual treatments and clinical
02:01:51 8 recommendations and follow that up with quality of
02:01:55 9 life surveys to identify what's worked and what's
02:01:59 10 not working. Someone who has been fit with a
02:02:03 11 hearing aid, in my estimation, should get an annual
02:02:07 12 audiogram and make sure that the hearing isn't
02:02:10 13 continuing to change and along the way you have
02:02:12 14 that touch point where new device technology can be
02:02:17 15 introduced and -- and the -- you can rest with some
02:02:22 16 surety that your device is properly set for your
02:02:26 17 degree of hearing loss.

02:02:28 18 MSGT MACKENZIE: I mean, that's kind of what
02:02:30 19 I thought too. I get an eye exam every six months
02:02:33 20 because of the nature of my eye; but yet hearing is
02:02:36 21 only if I happen to stumble into an audiologist and
02:02:39 22 ask, "Hey, you want to look at this while I'm
02:02:42 23 here?" So, that's why I was asking how this would
02:02:43 24 help prevent that from happening; but especially
02:02:45 25 with the number of people we have staying on active

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02:02:47 1 duty with injuries that may not have been common in
02:02:52 2 the past.

02:02:52 3 LT COL PACKER: Right. And speaking to that
02:02:54 4 comment, too, we'd like to see more people retained
02:02:56 5 with good in-house knowledge. Retain them rather
02:03:01 6 than set them on the street. You know, we have
02:03:04 7 good people that could be rehabilitated and
02:03:07 8 continue with their -- with the service that they
02:03:11 9 love.

02:03:15 10 MSGT MACKENZIE: Thank you, sir.

02:03:15 11 MR. REHBEIN: Sir, if I may. Having come
02:03:17 12 out of a background of research science, as I read
02:03:21 13 and listen it's sounding to me like you are not --
02:03:25 14 that the hearing center of excellence is not in the
02:03:28 15 funding stream for research; is that correct?

02:03:30 16 LT COL PACKER: Correct.

02:03:32 17 MR. REHBEIN: Can you project for me, then,
02:03:36 18 how you will be effective in influencing that
02:03:42 19 research, because those of us that actually do
02:03:44 20 research, we listen to the folks with the
02:03:47 21 checkbooks.

02:03:47 22 LT COL PACKER: Exactly. That's a great
02:03:50 23 question.

02:03:50 24 MR. REHBEIN: And so for you to stand --
02:03:52 25 well, frankly, it tends to remind me of the old

02:03:55 1 statement "I'm from the government, I'm here to
02:03:57 2 help." So, if you could talk a little bit about
02:03:59 3 your effectiveness and how you plan to achieve
02:04:02 4 that.

02:04:03 5 LT COL PACKER: What we've done so far is to
02:04:06 6 have the initial conversation with the research
02:04:09 7 directorates within the services. So, we've --
02:04:12 8 there's different lines of research granting
02:04:16 9 through MRMC, the combat casualty care, the
02:04:20 10 operational medicine, the clinical care and
02:04:21 11 rehabilitation. We've been into those directorates
02:04:24 12 and briefed them about the scope of the -- and
02:04:27 13 magnitude of the hearing loss problem. We've also
02:04:31 14 put together a product -- an auditory research road
02:04:37 15 map, if you will, that prioritize the list of big
02:04:40 16 rocks. The early translatable technologies, the
02:04:45 17 things that could make a difference today in the
02:04:48 18 military and prioritize those for research funding
02:04:51 19 and with -- within our research directorate what
02:04:57 20 we're hoping to accomplish is to have somebody
02:05:00 21 integrate into that system. So, right now I'm
02:05:02 22 sitting on a steering committee for some of those
02:05:05 23 directorates and I am involved in some of their
02:05:08 24 research reviews so that I can offer some hearing
02:05:12 25 leverage, if you will; but with the directorate

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02:05:16 1 standing up, we hope to combine that influence with
02:05:22 2 the network of researchers. The auditory research
02:05:26 3 working group is being chartered. We have
02:05:28 4 developed outreach discussions with the chief
02:05:31 5 scientists within the services and with the
02:05:34 6 clinicians that do auditory care and propose that
02:05:40 7 through this network and through conferencing and
02:05:44 8 meetings that auditory awareness will elevate. In
02:05:50 9 discussion with the VA research labs there are four
02:05:55 10 sites that -- that manage auditory research that --
02:05:59 11 that we've connected with and we've had combined
02:06:03 12 conferences and have shared products. They have a
02:06:06 13 very good tinnitus treatment paradigm that we hope
02:06:11 14 to outreach through our website and so as far as
02:06:17 15 the ultimate dollars flowing, the -- there is
02:06:21 16 discussion right now to try to quarantine at least
02:06:25 17 a pot that could be earmarked for hearing research.
02:06:30 18 That hasn't happened yet. All the efforts have
02:06:33 19 been to try to prioritize and create the awareness
02:06:36 20 so that we don't have to tuck everything under TBI
02:06:39 21 or so forth.

02:06:42 22 MR. REHBEIN: Is there -- is there
02:06:43 23 authority -- all these folks that you're going to
02:06:46 24 talk to, is there authority to get you into their
02:06:49 25 offices or are you having to fight your way into

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02:06:52 1 their offices?

02:06:53 2 LT COL PACKER: No. They are very
02:06:55 3 receptive. We've been to -- we've been in
02:06:58 4 discussion with NIDCD and NIOSH. We've been to the
02:07:03 5 VA research and development. We have an ongoing
02:07:07 6 effort with the office of naval research and with
02:07:10 7 the human systems integration and everybody sees
02:07:14 8 the relevance of hearing loss and auditory injury.
02:07:17 9 It's just the scope of the problem is huge and it's
02:07:22 10 nothing that can be ignored and it's very relevant
02:07:24 11 to mission accomplishment. So, within the
02:07:26 12 services, the intramural projects have high
02:07:31 13 relevance for enhanced communication and for
02:07:34 14 hearing protection and so I think that that sells
02:07:38 15 itself; but whether or not that causes dollars to
02:07:40 16 flow, you're right. It would be nice to have a
02:07:43 17 research line dedicated to auditory research.

02:07:49 18 LT GEN GREEN: And if I could chime in. So,
02:07:52 19 when it was originally designed, there actually
02:07:55 20 were dollars that were kind of earmarked, if you
02:07:57 21 would, to go to the various centers of excellence
02:08:01 22 and so some of the things that are going on with
02:08:03 23 the efficiencies and with the economy right now are
02:08:05 24 interfering with the normal flows of those dollars;
02:08:09 25 and so the best that they can do at this point in

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02:08:11 1 time is to tie in to existing research venues such
02:08:16 2 as MRMC to make certain that their agenda is
02:08:20 3 carried forward and make sure it's visible. There
02:08:23 4 is -- there are a lot of dollars from NIH grants
02:08:26 5 that actually come back into the military system as
02:08:29 6 well and so as they become better organized, there
02:08:32 7 will be dollars that come the other way; but I
02:08:34 8 agree with Mark. Eventually we need to have some
02:08:38 9 research dollars that are actually going through
02:08:40 10 the center of excellence, but you have to get your
02:08:42 11 infrastructure set up and make certain that we're
02:08:44 12 not in conflict with the larger organization that
02:08:47 13 does that, which is MRMC.

02:08:49 14 MR. REHBEIN: Yeah, one of the things that
02:08:50 15 you have to do in order to accomplish that is to
02:08:53 16 establish your level of expertise and really become
02:08:58 17 a center of excellence so that people want to come
02:09:00 18 talk to you because they know that they will learn
02:09:03 19 things coming to talk to you. So -- but that's
02:09:05 20 a -- that's a battle. That's a struggle. That
02:09:09 21 will take some time and a lot of hard work and I
02:09:12 22 wish you good luck with it.

02:09:14 23 LT COL PACKER: I think the registry will
02:09:14 24 help out along those lines, too, because that --
02:09:20 25 we'll get the folks come in to see the reporting

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02:09:23 1 flows. Some of the other research lines are --
02:09:26 2 there's -- there's a couple of national
02:09:30 3 longitudinal efforts going forth to look at
02:09:33 4 noise-induced hearing loss and to look at
02:09:34 5 age-related hearing loss and if there's a military
02:09:37 6 longitudinal study compared to these other cohorts
02:09:40 7 would be fantastic. Genetic testing. You know,
02:09:43 8 why don't some people in the military have hearing
02:09:46 9 loss. What's the genetic hardening that -- that
02:09:51 10 happens that creates that level of protection in an
02:09:55 11 otherwise -- in an environment that is otherwise
02:10:00 12 causing high percentages of hearing loss. So, many
02:10:06 13 lines of research that have cross links to academic
02:10:09 14 efforts.

02:10:15 15 DR. PHILLIPS: Great, Colonel Packer, thank
02:10:18 16 you very much. Thank you for coming.

02:10:19 17 LT COL PACKER: My pleasure.

02:10:20 18 DR. PHILLIPS: We'll move on to our next
02:10:23 19 panel. Private organizations. We've heard from
02:10:26 20 the DoD and the VA about the challenges related to
02:10:32 21 transitioning of wounded warriors and their
02:10:36 22 families and now we will hear from a panel of
02:10:42 23 private organizations related to those issues. I
02:10:48 24 want to welcome Commander Rene Campos, deputy
02:10:52 25 director MOAA. I won't go through the whole title,

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02:10:57 1 if it's okay. It's all written out. Retired Major
02:11:01 2 James Cunningham, also from MOAA, Alamo chapter.
02:11:06 3 Mr. Leighton Foreman, national services officer,
02:11:10 4 Disabled Veterans of American; and Mr. Joe Noonan,
02:11:13 5 supervisor of the San Antonio office for Disabled
02:11:16 6 Veterans of America. Thank you all for coming
02:11:19 7 today.

02:12:35 8 MS. DAILEY: For my VSO and MSO panel, thank
02:12:44 9 you very much for being here. We have truncated
02:12:47 10 your time a little bit. I apologize. So, we did
02:12:51 11 give you all some questions. Appreciate you
02:12:54 12 talking to those questions and it would be helpful
02:13:01 13 for my -- for my panel -- I know that you have lots
02:13:05 14 of questions for our MSO and VSO panels and keep it
02:13:09 15 brisk as we ask those questions and -- but I don't
02:13:15 16 want to deny you the opportunity to really --
02:13:17 17 really get a feel and take advantage of
02:13:20 18 opportunities to talk with these people in Texas.
02:13:24 19 I can -- we aren't going to be here again this
02:13:28 20 year. So --

02:13:33 21 CDR CAMPOS: Last slide, please. On behalf
02:13:44 22 of the Military Officers Association of America,
02:13:47 23 MOAA for a short title, we're -- really appreciate
02:13:52 24 being here and giving our perspective on transition
02:13:54 25 ing recovering warriors and family members. I'm

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02:13:57 1 representing our national headquarters in
02:14:00 2 Alexandria, Virginia. My background is I'm a
02:14:05 3 30-year Navy veteran and I have been at the
02:14:08 4 association for about seven years and I work
02:14:12 5 specifically wounded warrior and VA health care
02:14:15 6 issues in our government relations department. One
02:14:21 7 of the things that -- for those of you not familiar
02:14:23 8 with our association or with maybe a military
02:14:26 9 service organization, we are a military service
02:14:29 10 organization, a nonprofit. We represent about
02:14:33 11 370,000 members. Our role is to advocate on behalf
02:14:37 12 of them for, you know, a strong national defense,
02:14:42 13 as well as for -- for their benefits. As part of
02:14:46 14 that and part of our advocacy role we also have a
02:14:52 15 fairly robust network of councils. We have 34
02:14:57 16 councils. Excuse me. 35 councils and 418
02:15:01 17 chapters. And joining me today is our Alamo
02:15:04 18 chapter national president, Jim Cunningham. So,
02:15:07 19 I'm going to kind of give you the national
02:15:09 20 perspective on what we see as wounded warrior
02:15:13 21 issues and family caregiver issues. He's going to
02:15:17 22 give you a little more the San Antonio local
02:15:19 23 perspective.

02:15:20 24 Again, my -- my primary or our primary role
02:15:25 25 at MOAA is as an advocacy organization and we do

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02:15:29 1 that not only in collaboration with our grassroots
02:15:35 2 network, but we also work with a larger coalition
02:15:37 3 of military and veterans organizations called the
02:15:41 4 military coalition, which collectively represents
02:15:44 5 34 organizations and 5.5 million members.

02:15:48 6 Some of the major things that we see at the
02:15:50 7 national level in terms of the challenges during
02:15:54 8 transition are kind of listed here. Nothing new to
02:15:58 9 you. I think you've heard in these last several
02:16:01 10 days and then of course in the last little over a
02:16:03 11 year that you've been working on these issues.
02:16:05 12 Again, barriers related to programs and policies,
02:16:09 13 cultures and those kinds of things. Continuity of
02:16:13 14 benefits, mental health issues. You know, just
02:16:17 15 trying to get that -- you know, we're a little ways
02:16:20 16 still from continuity of care or seamless
02:16:23 17 transition. So, there's still eligibility
02:16:26 18 criteria, terminology, a lot of those kinds of
02:16:30 19 issues that still remain. There's challenges with
02:16:33 20 the disability and the benefits systems are
02:16:37 21 complicated. They're not easy to navigate and, you
02:16:41 22 know, they have their own nuances in each of the
02:16:45 23 services, as well, across the Department of
02:16:48 24 Defense.

02:16:49 25 Community reintegration and employment we

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02:16:52 1 know and you continue to hear and I think it will
02:16:55 2 become even a greater challenge as we start
02:16:57 3 bringing people back home; but there are a lot of
02:17:00 4 challenges with reintegrating and any -- a lot of
02:17:05 5 the -- in terms of wounded warriors is really their
02:17:09 6 readiness to transition may not always be on the
02:17:12 7 same schedule as the military or the same schedule
02:17:15 8 as what the wounded warrior or the family member is
02:17:19 9 ready for. So, they've got a lot of challenges and
02:17:23 10 their mourning still for their own identity.
02:17:26 11 They've been associated and had a lot of support
02:17:28 12 systems while they've been in the military and
02:17:31 13 that's a challenge, for them to move on; and it's
02:17:34 14 also a challenge for the family members and the
02:17:37 15 caregivers. They have quite a robust support
02:17:43 16 network of family support and, you know, support
02:17:47 17 systems and services; but when they move into the
02:17:50 18 VA system or out of the military, those aren't
02:17:53 19 always there. And then, of course, the issues of
02:17:56 20 secondary trauma and there's some families that are
02:17:59 21 at risk, as you know, of sec -- of suicide. Are at
02:18:02 22 risk of suicide. So, there are a lot of security
02:18:05 23 issues, safety, concerns about retirement and so
02:18:11 24 on.
02:18:12 25 Now, there are, though -- we are

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02:18:14 1 extremely -- extremely pleased and give the
02:18:19 2 Department of Defense, the military services and
02:18:23 3 the VA a great deal of credit. We've come a long
02:18:28 4 way and particularly in the last three years. And
02:18:30 5 so you can see here a list of things that we see in
02:18:34 6 terms of DoD and military programs to be -- you
02:18:38 7 know, in terms of the way that they help. They --
02:18:41 8 having multiple programs actually contribute to
02:18:44 9 providing a safety net. We've seen these programs
02:18:48 10 become more formalized and the policies allow for
02:18:53 11 more consistency and uniformity across the systems.

02:18:58 12 The -- bringing in the RCP program, the FRCP
02:19:05 13 program have been very well received by recovering
02:19:08 14 warriors and their families. They like having an
02:19:11 15 advocate and there's been a great deal of progress
02:19:14 16 in those areas. You've all seen the resources that
02:19:17 17 are put at psychological injuries and mental
02:19:19 18 health. Those programs continue to expand and
02:19:24 19 resources put at those. IDES has actually been
02:19:29 20 very well received and we think that it has a lot
02:19:34 21 of potential, though there are still some
02:19:36 22 challenges there; but people like the fact that
02:19:39 23 they're -- and the warriors know that they're
02:19:43 24 getting their -- it's a faster program and much
02:19:47 25 more streamlined process because the medical

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02:19:51 1 records and the personnel records are available a
02:19:53 2 lot sooner.

02:19:54 3 And then finally a lot of programs that have
02:19:57 4 been put towards helping family caregivers and
02:20:01 5 family members in general. The national
02:20:04 6 research -- or excuse me. The national resource
02:20:07 7 directory real warrior program, certainly the
02:20:09 8 caregiver programs in both the DoD and the VA.
02:20:15 9 Now, I probably -- I would change this -- I should
02:20:18 10 have changed this. It says "How do they not help."
02:20:24 11 I should probably say -- how could they be more
02:20:25 12 helpful might be a better way of saying this.
02:20:28 13 Again, on the other side of the coin, having
02:20:30 14 multiple programs and that overlap, while it can be
02:20:32 15 helpful, it can also be quite challenging and
02:20:35 16 confusing to those that have to navigate the
02:20:39 17 system. Those people that are representing the
02:20:42 18 recovering warriors and their families, but also
02:20:45 19 for those family members themselves. Plus, you
02:20:48 20 know, we know that there's -- recent reports show
02:20:51 21 that there's about -- over 200 now mental health
02:20:54 22 programs just in the Department of Defense. Each
02:20:56 23 of the services have their own wounded warrior
02:20:58 24 program. Some of the reserve components have their
02:21:01 25 own programs. So, there's a lot of overlap and

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02:21:05 1 there's also a lot of decentralization, which can
02:21:09 2 also kind of add to some barriers. DoD has placed
02:21:14 3 the responsibility of implementation and the
02:21:16 4 policies much more squarely on the services to
02:21:20 5 implement and we think that that kind of creates
02:21:23 6 those inconsistencies in the programs because there
02:21:26 7 isn't the oversight and accountability that's
02:21:29 8 probably really needed.

02:21:31 9 Care coordination and management continues
02:21:34 10 to be a challenge. You hear some people say they
02:21:38 11 don't have enough case managers, don't have an RCC
02:21:41 12 or FRC or they have too many people. Again,
02:21:45 13 there's role confusion and responsibility; but
02:21:49 14 overall those programs are very well received. The
02:21:54 15 DES process. Certainly we hear more of the
02:21:58 16 confusion on the legacy side of it; but, again,
02:22:01 17 there's multiple DES programs or systems. You have
02:22:05 18 the legacy DES, the IDES, the BDD, expedited DES.
02:22:12 19 I mean, there's a lot of, you know, ee ee i oh.
02:22:14 20 It's very, very confusing. So -- and people aren't
02:22:19 21 always getting into -- or some of those programs
02:22:22 22 aren't achieving the goals that they're really set
02:22:25 23 out to do. And then of course you have the
02:22:27 24 military and medical limitations in terms of
02:22:32 25 interoperability of records and shortages of

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02:22:36 1 providers and things like that.

02:22:40 2 Here's some of the post separation

02:22:43 3 challenges that we see in terms of the reserve

02:22:45 4 component versus the active duty component. These

02:22:48 5 are not surprising to you. We hear it all the

02:22:53 6 time. There are many more robust programs within

02:22:56 7 the -- both family support, but also wounded

02:22:59 8 warrior programs, within the active duty component

02:23:01 9 than with the reserve; and many times some of the

02:23:05 10 care coordination and getting into the MEB/PEB

02:23:09 11 process is kind of a hit or miss. You've heard a

02:23:12 12 lot of that over these last couple of days. And

02:23:13 13 with the reserve component there's a lot of

02:23:16 14 multiple touch points. They may be getting some of

02:23:19 15 their care in the military treatment facility or

02:23:21 16 they may be getting it in a VA center or civilian

02:23:24 17 and getting all that information together to

02:23:28 18 integrate it within the IDES process or within

02:23:33 19 their treatment, you know, can be challenging.

02:23:38 20 There's difficulty sometimes for these folks to

02:23:42 21 access their military and VA disability benefits

02:23:46 22 and those systems, again, are very complex. So --

02:23:51 23 and the timing of when those are supposed to

02:23:54 24 happen. We tend to see that on the reserve side

02:23:57 25 they just don't have somebody helping them walk

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02:24:00 1 through the system to the extent that the active
02:24:03 2 component does and certainly for the reserve
02:24:07 3 component the employment transition is a challenge.
02:24:12 4 There's kind of some inconsistency across that area
02:24:21 5 in all the reserve components and, of course, these
02:24:24 6 folks -- especially recovering warriors are -- if
02:24:26 7 they're not on active duty at the time or they're
02:24:30 8 under treatment, they may not have the financial,
02:24:34 9 you know, resources available to continue their
02:24:37 10 care or have their family members close to them.
02:24:40 11 They worry too about their -- you know, about
02:24:42 12 income. They have -- may have a loss of income or
02:24:45 13 their job may not be there anymore when they get
02:24:48 14 back; and just waiting on their disability -- the
02:24:51 15 process to play out. And, again, at the end of the
02:24:56 16 day, wondering, you know, how employable or
02:24:58 17 unemployable they'll be.

02:25:01 18 MSGT MACKENZIE: Can I ask you a quick
02:25:03 19 question?

02:25:03 20 CDR CAMPOS: Yes.

02:25:05 21 MSGT MACKENZIE: When you mention a
02:25:06 22 difference between reserve component and active
02:25:07 23 component, are you talking about delays and
02:25:09 24 inability of people to help them walk through the
02:25:10 25 process? Those reserve components that are back in

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02:25:12 1 their states or do you find that even when they're
02:25:16 2 at the active duty MTF?

02:25:20 3 CDR CAMPOS: We -- actually, some of both.
02:25:24 4 I think when they're at the MTF, I think we've come
02:25:28 5 a long way in knowing how to deal with these folks.
02:25:31 6 We don't have -- you know, we -- we can -- we get
02:25:36 7 access to their information and get them -- you
02:25:39 8 know, they're pretty much on -- on the medical side
02:25:42 9 they're, you know, okay. It's when they really
02:25:44 10 leave the MTF and -- but there usually isn't --
02:25:49 11 again, they may not have an RCC. They -- again,
02:25:54 12 it's -- I think it's kind of hit or miss. I think
02:25:56 13 the medical side is taken care of and if they're
02:25:59 14 away from the MTF, I -- if they are -- especially
02:26:03 15 out of state and they're -- they're with a
02:26:07 16 community-based WTU or something like that, the
02:26:12 17 communication distance may be quite extensive and
02:26:17 18 they're -- you know, they're kind of left on their
02:26:18 19 own. So, we're -- we're seeing it, you know, in
02:26:23 20 different -- in different areas. I don't know
02:26:25 21 exactly what's causing it. I do know just like the
02:26:29 22 active duty component everybody's busy, everybody's
02:26:32 23 short-handed. You know, all assets are on deck
02:26:39 24 doing what needs to be done and so I don't think
02:26:41 25 it's an intentional thing, it's just, again, you

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02:26:44 1 know, like routine -- using existing resources in a
02:26:47 2 smart way.

02:26:52 3 The other thing that we see is the warm
02:26:55 4 handoff and I guess there's different
02:26:57 5 interpretations we've heard in these last couple of
02:26:59 6 days of what a warm handoff is; but in terms of the
02:27:03 7 reserve components, they're not -- they're not as
02:27:07 8 likely to get that really warm handoff into the VA
02:27:11 9 system. Especially if they're not, you know, near
02:27:16 10 the MTF, you know, where there is the resources
02:27:20 11 that might be there for the active duty component.
02:27:25 12 So, they're not -- they're more likely to fall
02:27:27 13 through the crack and then we see if they do get
02:27:33 14 into the VA system, some of the providers,
02:27:36 15 including my provider in the VA medical center in
02:27:39 16 DC, are having challenges accessing the -- or
02:27:44 17 excuse me -- the AHLTA records. Sometimes it's too
02:27:47 18 hard to do and they just -- you know, it's just too
02:27:49 19 hard and so if they're -- you know, if they're not
02:27:54 20 too overwhelmed, they'll do it; but they may end up
02:27:57 21 going back to the military and asking for those
02:28:00 22 records or leave it to the military person to do
02:28:02 23 that. So, again, not necessarily the warm handoff
02:28:05 24 and then the reserve component individuals get into
02:28:09 25 a system and they don't know how to navigate.

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02:28:12 1 There's not the resources available there.

02:28:16 2 Here's just some -- I'm not going to, you

02:28:19 3 know, go into -- I mean, I think we've heard all

02:28:22 4 the IDES support. You know, what's the positive

02:28:25 5 side of things. Again, it's great. I think it's

02:28:27 6 been kind of the forcing mechanism to really get at

02:28:31 7 more of a singular, uniform way, consistent

02:28:35 8 process. So, I think -- I think we need to build

02:28:38 9 on that; but, again, oversight accountability.

02:28:43 10 There's still across the system a great deal of

02:28:45 11 variance. Records access still streamline. You

02:28:49 12 know, we're working towards that, but we also know

02:28:53 13 that with the record access and in terms of IDES

02:28:59 14 and getting through the process, there's still

02:29:03 15 challenges. The DoD has told us -- in the IDES

02:29:06 16 there's a big thing about the first 100 days and

02:29:09 17 everything after that is kind of -- you know, it's

02:29:11 18 up to the VA to, you know, do their part of the

02:29:13 19 process and so there's some frustration there with

02:29:16 20 the Department of Defense and, you know, the

02:29:19 21 services to get that moving along. So, that's --

02:29:21 22 you know, the process still is longer than they'd

02:29:24 23 like.

02:29:24 24 The PEBLO is an advocate and a navigator.

02:29:28 25 Families like that; but, again, there's -- some are

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02:29:31 1 better than others. The training is -- and
02:29:34 2 knowledge varies across the system and to families
02:29:37 3 and to the wounded warriors, they don't necessarily
02:29:40 4 see those -- the PEBLO as kind of their advocate
02:29:45 5 and taking their best interest. They see them more
02:29:47 6 as a government representative. The RCC and the
02:29:52 7 FRCs are seen more as the family advocate and they
02:29:55 8 like that one person to go to. And certainly we've
02:29:57 9 seen lots of program -- lots of changes in the --
02:30:02 10 in transition support; but, again, it comes back to
02:30:05 11 kind of a readiness. For some of these severely
02:30:09 12 injured folks it may be two or three years down the
02:30:13 13 road or longer before they're really, you know, at
02:30:15 14 a -- where timing and readiness is -- I mean, it's
02:30:18 15 time for them to really look at those challenge --
02:30:21 16 the next step.

02:30:23 17 CSM DEJONG: Ma'am, in responses to the
02:30:24 18 IDES. Yesterday we were briefed that the
02:30:26 19 military -- once the IDES is up and running, the
02:30:28 20 military service organizations really have no -- no
02:30:31 21 authority in what they do as far as representing
02:30:35 22 the service member for the rating. How is that
02:30:38 23 being accepted in your world in the military
02:30:40 24 service organizations and is there a push to allow
02:30:43 25 you more into the system or not?

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02:30:46 1 CDR CAMPOS: Some of us were just talking
02:30:48 2 about that yesterday and I know that the -- that
02:30:53 3 the VA sees that also as a problem because the
02:30:57 4 veteran service organizations and military -- some
02:31:00 5 of the military service organizations have been
02:31:02 6 working very closely on this with the VA and -- so,
02:31:07 7 we've always partnered with them and, again, it's
02:31:11 8 hard to get on an installation sometimes as VSOs
02:31:16 9 and MSOs and I know that the Army is trying to kind
02:31:20 10 of open that door and bring us into the process;
02:31:22 11 but we -- I think we believe that we need to be in
02:31:25 12 the process a little bit more because usually the
02:31:27 13 VSOs in particular will be often the appeals
02:31:30 14 process when it comes time to -- should there --
02:31:35 15 should they have challenges in the VA system.

02:31:40 16 MAJ CUNNINGHAM: I might just comment that
02:31:42 17 in the state of Texas, at least, which is what I'm
02:31:45 18 familiar with, MOAA and MOAA representatives are
02:31:48 19 involved in the TAP process, they're involved in
02:31:53 20 ITAP, executive ITAP with the Air Force. The Texas
02:31:57 21 Veterans Commission, which is a premier state
02:32:02 22 organization, state agency, is heavily involved in
02:32:05 23 those programs as well, as well as counseling and
02:32:08 24 benefits counseling and helping transition to the
02:32:11 25 VA. So, at least in the state of Texas there's

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02:32:16 1 heavy involvement in that regard.

02:32:22 2 CSM DEJONG: Can you speak also?

02:32:22 3 MS. DAILEY: Yes, I'd like to see the DVA
02:32:25 4 respond to that.

02:32:25 5 MR. NOONAN: Yeah, I'm Joe Noonan with the
02:32:28 6 Disabled American Veterans. We have what's called
02:32:29 7 a transition service officer at Brooke Army Medical
02:32:33 8 Center and he's available. Anytime a soldier, a
02:32:36 9 marine, whoever, needs to go see him in their
02:32:39 10 process, we'll help them. We'll do anything we can
02:32:43 11 to assist them and that does happen. So -- but
02:32:47 12 when the IDES first evolved, we had no play
02:32:51 13 whatsoever.

02:32:53 14 MR. FOREMAN: And I'd like to add.

02:32:53 15 CSM DEJONG: Yeah.

02:32:55 16 MR. FOREMAN: When you're talking about the
02:32:56 17 IDES system, it's such a compressed time hack. I
02:33:00 18 mean, you're looking at right now when they come in
02:33:03 19 for the VA exam 10 days, 45 days for the medical
02:33:08 20 exam, VA is giving them 15 days for the rating,
02:33:10 21 another five days for the disposition and so forth.
02:33:13 22 Well, I kind of call it the gunny factor. If you
02:33:15 23 tell me I have to have something done in 10 days,
02:33:17 24 I'm going to try to have it done -- have it
02:33:20 25 finished by eight days and if it ain't done by

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02:33:22 1 eight days, then the squad leaders are going to
02:33:25 2 have it done in seven days. So, although
02:33:27 3 throughout the process they stipulate in their
02:33:29 4 briefings that you can have a chance to seek other
02:33:32 5 counsel and so forth through the world of service
02:33:37 6 information, SFAC and us, when are you going to get
02:33:41 7 a chance? And if you do get a chance, even with
02:33:44 8 the individuals involved, i.e. the PEBLOs, the MSCs
02:33:46 9 and so forth, how much time do they really have to
02:33:49 10 help that veteran or future veteran, service
02:33:53 11 member? Because if you look at the realization of
02:33:54 12 it -- and I'm only going to go off of two briefs --
02:33:58 13 to you on two slides. That's a problem and it's --
02:34:01 14 it tracks them throughout not only this process,
02:34:03 15 but when they get home. It actually starts at the
02:34:06 16 very beginning at their command, before they leave;
02:34:08 17 and she mentioned it briefly. Especially with the
02:34:11 18 reserves component. Is that they have to have
02:34:14 19 everything there. Medical records equal evidence.
02:34:16 20 So, when they bring all their medical evi --
02:34:20 21 documentation, if they're missing something but
02:34:22 22 because of time hack they have to be there, they're
02:34:26 23 getting hurt in that process and then before --
02:34:29 24 myself, as a transition service officer, while I
02:34:32 25 was immediately over there, I was there when the

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02:34:34 1 legacy program as well as the transition over to
02:34:38 2 the pilot program, the DES; and it did knock us out
02:34:43 3 of the picture and it is a problem and she
02:34:45 4 mentioned it briefly, as well. They don't feel
02:34:49 5 always comfortable with talking to some of these
02:34:50 6 representatives of the military or government.
02:34:53 7 One -- the master sergeant mentioned it the other
02:34:55 8 day. You know, we were talking about checks in the
02:34:57 9 blocks. We've got to turn these young soldiers,
02:34:59 10 marines -- you know, a retired marine like myself,
02:35:02 11 you got to have them do 180 degrees what they've
02:35:06 12 been taught to do. Out of four years, 20 something
02:35:10 13 years, it's 180. Yes, I'm hurting and on a scale
02:35:13 14 of 1 to 10, if we're operating at 5, that's our 1.
02:35:17 15 How do you teach them how to actually explain
02:35:20 16 what's going on with them. That's very difficult
02:35:23 17 and then they come into the process like, well, you
02:35:28 18 know, I understand I'm hurt; but I still want to
02:35:30 19 stay in. Well, I'm sorry, partner, you have to
02:35:33 20 make a decision. This is the time you have to make
02:35:34 21 a decision. As much as it hurts because you want
02:35:36 22 to stay in and serve your country and you worked
02:35:39 23 hard and all the schools and everything you've been
02:35:41 24 to and your third combat tour, you now have to make
02:35:43 25 a decision whether or not you want to let the cat

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02:35:46 1 out of the bag and let everyone know what's going
02:35:48 2 on so you get properly evaluated or you're just
02:35:51 3 going to do what you've done probably in the past
02:35:55 4 five, six years and sucked it up and not tell them
02:35:58 5 everything that's going on with you, i.e. PTSD or
02:36:00 6 other injuries you have that will keep you out of
02:36:03 7 -- myself, air crew or some TI factor, the SF
02:36:06 8 community. Maybe it knocks you out of going to
02:36:08 9 schools. So, we were knocked out of the whole
02:36:10 10 process. Hey, this is what you need.

02:36:12 11 And our VSOs are located throughout the
02:36:16 12 United States and so are our MSOs. So, there's a
02:36:20 13 chance that they can actually come to us before.
02:36:22 14 And the commands have to get involved. I don't
02:36:25 15 mean to get on -- in the process; but I see it all
02:36:28 16 the time out there and it's a great program. Don't
02:36:32 17 get me wrong. But when you're talking about
02:36:36 18 expediting the process of the claim, that's great.
02:36:39 19 You need to streamline it and it's nice to get it
02:36:42 20 out there; but we want a good end product too.

02:36:48 21 CDR CAMPOS: On this slide I'm just going to
02:36:50 22 really highlight in terms of comparing the IDES to
02:36:55 23 the legacy DES a couple of concerns at the bottom
02:37:00 24 here. That is, there's still the concerns of the
02:37:03 25 recovering warriors and their families and the

02:37:05 1 systems in general. Trying to understand that
02:37:08 2 there are still two rating systems, the military
02:37:13 3 and the VA; and those are confusing and hard for
02:37:16 4 people to understand.

02:37:19 5 The other challenges we see are for those
02:37:25 6 people that are in a TDRL or new recruits coming in
02:37:30 7 that may get, you know, hurt or injured, they are
02:37:33 8 going to go through the legacy process and if a
02:39:09 9 TDRL person does go through the IDES but then later
02:39:09 10 goes through a legacy system, the legacy DES, that
02:39:09 11 can be very frustrating to those individuals. I
02:39:09 12 will give you an example of an Air Force person
02:39:09 13 that we've been working with this last year. This
02:39:09 14 person -- and I think the individuals that are in a
02:39:09 15 TDRL status, some of them almost feel like they're
02:39:09 16 like the reserve. That they're kind of out there.
02:39:09 17 And this particular wounded warrior was one already
02:39:09 18 frustrated because he was waiting for his Purple
02:39:09 19 Heart from the Air Force and that took a long time
02:39:10 20 coming. Yesterday I heard that he had just heard
02:39:10 21 that it -- the paperwork went through; but this
02:39:10 22 individual for 18 months had been in a TDRL status
02:39:10 23 and going back in the last couple of months to get
02:39:10 24 reevaluated. I mean, it's like short notice.
02:39:10 25 No -- they had two young children. No coordinating

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02:39:10 1 with his schedule. You've got to go from Georgia
02:39:10 2 to San Antonio, be there and, you know, didn't
02:39:10 3 even -- when they got here, didn't even have the
02:39:10 4 appointments laid out correctly. And then they go
02:39:10 5 back home and no information as to what's
02:39:10 6 happening. Didn't have an RCC, FRC. I mean,
02:39:10 7 they're the ones that we're constantly reaching out
02:39:10 8 trying to figure out what was happening with the
02:39:10 9 system and where they fit into it. When they got
02:39:10 10 the letter that finally gave them the Air Force's
02:39:16 11 findings, they didn't know what to do. So, they
02:39:18 12 called our association. We helped them walk
02:39:20 13 through the -- the letter and what their benefits
02:39:23 14 were and that sort of thing. So, at the end of the
02:39:26 15 day, to them that was very frustrating and to that
02:39:30 16 recovering warrior, he -- he felt demoralized. He
02:39:35 17 felt like the Air Force didn't care about him and
02:39:40 18 it was just, you know, kind of a sad situation.

02:39:42 19 MSGT MACKENZIE: So, I asked this in this
02:39:43 20 particular situation of this Air Force member.
02:39:46 21 Where was the wounded warrior -- where was the Air
02:39:48 22 Force wounded warrior advocate in this process?

02:39:50 23 CDR CAMPOS: Yeah. As a matter of fact, he
02:39:52 24 was -- they were recently brought here to San
02:39:56 25 Antonio and I think it was General Schwartz that

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02:40:00 1 had to engage and get his process kind of going
02:40:04 2 along too, even with his Purple Heart. And then on
02:40:12 3 top of that, the other thing is this service member
02:40:13 4 had a number of years in. Certainly not retirement
02:40:16 5 eligible, but the general was really surprised that
02:40:20 6 the Air Force hadn't done a retirement ceremony.
02:40:23 7 So, he's going to have a retirement ceremony.
02:40:25 8 So --

02:40:27 9 CSM DEJONG: Ma'am, is this a case where
02:40:28 10 they were trying to identify whether he was a --
02:40:31 11 the Air Force has very strict criteria on what
02:40:33 12 they're authorized for. Were they trying to
02:40:36 13 establish his -- the relationship between combat
02:40:39 14 and his injuries?

02:40:41 15 CDR CAMPOS: Huh-uh. Huh-uh.

02:40:43 16 CSM DEJONG: No? It was cut and dry from
02:40:44 17 the beginning?

02:40:45 18 CDR CAMPOS: Yeah. He -- yeah, it was just
02:40:47 19 the process and then trying to, you know, work
02:40:49 20 through that process.

02:40:50 21 MSGT MACKENZIE: So, this individual had no
02:40:51 22 Air Force wounded warrior advocate?

02:40:55 23 CDR CAMPOS: No. In terms of recovering
02:40:59 24 warrior employment efforts, I won't go into a lot
02:41:03 25 of this because we know especially in the last year

02:41:06 1 a lot of programs have sprung up and certainly all
02:41:09 2 the way up to the administration, Congress, there's
02:41:11 3 a lot of effort to -- you know, to get programs out
02:41:14 4 there and hire wounded warriors.

02:41:18 5 Programs now, you know, are focusing a lot
02:41:21 6 more on high risk populations, including the guard
02:41:25 7 and reserve component; but there will be bigger
02:41:27 8 challenges as folks come home from theater. Some
02:41:31 9 of these -- as you know, some of the wounds won't
02:41:35 10 even be recognized for a long time and of course
02:41:38 11 those reserve components coming back worry about if
02:41:42 12 they're going to have a job, are they going to be
02:41:45 13 employable and, you know, the financial impact of
02:41:47 14 that. And at the end of the day, though, I think
02:41:51 15 one of the things that -- we've done a great deal
02:41:53 16 of things, but the system isn't always tailorable
02:41:58 17 to the individual wounded warrior and at the end of
02:42:01 18 the day I think we all have to realize that in
02:42:04 19 terms of employment, too, these are very personal
02:42:09 20 and -- employment is very personal and very
02:42:12 21 individualized.

02:42:15 22 And in closing, this is kind of the list of
02:42:18 23 vocational and employment challenges. I talked to
02:42:23 24 some of these, but I would say that these also are
02:42:26 25 more systemic of the broader wounded warrior

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02:42:28 1 programs across all the services and DoD. Again,
02:42:32 2 the bureaucracies, culture -- cultural differences,
02:42:37 3 cooperation, collaboration and communication are
02:42:39 4 still issues. Funding and resource limitations
02:42:43 5 tend to sometimes create turfs.

02:42:46 6 There will be concerns about the long-term
02:42:49 7 viability of the post 9/11 GI bill because of the
02:42:52 8 budget situation. Enforcement of policy still is a
02:42:56 9 challenge and, again, the oversight, accountability
02:42:58 10 and standards and metrics. What's working.
02:43:02 11 What's -- what's the efficacies of these programs;
02:43:05 12 and then at the end of the day for us we wonder
02:43:08 13 about the long-term sustainability of these wounded
02:43:10 14 warrior programs and systems. We think that
02:43:14 15 they're going to be questionable in this fiscal
02:43:17 16 environment without further streamlining and
02:43:20 17 consolidating. And with that I'll be happy to take
02:43:23 18 your questions.

02:43:24 19 MS. DAILEY: We'll move into our next
02:43:28 20 briefer. We'll bring it home to Texas.

02:43:34 21 MAJ CUNNINGHAM: Well, again, I'm Jim
02:43:36 22 Cunningham. As well as being the president of the
02:43:41 23 Alamo chapter here in San Antonio of MOAA, I'm also
02:43:44 24 the executive vice president for state legislative
02:43:47 25 advocacy at the -- for the state of Texas and

02:43:54 1 what -- Rene went through the questions that were
02:43:56 2 presented and I would say that basically all of the
02:44:01 3 information that Rene gave is applicable and is the
02:44:05 4 same information that we as a chapter would agree
02:44:08 5 with. So, I'm not going to really go over those
02:44:11 6 again.

02:44:12 7 Basically, I just wanted to try to give you
02:44:14 8 a little bit of a flavor of what is going on in
02:44:17 9 Texas and what is going on in San Antonio, Bexar
02:44:19 10 County, since we are the military city USA. So,
02:44:27 11 basically -- oh, hello. So, basically, we are in
02:44:31 12 the role of advocacy and information for veteran
02:44:34 13 services and civilian provider entities. We have
02:44:37 14 members in all of our chapters that volunteer for
02:44:40 15 various activities that affect members and
02:44:43 16 families. Particularly in the reserve components.
02:44:48 17 It worked.

02:44:50 18 We participate in the Texas legislative
02:44:53 19 process and we are part of the Texas military
02:44:56 20 coalition, of which I'm the vice chair, which is a
02:45:01 21 conglomeration of about 35 different military
02:45:05 22 service organizations and VSOs in the state of
02:45:08 23 Texas that advocate for issues relating to
02:45:12 24 veterans, families, caregivers and even the active
02:45:15 25 duty component that is stationed here in Texas.

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02:45:19 1 We're very excited we -- in this last legislative
02:45:23 2 session a bill was passed to create the Texas
02:45:25 3 coordinated council for veteran services. This is
02:45:31 4 a new ward made up of various state agencies in
02:45:35 5 Texas to include housing, to include the Texas
02:45:39 6 Veterans Commission, the Texas Veterans Home Board,
02:45:41 7 the Texas Military Department, so forth; and also
02:45:46 8 some VSOs and MSOs. Their charge is to look at all
02:45:56 9 the issues related to veterans, families,
02:45:58 10 caregivers, the wounded warrior and in particular
02:45:59 11 the Texas Military Department members that are
02:46:03 12 coming back from deployment and they are to --
02:46:06 13 their charge is to gather information and make
02:46:08 14 recommendations which will go directly to the
02:46:12 15 governor and the governor, in turn, will make
02:46:14 16 recommendations to the legislature as to things
02:46:17 17 that he wants to see done where the military is
02:46:20 18 concerned in Texas.

02:46:21 19 Other things that we've done. We just
02:46:23 20 passed a hundred percent disabled surviving spouse
02:46:27 21 property exemption where the surviving spouse of a
02:46:31 22 hundred percent disabled veteran will get tax
02:46:35 23 exemption for her life. We have established a
02:46:37 24 women's advocate with the Texas Veterans
02:46:40 25 Commission, which is new to the state and sorely

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needed.

The Texas Veterans Commission is probably one of the premier organization state agencies in the country in that they have a hand-in-hand relationship with the VA. They have offices co-located in VA offices where veterans can come in and apply for VA benefits and register for the VA and they assist those veterans through all the nuances of getting applications and for their disability ratings, VA benefits and making sure that they're getting all the benefits to which they're entitled. They also have an employment arm. The -- they identify employers who are ready to hire and they help the veterans translate their military careers into resumes and get them employed.

One new aspect of what we are doing in Texas. We established and funded the veterans assistance fund which is funded through the lottery in Texas, which is designed to collect money and so far its collected about \$14 million, which is in turn granted through a grant process to various organizations in the state who are directly affecting and have direct projects that assist veterans, families and caregivers. This has been

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02:48:14 1 very successful and they just recently added a
02:48:17 2 housing component to that where the governor
02:48:20 3 requested and had moved housing funds that
02:48:24 4 previously were in the housing authority for the
02:48:28 5 state over to the Veterans Commission to provide
02:48:30 6 more direct aid to veterans that were in need of
02:48:34 7 housing.

02:48:36 8 One of the new things that we've done too is
02:48:38 9 college credit for experience. If a veteran has
02:48:40 10 experiences within the military that are applicable
02:48:43 11 to a civilian career, they can get that credit
02:48:47 12 either through licensure or through college courses
02:48:51 13 that are already paid for and are credited to them
02:48:55 14 for that experience. One thing that the City of
02:48:58 15 San Antonio just did was energy assistance for
02:49:00 16 veteran burn victims. We have a great number of
02:49:03 17 burn victims in this city who were unable to pay
02:49:06 18 their electric bills and so the City came forward
02:49:09 19 and they're assisting them in doing that. And it
02:49:13 20 can get quite hot here in Texas during the summer.

02:49:20 21 What we are doing here in Bexar County. I
02:49:22 22 wanted to back up a little bit and address
02:49:24 23 something that we have done here. MOAA about five
02:49:28 24 years ago was interested in working with the VA and
02:49:31 25 trying to assist getting various organizations

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02:49:34 1 within the city and Bexar County to work together
02:49:36 2 to better assist veterans and give them sort of a
02:49:39 3 one-stop shopping, if you will, for things that
02:49:42 4 they needed. What we found was that the -- we
02:49:46 5 alone could not do it; but about two and a half
02:49:50 6 years ago the Altarum Corporation -- pardon me --
02:49:53 7 the Altarum Institute came along.

02:49:57 8 Altarum Corporation is a 501c3 that does
02:50:00 9 various types of studies. Statistical studies,
02:50:03 10 things like this. They came forth with a two and a
02:50:06 11 half million dollar grant where they put in place a
02:50:08 12 project called the veterans community action team,
02:50:11 13 both here in San Antonio and in San Diego, where
02:50:15 14 they wanted to work with the MSOs and VSOs and
02:50:20 15 other providers within those two cities to try to
02:50:23 16 identify ways that those organizations could come
02:50:26 17 together and better serve veterans and their family
02:50:30 18 and their caregivers. After about two years of
02:50:33 19 study and work, that resulted in the creation here
02:50:36 20 in San Antonio of the alliance for veterans and
02:50:38 21 families, which is also a 501c3. Now, the purpose
02:50:43 22 of that alliance, of which I'm a board member, is
02:50:47 23 to identify service providers, whether they be
02:50:51 24 military, civilian, VA, whatever, that are trying
02:50:57 25 to work with veterans and families and help them

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02:50:59 1 coordinate their services to reduce duplication and
02:51:03 2 to also bring them together so that they can work
02:51:06 3 on joint projects which will better help that
02:51:09 4 veteran and family; and -- and in doing that,
02:51:20 5 provide them with more information. What we found
02:51:22 6 was -- in a lot of our meetings was that many of
02:51:26 7 these organizations didn't know that the others
02:51:27 8 existed nor did they know that they did anything
02:51:30 9 for veterans; and it was a great surprise to me.

02:51:33 10 Now, the alliance has come together and put
02:51:37 11 together various working groups that are producing
02:51:40 12 projects to help veterans. To give you a couple of
02:51:46 13 examples, we have the veterans information program.
02:51:50 14 Now, this is a program where about 10 of our
02:51:54 15 providers came together and they developed a
02:51:56 16 program called the veterans information program,
02:51:58 17 which is a series of eight modules which are
02:52:02 18 presented in the evening where if a veteran is
02:52:06 19 working, they can come in the evening and we will
02:52:09 20 put on a two-and-a-half-hour program, we will baby
02:52:13 21 sit their kids and we ask them to bring their
02:52:15 22 spouses with them so that we can talk to them about
02:52:18 23 their federal benefits, their state benefits and
02:52:22 24 their local benefits.

02:52:23 25 We also have VA representatives here to make

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02:52:26 1 sure that they get enrolled. It's amazing how many
02:52:29 2 veterans we come across that are not enrolled with
02:52:32 3 the VA and have never considered it. Regretfully,
02:52:36 4 many of them are Vietnam era veterans. And that
02:52:39 5 has been very successful. And we put these on on a
02:52:44 6 quarterly basis and they've been very well
02:52:47 7 received.

02:52:47 8 Now, one thing that we're very proud of is
02:52:50 9 the south Texas employment initiative. Now, this
02:52:54 10 particular initiative is a coalition of employer
02:52:56 11 support of the guard and reserve, Department of
02:53:00 12 Defense people, Department of Labor, Texas Veterans
02:53:03 13 Commission and Work in Texas. And what we have
02:53:05 14 done is we've come together and working together --
02:53:09 15 in particular with the Texas Veterans Commission we
02:53:12 16 are trying to ensure that veterans as soon as they
02:53:15 17 come out of the TAPS -- pardon me -- transition
02:53:19 18 process, if they're staying in Texas, to make sure
02:53:21 19 that they are enrolled in Work in Texas. Once they
02:53:24 20 are enrolled in Work in Texas, then the TVC picks
02:53:30 21 them up, they bring them in, they make sure that
02:53:32 22 they've got a good viable resume. They work with
02:53:35 23 them in translating that into civilianese and then
02:53:39 24 they educate them on interviewing skills, things
02:53:45 25 like this, to a great -- much more intensity I

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02:53:48 1 think than they do in transition.

02:53:50 2 Then, the other thing that we do is that we
02:53:52 3 put together job fairs or we participate in job
02:53:56 4 fairs where the TVC goes in and ESGR goes in and
02:54:02 5 they try to identify and have only employers who
02:54:06 6 are ready to hire a veteran. We don't want people
02:54:09 7 coming in with a lot of window dressing and start
02:54:12 8 collecting resumes and say, "Well, we'll call you
02:54:15 9 one day." We want those employers in there that
02:54:18 10 are ready to hire. One recent project that we had
02:54:23 11 that was put on by the TVC in September, we had
02:54:28 12 over 1500 veterans there and many of those veterans
02:54:31 13 were hired. We don't have exact figures because
02:54:34 14 we're still working on the tracking right now; but
02:54:38 15 the unique thing about this to us is that this is
02:54:42 16 the first time that agencies both state and federal
02:54:45 17 have come together like this to do a joint effort
02:54:47 18 and to reduce some of the duplication in looking
02:54:50 19 for employment. And that's what we're trying to
02:54:54 20 achieve.

02:54:56 21 Other projects that we're working on. We're
02:54:58 22 working on an individual -- pardon me -- invisible
02:55:02 23 wounds of war conference and we're doing this at
02:55:04 24 St. Mary's University here in San Antonio and we're
02:55:07 25 working with psychologists, psychiatrists, other

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02:55:11 1 interested parties in the city to try to put on a
02:55:14 2 two-day seminar where we will bring in first
02:55:19 3 responders, counselors, doctors, social workers,
02:55:23 4 etcetera and talk to them about the various aspects
02:55:26 5 of PTSD and TBI and how they can deal with it and
02:55:33 6 how they can better address it.

02:55:33 7 There are many civilian providers out there
02:55:35 8 that don't have a clue or they haven't taken the
02:55:38 9 time to see about it. And we're trying to pull
02:55:41 10 this together so that we will start that education
02:55:43 11 process and get them better equipped.

02:55:46 12 The other project we're working on, which we
02:55:49 13 think is very positive, is the spiritual health
02:55:53 14 project. In this particular project we bring
02:55:58 15 together both religious-based organizations and
02:56:01 16 secular organizations within the Bexar County area
02:56:03 17 to develop a program where at the invitation of the
02:56:09 18 clergy and/or others within a church or
02:56:13 19 congregation, we will come in and we will help them
02:56:17 20 set up a program where they can work with the
02:56:21 21 veterans that are within their congregation and
02:56:26 22 help them not only spiritually, but also if they
02:56:30 23 have practical secular problems, help them know
02:56:33 24 where to go to help get them help. This includes
02:56:37 25 things like, you know, maybe they're having rent

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02:56:39 1 problems. Well, they can go to Catholic charities
02:56:41 2 here and they can get rent money. Maybe they have
02:56:44 3 problems with their electric bill. They can go to
02:56:46 4 Military 211 and Military 211 will refer them to
02:56:51 5 people who can help them with their electric bill.
02:56:54 6 Things such as this. So, these are things that
02:56:57 7 we're trying to do.

02:56:58 8 I would also point out, too, that MOAA,
02:57:02 9 nationally, is working -- and this started I think
02:57:08 10 at the behest of retired General Mullen. Pardon
02:57:12 11 me. Admiral Mullen. And also from the White
02:57:15 12 House. I don't know if you've heard of the
02:57:17 13 community blueprint project. This is a project
02:57:19 14 that they're sort of pushing where they're working
02:57:23 15 with communities to try to do things similar to
02:57:26 16 what we have done. It may be a situation where
02:57:30 17 they're working like we are where we're bringing
02:57:32 18 people together to better serve the veterans or it
02:57:35 19 may be direct action.

02:57:36 20 Now, I know that MOAA -- MOAA national has
02:57:40 21 assisted and we have pilot projects going on with
02:57:43 22 chapters in Huntsville here in Texas. Also in
02:57:47 23 Tyler, which are seemingly very effective in
02:57:51 24 working with veterans setting up things such as
02:57:53 25 veterans court process, which is doing wonderful

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02:57:55 1 things. We have a veterans court here in Bexar
02:57:58 2 County, which is doing wonderful things to keep
02:57:59 3 veterans and active duty members out of jail and
02:58:05 4 put them on a path where things will not affect
02:58:08 5 their career or their retirement or whatever; but
02:58:12 6 also satisfy the legal issues that they've gotten
02:58:16 7 into. So, that basically is what I wanted to brief
02:58:21 8 you on and with that, any questions?

02:58:27 9 MS. DAILEY: I'm going to move it along to
02:58:29 10 our DAV and we are -- we're on a pretty close time
02:58:35 11 hack here, gentlemen.

02:58:38 12 MR. NOONAN: Okay. Again, my name is Joe
02:58:39 13 Noonan. I'm national service officer here in San
02:58:42 14 Antonio and I'm the supervisor. I'm a 30-year Army
02:58:45 15 veteran and I've held -- I've been doing this job
02:58:48 16 for nine years now. So, there's not -- you know,
02:58:51 17 there's probably not a whole lot I haven't seen;
02:58:54 18 but -- next slide, please. Yeah, since our
02:58:59 19 founding in 1920 by Captain Robert S. Marx, we were
02:59:03 20 chartered by Congress in June of 1932 and we have
02:59:07 21 one single purpose and that's building better lives
02:59:10 22 for our -- all of our disabled -- our nation's
02:59:13 23 disabled veterans and their families.

02:59:15 24 So, that's what we do. We do that every
02:59:17 25 day. I can give you gee whiz numbers; but I don't

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02:59:20 1 like to do that. We do thousands of claims a year.
02:59:22 2 Veterans that come into our office. We've got
02:59:25 3 people on all the military bases here in San
02:59:27 4 Antonio. So, we help them transition out of the
02:59:29 5 military. Then they all know they can come to us
02:59:31 6 once they're out for further -- further assistance.
02:59:35 7 At one time we were doing a lot of formal physical
02:59:39 8 elevation boards over at Fort Sam Houston? With
02:59:41 9 the new IDES, which is -- seems to be working,
02:59:45 10 we're doing very few of those now. We've also done
02:59:48 11 boards over at the Air Force here at Lackland. One
02:59:53 12 of the good things that happened -- and I'll just
02:59:55 13 mention this very briefly. About two years ago DoD
03:00:02 14 instituted the physical disability board of review.
03:00:05 15 That's a very good program. For those that have
03:00:08 16 gotten out since September 11, 2001, if they get
03:00:12 17 out of the military and receive 20 percent or less
03:00:15 18 for severance pay, they can appeal that result.
03:00:18 19 We've had some good results in that also. So,
03:00:20 20 those are the things we do every day. So, I'm
03:00:23 21 going to turn it over to Leigh and he's going to
03:00:25 22 get into this in a little bit more detail.

03:00:27 23 MR. FOREMAN: And I'll go through these
03:00:29 24 slides relatively quick. Basically, Joe mentioned
03:00:32 25 about transition service officers and how they're

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03:00:35 1 involved throughout TAP class. They also get
03:00:39 2 involved in pre and post deployment interviews and
03:00:43 3 briefs and so forth; and then I'll go straight to
03:00:46 4 the national service officers.

03:00:48 5 One of the major things about being a
03:00:50 6 national service officer myself, retired out of the
03:00:53 7 Marine Corps after 22 years, OEF/OIF vet, in
03:00:57 8 March -- well, January 2008. Was hired by the DAV
03:01:00 9 in 2008, in March, and was a transition service
03:01:05 10 officer for two years. Then became a national
03:01:08 11 service officer, which is almost a 16 to 18-month
03:01:10 12 course that you have to go through and an OJT time.
03:01:14 13 The reason being is because NSOs function as
03:01:16 14 attorneys in fact, they assist the veterans in
03:01:18 15 filing claims and so forth; but exactly like Joe
03:01:20 16 said, they also represent veterans and active
03:01:23 17 members and personnel before discharge and review
03:01:27 18 boards. Boards of correction, military records
03:01:29 19 and, of course, physical evaluation boards.

03:01:32 20 Major challenges and concerns. Again, it
03:01:34 21 comes down to time limitations reduce the
03:01:37 22 opportunity for the service members to receive
03:01:39 23 legal counsel that they deserve and the IDES system
03:01:43 24 is working great if they're coming straight off the
03:01:46 25 battlefield and they're active duty and even with

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03:01:48 1 the reserve component, if they're coming directly
03:01:51 2 off the battlefield; but the problem with that is
03:01:53 3 that given -- what's been said before is given that
03:01:59 4 information -- that evidence is medical
03:02:00 5 documentation. It's extremely important and
03:02:02 6 especially with the reserves components. I can
03:02:07 7 make one suggestion or recommendation is especially
03:02:10 8 with the reserves it would be better for them to go
03:02:13 9 through the legacy program. Although it takes
03:02:15 10 longer, they give us more of an opportunity to get
03:02:18 11 all their medical records and everything is spread
03:02:20 12 out all over the place. I served for three years
03:02:23 13 at 4th recon battalion at an INI staff and really
03:02:29 14 got my eyes opened up to what these reserves go
03:02:32 15 through; and as a TS0 and NS0 I've even seen more
03:02:35 16 of it in these briefs -- post and pre briefs that I
03:02:39 17 see. That they get augment to another unit, to
03:02:41 18 another unit, to another unit and then they come
03:02:44 19 back and then there's no way -- so, it's almost
03:02:46 20 impossible sometimes to track their paperwork. And
03:02:50 21 with the requirements of the VA -- with active duty
03:02:53 22 members, it's not that hard; but with the reserve
03:02:56 23 component you have to have LODs, title 10, title 32
03:03:01 24 orders. I'm asking a specialist who was just
03:03:04 25 following orders or a young PFC or corporal who

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03:03:08 1 just came in, "Where's all your orders, where's
03:03:11 2 your list of drill dates"; and I have actually sat
03:03:14 3 down with -- let's say veteran X, looked down at
03:03:17 4 all his records with a rating specialist and we had
03:03:20 5 to look at his drill dates and match the times that
03:03:22 6 he actually said this happened and it's actually
03:03:26 7 come down to if a reservist is brought up for like
03:03:29 8 a physical, well, he's not really training. So,
03:03:31 9 whatever medical documentation we get from that,
03:03:35 10 well, that's not relevant because he wasn't on a
03:03:38 11 training -- not on orders. So, let's say he was
03:03:41 12 prostrating -- well, not prostrating migraines; but
03:03:45 13 he had, let's say, frequent indigestion. Doesn't
03:03:49 14 sound too bad. A lot of us get but it once in
03:03:52 15 awhile; but if he's busy soldiering, as the first
03:03:55 16 sergeant said he was, and didn't have time to get
03:03:57 17 that treated and he went outside when he was not on
03:04:00 18 reserve status because they offered it to him and
03:04:01 19 found out that it was GERD and then go back to his
03:04:05 20 command and now -- so, now we've got GERD; now we
03:04:08 21 have indigestion. Try working that on a tight time
03:04:13 22 hack and working with them through the IDES system
03:04:17 23 when they come into it; and eventually the -- that
03:04:21 24 first sergeant X actually ended up having Barrett's
03:04:27 25 esophageal cancer. So, something that seemed so

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03:04:30 1 simple as indigestion when this individual service
03:04:32 2 member is going through the disability evaluation
03:04:34 3 boards, you don't know what it's going to affect
03:04:37 4 them way, way, way down the road. So, one of the
03:04:39 5 greatest things we have is taking care of one
03:04:41 6 another and there's some great days and some days
03:04:44 7 you're just like, oh, it's a gut check, because if
03:04:46 8 only, if only, if only we could have done this,
03:04:49 9 this and this; and that's with the reserve
03:04:54 10 components. And, again, I just say -- I kind of
03:04:57 11 already told you how it's incremental to the
03:04:58 12 outcome of the physical evaluation board. Again,
03:05:01 13 that GERD or something could have been rated at a
03:05:03 14 30 by -- zero for indigestion. All right.

03:05:09 15 Recommendations. You know, we have --
03:05:12 16 something in place has to be better; and, again,
03:05:15 17 VSOs can fill that void. Ensuring members have
03:05:19 18 everything ready for -- as soon as they find out
03:05:21 19 they're going to get boarded, they get everything
03:05:23 20 ready. Some kind of -- somebody to walk them
03:05:25 21 through that process. Again, the reserve probably
03:05:25 22 should be a legacy program known as the IDS and
03:05:28 23 then better utilization of information resource
03:05:34 24 centers such as VSOs.

03:05:36 25 One thing we bring to the table is years of

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03:05:39 1 experience. We don't have to worry about manpower,
03:05:42 2 gearing up, gearing down. We're always here. Been
03:05:46 3 here since 1920. Different organizations and we're
03:05:51 4 ready to help and we want to help and I think we
03:05:54 5 can bring a lot of continuity to this process, as
03:05:57 6 far as counseling and helping our service members.
03:06:00 7 Thank you.

03:06:00 8 MR. NOONAN: I just want to say one last
03:06:02 9 thing and then I'm finished. The Air Force had an
03:06:04 10 excellent program when I was a transition service
03:06:06 11 officer out at Lackland. They put together a video
03:06:11 12 and -- about this whole process. I don't know if
03:06:14 13 they still use it, but it was excellent for those
03:06:17 14 out in the field. They could just tap into that
03:06:19 15 video and it told them everything that was going to
03:06:21 16 happen. I don't know if it's still there, but it's
03:06:23 17 something that would really help in all branches of
03:06:26 18 service. Especially the reserves and national
03:06:30 19 guard. Thank you.

03:06:31 20 DR. PHILLIPS: Thank you. Let me ask a
03:06:33 21 couple of questions and perhaps you can help us
03:06:37 22 understand some of the --

03:06:38 23 MS. DAILEY: Very quickly, sir. If -- those
03:06:40 24 of you that want to catch an airplane tonight,
03:06:43 25 you're going to have to make a choice between

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03:06:46 1 questions and catching flights. So --

03:06:47 2 DR. PHILLIPS: I'll be very quick. You hit
03:06:49 3 on the briefing before discharge. Obviously, the
03:06:55 4 soldiers -- recovering warriors are not being
03:06:58 5 briefed enough about what the next steps are. Is
03:07:01 6 that related, do you think, to the education of the
03:07:04 7 cadre who's supposed to brief them or is it lack of
03:07:06 8 family member interaction or is it just a timing
03:07:10 9 issue? Do you have an opinion on that?

03:07:13 10 MR. FOREMAN: Do you mean post, when they're
03:07:15 11 getting ready to leave, sir?

03:07:16 12 DR. PHILLIPS: Well, I note on your last
03:07:18 13 slide you said ensure service members are
03:07:19 14 thoroughly briefed before leaving their parent
03:07:22 15 commands.

03:07:22 16 MR. FOREMAN: What I meant by that, sir,
03:07:23 17 before they leave their parent command starting the
03:07:25 18 MEB/PEB process.

03:07:27 19 DR. PHILLIPS: Right. I'm wondering why
03:07:30 20 aren't -- I mean, we hear this everywhere. There's
03:07:30 21 not enough information, they don't know what's
03:07:32 22 going on. Do you have an opinion as to why they're
03:07:35 23 not?

03:07:36 24 MR. NOONAN: I can give you an opinion on
03:07:37 25 that, sir. The --

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03:07:38 1 DR. PHILLIPS: Are they not educated enough
03:07:40 2 to brief them, is it timing, is it --

03:07:42 3 MR. NOONAN: Well, I think it's all of what
03:07:44 4 you said; but the PEBLOs, in a lot of instances,
03:07:48 5 don't know. What we tell people is -- I had a
03:07:51 6 soldier call me from Germany yesterday. He said,
03:07:55 7 "I'm in the MEB process. I don't know what to do."
03:07:57 8 He did not even know what questions to ask. So, in
03:08:00 9 that particular case I believe the PEBLO was not
03:08:04 10 helping that soldier very much. So, I think that's
03:08:08 11 the grass roots right there.

03:08:09 12 MR. FOREMAN: Also, when you talk about
03:08:11 13 PEBLOs -- and everyone who has their slice of pie
03:08:13 14 or land that they to worry about and they're
03:08:16 15 worrying about that land; but -- and I think the
03:08:18 16 social workers had a really good team concept that
03:08:21 17 I saw yesterday. That's great because there's
03:08:23 18 communication across the board, but I always tell
03:08:25 19 people when you're dealing -- you're dealing with
03:08:27 20 several things. And I'll do it real quick here.
03:08:30 21 It's -- you know, VA is a combination of several
03:08:34 22 different languages. You've got medical, you've
03:08:36 23 got legal, you've got federal regulations, rules
03:08:39 24 regulations. I think you mentioned, sir, yesterday
03:08:43 25 you have to be a liaison to liaison. I mean, you

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03:08:46 1 really have to be able to tell them where you need
03:08:49 2 to go and I tell people when they come in my office
03:08:51 3 here locally, in San Antonio you've got English,
03:08:54 4 Spanish and VA. That's what we're going to help
03:08:56 5 you with. And she mentioned it. It's very
03:08:58 6 difficult to navigate through this -- you know,
03:09:00 7 \$500.00 words and legal words and how they relate
03:09:03 8 to one another and when you ask the soldier --
03:09:05 9 Master Sergeant, you brought it up again. If
03:09:07 10 you're going to ask a young soldier yes or no and
03:09:10 11 check a block, well, his natural instinct is going
03:09:12 12 to be no because he's -- he's going to say I'm not
03:09:15 13 sure, no, and then I can't -- there's no
03:09:19 14 repercussions of no. That's what he knows or she
03:09:21 15 knows. So, it definitely goes down to education,
03:09:24 16 sir.

03:09:24 17 CDR CAMPOS: But even in the medical -- even
03:09:26 18 in the Department of Defense and even in the
03:09:28 19 services, some of the challenge -- like the VA is
03:09:32 20 that there's several organizations and I ask the
03:09:37 21 personnel side, the medical side and the people
03:09:39 22 that do family support who owns wounded warriors.
03:09:43 23 You know, you might get a lot of different answers.
03:09:45 24 So, trying to figure out who to go to, you know,
03:09:48 25 and those efforts across health affairs down into,

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03:09:53 1 you know -- you know, other areas of PNR and so on
03:09:57 2 and then down to the services and then some
03:10:00 3 folks -- you know, we know that some of the
03:10:03 4 services think that they can just go into the VA
03:10:05 5 and it's -- and it's -- they're going to be taken
03:10:09 6 care of. So --

03:10:10 7 LT GEN GREEN: I think that that's my cue.
03:10:11 8 Okay. You have to stop. But I do want to thank
03:10:16 9 you folks for coming and talking with us and also
03:10:19 10 for representing our veterans so well and for -- I
03:10:22 11 know a lot of the DAV, you folks have been there
03:10:25 12 for us for years and years; and so thank you so
03:10:25 13 much.

03:10:26 14 MR. NOONAN: You're welcome.

03:10:26 15 MR. FOREMAN: Thank you, sir. And thank the
03:10:26 16 board.

03:10:32 17 LT GEN GREEN: And thank all the services
03:10:34 18 providing for recovering warriors. So, we've been
03:10:36 19 talking to the Disabled Veterans outreach program
03:10:39 20 specialists and with us today are Mr. Dave Gonzales
03:10:43 21 from REALifelines and a representative I guess from
03:10:49 22 Department of Labor, Ms. Frances Desoto. And so
03:10:54 23 we'll see if we can't get the two different panels
03:10:57 24 transitioned and we're sorry that we're kind of
03:11:00 25 running out of time here.

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03:11:00 1 MS. DESOTO: My apologies. We have a very
03:11:03 2 small network here.

03:11:04 3 LT GEN GREEN: I did a rather poor job of
03:11:37 4 introducing you folks. So, if you wouldn't mind
03:11:37 5 introducing yourselves --

03:11:37 6 MS. DESOTO: Yes, sir.

03:11:41 7 LT GEN GREEN: -- and tell us about your
03:11:41 8 programs. Thank you.

03:11:47 9 MS DESOTO: Thank you for having us here
03:11:49 10 today. My name is Frances Desoto. I'm assistant
03:11:50 11 state director for the United States Department of
03:11:53 12 Labor Veterans Employment and Training Service.
03:11:54 13 And this is --

03:11:58 14 MR. GONZALES: My name's David Gonzales. I
03:12:00 15 work with the Texas Veterans Commission. I'm a
03:12:03 16 DVOP. This is a veterans program and I'm the
03:12:07 17 REALifelines representative at Fort Sam Houston --
03:12:09 18 at BAMC.

03:12:11 19 MS. DESOTO: The reason we've chosen to
03:12:12 20 speak to you -- the REALifelines program is not the
03:12:15 21 only program that is staffed by a DVOP or an LVER.
03:12:20 22 An LVER is local veterans employment
03:12:20 23 representative. The reason we've chosen to speak
03:12:24 24 to you today about REALifelines is because that is
03:12:26 25 the program that is staffed by a DVOP and they only

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03:12:30 1 work with wounded warriors. OEF/OIF wounded
03:12:32 2 warriors. So, they -- this is how we're going to
03:12:36 3 specifically talk about the DVOP's role in
03:12:39 4 assisting a wounded warrior from -- directly from
03:12:41 5 the military life to civilian employment. The
03:12:46 6 REALifelines program -- and I should advance
03:12:48 7 that -- stands for recovery and employment
03:12:51 8 assistance lifeline. One of the first steps is
03:12:54 9 obviously recovery. They have to be ready to make
03:12:56 10 that transition from being in physical rehab to
03:13:01 11 being job ready and so we make sure that they're at
03:13:04 12 that point where they're job ready, to be able to
03:13:07 13 focus on being able to work on a resume, being able
03:13:10 14 to figure out exactly what they need to do to
03:13:13 15 achieve that seamless transition. Right now in
03:13:18 16 Texas we have -- oh, program history. This began
03:13:22 17 when our previous secretary of labor, Elaine Chao,
03:13:25 18 went to Walter Reed and she saw the need. She saw
03:13:28 19 a gap and she said, "We've got wounded warrior who
03:13:30 20 are -- need that assistance. That face-to-face
03:13:34 21 interaction with transitioning from military life
03:13:36 22 to civilian employment." So, REALifelines was
03:13:39 23 created in 2004.

03:13:43 24 In Texas we have three sites. Fort Hood --
03:13:45 25 these are major military treatment facilities.

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03:13:49 1 Fort Hood, Fort Bliss and here at SAMMC or Fort Sam
03:13:54 2 Houston. I talk about a seamless transition. Let
03:13:59 3 me tell you why I can use those words effectively.
03:14:02 4 I told you that we have our REALifelines
03:14:04 5 representatives who are stationed on the mil -- at
03:14:06 6 the military bases. So, those three sites each
03:14:09 7 have a REALifelines representative, a DVOP, on site
03:14:13 8 and each of our sites in Texas the REALifelines
03:14:16 9 representative is in -- located inside the soldier
03:14:19 10 family assistance center. So, we are co-located
03:14:22 11 with the transition center, which has been very,
03:14:25 12 very effective; but I say that we can do a seamless
03:14:30 13 transition because we have DVOPs and LVERs
03:14:34 14 nationwide. So, if a person that's receiving
03:14:37 15 treatment at Fort Sam Houston says, "Well, I'm
03:14:39 16 moving to Denver, Colorado," we have the
03:14:42 17 REALifelines representative call DOL -- we partner.
03:14:45 18 They call DOL -- we call the representative in
03:14:49 19 Denver and we say we need the name of one person
03:14:52 20 who can assist this person with the transition from
03:14:55 21 military to civilian. We give that service member
03:14:58 22 one point of contact in Denver, Colorado who's
03:15:02 23 going to help them find employment. So, they're
03:15:04 24 not searching all over every single agency once
03:15:07 25 they get to Denver. They're going to call one

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03:15:10 1 person and that one person, that one DVOP or LVER
03:15:14 2 in Denver, Colorado is going to help them with
03:15:16 3 finding employment. Makes it seamless. And we
03:15:18 4 track. So, if you need tracking information, we
03:15:22 5 can track everything that we've done through our
03:15:23 6 Fort Sam REALifelines program.

03:15:26 7 DR. TURNER: Once again, what's a DVOP?

03:15:28 8 MS. DESOTO: Disabled veterans outreach
03:15:31 9 program specialist and an LVER is a local veterans
03:15:33 10 employment representative. And let me explain what
03:15:36 11 a DVOP does and I will further, but what they do is
03:15:39 12 there's DVOPs in -- not every workforce agency
03:15:44 13 nationwide; but in most state workforce agencies
03:15:48 14 nationwide. There's a DVOP or LVER located in
03:15:51 15 there with the employment representatives. Okay.
03:15:54 16 So, what they do is a veteran can walk up to the
03:15:56 17 front desk at the workforce agency and say, "I'm a
03:15:59 18 veteran and I want -- I need employment
03:16:01 19 assistance." That DVOP or LVER comes to the front
03:16:04 20 and says, "I'm here for you. Let's go work on your
03:16:07 21 resume, let's test you, let's see what your typing
03:16:09 22 skills are, let's see what you need to be
03:16:11 23 successful in your employment search"; and they sit
03:16:15 24 down with them -- they'll even do job development.
03:16:19 25 They'll -- we have a network of local employers and

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03:16:22 1 we know who hires veterans. So, the DVOP can call
03:16:26 2 up that employer and say, "I've got a veteran who
03:16:31 3 has everything you're looking for, can I send him
03:16:32 4 over for an interview"; and they'll interview him.
03:16:35 5 Okay. So, the network with the DVOPs and LVERs is
03:16:37 6 extremely important with the community and here in
03:16:40 7 San Antonio we have one of the strongest networks.
03:16:44 8 I can brag a little bit. But because of the
03:16:48 9 REALifelines representatives at the treatment
03:16:50 10 facilities, once they are -- okay. They're
03:16:55 11 assisting at the military treatment facilities, but
03:16:58 12 the minute they're leaving, they're no longer
03:17:01 13 inside the gate. So, they have to go outside to a
03:17:04 14 DVOP in the field and that's where we have that
03:17:06 15 nationwide network and we can talk about that
03:17:09 16 nationwide network that no one else has and that's
03:17:12 17 one of the reasons that the REALifelines program
03:17:14 18 and the DVOPs and LVERs have been so successful.
03:17:17 19 Nationwide network. Anywhere that service member
03:17:20 20 moves, they're going to get assistance.

03:17:28 21 MR. REHBEIN: Ma'am, I can't sit here and be
03:17:31 22 silent. Have you looked at the number of DVOPs
03:17:34 23 over the last 10 years?

03:17:35 24 MS. DESOTO: It's declined significantly,
03:17:37 25 yes, sir.

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03:17:39 1 MR. REHBEIN: Significantly?

03:17:39 2 MS. DESOTO: Yes, sir.

03:17:39 3 MR. REHBEIN: And it's continuing to decline
03:17:41 4 every year?

03:17:41 5 MS. DESOTO: Yes, sir.

03:17:41 6 MR. REHBEIN: So, when we say a nationwide
03:17:43 7 network, yes, in places like San Antonio and
03:17:46 8 Denver; but that RC component out there -- reserve
03:17:49 9 component, they're challenged. They are really,
03:17:50 10 really challenged in trying to find DVOPs.

03:17:53 11 MS. DESOTO: Yes. And we would love to have
03:17:55 12 more DVOPs in the field. We'll take as many as we
03:17:58 13 can get.

03:17:58 14 MR. REHBEIN: The other challenge here is
03:18:00 15 that the whole program is funded through grants to
03:18:02 16 the states. So, DVOPs and LVERs are not federal
03:18:07 17 employees. They're not Department of Labor
03:18:10 18 employees.

03:18:10 19 MS. DESOTO: Right.

03:18:10 20 MR. REHBEIN: They're State of Texas
03:18:11 21 employees.

03:18:12 22 MS. DESOTO: Yes, they are. The Department
03:18:15 23 of Labor Veterans Employment and Training
03:18:16 24 Services --

03:18:17 25 MR. REHBEIN: There's that extra -- do I

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03:18:18 1 want to use the word "conflict" on how we direct
03:18:21 2 our other resources and get control and I'm -- I
03:18:24 3 want this group to really understand what the
03:18:27 4 administration -- what the financial flow of the
03:18:30 5 administrative structure is in this program. It's
03:18:33 6 an excellent program, but it has challenges.

03:18:35 7 MS. DESOTO: Yes, and I agree with you
03:18:37 8 completely. And he's absolutely right. The
03:18:39 9 grant -- it's funded through the Department of
03:18:42 10 Labor Veterans Employment and Training Service and
03:18:45 11 that is funneled out to the states. I will tell
03:18:47 12 you that Texas is a little different. We're a lot
03:18:49 13 different. The other states it does go directly to
03:18:53 14 the state workforce agencies, the grant does. Here
03:18:55 15 in Texas we've removed that. The grant here in
03:18:58 16 Texas does not go to the state workforce agency.
03:19:01 17 We've had that changed legislatively and it goes
03:19:04 18 directly to the Texas Veterans Commission so that
03:19:07 19 we can monitor what the funds -- we can make sure
03:19:09 20 that priority of service is given to every veteran
03:19:13 21 that receives services. So, we, here in Texas, do
03:19:16 22 audits on every workforce center in Texas. Okay.
03:19:23 23 So -- and I think that --

03:19:23 24 MR. REHBEIN: Texas is one of the shining
03:19:25 25 lights in a lot of places.

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03:19:26 1 MS. DESOTO: Thank you, sir. We would like
03:19:28 2 to think so. Who do we assist with REALifelines.
03:19:32 3 Service members, active duty, guard and reservists.
03:19:36 4 Again, when they're at the military treatment
03:19:40 5 facilities, that's the best time to get in touch
03:19:42 6 with the guard and reservist and make sure that
03:19:44 7 they're receiving that assistance with resumes and
03:19:46 8 interviewing skills and all of those things that
03:19:49 9 are important to set them up for success before
03:19:51 10 they leave the military. So, that's what the
03:19:53 11 REALifelines representatives does before they even
03:19:56 12 leave the gate.

03:19:57 13 MSGT MACKENZIE: Ma'am. So, with that slide
03:20:00 14 you are dealing with these folks in the hospital.
03:20:02 15 Now, this seriously injured person decides --
03:20:05 16 warrior decides to stay on active duty.

03:20:08 17 MS. DESOTO: Yes, sir.

03:20:08 18 MSGT MACKENZIE: You say you track
03:20:09 19 everybody. So, you're saying if you've touched
03:20:11 20 that person, when they are ready to get out and --
03:20:15 21 they're still on your books?

03:20:19 22 MS. DESOTO: When they get out, yes, sir,
03:20:20 23 they're still on the books because we don't -- once
03:20:23 24 you're a REALifelines member, you're a REALifelines
03:20:26 25 member for life. Meaning you will not just see the

03:20:29 1 DVOP at the military treatment facility. We,
03:20:33 2 again, have a nationwide network of DVOPs. So, if
03:20:36 3 you stay in Texas, you will see a DVOP in the state
03:20:39 4 workforce agency to receive that continued
03:20:41 5 employment assistance for the rest of your life.
03:20:46 6 So, they could have one job when they leave the
03:20:49 7 military, lose that job and they can go right back
03:20:54 8 to the DVOP again and the DVOP will help them find
03:20:57 9 a job as many times as necessary.

03:20:58 10 DR. TURNER: So, this is a -- this is for
03:20:59 11 life?

03:21:01 12 MS. DESOTO: For life. Ongoing.

03:21:02 13 DR. TURNER: Do you find many service
03:21:04 14 members that were seriously injured by health care
03:21:06 15 professionals?

03:21:10 16 MS. DESOTO: By -- did I say by health
03:21:12 17 care -- oh, now I remember. They're classified --
03:21:14 18 with all due respect, they're classified as
03:21:16 19 seriously injured.

03:21:18 20 MR. REHBEIN: Only by flight surgeons.

03:21:20 21 MR. DRACH: If I might just add one thing.
03:21:22 22 If the person gets discharged or retired from
03:21:25 23 Randolph Air Force Base and goes to Saginaw,
03:21:27 24 Michigan, that person will be linked with the DVOP
03:21:30 25 in Saginaw.

03:21:32 1 DR. TURNER: Apparently, according to Mr.
03:21:34 2 Rehbein, I guess it's -- the availability is
03:21:38 3 somewhat uneven, is what I interpreted that. Would
03:21:41 4 you comment on that availability of DVOPs across
03:21:44 5 the country?

03:21:45 6 MS. DESOTO: Yes. But that doesn't mean
03:21:46 7 that -- because of websites and such it doesn't
03:21:51 8 mean that we can't put them in touch with a DVOP in
03:21:55 9 that general vicinity and let them talk to them;
03:21:59 10 but also assign them to an employment specialist
03:22:00 11 within the workforce center closest to them. And
03:22:04 12 it's classified as seriously injured by health care
03:22:07 13 professionals. Okay. So -- and they do have to be
03:22:11 14 classified as seriously injured to be able to be in
03:22:14 15 the REALifelines program.

03:22:16 16 Service members are informed of program
03:22:18 17 information. Again, for the person to be in the
03:22:22 18 REALifelines program, they have to want to be in
03:22:25 19 the program. They have to come and they have to
03:22:27 20 enroll. We don't go -- we go and let as many
03:22:30 21 people know about the program as possible. We go
03:22:32 22 to briefings, we do town hall meetings, whatever we
03:22:36 23 can, to let service members know about their option
03:22:38 24 to enroll in the REALifelines program; but no one's
03:22:41 25 forced to. We hope -- we wish that everyone would.

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03:22:44 1 We talk about the REALifelines program in our
03:22:47 2 transition assistance program. We talk about
03:22:49 3 training and placement opportunities with every
03:22:51 4 service member and we have a very strong network
03:22:53 5 and make appropriate referrals. A lot of times --
03:22:57 6 and the previous briefer said this. Service
03:23:00 7 members don't know what questions to ask. So, we
03:23:02 8 educate and inform them on what questions to ask.
03:23:08 9 We provide briefings, again, as I said, such as
03:23:10 10 this, to inform of REALifelines. We talk to the
03:23:14 11 case managers that work with the wounded warriors.
03:23:17 12 Each case manager at BAMC is assigned -- I mean,
03:23:20 13 each service member that's wounded is assigned a
03:23:23 14 case manager and we speak directly with those case
03:23:26 15 managers to find out specifically what the barriers
03:23:28 16 to employment are so that we know what steps to
03:23:31 17 take to make sure that they're successful in
03:23:33 18 employment opportunities. We have direct contact
03:23:38 19 with the Army wounded warrior program and we
03:23:41 20 have -- every branch has their own liaison, so we
03:23:44 21 talk directly with the liaisons to see if there's
03:23:47 22 any other barriers that maybe the service member
03:23:50 23 has spoken with the liaison about and not the case
03:23:53 24 manager. So, we try and cover all bases.
03:23:56 25 MSGT MACKENZIE: What's your connection with

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03:23:57 1 the Air Force wounded warrior program?

03:23:59 2 MS. DESOTO: Wounded warrior program, we
03:24:01 3 deal -- I deal, myself, deal directly with Lackland
03:24:04 4 Air Force Base. They have a very strong program at
03:24:07 5 Lackland and they actually send out fliers every
03:24:13 6 month to all the wounded warriors and we put
03:24:16 7 information in there about the different programs,
03:24:18 8 to let them know; and we have our contact
03:24:21 9 information on there so that they can contact us
03:24:24 10 directly, if they need to.

03:24:26 11 MSGT MACKENZIE: But on a nationwide type
03:24:27 12 deal? I mean, I know you guys just represent
03:24:29 13 Texas; but --

03:24:30 14 MS. DESOTO: Yeah. I'm sorry, I don't know
03:24:32 15 nationwide.

03:24:32 16 MSGT MACKENZIE: -- it's like you don't
03:24:32 17 have -- the only program -- or you don't have one
03:24:33 18 that links up with the Air Force wounded warrior
03:24:37 19 program, which is out at Randolph. So, that's why
03:24:39 20 I was just curious.

03:24:40 21 MS. DESOTO: Yes, sir. And because our
03:24:42 22 military treatment facility's on Fort Sam, it's
03:24:45 23 primarily Marines, Navy and Army that we deal with
03:24:49 24 on Fort Sam Houston. We don't -- we don't have a
03:24:52 25 lot of wounded Air Force on Fort Sam, which is a

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03:26:02 25

very good thing.

MS. DAILEY: We would recommend you go to the Air Force wounded warrior program headquartered at Randolph Air Force Base.

MS. DESOTO: Okay. Thank you.

MS. DAILEY: They spent two days with us and the Department of Labor opportunities never came up in any one of their briefings with us.

MS. DESOTO: And we don't deal with them directly and it could be too that --

MS. DAILEY: They need -- they need this briefing so that their nationwide services to Air Force wounded warriors can link up with your nationwide services for disabled veterans.

MS. DESOTO: I will make that happen. Thank you. Services provided by DVOPs. Intensive employment services. We're talking about case management. Sitting down face to face, finding out what the barriers to employment are, finding out what their goals for the future are for employment and being realistic. Once they've had these injuries, a lot of times they think, oh, I can go back to my civilian employer, I can do the same job I did before; and we need to have those conversations. Also, I'm USERRA. A federal

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03:26:06 1 investigator for USERRA. And so the DVOPs -- the
03:26:10 2 REALifelines representatives know that if they're
03:26:13 3 dealing with a wounded warrior who possibly cannot
03:26:15 4 go back to their civilian employer in the same
03:26:18 5 position, that they know that they need to call me
03:26:20 6 immediately because under USERRA I can possibly get
03:26:23 7 them a reasonable accommodation or a different
03:26:25 8 position within the agency prior to reinstatement
03:26:28 9 so they will get a proper reinstatement. So, we
03:26:31 10 have a very good partnership; but those
03:26:34 11 conversations need to happen about what that
03:26:36 12 service member wants for themselves and what's
03:26:38 13 realistic.

03:26:40 14 We find out -- we let them know about labor
03:26:42 15 market information. What's hot, what's not. And,
03:26:45 16 again, for the region that they're moving to, they
03:26:48 17 might think they're going to make \$100,000.00 and
03:26:51 18 we want to be realistic and say, "Okay, for that
03:26:53 19 area, this is what you're going to make for that
03:26:56 20 position," so they're not blind sided.

03:26:58 21 Career counseling, career guidance,
03:27:01 22 short-term placement. Some of them don't want
03:27:03 23 long-term placements. They just want something to
03:27:05 24 keep them busy for a little while or they might
03:27:08 25 want part-time positions. That's why these

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03:27:10 1 conversations need to happen. Job training, job
03:27:13 2 referral and placement, USERRA. I've already
03:27:15 3 spoken to that. And then, again, the network is so
03:27:19 4 important. So, you have to have a very strong
03:27:21 5 network and we utilize that network.

03:27:25 6 REALifelines services are also available for
03:27:27 7 spouses. Many times the spouses relocate for the
03:27:31 8 wounded warriors here at SAMMC -- BAMC. It's hard
03:27:36 9 to call it SAMMC. The spouses -- the service
03:27:42 10 members are in rehab for up to two to three years
03:27:44 11 sometimes. So, the spouses move here and we
03:27:46 12 provide them with that employment assistance, as
03:27:48 13 well. Caregivers. Sometimes the parents move
03:27:51 14 here, the grandparents. So, we'll assist those
03:27:53 15 caregivers as well. Sometimes there's challenges.
03:27:58 16 We talked about exiting the military. Sometimes
03:28:01 17 they don't want to, you know, and that's where we
03:28:03 18 have to speak realistically with the case managers
03:28:07 19 to say this person wants to stay in the military,
03:28:10 20 is there that option. Because if there is, then we
03:28:13 21 can start working towards the MOS they want to go
03:28:16 22 into. We can start working on training
03:28:19 23 opportunities and building them up to be able to be
03:28:21 24 successful to continue in the military. We can do
03:28:24 25 that as well. But if there's no hope of that, then

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03:28:26 1 we need to do everything that we can to set them up
03:28:29 2 for success when they transition. We are dealing
03:28:34 3 with TBI, traumatic brain injury. We're dealing
03:28:39 4 with PTSD. We're dealing with burns. We're
03:28:41 5 dealing with amputations. All of those severe
03:28:44 6 injuries that have to be taken into account when
03:28:46 7 we're looking at job opportunities and the future.
03:28:52 8 And then what we're seeing a lot -- and I don't
03:28:54 9 know if this has been brought up, but what we're
03:28:56 10 seeing a lot is when they're injured, sometimes
03:28:58 11 they come into a lot of money through Social
03:29:01 12 Security and such and the next thing you know
03:29:03 13 they've got a Viper in the parking lot because
03:29:05 14 they've spent all their money on this expensive
03:29:08 15 car, you know. So, we have to talk to them about
03:29:10 16 those type things and spending their money wisely
03:29:12 17 and taking care of their families and thinking
03:29:15 18 about the future and what impact the employment --
03:29:18 19 what employment opportunities they have. They
03:29:20 20 might actually have to take a pay cut. So, we have
03:29:23 21 to talk about those things and be realistic.

03:29:26 22 The purpose of the program. Respond to the
03:29:28 23 needs of the wounded and injured and their
03:29:30 24 families. One-on-one assistance. You can't put a
03:29:33 25 price on that. One-on-one assistance with finding

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03:29:36 1 employment and finding employment that is suitable
03:29:40 2 for them. That's the key. Any questions?

03:29:47 3 LT GEN GREEN: I really do strongly
03:29:50 4 encourage you to talk with the wounded warrior
03:29:51 5 program over at Randolph.

03:29:53 6 MS. DESOTO: I will. Thank you.

03:29:54 7 LT GEN GREEN: I think that will help.
03:29:56 8 These are the kind of programs that we're looking
03:29:58 9 for to make sure that people -- we do increase
03:30:00 10 their awareness and try to get these things out to
03:30:03 11 the veterans. Can you give me an idea of what
03:30:05 12 you -- how do you decide who's going to -- who is a
03:30:10 13 severely disabled veteran? What do you -- what's
03:30:13 14 your -- where is your cutoff?

03:30:14 15 MR. GONZALES: For the severely disabled?

03:30:16 16 LT GEN GREEN: Uh-huh.

03:30:17 17 MR. GONZALES: Sometimes it can be just
03:30:18 18 apparently obvious when you're looking at them. I
03:30:20 19 deal down there with burn victims, amputees, double
03:30:24 20 amputees, bullet wounds. It's pretty apparent.
03:30:29 21 When I sit down and do my assessment or just when
03:30:31 22 they come in and sit down, I do my assessment, you
03:30:34 23 know, I talk it over with them -- and just to tell
03:30:36 24 you a little bit of my background. I was infantry.
03:30:40 25 So, I kind of know -- have a little bit better

03:30:42 1 understanding where they're coming from. So -- and
03:30:45 2 when I take the information, you know. Also, you
03:30:48 3 know, I also consult with some of the other people
03:30:50 4 they talk to, the case managers, and find out a
03:30:53 5 little bit more about them; but it's -- it's pretty
03:30:56 6 apparent, really, when you're really talking with
03:30:58 7 them. You know, especially when the injuries are,
03:31:01 8 you know, visible.

03:31:02 9 LT GEN GREEN: So, it's based on injuries
03:31:04 10 that you see, not necessarily --

03:31:06 11 MR. GONZALES: Not necessarily. Not
03:31:07 12 necessarily. There's some that you won't see. You
03:31:10 13 -- like -- for example, there's one gentleman that
03:31:12 14 I have -- that I have to talk to sometimes. I have
03:31:15 15 to be very careful when I walk up to him because
03:31:18 16 he'll forget who you are and I can't just approach
03:31:20 17 him just like that because he will step back.

03:31:23 18 MS. DESOTO: There -- as on my slide, there
03:31:24 19 is -- based on classification by health care
03:31:26 20 professionals. So, we make sure that they are
03:31:29 21 receiving case management and they are classified.

03:31:33 22 DR. TURNER: Do you ever have to turn
03:31:34 23 anybody away?

03:31:36 24 MR. GONZALES: No, we don't turn anybody
03:31:37 25 away.

03:31:38 1 MS. DESOTO: We make proper referrals.

03:31:40 2 MR. GONZALES: Disability -- well, myself as
03:31:42 3 a DVOP, I've been in the employment for going on 10
03:31:45 4 years already and I'd say -- I'm down here at SAMMC
03:31:49 5 at the warrior transition battalion; and we never
03:31:52 6 turn anybody away. If they need services --
03:31:55 7 there's the ones that I can put into case
03:31:58 8 management, of course I'm going to do so; but I
03:32:00 9 will never turn anybody away. If there's a service
03:32:02 10 member that needs service, I will take care of
03:32:05 11 them. Now, one thing that I do work with -- it's
03:32:07 12 not necessarily I'm only working with the Army
03:32:10 13 components, since I am at the warrior transition
03:32:13 14 battalion. I also have the same kind of -- I go
03:32:15 15 down with the Marine Corps, I go with the Navy and
03:32:18 16 I do have an open line of communication with Nicole
03:32:21 17 Hart with the wounded warrior project out at
03:32:24 18 Randolph.

03:32:25 19 MS. DESOTO: There you go. He does. Very
03:32:27 20 good.

03:32:28 21 MR. GONZALES: One of the big things with
03:32:30 22 the REALifelines program is partnership. Okay.
03:32:34 23 It's a larger picture. It's not an individual
03:32:37 24 part. I mean, I work with -- just give you an
03:32:40 25 example of some of the people I work with. Mr.

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03:32:42 1 Zachary Gant, which is occupational therapy
03:32:45 2 transition coordinator; and also you have -- you
03:32:51 3 have Mr. Rodney Leonard. He's OPM, office of
03:32:55 4 personnel management. See, we don't take ownership
03:32:57 5 for anybody. As far as saying we don't compete
03:32:59 6 against each other. We compliment each other. We
03:33:02 7 help each other out. Because the overall picture
03:33:04 8 is to provide services to these service members. I
03:33:07 9 can't say soldiers because we don't just service
03:33:10 10 soldiers. If -- I work at a place called the SFAC.
03:33:12 11 It's called the soldier and family assistance
03:33:16 12 center. The thing is we don't just service just
03:33:19 13 soldiers. We service marines, we service people
03:33:22 14 from the Air For -- airmen, we service Navy.
03:33:25 15 Anybody comes in that's a wounded warrior category,
03:33:29 16 we'll provide services to them; but our strong
03:33:31 17 point is our partnership with other departments.
03:33:35 18 The SFAC itself, it has a lot of different
03:33:38 19 components. Okay. Just to give you an example, we
03:33:41 20 have people from education, finance, child care,
03:33:43 21 legal. So, these are the tools that I work with on
03:33:46 22 a daily basis. What I'm doing, I go out there
03:33:49 23 every day -- because I'm basically boots on the
03:33:52 24 ground. I go out there and I make -- and I
03:33:54 25 outreach them. I heard someone ask a question

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03:33:56 1 earlier about the briefings. There's a lot of
03:34:00 2 briefings that go on and unfortunately what happens
03:34:04 3 with a lot of these briefings is they kind of --
03:34:06 4 when you get so many of them so often, it's not
03:34:08 5 that they're paying attention, they just -- there's
03:34:10 6 just so many of them. So, what I do as a
03:34:13 7 REALifelines representative, I'm going to go out
03:34:15 8 there and outreach them one on one, because I
03:34:18 9 already understand this. I'll go out to the
03:34:19 10 formations. I'll go to the formations in the
03:34:21 11 morning for the Army, I'll go to the Marine Corps,
03:34:24 12 I'll go to the Navy, to the Navy musters and I'm
03:34:26 13 going to go make contact with them. It's about
03:34:28 14 relationships and once you get to know these
03:34:30 15 service members, you get to know them a little bit
03:34:34 16 better, you know about their situations. It's a
03:34:35 17 constant -- it's almost a constant you're out
03:34:37 18 there, always outreaching. Making contact not only
03:34:40 19 with the service members, but also the people who
03:34:42 20 have contact with them like their case managers.
03:34:44 21 Their case manager should know these people. I
03:34:47 22 also go to another organ -- another place called
03:34:49 23 the WFSC, the warrior and family support center,
03:34:54 24 down there with Ms. Judith. Now, this is a place
03:34:57 25 where a lot of family members just come together.

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03:34:59 1 Sometimes they have lunch. They have other
03:35:01 2 activities that go on there. Sometimes I'll go out
03:35:04 3 there and outreach them, the family members. The
03:35:06 4 non-medical attendants, the spouses. Because they
03:35:09 5 don't necessarily go to all the briefings, they
03:35:11 6 don't necessarily come to the SFAC all the time;
03:35:13 7 but this is also part of my target group and these
03:35:17 8 are some of the people that also need assistance.

03:35:20 9 MSGT MACKENZIE: Glad you mentioned her name
03:35:22 10 because that's one of the -- Ms. Judith is one of
03:35:24 11 those people that needs to be cloned and issued out
03:35:26 12 to the far corners of the earth. The -- two
03:35:29 13 things. Once again this is the same thing we see.
03:35:31 14 Based on where you are determines what level of
03:35:34 15 service you get. Where pockets in this country
03:35:38 16 will -- unless they happen to run across you guys,
03:35:40 17 will never hear of you. In that instance when
03:35:43 18 someone like myself who discovers those people,
03:35:46 19 what is the entry criteria of the individual who's
03:35:49 20 remained on active duty for multiple years and when
03:35:52 21 they finally do get -- you know, when they do get
03:35:54 22 out and they're just rolling on with their
03:35:56 23 business, they don't have a nurse case manager or
03:35:58 24 one of these entry criteria that you've mentioned
03:36:01 25 in order to qualify them for this process, what do

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03:36:04 1 you guys require in order to enter this process?

03:36:06 2 MS. DESOTO: DD-214.

03:36:09 3 MSGT MACKENZIE: DD-214's not going to say

03:36:11 4 they're seriously injured.

03:36:13 5 MS. DESOTO: Well -- oh, I'm just saying

03:36:14 6 that shows they're a veteran. Okay. Any veteran

03:36:16 7 can receive services at any workforce center --

03:36:21 8 employment services. Specifically with the DVOP.

03:36:23 9 They just have to show that they're a veteran.

03:36:25 10 Now --

03:36:25 11 MSGT MACKENZIE: I was referring more to the

03:36:27 12 lifeline thing rather than DVOP.

03:36:29 13 MS. DESOTO: Right. And maybe I

03:36:29 14 misunderstood your question. So, you're saying

03:36:31 15 when they leave military service --

03:36:33 16 MSGT MACKENZIE: Correct.

03:36:34 17 MS. DESOTO: -- if they have not been

03:36:35 18 enrolled in REALifelines?

03:36:35 19 MSGT MACKENZIE: Correct.

03:36:37 20 MS. DESOTO: They can go to any state

03:36:38 21 workforce agency and tell a DVOP I was injured and

03:36:41 22 that DVOP will know how to assist them, whether

03:36:44 23 they've in REALifelines or not.

03:36:46 24 MSGT MACKENZIE: I guess my question is how

03:36:47 25 do I advise a wounded warrior who was VSI, returned

03:36:50 1 to duty, continued on and to give them a little bit
03:36:53 2 of guidance I mention this REALifelines program?
03:36:56 3 What do I tell him or her in order to get him your
03:36:59 4 direction and get the assistance prior to trying to
03:37:02 5 go to their home state? Going to their home state
03:37:05 6 is not going to find a DVOP person. They may not
03:37:06 7 exist because of the lack of manpower that Mr.
03:37:09 8 Rehbein said. It's probably not good advice for me
03:37:12 9 as a liaison trying to help a wounded warrior.

03:37:14 10 MS. DESOTO: Okay. On our DOL website is
03:37:17 11 the 1-800 number for REALifelines and it gives --
03:37:21 12 there's a REALifelines advisor that can walk them
03:37:24 13 through the steps so that they can receive any
03:37:27 14 assistance for any state that they're going to.

03:37:29 15 MSGT MACKENZIE: Thank you. That's what I
03:37:31 16 was working --

03:37:33 17 MS. DESOTO: It's www.dol.gov/vets.

03:37:39 18 MR. DRACH: And let me just add to, Mac,
03:37:41 19 that as a result of decline in DVOPs and LVERs,
03:37:44 20 there's also been a fairly corresponding decline in
03:37:47 21 the state workforce agencies altogether.

03:37:50 22 MS. DESOTO: Yes.

03:37:52 23 MR. DRACH: 25, 30 years ago there were
03:37:54 24 30,000 people in the state workforce system. Now
03:37:55 25 there's about 18,000.

03:37:58 1 MS. DESOTO: Yes.

03:37:59 2 MR. DRACH: DVOP used to be over 3,000. Now

03:38:02 3 there's less than -- around 2,000. So, there's

03:38:04 4 been a decline in both; but also Congress has

03:38:07 5 enacted legislation that requires any veteran who

03:38:11 6 walks into a state workforce agency to get priority

03:38:14 7 service by anybody in that office. So, if there is

03:38:18 8 no DVOP or LVER, that veteran is still supposed to

03:38:22 9 be assigned to somebody in that agency who's going

03:38:24 10 to provide priority service to that veteran. You

03:38:27 11 may have read about the new gold card that the

03:38:30 12 president announced a couple of weeks ago. Every

03:38:33 13 separating service member is supposed to get this

03:38:35 14 gold card and he or she walks in to a state

03:38:38 15 workforce agency, that gold card is supposed to

03:38:41 16 guarantee priority service and additional services

03:38:45 17 that would not necessarily always be available to

03:38:48 18 the general population walking in; and if you look

03:38:51 19 at -- and in the case of you, if you're looking for

03:38:54 20 somebody to refer one of your people to, you can go

03:38:58 21 to servicelocator.org, I believe it is, and it will

03:39:02 22 connect you to every state. So, if your -- one of

03:39:05 23 your airmen are going back to Saginaw, Michigan,

03:39:08 24 you can go on servicelocator.org, click on

03:39:12 25 Michigan, scroll down, find Saginaw and you can

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03:39:15 1 find the point of contact in Saginaw.

03:39:18 2 MSGT MACKENZIE: Well, it also sounds to me
03:39:18 3 like what ought to be a pretty good recommendation
03:39:22 4 is these individuals that are here that have these
03:39:23 5 services, they probably ought to check in there
03:39:25 6 before they finally retire and move to a small
03:39:27 7 town.

03:39:28 8 MS. DESOTO: Yes, sir.

03:39:28 9 MSGT MACKENZIE: Because the -- probably not
03:39:30 10 a good idea to go back to a small town and try to
03:39:33 11 find this stuff.

03:39:34 12 MS. DESOTO: Yes, sir. And if we can get to
03:39:36 13 them before they transfer, we can give them one
03:39:39 14 point of contact.

03:39:40 15 MR. GONZALES: Can I add a little onto that
03:39:42 16 because the situation of finding a local service
03:39:44 17 rep back in their local area is something that I've
03:39:46 18 done numerous times already. What I do through our
03:39:48 19 national training center -- at VTI they have a
03:39:52 20 national database for DVOPs and LVERs. I use that
03:39:56 21 quite a bit. There's some -- some of the people
03:39:59 22 that -- some service members I deal with that, of
03:40:01 23 course, aren't going to go into case management.
03:40:05 24 Myself, as a DVOP, I'm always an advocate. Always
03:40:08 25 an advocate for the future veteran service members.

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03:40:10 1 Provide as much information as possible. At the
03:40:12 2 very least, what I can do if I do talk to them one
03:40:15 3 on one and I know they're going back home, is try
03:40:18 4 to put them in contact with veteran services. Now,
03:40:20 5 what I've done is that I will pull up the list --
03:40:22 6 and we've looked at it together. So, far I have
03:40:24 7 not run into a situation that there's not someone
03:40:28 8 at least close to their home area and we look at it
03:40:31 9 together and we've searched it and not only that, I
03:40:35 10 just don't give them a number. I'll pick up the
03:40:38 11 phone and call and I'll put them in direct contact
03:40:41 12 with each other, because we try to -- one, it's
03:40:42 13 going to be seamless transition; but also it's also
03:40:45 14 that warm handoff. We don't want to give someone
03:40:48 15 just a number because these are service members
03:40:50 16 and -- I mean, it just -- it's a little bit more
03:40:52 17 care that you put into it. When you've already
03:40:55 18 talked to a service member in their area and you
03:40:57 19 put them in direct contact with the exiting service
03:40:59 20 member -- for one, it means a lot, you know. So,
03:41:02 21 they're very appreciative that I do that for them
03:41:05 22 and, plus, they also have that direct contact once
03:41:07 23 they get back home because once they get linked in
03:41:10 24 with the DVOP or LVER in their area, they're going
03:41:13 25 to be linked into a larger network. Okay. And

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03:41:16 1 also we have also utilized them, just like you
03:41:19 2 mentioned right there, to find out about their home
03:41:21 3 area because sometimes they might be going back,
03:41:23 4 but going back might not be the same place they
03:41:25 5 remember when they joined the service if they've
03:41:27 6 been in like 20 years.

03:41:28 7 MSGT MACKENZIE: And it has -- I mean, like
03:41:29 8 I said, that's commendable. I wish I could send
03:41:32 9 everybody through San Antonio, but that's not the
03:41:33 10 case. So -- but those of us who are trying to
03:41:35 11 assist, we have to find ways to do it and that's
03:41:38 12 that national connection. The what ifs. What if
03:41:41 13 you're not in the great state of Texas, in San
03:41:45 14 Antonio, getting all these people to help you out.
03:41:47 15 So, I just hope that gets briefed. Maybe something
03:41:50 16 to send back up through the chain, their briefing
03:41:52 17 stuff. So, look at the other side too, not just
03:41:54 18 that part; but thank you very much for telling us.

03:41:57 19 MS. DESOTO: Yes, sir. And I'm going to be
03:41:59 20 completely honest. Not all of our REALifeline
03:42:02 21 programs are as strong as San Antonio. So, if it
03:42:05 22 does come down to that and the service member isn't
03:42:08 23 receiving the assistance they need, if you would
03:42:10 24 like to have them call Texas, I'm happy to help
03:42:14 25 them.

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03:42:14 1 DR. TURNER: Let me just try to quantify
03:42:16 2 that. That's very interesting. How many DVOP and
03:42:18 3 LVERs are there in the state of Texas?

03:42:22 4 MS. DESOTO: I don't know.

03:42:23 5 MR. GONZALES: Honestly, I don't know the
03:42:25 6 exact number.

03:42:27 7 DR. TURNER: Roundabout a hundred, 50?

03:42:30 8 MS. DESOTO: No. I think it's upward of
03:42:32 9 200. I'm not positive. I can get that for you.

03:42:34 10 DR. TURNER: Just a window.

03:42:34 11 MS. DESOTO: Yes, sir.

03:42:35 12 DR. TURNER: I -- it would just be very
03:42:37 13 interesting to me to see the numbers per state.

03:42:37 14 MS. DESOTO: Yes, sir.

03:42:40 15 DR. TURNER: Just because we have to -- you
03:42:41 16 guys are the dream. It would be interesting to see
03:42:45 17 what the reality is across the country and just
03:42:49 18 because we have to look at it from the whole thing;
03:42:53 19 but anyway, thank you so very much.

03:42:56 20 LT GEN GREEN: I think it's appropriate that
03:42:57 21 we end on you guys being the dream. Okay. And so
03:43:02 22 I'm afraid that some of these folks have flights
03:43:05 23 within the next two hours. So, we're going to have
03:43:07 24 to end the discussion and folks can talk privately;
03:43:10 25 but we thank you for coming and talking with us

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03:43:12 1 today. And for all the task members, it's been fun
03:43:14 2 to come together down here in San Antonio, our
03:43:17 3 first off site; and so I'm going to call an end to
03:43:19 4 the meeting and say thank you all for coming and
03:43:22 5 thank you all for coming. And with that, we're
03:43:24 6 adjourned.

03:43:27 7 (Meeting concluded at 3:43.)

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3 I, SHAN MORRIS BLANCHARD, Certified
 4 Shorthand Reporter in and for the State of Texas,
 5 do hereby certify that I was employed to and did
 6 report in shorthand the proceedings at the meeting
 7 of the Recovering Warrior Task Force and that the
 8 foregoing pages of typewriting were prepared under
 9 my direction and contain and constitute a full,
 10 true, and correct transcript of my shorthand notes
 11 taken at said time and place and reflect to the
 12 best of my skill and ability an accurate record of
 13 the subject proceedings.

14 WITNESS MY HAND AND SEAL OF OFFICE
 15 this the _____ day of _____,
 16 A.D. 2011.

21 mjc

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 Certified Shorthand Reporter
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