UNITED STATES DEPARTMENT OF DEFENSE

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

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WEDNESDAY
FEBRUARY 22, 2012

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The Task Force met in the Washington Ballroom in the Crown Plaza Hotel, 901 N. Fairfax Street, Alexandria, Virginia, at 8:00 a.m., Lieutenant General Charles Green, DoD Co-Chair, and Suzanne Crockett-Jones, non-DoD Co-Chair, presiding.

MEMBERS PRESENT
LT GEN CHARLES GREEN, Co-Chair
SUZANNE CROCKETT-JONES, Co-Chair
JUSTIN CONSTANTINE

CSM STEVEN D. DeJONG
CAPT CONSTANCE EVANS
MSGT CHRISTIAN MacKENZIE
KAREN MALEBRANCHE
STEVEN PHILLIPS, MD
DAVID K. REHBEIN
MG RICHARD A. STONE, MD

RUSSELL A. TURNER, MD

ALSO PRESENT
CAPT BERNIE CARTER, Director of the Navy Safe Harbor
NORA CLOUSE, Program Analyst in the Office of Strategic Outreach
COL DONALD A. GAGLIANO, Executive Director, Vision Center of Excellence
LCDR JON JEFFREYS, JAG/Legal Officer
COL LENARD KERR, State Surgeon, Joint Forces Headquarters Iowa National Guards
MERISSA LARSON, Strategic Support Officer
MARY LAWRENCE, MD, MPH, Deputy Director, Vision Center of Excellence
DERENDA LOVELACE, Case Management Nurse Consultant in the Population Health, Medical Management and Patient Centered Medical Home Division, Office of the Chief Medical Officer, TRICARE Management Activity
KEVIN McDONNELL, Director of the SOCOM Care Coalition
CHARLES E. MILAM, Principal Director for Military Community and Family Policy
LT DAVID NORIEGA, Operations Officer
VIRGINIA M. PAGANELLI, RN, MSN, MEd, CCM Spectrum Healthcare Resources Contractor Program Case Manager, Navy

Bureau of Medicine & Surgery
MICHAEL PARKER
LTC MARY PARMENTER, R3SP Branch Chief, Joint Forces Headquarters Iowa National Guard
LTC TIMOTHY PENDERGRASS, Health Staff Officer at the Office of the Army Surgeon
ROBERT POWERS, CORB PEB

GINNEAN QUISENBERRY, Director of the Population Health, Medical Management and Patient Centered Medical Home Division, Office of the Chief Medical Officer, TRICARE Management Activity
MAJ PATRICIA SMITH, Med Surgical Nurse and AMEDD Operation, Joint Forces

Headquarters Iowa National Guard
CDR DAVE WEBSTER, BUMED WII Office

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

2 8:00 a.m.

3 LT GEN GREEN: Good morning

4 everybody. So we're going to begin today with

5 our public forum section of the meeting. With

6 us this morning is Mr. Michael Parker. You

7 can find his information in Tab H.

8 Mr. Michael Parker, please step

9 forward. Thank you.

10 MR. PARKER: Good morning. We are

11 in a vicious cycle where Congress enacts

12 legislation to protect wounded warriors only

13 to have the military invent ways around these

14 laws to avoid paying disability benefits.

15 A great example is when a Physical

16 Evaluation Board deems that an unfitting

17 condition existed prior to service or is EPTS.

18 Such determinations can deny DoD disability

19 benefits.

20 Federal law now mandates that DoD

21 and VA follow the same rules on EPTS

22 determinations. However, there have been

multiple examples under the Integrated Disability Evaluation System where the VA has service connected a condition but the DoD did not. This is because DoD is blatantly ignoring the law.

I outlined a very specific example of the situation to Mr. Campbell who is the Deputy Assistant Secretary of Defense for Wounded Warrior Care and Transition Policy. A copy of that email was included with this statement. I ask that you please read it and demand that DoD account for disability cases where the VA service connects a condition but the DoD does not.

Another example of these issues involves the fit but unsuitable determinations. In the last two years Congress passed laws that prohibit administrative separations and denials of reenlistment due to conditions that a Physical Evaluation Board found to be fitting. I have several examples of the Navy simply blowing

1 off these laws.

2 Enclosed in the statement that I

3 gave you this morning is a letter from I.T.

4 Blanchard to his congressman. He was found

5 fit for a medical condition by his PEB only to

6 be told he could not reenlist if the condition

7 caused him to fail his overseas screening.

8 Another Navy member was found fit

9 by his TDR Review Board only to be denied

10 reentry in the service. Please take a deep

11 look into these fit but unsuitable laws that

12 are being ignored, especially by the Navy.

13 The Disability Evaluation System

14 has a deeply embedded culture that feels that

15 an individual who is not injured doing

16 military activities is not worthy of DoD

17 disability benefits. This workman's

18 compensation view of the DES is erroneous.

19 By law the DES provides disability

20 coverage and just like disability coverage

21 provided to other federal employees, it covers

22 all disabilities incurred in service absence

fraud or gross negligence.

I ask that the Task Force make efforts to change the broken culture of the Disability Evaluation System so that those who become disabled in service are properly compensated.

Pending your questions, that's my statement.

LT GEN GREEN: Give us just a second to digest a couple of things you've given us. Okay?

MR. PARKER: All right, sir. Take your time.

LT GEN GREEN: Can you give us any idea how often the VA grants disability for something the service has actually said was existing prior to service?

MR. PARKER: Well, it has happened a lot of time over the years. I think another great example, if anybody wants to take a deep dive into this, one of the laws that got passed recently by Congress was the expansion

1 of what's called the Disability Review Board.
2 That's been on the record since
3 1944 and it allows people who are discharged
4 for disability but were not given benefits an
5 opportunity to have a review of that
6 situation.
7 Up until last year that board was
8 limited to officers only but a change in the
9 2011 NDA extended that to all members. Next
10 week on the 29th Phil Riley, who is a retired
11 06 Silver Star winner and now works for the
12 Wounded Warrior Project, and I are going to be
13 representing a gentleman named Cory McDonald
14 at the very first Disability Review Board the
15 Navy has ever done in recent memory and
16 certainly the first one an enlisted member has
17 ever had.
18 He was found to have EPTS and
19 thought aggravation and immediately rated by
20 the VA for the condition that he incurred in
21 the Marine Corps basic. He was given a line
22 of duty yes by his command. His Medical

1 Evaluation Board said that his condition did
2 not exist prior to service in terms of the
3 nerve damage.
4 Again, the VA rated him
5 immediately a 40 percent. Yet, the Navy just
6 said it's EPTS and thought aggravation without
7 any explanation. We are going to now take
8 that issue now that we can go to the Board for
9 enlisted members.
10 If you all kind of want to
11 understand the grassroots issues here in terms
12 -- you see, DoD has always had great policy on
13 these things. DoD gets great grades on that.
14 They get poor grades on oversight and
15 enforcement from my perspective.
16 If they had been following these
17 laws back in 2003, and these things go back to
18 at least 1996 when that DoDI was published,
19 these issues would not be here. Again, great
20 policy but lack of enforcement and oversight.
21 I could certainly probably find you lots of
22 those. I mean, there's tons of them but you

1 would have to kind of go out to the network
2 and find them.
3 In terms of the IDES, though, I
4 think it would be fairly simple to go back to
5 DoD and say, "Okay, just find me the ones
6 where the military said EPTS." Then look at
7 those and if the VA rated it because they
8 service connect it, just shuffle those to us
9 so we can get a good look as to why there's a
10 delta because there really shouldn't be.
11 Absent the VA making a blatant
12 error on their service connection call, there
13 should be no difference. If one is saying yes
14 and one is saying no, there's a problem.
15 LT GEN GREEN: So I guess the only
16 question I would have with the IDES are you
17 certain that people with existing prior to
18 service have to go through the IDES?
19 MR. PARKER: Yes. Yes, they do.
20 They are identified as having a condition that
21 doesn't meet retention standards. That
22 triggers a MEB. If the MEB confirms that they

1 have a condition that will potentially make
2 them unfit they go to a PEB. Then the PEB
3 makes the call as to what is fitting or not
4 fitting as well as whether or not the
5 condition is compensable or not.
6 Once they deem somebody unfit,
7 then it rolls back to the VA who, by the way,
8 is now doing most of the medical exams through
9 the compensation and pension exams that they
10 are doing at the IDES. It goes back to them
11 for rating. Then the rating goes back to the
12 PEB and the PEB applies those ratings to the
13 conditions they found unfitting.
14 In this particular case -- and
15 it's a case I'm helping an individual on so if
16 you want deeper details, I can certainly
17 provide them -- they said the condition
18 existed prior to service, yet the VA rated it
19 at 20 percent.
20 LT GEN GREEN: Okay.
21 MSGT MacKENZIE: The only question
22 I had, Mr. Parker, these conditions you are

1 specifically addressing, were they the primary
2 reason for entering into the IDES? In other
3 words, at times the VA finds
4 conditions/service connected, but yet those
5 are not why the military put you through a
6 Physical Evaluation Board or the IDES.
7 MR. PARKER: In the cases I'm
8 aware of, that is true. Cory McDonald was
9 found for one condition and that was his nerve
10 condition that he was booted out for. The
11 other gentleman it was ankylosing spondylitis
12 which was the condition he was pushed out for.
13 By the way, he got 100 percent by the VA for
14 PTSD and the DoD did not find that to be
15 unfitting so that's another thing that makes
16 your eyeballs raise.
17 It's really kind of moot because
18 if they are put in front of a PEB and the --
19 you know, this whole thing about the primary
20 condition being the reason for them going is
21 a big issue within itself.
22 If you are thrown to a MEB, the

1 MEB is required to cover all conditions with
2 full clinical data because a combination of
3 those conditions can make you unfit as well
4 even if a single one is unfitting by itself.
5 In such cases, those ones that contribute are
6 suppose to be rated as well.
7 To me it's somewhat moot as to
8 whether it was primary or not. It was a
9 condition that was found not to meet retention
10 standards and found unfitting by the PEB in
11 regards to whether or not it was the one event
12 that triggered the process to begin with.
13 MSGT MacKENZIE: Did I ask that
14 correct, sir? I know like for mine there are
15 other conditions that the VA will find but
16 they weren't unfitting by the military.
17 MR. PARKER: And just to be
18 crystal clear, these are conditions the PEB
19 found to be unfitting, unfitting but EPTS. If
20 they had no other conditions, they are leaving
21 anyways. They get a stamp that says separate
22 without benefit.

1 MSGT MacKENZIE: Thank you, sir.
2 LT GEN GREEN: Okay. Thank you,
3 sir. We appreciate.
4 MR. PARKER: Thank you very much.
5 MS. DAILEY: We have a second
6 individual participating in the public forum.
7 PO2 DEMUNNIK: Good morning
8 General and staff. My name is Petty Officer
9 DeMunnik. I am an Active Duty Sailor speaking
10 to you today because I am what is commonly
11 referred to as a fit but unfit case.
12 I am here to talk about my issue
13 and in no way represent the Department of
14 Defense. I enlisted in December of 2006 and
15 during that time I have earned numerous
16 awards. I have been promoted in rank twice
17 and was the number one pick for the highly
18 competitive public affairs designator.
19 While preparing for my commission
20 at OCS I was diagnosed with celiac disease and
21 dropped from training. Because of a medical
22 condition, although I'm able to do my job, I

1 am no longer considered deployable. I went
2 through the PEB process and was found fit.
3 I was unable to negotiate for
4 orders at that time because I was informed I
5 would not be eligible for reenlistment. In
6 December 2011 my case was finally re-
7 adjudicated and PERS recommended to SECNAV
8 that I be found medially unfit for continued
9 Naval service. The recommendation was denied.
10 Unfortunately, I am a classic
11 example of fit but unfit, and even Navy
12 Personnel Command has recognized this and
13 after extensive review made a recommendation
14 for medical discharge based on Section 1214 of
15 Title 10 U.S. Code.
16 I was on the fast track until a
17 disease I had no control over destroyed my
18 career. I joined to serve my country. I
19 looked forward to telling the Navy story as a
20 deployed officer. Instead I stand before you
21 asking for justice.
22 By continuing to deny medical

1 discharges in fit but unfit cases, the Navy is
2 ignoring the intent of the NDA-11 and 12 and
3 will set a precedent. The Navy will continue
4 its practice of unfair treatment of Sailors
5 unless you step in and use your influence to
6 correct the record and force the Navy to abide
7 by the intent of the law.
8 Pending your questions, that
9 concludes my statement.
10 LT GEN GREEN: Just for
11 clarification, on the original PEB you were
12 found fit for duty? Is that what you said?
13 PO2 DEMUNNIK: Yes, sir.
14 LT GEN GREEN: Returned to duty
15 and then the next time you were unfit for
16 service in December of 2011. Was that another
17 PEB?
18 PO2 DEMUNNIK: No, sir. What
19 happened was in October of 2010 the PEB came
20 back and I was fit for service. I had to
21 undergo a second duty screening which I failed
22 and I received an email from my detailer

1 saying, "I was not able to negotiate your
2 orders." I was going to have to take hot fill
3 orders because I was not eligible for
4 reenlistment.
5 While PCS'ing from San Diego to
6 D.C. for my new set of orders, I learned that
7 the law required a re-adjudication of my case
8 and I requested re-adjudication for the next
9 nine months. It was finally granted in
10 December of 2011. I was going back and forth
11 with PERS.
12 After extensive review they made
13 the recommendation that, yes, I was, in fact,
14 fit to do my job but no longer deployable and,
15 therefore, under the law should be granted a
16 medical discharge, sir.
17 LT GEN GREEN: They didn't do a
18 medical discharge?
19 PO2 DEMUNNIK: Because of the way
20 the re-adjudication process had been decided,
21 PERS made the recommendation to SECNAV and the
22 Secretary of the Navy denied the

1 recommendation. They said that I did not meet
2 the guidelines for fit but unfit medical
3 discharge. I have that paperwork with me,
4 sir, if you would like to see it.
5 LT GEN GREEN: Yes, I would like
6 to see it. Thanks. Have you gone to the
7 Board of Correction and Military Records,
8 BCMR?
9 PO2 DEMUNNIK: No, sir. I'm still
10 in the process -- Mr. Parker, I believe I'm
11 not eligible for that yet?
12 MR. PARKER: I am assisting her on
13 her case. A situation that she probably
14 didn't make clear is the fact she's an E5 and
15 she has lost her PTS which in the Navy gets
16 you the ability to reenlist. In essence what
17 happened she is being timed out.
18 They are not going to deny her or
19 kick her out because of the law, but if they
20 don't let her reenlist, by the end of this
21 year she'll have to leave because they won't
22 allow her to reenlist so it's a time out type

1 of situation to avoid the disability
2 compensation.
3 She truly is unfit. She can't
4 deploy. Very restricted diet and things like
5 that. Either they should keep her in and keep
6 her competitive for promotion, which is not
7 happening. The paperwork that she'll give you
8 will see her Admiral sent she is not
9 competitive for promotion because she can't do
10 sea duty and all the other things she needs to
11 make rank.
12 In terms of the ABCMR she
13 technically could go there. The problem with
14 the ABCMR is that it operates on the
15 presumption that the government did everything
16 right and you've got to prove it wrong. You
17 don't get a formal board there. You just
18 submit a package and they adjudicate it based
19 on that.
20 I would recommend that her next
21 step, and we are still trying to resolve this
22 while she's on Active Duty, is to go to the

1 same board I spoke about which is the
2 Discharge Review Board where she is going to
3 be separated because of the impact of this
4 condition without benefits.
5 That Board is much more robust.
6 It has two doctors on it, five people, a
7 voting board. You get to go in front of it
8 and get your issues addressed. I would say
9 it's complicated but it's not. The fact is,
10 you know, the deployability alone should make
11 her unfit.
12 It goes back to my point that DoD
13 put out a policy in '07 that said
14 deployability could be the sole reason for
15 finding people unfit and none of the services
16 have implemented that DoD direction and DoD
17 has done nothing to enforce it. That's kind
18 of your root cause of this issue. Thank you.
19 LT GEN GREEN: Just one more
20 clarification. You started the story with
21 being selected for OCS as a public affairs
22 officer. How long have you actually been in

1 the military?

2 PO2 DEMUNNIK: I've been in the

3 military for just over five years, sir. I was

4 selected for commissioning and because of the

5 disease diagnosis I was dropped from training

6 and I am no longer commissionable.

7 LT GEN GREEN: Selected for

8 Commissioning in what year?

9 PO2 DEMUNNIK: I was selected in

10 -- I left in March of 2010, sir.

11 LT GEN GREEN: All right. The

12 timing makes more sense to me now. Thank you.

13 PO2 DEMUNNIK: Thank you, sir.

14 LT GEN GREEN: Thank you.

15 Just a comment. This is a good

16 case for the Discharge Review Board. I agree

17 with your adviser that you need to take this

18 to the Discharge Review Board.

19 MSGT MacKENZIE: Point of

20 clarification. It's actually the Disability

21 Review Board.

22 LT GEN GREEN: Right. I understand.

MS. CROCKETT-JONES: At this time I've got to check our time. Do we have any internal business or further public forum? Do you have anything you need us to --

MS. DAILEY: I haven't been overrun by individuals who are ready to go to Norfolk on the 12th and 13th. I know you're busy. Don't forget to give me your names if I need to put you on the list for Norfolk. I've got some declinations. I know you guys who are ready to go are just holding back checking your calendars a little more.

MS. CROCKETT-JONES: All right then. Barring other internal work, are the folks from Iowa ready a little early?

MSGT MacKENZIE: It doesn't look like it. We might have a little extra time here.

MS. CROCKETT-JONES: Okay. Then let's give everybody five minutes and we'll figure out what we're doing.

(Whereupon, the above-entitled

1 matter went off the record at 8:17 a.m., and
2 resumed at 8:34 a.m.)
3 MS. CROCKETT-JONES: Thank you
4 all. We will now have Colonel Lenard Kerr,
5 the State Surgeon from the Iowa National Guard
6 Joint Force Headquarters brief us. We weren't
7 able to make a planned visit this year but I
8 know we haven't quite taken that completely
9 off the table. We are happy that you can talk
10 to us here today to help us decide how we are
11 moving forward and give us your information.
12 The other briefers who are here
13 are listed in the agenda and we will rely on
14 you all to introduce yourselves. The
15 information is in Tab I.
16 I'll turn it over to you, Colonel
17 Kerr.
18 COL KERR: Thank you. Good
19 morning. Again, I'm Colonel Kerr, the State
20 Surgeon for the Iowa Army National Guard
21 comprised of approximately 7,700 troops. With
22 me today is my health service support director

1 Lieutenant Colonel Mary Parmenter, my Deputy
2 State Surgeon Major Patricia Smith.
3 We'll be briefing you on the
4 effectiveness of policies and program
5 supporting our recovering warriors. Does
6 anybody have any questions before we get
7 started?
8 Lieutenant Colonel Parmenter.
9 LTC PARMENTER: Thank you. Good
10 morning, ladies and gentlemen. First of all,
11 I would like to go over some of the
12 demographics of Iowa. Our force is about just
13 slightly under 9,500, both Army and Air.
14 About 7,400 of those are Army National Guard
15 which is what we really are focusing our brief
16 on today.
17 Last year we had a large
18 population that redeployed from Afghanistan as
19 we had a BCT that was in theater. Just
20 slightly under 3,000 soldiers redeployed last
21 year. The majority of the issues that we'll
22 talk about in this briefing are relating to

1 those soldiers returning from Afghanistan.
2 The deployment cycle for this
3 coming year, or this current year, you can see
4 is much less, around 200 soldiers who will be
5 deploying. Of those soldiers that have
6 deployed previously, we still have about 99
7 soldiers in a WTU or CBWTO. Open cases in
8 ECASE we have over 3,000 open ECASE issues
9 that affects over 2,200 soldiers in the state.
10 The end result of that is our
11 medical readiness is at 64 percent and
12 declining. We don't anticipate it leveling
13 out until sometime around the one year re-
14 deployment from the BCT which will be about
15 the end of July. Then we'll restart the PHA
16 cycle and we should start leveling out at that
17 point.
18 Of note here the ECASES that I
19 talked on the previous slide, the 2,264
20 soldiers, over 600 of those are behavioral
21 health issues. Then the balance would be
22 medical.

1 Also I would note here that 850 of
2 these soldiers are currently assigned to the
3 second BCT that deployed to Afghanistan. What
4 makes that noteworthy is if there's 2,264
5 soldiers with open ECASE issues and ongoing
6 medical issues and only 850 of those are
7 isolated to the BCT, when we reset and
8 soldiers went back to their units of
9 assignment, now the problem went from one
10 comment throughout the entire state. This is
11 a statewide issue for us.
12 The programs and services that we
13 identified here in this slide, I don't know
14 that they are dramatically different than
15 other states but I did want to highlight a
16 couple of things here. Our state sends up a
17 White Cell for all inbound and outbound
18 soldiers into theater.
19 We also conduct the Yellow Ribbon
20 1 event. At that Yellow Ribbon 1 event we
21 focus on doing surveys with the soldiers of
22 what they believe their medical and behavioral

1 health issues are.

2 We also have their family members

3 fill out those same surveys and do a

4 comparison of that data to see if we are

5 getting a true picture and provide the best

6 resources to them. At the Yellow Ribbon 2 we

7 continue to do behavioral health screens in

8 addition to the PDHRAs.

9 Our previous deputy state surgeon

10 she started doing weekly MEDSYNC meetings with

11 the BCT while they were in theater. We've

12 continued to do that and we've refined that

13 process so that over the course of a month we

14 would spend one week's meeting covering WTU

15 soldiers and their issues and how we can

16 integrate into that process to bring them back

17 into our state more effectively and

18 efficiently.

19 We focus one week on medical

20 readiness to try to increase our ever-failing

21 falling numbers. Then we focus one week on

22 training of systems and processes and we

1 really focus on the administrative side of
2 that with LODs and INCAPS and different
3 processes to help the overall medical
4 readiness.
5 The state of Iowa, the Deputy
6 State Surgeon, she also is actively involved
7 with the WTUs and the case managers at those
8 sites in hopes that we'll get soldiers back in
9 better shape than what we are sending them to
10 the WTU.
11 One of the other initiatives that
12 we do in Iowa is all soldiers if they are an
13 individual deployer or a soldier returning to
14 from a WTU we do a walk-through reverse SRP
15 where they do a PHA and get processed through
16 all the different offices to make sure that we
17 identify all their issues up front in hopes to
18 get them back in a readiness category.
19 MSGT MacKENZIE: Ma'am, can I ask
20 you a question?
21 LTC PARMENTER: Yes.
22 MSGT MacKENZIE: You made the

1 comment that you get your soldiers back -- you
2 hope you get your soldiers back better than
3 when you sent them. Is that saying there's
4 been a problem with getting them back better
5 than the way you sent them?
6 LTC PARMENTER: Absolutely.
7 Colonel Kerr will cover that as we get into
8 the briefing but good point. Yes, we get them
9 in often times the same status that we sent
10 them in terms of medical readiness or worse.
11 MSGT MacKENZIE: Thank you.
12 LTC PARMENTER: Yes. There are a
13 couple of hidden slides, one that goes over
14 the WTU process and the lengthy process to get
15 a soldier into the Warrior Transition Unit, as
16 well as the Medical Board process that would
17 take a soldier out of service due to medical
18 reasons. I won't go through those. Really
19 the take-away is that it's a very cumbersome
20 process. I think there are many ways that
21 these processes could be refined.
22 MSGT MacKENZIE: Let me ask you

1 another question on that. One of the things
2 that I think we've seen in several areas was
3 lots of communication from the state to the
4 WTU/CBWTU if you send them there, but their
5 discharge out of WTU/CBWTU that communication
6 is not the same. Do you guys find that to be
7 a situation in your state as well?
8 MAJ SMITH: Yes, we do. We send
9 them to the WTU for the reason to get them
10 fixed and they come back without being fixed.
11 They should be coming back either fit for duty
12 or have a Med Board while they are there and
13 they don't get that while they are there.
14 That's what we're finding.
15 CSM DEJONG: Further along with
16 that, what about the soldiers that are
17 actually Med Boarded out of the WTU? Is there
18 any coordination back to your state? I know
19 in our state we don't have it and we are
20 actually losing soldiers off of our rosters
21 because they get handed a DD214.
22 There is no coordination from the

1 WTU or CBWTU that we have discharged a soldier
2 on the Med Board and then they kind of
3 disappear. Along with that disappearance is
4 the added frustration of flipples and the rest
5 of losing equipment.
6 LTC PARMENTER: Major Smith, we'll
7 get into that in a little bit. Personally,
8 I've only been back from deployment about
9 seven months. I've not encountered that but
10 the communication loop isn't real clean on the
11 front end. While they are there I'm sure
12 we're in the same boat.
13 CSM DEJONG: I know on your last
14 slide you mentioned Yellow Ribbon 1 and Yellow
15 Ribbon 2. Most of the states have followed a
16 standard Yellow Ribbon Program. What we are
17 finding across the board is that a lot of them
18 are doing soldier and family surveys that
19 first Yellow Ribbon day back, maybe the second
20 Yellow Ribbon Program back.
21 What we are finding is that -- I
22 would like to get your opinion on it -- is

1 that too early? What we are seeing is that is
2 still the honeymoon stage for the families and
3 a lot of these behavioral health issues are
4 not showing up until much, much later in the
5 course of it.
6 We really don't have a good answer
7 and I would welcome some feedback as to what
8 would be the right time. Should we do this
9 again because we know we've got a one-year
10 reset. Should we do this again in eight
11 months, 10 months, a year, and see where we
12 are from there.
13 LTC PARMENTER: I agree that those
14 may very well be early but they are good
15 indicators to start the ball in motion to get
16 assistance for families. Colonel Kerr will go
17 through a recommendation that will touch on
18 that one year roughly re-deployment. He has
19 a recommendation that he will cover.
20 MR. PARKER: Ma'am, you mentioned
21 a lengthy process. Do you have any -- can you
22 give us any idea of how long, months, a year,

1 to get into the WTU?

2 LTC PARMENTER: To get into the

3 WTU? Well, our frustration in Iowa was really

4 at the very beginning that soldiers were not

5 adequately screened at the demob station. Of

6 3,000 soldiers from Iowa and around the nation

7 that deployed with the BCT we had eight

8 soldiers that were screened and found eligible

9 for entrance into the WTU.

10 Through statistical analysis going

11 into the deployment in preparation for the

12 demob station we anticipated that number being

13 around 300 to 500. Our numbers are

14 significantly different than maybe how other

15 states have worked that.

16 We went through an aggressive

17 campaigning with different entities to get our

18 soldiers eligible to go back into an MRPE

19 status to get that evaluation. Then we

20 further struggled with the lack of bed

21 capacity at the WTUs.

22 Of those 300 to 500 soldiers that

1 were estimated that needed to go into a WTU,
2 we were successful in getting 79 soldiers back
3 on through the course of the end of July to
4 probably the end of September. While this was
5 going on they were falling off of their
6 terminal leave from their Title 10 orders and
7 all kinds of other things were going on.
8 Lengthy might not sound -- you
9 know, a year sounds like a long time but when
10 you're in the throes of things two months is
11 an eternity.
12 MSGT MacKENZIE: Who did your
13 screening? Was it a contract?
14 LTC PARMENTER: I cannot answer
15 that. I was actually redeploying.
16 Do you know who did the rescreens
17 at McCoy?
18 MAJ SMITH: There were some
19 contractors but most of them were National
20 Guard soldiers or U.S. Army Reserve soldiers
21 that were assigned to Fort McCoy contracted to
22 work there.

1 LTC PARMENTER: The nonmedical
2 care case management, our Health Services
3 section, works with the returning warriors
4 with the standard programs, NCAB, LODs,
5 entrance into the Title 10 programs, emergency
6 care packets, MEMSO preauthorizations to
7 include those that are tied to LODs or those
8 that are tied to PDHRAs.
9 We also have a services branch
10 within the state and this right here lists
11 several of the resources that are available.
12 Then of note is the last bullet here that day
13 to day the unit full-time manning is
14 responsible to do case management for these
15 2,264 soldiers in the Iowa National Guard so
16 lots and lots of things going on.
17 If there are no further questions
18 of me, I'll be followed by Major Smith.
19 LT GEN GREEN: Can you give us a
20 range of medical conditions? You said 600
21 that have behavioral health. That leaves
22 roughly 1,600 with other types of problems.

I don't need specifics but I'm wondering what kinds of things you're dealing with.

COL KERR: The majority of the breakdown really hasn't changed nationally. It's orthopedic followed by behavioral health followed by general medical issues from -- well, still really a majority of it would be orthopedic from carpal tunnel to back is probably our leading to lower extremity, ankle pains, hip pains.

The orthopedic breakdown is by far our highest medical returning deployment issue starting with back and then going on down from there.

MAJ SMITH: Good morning. How do we manage the care and the transition of the National Guard? First thing we do is I am the new DSS for the state and I have taken Colonel Sutton and she has been very, very thorough in getting into the WTU tracker and keeping track of where our soldiers are.

If we notice that something is not

1 right with the soldier whether their orders
2 are coming up that will soon be ending, we get
3 in contact with the soldier or we contact the
4 case manager that is handling that soldier and
5 we find out what is going to happen from here.
6 We do see where soldiers are medically boarded
7 out or whether they are going through a board
8 process.
9 We do have eyes on that but we
10 don't actually get -- if we can contact the
11 soldier, we contact them but there are
12 sometimes that we can't get hold of the
13 soldier or the soldier calls us and says,
14 "This is what I'm going through right now,"
15 and they are frustrated because of the care.
16 They don't think they are getting what they
17 need.
18 We do open up a case, an ECASE. I
19 think you are all familiar with Med Chart, how
20 we keep track of all our soldiers that have
21 medical problems. We keep them in there on an
22 inactive status and we keep them there on an

1 inactive status until they return to the state
2 and go through that reverse SRP.
3 If they are found fit for duty
4 there, we close the ECASE out. If they were
5 not completely fixed while they were at the
6 WTU, then we close that case there and we open
7 it up and then our case managers that work
8 with the individual, we have a case manager
9 for the BCT and we have a case manager for the
10 troop command and the respective case manager
11 takes up their case then.
12 MS. DAILEY: Ma'am, do you have
13 numbers or is it further down on the slide of
14 those WTU individuals who have come back to
15 you and then you have replaced them on a case
16 management requirement?
17 MAJ SMITH: No, we don't.
18 MR. REHBEIN: Ma'am, one of the
19 questions -- one of the things we hear as we
20 visited particularly the WTUs, the CBWTUs to
21 some extent, too, is the soldiers telling us
22 that they don't hear from their home units.

1 Do you have a tracking system, an
2 accountability system? You talk about the
3 monthly leader calls here. Do you have an
4 accountability system to know that those calls
5 are actually making contact?
6 MAJ SMITH: We have our monthly --
7 excuse me, our weekly MEDSYNC where Colonel
8 Parmenter talked about how we get together
9 with all the battalions and we discuss all the
10 WTU soldiers, each individual name at least
11 monthly.
12 We instruct the leadership in that
13 unit to contact them or I have contacted them
14 myself when I've seen -- for instance, I had
15 a soldier that was -- his orders were ending
16 on February 16th and I saw nothing in the
17 tracker that they were going to extend his
18 orders so I personally called the soldier and
19 asked him, "What is going on with your care?
20 Is there anything I can do for you?"
21 I know that we are one of the very
22 few states that are very active in our WTU.

1 We know where they are at. I look at the WTU
2 tracker at least weekly and then I have
3 another case manager that also looks in it to
4 make sure that we know where our soldiers are.
5 Then we have our leadership that
6 will go down to the WTU sites when there is a
7 muster to meet with the soldiers and see if
8 they are getting the things that they need.
9 Then our HSS helps them with the
10 documentation that is needed for the boards
11 because even though they are going through a
12 Med Board on the Title 10 side, our HSS on
13 state keeps track of them that they are going
14 through that Med Board.
15 Adequate services. The services
16 are very adequate. It's time consuming and
17 frustration for the soldiers to get back into
18 the services. For instance, we sent 79
19 soldiers to Fort Carson and greater than 50
20 percent of them were sent back without any
21 treatment or coming back to state thinking
22 that they were still going to be on Title 10

1 orders to get their care done when actually
2 they were sent back, REFRADed back.
3 So once they're back and they are
4 not on Title 10, we have to put then on INCAP
5 pay if they had a job prior to deploying to
6 get their care done. We've had a few come
7 back that we've stuck into the RCMC Program
8 that will be on Title 10 orders who will get
9 their care done, but they will also have a
10 paycheck and benefits for their family.
11 This is currently what we have as
12 far as medical case management. We have
13 approximately 21 percent of our combat that
14 are injured right now. We have three case
15 managers -- we actually have four case
16 managers but one case manager is strictly for
17 Medical Boards.
18 We have two RNs and one masters
19 level social worker. The case management
20 looks like it's about one case manager to 755
21 cases. I don't know how that compares to the
22 WTUs and what the case managers see there. As

1 you can see, that's awful hard for a case
2 manager to get hold of a soldier weekly on
3 that.
4 Each case manager has a care
5 coordinator who assist the units with medical
6 readiness and getting appointments, getting
7 documentation from the units.
8 LT GEN GREEN: Can I ask a couple
9 of background questions?
10 MAJ SMITH: Sure, sir.
11 LT GEN GREEN: So what would be --
12 prior to the deployment what would be the
13 number of cases that have open med cases
14 across the state? What was your baseline?
15 MAJ SMITH: We opened up close to
16 1,400 cases while we were at McCoy for the
17 soldiers that just received referrals.
18 LT GEN GREEN: Nondeployers? This
19 is before they deploy?
20 MAJ SMITH: Right. I don't know
21 the exact number but I'm just going to give
22 you the number that we have. We have over

1 3,000 cases right now. Of course, some of
2 them are multiple cases. I would say roughly
3 600 for each case manager. So roughly 1,200.
4 LT GEN GREEN: Okay. You're
5 talking about the case managers but I'm trying
6 to get a broader understanding. So at the
7 state level when you're looking at open
8 medical cases, prior to this deployment, this
9 most recent deployment, what was your baseline
10 in terms of open medical cases that you were
11 following, about 600?
12 COL KERR: It was 600.
13 LT GEN GREEN: Okay. Then how
14 many people deployed?
15 COL KERR: 2,900 from the state.
16 LT GEN GREEN: And so of 2,900 now
17 you've got 2,400 that actually have something
18 going on? Ninety-nine you said that were in
19 the CBTU.
20 COL KERR: 2,262 is our total
21 deployed soldiers that had issues.
22 LT GEN GREEN: So roughly two-

1 thirds.
2 COL KERR: Correct.
3 LT GEN GREEN: Okay.
4 COL KERR: Those two-thirds -- the
5 reason why we have 3,000 cases is because out
6 of those two-thirds many of them had multiple
7 issues that boil down into separate cases.
8 For instance, behavioral health and
9 orthopedic, and dental. That's how come there
10 is a much higher number of cases than there
11 are soldiers.
12 LT GEN GREEN: Ah, okay. I'm
13 mixing metaphors here. So how many actual
14 people?
15 COL KERR: 2,264.
16 LT GEN GREEN: Oh, okay. I have
17 the numbers right.
18 COL KERR: You had the numbers
19 right.
20 LT GEN GREEN: I'm just startled
21 that two-thirds of the folks coming back
22 basically are in a medical hold status of some

1 type.

2 COL KERR: That is correct.

3 LT GEN GREEN: Okay. So -- okay.

4 I have to think about this for a minute.

5 LTC PARMENTER: General, we

6 redeployed through a facility that did not

7 have an MTF and so there was not treatment

8 available for soldiers going through Fort

9 McCoy. Colonel Kerr will talk about the

10 referral system in which the soldiers came

11 home a little bit later in the briefing.

12 LT GEN GREEN: Have you talked

13 with any of the other states? Is this common

14 to have two-thirds of the people who deploy

15 that need ongoing medical care when they come

16 back? I'm just not as familiar with the Guard

17 and so I'm trying to understand.

18 COL KERR: I don't think it's -- I

19 think that you are going to see similar

20 numbers of issues identified. I think the way

21 that they were treated was completely

22 different. I think as I get into some of my

1 slides, you know, the BCT coming back through
2 Fort McCoy this time was tried on a very
3 unique referral system that had never been
4 done before.
5 I think that is why we're going to
6 have some unique issues that other units will
7 not have. Deploying -- I've been deployed
8 four times since 2003. During those four
9 deployments I redeployed. Two of the
10 battalions that I deployed with completely
11 through REFRAD. The numbers weren't much
12 different percentage wise than what you are
13 seeing today.
14 The difference is those soldiers
15 were kept in a WTU at a much higher frequency
16 and they were returned either to duty fit for
17 duty, or they had Medical Board issues, or
18 they were returned to the state with very
19 minor issues that needed to be followed up; a
20 little bit more physical therapy; a follow-up
21 appointment for stitches, something like that.
22 That was the type of soldier that

1 was returned from the state. In this case
2 didn't happen. That's why we're having 2,000
3 open cases to deal with on our own.
4 LT GEN GREEN: And so the WTU the
5 normal way of reintegrating when they come
6 back for REFRAD -- I guess you call it. I'm
7 sorry. I'm not as familiar with the
8 terminology -- is that they would stay at a
9 site long enough to get the routine medical
10 care that they require before they would come
11 back to you.
12 A lot of this is fairly routine
13 care that folks just need to get something
14 taken care of or documented and then you
15 expect them to come back to your unit?
16 COL KERR: Correct, sir.
17 LT GEN GREEN: Okay. How long do
18 they stay at Fort McCoy?
19 COL KERR: I don't think we had
20 anybody stay at Fort McCoy more than just
21 their seven days. There is not a treatment
22 facility at Fort McCoy to house or to take

1 care of the troops.
2 LT GEN GREEN: I see. Okay. All
3 right. Thanks. I just needed to have the
4 site picture. Thank you.
5 CAPT EVANS: How are you working
6 with the 1 to 755 for the case managers? How
7 are you trying to resolve that because I think
8 that high. I'm not sure how are you working
9 to resolve or make sure that your warriors,
10 your soldiers, are receiving the management,
11 the care management, that they need.
12 MAJ SMITH: That's where we are
13 depending on the units to make contact with
14 these soldiers also. Our medical readiness
15 NCOs at each unit are working to get the
16 documentation that we need from the soldiers
17 so we can clear them.
18 MS. CROCKETT-JONES: I think one
19 of the things that we are having trouble
20 seeing, and I think I'm just beginning to
21 grasp it, is that even in that ratio that many
22 of these are not complex cases who would need

1 ongoing case management.
2 This is a circumstance that is a
3 result of the nonmedical treatment facility at
4 McCoy sending more routine issues back which
5 would normally not require case management.
6 Correct? I mean, are those part of your 700
7 numbers? Is that what I'm understanding?
8 COL KERR: That is correct.
9 MS. CROCKETT-JONES: Okay.
10 LT GEN GREEN: One final question.
11 Are these folks entitled to TRICARE benefits
12 for the six months post when they come back
13 home?
14 MAJ SMITH: Yes. They are
15 entitled to the six months but if they have an
16 LOD, line of duty, it's covered 100 percent
17 for the issue.
18 LT GEN GREEN: And if it's not an
19 LOD, then it's basically -- are they in
20 standard or prime?
21 LTC PARMENTER: They get the 80/20
22 TAMP for six months from the date of their

1 REFRAD or release from Active Duty. If it is
2 tied to a line of duty, an approved line of
3 duty, or it's an issue that has been
4 identified on a PDHRA event, then we can do a
5 MEMSO preauthorization.
6 Then the coverage for that care
7 will be covered at 100 percent as opposed to
8 the soldier having to pay 20 percent out of
9 pocket. That is part of the confusion of how
10 to go about getting medical care. We brief
11 the soldiers over and over again.
12 They are confusing for the
13 administrators who work these programs every
14 day and now you have an E3 or an E4 out there
15 and he's got an issue. Where does he go and
16 how does he do this? That's why we've
17 incorporated so much training into out weekly
18 MEDSYNC meetings to make sure that at the unit
19 level they know these programs inside and out.
20 DR. TURNER: Again, just to kind
21 of help paint the picture again, your case
22 manager for your MEBs. You have one contract

1 RN handling 324 people undergoing MEB. Is
2 that accurate?
3 MAJ SMITH: Yes.
4 DR. TURNER: She's pretty busy.
5 MAJ SMITH: She is.
6 MS. MALEBRANCHE: Another question
7 from the VA part. Are any of your returning
8 folks using VA facilities and do you get
9 briefed at the demob site by the VA about the
10 healthcare they can get for the five years?
11 I don't know if they are close to a VA or not
12 but are you aware of that and are they using
13 it at all?
14 LTC PARMENTER: Yes. The soldiers
15 are briefed at the demob station by the VA.
16 The VA also comes out during the Yellow Ribbon
17 1 event and briefs soldiers and their families
18 on the benefits that they are eligible for.
19 There are VA centers. The trouble is when you
20 have 3,000 people coming back into a state,
21 now a process that was already slow is even
22 greater.

1 Colonel Kerr will get into the
2 referrals but if a soldier came back and he
3 has 30 to 45 days of terminal leave and he's
4 trying to get into the VA and it takes him
5 three weeks to get his initial appointment,
6 which is very aggressive. Often times those
7 appointments take months to get into depending
8 on what their issue is, or issues are.
9 They get into this appointment and
10 they get a referral to a specialist and so
11 forth. At this point their leave is up. They
12 don't have pay. Now they are having miss work
13 to go to these appointments. Although that is
14 a nice benefit, how are we paying the soldier
15 to go to these appointments?
16 MS. MALEBRANCHE: Behavioral
17 health appointments, are they not done in a
18 more timely manner than a month?
19 LTC PARMENTER: No. When you get
20 into the VA system you are at the mercy of the
21 availability of the specialist in which you
22 are seeing regardless of what that specialist

is.

DR. TURNER: What is your current turn time for MEBs? Do you know? From once they start to when they have a result.

LTC PARMENTER: We don't have really good numbers on what those are because we had a backlog going into the deployment. These numbers are not reflective of the deployment. I would say six to nine months by the time they get into the funnel to the results.

MAJ SMITH: Anymore questions?

LT GEN GREEN: I have one more question. Out of curiosity, out of the 2,264 that you're currently working at open med cases, what's your expectation in terms of what the line of duty will be? In other words, is it going to be 100 percent of these people that actually have line of duty after a deployment?

COL KERR: That is correct. I perceive very few being non-LODs in that

2,264.

LT GEN GREEN: So is there a reason that you don't automate the LOD to basically say yes to someone who just recently deployed so they have 100 percent coverage and could go get TRICARE appointments?

LTC PARMENTER: That sounds really nice. Unfortunately, it doesn't work that way. The LOD module is an automated program but the MEMSO preauthorization is just another step in that process so we have the approved LOD that come back from Title 10 and then we have to go back into the module and request that MEMSO preauthorization, then we get that information back that document number goes back to the soldier so that they can provide that back to their provider to submit those bills. It's in a module but it's not an automated process. There is still a lot of manual work that goes with that.

LT GEN GREEN: And so the process takes how long?

1 LTC PARMENTER: Usually we have
2 MEMSO preauthorization back within about 72
3 hours.
4 LT GEN GREEN: And to actually
5 complete all this paperwork to get it to go
6 forward, how long does it take you? Months?
7 MR. PARKER: No, no. It's much
8 quicker than that. It's probably days. By
9 the time a soldier comes into their unit and
10 says, "I need to go to the doctor. I need a
11 preauthorization," they put the stuff in --
12 the documentation in and they get the number
13 back. It's probably a week to two weeks by
14 the time that happens.
15 The unfortunate thing is, again,
16 the soldiers retention of these programs being
17 what it is, I mean, we work the programs all
18 the time and don't know all the details of
19 these programs. A soldier forgets that he
20 needs to get a preauthorization and he goes to
21 the doctor.
22 Now we're going to work an appeal

1 to try to get that other percentage paid for
2 or reimburse his civilian insurance. That can
3 take weeks to months to get those appeals
4 worked. The good news about the appeal we've
5 not had one denied.
6 LT GEN GREEN: So I guess the
7 question that would be obvious is if they
8 brought them back through Fort McCoy who
9 didn't have a medical facility and, therefore,
10 couldn't do all these things, you need some
11 other type of TAMP where 100 percent is
12 covered for a number of weeks to let people go
13 and get their healthcare needs met. Am I
14 missing --
15 LTC PARMENTER: That would be
16 excellent because their 100 percent coverage
17 is only through the end of their terminal
18 leave and then the six-month 80/20 TAMP. If
19 that was six months to a year post-deployment,
20 that would be ideal.
21 LT GEN GREEN: Okay.
22 CSM DEJONG: Real quick, ma'am.

1 How much success are you having with gathering
2 all of these records from multiple providers
3 around the state to get them back into their
4 medical record?
5 COL KERR: I can answer that.
6 Those are the folks that work for me.
7 Extremely difficult simply because one of the
8 problems, and I think it's a global National
9 Guard problem, is when a soldier has a medical
10 issue and they come into the State Surgeon's
11 office and we request paperwork, or say you
12 need this exam or that exam, the soldier then
13 leaves the medical facility -- the National
14 Guard medical facility on the weekend and goes
15 off and does their thing and goes to their
16 appointment, we don't have any command and
17 control on what happens to that soldier or
18 those medical records.
19 So what will happen then is they
20 will be put on a 90-day profile to get all the
21 stuff back to us. That 90-day profile will
22 come and go. Then the unit will say -- they

1 will come back to us and say what's going on
2 with their soldier. We sent them there 90
3 days ago and they are still on temporary
4 profile.
5 The bottom line of the story is
6 without medical control of the soldier at the
7 state medical office, it's very difficult to
8 guide what happens with these appointments and
9 their medical charts. We do leave that to the
10 unit because the unit is command and control
11 and does own that soldier.
12 Being nonmedical it's very
13 difficult for them to guide what happens to
14 this medical paperwork, when are they suppose
15 to go to their appointments, so on and so
16 forth. To me that's one of my recommendations
17 that you'll see is there needs to be some sort
18 of command and control medically of the
19 soldiers while they are going through this
20 process for several different reasons.
21 The primary one is getting the
22 data collected in a timely manner which for

1 these 2,264 it's a difficult uphill battle for
2 our case managers getting the paperwork in.
3 Once we get the paperwork in, we can move the
4 process very quickly but that seems to be the
5 biggest downfall of the whole system.
6 MAJ SMITH: Okay. We'll move on
7 here. This next slide just looks at the
8 difference of our case managers, our social
9 worker, and our physician's assistant. Our
10 physician's assistant is an ADOS Soldier.
11 He's not here full-time, or he's
12 here full-time and we have to wait yearly to
13 find out if we have the funds to keep him on.
14 Our physician's assistant does a lot of work
15 for us. He has been inundated with all of the
16 medical documentation, writing the profiles.
17 He works very hard. One of our case managers
18 is a case manager certified. Then our
19 psychologist is a masters level.
20 DR. TURNER: Just to recall a
21 number, you said there are about 600 mental
22 health cases. I guess this one would carry as

1 well?

2 MAJ SMITH: Six hundred thirty.

3 DR. TURNER: Thank you.

4 MAJ SMITH: She actually has two

5 case -- excuse me, care coordinators that work

6 with her in the state to help her with the

7 documentation, setting up the appointments

8 because once they have their initial

9 evaluation from their civilian provider or

10 from the VA, then our care coordinators will

11 set them up an appointment with our behavioral

12 health provider.

13 The next slide talks about how we

14 interface with the facilities. When the

15 soldier is REFRAD'ed or released back to the

16 state, we get together with the soldier, the

17 soldier's readiness NCO, or his unit

18 administrator.

19 The AMEDD and HSS all sit down

20 with the soldier in one location and we ask

21 the soldier how he is and what he needs to get

22 done to bring himself back to be medically

1 ready for deployment. We have two times a
2 month where we have reverse SRPs where we can
3 take 10 soldiers that have a medical REFRAD to
4 reset them.
5 That is where our physician's
6 assistant really helps us out there because if
7 the soldier came back with a temporary
8 profile, by the time we get them in for the
9 reverse SRP, a lot of times they don't --
10 their temporary profiles are ready to expire
11 and he'll redo those for us.
12 The care coordinators -- excuse
13 me, the case managers are also in that meeting
14 and they meet with the case manager and then
15 she goes down what she needs to help get that
16 soldier cleared. The only way that we find
17 that these soldiers are getting out is by
18 myself or one of the other case managers
19 keeping check on the WTU tracker to see where
20 they are at.
21 MR. REHBEIN: Ma'am, I was a
22 little bit slow on the draw here. If we could

1 back up one to that behavioral health.
2 Knowing Iowa as being a fairly rural place,
3 very rural place in some ways, how much
4 challenge is it to find providers for
5 behavioral health?
6 MAJ SMITH: Well, we are actually
7 one of the few states that does have
8 behavioral health providers. We have two
9 psychiatrist in our unit and we have a
10 doctorate level psychologist. Then we have
11 two behavioral health social workers in our
12 state. There are some states we hear that
13 don't have any behavioral health providers.
14 MR. REHBEIN: So you have
15 behavioral health people in the Iowa National
16 Guard?
17 COL KERR: In uniform. Correct.
18 MAJ SMITH: Yes.
19 MR. REHBEIN: In uniform. So you
20 can provide some of your own services to those
21 folks that are having trouble finding a
22 provider?

1 MAJ SMITH: Our director of
2 psychological health is here on a full-time
3 basis. She is a civilian contractor. She can
4 interview a soldier but we don't actually do
5 any treatment. We refer them to the local VA,
6 the behavioral health clinics around the
7 state.
8 MR. REHBEIN: Are you able to get
9 people treatment I guess is what I'm asking.
10 DR. TURNER: Are you having
11 problems getting referrals?
12 COL KERR: We don't have problems
13 getting referrals once we see the soldier. We
14 can usually either get them into VAs or
15 civilian psychiatrists once we get the soldier
16 to us to figure out they need the referral.
17 That is where the big problem is.
18 For us the nice part about having
19 our own psychiatrist is they can evaluate --
20 what we do with our behavioral health team and
21 our psychiatrist is we evaluate our troops
22 that are in the behavioral health process to

1 make sure that they are getting to their
2 appointments, that their appointments are
3 going down the correct standard of care for
4 PTSD.
5 That is about the extent of what
6 our psychiatrist can do. The problem with the
7 behavioral health issue, and I'll get into
8 that, is really getting the soldier in for
9 that first look to figure out what type of
10 program to get him into. That is where it's
11 paramount that we do a much better job at the
12 demob site with the psychiatric issue, not so
13 much as at the state level.
14 Again, at the state level, just
15 getting a psychiatric patient or a PTSD
16 patient to come in for an evaluation, even if
17 directed by the unit, is still difficult at
18 times.
19 LT GEN GREEN: I'm still
20 struggling a little bit with your numbers.
21 Let me ask another question. Of the 2,264 how
22 many do you expect to stay in the unit? In

1 other words, do you expect the 324 medical
2 evaluation boards to actually be returned to
3 duty or do you expect them to be separated
4 from the unit? You don't have any experience
5 with this from the past?
6 LTC PARMENTER: Typically when a
7 soldier is identified in the MEB process they
8 do not come back to us.
9 LT GEN GREEN: Okay. So for --
10 LTC PARMENTER: Small numbers
11 would come back.
12 LT GEN GREEN: So for the 300 you
13 are expecting that they are actually going to
14 have conditions that will not allow them to
15 come back to the unit?
16 LTC PARMENTER: Correct.
17 LT GEN GREEN: Okay.
18 LTC PARMENTER: At the point that
19 a soldier is identified for a medical
20 evaluation board, they have to reach their
21 medical retention decision point so they have
22 already exhausted all of their temporary

1 profiles. They've met optimum care.
2 We believe they are as good as
3 they are going to get. At the point they are
4 as good as they are going to get medically,
5 then we send them to the medical board to get
6 medical compensation as they are leaving the
7 system. Typically we see very, very few come
8 back.
9 MR. CONSTANTINE: It seems to me
10 the number is so high for your soldiers who
11 have medical issues and especially since only
12 20 percent are combat related, and especially
13 since so many, a high percentage, going to the
14 MEB are going to be found unfit for duty, what
15 are the common medical challenges that they
16 are facing coming back from deployment?
17 LTC PARMENTER: These numbers,
18 sir, are just this recent deployment.
19 Obviously we've been deploying units for years
20 and so many of these are still medical issues
21 that we are resolving because the temporary
22 profile process you have to issue four

1 temporary profiles so that is at least a year
2 on the front end going into that medical board
3 process.
4 Some of those will be lingering
5 around in the ranks for several years before
6 they go into that board cycle. Then if they
7 hit all the gates going through the MEB
8 process, it's six to nine months, 12 months to
9 separate them. It's a very lengthy process.
10 MR. CONSTANTINE: What are the
11 medical -- I mean, if you could generalize
12 what are the common things you see that aren't
13 combat related?
14 COL KERR: The breakdown really
15 doesn't change. Our numbers seem to be high
16 but the breakdown is still the same. Outside
17 of behavioral health the majority are
18 orthopedic.
19 Out of the orthopedic breakdown
20 the majority of those are back followed by
21 knee and the followed by carpal tunnel or
22 wrist issues. That's the majority of the

1 medical issues. There are other breakdowns,
2 of course, but I would say if you want the
3 highest numbers, it's those three diagnoses.
4 LTC PARMENTER: And, sir, of our
5 MEB cases only one is non-combat related.
6 Only one.
7 MAJ SMITH: These are what
8 services we have available for soldiers with
9 the PTSD. When the soldiers demobed from Fort
10 McCoy if they were involved in numerous blast
11 injuries, they were all given a Level II ANAM
12 or TBI testing.
13 We would request the results from
14 Fort McCoy. Right now I don't know how we
15 request them because Fort McCoy is no longer
16 a demobilization site. Then a lot of times if
17 we don't request them, they don't routinely
18 make it back to the soldier's medical records
19 so we have trouble getting them.
20 We have the VA, the Vet Center,
21 and several civilian medical providers that
22 treat our soldiers and we use them to profile

1 the soldiers and we take their
2 recommendations.
3 MSGT MacKENZIE: Ma'am, quick
4 question for you. I'm just trying to get my
5 head around this. The soldiers are receiving
6 this Level II ANAM TBI testing.
7 MAJ SMITH: Correct.
8 MSGT MacKENZIE: But there is no
9 accountability back to the state medical folks
10 that this has even been completed or what the
11 results were unless you just hear it from the
12 soldier? Is that what I'm getting here?
13 MAJ SMITH: We can see in their
14 medical records that they have been sent for
15 one but we don't actually see the results.
16 Before Fort McCoy closed down for the
17 demobilization process we were able to request
18 them, but now we've been given no guidance as
19 to how to request them.
20 MS. DAILEY: How to request the
21 test?
22 MAJ SMITH: Yes, the results of

1 the test.

2 MS. DAILEY: But I thought you

3 just said you could see the results of their

4 test in the medical record.

5 MAJ SMITH: We could see that they

6 were referred for one because every soldier

7 would see a behavioral health provider during

8 the demob process and they would refer them.

9 Our local VAs offer psychiatric/psychological

10 and individual therapy. One of our VAs offers

11 an in-patient 45-day, it's very aggressive,

12 therapy.

13 MS. DAILEY: Real quick as I see a

14 lot of distress in the Board here, how many

15 cases of testing for TBI do you think you have

16 that you don't have adequate records for?

17 MAJ SMITH: Truthfully every

18 soldier should have been tested for that. Any

19 soldier that was within 50 meters of a blast

20 exposure, I'm sure a majority of the soldiers

21 were within 50 meters, should have received

22 that test.

1 MS. DAILEY: So if you've done a
2 records review and you've seen that exposure,
3 have you cross-walked those records that would
4 indicate a requirement against -- the referral
5 against the actual having those records with
6 you? Do you know what that number is?
7 MAJ SMITH: No, ma'am.
8 MSGT MacKENZIE: Let me add
9 something. I think I might be able to word
10 this a little bit differently. The number of
11 referrals you have in the system that you do
12 not have medical records for --
13 MAJ SMITH: Medical testing?
14 MSGT MacKENZIE: Yes.
15 MAJ SMITH: I would have to get
16 with our Director of Psychological Health for
17 that. She will be able to answer that for me.
18 MSGT MacKENZIE: How large is this
19 problem? You said you can see all the
20 referrals, or have access to the data that the
21 referral was made but you don't have access to
22 the testing information.

1 COL KERR: I don't think we have
2 access -- I think it's an extremely low
3 number. I don't think we have access to the
4 data from that testing at all.
5 MSGT MacKENZIE: That's what I
6 mean. You said you had access to the fact
7 that a referral was made.
8 COL KERR: We can see that they
9 have been referred but we do not get the
10 information.
11 MSGT MacKENZIE: What's the
12 disparity?
13 LTC PARMENTER: Can we research
14 these numbers?
15 MSGT MacKENZIE: That's fine.
16 That's fine.
17 MS. DAILEY: This is intriguing
18 but we are not able to bring back actual
19 numbers. No doubt you see the records. You
20 see the requirement for the record but you
21 can't tell us exactly what the exact number of
22 -- what the numbers are.

1 That comes back to my earlier
2 question. You are case managing 2,264.
3 You've said that we've got soldiers that are
4 coming back from the WTUs and the community-
5 based Warrior Transition Units that are in
6 that 2,264 but you can't tell me how many.
7 Those are helpful numbers. I'm not saying
8 you're not doing your job but that brings a
9 lot more fidelity and gives us a lot more
10 teeth.
11 LTC PARMENTER: Right. Would you
12 be willing to accept those? After we leave
13 here we can go back and pull data and just
14 send those to you?
15 MS. DAILEY: Yes. That would be
16 great. This is -- I'm just trying to
17 synthesize your case here which we want to
18 understand to -- that are the primary issues.
19 One, it's difficult to treat them at McCoy or
20 not at all. They are not getting sufficient
21 numbers into the community-based Warrior
22 Transition Units and the WTU.

1 When you do get them into those
2 opportunities, they don't come back to you
3 fixed. The other issue is you are not able to
4 get them treated in a timely enough manner and
5 your staffing is not allowing you to move them
6 through the system fast enough.
7 MR. CONSTANTINE: The system
8 doesn't allow for you to know if your soldier
9 has had a traumatic brain injury or not.
10 LTC PARMENTER: Correct.
11 MSGT MacKENZIE: The other thing,
12 too, a couple perspectives here. Talking with
13 Mr. Rehbein and having the unique pleasure of
14 driving through the state of Iowa, we had
15 better start looking at the National Guard
16 situation here. A lot of this -- it's not as
17 simple as I just go to the hospital and get
18 something.
19 There is a significant level of
20 distance and cost to the soldier that they
21 either may not want to or are unable to incur
22 in order to get the treatment they need. Is

1 that something that you see in a large scale,
2 due to the breakout of where your soldiers are
3 at in comparison with, in some cases, the
4 extreme ruralness of the state of Iowa?
5 MAJ SMITH: Correct. We have --
6 there are four VAs in the state.
7 Unfortunately, they are in the larger cities
8 so if our soldiers live, say, in northeast
9 Iowa, in order for them to go to the local VA
10 it's at least a two to three-hour drive. That
11 is a significant problem for them, especially
12 if they have to work or if they aren't working
13 and getting to the VA.
14 MS. CROCKETT-JONES: I'm trying to
15 understand -- okay. In the past have you
16 always demobed at a place that does not have
17 a medical treatment facility? Is this the
18 standard that you've had for years? In the
19 past have you demobed where there was a
20 medical treatment facility?
21 COL KERR: That is correct.
22 Usually it's been like Fort Carson. That is

1 probably the most common site that has a
2 medical treatment facility.
3 MS. CROCKETT-JONES: So how has
4 that changed your numbers for this case
5 management issue and for tracking your injured
6 soldiers? How many in the past -- if they
7 demobed where there was medical treatment, how
8 many did you filter out through onsite
9 treatment when you demobed where there was
10 medical in the past? How has that number
11 changed with the new -- with this current
12 demob?
13 MAJ SMITH: This was a very large
14 deployment for us. It's one of the largest
15 we've had.
16 COL KERR: I would say percentage
17 wise 10 times from a battalion. The biggest
18 unit that we've deployed commonly is a
19 battalion-size element. Coming out of a
20 battalion-size element you would have about 10
21 percent would be in some form of a WTU, not
22 the 30 percent that we're seeing now or the 40

1 percent that we're seeing now.
2 That would be my rough answer for
3 you number wise. If I had to extrapolate from
4 a battalion-size element that came out of a
5 medical treatment facility as opposed to the
6 brigade element that came without a medical
7 treatment facility.
8 MS. CROCKETT-JONES: So are you
9 saying -- I mean, I'm trying -- this seems to
10 have been not an optimal way to demob to me.
11 I mean, what I am not hearing you saying
12 exactly is you would really rather demob where
13 there's a medical treatment facility but I
14 haven't heard you actually say that.
15 COL KERR: We're not to that slide
16 yet, ma'am.
17 MS. CROCKETT-JONES: Okay.
18 MS. DAILEY: I'm happy to move to
19 your recommendations. It might generate some
20 discussion unless you see something between 13
21 and 21, which is --
22 COL KERR: We've already hit all

of those topics. I'm very happy to move right to the recommendation.

MS. DAILEY: Excellent.

COL KERR: Can we move to the issue slide? That's really part of the recommendation.

MS. DAILEY: Yes, yes. Good, good. Good, good.

COL KERR: The biggest part is exactly what you pointed to was you cannot demob -- I would not demob a battalion-size unit at a demob site that does not have an organic medical treatment facility for the reason this new referral system that they brought out to us in McCoy, I think in concept it was okay but the problem was these referrals were kind of -- these referrals in my eyes were made into the wind.

The soldiers made referrals on site. When the soldier took that referral and tried to get it made at whatever treatment facility whether it was one that was closest

1 to Fort McCoy, which I know some of that was
2 attempted, but the majority of those referrals
3 were made with specialist on a civilian market
4 back home.
5 When they tried to make those
6 referrals for one process or another, and we
7 won't get into the specifics, that referral
8 time took them past their point of terminal
9 leave. Therefore, the whole process was
10 defunct for just that one referral.
11 Then the whole process for that
12 soldier started back over. That was problem
13 number one. I would say my first and most
14 important recommendation is demobs have to be
15 done at an installation that has a medical
16 treatment facility.
17 The next biggest problem is
18 soldiers cannot be allowed to return to home
19 state unless they are either fit for duty or
20 medically boarded. The classic example I will
21 give you is I can't tell you how many times
22 soldiers were given the option of -- I

1 understand the WTUs were full.
2 They were having problems six
3 months prior to the brigade demobbing. We
4 were sitting in conferences talking about
5 where are we going to put our estimated -- at
6 one point we had 300 soldiers that we knew for
7 a fact were going to have to be WTU'ed six
8 months out before the soldiers came back.
9 We were already in conversations
10 that the WTUs were full and where were we
11 going to put them. I know that played a part.
12 When a soldier is given the opportunity at the
13 demob site, "Soldier, would you rather stay
14 here and be put into a WTU somewhere in the
15 United States or would you rather go home for
16 treatment? What would you rather do?"
17 Well, of course, the soldier is
18 going to say they want to go home for
19 treatment. The problem is the demob site
20 doesn't understand the home state process.
21 Telling a soldier that, "You can go home and
22 be treated and put on INCAP," is not the

1 answer.

2 INCAP is really just a bridging

3 mechanism to help the soldiers that were

4 REFRAD'ed fit for duty, came home, had a

5 medical issue from their fit for duty process

6 that has now popped back up that is a short-

7 term fix. It's not designed for long-term

8 medical fix.

9 That, to me, was -- the other

10 biggest recommendation is we have to close

11 that cap. The medical treatment facilities at

12 the demob site have to have some sort of

13 conference set up with the state for soldiers

14 so they understand what programs that state

15 uniquely can offer their soldiers. Again, the

16 way it's put to the soldier at demob is not

17 really what they are getting when they get

18 back to the state.

19 MSGT MacKENZIE: So you as the

20 medical guy, so to speak, is one of the things

21 that you're asking saying that you at the

22 surgeon level should have the authority or, at

1 least, the opportunity to accept or deny a
2 soldier's return to the state for receiving
3 medical care at home?
4 COL KERR: That is 100 percent
5 correct. As a state I feel I should at least
6 be able to review that record. I should be
7 able to review the recommendations and I
8 should be able to talk to the soldier because
9 I will tell you we've had some return fit for
10 duty and the soldier comes in with a cane or
11 a crutch or something and its very obvious
12 they are not fit for duty.
13 The chart itself says fit for duty
14 so it needs to be a conference with either the
15 soldier's representative, the state, and the
16 WTU before that soldier is REFRAD'ed to make
17 the system work the way it's intended to.
18 Otherwise, we get what happens now.
19 You heard Colonel Parmenter tell
20 you that we got 79 soldiers put back on WTU at
21 Fort Carson, the soldiers that went to Fort
22 Carson. Thirty-five soldiers within that week

1 were returned back to us without even a
2 medical exam fit for duty.
3 It's very obvious without even a
4 medical exam going back out to the WTU, there
5 was no way they were fit for duty and we had
6 to work yet again. These were soldiers we had
7 to pull away from their civilian contractors
8 because they were having issues. I mean, I
9 could go through the whole litany. That is
10 one of the problems and the issues with that.
11 Again, once we got those soldiers
12 back out there, if there was a defining end
13 conference between us, the WTU, the soldier or
14 the soldier's representative, you know, a lot
15 of that could have been cleared up on whether
16 they were medically ready to return.
17 DR. TURNER: Just to get a little
18 bit more detail about your case management,
19 again, while I think it's pretty safe to say
20 that you are overburdened as you say here with
21 your staff taking care of these people, is the
22 fact that you don't have enough people to run

1 this is that a primary resource problem like
2 money or is it you can't get those people or
3 is there some other process that prevents you
4 from having enough people to do that?
5 COL KERR: I think it's a resource
6 of money. My final page of the
7 recommendations is to have a medical reset
8 team, not just for our state but I think our
9 recommendation is to have a medical reset team
10 put in place for every redeploying battalion
11 size or higher element for 12 months for a
12 battalion-size element, 18 months for a
13 brigade-size element.
14 What that team does it's a whole
15 other medical professional like a PA, two more
16 case managers, two more care coordinators, and
17 an admin NCO. What that group can do is
18 really -- our limitation we currently have
19 with our three case managers is they are so
20 overloaded we cannot get them out to the
21 units.
22 By taking this team and have them

1 go to a unit on an AT status, have them go to
2 a unit on a drill status, hitting one armory
3 on Saturday, another armory on Sunday, they
4 can get face-to-face medically with these
5 soldiers finding out how the process is
6 working.
7 "How is your paper going? You
8 know what? We really need you to come down to
9 the state medical facility. This is too
10 complex for us to deal with here. We're going
11 to make you an appointment."
12 Have that appointment made then
13 and there. That to me is at least how we are
14 going to internally try to solve our problem
15 with these 2,264 on a much quicker scale than
16 what is happening.
17 DR. TURNER: Do you have the
18 funding available to do this?
19 COL KERR: Currently we do not but
20 we are working to come up with creative ways
21 to make the team happen quickly.
22 DR. TURNER: I don't understand

1 the Reserve and Guard as much. Tell me where
2 you would get the money to do this.
3 COL KERR: I'm going to pass that
4 off to Colonel Parmenter. She can probably
5 give you a better idea than I could.
6 LTC PARMENTER: We have a couple
7 of different ways. We would either come back
8 to the National Guard Bureau with a UFER and
9 finance requirement or we would cross-level
10 funds within the state, somewhere within the
11 state. Some other program would suffer.
12 MSGT MacKENZIE: In the state
13 program or state Guard program?
14 LTC PARMENTER: The Iowa National
15 Guard, the Iowa Army National Guard.
16 MS. DAILEY: Can I just try and
17 ask you to kind of reconcile something for us?
18 We, whether my team here knows it or not,
19 probably have got a lot of exposure to
20 National Guardsmen through our visits to the
21 Joint Forces Headquarters and then the
22 downstream look at the installations of WTUs

1 and the community-based Warrior Transition
2 Units.
3 I honestly believe these
4 individuals have got one of the best looks in
5 the Department of Defense. I can say with
6 some honesty that National Guardsmen do not
7 like the WTUs and they do not like the
8 community-based Warrior Transition Units. I
9 could even go as far as saying they hate them.
10 They don't want to go to them, particularly if
11 they are outside their state.
12 Do you honestly feel that is the
13 best place for them or would you like to keep
14 them in state?
15 COL KERR: My answer to that is
16 yes. That is the best place for them simply
17 because when they come off Title 10, once they
18 leave Title 10, as you can see the issues and
19 the time frame to try to get them medically
20 healed and corrected, I think, is going to be
21 10-fold that of keeping them in a WTU or a
22 CWTU.

1 I think the problem is nobody
2 forecasted how many soldiers are going into
3 the WTUs and the CBWTUs so they are overworked
4 and overburdened and that is why it was such
5 a long involved process for those.
6 It could be fixed with two things.
7 It could be fixed by, No. 1, not overburdening
8 the WTUs and CBWTUs, and then providing a
9 better liaison between the CBWTUs and the WTUs
10 while the soldier is there.
11 One of the comments that was made
12 earlier is there is not enough contact between
13 the soldier and the home unit. Our state has
14 come up with the medical readiness NCO and
15 that is one of their sole functions is to
16 track their medically-issued soldiers. That's
17 what they do.
18 They contact those soldiers on an
19 individual basis to make sure they are getting
20 through the process from a home unit and they
21 are not even -- they are still on Title 10 but
22 we're still using that medical NCO to contact

1 them at the unit level, not at a state and
2 medical level so they should be having
3 contact.
4 MS. DAILEY: If we go to Rock
5 Island we're not going to hear from the Iowa
6 National Guard Soldiers at Rock Island that no
7 one is talking to them, that they don't hear
8 from their home units, that this is a good
9 place for them and that they are getting good
10 care at Rock Island.
11 LTC PARMENTER: I wouldn't go so
12 far as to say that. I would say that we do
13 due diligence in contacting all of our
14 soldiers and retaining that line of
15 communication. Are we 100 percent?
16 Absolutely not. I would never go out on that
17 limb and say that.
18 Also, our soldiers would not say
19 that they love the WTU or the CBWTU and that
20 this is the best place for them. I have a
21 couple of comments about it. If we were
22 resourced within the state to manage our own

1 WTU and let them be at home and go to
2 appointments, I think that would be a viable
3 option.
4 I think that resources are
5 available within the State of Iowa. We just
6 don't have the mechanism to pay and track and
7 case manage all of these soldiers. If the
8 resourcing came, much like what's happening
9 with the RCMC Program for the less-than-six-
10 month programs, I think that it would be a
11 viable option. We don't give soldiers an
12 option to deploy. We order them. Why do we
13 give them an option to seek medical treatment?
14 MSGT MacKENZIE: That is a couple
15 things that I will say some of the Iowa
16 National Guardsmen that we talked to at Fort
17 Carson. It was not Iowa they were having an
18 issue with necessarily as it was the WTU
19 there.
20 You brought up a very interesting
21 point and that was one of the questions I was
22 going to ask because it's been brought up to

1 us before. We get into this disparity between
2 Title 10 and Title 32 and it's like I've been
3 deployed on Title 10.
4 The state feels in one area we
5 were at the state felt -- the individuals felt
6 very strongly that the state should have their
7 own WTU. It's not so much that they were
8 concerned about the state providing the
9 funding. It's like this need has arisen. We
10 can do a better job but it's arisen because of
11 Title 10 orders.
12 We are trying to figure out, you
13 know, they made the request but didn't quite
14 have all the data for the recommendation which
15 was we should be receiving Title 10 funding to
16 do what we should do as a state to take care
17 of our warriors. Thank you for making that
18 because it is moving around quite a bit as an
19 idea.
20 COL KERR: And I can clean up my
21 soldiers' issues much faster within my own
22 state borders with my own guidance than I can

1 with your Title 10 money. That is just a
2 fact. It's because the CBWTUs are just so far
3 displaced, they are so far out there as
4 opposed to their own units, their own state
5 monitoring them, following them, taking care
6 of them. I think you could cut the time by 60
7 percent, not even 50 percent. I think you
8 could cut two-thirds off of it.
9 I do want to make one more
10 recommendation from the sergeant major's
11 comments earlier about behavioral health. I
12 think the screening process, bringing the
13 families in later in the Yellow Ribbon process
14 I think is very intriguing. I think it is --
15 it would be the second part of a better
16 process for behavioral health to bring them in
17 three months later then what we currently at
18 Yellow Ribbon 2.
19 If you look at the PDHRAs of those
20 soldiers that are identified late in the
21 process, they had positive answers on their
22 PDHRAs going through demob. To me I think the

1 first paramount issue is to have a better
2 psychiatric evaluation on those soldiers that
3 have positive answers at the demob site.
4 The medical professional that sees
5 a lot of the positive yes/positive no answers
6 is not behavioral health, it is a medical
7 professional. It is a medical professional
8 reviewing those questions saying, "Tell me
9 about why you're not sleeping. Tell me about
10 why this is positive or that's positive."
11 It is not a true behavioral health
12 professional or a psychiatrist that
13 specializes in PTSD and military psychiatric
14 issues that are reviewing those soldiers. To
15 me that is what is paramount for the
16 behavioral health problem to be fixed. Along
17 with we do have to come up with some sort of
18 process later on in the events. One of the
19 slides that we passed by was we had 193
20 behavioral health issues at demob site.
21 At Yellow Ribbon we picked up 290
22 more. At Yellow Ribbon 2 we picked up another

1 300. That is how fast that process grew
2 between demob and Yellow Ribbon 3. Out of
3 that, that boiled down to about 730 some
4 cases.
5 To date we have 100 of those clean
6 so we are down to the 623. That is how we
7 came to that number. Again, it was a
8 blossoming of doubling every time we had a
9 Yellow Ribbon event for psychiatric cases.
10 MSGT MacKENZIE: This is another
11 question. Unfortunately in other locations
12 we've had the ability to speak to both. The
13 Army portion of the Iowa National Guard
14 obviously has the largest numbers.
15 Is there any and what is the
16 relationship of the Air National Guard in
17 assisting you in this issue and these medical
18 issues or trying to get these guys care. To
19 me I spent the majority of my career in a
20 joint environment so what uniform somebody
21 wears is really irrelevant to me in anything
22 I've ever done.

1 In the State of Iowa, I mean, is
2 there that coming together? Are they
3 providing -- is the Air National Guard or
4 anything coming form that side assisting you
5 in working with these numbers?
6 COL KERR: We are in the infancy
7 stages of that. Currently the answer is no.
8 How our state boils down to is the Army side
9 of the house has the majority of the
10 equipment. The Air Force side of the house
11 has the majority of the medical professionals.
12 We are currently coming up with a
13 joint process or a joint medical annex that
14 would at least assist in some of those issues.
15 We've already had a few pilot programs where
16 we brought some of the Air Force physicians
17 over, put them into the Army MEDPROS system
18 with signature cards, the whole nine yards, to
19 see if we cannot get them as medical
20 professional assistants.
21 Again, on the National Guard side
22 of the house, remember all that is doing is

1 what we do on a weekend, is just screen and
2 refer. We do not do any type of treatment,
3 even with our behavioral health psychiatrist.
4 Again, we are just a screening and a referral
5 process on Title 32.
6 MSGT MacKENZIE: The reason I
7 brought that up is because in other states
8 we've been to the footprint across the state
9 if you don't look at it as Air or Army
10 National Guard, you look at it as National
11 Guard, you've increased the ability of uniform
12 members to be closer to where the folks are
13 at. It seems kind of silly for an Army
14 National Guardsman who is closer to an Air
15 Guard base versus his unit that it can't be
16 seamless to see a medical -- a uniformed
17 medical professional, not Army or Air Force.
18 COL KERR: Geographically it
19 doesn't help Iowa much. We have two Air Force
20 National Guard installations and that is in
21 Des Moines where the majority of our Army
22 National Guard is stationed, and then in Sioux

1 City where we also have Army National Guard.
2 MSGT MacKENZIE: Okay. Thanks for
3 helping me with my geography on that. You
4 understand my point though?
5 COL KERR: Absolutely.
6 MSGT MacKENZIE: When we are
7 looking at the recovering service member, it
8 shouldn't matter what uniform they are seeing
9 as long as we are getting them the
10 professional help they need.
11 COL KERR: On a drill weekend I
12 would love to have five more medical
13 professionals help me expand my numbers so I
14 could get them through quicker.
15 MR. PARKER: It is an interesting
16 point, just a sidebar comment. Thirty years
17 of practicing medicine, sitting in doctor's
18 lounges, most of the docs I know were in the
19 Air Guard. For some reason the Air Force was
20 sexier than the Army or anything else.
21 There are a lot of issues. We
22 heard lots of issues. Would a robust

communication and information system be helpful? I mean, would that be a step or stopgap until you can get these other things fixed?

COL KERR: Absolutely. If I could see all the testing that everybody has done on my soldiers, I would at least know where I stood with my soldier and not have to try to recreate three or four of the different tests that the soldier gets exacerbated saying they've already had. To me I think that would be paramount.

MR. PARKER: I mean, would you have some sort of authority to establish a social media system, or some sort of system, with your soldiers, or is that something that is beyond your authority? I mean, just to create something.

COL KERR: I don't know if I can answer that for you, sir.

MR. PARKER: Okay. That would not be very costly. It just would be some sweat

1 equity that would take someone who had the
2 ability to do that to establish that with cell
3 phones or something. I mean, it's not perfect
4 but it would be a step.
5 LT GEN GREEN: Can I just -- so I
6 have limited knowledge of the Army National
7 Guard and a lot of knowledge about the Air
8 National Guard. Let me just ask a couple of
9 background questions again. In a normal --
10 not considering deployment, even prewar, a
11 Guardsman is expected to basically get his
12 medical care on his own and maintain his
13 readiness. Correct?
14 COL KERR: That is correct.
15 LT GEN GREEN: And, so, in essence
16 the units that you have are basically there to
17 ensure readiness and when you see a member, or
18 when they come in on a UTA weekend, in essence
19 they are to report if they have something that
20 is a problem from a medical standpoint?
21 COL KERR: That is correct.
22 LT GEN GREEN: So I have a little

1 bit of trouble then after a deployment when we
2 are doing this that we walk away from what has
3 worked for us in terms of the Guardsman. Not
4 that we shouldn't be providing the care, don't
5 misunderstand me, but letting them get their
6 care wherever they normally get it.
7 We should be paying for it and
8 then having them bring it back. Your job is
9 essentially again to screen in terms of who is
10 ready, who is not ready, and who can stay in
11 the unit, whether or not we're going to have
12 a medical board.
13 I have a little bit of a problem
14 as we try and create a system that is not the
15 way we normally do business because I think
16 you are way underestimating your numbers in
17 your recommendation for how you are going to
18 deal with 2,200 people at this point in time.
19 I mean, maybe they could go around
20 and decide and help you with your line of
21 duties and get them their 100 percent coverage
22 that they need. The real question in my mind

1 is on a much broader scale.
2 Don't you simply need kind of the
3 ability for them to get the medical coverage
4 and then to bring things to your attention if
5 they are not going to be able to continue in
6 the unit, etc. That is the way you normally
7 do business so why would we change that?
8 I'm kind of wondering why we are
9 trying to establish an infrastructure that
10 basically is tied only to the deployments
11 versus using the system that normally would
12 support these folks which is whatever their
13 hometown healthcare is, and then the referral
14 mechanisms, especially once you had payment to
15 take care of that.
16 Whether that's through TAMP or 100
17 percent line of duty for a year or whatever it
18 takes, that basically makes certain that we
19 are paying for the care. I understand the
20 travel issues and things but, remember, these
21 folks are getting care. In terms of the
22 guardsmen they get their care based on

1 whatever system they have in place.
2 I'm trying to understand why you
3 feel we need to set up a military system of
4 care when you basically would normally do this
5 through usually their insurance, but now an
6 insurance plan that allowed them to go and get
7 care and then get records to you if they had
8 a problem that precluded them from being
9 ready. Am I missing something?
10 LTC PARMENTER: I think those are
11 valid points, sir. However, I would say
12 previously we didn't injure them. We didn't
13 cause these medical issues. They are coming
14 out of combat zone with issues, medical,
15 injuries, illnesses that we've created and now
16 they are going to potentially miss work to go
17 to this appointments.
18 They are going to incur additional
19 cost to go get psychological treatment. In
20 the example that Major Smith used, if they go
21 to the VA and it's three hours away and they
22 have an hour-long appointment, that is one

1 hour -- excuse me, one day out of the week.
2 If they go twice a week to
3 appointments, they can't work those days plus
4 the fuel that it cost and everything else
5 that's involved when they already have
6 psychological issues in this example. It is
7 distinctly different in my mind.
8 If things weren't caused by us and
9 these were issues that they came in and said,
10 "Oh, last month after drill I got into a
11 snowmobile accident and I broke my leg and
12 here's my medical documentation," we issue a
13 profile and we work them through the process.
14 I get that. We would continue to do that but
15 that is not the case here with these 2,264
16 soldiers.
17 LT GEN GREEN: But my point is,
18 given the line of duty, yes, and let them get
19 the care that they need in the community and
20 then track them. I'm not saying you walk away
21 from the tracking or the MEBs or the normal
22 process that you would do for readiness.

1 I'm just questioning why you think
2 that you need to bring in, you know, our
3 healthcare providers or do something different
4 than what they would normally receive.
5 COL KERR: I think the process
6 would be quicker if it's a captive audience.
7 MS. CROCKETT-JONES: And are you
8 saying that what doesn't exist currently is a
9 mechanism for them to stay on pay?
10 LTC PARMENTER: That's correct.
11 They have no pay and allowances to cover that.
12 Sure, we can do INCAP.
13 LT GEN GREEN: I mean, we make
14 decisions all the time on who is going to stay
15 on Title 10 orders. I mean, based on a
16 disability that drives that kind of care. I
17 mean, that is something else that you do. If
18 they are injured on a UTA weekend, you can
19 decide whether or not they are going to stay
20 on --
21 LTC PARMENTER: No, sir. We do
22 not decide. We submit a packet and someone

1 else decides. The trouble is, especially in
2 this --
3 LT GEN GREEN: We are all wearing
4 the cloth so, yes, the system decides who is
5 going to stay on Title 10 orders. If you've
6 got somebody who is requiring in-depth care,
7 I agree, bring them on Active Duty, take them
8 to a site where they can get that.
9 For the 1,600 roughly -- I'm
10 taking out all the mental health okay, but for
11 the 1,600 roughly that have orthopedic type
12 diagnoses and things, I mean, I feel like
13 we're simply delaying their care because we
14 don't give them the line of duty to get this
15 stuff squared away.
16 A lot of it would be taken care of
17 and they would be back in your unit. Am I
18 wrong? Or give them 100 percent TAMP for a
19 year so they can deal with all this stuff. I
20 mean, you understand I'm just weary of setting
21 up a system that has no chance of being
22 sustained and basically, you know, rather than

1 using the way we would normally do business.
2 That is the only thing that bothers me about
3 your suggestion right now.
4 COL KERR: It sounds like what
5 you're asking is to have an internal state
6 CBWTU and that's in essence what we're talking
7 about. If we are going to put them on full-
8 time dollars, then we are going to have to
9 have somebody to track them to make sure they
10 get to their appointments, to make sure that
11 everything happens for them. In essence
12 that's a state run CBWTU.
13 MSGT MacKENZIE: One of the things
14 we ran into with this, and correct me if I'm
15 wrong anybody, but if I remember correctly, in
16 order for them to be on Title 10 orders they
17 must be within a CBWTU or WTU structure.
18 In order to be on Title 10 orders
19 receiving the medical care in the State of
20 Iowa, right now that can't happen because in
21 order for them to be on Title 10 orders
22 receiving care, they have to be at a CBWTU or

1 WTU. They can't be in the state. Am I
2 missing the point or is that correct?
3 COL KERR: That's correct.
4 LT GEN GREEN: Okay. But on the
5 Air Force side, I essentially expand or
6 contract a call center that supports 300 to
7 500 people, making sure that they get their
8 appointments and that we track them until
9 completion.
10 I mean, we provide some
11 augmentation for the people who are on Title
12 10 orders and then work with the states as
13 well. I guess what I'm trying to drive to,
14 there are a lot more numbers on the Army side
15 so I'm not saying it should be done centrally.
16 It may well be best to do it by state so I'm
17 not arguing with you there.
18 It's just that I think that we
19 create some of the delays in people getting
20 the needed healthcare because we either, one,
21 don't give them full TRICARE benefits which
22 would be fairly straightforward to give it for

1 a longer period of time, or give it for a
2 period of time.
3 Or, two, if we're going to keep
4 them on Title 10 orders because of the issues
5 of travel and all the other things with not
6 being able to function at their job, then to
7 put them on Title 10 orders and essentially
8 get them the care that they need whether in
9 the state or basically back in a military
10 treatment facility.
11 I just am wary that bringing in
12 special teams, in essence I think you're
13 creating another CBWTU or another version of
14 this that's going to be mobile and go from
15 unit to unit where essentially now they can't
16 get care until the group of people comes to
17 their unit and finds it, versus giving them
18 authorization to go get the healthcare they
19 need to people who normally get the healthcare
20 they need.
21 COL KERR: Remember, sir, this
22 team is not giving care. This team is just

1 the aid to help track the care to get them to
2 their appointments quicker, to get them moved
3 through the system faster which currently
4 that's our biggest delay because we just don't
5 have the personnel to do that.
6 LT GEN GREEN: And the system that
7 you're trying to get them through is actually
8 the healthcare that they need or the
9 evaluation for readiness that they need?
10 COL KERR: It would be both.
11 LT GEN GREEN: And my concern is
12 are we delaying the healthcare that they need.
13 COL KERR: If you're comparing
14 this team to keeping everybody on Title 10 and
15 getting them care, yes, you are delaying them
16 by this.
17 LT GEN GREEN: Okay. I apologize.
18 I'm just trying to figure out why we are
19 building things differently than the way we
20 would normally do this. It seems like we
21 should be able to use existing systems.
22 MR. REHBEIN: If I may, I would

like to make a couple of remarks about the resource challenge that these folks have in front of them and just to help the Task Force get their arms around the Iowa situation. We are talking about 3,000 soldiers in a population of three million.

So that is a significant percentage of the population of the State of Iowa. To try to develop the resources there to support that population of wounded soldiers is a very -- is a very steep hill to climb, particularly in an economy where resources are being strained to begin with.

I just want to help people understand Iowa. I want to ask a question of these folks. The demob site at Fort McCoy. Are there any other demob sites that are operating without an MTF that you're aware of? Is it fair to characterize that as an experiment and possibly a failed experiment?

COL KERR: I would characterize it as a failed experiment. There are a few other

1 installations out there but the numbers are
2 very few and very low. The majority of demob
3 sites do have MTS, at least the demob sites
4 that would demob a brigade-size element.
5 MS. DAILEY: Of your 2,264 how
6 many do you think right now would be better
7 served by a community-based Warrior Transition
8 Unit or a WTU? Ten, 15, five percent?
9 COL KERR: Twenty-five percent.
10 MS. DAILEY: Twenty-five percent
11 of the --
12 COL KERR: Our MC 3As and 3Bs
13 would be better suited in a CBWTU.
14 MS. DAILEY: Okay. Just to follow
15 up on General Green's point, you are concerned
16 or one of your premises here is that your
17 units are not resourced to move these 2,264
18 through the system and get them the care they
19 need?
20 COL KERR: That is correct. Right
21 now the majority of it is done with our case
22 managers and their case care coordinators.

1 MS. DAILEY: I really appreciate
2 you nugging through this with us because even
3 though I said I think this team has the best
4 look at the National Guard issues and the
5 downward streams, I appreciate you nugging
6 through this with us because it is probably
7 the first time we have really had a chance to
8 look at this with you all here and everyone
9 getting to talk with you about it. Very
10 helpful.
11 COL KERR: We thank you for having
12 us. We hope this was very informative to you
13 and helpful.
14 MR. CONSTANTINE: Regarding the
15 cost that you identify as a problem to
16 individual service members, I understand in
17 the Wounded Warrior community, particularly
18 with Reservists and National Guardsmen, it's
19 a big problem having the ability to take time
20 off work to go to your appointments. I deal
21 with that and I'm sure everyone else does who
22 is in this category. That's not just Iowa.

1 That's everywhere.
2 Regarding the cost, though, I'm on
3 long-term LOD within the Marine Corps Reserve
4 and I'm able to file a travel claim for every
5 time I drive out to Johns Hopkins for an
6 appointment to be reimbursed for mileage. Do
7 you not have that ability for your service
8 members to be compensated for the fuel?
9 LTC PARMENTER: Are you in s Title
10 10 status on a long tour order?
11 MR. CONSTANTINE: No.
12 LTC PARMENTER: No? No, we do not
13 have that availability.
14 MS. MALEBRANCHE: I think the VA
15 covers some of that. I have another question,
16 though. We were talking about the Air Guard
17 and you mentioned case managers. Does the Air
18 Guard have case management assets?
19 COL KERR: I cannot answer that
20 for you.
21 MS. MALEBRANCHE: I was just
22 thinking of the numbers being smaller and one

of the things -- I think Mac brought this up.

LT GEN GREEN: The Air Guard is using centrally done case management so there is a cell down in AFMOA that the Guard is getting ready to expand because of some of the growth and the numbers on the Air Guard side, too, but it's done centrally for the Air Guard.

MS. MALEBRANCHE: Okay.

MSGT MacKENZIE: And there is some other resource that the Air Force uses locally within the state but one of the advantages in a couple of the states we went to was that the majority -- their personnel aren't as spread out rurally that are supporting based on the difference in personnel that are assigned to the Air Guard.

It's a little different dynamic and it's hard to -- it's in a lot of our notes, especially when we went to see all the guys in Massachusetts. It's different challenges that were posed to the Air Guard.

1 My whole point in that comment was that, you
2 know, the joint environment coming together to
3 assist and that was my question on that part.
4 MS. MALEBRANCHE: I guess the
5 other thing is the VA has immense case
6 management assets. We have more than doubled
7 our social work case managers over the course
8 of this 10-year war. I was just wondering if
9 any of those folks were used because VA is
10 also a TRICARE provider.
11 We also do have, similar to
12 TRICARE where you have some outline providers,
13 we also have some fee base of sorts and I
14 didn't know how much you were using the VA.
15 Also at the demob sites because the VA does
16 the TBI screening and then the follow up,
17 understanding that some of these areas are
18 very far.
19 A couple of things that are in
20 play, and I don't know how much in Iowa, but
21 it sounds like we are doing some telemedicine
22 and telepsychiatry. General Korelly had

1 actually been very forceful in his wanting to
2 use that more so as people were coming back.
3 I just wondered if any of those assets or any
4 of that has been explored at all.
5 COL KERR: No. The only VA system
6 for us that does TBI testing would be the
7 University of Iowa which is centrally
8 easternly located for us. We have not looked
9 into any telepsych medicine from the VA simply
10 because we've had our own psychiatrist on
11 board with us. We can certainly look into
12 that, too.
13 LT GEN GREEN: I think it's fair
14 to say that you've got our attention. Okay?
15 We're listening. We're actually kind of in
16 the weeds now trying to help you find
17 solutions. We'll also deal with a lot of
18 other folks in terms of trying to figure out
19 how we can help you in terms of what we do in
20 the report.
21 I think, at least up here at the
22 top of the table, I think a site visit is

needed. We would very much like to get General Stone to be on that site visit if we can make that happen. We'll be working to see if we can't get some folks to come out and visit out at Rock Island.

Then we are going to have to think through what some of your recommendations and see how we can pull this together to give you folks some assistance. I think short-term it would be good. I wish General Stone would have been here to hear some of this this morning but I think we need to get him to do a site visit with us.

MSGT MacKENZIE: Can I throw a comment in, sir? One of the things unfortunately -- hopefully we can get some of the notes referenced from the states that we went to. The VA thing is actually state by state. It's not uniform across states.

Also in several -- the difference in what certain VAs in certain states do and other states is different. Some are great and

1 some aren't at the level of greatness as other
2 states. Also, the question was asked and
3 answered in multiple locations which was,
4 although you are a TRICARE provider, has
5 manpower assistance, resources changed in
6 order to add on that additional
7 responsibility?
8 In both locations the answer was
9 responded, no. Although this stuff is there
10 in writing in each location, we need to get a
11 very specific answer. It's not across the
12 board unfortunately.
13 LT GEN GREEN: And I think that's
14 where the role of the Task Force comes in in
15 terms of trying to put this in a bright
16 spotlight in terms of potential gaps. I
17 agree.
18 MS. DAILEY: Some of our
19 recommendations we saw it's not necessarily
20 fixed by demobing through a military treatment
21 facility. Fort Stewart and Fort Lewis
22 demobed, Florida and California respectively,

1 and the joint forces headquarters brought
2 these same issues to our attention.
3 They got referrals. They weren't
4 put in the WTUs. The referrals went back into
5 the community, the ability to track the
6 referral in the community, the ability to keep
7 people employed and not let them go destitute
8 while they were going to these appointments
9 all came up in Florida and California.
10 LT GEN GREEN: Right. So the
11 question becomes how do we share best
12 practices and make certain that we are given
13 the options that are required to meet the
14 different individual's requirements.
15 Understood.
16 MS. CROCKETT-JONES: Are we ready
17 for a short break before we move on?
18 MAJ SMITH: I just have one
19 comment. As far as the VA, I know that Iowa
20 is one of the pilot states for the traveling
21 or the satellite kind of like an RV trailer
22 that will travel around the state.

1 I believe that we will be getting
2 one in the fall so I know we are very excited
3 about that traveling satellite clinic that
4 will go, as far as behavioral health. I know
5 we are the satellite for the first one. We
6 are very happy with that.
7 MS. CROCKETT-JONES: You are going
8 to be hearing from us, I think, some more and
9 we will be asking you some more questions over
10 time, just not in this particular forum today.
11 MS. DAILEY: We will take a quick
12 break. I apologize to my Military Community
13 Family Policy briefers standing by. We'll set
14 your slides up and we'll give you as much time
15 as you need and as much attention. I
16 apologize for the delay. Thank you.
17 (Whereupon, the above-entitled
18 matter went off the record at 10:09 a.m. and
19 resumed at 10:22 a.m.)
20 LT GEN GREEN: Welcome back,
21 everybody. So we have been interested in
22 learning more about the resources offered by

1 OSD's Office of Military Community and Family
2 Policy such as Military OneSource and the
3 Wounded Warrior Resource Center, specifically
4 how they assess recovering warriors and their
5 families and how the effectiveness of these
6 programs are quantified.
7 With us from the MC&FP is Mr.
8 Charles Milam, Principal Director for Military
9 Community and Family Policy. Chuck, thank you
10 for joining us this morning.
11 There are going to be some other
12 briefers and I don't have the list of all the
13 names. Ms. Nora Clouse. Is that correct?
14 MS. CLOUSE: Yes, sir.
15 LT GEN GREEN: Okay, who is a
16 program analyst in the Office of Strategic
17 Outreach. Thank you for joining us. We are
18 very sorry to be an hour late and be burning
19 some of your time but I think if you heard any
20 of what we were just discussing, it's very
21 pertinent in terms of what this Task Force is
22 up against.

1 Please, over to you, Chuck.
2 MR. MILAM: Good morning. I am
3 delighted to be here. Nora came to brief me
4 a few weeks ago and said she was coming here
5 to give you all a presentation specifically
6 answering some questions that you had.
7 Just by way of introduction, I
8 used to run the Air Force Wounded, Ill, and
9 Injured Program before coming over to OSD so
10 I'm very passionate about the work that is
11 being done here. I appreciate the work that
12 is being done by the Task Force. I know Mac
13 and I worked together on a few initiatives out
14 there with John Beckett who has since passed
15 away.
16 I'm very interested to hear not
17 only the response to the questions that you
18 have asked of us today but also to take a look
19 at what else we can do for you from an OSD
20 standpoint. I have a completely different
21 perspective now that I'm over at OSD on the
22 capability of Military OneSource and the reach

that it can have.

I can tell you that one of the major challenges that I always faced when I was running the program for the Air Force was communication, or the lack thereof. It always became a crisis when a senior leader went into one of the military medical facilities and would discuss with a service member, are you getting the support that you need, and the answer was no. Then we got things going.

I'm not sure if that has improved much over time but I can tell you that there are challenges out there with reaching our wounded, ill, and injured. The fact that 70 percent of our families live off-installation, it almost becomes the Guard and the Reserve model.

Many of our programs are installation support-based. I'm trying to get into the mindset of reaching, targeting, I think, support out to the communities more looking at public private ventures, leveraging

technology through websites like OneSource.

I will tell you that OneSource, it's work in progress. We are making changes to it. We are making it better but I want it to be more than just a click on a certain button and get information. I want it to be engaging. I want it to be interactive.

I want it to support the wounded, ill, and injured in any way we can. I'm very interested in seeing where we have overlap, where we have duplication from the other services in terms of call centers and information that they provide. How can we leverage the support that we have between the services in OSD and target the resources where they are needed.

With that, I think I'm going to be asking questions of you as well and hopefully getting back in the groove, so to speak, and what is going on out there with our wounded, ill, and injured and figuring out how we can, again, use the resources we have available to

1 us, not only Military OneSource but also our
2 military family life consultants in targeting
3 the resources where they are needed.
4 We are working on some social grid
5 work where we are trying to target where our
6 military population and families are located.
7 Instead of just doing a peanut-butter spread
8 with program support, we can target our
9 inflects to the areas that they are needed.
10 I think that is very important.
11 With that, I'm going to turn the
12 presentation over to Nora who is going to
13 answer your questions, but I would like to
14 take some time towards the end and discuss
15 some of your ideas and your thoughts on how we
16 as OSD can improve communication, improve
17 support to our wounded, ill, and injured and
18 their families, those caregivers that are so
19 critical in helping our service members.
20 Thank you.
21 MS. CLOUSE: Thank you, sir. So I
22 was intentional, very intentional, in limiting

1 the information today to the nine questions
2 from the Task Force, along with some metrics
3 and data that I'll be providing the way ahead
4 as we currently see it as it's my
5 understanding that the members are all
6 familiar with the congressional mandate for
7 the Wounded Warrior Resource Center.
8 We welcome the questions from the
9 Task Force and clearly the insights, those
10 questions and subsequent answers contained
11 therein.
12 For the purpose of the Military
13 OneSource brief, I just wanted to clarify
14 since I was in attendance yesterday that MOS
15 stands for Military OneSource and not Military
16 Occupational Specialty.
17 Before I begin, I would like to
18 clarify my role on the Military OneSource
19 Program staff. One of my areas of
20 responsibility is to provide oversight of the
21 efforts of the Wounded Warrior Specialty
22 Consultant in the MOS call center.

1 My other area of responsibility is
2 to provide oversight to the community outreach
3 team which includes the Joint Family Support
4 Assistance Program, Military OneSource
5 consultants in the state and territories,
6 primarily working at the Joint Force
7 headquarters.
8 Okay. First question. What ways
9 does OneSource specifically target the needs
10 of recovering warriors? Some ideas were
11 provided regarding content on Military
12 OneSource online, navigational aids, and
13 dedicated information or services.
14 In all honesty what we provide is
15 what the congressional mandate called for.
16 Basically it's information for wounded,
17 injured, ill service member and their families
18 or caregivers regarding resources, military
19 benefits, and information related to living
20 and coping with disabilities.
21 We also provide a link to the
22 National Resource Directory for additional

information. I know you are all very familiar with the NRD.

MSGT MacKENZIE: So you guys actually know what type of personnel are accessing your website?

MS. CLOUSE: We do, sir. We can -- we actually track the hits and where they are coming from, yes. I heard some information provided yesterday in terms of the depth of tracking where hits to websites come from and the challenges associated with that but we have a pretty good handle.

Certainly we have a good handle on who is touching all of our social media. For example, the Facebook page and that type of thing.

MSGT MacKENZIE: Sounds like the individual that briefed us yesterday needs to talk to you guys to answer that question.

MS. CLOUSE: We've got a pretty robust Office of Communications and they are doing a great job.

1 Any other questions?
2 MS. DAILEY: Military OneSource
3 has been around for a long time. This is a
4 robust program, relatively mature.
5 MR. CONSTANTINE: Just to clarify
6 that, you can tell using programs like Google
7 or other isometrics, you can tell where people
8 are coming from when they come to your site,
9 but you can't tell who that person is.
10 MS. CLOUSE: That's correct.
11 That's correct.
12 MR. MILAM: I think more
13 importantly, you know, kind of my opening
14 comments here, we are hitting the mark. I
15 mean, we've got thousands of people calling
16 OneSource for help. We have arm hand-offs
17 where help is needed. I think we lack that
18 feedback mechanism did we really make a
19 difference. I mean, I think we are all
20 challenged with this, the healthcare systems
21 as well when they look at our programs.
22 They are looking for the empirical

1 data of did we help from that member
2 committing suicide, from committing domestic
3 violence, from hurting themselves, their
4 families.
5 That is, I think, a feedback
6 mechanism that we are working towards, not
7 only with this program but with other programs
8 as well to really know, to kind of drill down
9 to figure out are we hitting the target when
10 thousands of people are calling OneSource and
11 they are asking for information and we're
12 counseling them. Are we hitting the mark
13 here? That is where I am very interested in
14 taking a look at to make sure that what we're
15 providing is, in fact, on target.
16 MS. CLOUSE: Okay. So speaking of
17 numbers, the numbers speak for themselves.
18 Clearly there may not be any surprises here in
19 terms of the fact that the Army is utilizing
20 touching OneSource more than the other
21 services. We do have a breakdown with regard
22 to service members and family members which is

1 quite interesting.
2 I think people often think that
3 family members are reaching OneSource more so
4 than service members and clearly our data
5 shows otherwise.
6 It's important to note that the
7 data listed here consist of emails, in-person
8 counseling sessions. That includes both the
9 non-medical counseling and financial
10 counseling, telephone contacts through the 800
11 number, and online visits. These numbers do
12 include both Active Guard and Reserve.
13 Questions?
14 Okay. The Task Force had a
15 question regarding the KIAT, Keeping It All
16 Together binder, which is a resource that I
17 know you are well aware of. The question was
18 whether or not we can distribute this resource
19 in bulk.
20 Really the answer is that we have,
21 in fact, provided the resource in bulk, but
22 really we've targeted our recipients in

1 working with the representatives from the
2 Wounded Warrior units or casualty sections at
3 the branch and component level.
4 It is important for you to know
5 that individuals can obtain copies of this
6 resource by calling the 800 number and
7 identifying the fact that they've got a
8 service member or a family member who is
9 wounded, ill, or injured. I know you are aware
10 of that. Really the issue is the fact that
11 people don't have them sitting on shelves
12 available in the event that there is a need.
13 I get that.
14 It's important to note that the
15 binder was created in late 2005/2006 with
16 input from the casualty and Wounded Warrior
17 reps from all the services. They are the ones
18 who really determine the distribution process
19 at that time at the service headquarter level.
20 Clearly, the fact that through
21 your site visits have identified the need for
22 people to have them more readily at hand.

1 It's clear that we need to take a look,
2 reevaluate our bulk policy for this resource
3 and we are certainly committed to doing so.
4 CAPT EVANS: Have you received any
5 feedback directly from the family members? A
6 lot of the -- we used the binder for our
7 family orientation so that is automatic
8 distribution during family orientation. A lot
9 of the mothers and the wives will come back
10 and say, "It's a great binder but I would like
11 to have something that I can slip in my purse,
12 pull out, document in, or put all my business
13 cards."
14 They get several thousand business
15 cards. It's a great binder, it's a great
16 tool, but I have had some feedback from family
17 members. I'm not sure if you solicit feedback
18 or not.
19 MS. CLOUSE: Actually, ma'am,
20 we've not heard that feedback but clearly it's
21 the wave of the future. We all, I think,
22 would desire the types of resources that are

1 more portable and mobile. I will be talking
2 to that later in my presentation. Thank you
3 for that.
4 MR. MILAM: One of my first
5 questions when I got briefed on this was
6 looking at an automated type of program that
7 we can download to hand-held devices as well
8 as to tablets and iPads. I'm not saying
9 replace the binder because what we find is
10 that the boomers out there love the binders.
11 They love paper but millenials are very
12 technologically advanced so they want
13 something in a hand-held device.
14 When we develop that, it's going
15 to have to be more than just clicking a button
16 and opening up the information. I'm thinking
17 of something more interactive where you go in
18 there and you have a series of questions in
19 there.
20 You click on it and it kind of
21 feeds you through the myriad of answers that
22 you can have almost like, you know, MEDMD.

General Green probably thinks it's probably not a great resource but it's the same concept.

I've challenged the team, I think, to take a look at that. We can also look at brochures and make sure that we have the right information that people can carry and their purses. I think we need to look at the more advanced digital electronic version of the binder.

MSGT MacKENZIE: One of the things along that, I know in my job as a liaison for SOCOM we took that information and rolled it into the day planners that we were using in order to provide that portability and the combination of being able to -- most importantly this information is found to be very resourceful to the quiet nights when spouse or mother or father, or whatever, is sitting in the room watching their loved one sleep.

The timeliness in getting that

1 information is almost the longer post -- the
2 connection of wounded service member in the
3 family and actually getting the documents to
4 you to keep this all together certainly change
5 the amount of use this material gets which is
6 why we made this comment about being able to
7 issue it immediately versus having to wait
8 whatever period of time it takes to link up.
9 I applaud you. The number of
10 iPads and iPhones you begin to see start
11 running around and devices of that nature will
12 definitely show that this resource being
13 accessible to that and interactive will be
14 huge for the families.
15 MR. MILAM: I think even, you
16 know, the one phase. I think there is even a
17 shorter term solution and that is getting this
18 information on the website electronically so
19 that if they don't have the binder yet, since
20 we are mailing it bulk mail through the U.S.
21 Postal Service, that's going to take some time
22 to get there, that they can click onto the

website immediately and go through the myriad of resources that are available to them and look at the second phase of that technology as well.

MSGT MacKENZIE: Which will work as long as they've got a laptop and internet access while they are sitting there when they want to write down these thoughts.

MR. MILAM: Right. It's an alternative. I think, you know, when I looked at this I said, "What do we have in addition to this binder?" That's pretty much it. If you don't have the binder, you don't have the information. What we are looking at is, again, many of the complaints that I hear from wounded, ill, and injured is lack of information or incorrect information.

How do we use OneSource and any other resource we have available to us to reach wounded, ill, and injured family members out in every part of this world and how do we get information to them? How do we

1 communicate with them?
2 I can tell you right now it's a
3 challenge. It is a challenge. I can tell you
4 that the wounded warriors that I've talked to
5 they get results when they talk to senior
6 leadership. When they try to work through
7 this maze of bureaucracy that we have, and it
8 just takes forever to get stuff done, I would
9 like for them to call a single source.
10 I mean, obviously the services all
11 have their call centers. I know that is a
12 cultural thing. We want to make sure that we
13 have personnel connected with the right
14 resources and everything.
15 OneSource is available there, too.
16 Even if that becomes the very first call
17 that's made, I want to make sure that we have
18 the right timely accurate information that we
19 can give back to the service members and their
20 families.
21 MS. CLOUSE: One final comments
22 before we move on from this slide. Part of

1 the reason the original bulk order policy was
2 developed was because it was cost prohibitive
3 just to ship these out in bulk to every unit
4 in every service.
5 I mean, we're talking about a $28
6 resource per binder so that is part of what
7 was considered when the original decisions
8 were made. Another reason for moving toward
9 a more mobile electronic version.
10 MS. DAILEY: As far as units go, I
11 mean, the Marine Corps is incorporated to Keep
12 It All Together very effectively and they were
13 the ones who said, "Great resource but we
14 can't get in bulk." When it comes to shipping
15 and bulk issues, I mean, they've got one on
16 the west coast and one on the east coast and
17 they can handle it from there.
18 MS. CLOUSE: Great.
19 MS. DAILEY: You know, we haven't
20 seen it at all in the Army which is wise.
21 MS. CLOUSE: Right.
22 MS. DAILEY: We would like to see

it fumigated. Just working through the NCOMs, working through those SFACs, those are discrete locations that you could ship to. Then the Air Force has a program right there in San Antonio so there is a discrete location, and the Navy Safe Harbor. They can take the cost from there.

MS. CLOUSE: Absolutely. Actually, we have had it available --

MS. DAILEY: I volunteer them for it.

MS. CLOUSE: Okay. We have had it available on OneSource for some time in PDF form and we do hear feedback that, darn it, they want it to arrive in the nice looking three-ring binder. As we go through these next couple of slides, I'll share some of the challenges associated with distribution of it.

MSGT MacKENZIE: Real quick before you jump ahead. Something that you mentioned that sort of grabbed my attention was things get done with access to senior leadership, but

1 yet there is so much bureaucracy.
2 I mean, can you clarify that a
3 little bit and kind of expound on what it was
4 -- the point you were making in that in
5 relation to especially a single focal point
6 for getting this information?
7 MR. MILAM: Well, Mac, I think you
8 lived it. I think, you know, with our
9 Wounded, Ill, and Injured Program, I mean,
10 we've been writing the book as we go on this
11 thing. Eleven years of conflict. We've got
12 new issues coming up every single day.
13 We know that our personnel
14 policies don't match the needs of our service
15 members and their families. It takes
16 feedback, I think, from the wounded, ill, and
17 injured when we have forums to figure out why
18 we need unique policies and rules and
19 legislation to be able to work through this
20 myriad of challenges that we have.
21 I mean, Matt Slayton was a great
22 example. I mean, we have several of them out

1 there when we are asking them for promotion
2 testing. Some that are blind. I mean, how do
3 you go through those things?
4 I think my point is that for the
5 Air Force the Recovery Care Coordinator
6 Program worked well. I'm not certain about
7 the other, and I know I'm getting off lane
8 here.
9 I don't work in the WWCTP Program
10 but I'm just giving you some experience here.
11 It worked well because we had a much smaller
12 wounded, ill, and injured to recovery care
13 coordinator ratio. It was very personalized
14 service.
15 You have a guy like John Beckett.
16 He knew that when we had one of the wounded
17 warriors getting ready to step off the ledge
18 and he worked those things personally. Okay?
19 But when you don't have that connectivity,
20 when you don't have that voice that reaches
21 back to the highest levels, I think people
22 fall through the cracks.

1 It's then where -- I used to think
2 we had things under control. We had General
3 Schwartz go up to Walter Reed. He would come
4 back and say, "Hey, I just talked to so and so
5 and so and so and they have been trying to get
6 this for a long time and they haven't been
7 able to do this yet." Then things get done.
8 How are we communicating? How are
9 we getting the communication from our wounded,
10 ill, and injured to the very highest levels?
11 That's my concern. My concern is being able
12 to voice their concerns to the top without the
13 bureaucracy in the middle.
14 MSGT MacKENZIE: That is exactly
15 where I was going with this. Forgive me for
16 taking a sidebar here but you opened a point
17 that I really wanted to make. It seems that
18 when the service chiefs are saying, "Hey, get
19 this done," it gets done.
20 But there seems to be way too many
21 levels between the action folks in getting
22 that information back to the chief to say,

1 "Hey, we need more assistance here in order to
2 meet your requirements." I mean, it seems
3 like there are too many levels between the
4 program and the commanding officer.
5 MR. MILAM: There is. There is.
6 I think we all recognize that. We have
7 thousands of people who need support and help
8 out there. The challenge is trying to get
9 their concerns but reach to the highest level.
10 How can we -- I'm going to put my other hat
11 back on in Military OneSource.
12 How can we bridge some of that
13 connectivity? This is just a question. I
14 mean, I'm looking to not necessarily grow the
15 program or go off course but I'm looking at
16 how do we improve communication, not only help
17 in service but feedback as well because that's
18 my biggest concern is how do we improve the
19 care, the quality of life for the service
20 members and their families that are out there.
21 How do we do that most
22 efficiently? I don't know if four call

1 centers plus OSD is the right answer. I don't
2 know if the bureaucracy that we have today is
3 organized properly. I can't speak for the
4 other services. I can't speak for the Air
5 Force.
6 MSGT MacKENZIE: I've asked the
7 same question because I know when we were
8 setting up some of the programs in the Air
9 Force the fact that I could speak directly to
10 the Chief Master Sergeant in the Air Force got
11 things done.
12 MR. MILAM: Is that the same in
13 the other services, though?
14 MSGT MacKENZIE: Well, that was --
15 it is the same when the person can make that
16 connection.
17 MR. MILAM: Right.
18 MSGT MacKENZIE: It almost seems
19 like an organization like yours if the action
20 folks are directly connected to the commander,
21 then you have the ability to funnel things
22 that come into your website to go, "Hey, guys.

We just saw this Air Force. We just saw this Marine Corps." It would give you an opportunity to funnel this data directly to the people who can fix it in connection with the person responsible.

MR. MILAM: We ought to be able to raise the yellow or red flag when it comes in and push the right buttons in the services to get action.

MSGT MacKENZIE: But I would also hope that the service call centers have that same level of support. That is just a comment. Okay? So when an Air Force wounded member calls down to San Antonio to the call center down there, do they have the same connectivity that I'm willing to provide up in OSD. If not, we have a breakdown. Okay?

Because what will end up happening, Mac, is people won't be calling that call center anymore. I now that senior leadership within the service will want to have that information. They don't want us

1 running their programs for them.
2 MS. CLOUSE: To your comment, sir,
3 I think when I showed the data in terms of who
4 utilizing the Wounded Warrior specialty
5 consultants which is really meant to be a
6 second point of contact for service members.
7 You will see that clearly service
8 members and family members and caregivers are
9 having challenges obtaining assistance in the
10 areas that they need because by the time they
11 call our call center for Wounded Warrior
12 consultation, they have already really tried
13 to work through their own service Wounded
14 Warrior Programs.
15 MR. MILAM: Can you explain that
16 just to the group?
17 MS. CLOUSE: Sure.
18 MR. MILAM: We are basically
19 considered a secondary call center for this.
20 MS. CLOUSE: And, again, this is
21 the information that I didn't want to provide
22 if you are all very familiar with the

1 congressional mandate, the Wounded Warrior
2 Resource Center. Is that clear or should I --
3 okay. All right. Let's get back on track
4 with the questions here.
5 MR. CONSTANTINE: Ms. Clouse, I
6 think you said $28 cost for the binder?
7 MS. CLOUSE: That's a ballpark
8 depending on the quantity ordered.
9 MR. CONSTANTINE: That doesn't sit
10 well with me.
11 MS. CLOUSE: Okay.
12 MR. CONSTANTINE: Something this
13 beneficial, this necessary when someone is
14 drawing the line in the sand $28, which is
15 nothing.
16 MS. CLOUSE: In terms of it being
17 cost prohibitive?
18 MR. CONSTANTINE: Yes. I mean,
19 that is what one dinner cost or something.
20 Here is something that helps these wounded
21 warriors exponentially.
22 MR. MILAM: We are going to get

1 these binders out. $20 in my opinion is not
2 cost prohibitive for this program. But I will
3 tell you that we need to leverage technology
4 as well.
5 I think when we do that, we are
6 going to have a large majority of people that
7 are out there that don't want to carry a
8 three-ring binder around and they would rather
9 have the resource either through tablet or
10 even a hand-held device.
11 We are not replacing one with the
12 other. All I'm saying is we need to leverage
13 technology and use it. I was surprised when
14 I saw this that this is the only way we get
15 this information out is through a three-ring
16 binder.
17 MR. CONSTANTINE: You're right.
18 MR. MILAM: This is not how we
19 communicate.
20 MR. CONSTANTINE: The technology
21 should be secondary that you're talking about
22 because it's easy when you are not wounded and

1 in your office everything works great. If it
2 doesn't, you can call the tech guy and they
3 come and take care of it.
4 When you are sitting there and
5 maybe you're lucky and you're in Bethesda and
6 you have those resources but probably you're
7 not. Up until very recently when I was in the
8 hospital it wasn't even there.
9 MR. MILAM: I think --
10 MR. CONSTANTINE: The family has
11 their hands on something because we don't
12 mandate that for anyone else so why would we
13 make it for wounded warriors?
14 MR. MILAM: I think it's not
15 replacing the binder but it's providing
16 additional ways to get the information for the
17 binder. I think that is the key here is that
18 if people still want the binder, they'll get
19 the binder.
20 Understanding the special needs
21 for wounded and their families and being
22 sometimes in hospitals and remote locations,

1 military treatment facilities, we understand
2 the need to have a document or a piece of
3 paper in place.
4 I will also tell you that I think
5 once you get this word out that there's other
6 ways of getting this information, I think that
7 need will drive up the requirement for more
8 electronic versions of this. In the meantime
9 we are going to continue with the binder.
10 MR. PARKER: The electronic
11 versions can be updated and modified. I don't
12 know if there's an answer with a binder except
13 to mail out new stuff.
14 MR. MILAM: When the binder is out
15 there and you have dated information, it's
16 only updated when the information is updated
17 and sent back out again. There is a need for
18 it but it is more of an antiquated system. We
19 just have to figure out -- this is about
20 communication.
21 This is about figuring out how to
22 leverage technology, leverage the resources

1 that we have today to reach our wounded, ill,
2 and injured and their families. That's what
3 this is about. That's what I'm trying to
4 figure out using Military OneSource.
5 MS. DAILEY: How about if we go to
6 slide 7. We've kind of kicked the Keep It All
7 Together pretty aggressively.
8 Okay. Basically the question was
9 regarding the services provided through the
10 Wounded Warrior Resource Center. Again,
11 actually we've spoken to this.
12 Basically specialty consultation
13 services, accessed via Military OneSource,
14 allow for the provision of immediate
15 assistance to be provided to wounded warriors
16 and their families with issues related to
17 these specific areas per the congressional
18 mandate; healthcare, facilities, or benefits.
19 As Mr. Milam pointed to earlier,
20 these consultants work collaboratively with
21 the services' Wounded Warrior Programs, not in
22 lieu of. And directly with VA to ensure the

1 callers are promptly connected.
2 Part of the job of the
3 consultants, they sort of wear two hats. Part
4 of what they do is information referral
5 services clearly. The other part of what they
6 do is all of this coordination with the
7 military services and VA and the case
8 management that goes along with that.
9 Let's assume there is a caller who
10 does need some case management services. I
11 mean, this could entail several months worth
12 of effort on the part of all parties involved.
13 What happens in such a case the
14 call comes in and within a 24-hour period they
15 must reach out to the appropriate
16 organizations and services programs. Within
17 96 hours the services or VA or TRICARE must
18 submit a plan of action toward working to
19 resolve this issue. So that's the process in
20 place for case management.
21 Questions about that?
22 Okay. This is basically

1 information regarding utilization. You see
2 here all of the data that I'll be speaking to
3 is FY '11 data. The call center received
4 approximately 3,000 calls specific to wounded,
5 ill, and injured.
6 As you see there, the 2,939 calls
7 resulted in about 4,200 referrals for support.
8 We've got a team of -- currently we've got a
9 team of six specialty consultants and a
10 program manager. They are all contract
11 employees so they are the one doing this work
12 for us.
13 3,000 calls were directed to
14 TRICARE, VA, or the services Wounded Warrior
15 Programs. The third bullet basically speaks
16 to a data point that Health Affairs is
17 typically interested in. They are always
18 curious about whether any of these calls were
19 related to adequacy, quality, or state of
20 repair of medical related support facilities.
21 MSGT MacKENZIE: So they are not
22 asking you about access or availability, just

1 whether it's adequate quality and state of
2 repair?
3 MS. CLOUSE: We get that question
4 annually.
5 MSGT MacKENZIE: The reason I make
6 that point in this over-arching deal if they
7 had access and availability, they probably
8 wouldn't be calling you guys because they
9 would already have the care they need --
10 MS. CLOUSE: That's a valid
11 question, sir.
12 MSGT MacKENZIE: -- in most of
13 those cases.
14 MS. CLOUSE: Absolutely.
15 MS. DAILEY: That third bullet is
16 addressing state of repair of the medical
17 facilities.
18 MS. CLOUSE: Facilities. Correct.
19 MS. DAILEY: That's not about
20 access or care. No one seems to be
21 complaining through this avenue of the state
22 of facilities.

1 MS. CLOUSE: Understand. Point
2 taken, ma'am. I think that was the point,
3 yes.
4 And then the final bullet,
5 basically 31 percent of the callers were
6 directed to other non-medical resources. For
7 example, individuals who are having financial
8 constraints and perhaps have been addicted,
9 those types of things. Banking, community
10 services, and school system issues.
11 Okay. The question from the Task
12 Force was was whether or not we maintain data
13 with regard to family utilization. The short
14 answer is no, we do not. Cases are documented
15 in the Wounded Warrior case tracking system on
16 the premise that family members and caregivers
17 can call for support if necessary, but
18 ultimately the issue is tracked to the service
19 member.
20 Really the rationale is because of
21 the potential deficiency in military benefits
22 which are ultimately tied back to the service

1 member. I can say that currently we are not
2 tracking family utilization. I see some
3 concerned looks here.
4 LT GEN GREEN: Do you have any
5 breakout -- since you don't collect family, do
6 you have any breakout on Reserve versus Active
7 Duty?
8 MS. CLOUSE: Yes, sir. We do. I
9 did bring that with me today.
10 Okay. This first bullet depicts
11 the number of cases that were actually
12 resolved. This goes back to what I spoke to
13 a few moments ago, case management versus
14 information, resource, and referrals.
15 Next bullet, the top three issues
16 concerning callers. Clearly health care
17 always tops out at the highest, the number one
18 issue followed by VA benefits and military
19 benefits.
20 Are you interested in some
21 examples? Okay. I've got a couple here. An
22 example of health care would be a guardsman

1 attempting to get medical appointments at an
2 MTF. Another would be a spouse calling
3 because the service member isn't getting PTSD
4 treatment and is concerned about that. With
5 regard to VA benefit issues, a veteran who has
6 applied for benefits perhaps nine to 12 months
7 ago and has received no correspondence.
8 A veteran who lives 75 miles from
9 the nearest VA center and cannot -- is unable
10 to get to appointments. As I mentioned a
11 moment ago, perhaps a veteran who has been
12 addicted and is now homeless.
13 With regard to Military benefits.
14 Examples a guard -- these are all very current
15 examples. A guardmember who has been seeking
16 incapacitation pay for an injury sustained
17 while mobilized but denied due to the fact
18 that he is missing medical records. We see
19 that one quite often.
20 A second one would be a service
21 member experiencing extended delay in the
22 MED/PEB process. Those are concrete examples

1 of the types of calls that we get.
2 MR. MILAM: Is the Task Force
3 getting updates from the services on the same
4 issue for their primary call centers? That's
5 a question. When the services are coming in
6 to brief, are you getting any feedback from
7 them on what their top three concerns are?
8 MS. DAILEY: We have not asked
9 them for that information.
10 MR. MILAM: Would it be helpful
11 for you? I don't know. Again, those are the
12 primary call centers. We are the secondary.
13 I don't know statistically taking a look at
14 what their primary concerns would be with the
15 services. Again, this is about reshaping our
16 responses as well.
17 DR. TURNER: Ms. Clouse.
18 MS. CLOUSE: Yes.
19 DR. TURNER: On your health care
20 on the calls in, I assume they are probably
21 non-health care people answering the phone on
22 these typically. Do you have like protocols

1 in place on how you refer them? I would be
2 interested to know if someone is calling for
3 a referral, what are you protocols for getting
4 them in the system?
5 MS. CLOUSE: Sure. We have very
6 strict protocols. Like I said, the first
7 point of business, and these are all licensed
8 master's level social workers actually.
9 Again, they first connect immediately with the
10 services Wounded Warrior Programs unless the
11 service has asked otherwise which would be the
12 case of the Army.
13 They have asked that we go
14 directly to MEDCOM as opposed to their Wounded
15 Warrior Program. I heard a bit of the
16 discussion yesterday with regard to the
17 Wounded Warrior Program versus the AWW Program
18 and MEDCOM. There is inconsistency with
19 regard who we've been asked to communicate
20 with. That is a great question.
21 MR. CONSTANTINE: When you talk
22 about these cases being resolved by your

1 specialty consultants, if someone calls in and
2 says, "I've been on this med for so long and
3 it's taking forever for the VA," you don't
4 answer that. You don't handle it for them.
5 You just tell them who to talk to or
6 something. Right?
7 MS. CLOUSE: Correct. So what
8 happens typically -- this is what we hear
9 quite often. "I've contacted my service's
10 Wounded Warrior Program. I've contacted VA.
11 I can't get resolution to my issue."
12 When they call us because of the
13 congressional mandate, there seems to be a bit
14 of weight associated with that and all of a
15 sudden doors open. With a lot of effort and
16 work, obstacles can be overcome and resolution
17 of a case would literally be perhaps weeks,
18 months, days after the call and constant
19 communication back to that caregiver, service
20 member, family member to ensure that their
21 issue has literally been resolved.
22 It's not just a referral and then

closed at all. We ensure that the issue has fully been resolved. We track all of this, all of the communication in a case tracking system that we developed at DoD.

DR. TURNER: When these people become de facto case managers, do you keep them on with one person or is it a team that takes care of them?

MS. CLOUSE: When a case is opened our goal is to provide consistent support with the case manager. Now, hypothetically -- and I've witnessed their handling of cases. I've monitored the way they handle cases and it's incredible the amount of communication back and forth with individuals.

However, if an individual calls when that case manager isn't on duty for some reason, someone else can certainly assist and then they plug in the communication that occurred into the case management system. When the primary case manager goes back to reconnect, they can see everything that has

occurred. It's very comprehensive.

MR. MILAM: Also, I welcome Task Force members to come by Military OneSource, kick the tires, you know, put some headsets on and actually listen in to some of the discussions. It's fascinating.

I mean, we have people working there that are very passionate about the work that they are doing here. Like Nora said, I think all efforts were made to make sure when a person has worked with one of our counselors that we go back to that primary person again.

DR. TURNER: What's your average wait time?

MS. CLOUSE: We've got a wait time built into our quality assurance plan. It is extremely minimal. I mean, it's like under -- gosh, I don't know, under a minute. What happens is the phone doesn't ring off the hook if somebody is trying to call the Wounded Warrior Resource Center.

Somebody in the Military OneSource

1 call center will pick up, gain the relevant
2 information, and then as soon as a consultant
3 becomes available, it's transferred over
4 immediately.
5 Okay. How do families and
6 recovering warriors learn about the Wounded
7 Warrior Resource Center. Primarily through
8 Military OneSource Online, by calling the 1-
9 800 number which is very, very common.
10 People may call asking for
11 financial information. They may call asking
12 where the nearest MTF is. Ultimately once
13 it's determined that they are a wounded
14 warrior, they will be referred over to the
15 Wounded Warrior Resource Center.
16 Or they can call directly once
17 they are already aware of it. We do have a
18 number of individuals who have utilized,
19 tapped into Wounded Warrior Resource Center on
20 multiple occasions. Once they realize the
21 resource exist we have a lot of return users.
22 MR. MILAM: There is also

1 confusion, though, between the services having
2 their own centers. You have an Army
3 OneSource. I mean, there are a lot of
4 websites out there with the individual call
5 centers and who gets called first? Are we
6 truly the secondary call because they are not
7 getting the service they need from the
8 service?
9 I mean, that is a question that I
10 think is worth asking. Or are we the first
11 contact? These are things I think we have to
12 work through as we look at, again, improving
13 the communication, I think, for our recovering
14 warriors out there.
15 MS. CLOUSE: And to that point,
16 sir, one of the -- I will be honest in saying
17 that it was a challenge when Congress mandated
18 that we stand up the Wounded Warrior Resource
19 Center because the services were not too
20 thrilled about it since they already had their
21 own call centers.
22 As you can imagine, working

1 through those relationships so that it could
2 be collaborative in addressing the concerns of
3 service members and family members has been
4 interesting. I would say that it's going
5 quite well at this point.
6 Okay. I think we have really
7 spoken to question 7 and 8. Question 9, the
8 relationship with NRD. I'll be very frank.
9 It's a one-way relationship. Basically the
10 Wounded Warrior Resource Center we had a
11 website prior to NRD standing up their
12 website. The deal was struck that once that
13 website stood up, we pulled our down.
14 They have a portal whereby people
15 can email complaints or concerns to the NRD.
16 When they get those they shoot them straight
17 over to the Wounded Warrior Resource Center.
18 That's the relationship that we have with the
19 NRD.
20 DR. TURNER: I'm on your website
21 right now.
22 MS. CLOUSE: Oh, great. Good.

1 DR. TURNER: It's great. Tell me
2 about -- I really like the fact you have the
3 National Suicide Prevention line right under
4 your phone. That's very nice.
5 You have international calling
6 options on here. You didn't mention your
7 international business. Could you tell me a
8 little bit about that?
9 MS. DAILEY: Ladies and gentlemen,
10 we are an hour behind. Can I get you to give
11 me those statistics later?
12 DR. TURNER: That will be fine. I
13 can get them later.
14 MS. CLOUSE: Sure. Okay. We'll
15 move onto the next slide which talks about the
16 satisfaction ratings for Wounded Warrior
17 Resource Center. These, again, are FY '11
18 numbers. The numbers speak for themselves.
19 Could they be higher? Indeed they could be
20 but these are the FY '11 percentages.
21 Before somebody asks, this is
22 based on 111 surveys that were completed.

1 That's a low number of surveys considering the
2 number of cases that were resolved and that is
3 something we are looking at.
4 Okay. Next slide. Basically this
5 goes to the services and the utilization.
6 Clearly Army utilizes Wounded Warrior Resource
7 Center the most, followed by the Navy. It's
8 important to note that we serve in a dual
9 capacity for the Navy. We are both the
10 primary call center for the Navy and the
11 secondary call center for Navy Safe Harbor
12 programs. That was per an agreement that was
13 made a couple of years ago and that is
14 something that we are looking at. They are
15 looking at resuming that primary
16 functionality.
17 MS. DAILEY: So Navy Safe Harbor
18 doesn't have their own call center?
19 MS. CLOUSE: That's correct. Not
20 at this time. It's been us since the
21 inception of Wounded Warrior Resource Center.
22 MR. MILAM: I think when you go on

1 their website and you start dialing the
2 number, it links right into OneSource on that.
3 Now, that doesn't meet the intent of
4 legislation of us being the secondary call
5 center.
6 MS. CLOUSE: Right. Okay. Any
7 questions about the pie chart?
8 Next one really sort of breaks
9 down the types of issues that individuals have
10 when they call us. As you'll see clearly
11 again, health care is number one, VA benefits
12 is second. We've got counseling identified as
13 the third top issue. Basically that's a
14 subset of military benefits.
15 Question?
16 This last chart really -- this is
17 information that is provided for the annual
18 report to Congress that Health Affairs
19 submits. They come to us for this breakdown
20 every year. I think this goes back to an
21 earlier question, sir, with regard to the
22 National Guard and Reserves.

1 Okay. This is a slide of
2 interest. Basically Army utilizes OneSource
3 and the Wounded Warrior Resource Center the
4 most. With regard to OneSource, not
5 surprisingly, the Air Force is second followed
6 by the Navy and then Marine Corps. Then the
7 Wounded Warriors, this changes a bit. Army
8 followed by Navy, Marine Corps, and then
9 Reserves all services.
10 Are there any other questions?
11 MR. CONSTANTINE: I would like to
12 ask you a very quick question. The first
13 slide you had a lot of numbers up there. It
14 looks like there is a difference of a couple
15 hundred thousand between the Army, Navy, and
16 Marine Corps, and Air Force compared to
17 service member and family member.
18 MS. CLOUSE: Yes.
19 MR. CONSTANTINE: I would have
20 thought they would have equaled each other.
21 MS. CLOUSE: So you're saying the
22 services number should add up to both the

1 service and family member?
2 MR. CONSTANTINE: I thought the
3 services added up would equal the service
4 member plus family member.
5 MS. CLOUSE: I understand your
6 point. I would think so, too, so I'll go back
7 and do the math and figure out why they don't.
8 There must be another population. More than
9 likely it was care providers would be my
10 guess. Or we often have helping professionals
11 reach out to Military OneSource and the
12 Wounded Warrior Resource Center for some
13 resource information.
14 MR. CONSTANTINE: Thank you.
15 MS. CLOUSE: Thank you. Thank you
16 all very much.
17 MS. MALEBRANCHE: I have a
18 question on VA.
19 MS. CLOUSE: Yes.
20 MS. MALEBRANCHE: You mentioned
21 health benefits and then you mentioned for the
22 VA it was mostly benefits. Were there any

1 questions asked about VA health care or is
2 that inclusive in that health care number?
3 MS. CLOUSE: That is inclusive in
4 the health care number.
5 LT GEN GREEN: It's a great
6 program. Thank you so much. Sorry to keep
7 you guys late but we really appreciate the
8 information. Thank you for the outreach you
9 provide.
10 MS. CLOUSE: Thank you, sir.
11 Thank you for the opportunity.
12 MS. DAILEY: Steven, can I get the
13 SOCOM slides up? We do have our briefing here
14 from SOCOM. We're going to cut into lunch
15 here. We are going to try and give Mr.
16 McDonnell at least 45 minutes. I'll leave you
17 all half an hour for lunch but we are going to
18 be starting here right now.
19 LT GEN GREEN: Ladies and
20 gentlemen, I think we are going to go ahead
21 and get started here. Last year we received
22 a briefing from the SOCOM Care Coalition and

1 now we have Mr. Kevin McDonnell, the new
2 Director for the SOCOM Care Coalition.
3 He'll provide us with an update on
4 their programs including their support for
5 recovering special operators and their
6 involvement in the integrated disability
7 evaluation system process. The information
8 for this briefing is in Tab K.
9 Mr. McDonnell, welcome to your new
10 job and thank you for briefing the Task Force.
11 It's been an honor to meet you and we've been
12 very impressed with some of the things your
13 people are doing. Thank you.
14 MR. MCDONNELL: Thank you,
15 General. I can't tell you what a privilege it
16 is to be in this organization and in this job.
17 I thank each of you for what you are here
18 doing and for the focus that you're putting on
19 this tremendously important issue.
20 You all sent us the agenda so this
21 is what we'll talk about but we can go into
22 whatever other points of discussion that you

1 want to discuss as well.
2 I'm not a big fan of the survey.
3 I looked at the survey -- I believe it's in
4 your packet. I looked at what the survey did.
5 I had the opportunity last fall in my previous
6 job to sit in with Dr. Brummell at CAPE when
7 we did the review of the mental health and
8 family care programs at OSD.
9 One of the things I really took
10 away from that for all the services, for
11 everything we're doing to support mental
12 health and family care, a lot of the surveys
13 that are taken to make us feel good as a
14 program providers do just that.
15 There is nothing scientific behind
16 them. There was nothing scientific behind the
17 survey that we did. It gave some indicators
18 that the people that we're serving were happy
19 with how they were served but that doesn't
20 point me in a direction that I really want to
21 take the organization because it doesn't
22 necessarily tell me what else we need to do.

1 One of the things I'm talking to my boss about
2 now is the possibility of bringing in Deloitte
3 or UCLA or University of Virginia.
4 Somebody from the outside who can
5 really take an objective look at what it is
6 we're doing and help us figure out through
7 scientific means and through some real
8 statistics that I think mean something.
9 How better to do what we're doing. In some
10 cases how to export some of the best practices
11 that we've figured out by trial and error.
12 Are there any questions about this
13 particular slide? Like I said, the survey
14 that was done was Survey Monkey I believe they
15 call it. It's a very common survey practice.
16 If you look through the questions,
17 if you look through the answers that were
18 given, there were a lot of things -- I think
19 in that survey there were a lot of questions
20 that we actually asked questions about that
21 even to us didn't have a whole lot of merit
22 because we had already come to the right

1 conclusions just in the direct contact with
2 troops and families over the course of the
3 last previous couple years.
4 Area to improve. That's really
5 where I want to focus on. I think one of my
6 biggest frustrations when I go around to units
7 and talk to troops is that many troops have no
8 idea who we are or what we do. That's many of
9 my own troops.
10 My previous job in uniform, or two
11 jobs back, I was aware as a commander what the
12 Care Coalition does. I was aware they did
13 some miraculous things for individuals once
14 they were injured. That's really where my
15 interest started because I had so many other
16 things on my plate.
17 I was confident that this
18 organization was there but I didn't really
19 feel like I needed to know a whole lot about
20 what they did in advance. That is sort of the
21 attitude, I think, that's prevalent in our
22 community.

1 As my boss goes around and talks
2 to component commanders, as he makes his
3 rounds across the U.S. and around the globe,
4 this is one piece that he always makes time
5 for in every single stop. That's one thing
6 that's unique.
7 The gentleman that was speaking
8 previously, I think, made a very, very
9 important point. This is the commander's
10 program. This isn't my program. I manage it
11 for the commander but my boss is the combatant
12 commander, Admiral McRaven. There is nobody
13 in between me and him.
14 When an issue comes up, it's his
15 issue. He reminds me on a regular basis that
16 every member of this command, wounded, ill,
17 and injured, as a four star advocate and he
18 means that. The circumstances and the times
19 where staff get in the way of doing things,
20 that BFR direct capability to him is immensely
21 useful in solving problems very, very quickly.
22 Getting what we do out because we

1 don't just take care of combat wounded. We
2 take care of injured, ill, and families as
3 well. This is where we see the function of
4 this organization as a tremendous readiness
5 capability for the command.
6 If I have a master sergeant who is
7 deployed in Afghanistan who's got a child with
8 special needs back in the states and he
9 realizes that in this organization he has an
10 advocate back here that has access and
11 understanding of how TRICARE works and how to
12 get around impediments and the bureaucracy of
13 TRICARE.
14 He's much more likely to be
15 focused on the mission we've deployed him for
16 and a lot less likely to be overly worried
17 about what is going on at home as long as
18 we're effective. In that regard, we have a
19 tremendous impact on readiness as well.
20 Again, the last bullet there one
21 of the big take-aways I brought out with me
22 from the CAPE studies where the programs that

survived their processes were programs that had solid metrics of effectiveness that were objective and were scientific. Program that had cuts made to them were programs where we either didn't do our homework there, didn't feel that external observation was effective. They were the ones that ended up paying the price.

Next slide, please. As I said, this is the commander's program and through the effectiveness of senior leadership, not just Admiral McRaven, but the senior leaders we have here in the D.C. area as well. They pay very close attention to each individual we have in the process.

It doesn't matter which service they come out of. If there is something that individual or that family doesn't feel they are effectively getting, we get direct command feedback from that.

That is actually something I see of tremendous benefit to me because it allows

me to focus my time where we can have the most value added and focus the resources that we have for most value added.

Tailored, comprehensive approach to the management of each of the four lines of operation that we have; recovery, rehabilitation. Our primary goal is to get people back to their units. Then we are developing more and more and I'll talk a little bit more about the transition initiatives.

Again, the staff that I have is hand selected by the component commanders. The USASOC commander at Fort Bragg has hand selected out of his units people that will represent his interest with wounded, ill, and injured.

That provides at the component level a direct line of communication between the Care Coalition representatives and a special forces group and the USASOC commander and the USASEC commander. That direct

1 commander involvement, that direct command
2 communication, again, is very important.
3 CAPT EVANS: Sir, excuse me. Just
4 a quick question. A couple times we've had
5 the breakage of trying to follow a member EOD
6 or see what's going on as far as Navy. I
7 think sometimes I'm not sure if the
8 communication back to us as a service, what is
9 the status of the member getting back to the
10 unit, where he is. I mean, all those things.
11 I'm not sure if that's required because they
12 fall under.
13 MR. MCDONNELL: It's absolutely
14 required. Every service has complete access
15 to what we're doing. We run our tracker on
16 the SIPR Net, not on NIPR.
17 CAPT EVANS: Right.
18 MR. MCDONNELL: Each of the
19 service programs has access to that tracker.
20 We will tailor anybody and grant anybody that
21 the service determines needs access to that
22 data. Now, we do have -- because of certain

1 security requirements we do have certain
2 levels of security for certain people that are
3 in certain organizations. But if an
4 individual is in your service, then you have
5 access to -- you have people who have access
6 to that tracker on SIPR.
7 Yes.
8 MSGT MacKENZIE: Let me help
9 answer that because I was directly involved
10 with that and still to this day have no idea
11 what action was taken. However, that was
12 brought up almost a year ago with the Chief at
13 Navy Safe Harbor that this information was
14 available.
15 If there is still a disparity in
16 the access to the information that we have on
17 Navy personnel, it's back on Safe Harbor.
18 We've provided the opportunity. We don't know
19 where they've gone with the request.
20 MR. MCDONNELL: I think sometimes
21 just in the normal process of transition of
22 personnel that can be one of those things that

1 just falls off but that is nothing more than
2 a matter of somebody who has that
3 responsibility in the service getting a hold
4 of us and us putting -- granting access to
5 that part of the tracker through SIPR.
6 Now, for example, our tracker is a
7 living, breathing organism that I make changes
8 to every single week. I go in there and I
9 say, "I want to be able to track this
10 particular aspect." Or, "I want these
11 advocates in these units to have access to
12 this information and I don't want them to be
13 able to see this information in this
14 classified unit."
15 The way we constantly reshape the
16 tracker for functional use, I think the guys
17 that run my tracker are some of the most
18 gifted IT folks that we have in the command
19 because we put a tremendous burden on them.
20 MFLC. I think the MFLC Program is
21 great. Rob Gordon and I have had
22 conversations a number of times over this

program. But the general program doesn't serve our community as well as it serves the conventional force. We are running a special pilot program now with the MFLC.

We've asked for stability and continuity with the Military Family Life Consultants that center around our units' deployment schedules. If I've got a MFLC at Fort Carson, Colorado, for example, and the 10th Special Forces Group is returning from a deployment.

I don't want that MFLC rotated based on the contract that they have with OFD. I want them rotated based on a system of stability that is forecastable and is coordinatable with that unit commander. We have a couple of MFLC-like positions in some of our units that are permanent.

One of the things we're exploring right now is the feasibility of expanding those functions throughout the whole command, throughout all the services, all the

1 components of SOCOM. They've proven
2 tremendously, tremendously successful.
3 Admiral McRaven has an initiative
4 and is continuing an initiative now that
5 Admiral Olsen started that morphed in name.
6 It's now referred to as Preservation of the
7 Force. What this does is it tends to look at
8 the pressures on our organizations left of an
9 event like an injury.
10 Those routine pressures on an
11 organization is those pressures on families
12 that cause us to lose talent, that cause us to
13 lose skill sets and how to reduce those
14 pressures.
15 What I end up seeing is you think
16 of a Venn diagram, the Care Coalition
17 operating inside of a circle that is much,
18 much larger and all those efforts to reduce
19 pressure on the force proactively.
20 We see the Military Family Life
21 Consultants and social workers and people who
22 can effect that link between the service

1 member and his support network, families, kids
2 is tremendously important to everything we're
3 doing. The higher the deployment cycle for
4 our forces the more important those are.
5 The last time I looked we had a
6 deployment ratio of about a little less than
7 .5 to 1 which means we are way outside of what
8 the DoD standard that has been given to us for
9 deployment demands so that deployment schedule
10 causes a lot of friction internal to families.
11 When you have somebody injured and you have
12 all this pressure that is already there, it
13 can make families -- if you don't provide that
14 support it can make families lose faith with
15 us very, very quickly and no longer be willing
16 to donate their family members to what it is
17 we're trying to do for the country.
18 Next slide. Okay. This is having
19 troops recover in an operational unit. It's
20 a little bit different for our community.
21 Most of the troops that I have in our units
22 have been in the military quite a while.

1 They aren't first term enlistees.
2 We have a different community. We have a
3 different population than the services have.
4 That gives us some challenges and it gives us
5 some opportunities as well.
6 When you take a troop who has --
7 take one of my special forces soldiers from
8 the 5th group, when he's injured -- I had
9 troops that had been on the same team for 15
10 years and some of them longer than they had
11 been married. That creates a sense of
12 belonging to them in that organization, in
13 that unit.
14 Their sense of recovery is
15 enhanced by being back around that group of
16 people. It's enhanced by being plugged back
17 in to the purpose and relevance that they felt
18 when they were in that organization.
19 So we have to really strike a
20 balance and look at them individually. Again,
21 this is that tailored approach to each
22 individual whether it's best for them to be in

a WTU or it's best for them to be back in the unit.

About 99 out of 100 of these guys are going to say, "I want to return to duty." I can give you a list of kids we have. I think when I was deployed last with the 5th group I had about 16 people serving in the organizations deployed that had prosthetics.

That sense of I still have something very important to offer this organization is really there. Quite frankly, after all the training and experience, especially the combat experience they gained in the last 10 years, these people are absolutely invaluable to our organization.

As long as they want to maintain focus, as long as they want to stay in uniform, Admiral McRaven and the component commanders are going to continue to advocate with the services that they have value added for our organization, even if it's not out there on the ground, on the side of a mountain

in Afghanistan.

We have need for their experience, for their maturity, for their judgment in helping bring the next generation of special operators on board.

MS. DAILEY: Mr. McDonnell, did I hear you say that at one point you thought you were serving with a unit in which 16 percent had prosthetics?

MR. MCDONNELL: I'm sorry?

MS. DAILEY: Did I understand your comment that at one time you were serving with a Special Operations Unit in which 16 percent of the unit had prosthetics?

MR. MCDONNELL: No, that is not correct.

MS. DAILEY: Okay. Good. I want that on the record. What is it you said?

MR. MCDONNELL: I had 16 individuals that had some type of prosthetic device that were deployed with us and that included attachments and augments and

1 everything else. In our community that's
2 quite common.
3 One of the things that people join
4 this community for is a very intense sense of
5 purpose and relevance. When someone is
6 injured, that sense of purpose and relevance
7 I think intensifies because of the anxiety of,
8 "Am I going to be able to continue doing what
9 I've been doing."
10 I think as we all get ready to --
11 I think as I got ready to retire, I thought
12 about the same thing, not wounded, no injured
13 but thought about a lot of the same thing. I
14 think that is sort of the universal trend in
15 this community.
16 So one of the ways we're looking
17 at transition if you think of it in three
18 tiers. We're trying to take advantage of
19 everything that John Campbell and OSD are out
20 there, everything that the services are doing.
21 Admiral McCoy is a phenomenal
22 friend and partner in this process of opening

1 up NAVSEA to the talent that comes out of this
2 community. We are looking at each of the
3 services for that federal tier of
4 opportunities. We work actually quite closely
5 with the NAVSEA team.
6 If you think of three tiers, the
7 first tier that we've built internal to SOCOM
8 Admiral McRaven first, who is O to A, or
9 Operator to Acquirer. That's recycling soft
10 skills. It's taking the Green Beret, the
11 Seal, the Ranger.
12 It's taking his combat experience,
13 it's taking his security clearance which is
14 quite significant, and it's getting them
15 credentialed through normal acquisition
16 processes in our development Research and
17 Acquisition Directorate within SOCOM.
18 Right now I can use a couple of
19 examples. I have a Green Beret who is missing
20 a leg. Because there are things that he still
21 needs done that the VA will not do, TRICARE
22 will cover. The VA won't cover those

1 procedures.
2 He's still very much value added
3 to out community, the way he thinks, his
4 experience. So we've incorporated that back
5 into our research directorate. We're getting
6 him credentialed as an acquisition executive
7 while he is still on Active Duty. Then he
8 still has access to the Active Duty TRICARE
9 medical systems.
10 But it's recycling the skills and
11 it's adding additional skills to him. When he
12 gets ready to get out, Jim Gluck, who is our
13 acquisition executive, has tremendous
14 opportunities in the command for him. Or he
15 could look at NAVSEA as another option. Or he
16 could go to the private sector.
17 Combining and packaging all those
18 skills and maybe adding some to it gives him
19 tremendous leverage when he gets out of the
20 military. What we want to do is look at each
21 individual and see what fits each individual
22 best.

1 We have a Seal in the program. We
2 have a EOD officer who was blinded in August
3 that is also considering this program. We
4 want to tailor each opportunity to that
5 individual. We want to use the same team of
6 advocates and liaisons that's been working
7 with him since the injury, since they were in
8 the hospital, to best tailor those
9 opportunities.
10 The U.S. Government agency
11 opportunities, that is mostly Operation
12 Warfighter. It's the internships. The
13 internships at the federal level what we're
14 finding are some are good and some are less
15 good.
16 There are some troops out there
17 that are on their third or fourth internship
18 and some of them have been a great opportunity
19 and others they've described going into the
20 agency and not really being any value added.
21 They were clearly there because
22 they were wounded. That's exactly what we

1 don't want. We don't want anybody to hire our
2 guys because they're wounded. We want them to
3 hire them because they are value added to the
4 team. We make that very, very clear to the
5 private sector as well.
6 The last part, the last tier,
7 which I think is probably the most important,
8 is interaction with local communities and
9 private institutions, both for the internships
10 that we now have authorization under the NDAA
11 12 as well as private sector employment.
12 An organization like NAVSEA, an
13 organization like our SOCOM we have tremendous
14 connections with the industrial base. The
15 industrial base is very interested in the
16 talent that we have in uniform and recruits
17 that talent very heavily when they leave the
18 military anyway.
19 So making those connections and
20 talking to the senior levels of these
21 companies, not the HR folks, the senior levels
22 of these companies about individuals that we

1 have and really acquiring the interest of
2 those CEOs about the types of talent that we
3 have in uniform.
4 Some of those CEOs are legacies of
5 our commands. Some of them sell things to our
6 command and some of them just have a lot of
7 understanding of what we do and understand
8 that is talent they want on their team and in
9 some cases not their competition.
10 We have developed a dialogue and
11 we have a running and a growing dialogue with
12 a lot of companies to develop relationships
13 and to develop memorandums of agreement where
14 we can use the new authorities in NDAA 12 for
15 unpaid internships. What I believe most of
16 that will do is it will transition into job
17 opportunities once they get the DD 214 in
18 their hand.
19 I believe once we showcase that
20 talent, and talent is not exclusive to this
21 community, the talent that exist in the
22 military today is unprecedented across all the

1 services. I think if we showcase that talent
2 in the right way to the private sector, I
3 think the opportunities that open up for
4 troops are just huge.
5 MS. DAILEY: Can I clarify for the
6 Task Force also that we did get new
7 authorities in the NDAA. There is a dichotomy
8 in the Department of Defense right now in that
9 either they are not aware of the new
10 authorities or they are not developing them or
11 some of them are concerned that they need a
12 legal review before they move into these new
13 areas, i.e., local communities, private
14 sector.
15 SOCOM has gone ahead and is moving
16 into these areas. You are developing and you
17 don't have actual boots on the ground for a
18 local community or a private sector internship
19 at this time. Correct?
20 MR. MCDONNELL: That's correct.
21 We are in the final stages of the memorandums
22 of agreement with a number of companies. Let

me make something really clear. The authorities that we got in NDAA 12 are for unpaid internships.

As the 5th Special Forces Group commander I have always had the authority to allow one of my soldiers to have a second job. As the commander I determine his place of duty. We are not talking about a massive shift and taking people and putting people out in the private sector.

Our concern when this legislation initially came up was just the potential for abuse if unsupervised. That was really the reason for the unpaid part of this. As soon as that kid gets a DD 214 in his hand, that unpaid internship can transition immediately into a paid position.

If the company is smart, they are going to hire these guys. If we are smart about how we are placing them, too. I don't want to take a kid whose got no interest in computers and have them do an internship with

1 Microsoft. That would be a wasted
2 opportunity.
3 I had kids deployed with me who
4 when they went to sleep at night dreamed in 1s
5 and 0s. When they get out of the military,
6 that's the place they really belong,
7 symmetrical or not.
8 I don't have any -- I had heard
9 this before yesterday in a couple of the
10 service briefs. The IDES process for somebody
11 who is going through it the first time is
12 amazed that it requires navigation with an
13 advocate and liaison.
14 I don't think it speeds the
15 process up any. I don't have any indication
16 that shows that. I think having that
17 combination of advocacy that can explain the
18 stages and can explain the processes to the
19 service member, I think it reduces anxiety.
20 I think it focuses and sharpens expectations.
21 I think it's extremely helpful.
22 It's not about -- advocacy is not

about reducing the time, in my opinion. It's about increasing the understanding of the process for the service member, what his obligations are, what the services obligations are. And, again, focusing expectations in the right spots.

Just some statistics. I've got a total staff globally of 63 people. They are a combination of Active Duty, a very small number of civilians and contractors. The contractors give me the ability to surge very senior-level talent.

I mean, I have contractors that are former brigade commanders, former command sergeant majors, former first sergeants. That level of talent at the contractor level for advocacy, they bring with them an understanding of how the services work, how these systems work. They know how to cut through bureaucracy to get answers.

Some ratios. Couple of other points I'll make. We got a brief yesterday

1 from the VA. We actually have a federal
2 response coordinator on my staff. We have one
3 of the 22 FRCs in the country on our staff as
4 part of our staff.
5 I also another VA employee who
6 works for Rob Reynolds in VBA on my staff as
7 well. What that gives me the ability to do is
8 figure out the right spot in the Veterans
9 Administration to touch for the right answer
10 to a question. I don't just handle wounded,
11 ill, and injured from September 11, 2001
12 forward.
13 I'll have troops come to me that
14 served in Vietnam that have a certain type of
15 cancer that is associated with Agent Orange
16 but they don't have any records that show they
17 were in Vietnam. In partnership with the VA
18 we will go out to St. Louis and we'll dig
19 through boxes of personnel records until I can
20 put them on the ground with one foot for one
21 day in Vietnam.
22 I mean, we reach back into our

1 community prior to SOCOM existing as a command
2 to support that whole community. The
3 partnership that we have with the VA is
4 tremendous. The FRC that's on our staff
5 allows us to do things and allow me an
6 understanding and allows me to cut through
7 again red tape to get access to action.
8 That's just -- we see that as a
9 huge benefit to us. I also have a MFLC on my
10 staff. That is another just incredibly
11 supportive tool that goes to supporting the
12 support network of that soldier or sailor or
13 airman or marine.
14 The integration of the staff
15 laterally out through the interagency to have
16 that interagency contact for innovative ideas
17 on how to solve some unique problems that we
18 might not have seen before, that's
19 tremendously effective for us. We are well
20 within the ratio on both of those.
21 That's just a footprint of -- a
22 CONUS footprint of where we have people. I

1 have -- I keep a senior Care Coalition
2 representative deployed forward at our
3 headquarters in Bagram.
4 I have a team of people in
5 Landstuhl, Germany that facilitate the
6 movement process and give us good situational
7 awareness and visibility of wounded, ill, and
8 injured once they are in the pipeline.
9 We will certainly step out and
10 help any part of SOCOM or not, if there
11 systems are overburdened or if they need help,
12 if they've got new people on the ground
13 because we do a pretty good job of doing
14 pretty extensive overlap and turnovers in a
15 lot of these.
16 We found having people forward
17 like that almost hit the point of injury is
18 tremendously effective in getting the right
19 kind of treatment and care set up on the CONUS
20 side when they come up as to whether we want
21 to bring them back into the NCR or whether we
22 want to send them to Balboa or BAMC or even

1 back to home station.
2 I think that's the last slide I
3 have. It's just a diagram of the three tiers
4 we were talking about for transition
5 opportunities internal to SOCOM, external
6 within the U.S. Government, and in the private
7 sector.
8 One other thing I'll say about the
9 local communities. In the military we've
10 gotten less and less willing over time to talk
11 with local communities about what we're doing
12 next. Sometimes as individuals we just don't
13 know what we are going to do next.
14 One of the big fixes to the exodus
15 that is getting ready to come from the
16 services as a whole focusing exclusively on
17 this community if you want to, are community-
18 based solutions. There is a group that we've
19 helped define their missions and goals as
20 they've stood themselves up.
21 In Charlotte, North Carolina, over
22 the last four years, it's called Charlotte

1 Bridge Home. It's a group of people in
2 Charlotte that some of them have military
3 background and some of them are just community
4 leaders; Bank of America, Wells Fargo, BF
5 Goodrich, PriceWaterhouse based in Charlotte
6 wanted to be able to reach out to the veteran
7 community in Charlotte, North Carolina and the
8 wounded warrior population throughout the
9 country and encourage service members and
10 their families in this community to move to
11 Charlotte. When I say in this community, I
12 mean the Wounded Warrior community not
13 exclusive to SOCOM.
14 They have organized themselves in
15 a very unique way. The Henry M. Jackson
16 Foundation I know is looking at them as a
17 model as they move forward as a model that
18 works for Charlotte and may be replicable in
19 other places.
20 But communication with community-
21 based organizations like this to let them know
22 who is getting out of the service well in

1 advance of a DD 214 is tremendously effective
2 for them so they can figure out do we have
3 employment, do we have the right medical
4 services.
5 Charlotte has a tremendous medical
6 network there, but four years ago they didn't
7 take TRICARE. Charlotte wasn't affected by
8 the economy the same way a lot of the country
9 was. There were a lot of reasons that were
10 very attractive to move to Charlotte but they
11 don't take TRICARE.
12 That's one of the things that they
13 have had to get over, they've had to change
14 internal to the community. Community-based
15 organizations I think hold a tremendous key
16 here to reducing the burden and helping
17 cushion the transition for wounded veterans
18 and their families.
19 I think I would encourage all of
20 you to look at that organization. Go down
21 there and visit Tommy Norman. I mean, you're
22 making the rounds. Go visit Tommy Norman and

1 see what they are doing down there because
2 it's a tremendous -- I think a tremendous
3 effort that I think poses some great potential
4 success.
5 Let me see if I've got one more
6 here.
7 MS. DAILEY: I think we struggle
8 sometimes to cross-walk the SOCOM Care
9 Coalition into the services efforts, this one
10 it would translate. We are particularly eager
11 to see you exploit the new legislation and see
12 if you can kick some doors down for the
13 services which are either not aware right now
14 or are struggling with the bureaucracy to
15 implement.
16 MR. MCDONNELL: One last thing
17 I'll say. I think that is my last slide. I
18 know a lot of times people want to compare us
19 to what the services do. That's not what we
20 stood up for. I'm only able to do what I do
21 because of what the services do.
22 Without what Bernie Carter and

1 Darryl Williams and everybody else does in the
2 services, I can't do what I do. I think we're
3 really well integrated and tied in. I think
4 we have pretty cross-talk with what the
5 services do but I can't emphasize enough the
6 great things the services do provide a
7 starting point for me.
8 My hat is off to what they are
9 doing because whether it's for the Navy or for
10 the Air Force or for the Army or for the
11 Marine Corps, I leverage all the things that
12 they already do really, really well and it
13 allows me and my staff to focus on some things
14 that we might see as gaps and we might see as
15 unique requirements for a community that has
16 some pretty unique requirements.
17 Subject to your questions, that's
18 all I have for you.
19 MS. CROCKETT-JONES: Thank you
20 very much, Mr. McDonnell. I know we were
21 running awfully late. Thank you for being
22 patient with us. I think it's time for us to

1 go to lunch.

2 LT GEN GREEN: I would just say

3 the places where we visited and we've run into

4 the Care Coalition assets I've been very

5 impressed. You do hire well, present company

6 accepted.

7 MR. MCDONNELL: We all have our

8 burdens.

9 LT GEN GREEN: Thank you.

10 (Whereupon, at 11:55 a.m. the

11 above-entitled matter went off the record and

12 resumed at 12:52 p.m.)

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1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 12:52 p.m.

3 LT GEN GREEN: Ladies and

4 gentlemen, I think it's time to get started.

5 Welcome back. With us now is Captain Bernie

6 Carter, Director of Navy Safe Harbor, who will

7 be providing an update on the Safe Harbor

8 Program, and also on BUMED who will be

9 addressing -- also from BUMED who will be

10 addressing the medical needs of our recovering

11 warriors.

12 There are several other briefers.

13 Actually quite a few other briefers out here

14 potentially. They are listed in your agenda

15 and will introduce themselves as they appear.

16 Please look at your agenda for specific

17 questions they are addressing. Their

18 information is in Tab L.

19 I'll let you introduce your team,

20 Bernie.

21 CAPT CARTER: Thank you, General.

22 Good afternoon, all. It's nice to

be back here. Nice to see some nice faces from last year when we did this in March of 2011. I think we were over at the Gaylord Hotel last year in a much more cramped room. This is a little bit more expansive so we've got enough room for everybody here at the Task Force and the panel here as well.

As the General said, I'm Captain Bernie Carter, Director. I'm a surface warfare guy by trade. I've been in this job for about a year and three months now so I've learned a lot. I kind of came on board last year not knowing a lot but I've learned a lot since that time frame and a lot has happened with Navy Safe Harbor in the past year since we last updated you.

I brought with me today my operations officer Lieutenant David Noriega right here. Ms. Merissa Larson who you met last year as well who is my strategic support officer, and still my strategic support officer.

1 My deputy Commander Mike Varias,
2 and my JAG Lieutenant Commander Jon Jeffreys.
3 I also have with me my new policy person.
4 She's a Reservist, Captain Val Zimmerman.
5 She's in the back there. I don't want anybody
6 to jump out of their seats because I've got my
7 microphone with me.
8 I have some personnel here from
9 BUMED because this is a joint brief today.
10 We'll kick this thing up with myself and then
11 I'll let BUMED get into this and then I'll
12 start back again with the Navy Safe Harbor
13 part.
14 But I also have here from BUMED
15 Mr. Robert Powers who is from the Corps PUB
16 right here. And Mr. Mike -- is it Webster?
17 CDR WEBSTER: Dave Webster.
18 CAPT CARTER: Dave Webster.
19 Excuse me, Dave Webster. Ms. Virginia
20 Paganelli right next to Commander Varias.
21 Thank you guys for all being here.
22 Okay. We'll get right into it.

1 Next slide.

2 A lot has happened since last

3 year. Our enrollment has increased to over

4 800. That's about an average of about 14

5 members a month since the last time we talked

6 with you. We've had some great things

7 happening out there in the field.

8 We had a great Navy/Coast Guard

9 team place well at the Warrior Games last May.

10 We won 27 medals. Since that time building on

11 that success we've had three camps since that

12 time frame. We've also had one joint camp

13 with the Air Force back in September.

14 We are going to have our next camp

15 with our full team that we just selected here

16 15 through 19 March out at Port Hueneme which

17 has now become our de facto ground for

18 training our athletes right now. You are more

19 than welcome to come out there 15 through 19

20 November -- March in Port Hueneme, California.

21 We had our first family symposium

22 back in September that went extremely well.

1 We also have a new website that we just
2 started off this year. We've had about three
3 Pentagon open houses. We're spreading that
4 community awareness.
5 We had a great wheelchair
6 basketball event during the month of November
7 when all the services proclaim November as
8 Wounded Warrior Month. We hosted a very large
9 event in the Pentagon PAC, physical activity
10 center with all the other services involved.
11 That was a very successful event and we are
12 very proud of that.
13 Next slide. Here is kind of our
14 agenda. I'm going to let BUMED take over from
15 here. We are going to address all of the
16 areas of concern that you had in your report,
17 the 10 of 21 areas here. Then we'll pick back
18 up with Navy Safe Harbor.
19 CDR WEBSTER: Good afternoon,
20 ladies and gentlemen. My name is Commander
21 Dave Webster. I am the program manager for
22 IDES for BUMED. I would like to thank you all

1 for the opportunity to come out and talk to
2 you today about what we are doing from the
3 Navy medicine side of things.
4 Next slide, please. Just to go
5 over some of the BUMED specific items and to
6 talk a little bit about the recommendations.
7 For Recommendation No. 3, Condition Specific
8 Care, Navy medicine works on the premise of
9 patient-centered care.
10 What we do is we look at each
11 person as an individual and kind of tailor
12 what their treatment needs are as well as look
13 at what their specific MOS is before making
14 determinations on what types of care they
15 require and what types of recommendations
16 long-term for employment opportunities that
17 they may have such as does this individual
18 have a military-specific job that they would
19 need to be referred into IDES or is it
20 something that reasonably they may be expected
21 to be able to perform the duties of their MOS.
22 LT GEN GREEN: Just so you know,

1 we understand. Patient-centered really means
2 that you are giving the patient milestones and
3 ideas on what his recovery time would be. So
4 the question is do you have enough -- I don't
5 know whether you actually have enough data but
6 are you actually looking at your data for
7 above-knee amputation, single limb, to say
8 based on this and no comorbid conditions would
9 you be able to -- we would expect you to
10 basically be in a prosthetic in about four
11 months, walking by six, and possibly able to
12 participate in other activities, giving them
13 some targets and ways to look at how they are
14 going.
15 It's not about the IDES. This
16 particular finding was really about are we
17 gathering the data that we have to try and
18 make certain that we are giving patients, back
19 to your patient-centered care, the best
20 information on what to expect.
21 CDR WEBSTER: Yes, sir. That is
22 not an area that we delve into really with the

IDES program but I know that our treatment teams are looking at that data.

MG STONE: Who would be the individual that we would talk to that would identify for us the process of making decisions on milestones for patients?

CDR WEBSTER: It would probably be within BUMED current ops, sir. I don't have a specific name for you right now but I can research that and get that information to you.

MG STONE: Thank you very much.

CDR WEBSTER: Yes, sir.

For the next couple of slides I'm going to ask that Virginia Paganelli, one of our case managers at BUMED, come up and address those.

MS. PAGANELLI: Good afternoon, ladies and gentlemen. I'm Virginia Paganelli. I'm one of the program case managers at BUMED. Two of my colleagues are here, Joan McLeod and Rose Gingery in the back. The fourth case manager at BUMED is just manning the office.

1 I'm delighted to be here. I don't
2 know if you remember the presentation last
3 year but this is essentially a recap of our
4 program.
5 Navy provides case management
6 services to approximately 6,000 patients.
7 Those patients are divided into three
8 categories; Active Duty combat, Active Duty
9 non-combat, and other. By other these are
10 spouses, children, retirees, and independents.
11 We have approximately 200 case
12 managers. I must say that 54 percent of our
13 case managers are certified and 100 percent --
14 I'm sorry, 99 percent have completed the MHS
15 learning modules. These are modules related
16 to TBI, PTSD, TRICARE benefits and so forth.
17 We receive a bi-weekly case
18 management spreadsheet. On this spreadsheet
19 we have a list of all of the MTFs with the
20 number of case managers who provided those
21 services the preceding week. They are broken
22 down in the aforementioned categories; combat

1 related, non-combat, etc., and by acuity
2 levels. When this report comes in, we are
3 able to see by MTF the case load for the
4 preceding week, see it by region and the total
5 case load which --
6 Next slide, please. I'm sorry.
7 You can see we have 199 case managers and the
8 average case load is 30. BUMED instruction
9 allows a caseload to range between 10 and 50.
10 This is, of course, contingent upon acuity
11 levels and the case manager's judgment.
12 As you can see, the majority of
13 actually 75 percent of our total population of
14 the 6,000 patients fall into levels 1 and 2.
15 Our case mangers work on an out-patient basis.
16 It's not in-patient. Then it's all broken
17 down, as you can see there. Level 5 is the
18 least amount of patients involved in that pie
19 chart.
20 That is essentially it. If you
21 have questions, I would certainly be glad to
22 answer any questions that you have.

1 MSGT MacKENZIE: One of the things
2 I was going to ask and maybe just because I'm
3 not knowledgeable, but where do your Naval
4 Reserve folks fall into these categories?
5 Your Reserve Navy personnel, where do they
6 fall into these categories. All you mentioned
7 was Active Duty, combat Active Duty, non-
8 combat, and other.
9 MS. PAGANELLI: Well, you're
10 right. You're right, sir. I mean, these are
11 all of our patients. I mean, if they are
12 Reserve and they are receiving case management
13 services, they are included in that
14 population. You're right.
15 MSGT MacKENZIE: Thank you.
16 LT GEN GREEN: I'm sorry if I
17 missed it but with the acuity levels as you
18 are able to break out here, are you also
19 sensitive and assigned by acuity levels to
20 kind of equal out that burden on each of your
21 case managers?
22 MS. PAGANELLI: When that report

1 -- when that bi-weekly report comes in, we
2 look at the case load of every MTF. If it's
3 within the range of 20 or 25 or 30, that looks
4 good. But if it starts encroaching up to 35
5 or 40, we look at it.
6 We double check the number of
7 patients, the acuity levels that are assigned
8 to that MTF, and we call the lead case manager
9 to find out how they are doing. If there is
10 anything that we can do in terms of to see
11 about getting them additional help, we will do
12 that. Now some of the we funding of the
13 funding has been kind of cut off, it's kind of
14 difficult to do that.
15 We try to suggest alternative
16 solutions like perhaps hiring an LPN to assist
17 the case managers in making referrals, doing
18 some of their administrative paperwork to take
19 some of the paperwork burden off of them.
20 LT GEN GREEN: What I'm actually
21 looking for is since you've shown us the
22 acuity levels up here for each individual case

1 manager, are you actually assigning a certain
2 mix of levels or is it just who they have.
3 Then obviously one of the reasons
4 I'm asking is because I don't really care
5 whether you are actually equalizing the burden
6 on each case manager or not. I am curious as
7 to whether or not each of your levels also
8 corresponds to a certain amount of work. If
9 it does, when your case load averages 30, if
10 you have all level 1 patients, can you take
11 care of more?
12 MS. PAGANELLI: When that case
13 load is determined, the acuity levels are
14 taken into consideration in making that
15 determination, sir.
16 LT GEN GREEN: Okay. The reason,
17 again, I'm asking because if these levels 1
18 through 5 are associated with a certain amount
19 of work, the question is are DoD standards for
20 the ratios realistic and should we be looking
21 at the level, the acuity level, of the patient
22 in terms of what our actual standards are.

1 You are the first, I think, that
2 has actually shown us acuity levels 1 through
3 5. I wondered if there is a workload
4 associated with level 1 through 5.
5 MS. PAGANELLI: No. There is a
6 formula that we use that makes that
7 determination. As I said, it takes into
8 account the acuity levels of the number of
9 patients that a case manager has.
10 It's up to the lead case manager
11 to make assignments as she deems necessary
12 because only she knows what the case manager's
13 workload is like and make that determination.
14 MS. CROCKETT-JONES: I guess I
15 have a question. I assume that formula is
16 based on professional association standards
17 nationally or is that formula from --
18 MS. PAGANELLI: This is something
19 that Navy has devised. I think we are the
20 only service that has this.
21 MS. CROCKETT-JONES: Okay. Then
22 that formula would be probably something we

1 would want to look at, or at least --
2 MS. DAILEY: We did highlight this
3 last year as a best practice, I believe, the
4 Navy's acuity level determinations. We didn't
5 get the formula but we identified the Navy as
6 a best practice for their nurse case
7 management being determined by acuity level.
8 MS. CROCKETT-JONES: Acuity level.
9 MS. DAILEY: And I talk them up
10 every time I get the chance because, yes, they
11 are the first ones to put an acuity level
12 based case management process on the table for
13 us.
14 MS. PAGANELLI: I must say we have
15 presented this to TMA and now TMA is beginning
16 to look at acuity levels as a tri-service ad
17 hoc work group. Joan McLeod in the back is on
18 that work group. If you have any questions
19 about the development, I'm sure she can answer
20 those questions.
21 As a result of that, I must say
22 that Navy was the lead in that, that we have

1 this group that is coming up with standardized
2 -- a standardized acuity chart of levels.
3 MS. CROCKETT-JONES: That's what I
4 was trying to get at. I'm glad to hear that.
5 I have one more question. Do you have a plan
6 in place to increase the number of certified
7 case managers? Did you say 54 percent?
8 MS. PAGANELLI: Fifty-four percent
9 of them are certified.
10 MS. CROCKETT-JONES: Are
11 certified. Is that the appropriate level, I
12 guess, is what I'm asking?
13 MS. PAGANELLI: Oh, no. We are
14 always encouraging. In our BUMED instruction
15 it is strongly urged that case managers after
16 they are employed for two years get their
17 certification. It is not yet a requirement
18 but that exam comes up twice a year. It's
19 amazing the number of nurses that have become
20 certified. I expect that rate will continue
21 to grow.
22 MS. CROCKETT-JONES: Thank you.

1 DR. TURNER: Very good. Thank
2 you. Just to reiterate, we absolutely would
3 love to see this formula if you could get us
4 a copy.
5 MS. PAGANELLI: Sure.
6 DR. TURNER: The second thing, do
7 you also use this acuity and manning as a trip
8 wire or a guidance for hiring more case
9 managers?
10 MS. PAGANELLI: We can make that
11 recommendation to the lead case manager or to
12 the head of the department that they use that,
13 I guess, as a leverage to try and get more
14 staff. We don't intervene. I mean, BUMED
15 does not -- we can only suggest to the
16 command. We can't tell them that they must
17 hire another. Do you understand, sir?
18 DR. TURNER: I understand.
19 MS. PAGANELLI: Okay. We can use
20 it as a leverage.
21 MR. PARKER: Ma'am, you mentioned
22 that you do a review of the acuity and let the

1 folks in the field know whether or not that
2 ratio is adequate and make recommendation.
3 MS. PAGANELLI: We do.
4 MR. PARKER: But do they have a
5 way to let you know that they may be
6 overloaded or the acuity --
7 MS. PAGANELLI: I will tell you,
8 sir, that our case managers -- I've been with
9 Navy BUMED since 2007 -- I'm sorry, 2003.
10 Joan and Rose have been there for four years
11 and they know us very well. They will pick up
12 the phone and say that they need some help.
13 I must say that Captain Willis, who is the
14 director of the program, tries to do
15 everything he can to get additional staff for
16 them.
17 MS. DAILEY: They are sending you
18 bi-weekly reports. Right, Virginia? That's
19 their way to communicate their status to you.
20 Correct?
21 MS. PAGANELLI: Right. And then
22 also we look at their case load and contact

1 the lead case manager when it looks as though
2 it's getting kind of high.
3 MR. PARKER: And I assume you keep
4 those statistics and you can use those for
5 future planning?
6 MS. PAGANELLI: I'm sorry, sir?
7 MR. PARKER: You keep those
8 statistics, the reports, the bi-directional
9 information that you get related to acuity and
10 case load?
11 MS. PAGANELLI: Yes. They are all
12 backed up on my hard drive.
13 MR. PARKER: Thank you.
14 CAPT EVANS: Virginia, with the
15 integration over at Walter Reed/Bethesda,
16 there was clearly a disparity with in-patient
17 case management and out-patient case
18 management between the Army and the Navy.
19 When we looked at it we found that
20 we wanted in-patient case management on the
21 Navy system. Is there a plan to move across
22 the MTF throughout the system to in-patient

1 case management?
2 MS. PAGANELLI: There is no plan,
3 ma'am, as far as I know. This is something
4 that I personally would like to see done
5 because I can't recall -- I do recall in
6 Bethesda, I believe San Diego, the social
7 workers and the discharged planners do a lot
8 of the, for lack of a better term, case
9 management and coordinating referrals and
10 things like that.
11 The case manager picks them up on
12 the out-patient basis. If I could make that
13 suggestion, it would be ideal to have them
14 also function as case managers in-patient.
15 Right now there are no plans to do that as far
16 as I know.
17 MS. MALEBRANCHE: Virginia, a
18 couple of questions. I wasn't here last here
19 but are all your case managers nurses?
20 MS. PAGANELLI: Oh, thank you. I
21 forgot. They are all registered nurses. We
22 have social work case managers who are

1 licensed social workers.
2 MS. MALEBRANCHE: Okay. I know
3 for the case management society they have
4 both. I guess the other thing is do the
5 people that carry this case management
6 certification or designation, do you have
7 something in the system that identifies that
8 as an additional skill identifier so even if
9 they are not functioning perhaps as a case
10 manager in their current assignment that when
11 they go people would know that's a skill level
12 or is that not --
13 MS. PAGANELLI: There is a skill
14 level. There is a skill level that is
15 assigned to the RN case managers, but I don't
16 think there is one assigned for a social
17 worker case manager.
18 Joan, am I correct in that? There
19 is a skill level assigned for a RN case
20 manager but I don't think there is one for a
21 social worker case manager in the
22 documentation system. The case managers that

1 document in AHLTA have a MEPERS code and that
2 designates them as being a case manager.
3 MS. MCLEOD: I don't know if this
4 will help but the one thing I can add to what
5 Virginia has already explained is that we have
6 case management competencies that we adopted.
7 It was something that was developed from the
8 Navy Nurse Corps.
9 The same competency technically
10 stands for social worker and nurse case
11 managers so that when the different MTFs hire
12 the case managers, they have these competency
13 forms so they get checked off on certain skill
14 sets.
15 When we hire people from outside,
16 or perhaps that didn't have that case
17 management experience, which we do in the
18 Navy, they've had prior clinical experience as
19 a nurse or a social worker, they will have
20 those competencies at hand.
21 CAPT EVANS: So do we send them to
22 a training at all? I know there is a case

1 management training in San Antonio. Anyone
2 that is new in the system do we send them to
3 that training or any other training?
4 MS. MCLEOD: That's an Army
5 specific training that I'm familiar with that
6 you're talking about, I think.
7 Right, Virginia?
8 MS. PAGANELLI: Right.
9 CAPT EVANS: So that is just a
10 service-specific training?
11 MS. MCLEOD: Yeah. The only thing
12 I'll say about training is that when we hire
13 case managers we have a case management tool
14 kit that we've developed specifically for case
15 managers.
16 In fact, it's somewhat directed
17 for people that have never worked for the
18 military before so they get familiar with all
19 the nuances of being a military case manager
20 and all the programs that are involved with
21 being a military case manager.
22 Then they are trained in addition

1 at their MTF levels. They have the required
2 training that Virginia has mentioned, MHS
3 Learn. That is the extent of the program that
4 I'm familiar with.
5 MS. PAGANELLI: We also provide a
6 monthly camaraderie we called it. It's very
7 specific to Navy. Once a month we bring in
8 someone over on DCO bring them up to date on
9 what's happening in medicine, what's new, the
10 cutting edge of, for example, TBI treatment or
11 something like that.
12 For example, we had someone
13 present on this product called Alpha Stem
14 that's been used at some of the MTFs to
15 relieve chronic pain and to actually reduce
16 the use of medication, of analgesics and so
17 forth. They are looking at it in terms of
18 using it for PTSD. We try to keep them up to
19 date with monthly DCO presentations.
20 MG STONE: Yesterday we heard a
21 fair amount about satisfaction scores that
22 were generated at DoD through the TRICARE

1 management agency. How do you track service
2 member satisfaction with this process?
3 David, maybe this is better
4 directed at you. How do you use DoD-generated
5 satisfaction data in that process?
6 CDR WEBSTER: Sir, I assume you're
7 talking about the satisfaction data that's
8 generated by WWCTP for the IDES process. We
9 get that on a quarterly basis as a deliverable
10 from them. We then disseminate that to our
11 regions to disseminate to the MTF level, as
12 well as talk about it.
13 We have monthly VTCs that I'll get
14 into in a little bit. We disseminate that
15 data so that areas know specifically what the
16 feedback is being reported on that is so that
17 they can pinpoint focus on areas that need
18 adjustment.
19 MG STONE: Thank you.
20 MSGT MacKENZIE: One more question
21 for you. I believe it's probably towards you.
22 As you discuss the matrix that you guys use

1 with acuity and how you manage your workload
2 amongst nurse case managers, you said that you
3 use that tool to put in a request for forces,
4 or a request for additional case managers but
5 you don't have any authority to direct it.
6 Who has the authority to direct
7 the hiring of additional case managers for
8 increased acuity levels and how often are your
9 requests for additional forces -- do you have
10 any matrix that show how often those requests
11 are not filled by that individual or
12 individuals who are responsible for making
13 that happen?
14 MS. PAGANELLI: I'm trying to
15 think. I will say that we have -- over the
16 past years the patient population doesn't vary
17 that much. Where we run into difficulty is
18 when a case manager resigns. They are in an
19 area where due to the location it's very
20 difficult to get that position filled on this
21 one particular MTF that I know of.
22 We have -- funding has been

1 requested and funding is available but the
2 difficulty is getting a case manager to fill
3 that billet, so to speak, because of the
4 location.
5 I must say that if funding is
6 available, and I can't give you the number of
7 times quite honestly that we will go ahead and
8 do that. I mean, Captain Willis is very
9 aggressive about trying to get positions
10 filled. With funding being cut off now, I
11 don't know who the high authority would be to
12 override that request.
13 DR. TURNER: Ms. Paganelli, just
14 real quickly just a clarification. You just
15 said that your patient population doesn't
16 vary.
17 MS. PAGANELLI: Well, it's doesn't
18 vary. A few years ago --
19 DR. TURNER: Right. So what --
20 just to make sure I've got it right --
21 MS. PAGANELLI: Sure.
22 DR. TURNER: -- what that implies

1 is that you don't provide care forever. There
2 is a place where they come out of the program
3 to be cared for by somebody else.
4 MS. PAGANELLI: Right, right.
5 It's ongoing treatment. While they are
6 receiving their treatment on an out-patient
7 basis, yes, they are getting case management.
8 DR. TURNER: What is your criteria
9 for them leaving the program?
10 MS. PAGANELLI: Well, it might be
11 that they are transferred to another facility.
12 It might be that they are transferred, that
13 they are turned back to their unit, back to
14 duty. It could be that they die.
15 DR. TURNER: Okay. I'm just
16 curious because -- that's great. I know you
17 have input and I was wondering since you have
18 a stable population there has to be an outflow
19 and I was just curious on what the outflow
20 was.
21 MS. PAGANELLI: Right. Right.
22 MS. DAILEY: This is medical case

1 management so they are probably leaving your
2 care when their medical requirements are
3 completed. Whereas with Navy Safe Harbor the
4 non-medical care would probably continue a
5 little longer.
6 DR. TURNER: What is the criteria?
7 MS. PAGANELLI: When they reach
8 their treatment goals essentially.
9 MS. DAILEY: So in our
10 recommendation we recommended DoD establish
11 and implement acuity staffing standards. In
12 addition, care should be taken when
13 transitioning medical case care to medical
14 care managers among wounded warriors and
15 recovering warriors to ensure continuity of
16 care. What we hear, Virginia, and some of
17 your cohorts hear is that it looks like DoD is
18 looking at a acuity-based staffing model.
19 MS. PAGANELLI: Yes, ma'am.
20 MS. DAILEY: And there is a
21 working group for that.
22 MS. PAGANELLI: Yes.

1 MS. DAILEY: Okay. All right.
2 MS. PAGANELLI: Got it. Thank
3 you.
4 MS. DAILEY: Thank you.
5 CDR WEBSTER: This next slide for
6 evaluation of Recommendation 10, Commander
7 Rosemary Malone, who is our deployment health
8 expert, will be here tomorrow to discuss the
9 PTSD care. She is the correct individual to
10 address this and I know is planning on doing
11 so at that time.
12 Next slide, please.
13 For evaluation of Recommendation
14 No. 19 having to do with PEBLO staffing as
15 well as JAG support, currently BUMED is
16 adhering to WWCTP standards of PEBLO ratio
17 meaning 20 to 1. This has been funded and is
18 currently being met. These numbers are being
19 supplied to WWCTP on a quarterly basis.
20 For the JAG support I'm going to
21 turn it over to Commander Jeffreys to address.
22 LCDR JEFFREYS: Thank you, sir.

1 Good afternoon. I'm Lieutenant
2 Commander Jon Jeffreys. I'm the JAG for Navy
3 Safe Harbor and I'm going to be addressing the
4 legal support under Recommendation 19.
5 I want to address two things.
6 First, the OJAG, which is the Office of Judge
7 Advocate General for the Navy, legal support
8 for our recovering service members is a high
9 priority.
10 Navy Safe Harbor recently sat down
11 with Code 16 which is the Navy's legal
12 assistance department under the Office of
13 Judge Advocate General and they reiterated
14 that it's a high priority to ensure that our
15 recovering service members get the top quality
16 legal assistance quickly to ensure that they
17 are taken care of and their families are
18 supported.
19 I wasn't here last year so one of
20 the things you might have been briefed on
21 before was that there is a standard operating
22 procedure between Navy Safe Harbor and OJAG

1 and how we are going to handle legal
2 assistance for our recovering service members.
3 Basically just a little short
4 blurb. The recovering service members are
5 given basically front of the line privileges
6 so to speak. When any of our recovering
7 service members have an issue, the family have
8 an issue, we actually have all the Navy legal
9 services offices out there across the country
10 and overseas know that if they have a request
11 from Navy Safe Harbor to assist one of our
12 recovering service members, they actually have
13 a JAG assigned.
14 It's a collateral duty to assist
15 our recovering service members. They will be
16 pulled in directly to offer immediate
17 assistance to that person or to the families.
18 We just -- one of the other things
19 as far as the staffing, legal staffing, noted
20 under Recommendation 19, this is something
21 that is not Navy Safe Harbor's program but,
22 unfortunately Code 16 could not be here today

1 so they asked me to brief it for them.
2 To address the legal assistance or
3 legal support during the disability evaluation
4 system, the Navy has just -- they went ahead
5 and started a program called the Outreach
6 Attorney Program.
7 What this is -- the intent is to
8 assist service members as they are -- actually
9 prior to going into the -- as they enter into
10 the Disability Evaluation System prior to them
11 actually getting to the Physical Evaluation
12 Board to help them navigate through that
13 system to make sure they are answering any
14 questions or anything, any needs they may
15 have, the intent right now is to have their
16 hiring -- it's a new program.
17 They are hiring 12 civilian
18 attorneys to be permanent attorneys for them
19 and that's going to be their whole job is to
20 be part of this program. Right now -- my
21 understanding is they have eight attorneys
22 hired. By early May they should have all 12

1 hired.

2 It's the intent for the attorneys

3 to be assigned at all the major treatment

4 facilities; Pensacola, Balboa out in San

5 Diego, Great Lakes, Portsmouth. Pretty much

6 there to assist any folks. In fact, not just

7 recovering service members but any service

8 member, Navy service member, going through --

9 Coast Guard going through the Disability

10 Evaluation System.

11 CSM DEJONG: Sir.

12 LCDR JEFFREYS: Yes.

13 CSM DEJONG: Will they be assigned

14 to the service member or does the service

15 member have to seek them out?

16 LCDR JEFFREYS: That is a good

17 question. I'll be honest, my understanding --

18 I can clarify this for you, I can always go

19 back and do this -- my understanding is that

20 the intent of the program is for them -- I say

21 the attorneys, to go out and say, "Hey, we are

22 here to let the treatment facilities know

1 this, to let the commands know."
2 It's my understanding that the
3 command will need to put their service member
4 in touch with the attorneys if they need
5 assistance. Sergeant Major, I don't know the
6 full answer. I can get back to you on that
7 with an answer if need be.
8 CSM DEJONG: That is one of the
9 questions that you ask most service
10 organizations and they say it's available for
11 them but then you get some feedback from the
12 soldiers or service members and families and
13 it's, "Well, I didn't really know where to go
14 and find it." What we're looking at is how
15 readily accessible is it to them and how much
16 is it actually advertised that this is what
17 you have.
18 LCDR JEFFREYS: Absolutely.
19 Awareness is key. I'm tracking what you're
20 saying. One of the reasons why Ms. Morrisroe,
21 who is one of the attorneys, could not be here
22 today is she is actually traveling for that

1 whole awareness piece. Because it's such a
2 new program she's actually out shaking hands
3 and saying, "Hey, we're here."
4 Absolutely right. If service
5 members don't know that it's there, it's not
6 going to be very much help to them, but I know
7 the intent for Code 16 when we sat down with
8 them a couple of weeks ago is to say, "Hey,
9 it's our intent to get out there and let
10 people know we're here to make sure the
11 service members know that we are here for them
12 to assist them."
13 MS. DAILEY: Can you give me the
14 name again? We would probably like to get her
15 in to talk to the Task Force. I can't look
16 Code 16 up.
17 LCDR JEFFREYS: I apologize.
18 Commander Andrew House is the actual
19 department head for legal assistance for OJAG.
20 Karen Morrisroe is actually the lead attorney
21 for the program.
22 Any other questions?

1 MSGT MacKENZIE: Sir.
2 LCDR JEFFREYS: Yes.
3 MSGT MacKENZIE: I do.
4 LCDR JEFFREYS: Master Sergeant.
5 MSGT MacKENZIE: Two things.
6 These are JAG attorneys specifically trained
7 in the nuances of the Medical Evaluation Board
8 process?
9 LCDR JEFFREYS: No, they are
10 actually civilians who do have the experience.
11 They may be former JAGs but they are actually
12 civilian, actually GS employees being brought
13 on.
14 MSGT MacKENZIE: And they are
15 trained in the specific requirements of the
16 medical evaluation process?
17 LCDR JEFFREYS: That's my
18 understanding, yes, that they have to have
19 this background to be able to do the job when
20 they are hired on. Master Sergeant, I'm not
21 sure exactly what their job description is
22 when they hire them.

1 MSGT MacKENZIE: It would be nice
2 when we make that linkup to get that because
3 we have definitely been informed by several
4 JAGs that there is a definite difference in a
5 certification or training required to meet the
6 unique requirements in the Medical Evaluation
7 Board System.
8 LCDR JEFFREYS: Absolutely.
9 MSGT MacKENZIE: The third
10 question, or second question, however you want
11 to look at it, what -- is there a plan because
12 not everybody is going to be assigned at the
13 MTF that is going through disability
14 evaluation whether it's JAG, whether it's an
15 outreach attorney. What is the linkup
16 connection or briefing process between the
17 duty station JAG and this program? Say you've
18 got a sailor at Naples going through DES.
19 LCDR JEFFREYS: Yes.
20 MSGT MacKENZIE: That JAG person
21 is obviously -- more than likely not trained.
22 LCDR JEFFREYS: Yes.

1 MSGT MacKENZIE: Is there a
2 pipeline connection piece between that
3 outreach attorney and that JAG in order to
4 make sure that sailor is receiving the
5 appropriate guidance through this program?
6 LCDR JEFFREYS: Yes. If I hear
7 you correctly, basically for Naples my
8 understanding it's not going to be
9 specifically an outreach attorney. There in
10 Naples, however, again, I think it kind of
11 goes back to what the Sergeant Major was
12 saying, asking about awareness.
13 Is there going to be that
14 connection? Are the service members going to
15 get what they need when they need it? My
16 understanding again is that the outreach --
17 the intent of the program is to go out and
18 say, "Hey, we are here. We are here to assist
19 you." As a JAG myself, you don't necessarily
20 learn everything you need to know to give
21 proper service to a recovering service member
22 in this area.

1 My understanding is, yes, they are
2 supposed to be going out there to make that
3 connection to ensure that they make the
4 connection with the service member to provide
5 what that service member needs as they go
6 through the Disability Evaluation System
7 process. Does that answer your question?
8 MS. DAILEY: We'll get them in to
9 talk.
10 MSGT MacKENZIE: Yeah, we're going
11 to get them in to talk to us. It does in a
12 way but it also opens up the door for it not
13 working. We'll address them and I'll ask the
14 question again.
15 LCDR JEFFREYS: It is something
16 that I'm -- Code 16, this is their baby but I
17 know that they're --
18 MSGT MacKENZIE: I look at you as
19 an attorney, sir, and I say, okay, you're
20 trying to help this service member but they
21 have six days to fill out this paperwork?
22 LCDR JEFFREYS: Absolutely.

MSGT MacKENZIE: And if you're waiting for somebody to fly overseas to do this.

LCDR JEFFREYS: No.

MSGT MacKENZIE: But that question will go towards them.

LCDR JEFFREYS: I don't think -- again, I don't want to get out of my lane but my understanding is it's going to be one of those things where if they have six days, you know, the JAGs know they can get on the phone and immediately call for assistance.

If I was stationed in Naples, that's what I would be doing is calling right back to OJAG knowing that there is the outreach attorney program. "Hey, I need to get my service member hooked up with this program because he needs some help." We make sure we get it taken care of.

MG STONE: Let me make some comment on this.

LCDR JEFFREYS: Yes, sir.

1 MG STONE: Because of the large
2 number of casualties that we have in the Army,
3 we have found that the direct satisfaction
4 levels have to do with legal support to the
5 service member.
6 One of the reasons we are so
7 interested in this is every place we go it is
8 commented that the direct association of legal
9 support that is ongoing, that people learn
10 their cases, that doesn't just come and go on
11 an individual question basis, is essential to
12 satisfaction level.
13 We encourage you to continue to
14 develop this program and to make it integral
15 to the management of these cases will directly
16 correlate to the satisfaction levels as
17 service members and their families attempt to
18 negotiate the bewildering myriad of decisions
19 they need to make.
20 LCDR JEFFREYS: Yes, sir.
21 Absolutely. That is to go with what the
22 Master Sergeant was asking. For consistency

1 purposes one of the reasons why they are
2 hiring these civilian attorneys is for that
3 longevity so they are there and they can offer
4 consistent service. They are not going to be
5 moving in and out over a year or two years
6 like an actual JAG may do.
7 MR. POWERS: Robert Powers,
8 General, and Task Force members. If I might
9 assist co-counsel here. I am the president of
10 the Physical Evaluation Board. As you know,
11 it's basically an administrative law board and
12 unique from the other services as this Board
13 knows is we are actually at the Assistant
14 Secretary of the Navy level so we are above
15 the services regarding Navy and Marine Corps.
16 The marines also have a similar program. I
17 think to address some of the questions and
18 Lieutenant Colonel Morrisroe -- excuse me, Ms.
19 Morrisroe who worked -- we worked closely with
20 her.
21 The reality is this, the DES
22 outreach program, which is OJAG, has taken the

1 lead and hired -- also, in fact, I was briefed
2 on the 506 panel last year here regarding this
3 is an initiative by the services to go ahead
4 and, like you said, establishing DES attorney
5 experts.
6 What they are doing is they are
7 putting them at the hospitals to be the
8 resident basically specialist on the
9 attorneys. Now, we all know for just the
10 Department of the Navy there are 8,000 service
11 members who are going through a year. That's
12 pretty hard for just eight attorneys to cover
13 all that.
14 They are really the attorneys that
15 the other attorneys have established as a
16 priority to address. The other thing is when
17 we do hear from the marines or sailors, "I
18 didn't know about my attorney," it's sort of
19 like when you get your complaint whether
20 you're suppose to answer it.
21 In civilian court you know you
22 probably should get an attorney. They do know

there's attorney accesses out there. A lot of times we've seen where they are not necessarily invoking their rights as soon as they should.

The DES outreach program is expanding that and that is why Ms. Morrisroe is out there. I guess the point I wanted to add is, (1) this is a great initiative that has actually gone behind expectations. They have hired eight big issues.

The Marine Corps is doing the same thing. They've got DES attorneys. The other thing we are looking at is there is really a two-part approach to this on the DES attorneys. First part is just realizing what paperwork you have to follow, what type of timelines you have.

That is really the IPEB attorneys, DES attorneys. Then you've got the formal board attorneys. They are developing -- Ms. Morrisroe is developing a better spectrum across the whole enterprise there. The point

being I'm sure she will come here and brief you that this is a system that is working and it has been expanded substantially since really the last two years.

MR. CONSTANTINE: When you say the warriors -- all the warriors out there know that these lawyers are there for them, why are you so confident in that? How do you know that and what efforts are made to educate the people going through the system?

MR. POWERS: The reason I'm confident in that is just what was just briefed by the commander here. Also this is -- I've been at the Physical Evaluation Board now since 2005.

The members know once they are informed there are so many advocates in the system and so the issue now is making sure advocates are fully trained and making sure they are doing outreach.

What I think the big thing for the service members, and we are doing this, is I'm

1 confident that their patient admin/PEBLOs in
2 the Department of the Navy have told them
3 about their opportunities. I'm confident that
4 they know -- we all know intuitively that you
5 could always go to counsel.
6 What we've done now is also made -
7 - not only is it open, they have hotlines.
8 They have DES outreach attorneys there. Can
9 we do more? Of course. That is what this
10 program is about, to make sure that even
11 though the surveys are showing that there is
12 not as much outreach as we want, that we are
13 building it and that is what we are using the
14 surveys for is to go ahead and expand that
15 out.
16 MG STONE: So what is your
17 challenge rate?
18 MR. POWERS: I think that we are
19 meeting the challenge. The challenge is --
20 MG STONE: No, no. What is the
21 rate of challenges based on when the NARSUM
22 comes out and at the conclusion of the NARSUM

1 at the end of the MEB there is an opportunity
2 for the service member to concur or non-
3 concur. What is your non-concur rate?
4 MR. POWERS: For the Department of
5 the Navy if the challenge is I contest my
6 findings, I do not accept my findings, as we
7 know, there's two types of basically
8 adjudications. There is an informal
9 adjudication and a formal adjudication.
10 The first is really a decision by
11 a three-member board that, for instance,
12 hypothetical, Lance Corporal Benots, you are
13 found unfit. He is briefed by a DES
14 counselor/PEBLO admin and they are going to
15 tell them, "Hey, the Department of the Navy is
16 finding you unfit." How many people would
17 raise their hand and say I do not believe that
18 is a fair decision?
19 Basically we have 15 percent of
20 all our cases ask for a formal hearing. Last
21 year we had 1,009. We've seen a big jump. In
22 fact, since the IDES, which is so interesting,

1 in 2006 we had about 600 people ask for a
2 formal hearing.
3 Since then every year it has
4 increased substantially and last year out of
5 the 8,000 cases we had, both TDRL and Active
6 Duty, we had 1,009 ask for a formal hearing.
7 If you say that is basically they don't feel
8 content, and at that point they are scheduled
9 for a docket.
10 Now, what's interesting out of
11 that 1,009 only 273 actually walked into the
12 room with the counsel and said, "I want to
13 contest my findings because I don't believe
14 that they are fair." Because what happens up
15 to that point is we do additional information.
16 We gather information.
17 The attorney is providing
18 information from the service member and making
19 a more complete record because in the end what
20 you are trying to do is find the facts and
21 circumstances to adjust and support your legal
22 finding. Out of that 1,009 we had 273 or 279

1 walk in the hearing.
2 The reason I say 279 to 273 is
3 that was the same exact last year, the year
4 before. In FY 2010 out of the 960 or so cases
5 that ask that, "I don't believe the PEB is
6 correct. I want a formal hearing," 273 walked
7 in.
8 Of course, basically once you
9 contest the findings, then we go ahead and
10 transfer you to our legal section as far as
11 for case management purposes. Then we're
12 going to docket you at which point you'll be
13 assigned a government counsel.
14 MG STONE: Do you have the same
15 fidelity on the MEB process that you do on the
16 PEB process?
17 MR. POWERS: I do not have on the
18 MEB process -- I would defer that to as far as
19 how many ask for -- I can't speak of how many
20 said, and I think what you're saying is that
21 how many people got their Medical Evaluation
22 Board report down at the hospital and said, "I

1 want to rebut. I do not agree with these
2 findings."
3 MG STONE: Universally what we
4 found is the satisfaction level at your level
5 in all of the services is pretty high. Once
6 people get to the PEB they do pretty well.
7 There may be a disagreement about
8 whether it should be informal or formally held
9 but the PEB process is operating at a much
10 higher satisfaction level than the MEB
11 process.
12 What I think we are presenting
13 here is a discussion of the legal support that
14 is part of the MEB process dramatically lowers
15 the dissatisfaction levels as service members
16 and their families fully understand everything
17 that goes in. So by the time they come to you
18 in the PEB process, it's really pretty much a
19 done deal.
20 MR. POWERS: Actually, what we see
21 and, again, this is anecdotal but -- well,
22 it's based on the facts and circumstances that

1 occurs. What generally happens on these
2 individuals that have contested said, "I do
3 not believe my findings are fair," is they
4 don't generally decide months out.
5 What happens is they travel to
6 D.C. They meet with their counsel. The
7 counsel explains to them, "Here are the facts
8 and circumstances of your case. The PEB is
9 being fair.
10 "You are not going to get 50
11 percent when the VASRD says at the most you
12 are going to get 40 percent. You are not
13 going to get unfit for your gastroreflex
14 disease because that does not impact your
15 ability to shoot, move, and communicate."
16 So what it is they see a
17 disinterested party, the attorney generally,
18 who is telling them, "Hey, this is why this
19 was a fair decision." At the MEB level we
20 have that. The problem is I don't know if
21 they really believe it when a lot of it is
22 still sinking in.

1 I think that is what is so unique
2 about this process. Even when you do have DES
3 attorneys, and we've had DES attorneys,
4 outreach attorneys. In fact, many of the
5 eight that are hired have been in the DES
6 since 2007.
7 Many of them are active data
8 reservist who have just transferred because
9 they have become the experts. So even though
10 you know you have expert attorneys counseling
11 these service members at the MTF level, it
12 really doesn't come to fruition of full
13 understanding until they really do get to the
14 PEB and understand this is going to be an
15 ultimate decision.
16 What I'm proffering is we have
17 very confident and very capable MTF counselors
18 down there and attorneys. They will tell the
19 service member you have access to what it is.
20 They are not believing it. They have to move
21 through the system and mature through the
22 traumatic event, as we all know. This is a

1 life changing event for them.
2 They've just been diagnosed with
3 an incredible condition that they are still
4 coming to grips with. They are still not
5 realizing that they may separate it out. A
6 lot of this it takes time for them to even
7 register.
8 I guess the other reason I would
9 say that is on our TDRL population, Temporary
10 Disability Retirement List, for years when you
11 counsel them, and I'm sure the attorney here
12 knows, you can sit down and talk to a client
13 and you will tell them X, Y, and Z.
14 You can even write it down on a
15 piece of paper. You will go back a month
16 later and they will not remember what you said
17 because they are only remembering part of it.
18 Temporary Disability Retirement List by
19 analogy is a good example. You will explain
20 to them this is a temporary decision.
21 They will not hear that. Eighteen
22 months later I've written enough congrants to

1 know they did not understand it was temporary.
2 Party of it is certainly we are pushing very
3 hard from the enterprise to make sure that the
4 service member fully understands their rights
5 and fully understands this system right from
6 the beginning.
7 There will always be a percentage
8 of people who travel to the Department of Navy
9 at a cost of almost $300,000 a year because
10 actually that is why I'm aware of it. We
11 spend $300,000 a year for 1,009 people to
12 travel to D.C. when only 279 are going to walk
13 in.
14 The reason is because that is what
15 is actually right now they have to come and
16 meet and get away from their command element
17 to really sit down with a totally impartial,
18 independent counsel to explain to them their
19 process. That is what we're seeing. There
20 may be other reasons, sir, but that is what
21 we're seeing at present.
22 LT GEN GREEN: Let me see if --

1 there is one area of clarification. Rich, if
2 I understood what you said, you are advising
3 them actually on the MEB process and the issue
4 with the MEB process is technically the MEB is
5 determining whether or not they can be
6 retained on Active Duty or be retrained and
7 whether in their own MOS or in another.
8 I guess the question I would have
9 for you is is there a way for the lawyer to
10 intervene in the MEB process in terms of
11 whether they are going to be retained or
12 retrained?
13 MG STONE: Yes.
14 MR. POWERS: If I could add to
15 that, sir, the difference between that we're
16 the Department of the Navy. We don't do
17 profiling as the Army does.
18 MG STONE: We got that. I got it.
19 MR. POWERS: Okay. Sorry.
20 MG STONE: There is an
21 opportunity. A lot of what you are describing
22 in dissatisfaction could be dispelled by early

1 intervention of legal support through this
2 process. It usually occurs late in the MEB
3 process right before the dictation of the
4 NARSUM and the results of the NARSUM, the
5 narrative summary comes out.
6 At the point that comes out, there
7 is a lot of stuff in there that is very
8 difficult for service members to understand.
9 And the presence of legal support at that
10 point who is well trained can dissipate a lot
11 of the misunderstanding and potentially
12 control a lot of the challenges that you are
13 dealing with as you have just described.
14 There is an opportunity and what
15 we found in our very large population over
16 these ten years is the attorneys are
17 absolutely essential to helping service
18 members through this process. I won't debate
19 it. It's a suggestion to you.
20 You can use it or not use it or
21 you can continue to pay the bill to do it at
22 the PEB process. The point of intervention is

1 where I have described, sir, and it is very
2 effective and it relieves a lot of anxiety on
3 the part of families and service members but
4 it's a different level of intervention than
5 when they get to D.C.
6 You are exactly correct. Each of
7 the services has shown really good
8 satisfaction when they get to the PEB process.
9 They may not like the outcome but they do
10 understand the process at a much higher level.
11 Now, TDRL, the Temporary
12 Disability Retired List, is a whole other
13 enigma that we can work our way through in
14 another venue. What we encourage you to do is
15 to get the attorneys very early on in the
16 process engaged to help people understand this
17 very complex process.
18 MR. POWERS: Yes, sir. I concur,
19 sir. Actually, I may have misrepresented.
20 That's what we're doing. 100 percent concur.
21 100 percent agree that these attorneys are
22 very powerful.

1 LCDR JEFFREYS: Yes, sir.
2 MR. POWERS: That is why we're
3 using them.
4 LCDR JEFFREYS: If I may, as a JAG
5 for Navy Safe Harbor, sir, that is absolutely
6 what we want to try to do. I mean, that is my
7 job is to make sure -- is to take care of
8 those families and service members, to get in
9 there any legal issues beforehand. We want to
10 make their lives easier.
11 They've already gone through a lot
12 of problems. We want to take care of them
13 before they get to any other issues down the
14 road. We want to get them as soon as they
15 come in.
16 When a service member comes in the
17 Navy Safe Harbor Program one of the things
18 their evaluation is done to determine what
19 their needs are, one of them being legal
20 assistance. What do they need? Do they need
21 power of attorney?
22 Is a service member in such bad

1 shape that they will need a guardianship done?
2 These are the things we address from the very
3 beginning. Absolutely you want to get them at
4 the very start. It alleviates a lot of
5 problems down the road.
6 Are there any questions for the
7 panel? Thank you for your time. I'll turn it
8 back over to the Commander.
9 CDR WEBSTER: Actually, we can
10 skip this slide. I'm well aware the members
11 are aware of the IDES timeline.
12 The next slide is just reiterating
13 BUMED. We own the first 10 days and the last
14 35 days of this integrated process. That is
15 where I will focus my comments on.
16 Next slide, please. This is a
17 slide that we brief at our monthly VTCs. It's
18 a little bit of a busy slide but the solid
19 lines indicate the trends that we are seeing
20 in the 100-day timeline and the ability of our
21 MTFs to meet that timeline.
22 Just within the last couple of

1 months we have been able to as an enterprise
2 meet the 100-day goal for the Navy cases and
3 we are quickly approaching that goal for
4 Marine Corps cases as well.
5 Next slide, please. The question
6 is what are we doing about low-performing IDES
7 sites? In July of last year BUMED decided to
8 host monthly VTCs.
9 We invited all participants in
10 this process to include the VA, the PEB,
11 Assistant Secretary of the Navy, the VA, line
12 commanders to come to the table to discuss
13 open lines of communication and to point out
14 areas that needed focus as well as areas of
15 success with the goal of being able to
16 disseminate that success amongst our MTFs.
17 Since we've done that we've seen a 30 percent
18 reduction in our MEB timelines.
19 The next several slides also go
20 over other types of programs that we've done
21 to improve that. But to focus on this slide,
22 do we have data or evidence that Sailors in

1 Navy Safe Harbor progress through any quicker
2 than those without representation.
3 We do not track that. The
4 tracking mechanism that we use at BUMED is the
5 VTA. We do not delineate specific programs in
6 that so we do not have evidence to support
7 that.
8 MSGT MacKENZIE: Real quick, sir.
9 Is there -- you invited a conglomeration of
10 folks to these VTCs on the IDES. Any
11 indication of which key players within that
12 large group of folks -- is there any
13 correlation between specific personnel and the
14 decrease in processing time?
15 CDR WEBSTER: My feeling, and it's
16 one of those things where you don't really
17 have hard evidence to put your finger on one
18 specific reason.
19 My feeling is that the increased
20 leadership awareness and focus at the MTF
21 level, as well as the line in communication at
22 that level making sure that everybody feels

1 that it is important to meet these timeline
2 goals, that has driven that number down
3 because there's been a lot of areas where
4 cooperation between those two groups has been
5 needed to move these cases forward on time.
6 That is my feeling on this.
7 MSGT MacKENZIE: Thank you.
8 CDR WEBSTER: Next slide, please.
9 MS. DAILEY: So, real quick, does
10 it -- I mean, one of the reasons we're here is
11 because Congress was frustrated with the
12 length of time in the IDES and how long it was
13 taking. I mean, it's one of our mandates. Is
14 it really just that no one was paying
15 attention to IDES before July of 2011?
16 CDR WEBSTER: If I can get to
17 these slides, these are some other issues that
18 we are working through. One of the issues
19 that we had previously was personnel. We have
20 funded and we have met those PEBLO ratios.
21 I know that has been brought up as
22 an issue in the past. We've spoken with folks

1 from Johns Hopkins University who have looked
2 at the Applied Physics lab. They have come in
3 and they've done process management
4 suggestions.
5 We've also done Lean Six Sigma
6 efforts at both the enterprise level and the
7 MTF level. We've been able to fund renovation
8 projects to co-locate both the MTF and the VA
9 personnel so that has made an impact on
10 timeliness.
11 We are also educating and
12 supporting our regional training teams so that
13 we are making sure people are going out there
14 and they really know what they are supposed to
15 be doing in their day-to-day jobs.
16 For execution we've used harassed
17 existing technology to implement our narrative
18 summaries using AHLTA. We've had local
19 innovations. The Veterans Tracking
20 Application is the database for IDES.
21 We were able to have an individual
22 at Portsmouth develop a watch board based on

1 that VTA data looking at real time and coming
2 up with ways to proactively manage IDES cases
3 rather than being reactionary to when they are
4 not meeting timelines. That is driven down
5 the processing times as well.
6 At the regional and MTF level
7 comprehensive reviews have been done to really
8 go soup to nuts as far as what their processes
9 are and what works best for those local sites.
10 We've seen great improvement there as well.
11 Then for post-IOC visits teams
12 from BUMED as well as Mr. Powers and the PEB
13 have gone out to several sites over the past
14 year, provided training, and helped the local
15 MTFs make their way through what might be
16 problem areas and make those suggestions and
17 carry those best practices from site to site.
18 MSGT MacKENZIE: So question for
19 you just thinking here on the fly. When do
20 you, or do you, have a plan for moving from
21 promotion of best practices and actually those
22 becoming procedures that are implemented

1 across the MTF structure within the Navy?
2 CDR WEBSTER: We are already doing
3 that. Not in probably a formalized way but we
4 are already passing along those best practices
5 so that other sites can utilize those best
6 practices. That's an ongoing process for us.
7 MR. POWERS: Robert Powers. One
8 of the issues addressing the question is why
9 is all of a sudden are timelines being met.
10 Well, the first thing would be as we just went
11 into 100 percent implementation last year
12 October. At this point what does that mean?
13 It has taken a couple of months
14 for the entire enterprise to learn a
15 completely new disability evaluation system.
16 In essence, it is like the law court just out
17 in town. When you have a backed-up docket at
18 the county docket, what do you do? You hire
19 more judges and you hire more clerks.
20 I think what you've seen is we
21 have personally seen -- the Physical
22 Evaluation Board now that the entire

1 Department of the Navy MTFs have been on a
2 sustained less than 100 days processing time,
3 we have received all those cases.
4 Also let's not forget the
5 Department of Veteran Affairs for Disability
6 they have brought their timelines down to an
7 average of 30 days which is impressive. The
8 entire enterprise has really just now learned
9 the process and it is so staffed, or at least
10 getting staffed.
11 It's not fully staffed but it also
12 has got so much leadership interest behind it,
13 people understand that it is an issue of
14 prioritization and resource. The answer is
15 yes. As of just this year we've seen where
16 there is full emphasis by everyone to make
17 these timelines work which we're seeing them
18 start to work for the first time.
19 MG STONE: So let's go back to
20 slide 13, please. So where was the full
21 implementation of the IDES program in this
22 time frame? Was it between April and May?

1 MR. POWERS: By law October of
2 2011 everything was suppose to be 100 percent
3 IDES implementation. What that means is all
4 the MTFs, including overseas MTFs, were
5 onboard with this process.
6 CDR WEBSTER: Sir, all of our
7 CONUS facilities were implemented by June of
8 2011.
9 MG STONE: Okay. So I know what
10 the regulation was. What we are really seeing
11 in that jump is your preparation in May to go
12 into IDES which moved from a sequential
13 system, which shouldn't give you full
14 visibility, to this integrated system that
15 brought this down from 500 or so days between
16 the two into one. Is that a correct
17 statement?
18 CDR WEBSTER: Yes, sir. We had
19 five sites that came online in June.
20 Everybody else was prior to that. The five
21 sites that came on in June were some of our
22 smaller sites as far as the number of

1 referrals. I think that's inaccurate.
2 MG STONE: And then the engagement
3 of the line has occurred over these period of
4 seven, eight months it's begun to drive it
5 down further as you've begun to integrate
6 that?
7 CDR WEBSTER: Yes, sir.
8 MG STONE: This is very similar
9 data to what we found in the Army. Very
10 similar data that we didn't do very well when
11 the line wasn't engaged with the medical care
12 system. It was as simple as giving the line
13 visibility of upcoming appointments.
14 Some of those appointments were of
15 great distance and when they were missed
16 because of the low density of the specialist,
17 it was hard to get them back in. It would
18 cost 30 to 45 or 60 days. Having the line
19 engaged, especially the line NCO leadership,
20 to make sure a service member showed up was
21 taking huge numbers of days out of the plan.
22 Yes, the answer sometimes is as

simple as just paying attention to the process. In the MEB process someone told me there 66 separate subprocesses. It is a very difficult one to move through even before we get to the PEB. Your data is just very similar to ours.

CDR WEBSTER: Yes, sir.

MSGT MacKENZIE: Just a follow-up, sir. One of the reasons I brought up that question is there is a lot of comments that go around of we are sharing -- we are providing information.

We have a responsibility to our service members if we know something that works better to implement it and be accountable for it. When we at times talk to those personnel who have created the best practice, we hear comments like, "This takes a lot of work. Unless they make somebody do it, nobody is going to want to do what I'm doing."

Or, "They tell me I'm doing a

1 great job but when I talk to some of my
2 friends in another facility, they are not
3 doing it because they don't have to. They
4 know about it but they're not doing it because
5 they don't have to." Our responsibility is to
6 the recovering service member.
7 That's why I was asking when do we
8 go from sharing to it becoming part of that
9 regulation or directive or instruction because
10 we know it's going to get us the best result
11 for our recovering service members. Where do
12 we cross that line because as long as we keep
13 just sharing, we're not providing a hard line.
14 MR. POWERS: On that as far as
15 when we are basically putting in these best
16 practices in the regulation, I would say, as
17 you know, WWCTP has just issued their new
18 operations guidance.
19 As well as one of the things is
20 highlighted by these monthly video
21 teleconference we are going ahead collecting
22 best practices and then doing our best to put

1 them in either a policy letter updates or
2 regulations.
3 Basically new ideas, in fact,
4 without going into great details because I
5 don't want to sound like we are selling the
6 Department of the Navy, but we've just issued
7 just recent regulations on these electronic
8 signatures on the use of the electronic NARSUM
9 and non-medical assessment. The short answer
10 is we are taking best practices once they are
11 confirmed, putting them in policy updates, or
12 improving our regulations.
13 CDR WEBSTER: One of the things to
14 tag onto that, we've seen a lot of local IT
15 innovations. That's working. At the DoD
16 level we don't have that solution yet. We
17 keep being told that it's coming, it's coming.
18 What we are hesitant to do is to
19 build something that will remain unfunded as
20 well as it's going to be a process to take the
21 best pieces from each location because each
22 location has their own spin on things and has

1 their own unique system that addresses certain
2 topics but not necessarily others as much in
3 depth.
4 At the BUMED level we are taking
5 those from the MTF level and we are trying to
6 use our IT folks at the BUMED level and come
7 up with one system that can then be
8 implemented and mandated for use by all.
9 MR. POWERS: Actually, that
10 system, an IT system that is both a case file
11 transfer system and a case management system.
12 Right now we have ETA which is merely a
13 tracking system. It's not a case management
14 system or case file transfer.
15 That would greatly aid one of the
16 biggest things that we do see that service
17 members want to know. Not just about what
18 they are explaining in the system, where are
19 they in the system.
20 Constantly right now it would be
21 nice to have eBenefits or eLoan. They can
22 wake up at 2:00 in the morning and access that

1 record. Right now what they do if they want
2 to, and if they do use it, they can call their
3 PEBLO attorney.
4 But an electronic access would be
5 something. The problem that we're seeing is
6 right now there's nothing you can implement in
7 90 days that really is reasonable, as well as
8 meets the need for basically two things.
9 You do need a case tracking system
10 but you've got to have a case management
11 system that everyone can access and move the
12 record. Our concern is we don't want to spend
13 millions of dollars on something that is only
14 going to meet half the system. I know
15 leadership is looking at that right now.
16 CDR WEBSTER: Another example is
17 our use of the narrative summary inputing into
18 AHLTA. That is a policy that is with the
19 Surgeon General now and will be disseminated
20 shortly. We are in the process of formalizing
21 best practices.
22 MS. DAILEY: That's what we saw at

1 Camp Lejeune, LTJG Cook who is putting her
2 NARSUMs in the AHLTA.
3 MSGT MacKENZIE: That's what I was
4 getting at is the creativity of our service
5 members at the MTF level is more than -- is
6 mostly, in my opinion, driven by the fact that
7 they are not waiting on OSD or anybody else.
8 They are just trying to do the right thing and
9 get the job done.
10 From that service level, while we
11 wait for this bigger program, which was one of
12 our recommendations this year, this bigger
13 program needs to happen. However, we have to
14 meet the needs of our service members right
15 now. Let's get it in place. That was the
16 only reason I was bringing it up.
17 MR. POWERS: And the Department of
18 the Navy implemented that. In fact, that was
19 actually a BUMED-PEB decision regarding the
20 electronic use of -- as we know, we have AHLTA
21 electronic records. The short answer is we've
22 done that. Well done. In fact, that's

1 implemented across the entire Department of
2 the Navy's MTFs.
3 They have the ability if it works
4 for the case to go ahead and send it either
5 electronically through AHLTA or they can send
6 a record. Whatever works best for that case.
7 Again, each case is fact and circumstance
8 specific.
9 In fact, we do the site visits
10 regularly, take those best practices and
11 implement them as soon as we can. The unique
12 aspect with BUMED and PEB is we are able to
13 immediately consult and implement them.
14 CDR WEBSTER: Other things that we
15 are working on at BUMED, developing
16 standardized training platform. Our folks are
17 working with Health Affairs to do this on a
18 DoD level with the emphasis of having service-
19 specific items put in there so that we can
20 develop standardized training across DoD.
21 We continue our post-IOC site
22 visits to ensure that not only did they meet

1 the checklist to become certified to run the
2 program, but they were answering the needs of
3 that particular facility after they have
4 already been implemented in the process of
5 carrying out this mission.
6 We are working with our regions
7 and our MTF to provide whatever support they
8 need be it funding, be it personnel. We
9 continue our intrusive leadership to drill
10 down and to make what we own and what we have
11 in our control the best process that we can
12 possibly make it and to meet current
13 timelines.
14 Again, we are working with DoD and
15 VA to come up with the best IT solution that
16 works for all. So what training are we
17 providing for operational unit commanders and
18 senior enlisted leaders?
19 At the BUMED level ourselves, as
20 well as Mr. Powers and his PEB team, when we
21 are going out to different sites we are doing
22 training for the MTFs and the staff there, but

1 we are also doing training, inviting regional
2 line leadership to come to understand what the
3 process is, to ask specific questions that
4 they may have so that we can help solve the
5 misunderstandings in some cases, or the
6 misconceptions about what IDES really is and
7 how this process is suppose to work.
8 As far as the role of the regional
9 limited duty liaison NCO, this is an
10 individual and a function that is owned by the
11 line, by Navy personnel.
12 This individual works closely with
13 the MTF limited duty liaison to share
14 information about specific service members, to
15 provide information back and forth, and to
16 make sure that individuals are tracking both
17 in a limited duty status, as well as those
18 that may be headed towards having a case that
19 needs to be referred into the IDES process.
20 Any other questions for me? Thank
21 you.
22 CAPT CARTER: Thank you, Commander

1 Webster, Ms. Paganelli, and Mr. Powers for
2 that inside look into BUMED as it pertains to
3 care for our wounded, ill, and injured.
4 Next we'll get back into Safe
5 Harbor. The first area is evaluation of
6 Recommendations 3 and 4, Condition Specific
7 Care and Comprehensive Recovery Plans. As you
8 know, our process is simple and unique and I
9 am very serious about it.
10 The first thing we do is that
11 needs assessment piece that is part of that
12 whole comprehensive CRP process. Right now
13 I'm utilizing like a 36-point checklist when
14 I get with those families, they get into the
15 hospital and they are bedside.
16 Not to bother them, though, within
17 that first 72 hours because the family is
18 dealing with doctors. They are dealing with
19 medical case management and stuff like that.
20 When that family as had a chance
21 to breathe and they are ready for that non-
22 medical side to come in, then we get involved

1 and say, "Hey, what do you need?" We use all
2 those needs assessments to develop -- to
3 execute a comprehensive recovery plan.
4 We work that through the recovery
5 phase, the rehabilitation, and the
6 reintegration back in society. We work hand
7 in hand with our guys out in the field and our
8 guys here at headquarters under the Operations
9 Department led by Lieutenant David Noriega.
10 We also, which I like, is our
11 monthly case reviews where we try to get and
12 hit every non-medical care manager at least
13 once a month out in the field just to review
14 the comprehensive recovery plan to make sure
15 the things that we decided in the needs
16 assessment are being met, the timelines are
17 being met, are there any adjustments that need
18 to be done.
19 What does he need besides the
20 things he initially talked about in his needs
21 assessment and what do we need to add or take
22 out of that piece.

1 Another great thing about our
2 process implementation is that we have annual
3 surveys we conduct yearly. We added our
4 family one this past year gone by and we do
5 them with the recovering service members every
6 year.
7 We take that data, we take that
8 feedback, and feed that whole piece back into
9 the whole process. What do I need to do to
10 make my needs assessment piece better? What
11 do I need to add to it? What do I need to
12 help that Sailor or that Coast Guardsman get
13 through this process, through that whole IDES
14 to either come back to Active Duty or be
15 medically separated or retired.
16 Next slide. The next point was
17 the evaluation of the care for the recovering
18 Reserve component, recovering warriors. Hey,
19 I look at Reserve and Active the same. I give
20 them the same treatment.
21 If you are an active guy, if
22 you're a Reservist on Active Duty, you're

1 going to get the same treatment as if you were
2 an active component in the line within the
3 Navy or the Coast Guard. We look at them the
4 same. We don't treat them any different.
5 I think sometimes when these guys
6 are going through the Navy mobilization
7 process site sometime and they are coming back
8 from overseas that are being demobilized,
9 sometimes the system doesn't catch all the
10 incidents that are wrong with them or the
11 injuries that occur.
12 Sometimes three to six months
13 later they might have a problem. I think the
14 problem we're seeing is when they are trying
15 to come back in the system to get fixed.
16 We had some discussions with the
17 PERS-95 on that and a lot of the things we
18 found in that whole piece was just the actual
19 communication. The communication and the
20 education.
21 Our Reserve side, and correct me
22 if I'm wrong, Mr. Noriega, Captain Zimmerman,

1 and Command Varias because they are all
2 Reservists, I'm so hyped up on this and so
3 serious about the Reserve piece I went and got
4 all these Reserve guys and added them to my
5 staff so I can really address these problems
6 head on.
7 The problem that we were seeing
8 was, hey, when a guy goes to a Navy
9 mobilization site and if he has an injury or
10 something like that, he's going to stay Active
11 Duty and they are going to work with him and
12 get him back up to snuff. Sometimes these
13 guys are in such a hurry to get through that
14 process they may not show all the things that
15 are wrong with them.
16 When they are gone back home and
17 they are demobilized, they might figure out
18 three to six months later, "Hey, I've got a
19 problem."
20 Then they've got to go through
21 that whole line of duty determination process
22 back through their NOSC and back into PERS-95

1 to make a determination of can we provide them
2 TRICARE locally at their home of record, or
3 wherever they have been demobilized, or do we
4 have to bring these guys back on Active Duty?
5 When they were doing that whole
6 process, and I think this is where a lot of
7 the issues have come up, sometimes the
8 paperwork was not being done properly,
9 especially for some of the smaller NOSC to get
10 it back into PERS-95 to make that
11 determination.
12 What they've done is they started
13 doing that paperwork and they've had those
14 less-educated E-5 type medical types that
15 weren't accustomed to doing that line of
16 determination type paperwork, work that
17 through the larger regional NOSC who are
18 accustomed to seeing that kind of paperwork,
19 and then back to the PERS-95.
20 I think in their pilot program
21 they had just recently, and correct me if I'm
22 wrong, we are up to 135 days of getting that

1 LIMDU paperwork completed.
2 Then during the pilot program by
3 education and awareness at the CO-XO level
4 within those NOSC and using those larger
5 regional NOSC that are accustomed to doing
6 that kind of paperwork, move it up and assist
7 those smaller NOSC and they will be able to
8 knock that down to 20 days. That's huge. 135
9 days to 20 days.
10 MSGT MacKENZIE: Now, the question
11 I have for you, sir, you are looking at this
12 -- as you look at this issue, it almost seems
13 counterproductive that the Navy chose to bring
14 reservist only to do ports of entry for doing
15 their demobilization which then encourages
16 them to want to go home and stay 1,500 miles
17 away from their place. How is the decision to
18 do that exacerbating your goal of trying to
19 make sure they are treated before going home?
20 CAPT CARTER: Do you have anymore
21 on that, Commander Varias?
22 CDR VARIAS: Commander Mike

1 Varias, Deputy for Navy Safe Harbor. I would
2 say that I think those Navy mobilization
3 processing sites have been around for years
4 and years. I know that the Chief of the Navy
5 Reserve is addressing those issues.
6 I'm not exactly sure how to answer
7 that question as far as -- sir, are you saying
8 that the Navy should look at opening up more
9 sites, demob sites, in order to make that
10 process smoother or are you trying to --
11 MSGT MacKENZIE: I guess it's good
12 that I asked the question because it's getting
13 everybody looking at it now going are we
14 meeting the needs while yet confining them to
15 areas far away from their home? Are there
16 sites that Active Duty maybe receiving
17 treatment at that these folks aren't going to
18 because they have to go to this one site? Do
19 you see what I mean?
20 If a Reserve Sailor lives near
21 Pensacola and Pensacola is providing all this
22 great help, when that service member comes

1 form overseas, he's got to go to Portsmouth.
2 CAPT CARTER: He's going to come
3 to Norfolk because that's where --
4 MSGT MacKENZIE: Or Norfolk.
5 Right.
6 CAPT CARTER: Or San Diego.
7 That's correct.
8 MSGT MacKENZIE: And right there.
9 Whereas at Landstuhl the capability is there.
10 All the medical care is right there close to
11 home and his NOSC is near Pensacola. He can
12 simply go straight to Pensacola but instead,
13 because he's a Reservist, he's got to go right
14 there.
15 CAPT CARTER: But I can't speak
16 for the Reserve community wholeheartedly
17 because that might be a numbers equation
18 because our numbers are a lot smaller as far
19 as the amount of Reservists we are going to
20 bring on Active Duty to go overseas and so
21 forth which is why we only have two sites. To
22 go beyond that I can't.

1 CDR VARIAS: We can always
2 investigate with the Navy Reserve.
3 MS. DAILEY: We really need to
4 bring in the Navy Reserve for this. We are
5 also going to get another look at it when we
6 go down to Norfolk. We will be visiting the -
7 -
8 CDR VARIAS: On March 5th and 6th?
9 MS. DAILEY: Well, 11 and 12 or 12
10 and 13.
11 CDR VARIAS: 11 and 12. Sorry.
12 Yes, ma'am.
13 CAPT CARTER: But I think the
14 take-away is that --
15 MS. DAILEY: I wouldn't go down
16 this road anymore.
17 CAPT CARTER: On this piece just
18 to say there is no difference in care that we
19 provide between the medical side or the --
20 MS. DAILEY: I was trying to help
21 you not say that because according to your
22 Reserve component, that is probably not where

1 you want to plant your flag.
2 MG STONE: That is certainly not
3 where we want to plant our flag because we
4 know there is a difference. There is a
5 difference just by access to care and the fact
6 that you've got to wait 20 days in order to
7 get the orders written in order to then be
8 able to generate the orders that transport
9 them to the appropriate place.
10 It's a challenge for all the
11 services and we haven't gotten it fixed yet.
12 You are to be commended for bringing this down
13 to 20 days. It's way better than we do in
14 order to generate these. The problem we've
15 got is the recognition that many of the
16 disease processes that are signature to this
17 war have their onset in the many months after
18 the demobilization process.
19 We in the military services, in
20 the uniform services, are saddled with
21 installation-centric health care delivery
22 systems. Until we break that, until we

1 recognize the fact that we've got to get
2 service members' care where they live, we're
3 not going to get this one fixed.
4 It's not the same. Our Reserve
5 components demonstrate for us the need to move
6 to noninstallation-centric care whether it be
7 owned or purchased. That is a whole
8 discussion we can have in another venue but
9 don't plant your flag here.
10 MS. LARSON: If I may, this is
11 Merissa Larson from Safe Harbor. Just to
12 clarify, too, I think what the Captain is
13 trying to get at is from the non-medical side,
14 which Safe Harbor owns, we do provide the same
15 non-medical care both to our Reserve and
16 Active component. In regards to the medical
17 side of the house, that is a different story
18 in regards to the med hold locations. Thank
19 you.
20 CAPT CARTER: Nicely said, Mr.
21 Larson.
22 Okay. Next slide. Evaluation of

1 Recommendation 12 - Training for NSH Staff.
2 I think we are pretty good here. We are
3 getting better. We have our first resource
4 guide that talks about all the training we do
5 for our SMEs and our care managers out in the
6 field. We have a lot of formal face-to-face
7 training. As I said earlier, we do a lot of
8 monthly case reviews as far as the care
9 managers out in the field.
10 We provide monthly newsletters out
11 to the family members and to the RSMs
12 themselves. We take part externally in all
13 those PEBLO conferences that are held once a
14 year. We do the RCC training four times a
15 year and, of course, with the WWCTP. We also
16 take advantage of that CACO training that is
17 implemented down at the MTF levels at all the
18 various MTFs around the country.
19 Next slide. Evaluation of
20 Recommendations 13 and 14 - Resources and
21 Caregiver Support. Again, as I have indicated
22 here, we provide a lot of support to the

1 recovering service member and his family in
2 the form of the NGOs, childcare, bedside
3 family kits with books and journals and so
4 forth to help them as far as the whole
5 comprehensive recovery plan.
6 Again, I'll mention our family
7 caregiver newsletters. We take advantage of
8 the FOCUS which is a great view med program.
9 Families overcoming under stress. The SCAADL,
10 as you all know, was implemented back on 31
11 August, 2011. We have 24 members that are
12 receiving funding via the SCAADL program.
13 Again, like I said, we had our
14 first Family Symposium. We are also looking
15 toward our next Flag Spouse Advisory Council.
16 That was one of the outputs of the actual
17 Family Symposium.
18 Next slide. Vocational Rehab and
19 Employment and Meaningful Work. This is an
20 area that is getting a lot of attention out
21 there. How do we help these wounded, ill, and
22 injured transition better? When I say

1 transition, not the transition of being
2 medically separated but how do we help them in
3 their whole job piece, their resume, and
4 finding work, and meaningful work, after they
5 are no longer within Navy Safe Harbor?
6 I have a single transition liaison
7 officer right now but I'm trying to grow this
8 program because it's going to need a lot more
9 attention. This is just an example of some of
10 the assistance we provide to some of our
11 wounded, ill, and injured as they get ready to
12 make that transition out of the service.
13 Next slide.
14 MS. DAILEY: On your
15 Recommendation 18 we have Employment and
16 Meaningful Work. This is 2012 data as the
17 green, purple, and blue barchart?
18 CAPT CARTER: The first chart on
19 slide 24 shows the --
20 MS. DAILEY: Okay. I get it. I
21 get it.
22 CAPT CARTER: Okay.

1 MS. DAILEY: All right. Thank
2 you.
3 CAPT CARTER: This chart shows
4 since our inception we've had a total that
5 have already transitioned out of the Navy of
6 366 out of that over 800. As of 30 September
7 2011 366 have transitioned. Out of that 366
8 there were 170 that were assisted.
9 In the education piece, we were
10 helping them with the GI bills, 9/11,
11 Montgomery GI Bills. How do we get additional
12 education? Do you want to go to college? Do
13 you want to get an associate degree? Do you
14 want to get your MBA and so forth.
15 Job assistance. There are a lot
16 of programs with leverage for job assistance.
17 that's the TAPs, the DTAPs. There are a lot
18 of NGOs out there and NFEs that provide
19 assistance and job assistance. We leverage
20 that stuff.
21 It's nothing I'm inventing that's
22 new. Then the job internship, No. 45, shows

1 you some of the guys that are working some of
2 the intern programs out there with DoD, other
3 government agencies.
4 This is as of 1 October of 2011 to
5 now. There are guys that are in transition or
6 have transitioned out of this number here.
7 Out of that 80, again, we have assisted 58 of
8 that 80. This is voluntary. They have to
9 want it.
10 We talk to all of them about it
11 but sometimes these guys will get jobs on
12 their own and they don't really need any
13 assistance from Navy Safe Harbor. If they
14 want it, we encourage it and we are there to
15 help them.
16 Next slide. The way ahead, we are
17 going to continue a lot of the things I've
18 discussed, be proactive. We are going to
19 create more awareness about the program. We
20 are going to touch up on our IT database.
21 You can always make improvements
22 on that on getting data and better

1 categorizing data when it comes to wounded,
2 ill, and injured. We are going to keep going
3 with our robust adaptive athletic program we
4 have right now.
5 Like I said, I want to go to a
6 more focused transition team but that's
7 getting larger and larger every year.
8 Continue to leverage all the existing programs
9 and resources that we have out there.
10 Barring any questions, that's our
11 presentation from Safe Harbor and BUMED.
12 LT GEN GREEN: I have one question
13 that I think goes to your PEB, Mr. Powers? Is
14 that it?
15 MR. POWERS: Yes, sir.
16 LT GEN GREEN: We had in open
17 session this morning a couple people tell us
18 that the Navy was still doing some
19 administrative discharges after PEB. Is that
20 accurate or not accurate?
21 MR. POWERS: I can't speak to
22 that. That would actually be the service

1 headquarters issue. We would find them fit
2 and it wouldn't be proper for me to say
3 whether that's true or not.
4 LT GEN GREEN: Okay. I guess the
5 other question is, and I'm going to go back to
6 my own service and ask, but are we looking at
7 all at the disabilities that are given by the
8 disability system, i.e., the service
9 disability system, as compared to what the VA
10 may be giving in terms of service connected
11 disabilities. Do you look at all of that kind
12 of data now that we're in the IDES?
13 MR. POWERS: Yes, sir. We are.
14 The reason we are is we don't have a choice.
15 As you know, we send the case over to the VA.
16 They send us the proposed writing decision.
17 In it it has the unfitting referred conditions
18 and all of the claim conditions so we're
19 seeing that. There are many times where if
20 the member does contest and says that, "I know
21 you found me unfit for two conditions but this
22 claim condition would say my ankle is also

1 unfitting." If they demonstrate that it's
2 impacting their ability to serve, then we'll
3 just add that and make that a preferred
4 condition. We are looking at both, the entire
5 package.
6 LT GEN GREEN: Then the final
7 question is have you done any assessment at
8 all looking at -- again, this is something
9 that came up this morning so we haven't asked
10 the other services, in all fairness, and I
11 haven't gone back to my own service to ask
12 this question, but are we looking at the end
13 results of the PEB versus what is coming out
14 of the Disability Review Board now? I believe
15 that's what it's called.
16 MR. POWERS: The Physical
17 Disability Review Board, sir?
18 LT GEN GREEN: Yes.
19 MR. POWERS: Yes, sir. In fact,
20 the director just came over last week. We
21 looked at their stats and on that, in fact,
22 what is very interesting is out of basically

1 almost $13,000 eligible in the class to file
2 petition with the PDBR -- that's rough, sir --
3 is the PDBR has received only about 600 and
4 out of that 600 they upgraded 300.
5 That was a preponderance of
6 evidence standard. It wasn't clearly
7 erroneous standard. They upgraded that so we
8 are very aware of what that is.
9 In fact, above the Physical
10 Evaluation Board we have an Appellate Board
11 and they are the ones that actually look at
12 that and review the PDBR determination so they
13 also brief me on whether there is an upgrade
14 or what that fact is.
15 Back to the first question as
16 well, sir. We are very keenly aware of the
17 service members we find fit. Right now it's
18 the lowest it's been in about a decade. Only
19 15 percent of our service members are found
20 fit. We are very aware that our
21 determinations have to be fair and impartial.
22 When you make a fit determination,

1 that is a huge impact basically because there
2 is obviously an implication that a service
3 member is unfit. We look very hard at the fit
4 cases. Regarding the services, they let us
5 know immediately if they think we have a fit
6 case that they disagree with.
7 LT GEN GREEN: (Off microphone.)
8 MR. PARKER: I'm sorry, General
9 Green, but the point of my question this
10 morning was we have a case where a guy was
11 found unfit. You guys says he was unfit for
12 a condition. He was rated 100 percent for
13 PTSD. For the ankylosing spondylitis you guys
14 said it existed prior to service. The VA said
15 it was service connected.
16 They rated it. They gave him 100
17 percent for the PTSD. You guys called it a
18 Cat 2 condition. Your Cat 2 conditions are
19 suppose to be rated for your own manual. Yet,
20 he's leaving with no benefits because you said
21 it was EPTS ankylosing spondylitis and you
22 didn't rate the other condition called Cat 2

1 by your own PEB.
2 MS. DAILEY: I'm sorry. We're
3 going to let you guys handle this off line.
4 I apologize.
5 LT GEN GREEN: My questions were
6 designed more to find out whether or not we
7 are looking at equity within the system since
8 there are two new measurements. One, the VA
9 doing the disability evaluations and
10 differences between that and the services.
11 And, two, not that we have a
12 Physical Disability Evaluation Board are we
13 looking at what's coming out of there in terms
14 of whether or not there are a lot of cases
15 being overturned. I asked the question and I
16 appreciate your answer.
17 MR. POWERS: Yes, sir.
18 LT GEN GREEN: Thanks.
19 Quite a team that you folks
20 brought in here today. We are impressed.
21 Thank you for all the effort of bringing this
22 all together. I think we are overdue for a

1 break so let me let everybody take -- we're
2 about 15 minutes late. Why don't we take 10
3 minutes and come back. Thanks.
4 (Whereupon, at 2:28 p.m. the
5 above-entitled matter went off the record and
6 resumed at 2:49 p.m.)
7 MS. CROCKETT-JONES: While we
8 might be having a couple members still
9 trickling in, I think we should get started
10 again. Last year we received a briefing from
11 Centers of Excellence and in December we had
12 an update from the Hearing Center of
13 Excellence.
14 We will now have Colonel Gagliano,
15 the Executive Director of Vision Center of
16 Excellence. And Dr. Mary Lawrence and
17 Lieutenant Colonel Timothy Pendergrass
18 providing us with an update on VCE and
19 Traumatic Extremity Injury and Amputation
20 Centers of Excellence. Items are at Tab M.
21 Welcome. We are looking forward
22 to hearing from you. Thank you.

1 COL GAGLIANO: Thank you. Good
2 afternoon everyone. Again, thank you for
3 allowing us to come and tell you a little bit
4 about the Vision Center of Excellence. I'm
5 here today with Dr. Mary Lawrence, the Deputy
6 director.
7 Dr. Lawrence is from the VA and
8 I'm from the DoD. This is, just as we said
9 last year, representative of the partnership
10 as we evolve the Vision Center of Excellence.
11 You will see as we move through this that, in
12 fact, it is a pretty strong partnership.
13 The first slide is -- I want to
14 just kick this off with a quote that I've
15 repeated. In fact, I've used it in many forms
16 and it just hit home with me and I remember
17 it. Some of you may know Sara Wade and her
18 husband Ted Wade. Sara sits on many of the
19 Joint Planning Committees and research panel
20 reviews.
21 On 28 June at the JPCA, Joint
22 Planning Committee for Rehabilitation and

1 Clinical Medicine Joint Planning Committee,
2 she opened it up with some words about her
3 recent visit to Walter Reed. Sara said that
4 she certainly -- I'll read it to you.
5 She said, "I walked around and I
6 noticed that we have accomplished a lot over
7 the past three years but there still is a lot
8 to be done towards giving people their lives
9 back."
10 That one comment about giving
11 people their lives back still gives me
12 shivers. It resonates with me. That really
13 is what we are trying to do in the Vision
14 Center of Excellence is find a way to give
15 people their lives back once they have been
16 injured.
17 True, to prevent the injury but we
18 don't want to lose the focus on that patient
19 and the family who have been injured. I want
20 to lead off with that because that is sort of
21 the underpinning of the Vision Center of
22 Excellence.

1 You are familiar with the Centers
2 of Excellence, the five that were established,
3 consolidated, two of them under one single
4 center, the Defense Center of Excellence. The
5 issue for the establishment of these centers
6 by Congress partially is a result of the
7 changing in the injury characteristics of this
8 current conflict.
9 Most notably is the increase in
10 head and neck injuries compared to previous
11 conflicts. That includes hearing and vision
12 and traumatic brain injury and psychological
13 health. Amputations remain high and you are
14 going to hear after the Vision Center of
15 Excellence presentation about the Traumatic
16 Extremity and Amputation Center.
17 Just a few details about that.
18 The overall in OIF/OEF eye injuries have
19 averaged about 13 percent. That doesn't tell
20 the whole story. In the last two years we've
21 seen a significant increase because some
22 change in the tactics and techniques of the

1 injury mechanism and almost a doubling, not
2 quite, of the incidents of eye injuries and in
3 the casualties returning.
4 This correlates with, I think, a
5 more complex extremity injury that you may
6 hear the Center of Excellence Director for
7 Extremity, talk about this. So this means
8 that although we've enjoyed somewhat of a
9 decrease and we are glad about it, this
10 partial decrease was because of the increased
11 use of eye protection.
12 One of the programs that all the
13 Armed Forces are utilizing and Dr. Lawrence
14 will tell a little bit about the APEL program.
15 We have some demonstration projects here to
16 give you some idea of what that is. We still
17 have a problem.
18 Even though we are seeing a
19 current increase in this incidents of eye
20 injuries, the real key to this side is that
21 even though the wars are ending, the
22 consequences of losing vision remain with

1 someone for the rest of their life.
2 We do not have the ability to
3 provide a prothesis that restores function as
4 you would if you had an extremity injury or
5 some other type of injury. That's part of
6 what we're trying to do in the Vision Center
7 of Excellence is find ways to address that.
8 You'll hear more about that later
9 in the brief. I want to just highlight that
10 we are just starting down this path of trying
11 to find ways to provide and restore capability
12 for people who have lost vision and visual
13 function.
14 MSGT MacKENZIE: Can I ask you a
15 quick question as we go along? I was looking
16 at your eye protection. In 2004 when I was
17 addressing a lot of these issues due to my own
18 eye injuries from part of your 2004 numbers
19 there, the -- actually it was close -- yes, it
20 was 2004.
21 There was a lot of testing that
22 was done towards impact protection from a

1 projectile. When I brought up the question
2 and I said, "What are the test parameters for
3 blast impacting that item?"
4 Because when I asked the experts
5 and I said, "If I took a bullet to the visor,
6 you can tell me whether it would have stopped
7 it or not, but you are unable to tell me that
8 the blast would not have shattered that visor
9 and exacerbated the problem." Have we changed
10 or added into our testing and providing of
11 protection to include that blast impact to
12 these protective lenses?
13 COL GAGLIANO: I'm going to
14 presume the answer to your question is we
15 hadn't addressed that issue back in 2004/2005.
16 The answer is it's starting to be addressed.
17 In the back of our slide deck we
18 included the currently funded research
19 projects of which you'll see many of them are
20 specifically to understanding the blast
21 physics and the blast dynamics, particularly
22 on the eye.

1 The protection of that blast is
2 going, of course, be derived from
3 understanding how the impact of that wave on
4 the eye. We have two new blast tube centers
5 that are just being implemented, one down at
6 San Antonio at our intramural lab specifically
7 to address the issues of protection.
8 There is nothing new about the
9 protective mechanisms at this point in time to
10 address the issue of high energy blast wave
11 and eye injuries. It doesn't exist but it
12 needs to and that's a priority.
13 MSGT MacKENZIE: And that's why
14 I'm asking the question because here we are.
15 I'm about to approach my eight-year
16 anniversary and yet that's still -- we haven't
17 gotten there yet. From a guy who took -- you
18 know, the blast we three feet in front of me.
19 The foot-per-second travel of the
20 projectiles is one thing. That blast wave to
21 that eye protection and to my eyes was
22 something that still hasn't been looked at.

1 Thank you, sir.
2 COL GAGLIANO: And what we're
3 tracking is who was wearing their protective
4 devices at the time as they exist now and what
5 happened to those protective devices so we can
6 have, again, a better understanding of that.
7 One other point in that area is I
8 know Natick Laboratories started work along
9 that direction but I think it's the lack of
10 information. There was just a recent
11 publication in New England Journal of
12 Medicine.
13 We have copies of this if anybody
14 is interested that came out of Palo Alto where
15 they looked at -- the Palo Alto Polytrauma
16 Center looking at the evidence of eye injuries
17 and the absence of an external eye injury in
18 those post-blast wounded warriors and, in
19 fact, found a very high prevalence of
20 undiagnosed or unrecognized eye injuries when
21 a very careful eye exam was conducted.
22 Well, maybe those symptoms aren't

1 really manifested now but knowing that and
2 putting in place some way to track and monitor
3 these cases will allow us to correlate, for
4 example, the development of glaucoma later in
5 life and relate it back to the blast exposure,
6 or a cataract later in life.
7 Perhaps even a complication from a
8 cataract because cataracts develop and you get
9 some weakening of the eye support system and
10 you can have higher incidents of a
11 complication if you didn't anticipate that
12 person was going to have a complex case before
13 you started surgery.
14 This is where it becomes important
15 to not just protect it but to know the full
16 scope of damage that has been caused by these
17 blast injuries. It's becoming pretty evident
18 to us that somewhere around 75 or 80 percent
19 of people who are exposed to blasts are going
20 to have -- and have TBR are going to have some
21 element of eye injury or vision dysfunction.
22 And that doesn't really -- it

1 isn't really told by this slide because we
2 don't have those numbers because we are just
3 starting to uncover some of these new
4 findings. That brings me back to the bottom
5 bullet there, that the consequences will be
6 with us for a long time.
7 I just want to highlight one more
8 thing on here when I talk about consequences.
9 The majority of the injured are young males,
10 20 to 24 years old. I don't know if that was
11 you but somewhere around 97 percent are in
12 that category. That's a significant event.
13 I put this picture in here because
14 it's not just a statistic. It's an emotional
15 event to lose your eyes. We know that loss of
16 vision is one of those categories for urgent
17 evacuation; loss of life, limb, or eyesight
18 and we follow that.
19 But eyesight remains the most
20 feared injury on the battlefield, again,
21 because we don't have the capability to bring
22 someone back to functioning as we have been

1 evolving with some of the other injuries we're
2 experiencing.
3 We have three primary outcomes.
4 This is a revised vision statement. This was
5 approved when our CONOPS was approved. Both
6 the CONOPS and our strategic plan were
7 presented and approved to the Center of
8 Excellence Oversight Board just a few months
9 ago.
10 We have really three primary
11 outcomes; optimizing readiness, improving
12 vision health, and providing the best possible
13 quality of life for our wounded warriors and
14 their family members. Everything you are
15 going to hear today is about that focus.
16 Last year you told us, "Tell us
17 about your patient focus, your family focus."
18 This year the brief is really telling you
19 about how we are addressing issues across that
20 continuum of care, specifically focused on
21 patients and families. Hopefully the message
22 that you gave us last year will be followed.

1 This is a diagram to demonstrate
2 that. I'm going to turn the podium over to
3 Dr. Lawrence to go into details of the
4 description of our projects and programs.
5 DR. LAWRENCE: Thank you very
6 much, Colonel Gagliano. It is a great
7 pleasure for me to be here and to tell you a
8 little bit about some of our patient-focused
9 initiatives.
10 First of all, we have a lot of
11 stakeholders for the Vision Center of
12 Excellence. You, the Task Force, are
13 represented by Congress at the top. We have
14 patients and families always at the center,
15 service members and veterans and many
16 stakeholders.
17 As a patient goes through the
18 continuum of care as you look along the top
19 line there, we need to focus on all the
20 different aspects of care as we are going
21 through the continuum.
22 The injuries tend to cause two

1 injuries; the eye and the vision which is the
2 ocular trauma, and to the brain. The brain
3 injuries include optic nerve injuries, diffuse
4 brain injury to visual processing, and cranial
5 nerves (eye movement.)
6 About 75 percent of all patients
7 with TBI are seen at the Palo Alto Polytrauma
8 Center have difficulty reading, 75 percent of
9 everyone with TBI. That is mild, moderate,
10 and severe TBI.
11 This is something that we really
12 haven't fully -- we don't fully understand.
13 The eye injuries are terrible and they are
14 more straight forward. We have a better of
15 understanding of how to treat them.
16 We've broken up the continuum of
17 care into three different categories. The
18 first would be surveillance, prevention, and
19 readiness. That speaks to some of the
20 comments that were made earlier about the eye
21 protection.
22 In the interest of time I'm not

1 going to go through all the bullet points but
2 I will talk about the authorized protective
3 eyewear list approved eyewear. We have a
4 little card that we give out to our service
5 members.
6 One of the things that we're
7 finding is that some of our service members go
8 into a retail store and they get some Oakleys
9 that they think are cool but they aren't truly
10 APEL approved eyewear. We need to encourage
11 them to do that. At least that helps protect
12 them from some of the small fragments of
13 shrapnel that come up in the blast.
14 We also are looking at some of the
15 regenerative biomaterial to prevent vision
16 loss from blast injuries. I just picked out
17 a few of the research projects to put onto the
18 slide. You can see the complete list in the
19 back in the backup slides.
20 One of the underpinnings of what
21 we're doing, and actually what we are spending
22 most of our resources, the majority of our

1 resources on, is to develop the Vision
2 Registry.
3 You will see as we go along the
4 continuum of care that the Vision Registry is
5 in every single aspect of helping us to
6 understand, helping us to track, helping us to
7 know in near real time how best to treat
8 patients as they are going along the continuum
9 of care both in the VA and in the Department
10 of Defense.
11 So the middle third of the
12 continuum of care is really more of what we
13 talk about as sort of the traditional medicine
14 and that is obviously a focus. We want to
15 improve the care for our eye and vision
16 injured warriors.
17 I'll pick out a couple of bullet
18 points. The Worldwide Ocular Trauma Video-
19 teleconference is a program we have started
20 since we briefed you last year. We have
21 eyecare providers and basically anyone that
22 touches a patient from the time they first

1 reach an eyecare professional all the way
2 through to VA Polytrauma Centers on a call.
3 We use a case presentation format
4 and it's done much like a grand rounds would
5 be done in a hospital. We have people calling
6 in from all over the world. We have the
7 ophthalmologists in Afghanistan, Landstuhl.
8 We have people in the evacuation, AIRVAC
9 systems, on the call.
10 Everybody can learn -- the
11 ophthalmologist in theater can learn from the
12 ophthalmologist in CONUS, can learn from the
13 optometrist in the blind rehab out-patient
14 specialist in the VA medical centers what
15 really worked, what was the good thing to do
16 at each stage along the care process.
17 We also are focusing on putting
18 fox shields in the individual first aid kits.
19 That is now standard equipment in both the
20 Navy and the Air Force individual first aid
21 kit. Fox shields are little metal shields
22 that can also be made out of plastic but we

1 use mostly metal ones. When an eye is injured
2 -- well, when any part of the human body is
3 injured, usually you put pressure on it, a
4 pressure dressing.
5 With you eye you don't want to put
6 a pressure dressing on it because important
7 contents can be extruded with pressure and you
8 can turn an eye that could have some vision
9 potential into an eye that has no vision
10 potential by the time they get to an eye
11 surgeon. We are putting these fox shields in
12 individual first aid kits and teaching the
13 medics how to use them.
14 When I first saw this picture, I
15 thought, "Oh, gosh. They are not doing the
16 right thing. This is the Army. The Army
17 doesn't have it. They are just wrapping an
18 eye." But if you look very closely, actually
19 this patient here has glasses on so they are
20 wrapping the bandage over the glasses which
21 actually is protecting the eye.
22 I went from being not very happy

with the picture to being really very happy with the picture. This Army medic is actually doing the right thing even though they don't have a fox shield in their kits.

MR. CONSTANTINE: Why is that? The Army and the Marine Corps I'm sure suffer the lion's share of these injuries. Why don't they have them?

DR. LAWRENCE: We're working on it. It's a big bureaucratic system and I think it will be very soon. Yes, we're working on it. It just takes a little time to get through all of the bureaucracy. Again, the Vision Registry is important as we go through the whole care process.

The last third of the continuum of care is the vision rehabilitation and reintegration. The Department of Defense has an absolutely superb medical care system when it comes to eye care but they don't have -- the Department of Defense does not have any vision rehabilitation.

1 An injured service member needs to
2 go over to the VA. The VA has longtime been
3 the vision rehab for the Department of
4 Defense. The patients that need vision rehab,
5 which there are quite a number of them, need
6 to be seen in VA medical centers which is one
7 of the reasons why we are very, very
8 integrated.
9 We don't have two systems that run
10 through the whole gamut. When a patient is
11 coming down the DOD system, they have to go
12 over to the vision rehabilitation system in
13 the VA. A lot of patients before we came into
14 existence were actually falling through the
15 crack as we were moving across this as they
16 were getting into the VA system.
17 We have actually created a vision
18 service -- a vision service care coordinator.
19 We've hired one, created a whole new name for
20 a new position to help with the interface and
21 the bridging of care as we are going across
22 the systems between VA and DoD.

1 CSM DEJONG: Ma'am, as long as we
2 are talking across systems between VA and DoD,
3 part of what I've seen in history is that I
4 think that gap was created because whatever
5 military service it was would start to rate
6 them, test them post-deployment, post-service.
7 Then they would go to VA for their
8 compensation. It was a far different test.
9 Have those tests been standardized for post-
10 deployment along with the VA? Has that meshed
11 together both on the hearing side and on the
12 eye side? I know it was kind of the same way.
13 DR. LAWRENCE: I'm not an expert
14 on that but I understand they are making
15 headway to making them very similar, if not
16 the same. I don't know if anyone else in the
17 room has any knowledge of that.
18 CSM DEJONG: The way I see it, a
19 service member could fall through the cracks
20 because they stand at the 20-foot line and
21 read, "Okay, your vision is 20-40. You're
22 good." We check the block and they go out.

1 They go for -- they say they loss
2 vision. They go to the VA right now for
3 compensation, goes through a far superior test
4 dilating the eyes, whatever else they do,
5 comes back and says, "Your eyes are far
6 better. What caused you to write the claim?"
7 Somewhere along the line we have to tie those
8 together for compensation and for --
9 DR. LAWRENCE: We were -- the VA
10 is doing the service-connected disability
11 rating system called the VASRD. The Vision
12 Center of Excellence have two members. I
13 helped pick members for that. The VA helped
14 pick members for that. The vision part of the
15 VASRD, that was just done at the end.
16 The first meeting of that to
17 rewrite the VA rating, disability rating
18 system, is just being started. It's going to
19 be about a nine-month process I understand.
20 We just met a few weeks ago for the first time
21 in New York City so we are very much part of
22 the VA disability rating system.

1 You are right we've got to make it
2 -- this is really talking about the care of
3 the patient, actual care. The disability
4 rating system and the benefits that derive
5 from disabilities from the injuries is sort of
6 a different category and very important
7 because the benefits that the patients get
8 are --
9 CSM DEJONG: I just see us linking
10 the VA and the DoD in these Centers of
11 Excellence and I think that we've got to take
12 -- once we link them we've got to continue
13 that link across the continuum onto both the
14 compensation side.
15 COL GAGLIANO: So Dr. Lawrence
16 highlighted a very important point, the VASRD,
17 VA Service Related Disability forum which
18 included vision as a component of it and I'm
19 not sure it was all components at that
20 particular meeting but it was one of the first
21 times that the DoD has actually participated
22 in that VA forum to look at how we can bring

1 that commonality for that disability
2 evaluation perspective.
3 The other part, if you look on the
4 top bullet there, under TBI, Major, we
5 recently conducted a consensus panel of both
6 VA and DoD providers working towards evolving
7 a common evaluation framework. That is really
8 the most important thing, common evaluation
9 framework which will reside in both the DoD
10 and the VA electronic health record system.
11 We'll be able to track those parameters in the
12 registry, as she mentioned earlier, so that we
13 know that everybody is performing that same
14 evaluation on that same category of patient.
15 I don't know if that answers your question.
16 CSM DEJONG: Absolutely. Thank
17 you, sir.
18 MG STONE: I wonder if you would
19 go just a little bit further with that. Did
20 that consensus agree in what domain of care
21 service members should be in? For instance,
22 what is DoD's responsibility and what is VA's

1 responsibility?
2 The reason I ask this is I think
3 that your area is further down the road in
4 these 10 years of warfare of defining the
5 borders of the domains. We have been greatly
6 confused in many other areas including
7 extremity trauma as to who is responsible for
8 what.
9 Is it the uniform services? Is it
10 the DoD delivery system? Is it the VA
11 delivery system? Or should we continue to
12 blur that? In your area it's very clear cut.
13 COL GAGLIANO: To answer your
14 question, yes. We are looking for where is it
15 that the evaluation to the blind rehab centers
16 is one that -- when that should occur is it
17 part of that consensus. But in the process of
18 the evaluation, it would be the same
19 evaluation it would be the same evaluation
20 that we performed on the initial assessment of
21 the patient.
22 The answer is we are very closely

1 tied to the blind rehab centers. There are 13
2 blind rehab centers in the VA. One just
3 recently opened in Long Beach and named after
4 an optometrist who was killed in Iraq, Dr. Rob
5 Soltis. His wife works there.
6 It's a nice tie that we are really
7 proud of. But that discussion about when is
8 the appropriate time to refer and what is the
9 right category of patients to defer either to
10 some -- there's a couple of levels; the full
11 blind rehab center level, the low-vision
12 evaluation and care level. Those are pretty
13 much the two.
14 An anecdote if I may. In San
15 Diego there was concern because there was no
16 low-vision referrals occurring or uncertainty
17 about how to refer from Balboa. We made a
18 visit out there and realized there was a low-
19 vision VA service two miles away that had
20 never had a patient referred from Balboa to
21 that center.
22 After our visit and demonstrating

1 what needs to happen to make that referral, in
2 two weeks there were 17 referrals. I think
3 that is just an anecdote to address the
4 question.
5 MSGT MacKENZIE: I'm going to jump
6 on this rehabilitation giant hole in the net,
7 shall we say, because I'm one of those with
8 outstanding medical care and it's due to the
9 doctors as to why I can even see. However, the
10 quality of medical care I received now makes
11 me ineligible for many services.
12 As DoD addressed the fact that in
13 order for me to receive any assistance or to
14 receive low-vision therapy or address those
15 topics in order for me to quality because,
16 quite frankly, according to the rules right
17 now, you have to have less than 20-60 vision
18 in the unaffected eye, 20-60 or less vision
19 loss.
20 However, because I have 20-20
21 vision in my eye, I don't qualify for that
22 care. However, I only have one eye that works

1 so it's really frustrating to me to have to
2 coordinate with a neuro-optometrist that
3 specializes in low vision to just see me on an
4 optometry referral because if I actually
5 request a referral based on what I'm really
6 going to see him on, TRICARE won't fund it.
7 It's not a service I can receive because I
8 have 20-20 vision in one eye.
9 DR. LAWRENCE: Medicare and
10 TRICARE, I believe, follows Medicare
11 guidelines. I was in the private sector and
12 academia before taking this job. I think it's
13 in my bio that I was in charge of the vision
14 rehab center at the University of Minnesota so
15 I know all about private billing.
16 You're right. You have to have
17 certain visual acuity or visual field
18 limitations before Medicare will pay for it.
19 Most of the private insurers follow that. In
20 the VA, however, and if you're Active Duty,
21 you can get care in the VA, vision rehab care
22 in the VA.

1 In the VA we don't have rules like
2 that. We give care if anybody has any kind of
3 vision problem. Some people have 20-20 and no
4 eye injury in one eye and the other eye is
5 completely gone. They have problems with
6 depth perception and yet they are 20-20 with
7 a full enough field they would never qualify
8 for getting vision rehab care in the private
9 sector.
10 If you want to go to the VA and,
11 actually, the VA -- I don't know whether I
12 should put this on tape but VA has probably
13 some of the best vision rehab care in the
14 world right now. The VA has been doing it for
15 a long time.
16 We don't have these limitations,
17 arbitrary limitations. If people are having
18 trouble seeing, if people are having trouble
19 with their vision, I believe they should be
20 able to get some vision rehabilitation care.
21 They don't have to have some arbitrary cut
22 off.

1 MSGT MacKENZIE: The reason it
2 prevented me from going to the VA was because
3 as I'm testing and trial by fire adaptive
4 equipment to my vehicle in order to drive,
5 whether that be rubbing or impacting items, I
6 go to the VA for assistance in adaptive
7 equipment and then, once again, I'm told,
8 "Your vision is not bad enough to qualify for
9 adaptive equipment," and the grant is denied.
10 Me as an Active Duty service
11 member, you know, I don't have the information
12 you just presented but I look at it and go I'm
13 not getting any help. What is the VA going to
14 do for me if they won't even buy the equipment
15 I need in order to drive safely? The driving
16 conflicts are then connected to the anxiety
17 which is connected to -- you see what I mean?
18 DR. LAWRENCE: I know exactly what
19 you mean.
20 MSGT MacKENZIE: It brings you all
21 the way back to I'm not driving anywhere
22 because I can't handle the anxiety of driving

1 because I don't have the equipment in order to
2 get me there because I don't qualify for the
3 equipment because, low and behold, my doctors
4 were so good I have 20-20 vision in one eye
5 and so I'm out of luck
6 DR. LAWRENCE: And you take TBI
7 patients who haven't even had an eye injury.
8 They've had a traumatic brain injury and they
9 are having difficulty. Many of those patients
10 have difficulty with glare and they have
11 difficulty reading.
12 They can read on an eye chart
13 single octotypes, single letters; you know, E,
14 S, L. They can read that, but reading words
15 is much more difficult. A lot of them have
16 difficulty driving.
17 Well, in America you have a job
18 and there are very few places you can live and
19 walk to work or take the Metro to work or go
20 to the grocery store or get to your local
21 community center or your church or place of
22 worship. It's very difficult in America to

1 not drive. Many patients that don't even have
2 an eye injury have difficulty driving with the
3 TBI patients.
4 I've seen that at the Minneapolis
5 VA Medical Center which is where I used to
6 work. This is a big issue. We need to
7 address it. We probably need to move on but
8 I'm happy to answer any questions. We are
9 very happy. This is --
10 CAPT EVANS: I just wonder with
11 our DoD VA polytrauma nurses embedded into our
12 hospital system, they should be -- I'm not
13 sure if we are not utilizing them correctly to
14 capture these patients and say, "Here is when
15 you qualify to go into the VA system." I
16 heard you say you just hired another type
17 of --
18 DR. LAWRENCE: Yes.
19 CAPT EVANS: Again, that's one of
20 my -- how do we fix this correctly using our
21 VA liaisons, our VA DoD polytrauma nurses that
22 we have in the hospital to ensure that we

1 capture these patients early and get them into
2 the VA system.
3 DR. LAWRENCE: I think that is
4 being done much better. We are just going to
5 be moving in and jumping ahead a little bit
6 moving into a new facility up at Walter Reed
7 at Bethesda. We've had our vision services
8 care coordinator meet with some of the VA
9 nurses and social workers that are embedded in
10 Walter Reed.
11 A lot of people in medicine -- I
12 mean, many of you are physicians. How many of
13 you took an ophthalmology course in medical
14 school? It's not requires in many medical
15 schools so a lot of people the eye and vision
16 is sort of something that people maybe don't
17 know a ton about.
18 Our vision services care
19 coordinator is actually in Madigan and she's
20 working in terms of educating all the people
21 helping with the care about eye injuries. We
22 don't do that and that's a matter of just

1 getting out there and meeting people.
2 LT GEN GREEN: Excuse me. Just so
3 we understand, I think we have clearly
4 established you guys have lots of work to do.
5 DR. LAWRENCE: Yes, we do. We do.
6 LT GEN GREEN: And we are thrilled
7 that it's a partnership in terms of what is
8 going on. I know it's beyond just a
9 partnership but it's actually DoD and VA and
10 many others. I need to get you to move on
11 because we are going to get way behind the
12 power curve here. I'm sorry, Dr. Lawrence,.
13 DR. LAWRENCE: Thank you.
14 While he's coming up, I'll just
15 say this is a veteran, used to be an Active
16 Duty Army service member. He's completely
17 blind. Lost both eyes and he runs with a
18 sighted guide, a VA employee. We have a lot
19 of nice success stories, too, but we don't
20 want any stories that aren't successful.
21 COL GAGLIANO: We'll take your
22 question back. It's my understanding that one

1 eye allows you to get an evaluation for
2 techniques and capabilities and adaptive
3 techniques. You notice up here we did host a
4 technology seminar in August and brought in
5 some of the world leaders in about four areas.
6 One of those areas was driving.
7 Driving with one eye is different than driving
8 with both eyes. Driving with one eye where
9 the best vision is 20-50 is very different
10 than driving with both eyes at 20-20.
11 Techniques to help people exactly
12 like you and technology to help people like
13 you is part of the focus of that agenda. We
14 actually are publishing the findings of that
15 and we plan to continue to pursue that in
16 partnership with the VA. I do think you are
17 eligible. I wrote it down and we'll try to
18 find out. I am surprised to hear you say you
19 weren't eligible.
20 MSGT MacKENZIE: I got the initial
21 driving device five years post-injury and then
22 another one last year. It was very effective

1 and it was very good. However, once again,
2 "Here's all the stuff we would recommend you
3 do. Feel free to go out and why it on your
4 own." That's the problem. Thank you.
5 COL GAGLIANO: Just a quick answer
6 to the other question. It would be great if
7 everybody knew everything about everything
8 but, unfortunately, those care coordinators
9 don't have any knowledge about the eyes or
10 vision. We are there to provide help to them
11 in their care coordination role.
12 Someone has to do that. There is
13 nobody in the system to do that. That is part
14 of the reason why people with eye injuries are
15 falling through the gaps. It's not in
16 addition to. It's in support of is the key
17 word, I think, to use there.
18 COL GAGLIANO: I'm going to wrap
19 it up with some of the specific questions.
20 This slide shows our strategy map. It really
21 is just to show you that those three -- you
22 asked us last time come back with metrics.

1 We tried to decide what we want to
2 measure ourselves against. It's really about
3 impact on readiness, optimizing readiness,
4 improving health, and quality of life. All of
5 our programs and projects are focused on those
6 three outcomes.
7 As we evolve the Vision Center of
8 Excellence, our reports will be derived around
9 those three outcomes and where we are in
10 progress towards probably a never-ending
11 pursuit but where we are further along in that
12 pursuit.
13 I want to just take a moment to
14 highlight the partnership with the other
15 Centers of Excellence. I know you heard this
16 from Dr. Packer in December. This is his
17 slide actually. He talked about the sensory
18 ecosystem.
19 The Centers of Excellence
20 directors are sharing in the registry
21 development and we are sharing in a couple of
22 other areas so we are trying to avoid

1 duplication.
2 More importantly understand the
3 comorbid -- a patient who has lost sight is
4 different than the patient who has lost sight,
5 lost a limb, can't hear, and can't taste or
6 smell so designing rehabilitation systems
7 around that multiple sensory impact is part of
8 why we are working together very closely.
9 This is our detail slide. You
10 asked about staffing. We were at 14.6 people
11 last year. We are 14.6 people this year.
12 Hiring staff is a struggle even if you have
13 money in today's environment. We've shifted
14 a few. We found some opportunities in hiring
15 some public service corps officers, but it
16 really does have an impact on the capability
17 of the program.
18 I mentioned our CONOPS was
19 approved and we are moving forward. I'm sure
20 that could be provided if anyone on the Task
21 Force so desires. The Strategic Communication
22 Plan was a specific question. I'm rather

1 proud to say that we have been residing on the
2 health.mil.
3 Our website is vce.health.mil
4 which is the master image website. They are
5 undergoing a complete revision of the website.
6 I'm going to throw it out there that they
7 chose the Vision Center of Excellence website
8 as the one to transition to the new website
9 because of its readability and accessibility,
10 particularly for the patient population that
11 we designed the website to reach. We wrote
12 down here 508+.
13 It really is, I think, going to be
14 the standard for the other websites on
15 health.mil so that if you have a vision
16 impairment you aren't just reading the Vision
17 Center of Excellence website, but you will be
18 able to read all the websites that are part of
19 the MHS framework. I'll pass that on as
20 another place we've had some influence.
21 We have just moved into our
22 Crystal City office not too far from here. We

1 are about to occupy a space in the Bethesda
2 right adjacent to the clinical care
3 capability. That space will be primarily for
4 patient and family education so the providers
5 at Bethesda are very anxious to have us there
6 because they have a place to refer patients to
7 now.
8 If they want more information
9 about vision loss or if they want to know
10 about now to connect with other parts of the
11 VA system or other parts of the system. That
12 is the role that we hope to play at Bethesda
13 as a contribution.
14 We will also have some of our
15 veteran support or service organizations
16 helping us in providing information to the
17 patients and families as they deem necessary
18 or so desire. That is going to be kind of a
19 model or a pilot for us to see if that works
20 there that we might have that at some other
21 major medical centers as a source of
22 information.

IOC is one of those terms I'm not sure how to describe. I know everybody uses it but how we've defined IOC is leadership in place to lead the major components of our mission. We are about 60 percent if that is the definition we've used.

We still have ongoing programs across that full spectrum of the continuum of care. I've got those listed there. That's the point I want to make. There is no clear definition of IOC.

We've defined it as in order to be able to lead and advocate for the programs across the VA and DOD systems. That's really our role is to be the leadership for this for Army, Navy, Air Force, and VA. You need some key leaders to do that and we haven't quite brought those on board yet.

FOC is a moving target partially because when I open up this -- the problems that we're facing, we're just beginning to understand.

1 These injuries will, as we gain
2 understanding about the consequences of these
3 injuries and we evolve new science around
4 these, perhaps even a new prostheses for
5 vision, you keep reading about it in the news
6 and there is one available in Europe.
7 That's the first European FDA-
8 equivalent-approved developed at the
9 University of Southern California. We are
10 very excited about this.
11 There are about five centers in
12 the world that are working on vision
13 restoration and we've got some stem cell work
14 and some other projects. Those will, we hope,
15 be the pathway to hope for the future and
16 that's where we are going in the Vision Center
17 of Excellence.
18 I know we're running a little
19 behind time. This was meant to get your
20 feedback and other discussion but perhaps I'll
21 take a question while they are loading the
22 slices for the extremity center.

1 MSGT MacKENZIE: Specifically what
2 are the staff constraints, sir?
3 COL GAGLIANO: Staff is --
4 MSGT MacKENZIE: On the FOC.
5 COL GAGLIANO: FOC? We don't
6 know. We're projecting -- at this point we
7 are projecting somewhere around 58 people.
8 That is the projection we used. Fifty-five
9 back in 2008 when we designed the center.
10 Fifty-five was what we thought was the minimum
11 level of leadership and capability to the
12 oversee programs around the country.
13 In fact, around the world. That's
14 been our target. It still is our target. We
15 are adjusting it a little bit as we learn more
16 about research and what we need for research.
17 For example, we just learned the other day
18 that the Centers of Excellence are really
19 partially responsible for translating
20 research.
21 General Gilman at the Board said
22 not only are we responsible for implementing

and overseeing, but translating. That takes a whole new capability that we didn't have in our staffing model to begin with.

MSGT MacKENZIE: So our recommendation in last year's report if addressed fully, as we asked, will that help to assist you in that process of getting that staffing you need?

MR. GRIFFIN: The answer is clearly yes. We have a planned staffing model that takes us out to FY '18 so we have that but it's -- yes. Clearly that will be continuously looked at and we are phasing it in slowly. Yes, if we have the staff we can do our programs. That's the bottom answer.

LT GEN GREEN: Don, as I look at your org chart that you presented before us, are you still organized under BUMED?

COL GAGLIANO: Yes, sir. We fully transition to BUMED on 23 October. It just occurred.

LT GEN GREEN: Okay.

1 COL GAGLIANO: We are still trying
2 to transition some personnel fallout from
3 that. Just back pay and missed pay and leave.
4 Even until this day we are still dealing with
5 people who have lost their leave and lost
6 their comp time and things like that. We are
7 working through it. Thank you.
8 LTC PENDERGRASS: Good afternoon
9 to the Task Force. My name is Lieutenant
10 Colonel Tim Pendergrass and I thank you for
11 the opportunity to represent the extremity
12 trauma and Amputation Center of Excellence
13 today. Just a quick look at the agenda and
14 what I hope to cover today.
15 This slide just presents the
16 mission that EACE has at this point. I would
17 highlight that it's a joint DoD/VA venture,
18 multidisciplinary network really looking at
19 the continuous care and study of amputations
20 and extremity injuries mostly from trauma and
21 looking at point of injury through definitive
22 care and rehabilitation really, again,

1 focusing on the lifelong surveillance to
2 optimize the quality of life for these
3 individuals.
4 Scope of services that are listed
5 there. Again, predominately trauma, although
6 we do treat both traumatic and atraumatic.
7 The preponderance of atraumatic are going to
8 be limb loss to such things as diabetes
9 myelitis.
10 Also focusing on research which is
11 a big piece in a collaboration effort within
12 EACE, the education and training piece. Of
13 course, mitigating disabilities that follow
14 these traumatic events and outreach to
15 civilian institutions and the collaboration
16 and the partnerships that we develop with
17 them.
18 The organization is listed here.
19 The slide shows that it was approved for the
20 executive office to be located in San Antonio,
21 Texas. That was in 2011. There are then the
22 regional centers for the traumatic extremity

1 injury amputation that we pull together and
2 develop the collaboration and the sharing
3 initiatives within the EACE.
4 That includes the Center for the
5 Intrepid that is in San Antonio and the MATC
6 that is at Walter Reed National Military
7 Medical Center. Then the C5 out at San Diego.
8 Then there are seven VA regional centers
9 throughout the country as well.
10 Of course, I already mentioned
11 leveraging the research piece with this which
12 is a very large effort within east to make
13 sure that we have collaborative research and
14 research that is shared amongst all the
15 organizations including the MRMC and the BHT
16 and then, of course, Human Performance Labs
17 that are located at the three main CFI, C5,
18 and the MATC. This just is a geographic
19 representation of the centers, the seven VA
20 regional centers and the DoD centers that are
21 listed there.
22 The DoD centers being on the East

1 Coast, of course, West Coast, the Central and
2 then the VA centers that are interspersed
3 throughout the country evaluating current
4 rehabilitation and reintegration care
5 processes from the point of injury and
6 transitioning back either to Active Duty, to
7 retirement, to their local communities, or to
8 the Veteran's Administration as well. And
9 managing and tracking the patients and
10 managing them through their case managers
11 throughout the process.
12 This is the organizational chart
13 for EACE really starting there predominately
14 at the middle of the page there with the
15 director and then the 10 personnel that fall
16 under that with the bottom piece there for the
17 Director of Research and the clinical care
18 information and for global outreach.
19 LT GEN GREEN: Just a question on
20 the org chart. Today your money comes to you
21 from MEDCOM or Army Surgeon General's Office?
22 LTC PENDERGRASS: Sir, I do not

1 know exactly where the money comes from for
2 the EACE. There is a money slide later but I
3 would be remiss there if I --
4 LT GEN GREEN: I see your
5 reporting chain is through the Army Surgeon
6 General?
7 LTC PENDERGRASS: Yes, sir.
8 LT GEN GREEN: Okay.
9 LTC PENDERGRASS: I didn't mention
10 at the beginning. I'm the third string today
11 so I actually do not work for EACE but I am
12 representing them today so I'm going to do my
13 best to make sure that I --
14 PARTICIPANT: Who are you again?
15 LTC PENDERGRASS: I believe you
16 invited John Sherrill and I am Lieutenant
17 Colonel Tim Pendergrass. I work in
18 Rehabilitation and Reintegration Division at
19 the Surgeon General's Office. We do work --
20 I know someone who knows someone that works at
21 EACE.
22 The current status, as I mentioned

earlier, was that the headquarters was approved in May of 2011 to be located in San Antonio, Texas. The concept of operations was approved last monthly from the Centers of Excellence. Hiring is still ongoing. We do have several staff members that are on board including the Director.

MG STONE: Hold on a minute.

LTC PENDERGRASS: Yes, sir.

MG STONE: Are you really comfortable doing this brief? I mean, I'm deeply respective of your skill sets but since this is really not your area, should we really be briefing the DoD Wounded, Ill, and Injured Task Force with a non-member of the organization? Are you comfortable with this? I'm giving you a window.

LTC PENDERGRASS: I am moderately comfortable with the material that I have in front of me. I do also have a response -- a prepared response that I will get back with you with that answer if the question comes up

1 that I'm not prepared for. I could jump out
2 the window right now.
3 MG STONE: I've been in that
4 doorway before myself so let's take it a
5 different way. I would respectfully ask the
6 Committee to consider delaying this
7 presentation not because our briefer is not
8 competent.
9 I happen to know differently.
10 He's very competent and he's very well
11 respected within Army medicine and within DoD
12 but I really think we ought to be hearing from
13 people actually working within this area.
14 Respectfully I would ask the Chairs to delay
15 this presentation until we have people here
16 that are actually working for this. I would
17 ask you to consider that.
18 LT GEN GREEN: Yes, I tend to
19 agree. Some of the questions that are going
20 to come up, some are answered on the slides
21 and we can take what's in the slides, but some
22 of the questions are deeper.

1 There are reasons why I'm asking
2 about the alignment based on what I know with
3 regard to decisions that have been made but
4 not yet implemented with regards to the COEs.
5 I think if the group doesn't mind, I think
6 we'll simply postpone this for right now.
7 We've got your slides.
8 We appreciate it. You've
9 represented them well. This is no reflection
10 on you in anyway whatsoever. It may be a
11 reflection on this committee because we are
12 running so late so we are actually taking
13 advantage of you a little bit to get back on
14 time. Forgive us for just a second.
15 A couple of question just for the
16 group here. You said that you're spending the
17 majority of your money on a registry. I know
18 that's been in progress for probably three
19 years, probably talked about since you first
20 started. Can you give me an idea of the
21 dollars that are going into formation of a
22 registry?

1 COL GAGLIANO: Yes, sir. The good
2 news is we are actually developing this for
3 about half the cost that it might have
4 otherwise been developed. I'm going to lead
5 off with the good news first.
6 The other good news is what we are
7 developing the Vision Registry which is
8 transitioning into the Enterprise Solution for
9 Registry. Everything we've spent on
10 developing the Vision Registry is now reusable
11 and transferable.
12 The Hearing Center of Excellence
13 in their briefing slide had that they were
14 following the Vision Center of Excellence
15 pathway. In fact, they have gone through the
16 governance requirements of getting the
17 functional requirements approved by the CPMB.
18 They are the first to have
19 completed that level of readiness following
20 us. We are at the -- we are in the second
21 year of our development phase. The first year
22 was functional requirements, just as hearing.

1 That takes a long time to pull the stakeholder
2 group together.
3 All the users in the Army, Navy,
4 Air Force and the VA say what they think this
5 registry should be designed around and what it
6 should be developed to do. Then this gets
7 reviewed by a board.
8 The CPMB is the Clinical Portfolio
9 Management Board and then it goes through the
10 Clinical Portfolio Steering Committee. The
11 bureaucracy of getting the details of the
12 registry approved for funding is about a year-
13 long process at the moment.
14 Then we get into the development
15 phase and that's what we've been spending the
16 last year and three quarters on. We have a
17 contract that was -- I'm going to give you the
18 specifics of the contract. Last year we spent
19 $1.24 million on the contract to support this.
20 This year we are spending
21 approximately $4 million total -- a little bit
22 more than that. I'm getting my resource

1 manager in the back pushing the thumb up a
2 little bit here. We have two phases to this.
3 One is the data extractor
4 component which is to pull information from
5 the record into the registry. I don't know if
6 everybody is aware of this but when the
7 providers write a note on the specialty care
8 areas, they write it on a piece of paper and
9 scan it in so it's not some information we can
10 just pull off electronically. For those notes
11 it's basically a big electronic drawer.
12 Somebody has got to go in and read
13 it and transfer it into a note if we are going
14 to be able to use it to follow information.
15 That is one piece of it. The other piece of
16 it is the actual development of the framework.
17 This year -- all right. I'm going to leave it
18 at about $4.5 million this year that we are
19 dedicating towards the registry. It's
20 actually --
21 LT GEN GREEN: I'm just looking
22 for a rough estimate so that's fine.

1 COL GAGLIANO: We are moving along
2 very well. I'm going to throw out that going
3 through the full test evaluation, getting
4 approval for it to be a system of record,
5 getting approval for it to hold private --
6 personal information, PIA certification, and
7 getting the Defense Board certification
8 process which is a three-month process in
9 itself, is all the wickets that we've been
10 following.
11 As we look at the time, much of
12 that time is manned by the JCED process of
13 moving into acquisition. Sir, I know you are
14 familiar with that. We are on target, ahead
15 of schedule by about six months, and under the
16 projected budget for what we had originally
17 allocated.
18 The other good news is we probably
19 cut out most of that cost for the subsequent
20 COEs as they come into the registry
21 requirement because we have built the
22 framework so it can ingest and accommodate all

1 the Center of Excellence requirements.
2 LT GEN GREEN: Okay. Thank you.
3 I think we're going to let you off the hook.
4 We are going to catch up on time. We've got
5 your slides and we thank you for coming over
6 today.
7 LTC PENDERGRASS: Sir, I'm glad I
8 could give you a little extra time this
9 afternoon.
10 LT GEN GREEN: You're a good man.
11 Thank you.
12 Folks, I think we are back to
13 break time if I look at my schedule so why
14 don't we take 10 minutes and reconvene at
15 4:00.
16 (Whereupon, at 3:49 p.m. the
17 above-entitled matter went off the record and
18 resumed at 4:00 p.m.)
19 LT GEN GREEN: Okay. As per
20 legislation we are looking at case management
21 policy from OASD Health Affairs. With us
22 today -- I'm going to do terribly on this name

1 so forgive me. Ms.?
2 MS. QUINSENBERRY: Ginnean
3 Quinsenberry.
4 LT GEN GREEN: Quinsenberry.
5 Okay. And Ms. Derenda Lovelace?
6 MS. LOVELACE: Very good. Yes.
7 LT GEN GREEN: Ms. Quinsenberry is
8 Director of Population Health, Medical
9 Management, and Patient Centered Medical Home
10 Division with the Office of the Chief Medical
11 Officer in the TRICARE Management Activity.
12 Ms. Lovelace is the Case
13 Management Nurse Consultant in the Population
14 Health, Medical Management and Patient
15 Centered Medical Home Division, with the
16 TRICARE Management Activity.
17 Both of these folks, I guess,
18 briefed us at our October meeting and their
19 information is in Tab N and I'm going to pass
20 it over to Ms. Quinsenberry.
21 MS. QUINSENBERRY: Thank you.
22 Thank you, sir.

1 I wanted to take the opportunity
2 at the outset to thank all of you for inviting
3 us back so we can give an update. I had made
4 a promise as far as with what drives some of
5 our success with the education and training.
6 I wanted to make sure that a question posed to
7 us I was able to follow up on. I'll make sure
8 that I address that today.
9 So before I begin today, I also
10 wanted to take the opportunity to recognize
11 the dedication and resiliency of the case
12 managers that exist in the system today.
13 Certainly there's case management
14 and care coordination challenges still ahead
15 for us but over the last 10 years of us being
16 at war and, quite frankly, working through all
17 of these efforts with our case management and
18 care coordination between the platforms of
19 DoD, VA, Direct Care System, Purchase Care
20 System, we certainly have come a long way.
21 In speaking to that, we are in
22 June of this year again taking part in the

1 Case Management Society of America in the Tri-
2 Service Day where they recognized the DoD and
3 our case managers have the opportunity to be
4 show cased on that first day.
5 It gives really an opportunity for
6 us to hear back from not only our DoD VA
7 partners, but also from the civilian sector
8 with those case managers that we interact
9 with.
10 Specifically, what we've been
11 asked to discuss today is the unified
12 coordination that we have with the services
13 and how we work towards driving continued
14 success with case management.
15 Also, the medical information or
16 what information that we work with and that
17 the services provide us and what we at TMA
18 have the opportunity to work with the services
19 on improving case management capture and
20 what's going on in the field.
21 As well as the policy development
22 and the coordination and what's involved in

1 that and what steps that we're taking because
2 currently most of you are familiar with the
3 directive type memo that currently exit out
4 there for case management but how we are
5 pulling that back in because when you look at
6 case management, it is one of three lanes that
7 fall under medical management and medical
8 management includes utilization case and
9 disease management.
10 Certainly just taking disease
11 management our soldiers are overall the
12 members that are having case management within
13 the system may not only have just the injury
14 itself but they have a comorbidity of a
15 disease that absolutely needs to be taken into
16 consideration. Pulling that back under the
17 umbrella and bringing in those other aspects
18 or lanes is very important with our case
19 managers.
20 In starting out, what I wanted to
21 do is how do we drive the efforts to unify the
22 services and continue to drive success in case

1 management. Certainly one responsibility that
2 we have at the HA TMA level is help drive the
3 policy with our service partners implementing
4 that case management out into the field.
5 In doing so we seek partnerships.
6 What we've done since we have been at HA TMA,
7 and certainly both of us come from the VA side
8 as well, me standing up the FRC program and
9 Derenda coming from the OEF/OIF side with that
10 national program, coming into HA TMA
11 recognizing the platforms of what partnerships
12 haven't been at the table, how can we close
13 those gaps a little bit.
14 We talked last time about reaching
15 out to the VA. We brought them in but we've
16 looked further into that and said what levels
17 are not at that table. So we have our
18 national program OEF/OIF representatives and
19 we've invited them now, the national program
20 managers.
21 We also have the other layer of
22 MTF liaisons that we heard a little bit about

1 in the previous briefing. Those MTF liaisons
2 are embedded in the major medical facilities
3 and they have been growing on the VA side and
4 expanding out to other MTF sites.
5 We need to bring them in and
6 capture their activities, their best
7 practices, what they are saying, and bring
8 them into the mix as well.
9 We also are reaching out to our
10 FRC. We've reached out to the FRC director
11 there and they are bringing in that aspect of
12 the programs to us. Finally, our non-clinical
13 case managers. We talk about medical care
14 case management and the clinical aspects but
15 we recognize the fact that there's a lot of
16 confusion with the case manager and everybody
17 is a case manager.
18 What about our non-clinical case
19 managers? So we have reached out and asked
20 the recovery care coordination, those non-
21 clinical aspects, to now come to the table as
22 well and partner with us as we work towards

1 policy, recognizing gaps, looking at care
2 coordination, hearing back what's going on in
3 the field.
4 That's how we're unifying the
5 services. Then that is also a piece of
6 driving success. One opportunity I was able
7 to talk with you about last time is what are
8 we doing for training. How are we making sure
9 that those individuals or those case managers
10 are working at the top of their license, at
11 the top of their game.
12 One question asked, and I cannot
13 see his name but he is sitting right next to
14 you, was -- no, I'm sorry. He's across the
15 table. But one question asked by the -- one
16 question you had asked -- I'm sorry. I can't
17 see your name -- when we are doing the
18 training how are we reaching those case
19 managers, or those non-clinical case managers,
20 in those remote sites. Correct?
21 We talked about when we do the
22 onsite medical management course and we have

1 since started the advanced medical management
2 course where they learn to optimize and
3 utilize the tools and how they do their care
4 coordination and optimizing resources. How
5 are we going to reach those remote sites?
6 I stated that we would start doing
7 medical management webinars and have since
8 been able to successfully deploy that. We've
9 had about eight courses. As a matter of fact,
10 at 2:00 today our VA partners, the FRC
11 program, will be presenting to our DoD.
12 Last week, I believe, we had our
13 OEF/OIF as well come to the table and our MTF
14 liaisons. We have been able to successfully
15 deploy that. So far we've had about 200
16 individuals attend these webinars. It's
17 completely free. We are leveraging the
18 Defense Connect Online so we're not requiring
19 any additional resources.
20 The feedback that we're getting to
21 the point of you asking how are we driving
22 success for this is how are they finding it

1 successful. Is this something that they can
2 use. What else do you need to hear.
3 What has happened in launching
4 these was I had hoped to do this about once a
5 month and it has kind of turned out to be
6 three or four times a month. It's been a
7 tremendous influx and so far a wonderful
8 opportunity for them. We are just continuing
9 to go down that road.
10 The other we had talked about the
11 disability evaluation system self-paced
12 module. We were in the process of having that
13 come to fruition and launch in the October
14 time frame. That did, indeed, happen.
15 What this course specifically is
16 identified to do is take those case managers
17 and work through scenarios that were born from
18 the individuals out in the field from warriors
19 and those individuals that they worked for so
20 they are real time type scenarios and what do
21 these case managers need to have knowledge of
22 when they are interacting with the physicians,

1 those PEBLOs, those liaisons out there instead
2 of them either taking on those roles or
3 getting the roles mixed up. How do they need
4 to interact with that. Those have, indeed,
5 occurred.
6 MSGT MacKENZIE: Ma'am, can I --
7 quick question. When you say you're looking
8 at the non-clinical case management
9 interaction and collaboration
10 MS. QUINSENBERRY: Yes.
11 MSGT MacKENZIE: When you interact
12 with the Recovery Care Coordination program,
13 RCC program, it's -- I don't know if I've got
14 the right term in my head but it is
15 implemented different across the services so
16 are you getting a cross section of the RCC
17 program within each of the services and this
18 additional training you provide, how does that
19 get sent to people to know that it's available
20 to them to go to?
21 MS. QUINSENBERRY: Great
22 questions. What we do is we have a tri-

1 service representation so we do have Army,
2 Navy, and Air Force all at the table. When
3 that Recovery Care Coordination program comes
4 to talk to us, we'll be able to have all the
5 services present so when they take that, they
6 will be able to go out and implement that in
7 the field or get that information out there as
8 far as the recovery care coordination answer.
9 The education and training, what
10 I've done is I've leveraged every type of
11 avenue that I could to get this information
12 out to include the DSG reps that sit on our
13 work group for our case management personnel.
14 We have clinical decision support
15 tools where I've built in metric type
16 capturing as far as when you sign up for a
17 course I need to know are you a case manager,
18 are you utilization, are you a disease, who
19 are you.
20 I have your name and then I do a
21 broad type of blast out of this education and
22 training is available. We are trying to have

1 our TRICARE regional offices identify this.
2 I went and spoke to the West Regional Medical
3 Management.
4 Every avenue that is available
5 that our partners can let them know this
6 training is out there is out there. We have
7 it on our updated OCMO, Office of the Chief
8 Medical Officer, website. We have it set up
9 where it is a flyer per course so it gives you
10 the specifics; who the speaker is, stuff like
11 that.
12 The other is we have the self-
13 paced modules that are also available. We
14 talked about the required training within the
15 current instruction that is currently under
16 revision. Additional is we've updated our
17 clinical decision support tool training.
18 What that does is akin to clinical
19 practice guidelines is it kind of walks
20 through different platforms if you're looking
21 at somebody who has a certain diagnoses when
22 do you want to be hitting like a discharge

1 platform or when do you want to be considering
2 as they are moving from in-patient to out-
3 patient what type of questions would you want
4 to ask.
5 This is a tool that is evidence-
6 based tool that we have in place and TMA holds
7 the license for that is available to any and
8 all services.
9 Service documentation. What we
10 are looking at and what we currently are
11 required to capture within the instruction is
12 we look at the number of case management
13 personnel by service. How that's captured is
14 basically the way they identify personnel data
15 reporting and how they implement that or put
16 that in their system.
17 When we get a number we then work
18 with our case management DSG representatives
19 and are able to validate that number so we are
20 able to give them what we are seeing and they
21 are able to then utilize that by site and
22 where they are located.

1 The other we talked about is the
2 education and training. We capture that and
3 certainly work with our services to make sure
4 that they are continuing efforts there and
5 what we are seeing and they can take that back
6 to their services.
7 Most importantly I know everybody
8 is looking for that magic number on how many
9 cases per case manager. Right now we indeed
10 are working with our service personnel. we do
11 not have that number yet and that is primarily
12 due to such high variability.
13 When you have an individual in an
14 in-patient setting or by injury or moving to
15 an out-patient setting, that is a very hard
16 thing to capture. We not only are trying to
17 do this in a vacuum but we work with our
18 services.
19 They have a lot of efforts ongoing
20 with how they have individual work groups that
21 they bring. We also go out and have been
22 talking to the National Case Management

1 Society of America and say, you know, "As you
2 are, have the empirical evidence as opposed to
3 anecdotal and this works or this doesn't work,
4 what are you all identifying as numbers?"
5 Their stance still is, "We do not have that."
6 MS. CROCKETT-JONES: Earlier we
7 heard from --
8 MS. QUINSENBERRY: Ms. Paganelli?
9 MS. CROCKETT-JONES: Navy Medical
10 Case Management that there is a formula that
11 they use, an acuity-based formula.
12 MS. QUINSENBERRY: Yes.
13 MS. CROCKETT-JONES: How does that
14 -- do you factor any of that? Do you use that
15 or --
16 MS. QUINSENBERRY: Yes, we do.
17 That's where I was going next. What we are
18 doing is with the new transition of the
19 directive type memo this work group has gotten
20 together and we have tried to take into
21 consideration time.
22 Time for an individual as far as

1 when you're working with certain cases, how
2 long does it take you to factor in an acuity
3 base? We have it in a 1 through 5, lowest to
4 highest. We also have considerations within
5 that as far as -- the frequency is how often
6 you are interacting with that individual.
7 If I'm working with somebody who
8 might have an injury that may take me over a
9 week's time I might work with them over a two-
10 hour time period, but my interactions might be
11 three to five times. That is going to fall
12 instead of like maybe a 1, that may move me to
13 a 2.
14 We are trying to implement that to
15 try and get our arms around that and working
16 with the services to try and see, okay, there
17 is no way to just say it's 1 to 30. We have
18 to put some parameters around that. Frequency
19 of interactions, time that it's taking to work
20 with individuals.
21 We are also looking at diagnosis
22 specific. What are we finding are the highest

1 level of acuity and how can we capture that
2 because all that has to be taken into
3 consideration.
4 MS. LOVELACE: It also considers
5 the amount of services they are receiving like
6 rehab. You know, all those different services
7 because that makes a difference. How much
8 time it takes you to spend with them for case
9 management is how intensive is their
10 treatment.
11 MS. QUINSENBERRY: In terms you've
12 probably heard associated with that were the
13 recovery and then the recovery to
14 reintegration so there's wide variances in how
15 much you would work with an individual over
16 that. We are trying to really look at what we
17 can get our arms around to start identifying
18 some ratios.
19 We are still trying to work
20 towards that. What we don't want to do was
21 say, okay, we're going to say 1 to 30 and then
22 find that they are either so overwhelmed or

1 the ratios aren't specific and then you're
2 having trouble with that.
3 LT GEN GREEN: Can I ask just a
4 couple of background questions? I was looking
5 over your bios and so how long have your
6 various offices -- you're in two different
7 offices or are they the same office?
8 MS. QUINSENBERRY: For the both of
9 us?
10 LT GEN GREEN: Both of you.
11 MS. QUINSENBERRY: We are both in
12 the same.
13 LT GEN GREEN: In the same office.
14 How long as that office been in existence?
15 MS. QUINSENBERRY: Wow. Let's
16 see. Population health has always been there.
17 We've expanded certainly with Patient Center
18 Medical Home. That just came into being. I
19 would have to get back with you on that. I
20 would have to get with Dr. Kubler.
21 LT GEN GREEN: How long have you
22 been in your position?

1 MS. QUINSENBERRY: I guess it's
2 going on about a year-and-a-half to two years
3 now.
4 LT GEN GREEN: And for you?
5 MS. LOVELACE: About a year.
6 LT GEN GREEN: So about a year.
7 Okay. So basically you were brought on board
8 to do this kind of work.
9 MS. QUINSENBERRY: I was actually
10 brought on board to do medical management.
11 When I came in because of all the staffing and
12 things like that, I just kind of took on a
13 couple different roles and now have moved up
14 to the director position.
15 LT GEN GREEN: Was there anyone
16 before you working case management or the
17 standardization issues with case management?
18 MS. QUINSENBERRY: There was and
19 she was there, I think, about six months and
20 had moved on.
21 LT GEN GREEN: So very short time.
22 MS. QUINSENBERRY: Yes.

1 LT GEN GREEN: So it's a
2 relatively new office within the last two
3 years that TMA has been focused on trying to
4 get the case management standardized?
5 MS. QUINSENBERRY: Well, there
6 were individuals before that. Certainly we
7 took part in the Senior Oversight Committee
8 efforts with the line of action three. Case
9 management and trying to identify these ratios
10 has been there for some time. Certainly it
11 was identified in the NDAA as well. This has
12 been an ongoing effort.
13 LT GEN GREEN: Thank you.
14 DR. TURNER: Just one quick
15 question. First, I would like to applaud your
16 use of Defense Connect Online. It's a great
17 resource --
18 MS. QUINSENBERRY: It is.
19 DR. TURNER: -- that is highly
20 under-utilized. Talking about your DoD-wide
21 standardization, initial versus recurrent
22 training. What are your thoughts on, you

1 know, what are the requirements for the
2 initial training? Maybe I misheard but I
3 didn't hear what is the different between the
4 initial and what do you require for ongoing
5 recurrent training?
6 MS. QUINSENBERRY: The services.
7 What we do at HA TMA is we make the required
8 training available. Then the services have
9 their competency-based requirements that they
10 will drive as to how often they require their
11 individuals to update that.
12 DR. TURNER: So there is no DoD-
13 wide standard? The services set their
14 recurrent training standards themselves?
15 MS. QUINSENBERRY: Right.
16 Next is the policy coordination.
17 The policy that was initially put in place,
18 again, under medical management was there in
19 2006. With the efforts of the recognition and
20 all that had occurred with the Dole-Shalala
21 Act and things like that with the focus being
22 on the wounded warriors, they carved out case

1 management out from under that umbrella and
2 put in place the case management directive
3 type memo.
4 That is what has been in place and
5 we are currently working with the services now
6 to revise and put that back under the umbrella
7 of the Department of Defense instruction.
8 That way we line everything back up under one.
9 The time frame in order to get something like
10 this accomplished can be anywhere from eight
11 months to a year.
12 Certainly why that takes that long
13 is it has to go through service coordination,
14 first through HA TMA and then out to the
15 services. As individuals read this and
16 questions are asked, it certainly comes back
17 to our office and we take a look at that and
18 do not update those in a vacuum.
19 We certainly go back out to our
20 tri-service DSGs. As a matter of fact right
21 now have taken that and are incorporating our
22 recovery care coordination definitions, FRC

1 definitions because certainly I think what is
2 the recurrent theme is we need to have some
3 clear definitions of what falls under clinical
4 case management and non-clinical case
5 management.
6 That is why we are working with
7 those individual offices to try and get those
8 definitions built into that. It does take
9 some time. And that --
10 MS. DAILEY: Is case management --
11 do I understand you correctly, is case
12 management going to be stand-alone DoDI? Are
13 you incorporating it in another DOI?
14 MS. QUINSENBERRY: We are taking
15 it from the stand-alone and we are putting it
16 back under medical management to make sure
17 we're aligning it along with the disease
18 management utilization management and case
19 management under the umbrella. This then will
20 help our colleagues in the field not have to
21 go to one directive and then yet to another.
22 They will be able to have one reference point.

1 MS. LOVELACE: And something else
2 about that, too, that I would like to say
3 coming from a small MTF. When I was at a
4 small MTF you could do all three of those --
5 you could wear all three of those hats at one
6 time so it really helps to have it coordinated
7 in one place for those smaller places where
8 you have a person that does utilization
9 management, case management, and disease
10 management.
11 MS. DAILEY: Generally there is an
12 action officer for these types of Department
13 of Defense instructions. Is there one action
14 officer who is collating those three lines?
15 MS. LOVELACE: There is suppose to
16 be a medical manager named at -- somebody
17 doing the medical management role at each of
18 the MTFs.
19 MS. DAILEY: No, no, no, no, no.
20 The Department of Defense instruction there is
21 usually an action officer responsible for
22 Department of Defense instruction who

1 shepherds it through this very long process
2 you've just described. Who is that?
3 MS. LOVELACE: That would be me.
4 MS. DAILEY: Okay. So you are
5 pulling together -- okay, so you are pulling
6 together case management, disease management,
7 and utilization.
8 MS. LOVELACE: Yes, ma'am.
9 MS. DAILEY: Okay. So you are the
10 right person to be here. I wouldn't want you
11 to get kicked off the panel like my last
12 briefer because you aren't the right person.
13 You're here. Very good. I appreciate that.
14 MS. QUINSENBERRY: Yes. We have
15 not had -- I think there's been -- it's been
16 quite some time. We haven't had a medical
17 management person in that role so we've been
18 covering that role between the two of us.
19 LT GEN GREEN: So who is the
20 signatory on the DoDI? Is it going to come
21 out of -- does it come from Dr. Woodson? Is
22 that where it goes?

1 MS. QUINSENBERRY: Yes.
2 LT GEN GREEN: Okay.
3 MS. DAILEY: It will go to Dr.
4 Woodson but if it's a DoDI, the USDPNR can
5 sign it. It's not going to be DoDD, is it?
6 MS. QUINSENBERRY: No.
7 MS. DAILEY: Okay. It's going to
8 be DoDI. It has to be coordinated in all of
9 DoD but the final signature is the USDPNR.
10 MS. QUINSENBERRY: That means it
11 will go outside.
12 MS. DAILEY: Yes, you are inside
13 the USDPNR.
14 MS. QUINSENBERRY: Yes.
15 MS. CROCKETT-JONES: I get an
16 impression that you are pushing toward this
17 big view, toward this DoD-wide sort of
18 standardization in many ways which is in line
19 with, I think, a lot of what this Task Force
20 has been trying to get a handle on;
21 differences between services, standardization,
22 knowing that we can have standardization of

1 care.

2 I'm surprised that we are just

3 getting to defining clinical versus non-

4 clinical. I am like surprised that we -- that

5 seems like such a basic element. Here is what

6 I guess I'm asking from you. What do you

7 think this Task Force needs to recommend to

8 get this more traction?

9 MS. QUINSENBERRY: Actually, when

10 I say to define the clinical and non-clinical,

11 non-clinical the RCC program has a stand-alone

12 DoDI of itself, 1300.24. That is in place.

13 What we are trying to do within ours is just

14 bring that definition, just a blurb in there.

15 When our colleagues are reading

16 this, they can readily see the difference. We

17 are trying to give the broader brush of it.

18 Not that that non-clinical doesn't exist

19 because certainly that Recovery Care

20 Coordination Program has that lead on that.

21 What we have seen in going through

22 our concurrence and what has been asked of us

1 is to include those definitions within that
2 existing DoDI for this clinical case
3 management.
4 Then when our clinical case
5 managers are looking over that, they can then
6 have a reference, ready reference, and we will
7 certainly put in the reference area there, the
8 non-clinical or the RCC DoDI and identify
9 where they can then go to that. We have been
10 asked to clarify that role within there.
11 MS. CROCKETT-JONES: Okay. Thank
12 you.
13 MSGT MacKENZIE: Let me throw in a
14 quick question here. From a joint
15 environment, this pushes this very fundamental
16 question. Will this DoD drive standardization
17 across the services or will the services still
18 be allowed to modify this based on outside
19 parameters based on what you're writing?
20 When I'm dealing with Army, Navy,
21 Marine Corps, Air Force wounded warriors, I
22 shouldn't be getting an answer from different

1 service branch clinical case managements to
2 work with my guys. Is this going to
3 standardize across the services or are we
4 still going to have a disparity between
5 services even though this is coming into play?
6 MS. QUINSENBERRY: The intent
7 certainly is to try and get this standardized
8 across the services and that is why we have
9 our Deputy Surgeon General case management
10 representatives at the table. We are taking
11 their information forward and working with
12 them, certainly even in identifying case load
13 acuity to help drive one standard approach to
14 this.
15 MSGT MacKENZIE: So then the
16 answer is no unless they all decide to play
17 along?
18 MS. QUINSENBERRY: I would say yes
19 because they are -- they are at the table now.
20 That is the intent of this. I'm not
21 understanding the question.
22 MS. LOVELACE: And they are doing

1 a good job of playing in the sandbox together.
2 CAPT EVANS: They are but, I
3 think, again, it's just basic. When you look
4 at WTB case managers they belong to the line
5 WTB. When you look at Navy Marine Corps, we
6 belong to the MTF. I mean, we have to start
7 there.
8 Either you are going to belong to
9 the line side of it or you are going to belong
10 to the MTF. That is one. Then when you look
11 at the management of patients, I believe Army
12 mandates that their case managers are
13 certified across the board.
14 I'm not sure. I have to take it
15 back to my counterpart, but we do not. That
16 training, the level of training, again, we
17 need to just start with the basics where
18 should we fall and then how are we going to be
19 trained.
20 DR. TURNER: How far along are you
21 in writing this so far? I mean, how much
22 progress have you made?

1 MS. QUINSENBERRY: We had the DoDI
2 written and put into concurrence. What we've
3 been getting now is getting it back. It's
4 just at the beginning stages of it so as it
5 goes to every wicket, then we get input every
6 level up. We are at the very beginning.
7 MS. DAILEY: You are at the
8 coordination stage.
9 MS. QUINSENBERRY: Yes.
10 MS. DAILEY: You've got it out to
11 the services or internal to DoD?
12 MS. QUINSENBERRY: Internal.
13 MS. DAILEY: Internal to USPNR?
14 MS. QUINSENBERRY: Internal.
15 MS. DAILEY: Internal to USPNR?
16 MS. QUINSENBERRY: Yes.
17 MS. DAILEY: The services have not
18 provided a concur or non-concur yet?
19 MS. QUINSENBERRY: No.
20 MS. DAILEY: Do you have a feel
21 for the -- have you fielded it to them in an
22 informal "This is what we're doing informally.

1 If you had to concur or non-concur today, what
2 would you say?"
3 MS. QUINSENBERRY: I would say
4 they would concur as they helped write it with
5 us. We did not put this forward without them
6 being at the table. That is part of this work
7 group.
8 DR. TURNER: Just to -- perhaps
9 this is -- if this is unfair, tell me. In the
10 sections of this DoDI that you've written,
11 what are some of the things like as you move
12 toward standardization do you like address
13 like the selection, the certification,
14 training, recurrent training procedures? Do
15 you recall what the sections of the DoDI are
16 and what you address or could you get us just
17 a sample copy of what is in circulation now?
18 MS. QUINSENBERRY: We can get you
19 -- we can get you the existing DTM and the
20 current DoDI. I would certainly have to --
21 that would be something I would have to get
22 back with you on that as far as taking it

1 outside the concurrence process before it's
2 gone those steps.
3 DR. TURNER: It would just be
4 interesting to see your approach. As Mac
5 said, how far toward standardization does this
6 go? I guess I would just like to get an idea.
7 Is it vague? Is it very, very specific?
8 Where have you all drawn the line as far as
9 specificity in the DoDI and how much do you
10 leave up to the services?
11 MS. QUINSENBERRY: There is -- you
12 know, services have their own -- we at the
13 policy level will work with them but how the
14 services actually say what case manager, you
15 know, where they are, what they will do, we
16 certainly at the policy level cannot kind of
17 go into the house of the service member and
18 say this is how you are going to break this up
19 or do that. We would have to -- we are happy
20 to show you.
21 LT GEN GREEN: If I could come
22 back up to Suzanne's question. Is there

1 something that we could do that would help
2 you? We ask because as we go out and look at
3 the variants in terms of who is the key
4 member, you know, you see it now in the press
5 about the warriors, the wounded warriors and
6 their families talking about all the people
7 who come see them.
8 Typically, depending on the site,
9 the case manager, the clinical case manager is
10 a trusted entity by the wounded warrior or the
11 family. One, we are trying to make certain
12 those case managers have the right skills and,
13 therefore, would be trusted also by the line
14 of people that they have to interface with.
15 Two, we would love to help clarify
16 for the wounded warriors in terms of who
17 should be their principal contact in terms of
18 medical assistance.
19 I think that is where we are
20 trying to drive this if I'm not overstating.
21 The question is how could we with what we are
22 seeing out there in terms of some confusion

1 help you to advance your cause?
2 MS. QUINSENBERRY: I would
3 probably first go down the road in helping us
4 clarify what a clinical case manager would
5 function as because I think in starting out
6 that is a very difficult thing to identify and
7 help clarify because so many people we see
8 them hold up the cards.
9 I have this many case managers and
10 everybody appears to be a case manager so
11 helping clarify that role I think would be
12 paramount. Then working with the services.
13 Certainly as we identify the acuity case load
14 we would go through our governance of coming
15 up through the clinical preponderance steering
16 committee with those representatives.
17 As soon as we are able to get to a
18 decision on identifying case loads and
19 bringing that up, having those representatives
20 there at the table and helping us drive that
21 once identified and then through the services
22 would be very helpful. Having that backing

1 because that's going to make a big difference
2 in the loads out there and how they are
3 working with our families and beneficiaries.
4 MR. PARKER: I don't want to give
5 you extra work and I don't know if we should
6 be doing this but it might be helpful for you
7 to just give us a one-page PD and describe --
8 give us the language that would be helpful to
9 you and we could try and incorporate it.
10 MS. QUINSENBERRY: Right. That is
11 where in driving those -- as far as the
12 definition, you know, certainly but the acuity
13 case mix that is where we are trying to
14 identify that. Again, there are many
15 variables to just identify an acuity and a
16 case mix.
17 MS. DAILEY: So acuity case mix
18 and the clinical definition of case management
19 is not included in the DoDI?
20 MS. QUINSENBERRY: We have those
21 categories certainly as the Navy talked about
22 with the time, the internals, the frequency

1 that we are incorporating.
2 MS. LOVELACE: One thing we did
3 not do with things that change real frequently
4 like if you want to update something like
5 acuity, we did not include that specifically
6 in the DoDI. That is done in the MHS
7 documentation guidance.
8 We chose to do it that way because
9 we can update that more frequently as things
10 change rather than having to go back and
11 update the DoDI every time something little
12 changes. The documentation guidance speaks to
13 the acuity. We mention it but the actual like
14 breakdown of level 1, 2, 3, 4, and 5 are in
15 the MHS documentation guidance.
16 MS. DAILEY: Ma'am, that is not
17 the document they are talking about. They are
18 talking about the revision to that document.
19 CAPT EVANS: I was trying see the
20 new draft, if they had it.
21 MS. DAILEY: It's not in there.
22 CAPT EVANS: It's not in there?

1 MS. DAILEY: It's not there.
2 CAPT EVANS: All right.
3 MS. DAILEY: And then the other
4 piece is is the definition of clinical care
5 management in the DoDI?
6 MS. LOVELACE: Yes, that will be.
7 I am really trying very hard to define each of
8 the different case managers. I am working
9 very hard with the VA to identify their case
10 so that we can have very clear definitions in
11 there as to what each one does. It's got some
12 separations so you can tell this is what this
13 person does and this is what this one does.
14 MS. DAILEY: Okay. I'm not sure
15 but I think that's where we want them to be.
16 MS. QUINSENBERRY: The DTM has
17 that information and they were trying to not
18 have to revise the DoDI every time because if
19 we are looking at the intervals and we put
20 something out there and then that is not going
21 to work and we have to revise that, we don't
22 want to get in a position of taking another

1 year to update a DoDI.
2 MS. DAILEY: And you've
3 coordinated it with the services and you think
4 you've got service buy-in?
5 MS. QUINSENBERRY: Yes, ma'am.
6 MS. DAILEY: So when the real day
7 comes for them to concur or non-concur, you
8 are not going to end up with non-concur with
9 comment which is another two years starting
10 over again?
11 MS. QUINSENBERRY: Right, no.
12 They are at the table with us right now.
13 MS. DAILEY: All right. That's
14 where we want them to be. I think we helped
15 them get there because we have been dragging
16 them in here twice. Her bosses know that
17 we're dragging them in here and we've been
18 pretty clear about our interest in the
19 publication of the policy. I think that is
20 resonating a little bit in Health Affairs.
21 MSGT MacKENZIE: I agree, Denise,
22 that is definitely where we want them at. I

1 guess the problem is as an aviator my
2 interpretation of standardization is
3 significantly different because when you
4 standardize across the job description, it is
5 the same no matter where you go. It's
6 directive in nature and you comply.
7 I guess that is where a little bit
8 of my misunderstanding comes in because if I
9 go to a Navy MTF, if I go to an Army MTF, or
10 if I go to an Air Force MTF and it's
11 considered standardized, then it should be the
12 same across all three services.
13 I guess when we go to -- as you
14 guys are working so hard to get this done, I
15 guess I'm looking for that solid confirmation
16 that that is the way it's going to be and that
17 is not what I'm understanding. I have to
18 adjust my understanding of the word
19 standardization.
20 MG STONE: I think you heard
21 yesterday from the principal deputy the
22 difficulty implementing DoDIs. I think one of

1 the things that we offer you is the ability to
2 get some direct contact up through Congress as
3 we do our reports.
4 I would not be confident that we
5 aren't going to get hung up at some level
6 here. We all have struggled through our
7 frustration of DoDIs. Every place this group
8 goes to universally it is some form of case
9 management which is identified as the most
10 important item in the recovery of these
11 wounded warriors.
12 I think the ability to span over
13 the entire, I use the term life span of the
14 disease or injury process, or recovery process
15 continues to be challenged by all these
16 barriers and domains of care that I've come
17 back to a couple of times in the last few
18 days.
19 Case management should span the
20 domains, should bridge the domains, should not
21 require handoff between DoD and VA or civilian
22 care but should bridge all of that. We need

1 to get to that point to ensure continuity.
2 As a physician I will tell you
3 it's been shocking to me how few of our
4 wounded warriors and families identify
5 physician care as being most important in
6 their recovery. Almost universally it has
7 been this case management.
8 This needs to move a lot faster
9 than a two-year staffing process through the
10 Department of Defense in order to get this
11 thing out. I can guarantee you that the DSGs
12 who you have referred to very kindly three
13 times as our representatives --
14 MS. QUINSENBERRY: Oh, did I do
15 that?
16 MG STONE: Yes, I heard it very
17 clearly as a DSG. We're talking to each other
18 every day. At the direction of our bosses we
19 are talking to each other every day trying to
20 make sure that we unify effectively.
21 I'll bring this to the table, I
22 hear you, to make sure we've got visibility of

1 what our representatives are doing. But we
2 still are at the mercy of a staffing process.
3 It will be another six months before it even
4 comes out of your department so we need to
5 move this faster. We're offering you that
6 opportunity.
7 MS. QUINSENBERRY: I think we are
8 lucky to have those type of representatives,
9 quite frankly, at the table because they are
10 the ones that have the ear of where it needs
11 to be and can definitely help us move to the
12 point where we have a policy much faster.
13 Certainly having that type of
14 governance in place makes all the difference
15 in the world. It's having our tri-service
16 representatives there.
17 As it goes through the concurrence
18 process, though, I can tell you we do try to
19 watch that. On a daily basis we certainly
20 update our leadership every week as to the
21 status of any type of -- I know anything that
22 comes out of my division I update my

1 leadership on a weekly basis, that be case
2 management, that be patient center medical
3 home, that be disease management programs. So
4 that is certainly something that I have the
5 action officers watch carefully. I think
6 Derenda can attest to that. We do not want to
7 have any lag or gap in our response or as to
8 who we need to bring to the table if we have
9 a question or we have a concern or we have
10 some type of clarity needed that we try to do
11 that as quickly as possible.
12 MS. LOVELACE: Every time that I
13 ask for clarification from someone, I say,
14 "I'm really trying to get this moving along.
15 Please get me back a quick response." I'm
16 really trying to push that as questions come
17 up. I integrate them into the document.
18 LT GEN GREEN: One naive question
19 from a family doc. Okay? Two years ago I was
20 fortunate enough to be invited down to speak
21 with the Association of Clinical Case
22 Management folks. I don't know the exact name

1 of the association but I was non-memorable
2 because I followed Mrs. Woodward but that was
3 okay.
4 I was startled when I walked into
5 the room and saw probably 5,000 people in the
6 conference. My naive question is with that
7 many people doing this kind of work around the
8 country, I'm surprised there aren't national
9 standards. Are those national standards so
10 difficult that the military can't implement
11 the national standards?
12 MS. LOVELACE: We do use the
13 national standards.
14 MS. QUINSENBERRY: No, he's
15 looking for --
16 Are you looking for numbers as far
17 as case mix?
18 LT GEN GREEN: Well, I mean,
19 whether case mix or how it applies to our
20 wounded warrior. I mean, I see the issues in
21 terms of the level of acuity with some of our
22 folks that we are dealing with, but we have

1 also, therefore, laid in layers of case
2 management, both medical and non-medical. I'm
3 just kind of wondering what makes this so
4 hard?
5 MS. QUINSENBERRY: Well, we do as
6 far as standards -- you know, as a doc, as a
7 nurse we have our standards of practice.
8 Certainly if either of us are held to case
9 management, we are going to be in front of
10 these standards, revised 2010.
11 We certainly follow those
12 standards and make sure that when we're
13 talking about that with our colleagues
14 everybody is following those guidelines. The
15 difficulty comes into play as far as the
16 different aspects of the care.
17 There are so many variables
18 associated with it and so many different
19 platforms of care. Dealing with a TBI patient
20 and to have a case load of 10 TBI patients
21 could be very different than Derenda having
22 just TBI.

1 Just the basic needs, the basic
2 type of recovery, interactions needed. There
3 are just so many variables in the care itself
4 that I think that is where the difficulty
5 comes and how they are accessing the VA as far
6 as they may need prosthetics.
7 They might need enrollment into or
8 some type of VBA type of support as opposed to
9 just being on the DoD side accessing purchase
10 care type of recovery. There are so many
11 variables with that that it makes it
12 difficult.
13 MS. DAILEY: Ginnean, didn't you
14 say that the national organization does not
15 have acuity standards?
16 MS. QUINSENBERRY: As far as the
17 number of cases per case manager but they have
18 standards of practice as far as what a case
19 manager does.
20 MS. DAILEY: But the acuity and
21 the case load and the ratio was something they
22 would not even make a commitment to?

1 MS. QUINSENBERRY: I did as a
2 member of CMSA call up the other day because
3 we were responding to an IG report and I said
4 do we have any numbers. I don't want to sit
5 here as a member of CMSA and be on the record
6 as far as speaking on behalf of them so I need
7 to be very clear in stating that.
8 However, we go to them and we say,
9 "Has there been a change?" They certainly
10 met, I think, it was about two years ago with
11 the social workers side of the house. They
12 tried to come together and identify do we have
13 a ratio that we can go to. Their stance is,
14 "Ginnean, I'm telling you we don't have a
15 number. We can't give you that number."
16 Okay. But we on the DoD side are
17 trying to drive to that number to make sure we
18 are looking at the Army categories and how
19 they look at the wounded warriors and how the
20 WTUs are addressing it. Not only with our
21 recovering service members but our families
22 that may need case management.

1 Even though that is not out there
2 in national standards, we can still work
3 towards driving that and we can be the leader
4 possibly for that. That is how we are going
5 forward with that. As far as the standards of
6 practice for a case manager, those are laid
7 out and we do make sure those are known.
8 LT GEN GREEN: And so is that
9 where the DoDI starts? Are you going to
10 reference initially the standards as set up by
11 whatever the national association is? Then
12 essentially then you go further to say for
13 this type of work there may be additional
14 training, etc. I'm just trying to understand
15 how you are going to proceed here.
16 The difficulty is, I mean, it's
17 kind of like asking what the enrollment ratio
18 should be for patient center medical home.
19 The problem is there are a lot of variables
20 there. Is it going to be a single provider or
21 multiple providers? Is it going to have
22 extenders or no extenders? You can go through

1 all of that.

2 MS. QUINSENBERRY: Right.

3 LT GEN GREEN: But the reality is

4 it starts with you are going to have a

5 credentialed provider. In your case you are

6 going to have something who has met the

7 standards of whatever constitutes the national

8 standard for case management and then go from

9 there in terms of additions. Am I

10 misunderstanding?

11 MS. QUINSENBERRY: No, you're not.

12 With the DoDI as far as we go at it as far as

13 like what each entity addresses. The services

14 are really how that gets addressed because

15 they are at the point of care site. They are

16 the ones implementing as far as the standards

17 of practice that they require by competency

18 based. We address it at the policy level what

19 rolls up to us.

20 LT GEN GREEN: So now I'll step

21 one place further that probably will get me in

22 trouble, but are not the platoons sergeants or

1 the squad leaders in many cases extensions,
2 almost like an extender, for a case manager
3 because they are the people who are there to
4 help you get people to appointments, etc. and
5 how are you covering that?
6 MS. QUINSENBERRY: Again, I would
7 have to go back. We're not putting that in
8 the DoDI as far as again that goes to the
9 service specific role out of that but that is
10 certainly something we can take back and
11 consider into it.
12 LT GEN GREEN: But talking to the
13 idea of extenders would make some of the work
14 you're doing with acuity and --
15 MS. QUINSENBERRY: Identifying
16 those cases?
17 LT GEN GREEN: Right. Essentially
18 identifying those case loads. If you are
19 working with an extender, that may make your
20 time and number of contacts different.
21 MS. QUINSENBERRY: Yes.
22 LT GEN GREEN: Without referring

1 to any specific service, you could talk to
2 extenders who are responsible for assisting
3 and getting people to appointments or ensuring
4 that they do not no-show for an appointment.
5 Do you understand where I'm going?
6 MS. QUINSENBERRY: Yes, I do.
7 LT GEN GREEN: Okay. All right.
8 Thanks.
9 We got very much into your weeds
10 and I apologize for that.
11 MS. QUINSENBERRY: No, no.
12 Actually, it's a very good thing. I mean,
13 looking at case management, you know, growing
14 up through the MTFs, being deployed myself Air
15 Force flight nurse, you know, having family
16 that's deployed, you know, thankful they are
17 all home safe, this is important.
18 This is something where, you know,
19 it's good to get into the weeds and good to
20 try and get an answer to this. I see us as
21 being able to be the leaders. I have
22 tremendous respect for CMSA. We can possibly

1 help the nation in this. Certainly a lot of
2 things over these last 10 years of war we've
3 been able to share with our civilian
4 counterparts.
5 We've changed medical care so
6 getting into the weeds is not a bad thing.
7 It's something that challenges us and that is
8 why we in the DoD and MHS are so successful in
9 what we do and are looked at so favorably. I
10 appreciate the questions.
11 LT GEN GREEN: Okay. Any further
12 questions?
13 Suzanne, I think it's your time.
14 MS. CROCKETT-JONES: Thank you
15 very much, Ms. Quisenberry, Ms. Lovelace. The
16 end of the day here. Let's reconvene tomorrow
17 morning at 8:00 a.m. Thank you all so much.
18 MSGT MacKENZIE: Can I bring up a
19 quick point on a sidebar discussion? Well,
20 two things. First of all, General Stone, you
21 will always hear me refer to my doctors.
22 However, that was due mostly in part to the

1 lack of case management for five years. Then
2 my return to my doctors due to the difference
3 in case management between one facility and
4 another. I do appreciate that and I do
5 mention it on a regular basis.
6 One of the things we brought up in
7 one of our recommendations was, of course,
8 providing the staffing and manpower to these
9 Centers of Excellence. You know, the funding.
10 Let's roll it out there. However, it was
11 brought to my attention that the funding
12 exist.
13 The people exist but the hiring
14 can't happen because of the FTE ceiling. I
15 think we have learned another way to ask
16 questions appropriately to get the answer we
17 need to assist these agencies. I would ask us
18 as a group to relook at that, please.
19 LT GEN GREEN: It's a little more
20 complex than that. Okay? The FTE ceiling is
21 applicable to TRICARE management activity and
22 has to do with a host of things here in the

1 National Capital Area. The FTE ceiling really
2 is because of alignment within TMA.
3 There have been multiple
4 conversations in terms of how to align and how
5 to avoid duplication of services which led to
6 a recommendation that these be aligned to MRMC
7 for common services.
8 The service is still executing
9 similar to the way the org charts are, but
10 actually having the money pass through MRMC
11 and going to the Centers of Excellence to
12 basically try and make certain that we are not
13 duplicating things.
14 I don't know how many. I'll use
15 the vision of 55 people. I don't know how
16 many are lawyers or public affairs or
17 congressional liaisons, or all the kinds of
18 things that probably should represent all of
19 the COEs rather than each of them having one,
20 but that is the kind of work that we thought
21 was going to be done at MRMC based on having
22 a commander who actually had control of the

money to look at common services versus what was there.

That is why there is some confusion. That is why I asked about the org charts because that's not reflected right now. Does that help you?

MSGT MacKENZIE: It does help me quite a bit because it caught me off guard. That's why I was trying to ask while we had the experts here because I just kind of very quickly went to an NFL analogy that I've got all the money in the world but I can only spend so much on my people. It limits what I can get. It seems when we were putting the recommendation together last year we were trying to help them get everything they needed but now I'm wondering where that is in comparison to this limit.

LT GEN GREEN: The reality is that now we are into a different economy and so even though the money is there, there are a host of things going on across each of the

1 services with regards to civilian hiring
2 freezes and issues with regards to how they
3 are going to get end strength to the levels
4 that are being proposed in the President's
5 budget.
6 It gets a little bit complex but
7 the simplest thing is that the alignment was
8 set so that we would basically remove
9 redundancies. At least from General Stone and
10 my perspective we weren't seeing that. That
11 was one of the reasons why we didn't have the
12 amputation center, the EACE, proceed because
13 we really need to hear from the director how
14 they are getting their money and how it is
15 actually being -- letting them execute if that
16 helps.
17 MS. DAILEY: And, sir, what is
18 MRMC?
19 MG STONE: It is an Army Research
20 --
21 MS. DAILEY: Okay. Good. And
22 then they also mentioned a new Center of

1 Excellence Oversight Board. Would anyone be
2 interested in bringing those guys in?
3 LT GEN GREEN: The Oversight Board
4 was part of that decision to move it to MRMC
5 and that is why they were talking as much
6 about General Gilman who is the commander of
7 MRMC. It kept Health Affairs involved in the
8 way forward but, again, the dollars are still
9 flowing, I think, through that oversight
10 committee.
11 We can try and bring them in but I
12 think it's chaired by Dr. Woodson or Dr. Geiss
13 and so it's going to be an issue of are we
14 going to bring in Health Affairs to talk about
15 it.
16 MG STONE: I think we would be
17 better off bringing in General Gilman or one
18 of his representatives.
19 LT GEN GREEN: I agree because he
20 is the one who is technically suppose to be
21 working this now.
22 MG STONE: I know that he has been

1 an active participant of the board and I would
2 bring him in and discuss with him where this
3 should be going and where he sees the pit
4 falls.
5 MS. DAILEY: For all the Centers
6 of Excellence.
7 MG STONE: Correct. Yes.
8 MS. DAILEY: Okay. Good. Good.
9 That would be very helpful. We bring in the
10 Centers of Excellence, all of them every year
11 but we don't have a central oversight that
12 would be able to give us the big picture.
13 That would be helpful. This is the first I've
14 heard of it. Good.
15 MG STONE: Just by way of
16 housekeeping, since we've solved all the other
17 problems, we need some time to define the way
18 ahead in the Iowa piece. Can that be
19 lunchtime tomorrow? Can we add that in? Is
20 that an open hour for us?
21 MS. DAILEY: Tomorrow morning we
22 have a half hour tomorrow morning at 8:00 to

8:30 that we can also discuss it. I would be more comfortable doing it in the open. Yes, tomorrow morning 8:00 to 8:30.

MG STONE: Okay. Thank you.

LT GEN GREEN: Sounds great. We'll see everybody at 8:00 tomorrow. Thanks.

(Whereupon, the matter went off the record and resumed at 4:54 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

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

Before: US DOD

Date: 02-22-12

Place: Alexandria, VA

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

Court Reporter