U.S. DEPARTMENT OF DEFENSE

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

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BUSINESS MEETING

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TUESDAY

MAY 15, 2012

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The Task Force met in the Commonwealth Ballroom of the Holiday Inn & Suites Alexandria-Historic District, 625 First Street, Alexandria, Virginia, at 8:00 a.m., Lt Gen Charles B. Green, DoD Co-Chair, and Suzanne Crockett-Jones, Non-DoD Co-Chair, presiding.

PRESENT

LT GEN CHARLES B. GREEN, M.D., USAF, DoD Co-Chair
SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
CSM STEVEN D. DEJONG, ARNG, Member
RONALD DRACH, Member

CAPT CONSTANCE J. EVANS, USN, Member
LT COL SEAN P.K. KEANE, USMC, Member
MSGT CHRISTIAN MACKENZIE, USAF & SOCOM, Member
KAREN T. MALEBRANCHE, RN, MSN, CNS, Member
STEVEN J. PHILLIPS, M.D., Member
DAVID REHBEIN, M.S., Member

DENISE F. DAILEY, PMP, Executive Director,
ANNE SOBOTA, Alternate Executive Officer

ALSO PRESENT

CDR MIKE VARIAS, USN, Deputy Director, Navy Safe Harbor

CAPT MATT GIBBONS, USN, Director, PERS-95

CLEMENT MCDONALD, Director, Lister Hill National Center for Biomedical Communications, National Library of Medicine

BRIG GEN EDEN MURRIE, USAF, Director, Air Force Services

COL GIANNA ZEH, USAF, Deputy Director, Medical Services

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

8:12 a.m.

MS. DAILEY: Yes, sir, that sounds fine and I am still missing two other members, Lieutenant Colonel Keane and Captain Evans. I'm positive it's traffic. I don't have any immediate requirements for them to be here, so I think we've got some grace time there. We do have individuals making calls so that we can assess when they would be arriving.

I would like to have an opportunity to start, and so I'm going to turn it over to the two chairs. We have some scripted information that will introduce our briefers and our topics, and then we will go from there.

There's one of them.

CO-CHAIR CROCKETT-JONES: Thank you, Ms. Dailey. I'm going to ask the members who are here again to introduce themselves at this time. I'd like us to go around starting with you, Mr. Drach.

1 MR. DRACH: Good morning. Ron
2 Drach, independent member, retired from the
3 Department of Labor about a year-and-a-half
4 ago, worked on veterans employment training
5 voc rehab issues for the last forty years.
6 MSGT MacKENZIE: Master Sergeant
7 MacKenzie, Community Outreach Lead for US
8 SOCOM Care Coalition, here representing
9 special ops. Spent the majority of my career
10 in special ops in the last five years directly
11 working with the special operations wounded,
12 ill and injured.
13 MR. REHBEIN: Dave Rehbein. I'm a
14 research scientist at Iowa State University
15 and past National Commander of the American
16 Legion. Spent about 35 years working in
17 veterans issues.
18 MS. MALEBRANCHE: Karen
19 Malebranche. I'm here representing the VA.
20 I've been with the VA for 10 years. I'm the
21 Executive Director for Interagency Health
22 Affairs and a former Army nurse for 30.

LTCOL KEANE: Lieutenant Colonel Sean Keane. I'm the Marine Corps liaison to the VA and I'm part of the Wounded Warrior Regiment.

DR. PHILLIPS: Steve Phillips, physician. I work for the Department of Health and Human Services at the National Institutes of Health.

CSM DeJONG: Command Sergeant Major Steve DeJong, National Guard Bureau.

CO-CHAIR GREEN: And I'm Bruce Green, the Air Force Surgeon General and Co-Chairman.

CO-CHAIR CROCKETT-JONES: And I'm Suzanne Crockett-Jones. I'm the Civilian Co-Chair and spouse of a recovering Army infantry officer.

General Stone, Major General Horst, Dr. Turner and Mr. Constantine are not going to be joining us for this meeting, unfortunately, but it makes for such a nice intimate setting for us for our discussion.

1 Thank you for joining us at our
2 fourth meeting, second year of effort. I have
3 a note of interest that the Warrior Games
4 concluded last week and the Marine Corps once
5 again won the Chairman's Cup for the third
6 straight year and Marine Captain Jonathan
7 Disbro became the ultimate champion. Here's
8 a tidbit to start our day. Turn it over to
9 you.
10 CO-CHAIR GREEN: Okay, folks. So
11 throughout the meeting we'll be discussing
12 various topic areas for our fiscal year 2012
13 annual report. These areas have been assigned
14 to four groups and the groups and the members
15 assigned to them can be found in tab B as
16 follows: The groups were: Restoring Wellness
17 and Function, which was Dr. Turner, Dr.
18 Phillips and Lieutenant Colonel Keane;
19 Optimizing Ability, which was Mr. Drach, Mr.
20 Constantine and Master Sergeant MacKenzie;
21 Restoring Into Society, Captain Evans, Mrs.
22 Crockett-Jones and Command Sergeant Major

1 DeJong; and Enabling a Better Future, Major
2 General Stone, Ms. Malebranche and Mr.
3 Rehbein.
4 Our first item today is to review
5 the installation visits we've attended since
6 our February meeting. And we're changing the
7 format for site visit reviews. We've invited
8 two of the proponents for our responsible
9 agencies for the sites to talk to us about the
10 task force observations. The task force
11 visited the Marine Corps Air Ground Combat
12 Center at Twentynine Palms, and Colonel Mayer
13 asked that he be able to talk to the task
14 force tomorrow after the public forum as he
15 was not available today.
16 And today we'll be discussing the
17 Naval Medical Center-Portsmouth, and in
18 particular the Naval Reserve Medical Hold
19 Company. And to facilitate the discussion
20 today we've asked the proponents for the Naval
21 Reserve Medical Hold to join us from 8:45 to
22 9:15.

1 So our first order of business is
2 Iowa Joint Force Headquarters visits. We were
3 able to invite them to our last meeting, and
4 this will be a review of the actual site
5 visits which Lieutenant Colonel Keane, Ms.
6 Malebranche and Command Sergeant Major DeJong
7 and Mr. Rehbein visited in March.
8 So why don't you tell us about
9 what you found?
10 MR. REHBEIN: Well, let me start
11 off here. As an Iowan, that was a very, very
12 serious look at a lot of my fellow
13 Midwesterners and some of the things that
14 they're going through.
15 That particular brigade came home
16 through an unfortunate set of circumstances,
17 I think might be a good way to characterize
18 it. They had been in discussions with the
19 unit that would be receiving them at Fort
20 McCoy, and let me say right up front that Fort
21 McCoy is one of those places that does not
22 have a medical treatment facility. So many of

1 the things that a demobilizing unit goes
2 through in a normal demob with an MTF did not
3 happen there. They had been in discussions
4 with the unit that would be receiving and
5 demobilizing them for quite some time to
6 develop common understandings. And then as it
7 got very close to demobilization, that unit
8 was changed and a new unit was brought in.
9 That unit had much different priorities
10 because of their history than the original
11 did.
12 And so, I'll cut to the chase
13 here. The upshot was that the second brigade
14 was anticipating possibly as many as 200 to
15 300 of their members going into Warrior
16 Transition Units somewhere. They wound up
17 with three. Everyone else was referred home
18 to TRICARE and VA. Referrals happened, but I
19 think in this case, particularly with the
20 numbers of people coming home -- it's not a
21 major metropolitan area. There are not huge
22 numbers of medical personnel. It's in some

1 cases considered a rural area, some cases very
2 rural area.
3 So the medical care facilities to
4 receive them on those referrals, it also
5 strained them considerably. We met with the
6 Des Moines VA Central Iowa System and I think
7 they had done a reasonably good job based on
8 the numbers that they reported to us for wait
9 times, but some of the wait times were still
10 far too long.
11 But I think there's lots of
12 lessons to be learned from that
13 demobilization. I hope they are learned and
14 some of those things don't happen again.
15 The focus groups we met with were
16 very well populated. We had quite a number of
17 recovering warriors, quite a number of family
18 members, and they had some things to tell us
19 that were at times almost heart wrenching.
20 Families on the verge of eviction because the
21 soldier is not yet capable of going back to
22 work, but the soldier is no longer on Title 10

orders, and so there was no income for the family. They were depending on community resources to help get them through tough times, really tough times. Two or three of them specifically talked about how they had been right on the verge of homeless.

I guess I don't know what else. I guess I'd turn it over to the other folks that were as part of the trip, but that's what I saw as something of a summary. There would be transcripts I'm sure of the focus groups if you wanted to know more detail of what they had to say.

CO-CHAIR GREEN: I guess the one question I would ask is, so they planned on 200 to 300. They only had three that went through the brigade. But ultimately, if the numbers that were reported to us last time were correct, had 2,200 out of 3,000 that actually were being looked at for extension on Title 10 orders? I mean, that's a massive disparity.

1 MR. REHBEIN: If I remember
2 correctly, there were 2,200 medical issues
3 reported being treated one way or another. I
4 don't believe it was ever 2,200 that they
5 anticipated would go into a transition unit.
6 It's just that that was the total number of
7 medical issues that were eventually reported,
8 either through the health assessment or the
9 health reassessment.
10 CO-CHAIR GREEN: Were they going
11 to have to extend them on Title 10 orders to
12 solve the 2,200? Was it actually 2,200
13 individuals that needed assistance?
14 CSM DeJONG: Not necessarily. It
15 was 2,200 line of duties, sir. So throughout
16 the --
17 MR. REHBEIN: That's the word.
18 CSM DeJONG: -- deployment there
19 was 2,200 line of duties that were actually --
20 formal line of duties that were filed.
21 CO-CHAIR GREEN: Okay. That's
22 still -- I mean, the line of duty usually

1 infers discussions on whether they're going to
2 be put back on Title 10 orders to get their
3 things taken care of, correct? I mean, that's
4 the way it was --
5 CSM DeJONG: Not necessarily. The
6 line of duty could be something as simple as
7 it could have been treated by a theater
8 hospital or a theater aid station. It was
9 still reported as a line of duty just for any
10 future reference to that injury, however
11 severe or benign it might be.
12 CO-CHAIR GREEN: So when you say
13 "line of duty," you're not saying that they're
14 seeking additional medical care, just
15 documenting medical care?
16 CSM DeJONG: Yes, sir.
17 CO-CHAIR GREEN: Okay. Do we have
18 any idea how many were seeking additional
19 medical care?
20 CSM DeJONG: That was the 200 to
21 300 that they were anticipating to move to
22 remain on Title 10 and get further follow-up

1 care.

2 MR. REHBEIN: They didn't give us

3 names obviously, but they reported instances

4 of attempts to get people back onto Title 10,

5 you know, particularly some folks that had

6 been sent back out to Fort Carson for

7 evaluation to get back onto Title 10 and were

8 refused and sent back home. So they had made

9 some attempts to do that, but they didn't seem

10 to be having much success.

11 CO-CHAIR GREEN: I'm just trying

12 to put in my own mind what they told us with

13 what you guys are now kind of filling in the

14 blanks here. They also were -- there were 600

15 of the 2,200 that were PTSD claims. And so we

16 were dealing with 1,400 minor -- or I

17 shouldn't say minor, but other types of

18 medical issues, and 600 that were PTSD. So

19 with the Army, do they not -- when they do a

20 line of duty and it is PTSD or PTS, do they

21 not bring them back on Title 10 orders so that

22 they can get healthcare?

1 CSM DeJONG: Not necessarily, sir.
2 That's still a tough one as far as figuring
3 out the severity, validating it and then
4 determining whether or not they can -- they
5 need to be back on Title 10 or whether they
6 refer them to the VA.
7 CO-CHAIR GREEN: I guess the
8 reason I'm asking is, as I understood it, a
9 lot of these people, because of their absence
10 of medical processing, at about the five-month
11 point where they were running out of their
12 TAMP benefit, essentially were seeking further
13 care. And I'm not aware of another venue for
14 them to get that care other than putting them
15 on Title 10 orders again.
16 CSM DeJONG: That is correct, sir,
17 and that's the battle of trying to get them
18 back on Title 10 and validating it, too, at
19 that five-month point, because now you're
20 going back. Generally, as far as the National
21 Guard or reserves, if you're not held on Title
22 10 right at your demob or right at your PDHRA,

1 it's very difficult, if not impossible, to go
2 back onto Title 10 orders at that five, six-
3 month point, which is part of the discussion
4 we've had throughout the last couple years,
5 that a lot of the PTS symptoms aren't showing
6 up until five, six, a year down -- you know,
7 12 months down the road, and now what do we
8 do? How do we get them back on Title 10 for
9 the proper care?
10 CO-CHAIR GREEN: And this kind of
11 leads -- one of the reasons I'm kind of trying
12 to ferret is is there -- are you anticipating
13 a gap? I'll just use the PTS for the roughly
14 600 that they were worried about post-
15 traumatic stress. Are we worried about a gap
16 in terms of them being able to get care? How
17 long does the line of duty process take for
18 those reservists? If it's going to take six
19 months, are there going to be people who can't
20 receive care while they're going through the
21 line of duty process?
22 CSM DeJONG: Bottom line is yes,

1 sir.

2 MSGT MacKENZIE: One of the

3 questions I had is as they were going through

4 all that stuff; and then what you briefed, Mr.

5 Rehbein, was so the medical folks within the

6 unit were stating between 200 and 300 people

7 they expected to go to a transition unit for

8 follow-on care, their condition required a

9 higher level of care, that they anticipated

10 that, but yet where was the decision point

11 made that only three of these folks ended up

12 going to a transition? I mean, where was that

13 point of failure that, you know, the medical

14 professionals that thought these guys needed

15 further care were then superseded by others to

16 say they can all just go to the local

17 community to get care?

18 MR. REHBEIN: I think that was in

19 the communication between the second brigade

20 and between the unit that was receiving them.

21 The priority of that unit appeared to be -- of

22 the receiving unit appeared to be getting the

1 line of duty documentation taken care of, the
2 paperwork done before they left McCoy. And
3 that then resulted in less time being
4 available to be spent on making the best
5 medical determinations as to who should go
6 where.
7 One of the things that we saw out
8 there, we talk about -- and I'm going to go to
9 another subject for a minute. We talk about
10 case management levels. They are stretched so
11 thin that they were using -- essentially using
12 the medical NCOs at the unit level as
13 assistant nurse case managers. Most of the
14 people we talked to in the focus groups; the
15 recovering warriors, the family members, had
16 no clue who their nurse case manager was. All
17 they knew was that Medical Readiness NCO in
18 their unit, because that person was
19 effectively acting as an assistant nurse case
20 manager. With no training. OJT. Pick it up
21 as best you can. Depending on the dedication
22 of the Medical Readiness NCO to really provide

1 the kind of service. Because we were talking
2 case loads out there in the nurse case
3 managers over 1,000. Just horrendous numbers.
4 MS. MALEBRANCHE: I went back with
5 one of the nurse case managers, and she went
6 through her screen, and I think she had over
7 1,200 she hadn't even gotten to yet. It was
8 astounding, the number that they were supposed
9 to take care of.
10 And then, too, like Mr. Rehbein
11 noted, the NCOs had -- this was a collateral
12 duty they're picking up with this case
13 management. Some of them were like log guys
14 and they were supposed to be doing other
15 duties to get their units ready and, you know,
16 full up or full back.
17 One of the things on these line of
18 duties that I thought was interesting that
19 they brought up, but they said some of these
20 line of duties could have been done in-
21 country, but were not. And so, when they came
22 back, they were busy trying to recreate and do

1 some of this. So that put them behind
2 already.
3 But the big thing that I was
4 focusing on was the case management. And
5 also, their computer systems. The nurse could
6 -- they could only have like two
7 authorizations to get into -- I'm trying to
8 remember the name of that program. Colonel
9 Keane, do you recall? There was a program
10 that they couldn't get into, so they had like
11 three people. Two of them couldn't get into
12 one of the programs. She couldn't get into
13 another. There was no interoperability within
14 the unit there for them to put in their cases,
15 be able to look at them and each have access.
16 It was a limited amount of usage that they
17 were allowed in there. So the case management
18 ratios were just incomprehensible. There is
19 no way those people can do what they need to
20 do with the numbers that they have to be
21 taking care of.
22 LTCOL KEANE: That being said, if

I remember correctly though, they had three accesses, but only two people were assigned them.

MS. MALEBRANCHE: Right.

LTCOL KEANE: There was some mis-communication between --

MS. MALEBRANCHE: Right, but we --

LTCOL KEANE: -- the reserve doctor and the active duty.

MS. MALEBRANCHE: Yes.

LTCOL KEANE: What we found out during the discussion --

MS. MALEBRANCHE: Yes.

LTCOL KEANE: -- was that we need 25 of these. Well, you're not even using the third one that you have. So that was another discussion.

MS. MALEBRANCHE: Yes. Yes, so there were some discrepancies that I think some discovery along the way, too, that was helpful.

1 LTCOL KEANE: Another major point
2 that we found out was the misunderstanding
3 from the command all the way down to the
4 wounded, ill and injured soldier about the VA
5 care and who is eligible for VA care. They
6 were told that they could only be on active
7 duty in order to get VA care. And Mr. Rehbein
8 and Ms. Malebranche and I went back to the VA
9 on the last day and said what is this? Maybe
10 we're misunderstanding something, because as
11 long as it's TRICARE-authorized, reserve
12 members or post-DD214, they can get care
13 through the VA. They don't have to be
14 recalled back on orders, Title 10, to get VA
15 care.
16 MS. MALEBRANCHE: Yes, and they
17 didn't know, but the VA person said she had
18 told them that they -- VA's a TRICARE
19 provider, plus VA can do a certain amount of
20 care for active duty. And they had the
21 ability and they seemed to be needing what
22 they got, but I don't know if they were

1 getting all that. So, but she had been
2 communicating and they did know each other by
3 their first names, so -- but then, I think the
4 previous commander had left and there was a
5 new person in, but there had been some good
6 relationship building. But it still wasn't
7 utilized to the maximum extent possible.
8 CO-CHAIR GREEN: So that would
9 only be applicable for that last month that
10 they had a TAMP, right? So in other words,
11 the TRICARE authorize was -- is something only
12 available while they're in the TAMP system?
13 LTCOL KEANE: I'm not sure how to
14 answer that, sir, but I could give you an
15 example. We had a soldier on active duty, had
16 all his appointments lined up and he was told,
17 hey, once you come off orders you're not
18 eligible for care. He called the VA and said,
19 hey, I have to cancel my appointment. The
20 gentleman on the other line is an appointment
21 person, not a doctor, saying all right we'll
22 cancel it, because that injured soldier

1 thought that he had to cancel, he wasn't
2 eligible for it. And then the gentleman would
3 come back on orders because the problem
4 persisted. Tried to make another appointment.
5 This went on for six, eight months because he
6 was ebbing and flowing from active duty to
7 reserve duty.
8 CO-CHAIR GREEN: So they just
9 didn't understand the TAMP benefit persisted
10 just by the end of their Title 10 orders?
11 LTCOL KEANE: That's definitely
12 correct, sir.
13 CO-CHAIR GREEN: Ah, okay.
14 Unfortunately, at the point where you were
15 seeing them, which I think was five months
16 after the deployment, they were about to run
17 out of their TAMP orders. So he really was
18 going to run into that in about another 30
19 days.
20 DR. PHILLIPS: I just have a
21 comment. I missed the trip because my flight
22 got canceled, but I did have a chance to spend

1 two hours -- I got to Iowa two days after you
2 guys had left -- two hours with the commanding
3 colonel, who we exchanged cards and so forth.
4 I don't want to repeat what has been said,
5 because everything that has been said is very
6 accurate from what I heard.
7 Bottom line to me was that they
8 just lacked, seriously lacked administrative
9 support from the time they demobilized to even
10 the present time. People did not know the
11 system and what to do. I said why did you
12 lack administrative support? They said, well,
13 it's just lack of funding. They just needed
14 30 or 35 more case managers, and they just did
15 not have the federal funding. So everything
16 just went downhill from there. That's what
17 I've heard.
18 MR. REHBEIN: There is one other
19 thing that I heard that I don't understand.
20 I don't even know if it's true. But the
21 comment seemed to be made a couple of times in
22 regard to the line of duties. The active

1 component does them in-theater, but the
2 reserve component waits until they get home.
3 Is that wrong?
4 MS. MALEBRANCHE: That's what they
5 said.
6 CSM DeJONG: Okay. It shouldn't
7 happen like that. That's a command-level
8 decision if they're not done. I don't know
9 how to explain it any other way. It's just a
10 matter of personnel management at that point
11 in time.
12 MS. MALEBRANCHE: It sounded like
13 that and it sounded like the people in-country
14 didn't know how to do it, is what I believe
15 they mentioned. And so, there was discomfort
16 there. And so, they could have been one step
17 ahead had that been done.
18 The other thing to mention that I
19 found somewhat disturbing, especially in light
20 of our secretary's push on homelessness, was
21 that they mentioned that they had two or three
22 soldiers that they actually put up in the

1 barracks because they had no place to go after
2 they were back. And our VA person who is in
3 charge of the Homeless Program at the VA was
4 not notified, nor did she have any visibility
5 of them. And I thought that was -- I mean,
6 the fact that they would have been literally
7 on the street if they had not put them back in
8 the barracks, that was very disturbing because
9 we have such an active program, but they
10 didn't know what to do.
11 DR. PHILLIPS: You know, just
12 again, the impression I got was a lack of
13 knowing and administrative support. Whoever
14 is supposed to be doing that, they just didn't
15 have it.
16 MR. REHBEIN: I'll simply make one
17 more comment about those LODs then. If that
18 truly was a unit decision, regardless it --
19 getting the LODs done at McCoy ate up a lot of
20 the time of the administrative support people,
21 both within and outside the second brigade
22 that could have been spent on preparing people

1 better to get back home, I think.
2 CO-CHAIR GREEN: So did they have
3 a way ahead? I mean, do we have a solution
4 set? What was going to happen? I mean, this
5 is one I was hoping General Stone would be
6 there to see how we were going to basically
7 solve this. But did they give you any way
8 forward?
9 DR. PHILLIPS: Colonel told me
10 they really had no response because state
11 funding is very limited, and they were
12 depending on federal funding to be able to
13 hire more administrative support and they
14 weren't getting it. And he hasn't followed up
15 with me or I don't know if he followed up with
16 anyone else. I asked him to, but I haven't
17 heard.
18 MR. REHBEIN: No, I don't
19 necessarily think there's a way forward for
20 this unit. I think they're simply going to
21 have to struggle with the issues as best they
22 can, get way outside the box like they did

with the Medical Readiness NCOs to try to provide help. I think the lesson to be learned here is that there is -- this is definitely a way not to do it, not to demobilize.

CO-CHAIR GREEN: Yes, I agree with that. I'm just surprised that we haven't seen some type of outreach. So command sergeant major, I mean, you worked in this world, so what's the reserve options to basically ask for assistance from the active side when we run into this?

CSM DeJONG: Again it comes down to the bottom -- or comes down to money, sir. I mean, they could reach out to the National Guard Bureau and see what they can get. Otherwise, it's up to the unit. And once they get into this position of demobilizing and people start going back to parent units and cross-leveling and that, it's just going to be a compounding problem of trying to track down the appropriate level of signatures for the

1 LODs. You're going to have commanders that
2 are no longer commanders and then it becomes
3 an access through the system as to what UIC
4 you're going to get access to because -- so
5 it's going to be a compounding problem as this
6 progresses.
7 The answer of how to do it and how
8 to get funding, that's between the state and
9 National Guard Bureau, and them presenting it
10 in a certain way.
11 LTCOL KEANE: Sir, it felt like to
12 me that they were looking for answers from us.
13 MS. MALEBRANCHE: I think they
14 were, and we reconnected them to the VA. We
15 did suggest that they should talk to the Air
16 Guard about the case managers, or back to the
17 state, and also back to the active component
18 about the case management piece. I don't know
19 what the follow up would have been on that.
20 But case management was so distressing because
21 of some of the cases they brought forward that
22 they needed help, that I did give them my name

1 and number to get to their case manager,
2 because there were a couple of cases that were
3 very, very significant.
4 And one was a young man who had a
5 terminal illness who was getting care under
6 his father's insurance and he was diagnosed
7 in-country, and I thought that was very
8 significant that nobody knew to help him or
9 how to help him. And I'm not sure where it
10 was that he came in. It's hard to tell where
11 they came in on the system.
12 But it was interesting that we had
13 a focus group with administrators which
14 apparently hadn't been done. This was my
15 first group like this. And they were
16 basically, like you mentioned, asking for help
17 and they were very concerned and put forth
18 their issues. And it was a huge group. For
19 a focus group it was almost too large. It was
20 about 14 people or more and they all had a
21 great deal to say. So they were really
22 reaching out, I think grasping to try to find.

1 CSM DeJONG: Part of what we're
2 learning throughout this, especially on the
3 Guard and reserve side, is the lack of
4 knowledge and the lack of knowing how to reach
5 out to support that's out there, which was
6 part of the reason we had brought in and we
7 did the focus group in Indiana, because they
8 seemed to have a best practice going with
9 their J9 advocate. But we're still at a
10 point, and as we're reaching the point of
11 making recommendations and best practices,
12 we're still at a point to where every state on
13 a Guard and reserve side -- kind of each
14 adjutant kind of runs things their own way.
15 So you got 50 states doing 50 different
16 things.
17 And as we can see with Iowa, it's
18 done a different way than it is done in
19 Indiana and there's a lack of knowledge, a
20 lack of training and a lack of access to
21 resources that are out there; i.e.,
22 homelessness, case management and just tying

1 the VA into the medical side to streamline
2 this process best as they can.
3 MSGT MacKENZIE: One of the things
4 that I'm -- and along the same lines what you
5 were saying, I mean, we've been to several
6 states and, I mean, it's the same thing. It
7 all depends upon what the adjutant general's
8 doing.
9 But one of the things that keeps
10 popping up in my head is what is the active
11 component responsibility to these states when
12 they mobilize these folks? I mean, the
13 standardized support package, the standardized
14 way of briefing, those kind of things. I
15 mean, it seems like we keep looking at the
16 states as to what they're doing right or what
17 they're doing wrong, but I also think we need
18 to really take a look at what is the active
19 component doing right or wrong to support
20 these mobilizing units?
21 I mean, at the end of the day, you
22 know, when I'm out there on the battlefield

with, you know, reserve and Guard folks, I mean, they're out there with me the same way. You know, we're responsible to them, but yet it seems like when they go back to the state, it's all, you know, hail Mary. You know, whatever the state's doing is what they're doing. I wonder if there's a portion of that or, you know, a funding or a standardized deal where it says, hey, this is our responsibility when they're demobilizing from the active side to make sure each state has the resources it needs for X period of time, and then that goes away. It's part of that request to mobilize to support, you know, these activities. I mean, that's --

CO-CHAIR CROCKETT-JONES: Sort of in vague connection to that, I'm a little concerned about if -- you know, the 200 number expected to go to transition unit seemed high. Three seems low. A follow up to that was to try and send some who maybe should have initially gone to a transition unit to a

1 transition unit later and then they were
2 rejected. I'm a little concerned about that.
3 Did we have any more information on why they
4 were not taken into the transition unit? I
5 mean, what -- did they not meet criteria?
6 What was the -- I'm not understanding that.
7 LTCOL KEANE: I think I remember;
8 and hopefully this will jog your own memory,
9 there was a restructuring of the way the WTU
10 did and included that state. In my mind, they
11 had done everything correctly in preplanning
12 with this other demob'ing unit. It wasn't
13 until the ninth hour that they changed and
14 went from the 118th to the 119th they had a
15 different focus.
16 Before they deployed they expected
17 200 to 300 people would probably need to have
18 beds. And close -- three weeks before they
19 redeployed they again talked to those same
20 people they -- at the WTU and they said, oh,
21 no, we don't have the beds. Because of the
22 restructuring it's not -- you know, we don't

have the beds. And I thought they originally sent seven, but only three of those seven stayed.

CO-CHAIR CROCKETT-JONES: Do we know why? What was it criteria-wise that got them sent back? I'm -- just -- it was just bed space?

MS. DAILEY: Ladies and gentlemen, I would ask -- I got a couple more minutes here, but if I can get you to wrap. I need to bring the Navy up for the Norfolk visit.

MR. REHBEIN: One more point that I think we need to make that is very close to the Co-Chair's heart. The families out there, they're trying to deal with this and because of their location, because they're all dealing with reserve component soldiers, they have no SFAC support at all. The only support they have is what they can find in the home unit and find with each other. And it is very difficult for them to receive the right information because they don't have an SFAC to

go to to ask some of these kinds of questions.

And I think that contributes to the misinformation that's out there among the families, but among the troops, too, as to what you can and can't do as regards to the VA and all of these kinds of things, because you know how that process works as information passes from one person to the next to the next. It evolves. It changes. And without a single point to go to to ask questions, it makes the process a lot worse.

So if we can figure out a way to deliver some kind of SFAC services to people in these situations out there in the more rural areas. I don't know how to do it. I'm not saying I've got a bright idea. I'm just saying that I think there's a real need out there.

CO-CHAIR CROCKETT-JONES: Do they have any sight on Military OneSource, National Resource Directory? Were those known or were they pretty much off the table, too?

1 MR. REHBEIN: Spotty. Very
2 spotty.
3 DR. PHILLIPS: One quick final
4 comment. I spent 30 years in Iowa. I was a
5 reservist. I volunteered at the VA for those
6 30 years. From what I can see and what I
7 heard and over those 30 years and the recent
8 interview, it looks like they need an outside
9 intervention as a group. You know, we
10 intervene for individuals. I don't know how
11 to do that. I don't know what mechanism is
12 available. But it just seems like a team
13 needs to go there and help them for a week or
14 a month and get it organized.
15 MS. MALEBRANCHE: I would say that
16 that's probably very true. And the
17 standardization that Mac suggested, I think
18 there are some standardization things that we
19 need to do for them. But I do think that this
20 visit created some of that family support.
21 Those people bonded. And it was interesting
22 they had never met each other before, the

1 wives. And I thought that was kind of an
2 interesting outcome of this, but not near
3 enough. Not near enough.
4 CO-CHAIR GREEN: So I guess the
5 other question I would ask -- and I'm going to
6 go back to the command sergeant major. So if
7 the active duty doesn't have a role in terms
8 of this; I mean, I'm just a little surprised
9 that the active duty doesn't since these are
10 demobilizing soldiers, then are there things
11 along the lines of demax or interstate
12 agreements where there could be assistance by
13 the resources available to another state who
14 may not have deployed? Do you see what I'm
15 asking?
16 CSM DeJONG: I can't answer that
17 intelligently, sir, but there is -- looking at
18 next year and going down, First Army is the
19 one that handles a lot of the mobilizing,
20 demobilizing. As far as the medical portion,
21 I don't know how much they get involved, but
22 it may be worth a look next year to see.

1 Mobilizing, they have a complete set of
2 criteria you have to meet before you go into
3 theater. Demobilizing, it almost seems like
4 they're a little bit more hands off because
5 you're back. I don't know what role they play
6 into that as far as -- but First Army is the
7 controlling agency, active duty agency over
8 all mobilizing reserve and Guard troops.
9 CO-CHAIR GREEN: Okay. And then
10 the kind of final comment and we'll move on,
11 but they -- I mean, just from my own services
12 experience, getting people the mental health
13 care they need longer than the TAMP period is
14 kind of a recurring theme. And so, should we
15 be advocating for something where the
16 reservists, if not the families, but at least
17 the active duty, could do the same thing as
18 our military families do, which is they get
19 update visits. You know, so do you create a
20 benefit where the reservists would have the
21 same aid visits that we give to every active
22 duty family member?

1 The advantages being that
2 essentially it would give them, the PTS --
3 when you look at what the projections are,
4 it's actually somewhat frightening to think
5 that you're going to have all these folks now
6 think -- take all of these different units
7 that may have some of these kinds of problems
8 and look at what's available out there if they
9 don't have any coverage to do this without
10 going back through a line of duty process.
11 It's just concerning to me. On the Air Force
12 side it takes typically months to get the LOD
13 essentially completed. And so, that's months
14 that they may not be able to get care.
15 So just a worry and something we
16 may want to talk about as we think about where
17 we want to go in terms of recommendations.
18 DR. PHILLIPS: I may not have it
19 exactly right, but I know last meeting we
20 talked about the clock starts ticking when
21 they get back to CONUS as far as medical
22 appointments. And we did discuss the fact

1 that maybe it should start ticking when they
2 make their first appointment. So just to
3 support what you were saying.
4 CO-CHAIR GREEN: That's an
5 interesting approach. So then the TAMP would
6 be from -- they'd have six months of coverage
7 from the time they make their first
8 appointment. Interesting. The problem --
9 that's going to be an interesting dynamic with
10 the -- whether or not -- because one of the
11 reasons for the six months is that they
12 basically give them a bye on their active duty
13 -- whether they're active duty or not. So
14 could you give them six months without
15 actually giving them -- that's an interesting
16 thought, especially if it's not being utilized
17 right now. Yes, clever.
18 DR. PHILLIPS: Yes, especially
19 since things happen. You know, you come home.
20 You're excited. You don't get your need
21 fixed. Post-traumatic stress, whatever, it
22 really shows up late.

1 One thing we could do is survey
2 and see when these things happened, because
3 people make appointments perhaps unnecessarily
4 early because they know the clock is ticking
5 as opposed to waiting when they really need
6 it. Something we can discuss.
7 CO-CHAIR GREEN: There's not
8 enough green of me left, but there's a lot of
9 green on the page. Sorry.
10 All right. So I think that our
11 next step here is, based on the timing, which
12 we're already running late, we have Captain
13 Evans and Ms. Crockett-Jones attended the
14 Portsmouth visit.
15 And so, Captain Evans, you had the
16 lead on Portsmouth. Can you tell us a little
17 bit?
18 MS. DAILEY: And ladies and
19 gentlemen, I do have representatives from the
20 Navy here, so this will be an opportunity to
21 kind of dialogue back and forth.
22 Can I get our representatives from

1 the Navy to step up, please? We're going to
2 bring you to the front. You can have a seat.
3 I do have a panel, a place for you to sit down
4 up there. We have a microphone for you. And
5 Captain Evans is going to lead this
6 discussion.
7 CO-CHAIR GREEN: Either this is
8 really controversial or you're going to
9 overwhelm us with numbers. We're impressed.
10 MS. DAILEY: And one thing I'd
11 like you to do, gentlemen, is introduce
12 yourselves. Obviously we'll have a lead team
13 and then backup. So I will let Commander
14 Varias; he's the Deputy Commander for the Safe
15 Harbor, introduce everyone. And then I'm
16 going to turn it over to you, Captain Evans.
17 CDR. VARIAS: Ladies and gentlemen
18 of the task force, good morning. Commander
19 Mike Varias, Deputy Director for Navy Safe
20 Harbor, and I've brought a cast of thousands
21 to represent Navy today.
22 To my right is Captain Matt

1 Gibbons. He's Director of PERS-95, who
2 oversees the med hold, lease benefits
3 authority for med hold, Navy Reserve Med Hold
4 and line of duty.
5 CAPT. GIBBONS: Good morning.
6 CDR. VARIAS: To my left is
7 Commander Doc Paver, who is the Senior Medical
8 Officer for -- Commander, Naval Reserve Forces
9 Command.
10 Behind me to my right is
11 Lieutenant Dave Noriega, my operations
12 officer.
13 LT. CDR. GILBRANSON: Lieutenant
14 Commander Jack Gilbranson, Bureau of Medicine
15 and Surgery, Patient Admin.
16 CDR. VARIAS: Lieutenant Commander
17 Mike Watson. Works for PERS-95 as the
18 assistant medical officer.
19 Captain Mel Willis who is the
20 Bureau of Navy Medicine Case Management, as
21 well as Commander Doc Shapiro, who's our
22 Senior Medical Office for Navy Safe Harbor.

1 And I believe that's everyone. So
2 standing by for your questions.
3 CAPT EVANS: Good morning, and I
4 apologize for being late.
5 Before discussing the reserve, we
6 had the opportunity to speak with two
7 different focus groups down at Portsmouth.
8 The first focus group was the special ops
9 group. They were currently being followed,
10 but mostly by SOCOM. That group was very
11 happy with the -- very pleased with the care
12 they were receiving from the SOCOM recovery
13 care coordinators, as well as the case
14 manager.
15 The only concern we walked away
16 with is that they did not have the same --
17 across the board all members did not have the
18 same opinion of the case managers from the
19 hospital, to include Bethesda and Portsmouth.
20 They felt as though the case manager was not
21 very visible in their care, which was
22 different from when you read our reports from

1 other commands. The case manager is usually
2 the lead and they speak highly of the case
3 manager.
4 So I think from that group the
5 main concern we walked away was that across
6 the board they did not -- every member in the
7 focus group did not speak highly of their case
8 manager, did not feel like they were a key
9 member of the transitional team. And so we
10 definitely want to address that issue.
11 The main concern was the second
12 focus group, the reserve unit. So the second
13 day we spent some time with the Reserve West
14 -- I think they're the East Coast Reserve
15 Unit. We would like to get a little
16 historical background on why the Navy has
17 separated the reserves into the East Coast,
18 West Coast. San Diego has a Reserve Medical
19 Unit and then Portsmouth has Reserve Medical
20 Unit. So if we can get a little background
21 from one of the members of the team, just to
22 hear why the Navy went to that model

1 CAPT. GIBBONS: Yes, ma'am. Can
2 everybody hear me okay?
3 It was a couple years ago and
4 there had become a lengthy time frame to
5 process a sailor from the reserve to a fit
6 condition. And so, a couple variables were
7 taken into place, or taken into account.
8 Those are fleet concentration areas that the
9 Navy feels are -- we can provide the finest
10 care available from the Navy to sailors in
11 those two places and fleet concentration areas
12 where typically most of the sailors are from,
13 reserve sailors.
14 Secondly, we spoke to
15 efficiencies. We were sending sailors home
16 and to local MTFs, and when you get to reserve
17 sailors in Montana or whatever, that becomes
18 very problematic and difficult. So it was
19 mostly first and foremost the best care that
20 we could provide and for efficiency.
21 CAPT EVANS: And the reservists,
22 they spoke to the care at Portsmouth, and I

1 would say 50 percent were pleased with the
2 care. There was some concern with continuity
3 of care, not being able to get in to see the
4 medical provider, not feeling as though the
5 appointments were available in a timely
6 manner.
7 And they used the word
8 "malingering" quite a bit and the staff there
9 and the reserve unit accused them malingering
10 and not wanting to get better. So I'm not
11 sure if that's because we have it in East
12 Coast, West Coast or if it's just the
13 environment of the unit. So that's something
14 you may want to go back and look in that unit.
15 CO-CHAIR GREEN: Can I just ask a
16 clarification? When they said that, are they
17 talking -- on the reserve sides there's kind
18 of a -- again, I'm going to speak to what I
19 know, but there's an issue with line of duty
20 being for a specific thing, and then basically
21 you finish that one up and then they put in
22 another line of duty. And so, when you say

1 "malingering," are they talking about
2 something along those lines where you have
3 issues that basically keep them on Title 10
4 orders for a longer period of time, or are
5 they talking about, you know -- you understand
6 what I'm saying.
7 CAPT EVANS: Yes.
8 CO-CHAIR CROCKETT-JONES: It
9 didn't seem to be related to that. People who
10 had had the accusation right to their face who
11 -- that they were malingerers, who had been
12 struggling to get appointments and their
13 appointment times being long, combined with --
14 these are reservists who could go home, some
15 of whom have jobs that would cover their
16 medical care. If they could leave and they
17 have no reason to stay except for that they
18 wanted to get their care from a military
19 treatment facility and wanted to, you know,
20 finish the process as it had started without
21 changing continuity of care and their trouble
22 not being their lack of resources or interest

1 in getting better, but -- and they're sort of
2 frustrated in the system through the care they
3 were receiving. And I don't think that it
4 was, you know, paperwork extending their stay.
5 I think my concern was that there
6 seemed to be this concept that they had to be
7 kept here at the reserve unit because they
8 needed these appointments, but they weren't
9 given resources as if they were serious
10 patients. You know, there seemed to be this
11 dual attitude of, no, you must be -- you can't
12 be -- you're serious enough so that you can't
13 go somewhere else for treatment, but then
14 choices to move their case manager or their
15 non-medical case management outside of the
16 arena making them harder to get access.
17 Choices were being made that said
18 you're not that serious, and then there's this
19 -- sort of this drum beat of you're
20 malingering. But at the same time, they
21 weren't being allowed to -- you know, the
22 decision was made that they had to be there,

too. Their choices seemed to be -- some people felt that they had to take their medical care there and under these conditions, or basically forego any treatment anywhere. You can, you know, get out and get on your own.

I found it to be that they were getting a very mixed message. You're too serious to go take care of this on your own. You're not serious enough for us to give you support.

CAPT EVANS: And one of the things that we found out from the group; and it's mentioned I think if we look at the instruction, this is a volunteer program, a medical. It's very volunteer. If they decide not to stay, they have to come out of their pockets to pay, I believe.

CAPT. GIBBONS: No, that's not true. But I'd like to start with a couple very important clarifications.

There are two separate and

1 distinct programs. The one you're talking
2 about, the sailors you visited are on medical
3 hold. They're on order. They're on active
4 duty orders. The second program, it's a
5 program, is called Line of Duty. That's not
6 synonymous with service connection injury.
7 It's a program. The Line of Duty Program is
8 a sailor goes home. They're cared for under
9 TRICARE and they can receive incapacitation
10 benefits, incapacitation pay for their lost
11 civilian income.
12 So it's common for a sailor to
13 come off a mobilization with an injury that is
14 not that serious; maybe a twisted ankle kind
15 of thing, and be on the Line of Duty Program,
16 receive TRICARE medical and incapacitation pay
17 for their lost civilian. And the point was
18 brought up that it is entirely true that
19 medical hold, staying on active duty is
20 completely voluntary. Any sailor that's on
21 medical hold can go home at any time under the
22 Line of Duty Program.

1 CAPT EVANS: What we're not clear
2 on, if they elect to go home, what type of
3 benefits and how long are the benefits
4 provided to these sailors? Because they're
5 under the impression as soon as they go home
6 -- I believe they have a certain timeline.
7 Then the benefits -- their medical care stops.
8 CAPT. GIBBONS: The programs are
9 -- although covered by different instruction,
10 are very much the same. The Department of
11 Defense Instruction 1241.2 outlines the Line
12 of Duty Program as a maximum of one year
13 before being processed to the Integrated
14 Disability Evaluation System. And so, we have
15 sailors on LOD for significantly longer than
16 that --
17 CAPT EVANS: All right.
18 CAPT. GIBBONS: -- because we're
19 trying to make them fit, which is the same
20 with med hold. So there is no really distinct
21 time other than by instruction to say you're
22 supposed to process through the IDES because

1 you're not going to become fit. You're
2 disabled.
3 CO-CHAIR GREEN: Do we have a DoDI
4 problem in terms of the one year for some of
5 these warriors that are requiring treatment
6 longer than that, or how are you extending
7 that?
8 CAPT. GIBBONS: Sir, I don't
9 believe so. That's my opinion as a line
10 officer. I'm not a doctor. We have a senior
11 medical officer that evaluates each case and
12 makes a decision as to medically whether or
13 not he believes the sailor can become fit or
14 is disabled and needs to process through the
15 Integrated Disability Evaluation System.
16 And when you look at it from a
17 civilian perspective, the sources that the
18 Navy uses, you know, disability advisor, that
19 sort of thing, I mean, you know, 90-something
20 percent of injuries that are going to get
21 better are going to happen within six months.
22 So I think a year is a pretty liberal time.

1 CO-CHAIR GREEN: Well, I mean, I
2 think I misunderstood what you were saying.
3 So basically, at the one-year point you make
4 a decision, but you don't have to take them
5 off Title 10 orders? You can leave them on
6 Title 10 orders?
7 CAPT. GIBBONS: That's true under
8 both programs.
9 CO-CHAIR GREEN: Yes.
10 CAPT. GIBBONS: Medical hold and
11 Line of Duty.
12 CO-CHAIR GREEN: Yes, just for the
13 panel, so there are -- this is getting a
14 little confusing, but on the reserve side you
15 have the folks who are actually -- receive --
16 are put on Title 10 orders while they're
17 getting their treatment, and then you have
18 another category, which is this incapacitation
19 pay. Incapacitation pay, they're not -- they
20 don't get full Title 10 benefits, but they get
21 some -- a lesser remuneration that basically
22 augments because they go back -- typically

1 they're back. I'm surprised that you're
2 giving INCAP pay while somebody's still
3 staying at the site, but maybe they live
4 locally. Typically, INCAP pay -- I thought
5 went while they were back home but not yet
6 able to go back to their job.
7 CAPT. GIBBONS: The last thing you
8 said is correct, sir. The programs are --
9 medical hold is Title 10 orders or active duty
10 orders. If they go home under Line of Duty
11 and are receiving TRICARE benefits, then they
12 are eligible for incapacitation pay, which is
13 lost civilian income.
14 CO-CHAIR GREEN: A very sensitive
15 issue for the reservists because while they've
16 got INCAP pay, it -- you know, we ran into
17 this in -- with one particular unit. They
18 don't necessarily have all the benefits. And
19 so they can run into problems while receiving
20 INCAP pay and still not necessarily being
21 eligible for when they run out of the TAMP
22 benefit, that they still can't get healthcare.

1 CAPT EVANS: Right, and that was
2 apparent with this group, that that's a
3 concern. If they elect to, you know, go home
4 and get off orders and try to get --
5 CO-CHAIR GREEN: So we're back to
6 the issue with the TAMP, really.
7 CAPT EVANS: With the TAMP.
8 CO-CHAIR GREEN: Yes.
9 CAPT EVANS: Right.
10 CO-CHAIR CROCKETT-JONES: But
11 there was another issue with the folks in med
12 hold, and that was that their families can't
13 be there. Their housing is for single -- for
14 individuals, correct? Wasn't that? And so,
15 long distance. They've been deployed for a
16 certain amount of time. They're going to be
17 healing for -- you know, they're only doing
18 this if they are serious enough to require
19 staying on active duty and they don't have
20 their families. That's another length of time
21 that they would separated. The divorce rate
22 in the group was startling.

1 CAPT. GIBBONS: That is true and
2 that is a valid concern that we consider. But
3 the answer always come full circle, which is
4 you have complete medical coverage and
5 incapacitation pay potential under the Line of
6 Duty Program. You can go home, and many in
7 fact do.
8 So the reason a -- a sailor makes
9 a choice to stay on medical hold typically
10 because it's better for them financially.
11 Maybe their civilian income is less. But they
12 can go home and collect incapacitation pay,
13 which is their earned civilian income, and
14 have TRICARE benefits at a local MTF, or even
15 civilian provider. We have 300 sailors in
16 that case.
17 CO-CHAIR CROCKETT-JONES: So,
18 well, my concern is that someone whose
19 injuries seriously -- as a reservist's
20 injuries who seriously need more care, their
21 only choice is to not get adequate care at
22 home and save their marriage, or come to -- or

1 stay in med hold and get the appropriate care
2 and perhaps end their marriage.
3 CAPT. GIBBONS: I disagree with
4 your statement of inadequate care. They have
5 TRICARE benefits at an MTF or a civilian
6 provider. We have 300 sailor on Line of Duty
7 Program receiving care.
8 CO-CHAIR CROCKETT-JONES: Then I'm
9 wondering why anyone is given the option if
10 everyone can get their care in the civilian
11 thing, why bother to have med hold at all?
12 Why not just -- do you see? I'm seeing -- I'm
13 having a problem with this sort of cut-off.
14 CO-CHAIR GREEN: Yes, let me see
15 if I can help a little bit. So the one thing
16 I'm a little confused -- make sure I
17 understand the way you folks see it. So when
18 they're on INCAP pay, are you saying that they
19 have the TRICARE benefit the full time, or
20 they have it only for the six months?
21 CAPT. GIBBONS: The entire time.
22 When you're under the Line of Duty Program,

1 you have an authorized Line of Duty, you have
2 TRICARE benefits and you're eligible for
3 incapacitation pay the entire time, including
4 while you process through the IDES.
5 CO-CHAIR GREEN: Yes, I'm not an
6 expert. I'm trying to still understand the
7 difference between full-up Title 10 orders and
8 INCAP, because they are different.
9 CAPT. GIBBONS: That's correct,
10 sir. When you're on orders, whether they be
11 Title 10 or ADT, a reservists on orders is on
12 active duty, period. When you're on Line of
13 Duty, you are not on orders. You are at home.
14 You are a civilian receiving TRICARE and you
15 put in a claim monthly for incapacitation pay
16 for your lost civilian income.
17 CSM DeJONG: Okay. We ran into
18 this issue in other places. On the reserve
19 side and on -- Guard or reserve; doesn't
20 matter, INCAP pay is not designed to hold a
21 soldier or sailor or anybody from an active
22 duty injury. It's designed for an injury

1 during their reserve time throughout their
2 month, their two weeks a year. And we're
3 constantly running into this, what I call
4 misuse of INCAP pay, of holding somebody, of
5 giving somebody INCAP pay for an injury that
6 was sustained while on active duty. INCAP pay
7 was not designed for that.
8 So along with that, one of my
9 concerns that I had brought up to Navy Safe
10 Harbor before was having just simply East
11 Coast or West Coast.
12 And the comment that you had made,
13 sir, was most of your reservists are in one of
14 those locations. What percentage would you
15 say of your reservists are East Coast or West
16 Coast?
17 CAPT. GIBBONS: Force-wide or that
18 are on orders?
19 CSM DeJONG: Well, what I'm
20 looking at is the guy from Midwest, Illinois,
21 that's a Navy reservist that ends up having to
22 make the decision right now of going to East

1 or West Coast to get care, or go on LOD to be
2 home. That's a tough decision. So what
3 percentage would you say of sailors is that a
4 fact of having to make that decision?
5 CAPT. GIBBONS: I'm sorry, I can't
6 -- I don't have the data to speak to that.
7 CSM DeJONG: Okay. My last
8 question real quick is you said at the 12-
9 month point they can make a decision whether
10 to stay on -- who makes the decision after 12
11 months of being in med hold that that sailor
12 can stay there? At what level is that
13 decision made?
14 CAPT. GIBBONS: First, I mean, the
15 decision could be made at any point. And it's
16 important to bring that up. You're not
17 automatically on medical hold orders for one
18 year.
19 Per instruction, at 12 months it
20 is supposed to be the maximum, without the
21 senior medical officers, and that's done at my
22 shop at PERS-95. Our senior medical officer

1 looks at the case and decides whether or not
2 the case needs to go to IDES or continue for
3 care, being that they believe the sailor can
4 still become fit.
5 MR. DRACH: Can I follow up on a
6 question on the LOD and the incapacitation
7 pay? As I understand you, somebody's on LOD.
8 They go home. They're a civilian. Do they
9 get a DD214?
10 CAPT. GIBBONS: Yes, sir, they do
11 at the NOPS site when they demob.
12 MR. DRACH: Okay.
13 CAPT. GIBBONS: That's correct.
14 MR. DRACH: Okay. So now they're
15 a veteran. They can file a claim for VA
16 compensation. If they are awarded VA
17 compensation, how does that impact the
18 incapacitation pay or vice versa?
19 CAPT. GIBBONS: The VA
20 compensation piece would come only after the
21 Line of Duty. It's the Navy's responsibility
22 to try to make the sailor fit or process them

1 through the IDES where then they would receive
2 VA payments for their disability.
3 MR. DRACH: Okay. So they can't
4 get it concurrently?
5 CAPT. GIBBONS: That's correct.
6 MR. DRACH: Just like severance
7 pay. When somebody gets out on severance,
8 that would have to be recouped before they get
9 their VA compensation. So it's kind of a
10 trade-off.
11 CAPT. GIBBONS: That's correct.
12 MR. DRACH: Now do you have any
13 idea how the incapacitation pay compares to VA
14 compensation dollar-wise?
15 CAPT. GIBBONS: Incapacitation pay
16 is up to full pay and allowance.
17 MR. DRACH: Up to full --
18 CAPT. GIBBONS: So if a sailor is
19 unable to work at all, then that sailor would
20 receive full pay and allowance. If not, they
21 would -- if they can work; maybe they have,
22 like I said, a sprained ankle and they do a

1 desk job, they can go back to their place of
2 employment and work maybe part time, but they
3 receive incapacitation pay for their medical
4 appointments, as an example. That would be at
5 the rate of their civilian income.
6 MR. DRACH: Okay. I think. So
7 I'm on incapacitation pay $1,000 a month and
8 I go back to my job or get a new job and I'm
9 making $2,000 a month. So the $1,000 from
10 INCAP pay is offset, is that correct? I can
11 get both.
12 CAPT. GIBBONS: I think it's
13 really not that complicated in that it's your
14 lost civilian income. Whatever you would earn
15 as a civilian is what you would be paid
16 incapacitation pay up to full pay and
17 allowance. So if Bill Gates were a reservist,
18 he would not receive his income. He would
19 receive full pay and allowance for his rank
20 rate.
21 CO-CHAIR GREEN: Okay. The
22 difficulty is that you actually -- you don't

1 receive -- like you would an active duty
2 check, you don't get it all the time. You
3 have to file for it every month.
4 CAPT. GIBBONS: That's correct,
5 sir.
6 CO-CHAIR GREEN: Right. So I
7 think what we need is from our staff -- why
8 don't we get clarification and get them to
9 give us the rules on INCAP pay versus Title 10
10 so we understand fully what the differences
11 and the benefit are. So rather than --
12 because this is true for all the services.
13 One thing I think that is
14 important that folks understand, although some
15 reservists can seek care through the VA, when
16 you actually look at this, I don't think that
17 they can actually just get routine VA care
18 when they're an active reservist. Okay. So
19 when I say "an active reservist," I don't mean
20 active duty. I mean while they're just in
21 regular reserves. I think there are
22 restrictions on what care they can get, but

1 again, I'm not an expert on the VA. When
2 they're in an inactive reserve status or ready
3 reserve, you know, those kinds of things
4 typically are also people who retire going to
5 a reserve -- and so therefore, they are
6 eligible for veterans benefit.
7 But again, we might want to get
8 clarification from the VA as to which
9 reservists are eligible for care in the VA.
10 If they're getting compensation from active
11 duty, then TRICARE tends to pay for it, if
12 they actually have the TRICARE benefit. So
13 it's a little confusing with an overlap of
14 benefits here and it might be best to have the
15 staff get us the actual rule sets and talk.
16 And one other thing I wanted to
17 point out is -- so we're not as familiar with
18 the Navy system; or at least not everybody at
19 this table is, and so when you say you're from
20 PERS-95 or --
21 CAPT. GIBBONS: Yes, sir, Navy
22 Personnel Command in Millington, Tennessee.

1 CO-CHAIR GREEN: So I'm assuming
2 that's like our Air Force Personnel Center.
3 So you folks are really making decisions on
4 medical boards and IDES. I mean, they make it
5 locally, but then they send it up to you for
6 decisions on retraining and for decisions on
7 -- or not?
8 CAPT. GIBBONS: Sir, we're Navy
9 Personnel Command. We do not make medical
10 board -- we're not medical board, we're not
11 BUMED, we're not the IDES. No, sir.
12 CO-CHAIR GREEN: Correct. But who
13 does your PEP function?
14 CAPT. GIBBONS: That's done here,
15 sir. We don't do that.
16 CO-CHAIR GREEN: Ah, so you don't?
17 Okay.
18 CAPT. GIBBONS: Yes, the same as
19 the active force.
20 CO-CHAIR GREEN: Okay.
21 CAPT. GIBBONS: Council of Review
22 Boards.

1 CO-CHAIR GREEN: Okay. All right.
2 I think I understand. So you're solely a
3 reserve personnel unit then?
4 CAPT. GIBBONS: Navy Personnel
5 Command is an active command. We are reserve
6 personnel management. We are a code of Navy
7 Personnel Command. So the people that do what
8 we do for active duty are right upstairs.
9 There PERS-8. We're PERS-9.
10 CO-CHAIR GREEN: Got it. Okay.
11 CAPT. GIBBONS: We're the medical
12 benefits issuing authority.
13 CO-CHAIR GREEN: Okay. So you
14 make the decisions on who get INCAP and who --
15 CAPT. GIBBONS: Yes, sir.
16 CO-CHAIR GREEN: Okay.
17 CAPT. GIBBONS: And process.
18 CO-CHAIR GREEN: Got it.
19 CO-CHAIR CROCKETT-JONES: Okay.
20 So my question now is, so they've been in med
21 hold, and at a year they are going to be
22 referred to IDES and their appointment starts.

1 So now they have to complete IDES at med hold
2 as well?
3 CAPT. GIBBONS: They do not have
4 to, but most do.
5 CO-CHAIR CROCKETT-JONES: So how
6 would they go about if they opted not to
7 complete their IDES at -- who -- where would
8 they be referred to complete the appointments
9 and to get a PEBLO without being in med hold?
10 CAPT. GIBBONS: You know, you
11 brought up a good point, which is continuity
12 of care. And I would hate to see a sailor say
13 at that point that I want to go home. Because
14 it's a continuity of care and the med board
15 and all those things it would be problematic.
16 But they could. They can go home under the
17 Line of Duty Program and we would set them up
18 with an LOD and a PEBLO and all those things
19 you just mentioned, which does happen under
20 Line of Duty.
21 CAPT EVANS: You may want to look
22 at that process, because once they sign that

1 NARSUM, usually the appointments are minimal.
2 And so, that may be a point that you can
3 transition back to Line of -- you know,
4 transition back home. Something to consider.
5 I know the Army does that. When they sign a
6 NARSUM, they are considered to go -- they're
7 able to transition.
8 CAPT. GIBBONS: And I know that
9 that is something that Reserve Forces Command
10 Captain Paver is looking at --
11 CAPT EVANS: Okay.
12 CAPT. GIBBONS: -- the ability to
13 go home in the IDES. We don't do that today,
14 but it's on the table.
15 CAPT EVANS: One of the questions
16 I have is that since this change in the
17 process of reserves -- so you've moved to the
18 East-West hospitals. Do you find that to be
19 an efficient method of taking care of the
20 reservists? Is it cost effective? Are we
21 providing them the care that they need in a
22 timely manner, or are they there too long?

1 Are they getting lost in the system?
2 CAPT. GIBBONS: I'm sorry, I
3 missed the beginning of that question. You
4 said we're transferring people?
5 CAPT EVANS: No, since you
6 transitioned it, since you went into this new
7 process. I think it's been in effect for two
8 years that you --
9 CAPT. GIBBONS: Yes, ma'am.
10 CAPT EVANS: -- right, that you
11 have the reservists either at the West Coast
12 or East Coast facilities. Do you find this is
13 an effective process as far as managing the
14 reservists? Do you find that it's cost
15 effective and that you're getting their care
16 in a timely manner and getting them back to
17 where they need to -- back to home?
18 CAPT. GIBBONS: I would start with
19 a yes to that on a couple statistics. Cost,
20 I don't look at. I'm not sure anybody
21 actually looks at the cost. But what we do
22 look at it is the time it takes for us to get

a sailor back home to their family. Before we started the process, it was 440 days. It dropped to 220 days. It's now right at one year because of the Integrated Disability disabled Evaluation System, which you know takes more time. But certainly at worst case went from 440 to 365 today.

CAPT EVANS: Okay. That's good. Could we get that data from Navy? That would be good to see.

CO-CHAIR GREEN: Sure. The other question, going back to the family. So for someone who's got a more catastrophic injury, do you offer PCS for the families for reserve soldiers?

CAPT. GIBBONS: No, sir, they're not entitled.

CO-CHAIR GREEN: And so, if you have somebody who's catastrophic injury going to go into one of your transition units for a longer period of time, I guess my question is; they're on Title 10 orders, why wouldn't you

1 offer them PC -- now, I realize many people
2 would decline it based on where their housing
3 is, etcetera, but I'm not sure I understand
4 why it would be not offered.
5 CAPT. GIBBONS: Sir, you know, I
6 can't 100 percent answer that, but I believe,
7 it's my belief that they're not entitled under
8 the law to a PCS.
9 CO-CHAIR GREEN: I'm struggling a
10 little bit. So they're on Title 10 orders.
11 They're actually active duty because you
12 haven't demobilized them.
13 CAPT. GIBBONS: Well, actually
14 they're on a different order. They're not on
15 their mobilization order. They're on a
16 medical order. So the orders do change.
17 They're still -- if they are from theater
18 demob, you're correct, they would still be
19 Title 10 orders, but they're not the same
20 orders. They're ordered to a medical hold
21 site TDY.
22 MR. DRACH: Well, if they're not

1 under Title 10, what authority are they under?
2 CAPT. GIBBONS: They are under
3 Title 10, but it is a different set of orders.
4 They're demob'ed and they go from 12.301 to
5 12.301(h).
6 CO-CHAIR GREEN: So if I can help
7 just a little. So with active duty one of the
8 reasons that they may be on TDY orders is that
9 that changes the amount of money that they
10 receive. So now when the families come and
11 visit, they get dollars for being a medical
12 tenant including per diem and a whole host of
13 things. Whereas if you PCS them, then you run
14 into troubles in terms of them being able to
15 maintain a household. Because once they PCS,
16 it changes their housing allowances, etcetera,
17 to the new location.
18 On the reserve side, is it their
19 same -- the TDY orders, is that to basically
20 augment or to make certain they get the
21 maximum benefit? Because I kind of understand
22 what you're saying and yet I can think of

1 cases where the person is not going to leave
2 active duty until they've gone through the
3 IDES, which, you know, hopefully takes a year,
4 but could take longer depending on when they
5 hit their max medical benefit. And so, you're
6 still not offering those families the ability
7 to join?
8 CAPT. GIBBONS: That's accurate,
9 sir. And I can't speak as a Title 10
10 authority, but I don't believe any -- I don't
11 know of any reservist that's entitled to that.
12 I myself am a mobilized reservist at PERS-95
13 and my family is in Illinois and I'm in
14 Millington, Tennessee. And cell res are not
15 authorized to make a permanent duty station
16 change or a PCS.
17 CSM DeJONG: The Army does
18 authorize it. It's just basically -- if I'm
19 -- when I was at Fort Knox, Kentucky, I could
20 continue to get my VAH from my home of record,
21 if I wanted. Now if your family -- if you're
22 going to be there two, three, four years, you

do have the option to PCS your family there and then it changes -- your VAH then changes to Fort Knox region. But the Army does authorize it.

LTCOL KEANE: The Marine Corps does, too, and actually they encourage it. It's cheaper.

CAPT EVANS: So would that be a service-specific instruction? Then unauthorized? I would think it would be a joint instruction that says --

CO-CHAIR GREEN: I think it's the type of orders that you're issuing. I do think that it's an issue with the type of orders, if you're giving someone orders in terms of a TDY versus you're giving somebody orders in terms of a PCS. And the orders for a PCS really have to do with how long you're expecting someone to be there, but I could be wrong. But I don't think the other -- if it was a DoD problem, DoD instruction problem on how we do this, you wouldn't hear differences

1 between services.

2 CO-CHAIR CROCKETT-JONES: And am I

3 right in remembering, you know, or getting the

4 impression that the housing that they are

5 given is not really large enough to facilitate

6 families coming to visit them in their own --

7 in the rooms they were given?

8 CAPT. GIBBONS: I'm sure that's

9 accurate, ma'am.

10 CAPT EVANS: That's correct. And

11 if we could ask that we look into that,

12 because one of the issues with this unit --

13 the divorce rate. I mean, you're talking

14 about a greater than 50 percent of the members

15 in the unit going through a divorce. And so,

16 if we could look at -- if, you know, PCS'ing

17 the families or -- you know, and I know again,

18 they reminded me, this is a volunteer. But if

19 they're there for medical care, it would be

20 nice if we can get the families in that area.

21 CSM DeJONG: Well --

22 CO-CHAIR GREEN: Again, why don't

1 we get some clarification from the staff on
2 what the rule sets are for PCS of reservists?
3 Okay. So a permanent change of station. So
4 I think this is going to find -- we're going
5 to find that this an orders issue and what
6 type of orders are being done. But let's go
7 back and look at the DoDI and find out what
8 the actual rule sets are.
9 MSGT MacKENZIE: Sounds to me like
10 the biggest challenge you see here though is,
11 you know, making it voluntary is you can
12 either get this up here, or you can go ahead
13 and settle for whatever that is. No fault of
14 the Navy per se. Because, you know, if I
15 worked in a gas station back home and got
16 mobilized and I'm making E7 pay, you know,
17 that's for six months, eight months. I mean,
18 that's a heck of decision to make to go, hey,
19 I got to go back and work at a gas station
20 where I was temporarily employed. Also four
21 years at the bedside working with guys and
22 their families. I mean, you know, we do need

1 to see the rules so we're making the right
2 recommendations.
3 But at the same token, I mean, PCS
4 isn't always the answer. You're not going to
5 be able to sell your house. There's a lot of
6 things that go with just PCS'ing. And in
7 many, many, many cases that was turned down by
8 the individuals that I dealt with because of
9 that reason. I mean, that's home. I am not
10 giving up my home. But what they're looking
11 for is how do I offset the cost? How do I
12 offset the emotional, the family cost while
13 trying to get the medical care I need while
14 trying to support my family?
15 But if I go home, now every month
16 I have to go through this process of
17 submitting this application and I have to go
18 through and prove all this stuff. And, oh, by
19 the way, I have PTS and I'm on all kinds of
20 drugs and I'm trying to figure this stuff out
21 and my wife doesn't understand. And, I mean,
22 we got to look at this from the perspective of

1 the patient and the family dynamics.
2 I mean, sir, you're very eloquent
3 in being able to give us that information in
4 those regs, but it's sounds like from the
5 visit that that information, by the time it
6 gets trickled down to the individual, isn't so
7 clear and concise and their options aren't so
8 easily understood, or aren't so well
9 understood across the board. And but, you
10 know, so there is -- we do have a lot of
11 challenges here in what recommendation make,
12 because there's a lot of dynamics here that
13 aren't any fault of the service, but the
14 options given these sailors doesn't take that
15 into account either.
16 CO-CHAIR CROCKETT-JONES: Yes, if
17 the option to PCS is not really viable, but
18 there's no way to really facilitate visiting
19 your family either, you know, you've given
20 them no win on that front. If family can't
21 come and stay and visit and they can't travel
22 back to family easily, you know, then you've

1 basically made them choose between -- you
2 know, you've thrown the family under the bus
3 on that, in my opinion, and that's just
4 untenable.
5 CSM DeJONG: But we do have to
6 figure out the exact regulation and usage of
7 INCAP pay. Across the forces we have to
8 figure it out, because it goes as far as --
9 there's multiple congressionals out there for
10 what INCAP pay is supposed to be used for
11 versus what it's being used for.
12 CO-CHAIR GREEN: I agree, and I
13 think this is a very complex issue. That's
14 why I was trying to get the staff to go back
15 and get some of the rule sets. Most families
16 will opt to stay with their support systems.
17 And so, a reserve family -- more than likely
18 it will be a very, very rare case where
19 someone wants to PCS as a reservists, and it
20 would have to do with a very extended recovery
21 time. And of course we're trying to solve
22 that with the IDES and getting people back to

1 wherever their long-term care is going to be.
2 So I suspect it will be very rare
3 that you'd ever need to use a PCS, and yet we
4 have seen some cases where people are on
5 extended recovery. I mean, so think about a
6 triple amputee. And so where they may be
7 needing to be somewhere for several years and
8 the question becomes -- then it's an issue for
9 the family as to where their resources are
10 best to support the family. It may still be
11 better for them to stay with their support
12 system at home, and even for financial reasons
13 because of the way that the TDY reimbursement
14 actually augments the dollars for the member
15 who's -- you know, etcetera, etcetera.
16 So it's complex. That's why I
17 think we need to understand the rule sets.
18 And you guys understand them better than we do
19 because you deal with it everyday. So we just
20 need to make sure the members here understand
21 what you're dealing with in terms of the rule
22 sets.

1 MS. DAILEY: Let me get you to do
2 one more question.
3 CAPT EVANS: Okay.
4 MS. DAILEY: And then we need to
5 wrap for the break. And why don't we talk
6 about non-medical case management, if we can?
7 CAPT EVANS: Right. So when we
8 visited with the reservists, we found the case
9 managers were well imbedded into the reserve
10 unit. We found they had C2 there, also. We
11 did not see Safe Harbor. They come to visit,
12 I think I heard, monthly or occasionally. But
13 the members there were not on the recovery
14 transition plan, so they never heard of the
15 plan, nor had recovery care coordinators
16 really sat down with those members to talk
17 about going back home, get to the family,
18 financial issues. So that was -- we'd like to
19 hear from Safe Harbor. What's your process
20 for taking care of the reservists?
21 CDR. VARIAS: Ma'am, for Safe
22 Harbor we looked at the med hold numbers that

1 were provided for us by Commander Goldschmidt.
2 Of the 60 names, 29 of the service members
3 were either -- provided assistance from Safe
4 Harbor. Eleven of them are actually enrolled.
5 So, you know, I'm not exactly sure where you
6 received your information that Safe Harbor
7 wasn't providing assistance to the -- so we
8 have presence there. We have currently four
9 non-medical care managers, Safe Harbor care
10 managers in the Portsmouth and Norfolk area
11 providing a presence. So I'm confused on --
12 CAPT EVANS: Right. So used to
13 have one that was actually located at the
14 reserve unit. And across the board, every
15 reservist in the room said they had no contact
16 with a recovery care coordinator. And that
17 was -- I think we had 11, 10 or 11. I can't
18 remember the exact number of the focus group,
19 but across the board. So I'm not sure where
20 the disconnect -- I know you use to have one
21 that was right there in the unit and they
22 relocated that individual back to the

1 hospital, and now that individual goes back
2 and forth.
3 So I think, you know, we just need
4 to ensure that reservists are afforded the
5 opportunity to have a non-medical or a
6 recovery care coordinator, that they have some
7 time of transition plan. The case managers
8 typically don't work with the transition plan.
9 That's usually the recovery care coordinator.
10 The case managers were doing a lot of
11 administrative assistance with that group
12 there, but I think if you, you know, return to
13 imbedding one there actually at the unit, we
14 may see more than the 11. We may see the
15 entire unit feel like they have the assets to
16 a recovery care coordinator.
17 CO-CHAIR GREEN: The mismatch
18 between 60 that didn't and only 11 that didn't
19 have a non-medical case manager and what
20 you're saying bothers me a little bit. Are we
21 sure that the people who we interviewed knew
22 who the RCCs were? I mean, was it by name

1 or --

2 CO-CHAIR CROCKETT-JONES: Yes, and

3 I think that considering that a portion of the

4 people in our focus group were going through

5 the IDES process, my take on it would be that

6 they probably should have been at the level --

7 at least two and possibly more like four

8 should have been at the level to have had some

9 sort of non-medical case management

10 assistance.

11 CAPT EVANS: Some of them, they

12 knew the person that was there before. So

13 they mentioned we used to have a recovery care

14 coordinator here. Then they -- because that's

15 how we found out the individual was

16 transferred back to the hospital. And so,

17 they were fully aware of that individual and

18 the role that that individual pertained to

19 transition. But they clearly said there was

20 no one. When that member was transferred back

21 to the hospital, they felt like there was a

22 gap. They didn't have that service provider.

1 CO-CHAIR GREEN: And so as the
2 numbers get smaller, a lot of people are
3 centralizing their RCC support. And so, is
4 that what you're telling us, is that they
5 weren't necessarily feeling that they had the
6 central support from an RCC?
7 CAPT EVANS: Exactly. I guess the
8 reserve unit had larger numbers there before.
9 And once the numbers started getting a little
10 bit smaller, the decision was made to put that
11 number over to the hospital by just keeping
12 that recovery care coordinator at the reserve
13 unit.
14 CDR. VARIAS: Ma'am, that's
15 correct, absolutely. Like on the West Coast,
16 my understanding maybe two or three years ago
17 they had over -- between East Coast and West
18 Coast over 400 of them at med hold. As they
19 dwindled down specifically for the East Coast,
20 we're talking 60 that are in med hold, in Med
21 Hold East. So as those numbers decreased,
22 leadership determined -- Safe Harbor

1 leadership determined that our focus and our
2 mission is to provide support to wounded, ill
3 and injured that are seriously wounded, ill
4 and injured, category 2s and 3; based on the
5 DoDI instruction, that our focus is there.
6 Where, you know, the 60 members, not all of
7 them were considered seriously wounded, ill
8 and injured.
9 MSGT MacKENZIE: That's a
10 difference you guys see. I mean, you know, in
11 what you saw there. You know, it's that
12 advocacy, that direct contact, the resources
13 available, if they're educated enough to
14 realize there's a resource available to them
15 for the questions. But they're not all
16 actually enrolled because they only -- they
17 have to achieve a certain level of injury in
18 order to be enrolled, whereas with some
19 organizations, especially mine, it's 100
20 percent across the board and they're being
21 contacted and they're tracked. So that's
22 probably the difference that you saw there.

1 But that's the challenge. I mean,
2 with all the services, that's the challenge as
3 to how far do you go with this? But it's, you
4 know, the 60 folks there and if the 11 that
5 were in the room with you weren't qualified,
6 it kind of makes it a challenge to get a good
7 cross-section information on this one.
8 CO-CHAIR GREEN: I think we're
9 going to see -- you know, I mean, as time goes
10 by -- so the area -- when we look at these
11 things and see the numbers, I think that we
12 want to make certain that some of the
13 processes are codified. So in other words,
14 you want to RCC that's basically overseeing
15 this, but whether it's centralized or
16 decentralized, I don't know that that matters
17 to us. In the focus groups we may hear that
18 they no longer see the individual, but that
19 doesn't mean that they're not having phone
20 contact or somebody who is available to them.
21 We have to think about sustainability of these
22 programs eventually.

1 CO-CHAIR CROCKETT-JONES: Well, I
2 think that the other thing that we need to
3 look at is what is the criteria that gets
4 someone that advocacy versus someone who's not
5 considered serious enough. I know that for
6 instance the Army uses readings level to
7 discern, but that means someone has to be --
8 and they can postpone getting someone the AW2
9 advocate until they are practically out. You
10 know, it's how the criteria are implemented.
11 So if someone, you know, doesn't -- you know,
12 takes -- spends a year in WTU before getting
13 a rating, that's a year of not having that AW2
14 advocacy.
15 But the other thing is that, you
16 know, we have to start looking at everyone is
17 supposed to have a CTP or a CRP, and the
18 Secretary of Defense has said that the RCC is
19 the person who is responsible for that
20 document. And if we are saying that we have
21 -- people are not meeting criteria to get an
22 RCC, we have a disconnect. And it's that same

1 disconnect that I see in the basic concept of
2 these people have been sent to med hold, but
3 they're not serious enough to warrant
4 advocacy. Their families can't come to them.
5 They're just seems to be a disconnect between
6 intention and --
7 CO-CHAIR GREEN: So let me ask you
8 guys to tell us how you do it. But as you
9 centralized your program, which it sounds like
10 you did, my guess is that you still have some
11 type of a transition plan for these folks.
12 But now it's basically something that the RCC
13 is essentially watching and the question
14 becomes how knowledgeable are the patients
15 with regards to what the RCC may be putting in
16 the transition plan?
17 CDR. SHAPIRO: Well, yes, I mean,
18 sir, so when I heard about this -- I know that
19 care managers who are currently at Fort Smith
20 pretty well. I knew the person that used to
21 work at the med hold, because she used to call
22 us some stuff that was pretty interesting.

1 But, you know, my first question when -- so 60
2 people and then asking Lieutenant Noriega,
3 well have we seen any of these 60 people? And
4 his response was, well, we're providing
5 assistance to about half of them.
6 Okay. Well, there's obviously --
7 so my next question was, I know that there's
8 not a full-time human being sitting in the med
9 hold anymore. So I contacted the people at
10 the med hold and actually talked to them face-
11 to-face at a recent meeting and said, well, we
12 don't have a commander sitting there anymore.
13 How do you guys interface with the med hold
14 because there seems to be some sort of
15 disconnect? And I know that some of these
16 people are enrolled because they've talked to
17 me about it. And I said this is important.
18 So they told me they visit about
19 once a week. Okay. What is your relationship
20 with the command, which is pretty important.
21 The RCC has a chain of command and the chain
22 of command has a responsibility to the

1 members. And our relationship with that chain
2 of command is really important because the
3 chain of command can help us identify people
4 with issues or identify people that maybe we
5 missed. Because you know, what, no one's
6 perfect. But the first people that may be
7 aware of someone who's a little bit more
8 serious might be the chain of command. You
9 know, it's a medical component there. Our
10 people are non-medical. So they said that when
11 they go over there, part of that process is
12 sitting in on a meeting with the chain of
13 command to talk about who's there. And I
14 think this is a good thing. This isn't a bad
15 thing. You know, a lot of the people there --
16 you know, I like it when they don't need much
17 from us because that would suggest that
18 they're not seriously wounded, ill or injured
19 as in a category 2 or 3.
20 Does that mean that we don't help
21 people? I mean, my own experience and also in
22 interfacing with them is sometimes people will

1 be asked a question about something and then
2 be directed to use another resource that
3 exists to help them. I mean, fortunately or
4 unfortunately, for an immediate example,
5 there's a reserve unit out there that calls me
6 with all sorts of stuff simply because I seem
7 to be able to help their problems. They'll
8 call me with patients with low back pain and
9 stuff that they don't -- they're clearly not
10 seriously wounded, ill or injured, but you
11 know, our organization is pretty good at
12 still, hey, what do you think? Well, you
13 know, there's this asset or that asset.
14 I mean, one thing that we can
15 never forget; and I was a GMO and I had
16 responsibility for individuals that worked for
17 me, is there are resources out there, outside
18 of Safe Harbor also, that are pretty critical
19 in helping people in general in terms of
20 getting people assistance with life outside of
21 medicine.
22 So I thought that (A) it was

1 important to understand, well, are any people
2 -- are we helping those people or not? And
3 the answer was at least in the system we have
4 some objectivity. (2) What's our relationship
5 with our people in that area, which is -- you
6 know, it's pretty spread out. Getting around
7 there with the bridges and stuff can be
8 somewhat nightmarish. But what's our
9 relationship with -- our organization with
10 that chain of command? Because just as
11 important as kind of searching the individuals
12 is to have a good relationship with the chain
13 of command in charge of all these people,
14 because that allows you to kind of sit down
15 and provide them more team approach to, you
16 know, we're an asset to help out with the
17 people there.
18 But certainly, you know, I know
19 that our organization help people that don't
20 necessarily strictly meet the criteria. I
21 spend a fair amount of time on it, so --
22 CO-CHAIR GREEN: The mismatch.

1 Okay? Because what you're describing is going
2 back to a more routine system of the medics
3 caring for the people who are there and that
4 relationship with the line. But the mismatch
5 is that by the Wounded Warrior Program, by
6 what's published, there should be a
7 comprehensive transition plan or recovery plan
8 that's managed by the RCC. And so, if you're
9 not going to have the RCC; and I suspect you
10 do have the RCC, then the question is where is
11 the comprehensive transition plan?
12 And part of the issue that goes on
13 for this group is we find; not just Navy, but
14 across the board, that frequently the patients
15 are not very much aware of this comprehensive
16 transition plan. And so, what we're trying to
17 figure out is, okay, is that really going to
18 be the way DoD manages it, or is that what
19 they put on paper? Okay. And yet that's not
20 necessarily what's being done.
21 It makes sense for us to have a
22 comprehensive transition plan for people who

1 have serious enough injuries. Now the
2 question is, okay, as those programs get
3 smaller, as we do some centralization,
4 etcetera, where is that comprehensive
5 transition plan or recovery plan; I'm not sure
6 which one the Navy uses in terms of an
7 acronym, but CTP or CRP, whichever one it is.
8 Who's maintaining that? Who's filling it out?
9 Who's tracking it? And therefore how do we
10 make certain the patients know where to go to
11 ask questions about that comprehensive plan?
12 I think that's where Suzanne is coming from.
13 CAPT EVANS: Right. As far as the
14 centralization of the staff, that's fine. I
15 think what we were just really wanting to hear
16 from the service member, from the recovering
17 service member, that they were on a plan, they
18 had a comprehensive recovery plan, and they
19 could go to that point of contact, whether it
20 was the -- it's supposed to be the RCC, and,
21 you know, sit down with that plan as far as
22 getting reintegrated back to where they -- you

1 know, to home. So that was the concerning
2 part, not that the staff was relocated back to
3 the hospital. And across the board the
4 service member can do that.
5 CO-CHAIR GREEN: There's not a
6 single program that works this CRP and there's
7 not something that makes it available to the
8 patient easily. And so, you know, you can
9 make this an IT argument. The problem is that
10 the Department said it was going to do it a
11 certain way and we're struggling to see how
12 that's being implemented.
13 MS. DAILEY: We need to wrap.
14 We're well past your break and into our next
15 briefer's time period.
16 CO-CHAIR GREEN: Okay. So we're
17 going to take a short break. Thank you,
18 gentlemen, for coming over and talking with
19 us.
20 So let's take a 10-minute break.
21 Come back at five before the hour. Okay?
22 Thank you.

1 (Whereupon, at 9:45 a.m. the
2 above-entitled matter went off the record and
3 resumed at 10:00 a.m.)
4 MS. DAILEY: Ladies and gentlemen,
5 the good news is we are 15 minutes behind, but
6 the better news is that I do not have a
7 briefer at the 10:45 event. So you have some
8 leeway here to continue discussions with Dr.
9 McDonald. And not that we want to wear him
10 down, but I do have time at the other end.
11 So, please, do not feel compressed to truncate
12 your very important questions. Thank you.
13 CO-CHAIR GREEN: So let me get us
14 started here. So with us now is Dr. Clement
15 McDonald, the Director of the Lister Hill
16 National Center for Biomedical Communications
17 at the National Library of Medicine.
18 Thank you, sir, for joining us
19 today.
20 He has a long 40-year research
21 interest in electronic medical records. Forty
22 years. I'm very impressed. And so his work

1 includes development of the Regenstreif
2 Medical Records System that involved into the
3 Indiana Health Information Exchange, which now
4 carries 4 billion discreet results from more
5 than 30 hospitals and 7 million patients. Dr.
6 McDonald has authored more than 300 journal
7 papers, including randomized clinical trials
8 showing the benefits of electronic data,
9 clinical reminders and physician order entry.
10 He was the second president of the American
11 Medical Informatics Association and is now a
12 member of the Institute of Medicine.
13 We have asked Dr. McDonald to
14 provide us an outside look at the current
15 initiative of the Interagency Program Office
16 to overhaul the electronic health records at
17 both DoD and the VA. You can find the
18 information for this briefing in tab C.
19 Dr. McDonald, it's a pleasure to
20 have you here.
21 DR. McDONALD: Thank you. A
22 couple of things. I may have too much

1 technical stuff in these slides, so don't feel
2 obliged to read it all. But we'll go through
3 them.
4 But I wanted -- I had an
5 interesting experience flying back from Europe
6 last September. I sat next to a Marine. And
7 this guy was a wonderful person. He was a
8 specimen. Good looking, bright. Everything
9 about him you were proud. And he was three
10 tours in Afghanistan, or maybe one tour in
11 Iraq. And he kept talking about how I don't
12 want to -- a lot of guys in my position, they
13 go into FBI. I don't want to fight anymore.
14 You know, he was kind of depressed. I guess,
15 a little bit depressed.
16 And then a guy came up. I was in
17 an aisle, big aisle that goes right out the
18 door. It was back in economy. My wife was in
19 business class. And so, this guy came up and
20 sort of squatted down talking to him. And he
21 was another Marine. And, you know, he was
22 older. Maybe 40. This guy was only 29 or 30.

1 And the guy looked at him and said -- he was
2 talking and talking. He says you don't
3 remember me, do you, the guy that squatted
4 down in front of him. He goes, no, sir, I
5 don't. And he got up and he said, well, we
6 fought together for a year, last year.
7 So this is, you know, one of those
8 injuries. You know, he did recognize him.
9 And they went on and I left my seat. Let him
10 sit down there. Went up to -- I was sitting
11 next to my wife. They kicked me out of
12 business class when I tried to do that. But
13 anyway, I let him -- they talked for half an
14 hour. I wandered around the plane.
15 But, you know, so and then we
16 talked a lot. I said, you know, there's some
17 things that can be done and you ought to, you
18 know, get direct care. And I gave him my
19 phone number and stuff and I said there's
20 actually a program with the Navy. He's in
21 Virginia. So he never called me. So, you
22 know, I kind of feel the process here after

1 that experience and I understand what we're
2 talking about.
3 Now I'm going to talk about
4 computer systems, which are pretty mundane
5 compared to these life things, you know, that
6 are not, but all mundane. And I have maybe
7 pessimistic thoughts about information
8 systems, having worked with them all my life.
9 And maybe at some risk I should start out --
10 let me get this to the next slide. This is
11 all my own idea. This is nothing to do with
12 NLM, HHS or anybody else official. These are
13 personal opinions, to get that on the table.
14 I understand this is all recorded, so I can't
15 deny it or I shouldn't say as much as I might
16 otherwise say.
17 So I'm going to start out talking
18 about what I think is the big challenge and
19 why it's so tough. So you've got -- and I'm
20 oversimplifying. So you've got -- and that
21 is, trying to get this clinical data moving
22 around is one of the challenges. And we

1 organize stuff with specific focus on the
2 wounded warriors.
3 So you've got two very large
4 systems and extraordinary large systems with
5 lots and lots of historic data. I mean 30 --
6 I don't know, at least 30 years in the VA
7 system. Both have many separate local
8 systems. A hundred seventy VA -- I don't
9 know, a hundred -- over a hundred seventy, I
10 think, military. I'm not counting -- you
11 know, counting worldwide it's probably 200 or
12 so. And there are a lot of local variations
13 and specializations for various reasons.
14 And the goal is to create --
15 either merge the two; I know that's been
16 historical, or else create this new system,
17 new even better system. But, you know, keep
18 the trains running all at the same time. You
19 know, keep all the other care going. So
20 you're going to have -- think about having,
21 you know, a high-speed train. You're going to
22 build on the same track as a regular train.

1 And you keep everything going, you know, at
2 the same time. You can't just shut down for
3 five years and come back when it's done. And
4 you want to create one happy unified entity.
5 So this is just to emphasize the
6 size. And I may not be accurate on all these
7 numbers, but the VA treated 5 million patients
8 in 2009, and it's climbing. There's 7 million
9 registered vets, plus or minus, if I got the
10 numbers right. DoD treated 4.6 million
11 patients within the DoD. And I'll -- there's
12 more. And the military system has 59
13 hospitals, 364 medical clinics and 283 dental
14 clinics. And I'm not sure that counts, you
15 know, other countries and temporary sorts of
16 things.
17 Now as far as I know, no
18 commercial medical system has ever dealt with
19 anything as big as either of them. There's --
20 I don't want to get into too much. There's a
21 large system that sold to a large healthcare
22 environment in California and they told the

1 company -- they told the healthcare
2 environment we can't make one unified. We're
3 going to have to make seven, one for each of
4 your regions and then we'll do communication
5 in between. So those guys are -- I guess I
6 said it in the slide. So it's a tough
7 problem.
8 So, you know, even if the DoD
9 unifies, there's more data that's important
10 that won't be there, because both of them care
11 for patients. Patients get care outside of
12 the systems, in both environments. So the VA
13 -- there are lots and lots of reasons patients
14 get their care -- some of get most of their
15 care outside of the VA because it's only
16 qualified things, you know, they get care for,
17 or it's not convenient or they -- you know,
18 whatever. They're on Medicare and it works
19 out easier. Commercial option for TRICARE,
20 there's another 6.2 million patients that get
21 their care. Family members and I think
22 retirees and others. So it's really big, just

1 to put some point on it.
2 Now this is a book that you all
3 ought to read, or maybe not you guys, but
4 somebody in these procurement sort of sides of
5 information system should read. So this is
6 really interesting. It's written by a guy
7 from New Zealand and it's about government
8 information system projects. And it's highly
9 referenced. There's probably 200 references
10 in there with data and, you know, citations
11 and numbers and stuff. So it's not just
12 somebody's -- it's not just an opinion piece.
13 And he talks about the lessons of the past
14 decade for IT projects with a little extra
15 emphasis on health IT projects.
16 And the bottom line on page 121,
17 large projects fail as a rule. You know,
18 because you can almost -- big project, you
19 know, your odds are bad. In the U.S.; and he
20 cites some of them, I think the FBI, a $250
21 million project went on for a couple of years
22 and, you know, fell. In England, 14 billion

-- I don't know if that's pounds or dollars. It hasn't collapsed, but they've decided it's -- the direction's a mistake and they're retrenching and doing a whole other thing. The air control system here in the U.S., $4 billion, didn't work. Throw it away. So it's tough.

The requirements -- the other thing he says, invariably the requirements are unrealistic and/or unachieveable. And you go we're going to have the best. We're going to make the biggest. We're going to do everything. And when you start getting information systems, the thing gets so big that nobody knows enough about it, a lot of it, to make it come out right.

There are problems with outsourcing. He makes a big deal about outsourcing. And it's a double-edged sword. So if you don't have internal experts, you won't have the ability to procure and manage well. And I don't want to -- I guess I'm

1 going to say it. So the VA had some internal
2 experts and they mostly have pushed them all
3 out. The VA system kind of worked because
4 they had persistent people internally who knew
5 something and, you know, could keep it going.
6 So I think that's one of the important
7 lessons, if you can make it happen, where
8 you've got somebody inside who belongs to the
9 inside and says, no, you don't build stuff
10 that way. You build it this other way.
11 Big contracts never protect
12 against failure. This is -- I'm quoting the
13 book. It goes, you know, no matter how, you
14 can never figure all the eventualities. They
15 got better lawyers than you have. You can't
16 -- you know, when it goes sour -- it always
17 just goes sour and the contract doesn't save
18 you at all. What he argues is what you want
19 to do is a whole lot of little contracts so
20 that, you know, they get a renewal, or they
21 get a new guy, goes out and for different
22 pieces, you know, making it smaller.

1 And so, the other big thing -- and
2 this is -- there's a book I didn't bring
3 called, "Wicked Problems, Righteous
4 Solutions," which is a software development
5 book. It's a little skinny book, but it's
6 also highly referenced. And he decides --
7 defines a wicked problem is any -- this is a
8 software development problem -- is any problem
9 that has never been tried before. Nothing
10 you've not done before.
11 The other thing that makes it
12 wicked, if you have a single human being in
13 the loop that is -- it's not getting a tape
14 back from Mars and running it for four weeks.
15 It's someone's typing on the screen and the
16 machine isn't fast enough for them because you
17 put all this functionality in there. And it's
18 beautiful, you know, if they were, you know,
19 in a different time warp space, but you know,
20 humans can't sit there for 10 minutes between
21 key strokes. So and you never know how long
22 it's going to take when you build these

1 things. I mean, how long the capability will
2 take that you're building in to make all this
3 beautiful stuff. And so, you know, the
4 emphasis on this thing was write many
5 independent contract chunks.
6 The other thing is; I want to go
7 through this and I'll come back, extremely
8 ambitious and large projects. The bigger the
9 problems, the more -- bigger they are, the
10 more likely they fall. And he has numbers.
11 Twenty percent succeed if it's over some size.
12 Fifty percent succeed when it's smaller.
13 Eight percent succeed when it's another size.
14 Assuming long and complicated -- you say you
15 already said that. Depending solely on
16 consultants is a problem, so you don't want to
17 lose your expertise.
18 So the things to remember; this is
19 from the book, be modest about expectations.
20 Expect, plan on, you know, bet on problems.
21 You know, so figure that out. Leave
22 developments of work only when they're

1 actually working. So there's a lot of belief
2 in magic around computers by consultants, by
3 everybody. You know, this is a big -- you
4 know, we're going to solve everything here.
5 Long projects are a special problem because
6 they're more like to be overtaken by
7 legislative and/or technical things. And by
8 the time they're ready, they're old and no
9 good.
10 And there's another thing like
11 this is if you get -- so I've developed
12 software for a long time. And if you do what
13 people say they want, they don't want it when
14 you do it. You know how that is? Oh, we want
15 to have this and we want to have that and we
16 want to do this. And you get -- no, no, I
17 don't like that. They disclaim all the things
18 that they said they wanted. So users don't
19 know what they want until they use it. It's
20 kind of a sad sort of circle.
21 Now if you built one already, you
22 know, then there are some -- then they know

1 and they've said, yes, I want to do it this
2 way rather than that way and they're -- so
3 medical record systems aren't brand new, so
4 there's some experience.
5 And so the old style of software
6 development was called the waterfall. And
7 you'd start out and you make the specs. Very
8 broad specs. We want to have it do this and
9 this. Then you make a subset of specs that,
10 you know, dealt with the details. And you
11 would cascade down until you have a little
12 bitty programs or design. And then the
13 software developers would write them. Now
14 you're into a year-and-a-half by the time --
15 maybe two years. You got these specs all
16 developed and specified frozen, you know, from
17 two years ago.
18 And then the software guys start
19 writing the pieces and they put them together.
20 Well, it takes a while to get it. Yes, it
21 didn't quite work because this guy didn't
22 understand. And then they finally get it

1 together and something works. Now it's four
2 years. And, you know, people look at it.
3 That's not what -- and it's too late. It's
4 too long. So what you have to do is have some
5 -- well, two big -- you got to do something
6 small. You got to size things somehow that
7 some handful of bright humans can get their
8 head around it, you know, and really
9 understand it.
10 And the second thing is you've got
11 to continually change it. So that one of the
12 theories now is continuous prototyping. You
13 build something and you get people using it
14 fast and you kind of revise it. And on really
15 big things it's hard to get them built. So
16 there are these deep challenges in this stuff.
17 But there's just no limit to the ability to
18 believe in magic. Especially in America,
19 technology, you know, will solve all the
20 problems. So that may be sort of a gloomy
21 start.
22 So there's a couple ideas, and I

1 don't -- certainly don't have all the ideas
2 about what we should do or -- and I don't have
3 a clear enough picture of the particular focus
4 on the wounded warriors, because they're that
5 small. I mean, that's a smaller set of
6 people. There's other kinds of opportunities.
7 Maybe I'll jump ahead. This isn't
8 on the slides. But what you may want to do is
9 just build -- well, no, I'm not going to go
10 there. I'll get it the next up.
11 So what to do? You've got many
12 parts to a medical information system and you
13 might -- you know, somebody's got to think
14 about dividing it up and starting somewhere
15 and not trying to do it all, because it's
16 compelling. You know, well, it's more
17 efficient if we get it all. We make a great
18 big clean one. Clean up the house. Tear down
19 the building. Make something all new. But I
20 would bet money you can't get from here to
21 there with such a large system that's
22 operating in one big swoopy step.

1 So you consider how it can be
2 divided. And I don't know what that says.
3 This slide doesn't make sense to me, so we'll
4 skip.
5 So there's a few ways to divide.
6 You could focus in sub-populations and build
7 some kind of prototypic-sort of thing.
8 Connect it to the existing things and maybe
9 focus on the wounded warriors. Make problems
10 smaller and more tractable. But there's still
11 challenges. You could focus on a subset of
12 functions across the whole place. And there
13 might be some mix of these two. You could
14 focus on a subset of populations and a subset
15 of functions that might get you there. So the
16 function subset.
17 So now today, what we call
18 electronic medical records is everything you
19 do, all operations, all connections, all work
20 flow, all -- everything all in one. Now when
21 I started -- you know, when I was doing this
22 medical records stuff 20 years ago, we called

1 it electronic medical record when it was the
2 repository. It's the thing you could read on
3 the computer, manipulate it on the computer
4 like you could the chart. It wasn't order
5 entry. You know, it wasn't work flow. It
6 wasn't lots of other kinds of things. We did
7 have reminders and decision support.
8 So what it was was all the stuff
9 that a clinical person or maybe the patient
10 themselves would want to look at to figure out
11 what's going on with them. You know, I just
12 -- I recently had some small medical things
13 and, you know, you don't -- you think you --
14 I'm a doctor. I'm an internist. I should --
15 and I had some tests five years ago. I don't
16 remember what the heck they were, you know?
17 So I would like -- I wish I had a place that
18 I could look them up. I do have, you know, a
19 shoe box. I got some of the stuff in there.
20 But so that -- and the same with anyone. If
21 they got a problem, you know, how are you
22 progressing? How are they progressing?

1 What's their test before? How's their
2 cholesterol? You know, the regular old sort
3 of things.
4 So if one could get all that
5 clinical data easily available, even if it
6 didn't do everything, that may not be so bad.
7 You know, it would help, you know, caregivers,
8 et cetera. And when you think of that way;
9 and I'm going to jump ahead, you could also
10 think it doesn't have to be a big system. You
11 could give it -- put it on a little thumb
12 drive, give it to the patient. You know, this
13 Don Lindberg's idea for a long, long time.
14 But, you know, you don't have to have it all
15 structured and coded. If you just get the
16 paper documents that you would read in some
17 kind of reasonable order, you might give it a
18 whole lot.
19 And I think in the military
20 historically you gave the soldier the chart,
21 right? And they carried it from one place to
22 the other. So this would be a very -- except

1 you wouldn't give them the whole thing. You'd
2 just give them a copy of it. So there are --
3 these in this space, but this would need a lot
4 more thinking about where the key problems are
5 and how to fix them.
6 So what would it contain, this
7 thing, this old-style medical record? It just
8 has all the stuff electronically that you want
9 and it would have all observations that you
10 could get. You know, this would include, you
11 know, all your laboratory tests, your
12 measurements, your blood pressures, all those
13 kind of things, anything you'd get out of the
14 existing system, for sure. And a lot of those
15 systems for VA have that sort of thing.
16 You'd have narrative documents.
17 You know, the discharge summary, you know, the
18 operative notes, all the stuff, X-ray reports,
19 which typically are just dictated narrative
20 text reports. Images, scanned documents would
21 be great, too. You know, you get the X-rays
22 in there. People now, if you get a chest X-

1 ray, they'll give you a CD and you can carry
2 it on. So you could give them a big thumb
3 drive. They could carry all that stuff. I'm
4 not proposing a thumb drive, because you could
5 look it up on the Web, but I'm just saying
6 this stuff is in reach. It's not the same as
7 rebuilding a whole operational system with
8 management and personnel and all the other
9 stuff that goes in it.
10 You'd like to have the
11 medications, you know, the prescriptions, at
12 least the prescriptions filled, some idea of
13 that. Problem list maybe. You know, that's
14 what the physician thinks is the problem.
15 That's a trick here because then you have some
16 -- have to coordinate that across different
17 sites. Orders written maybe, but they're not
18 as important. Encounters would be good. When
19 did they come to the hospital? When did they
20 get their surgeries? You know, a date and a
21 record.
22 And I intended to show you a

1 little data model. It's not -- I don't know
2 if you -- anybody here knows data models, but
3 these are things computer people do. They
4 have boxes and arrows and it sort of
5 represents -- each box represents a file more
6 or less on a data system and the arrows
7 represent how they're connected. And getting
8 to that set of things, you can make this a
9 data model with four or five, six boxes. It
10 wouldn't be fully computer -- you know, it
11 wouldn't be computer -- it wouldn't satisfy a
12 computer geek and it would have more boxes.
13 But that's roughly what you're really dealing
14 with to do this sort of thing.
15 And you wouldn't do registration,
16 scheduling, material, management in this thing
17 because it's not going to directly help the
18 clinical care. And you got others -- you
19 know, that's just too much to doing all at
20 once. Bread and butter administration,
21 registration, you wouldn't do that. You
22 wouldn't do order entry. You wouldn't do all

1 these things that today are described as the
2 complete electronic medical record. And you
3 probably wouldn't worry about in-hospital
4 activity. Just get the summary at the end and
5 put it into this thing so that people have it
6 at the end.
7 So you might think of it as an
8 HIE, health information exchange. Have any of
9 you heard of that phraseology? And there's
10 some complexity here, but there are some
11 easier. So the advantages, these things are
12 not what's called transaction processing
13 systems. Transactions processing systems mean
14 that, you know, there are 15 people putting in
15 registration records, say like -- and the
16 computer's got to know that guy's got that
17 record. You can't change it now until he
18 releases it. And there's a lot of complexity
19 in the locking to keep one person from
20 clobbering something else.
21 These things are just lazy. Just
22 give it to me and I'm going to show it out.

1 You know, yes, if I get it in there in a
2 minute, that's not so bad because we're going
3 to do this -- this is a 10-year deal. And I
4 don't have it -- you can do simpler sort of
5 database systems. You don't need this
6 microsecond-to-microsecond synchrony.
7 The local systems. You depend on
8 the existing system to continue doing all the
9 heavy lifting and maybe tackle parts of them
10 at a time in some fashion in the grand design.
11 And there's something called NoSQL databases.
12 SQL is the formal query language for what's
13 called a relational database, which is what's
14 the heart of all big transactional processing
15 systems. But NoSQL databases are almost
16 perfect for these lazy updates.
17 And the advantage of them is that
18 they typically can become very large, larger
19 than you might -- so the challenge with a
20 regular database is you got to -- if
21 everything's just talking to the same
22 database, you really only can have one. And

1 there's a limit to how big that one can get,
2 and you're talking about monster big in the
3 whole DoD/VA world. And it may be bigger than
4 anybody can ever get with today's technology.
5 The NoSQL databases, you just put
6 it into 10,000 computers and you don't try to
7 synchronize them, but there are secrets
8 underneath that kind of takes care of it over
9 a minute or a half a minute, or something like
10 that. So that's an advantage.
11 And if you wanted to go for
12 something in the VA DoD, you make an HIE for
13 both of them, you know, and they could evolve
14 sort of separately. Now I'm speculating.
15 This is not a direct -- I'm not going to
16 warrant this is going to all work out
17 perfectly, but it's a way to think about it.
18 The HIE could also pull in records
19 from commercial care for those patients who
20 are mixing both kinds of care. Because you
21 get really blindsided. You know, medications,
22 you can clobber -- you know, you can give two

1 medications. One makes the other one really
2 dangerous. Lots of good things could come out
3 of it, if you can get there.
4 So what it might look like. Now
5 I'm a fan of medical records. I'm a fan of
6 HIEs. I built one of the first ones in
7 Indiana. And I'm going to show you a little
8 bit of how it looked when I left. I haven't
9 looked closely. It's gotten bigger since I --
10 I left Indiana about five years ago now at
11 NLM.
12 So this is the flow sheet. I
13 don't know if you need a flow sheet for
14 everything though. I Mean, you know, you can
15 see all the blood -- you know, this is a CBC
16 over time. And let's see if I can -- and this
17 up here -- no, I'm sorry. This is an EKG. So
18 this is the EKG diagnoses. That little
19 squiggly thing, if you click on it, you could
20 get the whole tracing as an image, as a PDF.
21 The abnormals are highlighted in red. And
22 these are all the routine measures on an EKG.

1 And then if you click on that EKG, you get --
2 that thing pops up.
3 Now this is a flow sheet of X-
4 rays. And I don't need to do all this, but
5 here's the summary statement chest X-ray.
6 Right fluid bilateral alveolar infiltrate
7 interstitial markings. Heart normal.
8 Bilateral alveolar infiltrate. Lingula
9 infiltrate. Same. Very, very kind of brief.
10 And this is -- somewhere here --
11 oh, there's this bone. You click on that bone
12 and you get the image of the X-ray. Now we
13 started out with a little icon that was aimed
14 to be a chest, you know, with the ribs, but it
15 looked just like a tick on the screen. And
16 people are, you know, what -- you know, they
17 didn't like it at all. So we went to the
18 bone. And you click on the bone and you get
19 -- you know, you get the X-rays.
20 Again, this may be more fancy than
21 you really need, but these are -- this is
22 1994, so this is not high tech to have to do

1 this kind of stuff. And now, you know, these
2 are the hospitals that are in it all over the
3 State of Indiana. Four billion results.
4 Twenty-four different hospital systems. About
5 70 hospitals.
6 And so, the scale of this is not
7 as big as VA DoD. Probably a fifth or
8 something like that. But you know, with
9 today's technology you could still build a big
10 database that could handle this ideally maybe
11 with an NoSQL database. It's got a lot of
12 kind of data. We got payers. Large medical
13 groups, freestanding labs and imaging centers
14 feed into it.
15 This is -- let's see, these are
16 the patients. This is where the patients are.
17 They're kind of centered in Central Indiana
18 and it kinds of gets thinner. The lighter
19 colors means there's less density. This was
20 I think two years ago, maybe a year ago. And
21 the providers are -- it's funny, they're all
22 over the place. There's a bunch of Chicago

1 providers. I don't understand that, but --
2 because the patients are all down here. But
3 anyway, that's what the graph says. Twenty
4 thousand physicians are roughly -- are hooked
5 up into the system.
6 And the challenge -- so this is a
7 pretty big system. Not as big as they said.
8 It maybe not be big enough. And they get
9 about 4 billion results a year. I don't know
10 what the numbers are. But I think you could
11 do this kind of a thing without radical
12 technology and unify across a very large space
13 using some of the newer technology without
14 having to do this transaction processing
15 stuff.
16 Now the problem with this, the
17 challenge with this is you got to get stuff a
18 little bit standardized coming out of wherever
19 you have the data. Now there's hope -- and
20 I'm going to get ahead of my story. There's
21 a little bit of hope with current regulations
22 coming out that this is going to happen; and

1 I'll tell you more about it in a few minutes,
2 that they will be more standardized.
3 This system we got, I think you
4 got, how many did I say, 4 billion HL7
5 messages a year or something. And HL7 is the
6 standard text -- I don't know how to describe
7 it. Are any of you guys database-oriented or
8 -- they're delimiter-based data systems so
9 that it's variable length and you get --
10 there's a thing in there called a segment,
11 which is a code of -- like a record in a real
12 database. And it's very, very widely used in
13 hospitals for; you know, discharge
14 administration, and very, very widely used for
15 laboratory and radiology.
16 And so we were able to fairly --
17 you know, we were easily able to connect up to
18 the hospital's HL7 processors -- I don't want
19 to say easily. It might have been a week, you
20 know, three or four days per hospital. But it
21 was really hard to get their codes lined up.
22 So a laboratory system might have 3,000

1 different tests. So that's 3,000 codes to
2 figure out what it really is and map it to
3 some universal code or some standard code.
4 And that's sort of the crux of the problem and
5 the challenge.
6 Now this is partly funded by
7 grants and enthusiasm in a city and some other
8 things, but they are coming along. So I think
9 you want to keep this idea.
10 So the secrets. Couple secrets.
11 Now this is technical and it may be way off
12 center and of no relevance to you guys, but
13 this is -- don't use a flat database. Use a
14 stacked database, however you're
15 conceptualizing it, either in -- and I'll show
16 you what I mean.
17 So a flat file, you have the --
18 this is a standard database. You have --
19 you're going to make up a database for your
20 hobby. You're collecting stamps. You make a
21 record per stamp. You make up fields that say
22 things about each stamp. You know, what year

1 it was, what country it was, what color it is.
2 And the name of the field is the field name.
3 I mean, that is where you put the name.
4 That's the common way. And so the variable or
5 the thing you're going to record is a pre-
6 specified part of the data structure.
7 Now this is a flat structure, and
8 this is sort of an abbreviation of a national
9 collection, I think, for bypass surgery. It's
10 a very small set of fields. So what they do,
11 cholesterol is a field name. You know, 180,
12 230. These are different patients. The
13 diastolic blood pressure is a field name. The
14 number of blood product units is a field name.
15 The number -- bypass minutes is a field name.
16 And this is how everybody just builds
17 databases, except if they really got into
18 medical records, and I'll show you in a minute
19 what I mean.
20 So the flat structure doesn't --
21 they're brittle and rigid. If you want to add
22 one more field, you got to reconstruct the

1 database, you got to take everything down, you
2 got to do a whole to of stuff. You can't just
3 arbitrary toss another field in. There's no
4 natural place to put the definitions. You
5 know, you got this little 25-character limit
6 for the field name in the database and maybe
7 you got another 250 characters you can
8 describe it. And, you know, five years from
9 now no one knows exactly what you meant by
10 that blood pressure. Was that sitting? Was
11 that standing? You know, was that just -- was
12 that what the patient told you? And you don't
13 have any place to put other stuff like what
14 time was it taken in that particular visit, if
15 you're interested in it.
16 So in general this is the
17 structure you really want. This is a stacked
18 -- what I call a stacked structure. And the
19 difference is here is you have -- some things
20 have, you know, the relevant date. That's a
21 field. Just saying what it is. But the thing
22 that carries the value just says value. The

1 test name is a value. So you don't have it
2 locked into the field. You say hemoglobin and
3 then you -- is 13. And then blood pressure's
4 95. And you can put many of them here if you
5 want and you can put who recorded it and the
6 place. And you can add other fields that help
7 you describe it. And this is what all medical
8 record systems look like inside.
9 Actually this is what inventory
10 systems look like, too, even, you know,
11 outside of medicine where you have a record
12 for inventory item and you have a field that
13 says what the inventory item is. And there's
14 another file that says everything about that
15 inventory item, usually called a master file.
16 So it really has a lot more flexibility. You
17 want to add another inventory item, "boom,"
18 you just type it in and, you know, the
19 database isn't touched. You want to add a
20 new test measurement or a variable, whatever
21 it is, you type it in. You build it into the
22 master file. Everything keeps on running. So

there are some big advantages to this.

You store results for each -- each value gets its own record instead of its own field. You know, let's you expand the width if you have more attributes you want to carry about each thing. It lets you expand in height. You can just keep inserting records sort of like sliding cards into a deck of card, a magician sliding them in. And then as I said there's a master file that describes in as much richness as you want text, paragraphs, links to files, you know, PDFs, whatever, what this thing is that you're talking about in that measurement.

And I worked with a long-term project at IU. It was an osteoporosis project. They'd been following patients for like 15 years and they put everything into a spreadsheet. They used the flat structure. And they had -- each year they would change the survey instrument a little bit, you know, that they're asking the patients which

1 represented these fields. And they wanted to
2 look across the 15 years. It took them like
3 two years to figure out what everything was
4 and glue it back together into a more unified
5 structure. So the stacked structure wouldn't
6 face that problem.
7 So this is the structure deal.
8 It's roughly the way the medical record system
9 would do it. And I think I've said all that.
10 Now the other part is this
11 messages. You know, messages are really a
12 fundamental part of information systems. If
13 you look inside of an operating system like
14 Microsoft's or Linux, what happened -- what's
15 going on inside that operating system, they
16 don't -- they're sending messages.
17 Everything's a message. You don't have -- I'm
18 stuffing something right in this record. The
19 problem with stuffing something right in the
20 place, you have no trace of what happened.
21 You can't replay it. You can't see whether --
22 if you have messages, you make copies of them

1 and you can see what's going on. So there's
2 a big advantage, but big unified medical
3 record systems typically are I just stuff into
4 a database file and, you know, you don't have
5 this ability.
6 Now if you get HL7 up on messages,
7 you know, where you have them, you get lots
8 and lots of things you can do with them. So
9 we encourage that. So HL7, we talked about
10 that already. I think we estimate 30 to 40
11 billion HL7 observation messages flow in the
12 U.S. per year, just observation messages.
13 And version 2, we hear a lot of
14 criticism about HL7 version 2. You know, it's
15 always -- anything -- well, they used to talk
16 about legacy systems. You know, it's a legacy
17 computer system. They're the only ones that
18 were working, you know? So it's always easy
19 to make -- you know, you're comparing
20 something that really is up. I mean, you can
21 criticize it's got warts and everything versus
22 something that's a dream. And so the dreams

1 take about five years to become legacy and
2 they're working, and then you have warts.
3 So HL7 version 2 is criticized
4 because it doesn't always work well. The big
5 weakness of it is the non-standard code
6 systems. So you get all the HL7 flowing and,
7 duh, I don't know what this means, I don't
8 know where to file it, because that code is a
9 idiosyncratic code of a local hospital.
10 So currently HL7 is being mandated
11 with specific --
12 CO-CHAIR GREEN: Can I ask you a
13 question?
14 DR. McDONALD: Sure.
15 CO-CHAIR GREEN: So most of the
16 work that's been done by DoD is actually in a
17 MUMPS database, CHCS, which was --
18 DR. McDONALD: It's a legacy
19 system.
20 CO-CHAIR GREEN: -- the legacy
21 system, which is still really the root of both
22 VistA and AHLTA at this point in time. And

1 so, in a MUMPS system do you have the same HL7
2 capability, or is it different?
3 DR. McDONALD: Well, it doesn't --
4 the operating system doesn't change whether
5 you have HL7 or not. A lot of -- you know,
6 MUMPS is also criticized. You know, it's an
7 old and all. But the biggest and most
8 successful; it's a secret, I think; I don't
9 think people highlight it, medical system,
10 which I won't name, actually still has its
11 core as MUMPS.
12 CO-CHAIR GREEN: Epic. Epic uses
13 MUMPS.
14 DR. McDONALD: Oh, you said it.
15 CO-CHAIR GREEN: Yes. Got it.
16 Yes, I'm actually pretty involved with this
17 stuff, but what I didn't know was whether you
18 could actually do the HL7 coding within a
19 MUMPS database.
20 DR. McDONALD: Sure. Sure. It's
21 just all -- what you do is you just program
22 something that says I want to, you know, put

1 it out in this format.
2 Now the codes are a problem in all
3 systems because the classic way people make
4 codes is I got a lab system and I got, oop,
5 here's my list of tests, and you just put the
6 first one in and that becomes number one.
7 Second one becomes number two. And it happens
8 even if you got the same system. They'll have
9 a different list, they'll get different
10 numbers or letter codes, whatever people use,
11 mnemonics.
12 So that's the deep challenge is
13 these little particles of codes that say what
14 the measurement or test is. And I'm going to
15 give you some encouraging news on all that.
16 I don't know really know --
17 there's another system that's like MUMPS.
18 It's MEDITECH. MEDITECH is very prominent in
19 small hospitals. I think they have 1,200
20 hospital customers in the country. They have
21 a system called MAGIC. But the guy that
22 started that company. His name is -- I think

1 that is -- he actually wrote MUMPS at Mass
2 General. And MAGIC is really a variant, you
3 know, sort of on MUMPS. So they have HL7 up
4 on site. I know that. So I don't think
5 there's any intrinsic issue about being MUMPS
6 or not MUMPS.
7 The challenge of MUMPS is it's so
8 flexible. You know, you can -- you know,
9 MUMPS has got a beautiful database. You know,
10 it's very, very fast. You know, everything's
11 stored in the indexes. But you can be
12 extraordinarily inventive on the fly and such
13 that things don't always, you know, work well
14 together because of the great inventiveness on
15 the fly.
16 So there's a notice of proposed
17 rulemaking which closed -- comments closed I
18 think March -- May 7th and included -- and
19 there's two of them. One of them is from ONC,
20 which is this Office of the National
21 Coordinator who's supposed to coordinate
22 information, health information systems. And

1 then there's CMS. And they're sort of
2 complementary. And I don't know what I should
3 say here. There are a lot of things that I
4 think are good in it and there are a lot of
5 things that are bad, in my opinion, in it in
6 terms of I think there are some things that
7 could kill primary care, and I'll come back.
8 So the other -- the less -- the
9 things that makes the clinicians happy is fast
10 systems. So there's no -- if you want to talk
11 about usability for clinicians, don't talk
12 about usability, because, oh, we got nice
13 colors and they can see the name and they --
14 if it isn't fast, it stinks. I got some other
15 stronger words I was thinking, you know? And
16 there's a big -- there is actually a big
17 problem with that.
18 So I think you're really looking
19 for a 10th of a second keystroke-to-keystroke
20 maximum and you like, you know, maybe a 25th
21 of a second field-to-field. It doesn't hurt.
22 And loading a patient maybe takes 10 or 20.

1 That's okay, you know, because you -- but all
2 that extra work.
3 So and what makes it slow is if
4 you add 40 more questions. And this is what
5 happens in a typical hospital information
6 install. So, okay. I'm writing my X-ray and
7 I write, you know, here's -- I want this
8 patient. I want him to get this X-ray.
9 "Boom." Whether it's a piece of paper or
10 whatever, you give it to him and he's done.
11 Now you're got on the screen is can they go
12 both a walker or a wheelchair? Can do this or
13 can do that? How tall are they? You don't
14 even have that data when you're writing --
15 filling out the order. Nursing used to take
16 care of that. So all of a sudden, what used
17 to take four -- you know, you can put three or
18 four answers in. Now you're putting 15. And
19 there's no end to group process, thinking of
20 more work for the clinician to do, because
21 wouldn't it be nice to know X? So there's a
22 lot of that wouldn't it be nice to know.

1 And just realize, data is
2 expensive and we -- it just -- it becomes
3 invisible in planners' minds, you know? Oh,
4 well, yes, we get them to fill it out. You
5 know, give it to Mikey. You know, this is --
6 it's deadly to -- and we did a little study at
7 NLM for entering codes, you know, just -- with
8 a really nifty system. So it was very slick.
9 The computer was fast. And it took -- it
10 surprised me. I did the test. Kin Wah did
11 this thing. I did -- you know, well, a lot of
12 us participated to see, you know, different
13 circumstances how long it would take you to
14 find the code you wanted by typing in a word,
15 or part of a word. It took 30 seconds per
16 code. I was surprised. It didn't feel like
17 it was taking that long, but he recorded it
18 all, on average. You know, you got seven
19 minutes with a patient, you know, and you just
20 fritter it away, you know, a large percent of
21 it with one code. You might have to put in
22 five. You know, then you -- so be sensitive

1 to that.
2 So we'll go a little further here.
3 So meaningful to HL7 version 2, meaningful,
4 the NPR requires it for certain kind of
5 messaging which will -- and it's much a more
6 specific standardized code, HL7. It's very,
7 very specific. You got to follow the rules.
8 So that will work easier. And they've also
9 specified codes. We're optimistic this will
10 work. So to really make the information
11 viable across time and space, we -- you go to
12 have standard code systems for at least
13 certain kinds of major shares of your data
14 movement. NLM and the federal regulations
15 support the use of LOINC. And I've been
16 involved in LOINC for 20 years now, so, you
17 know, I apologize if I'm too enthusiastic.
18 Now this -- what LOINC does, it
19 represents the code in -- well, I'll show you
20 in a minute. It represents the code in the
21 stacked data structure. RxNorm for drugs and
22 medications. SNOMED-CT for a broad range of

1 things, especially problems, organisms, body
2 sites. So I think if LOINC is the question,
3 code and SNOMED is the answer in a survey
4 instrument or a laboratory test. And these
5 are all the Web sites if you want to kind of
6 get to that.
7 So LOINC is recommended by the
8 federal government and many other countries.
9 It's standard in Canada, Germany, China -- not
10 China. It's not a standard in China, but it's
11 used there. It provides codes for lab tests,
12 clinical measurements, diagnostic reports,
13 survey instruments. I don't know. There's
14 things like the -- PHQ-9 is a commonly used
15 short survey for depression. There's the
16 Morse fall scale, which is a little survey you
17 can tell whether an old guy might be, you
18 know, at risk or falling, or old gal. Some of
19 these things -- PHQ-9. OASIS. It's got a
20 bunch of CMS data in it, too. At OASIS the
21 renal failure, ESRD thing from CMS.
22 Oh, I forgot. I was going to

1 bring something. I didn't bring it. SNOMED-
2 CT is also recommended -- used widely
3 internationally and provides a unified
4 approach for most clinical answers. There's
5 more than 300,000 codes in it and it has
6 hierarchical relationships and an elegant
7 formalism.
8 RxNorm, to complete the NLM triple
9 threat, these all come from NLM indirectly or
10 directly. It's the U.S. recommendation for
11 drug ordering, prescription writing,
12 medication profile, et cetera. I won't get
13 into the full details. There's a variant of
14 it also provided by NLM called RxTerms, which
15 is a little more convenient for ordering. A
16 little more user friendly.
17 So all these are supported by NLM.
18 And there's places you can try it. For
19 SNOMED-CT you might -- this thing I-Magic is
20 really a slick program. You can type in a
21 name. You type in -- let's see, you type in
22 -- I'm not sure what you type in. I know it's

1 slick. You type in a name I think and you get
2 an ICD. You type in a SNOMED name, it gives
3 you an ICD code, ICD-10 code, I think. And
4 you can find RxTerms here at this site here.
5 So the proposed rules coming out
6 of ONC is that one should use LOINC codes for
7 all clinical observations, reports and survey
8 measures so -- as the question, SNOMED-CT for
9 coding problems and the answer to any LOINC
10 variable that has multiple choice answers; so
11 think as SNOMED as the answer, and RxNorm for
12 coding drugs and drug allergies and other
13 kinds of things. And this is actually the
14 Federal Register thing. This is the previous
15 one from two or three years ago which
16 recommended LOINC, too, but not as strongly.
17 Now what's -- there's a lot of
18 places in the proposal that says you have to
19 use a structured result, especially -- they
20 really have focused on laboratories. So you
21 have to use a structured laboratory result for
22 public health, for storing your own data. And

1 this means using LOINC code and having a
2 particular structure that is HL7-compatible or
3 using HL7.
4 The had something, you know, that
5 -- which I think would be the oil that would
6 -- or maybe the spark that would set this on
7 fire in a good way. They had a thing that
8 said hospitals should report all the lab
9 results that they do to their referring
10 physicians to order them with HL7 version 2
11 and LOINC codes, you know, fully structured.
12 That would ice the system in the lab and I
13 think would show how good this life could be
14 if people really did them that way. And I say
15 "would," and I'll come back to that. Because
16 currently most of the big referral labs
17 already do that. And so the -- but the
18 hospitals basically don't, for practical
19 purposes.
20 And even this threat of this
21 regulation -- all the instrument vendors in
22 the last nine months have been pounding on

1 LOINC'S door saying we want a code for our
2 instrument, because the easiest way for
3 everybody to know what code to use is to have
4 it come when you by the instrument. It just
5 gives you the list. So Seismics, which is a
6 big blood cell count measurer. Ortho, which
7 is a -- I think it's Johnson & Johnson's. I
8 mean, it's a big lab company. Siemens.
9 They're all doing this.
10 So and once we got everybody using
11 it, then it will be self-fulfilling because it
12 would be so easy to do stuff that the market
13 would demand it. And we asked Seismic why are
14 you in such a hurry? They're bugging us,
15 bugging us. Because we get calls everyday
16 from our salesmen. We got to have it or we're
17 not going to be able to sell this device. But
18 it all has to do with this, that the people
19 see it coming and they're going to make --
20 that'll make it happen.
21 But CMS said this is what was --
22 we were thinking of doing, but we're not going

1 to do it. We're not going to make the
2 hospitals send out results, but we want to
3 hear comments. What do you think? What does
4 the world think about it? And I go, oh, we're
5 almost there. Everything else in the proposal
6 requires doctors to do more, not -- they're
7 not going to get anything from anybody else,
8 you know?
9 So we're optimistic. There's a
10 lot of comments went in. Their worry was, you
11 know, hospitals had to do it, but labs --
12 commercial labs don't have to do it, but
13 they're already doing it. That's the irony.
14 Because the market wants it. So anyway, we'll
15 see how it comes out.
16 If it stays in the proposal,
17 you're going to have codes -- now you may not
18 be HIPAA, so you may not have to -- you're not
19 -- you know, if you don't -- you guys may not
20 be obliged, but the whole environment will
21 become much easier to do messaging with if
22 this comes about the way I'm hoping it will.

1 CO-CHAIR GREEN: Wouldn't it be
2 easier to have the manufacturer be responsible
3 for the conversions, et cetera? So think
4 about how Amazon and some of the others do
5 this with Toyota, et cetera, that it basically
6 goes back to the manufacturer. So when you
7 put a lab test in, if you say what machine it
8 was done on and you want a conversion, it
9 would simply take you to the Web site for the
10 manufacturer who does the conversion to give
11 you --
12 DR. McDONALD: Well, no, that's
13 why we're joyously happy about the interest of
14 the vendors. They're not required to do it,
15 but the market is making -- but it doesn't --
16 it's tricky. At present, I think all we can
17 count on is that you'll be able to get, either
18 when you buy it or off the Web site, what it
19 is. It's not going to be automated to start.
20 One of the problems is the
21 interface from the instrument to the
22 laboratory systems are now ASTM-12; I don't

1 know, some number. I was actually -- wrote
2 part of that, but -- and that's 20 years old.
3 It only has room for one code. So labs
4 already have a code in there, and it works and
5 it's flowing in.
6 So, you know -- and there's other
7 complications, because if you order a glucose,
8 you don't know if it's a fasting glucose from
9 the instrument unless it's a sophisticated
10 instrument interface. So that won't come
11 right away. But if simply the lab knew this
12 is the code to use for this test, it's still
13 pretty easy for them, much easier than trying
14 to figure out what the heck is code 73258, you
15 know? They know what instrument. The other
16 thing, they do stuff that isn't instrument-
17 based, some of the blood cultures and things,
18 so they'll have some of their own.
19 So, but mostly what they'll have
20 in instrument-based and test kit-based stuff,
21 both of which will have -- we're hopeful, will
22 have a LOINC code come with them. And then

1 they also do send-outs to referral labs, and
2 they'll already supply the LOINC codes. So
3 it's as close as I've ever smelled it. You
4 know, I almost can taste it now, you know?
5 But we're not there yet.
6 But, yes, absolutely. You know,
7 the next stage we hope that will happen.
8 Let's see, what am I -- am I
9 pointing the wrong way? So I think I've
10 gotten ahead of all this stuff.
11 Now they also have something
12 called CDA -- another HL7 thing, CDA for
13 summary records. And that will also be an
14 opportunity, because -- well, assuming that
15 the data inside it is modestly structured.
16 And I think it's supposed to be. So if a lab
17 result goes in there, it's going to be
18 structured. They haven't yet gotten brave
19 enough to go for chest X-rays and EKGs, all of
20 which is just the same as a lab test
21 informationally. You know, I mean, it's got
22 -- it needs a code, and there are LOINC codes

1 and other codes available for it. So they're
2 just being cautious in their step forward.
3 So that's going to be another --
4 that's supposed to be delivered or made
5 available to patients at the end of discharge.
6 And I'm going to -- personal health records
7 are another mechanism by which one might be
8 able to accomplish some of the things, and
9 especially if they're wounded warriors. And
10 it has exactly the same limits as the HIE.
11 You got to get some kind of standard stuff
12 coming out from all the sources. Everybody's
13 got to be doing it so you can get most of it,
14 you know, in one place, and we'll come back to
15 that.
16 The other thing in the NPRM is
17 DICOM for images, which is pretty good,
18 although, you know, I -- and it wasn't too
19 severe about it, because JPEG works pretty
20 darn well for chest X-rays, too. It's -- you
21 know, DICOM, you got to get this thing to work
22 and that thing to work. You get this little

1 program. But JPEG you just "pfut" and it's in
2 your -- it's on your -- everybody's computer.
3 And a lot of the DICOM X-ray images are JPEG
4 on the inside and I hear they're doing
5 something to maybe make it easier to just use
6 the simple JPEG in some cases. I don't know
7 that for sure.
8 So where do codes fit in all this?
9 How are we doing? Are we doing all right with
10 time? We're okay? Because that other -- are
11 you getting tired of all this stuff? Is it
12 time for a break?
13 So this is the HL7 version 2
14 message. So each of these rows is a stacked
15 -- you know, sort of the stacked structure and
16 it represents one result. OBX is the lead
17 item on this record. It says I'm an
18 observation result. And what it has is that
19 thing says what data type the value is, and
20 which NM means it's a number. This is the
21 code. It has three parts. That's actually a
22 LOINC code. This is the name. And this is

1 the code system, LOINC. You can mix code
2 systems. This is the value, 4.9. This is the
3 units. This is the normal range. And there
4 are some other fields as well that you can
5 use.
6 So if you have LOINC codes, this
7 stuff can go in and your system that receives
8 it can know where to put it inside your
9 system. Otherwise, someone's got to sit there
10 and figure out Joe Blow's 6532 is the same on
11 line ABCX and -- which is a lot of work. As
12 I said, three to six months it took to do
13 3,000. They've gotten better since, but it
14 still is a lot of manual labor.
15 The problem with the lab is
16 particularly troublesome because the lab has
17 these small names because they want to fit
18 them, you know, on the tops of reports. So
19 they squish stuff down. They leave out parts.
20 You know, like it's -- so glycine is an amino
21 acid and they'll -- and when we would get
22 these glycine tests and it just says glycine,

1 is that serum or urine? One lab would say,
2 oh, it's serum. Everybody -- that's all
3 anybody does. And you go to the other lab,
4 it's urine. That's what everybody does. No
5 one does the serum. So, you know, it's a
6 different number. You know, it has different
7 meanings depending on where you get it from.
8 So the vocabularies. I'll give
9 you a short tour of LOINC. We --
10 MS. DAILEY: Can I redirect, sir?
11 Did you have any questions you wanted to ask?
12 Do you want to go through LOINC? I think
13 we've got a good overview of the systems, the
14 way industry is going. Is there any way, sir,
15 that you wanted to kind of overlay this on our
16 upcoming initiatives and ask some questions?
17 CO-CHAIR GREEN: So let me ask
18 that question related to where you were going
19 to go with the different languages for LOINC
20 and SNOMED, et cetera. The other thing that
21 I'm seeing when we work with leaders in the
22 industry like Kaiser and Group Health and

1 Ascension, some of the folks that are working
2 together for health information exchange, is
3 that there are so many different -- I don't
4 know what, languages, that a lot of people are
5 looking for the Rosetta Stone.
6 So what do you think of some of
7 the new things that are coming out in terms of
8 health data dictionaries or ways of
9 interfacing with this, the health language
10 integrator, which supposedly will interface
11 with multiple languages?
12 DR. McDONALD: Is that 3M's?
13 CO-CHAIR GREEN: 3M is a health
14 data dictionary. And actually the Health
15 Language Integrator, HLI, is a new product
16 that seems to be gaining some market share.
17 But essentially there are ways of transferring
18 your data into LOINC or SNOMED, or whatever
19 other format.
20 DR. McDONALD: I don't think
21 there's any magic. I think you basically --
22 you got to figure out what's my destination

1 language; and it will be different in
2 different contexts, and someone has to work on
3 it. And what I've seen is no magic. You
4 know, you've got -- except if you can get it
5 out of your vendors and things like that.
6 I don't know the last one very
7 well. And I don't want to kind of -- I've
8 worked with 3M on some other things and we get
9 along fine. I don't want to comment too much
10 on that. But I don't think there's any magic.
11 So what those tend to do, they'll
12 tend to maybe over specify. You know, maybe
13 offline we could talk more about that.
14 CO-CHAIR GREEN: No, I mean,
15 somebody who's worked with AHLTA, you
16 definitely overspecify when you try to
17 standardize physicians' language in terms of
18 words. So I guess what DoD is doing right
19 now, VA DoD, is basically starting with a
20 stacked database and linking that through an
21 extraction layer to an ESB, and so basically
22 taking that data to make it available through

1 apps, and hopefully doing it with small apps.
2 And the big question's going to be how much
3 integration do those apps have to have? How
4 many questions are going to be asked across
5 apps, because that's what will slow it down.
6 DR. McDONALD: Yes.
7 CO-CHAIR GREEN: And so it's going
8 to be interesting to see whether or not the
9 thing that they're trying to do can be done.
10 One of the things I would ask you
11 is, so -- and this is a personal rather than
12 so much for the committee, but one of the ways
13 that data can be linked in these databases;
14 because you talked about the complexity of
15 trying to keep a system operating as you go to
16 a new system, is each of the systems have
17 health data warehouses now. So the data
18 warehouses where the data has been replicated
19 from the primary electronic medical record,
20 are there opportunities to leverage what's in
21 the data warehouses to go to the new, because
22 that basically is giving you a new set of data

1 so you don't have to work off the old
2 database?
3 DR. McDONALD: Well, yes, the
4 assumption is that there's a cleansing
5 activity goes on between the raw data and the
6 data warehouse, and that's sometimes true and
7 it's sometimes not true. And that's kind of
8 like an HIE. You got two HIEs. You know,
9 maybe you put them together. So I think yes.
10 And there is this lazy -- it's
11 kind of a lazy update. Sometimes it's too
12 lazy. I don't know how fast. And in some
13 worlds, you know, the big database takes a
14 week or two weeks, and that might not be --
15 you don't -- shouldn't have to be that slow,
16 if it is. I mean, there's other ways to do
17 it.
18 CO-CHAIR GREEN: So on DoD's side
19 we actually get real time, within seconds,
20 feeds into the data warehouse. There is a
21 curation process. And so that curation is --
22 some of the questions on the data warehouse is

1 can it be done electronically and accelerate
2 that?
3 But I guess my question is at the
4 point where you go to a new electronic health
5 record, is there an advantage to basically
6 leveraging something that has been curated; so
7 talking about a data warehouse, and
8 essentially making that at some point become
9 your new reference database for the EHR? If
10 you build it towards the data warehouse, you
11 stop the feed at some point because now you're
12 collecting information in a different way. Is
13 that --
14 DR. McDONALD: I mean, I think
15 it's --
16 CO-CHAIR GREEN: -- a transition
17 strategy that could work?
18 DR. McDONALD: I think it's
19 certainly a strategy we want to look at. The
20 challenge is sometimes the warehouses compress
21 -- you know, they take the last result from
22 each visit, or they do sort of -- they may not

1 replicate everything you'd want for a clinical
2 care system.
3 CO-CHAIR GREEN: You are talking
4 to the government. We replicate absolutely
5 everything.
6 DR. McDONALD: Oh, okay. I mean,
7 I'd have to say there's -- it would depend.
8 But I think it's certainly something to look
9 at, to look at hard. You know, one of the --
10 there is a problem with -- information system
11 experts are not sufficient to build medical
12 information systems, you know, and it's almost
13 a lot of -- there's so much -- there's almost
14 a lot of chutzpah there, you know, where they
15 -- they don't even think that they may not
16 know enough to know how to do it. And I guess
17 somehow DoD/VA has to build some internal
18 full-time professional people that are them,
19 that are them and care about them, not the
20 next contract, and kind of guide and advise.
21 CO-CHAIR GREEN: The other
22 question I have is that -- and some of the

1 registries and things we do. So for instance,
2 when you develop a record for an
3 ophthalmologist and they pull all the
4 information they need, et cetera, et cetera,
5 then as you build that you're almost building
6 a registry of information in terms of how they
7 want to see the data presented. Can you then
8 leverage what you've done for one specialty to
9 look at the next specialty? It will be
10 different elements of information, but --
11 DR. McDONALD: I think they're all
12 the same except for visual of separate
13 graphics. It's just formulating. I mean, you
14 got variables. You got repeats of variables.
15 You got a name of them. You put it into the
16 master file. You know, so the ophthalmologist
17 made drawings and that can be tricky on a
18 screen. I know some systems, they don't get
19 to do it anymore because it's a screen, but
20 that's how they traditionally would say where
21 the spots were and stuff on the eye. And it
22 is -- so you got that thing which is sort of,

1 you know, like a photo, but it is -- in
2 sometimes they do take photos of the retina,
3 too.
4 And the other thing I think --
5 well, there are sort of the things you want to
6 fight. So you have -- how we always do this
7 is we say, you know, diastolic/systolic.
8 Well, that's a screwy thing to put into a
9 computer. I mean, you can't do the computing
10 on it. So some stuff, just because they did
11 that way, I think you should say it doesn't
12 make sense. And most docs will -- that's
13 fine, you know? But, you know, anyway.
14 I think it's almost a problem to
15 over specialize to each specialty because you
16 do -- they don't glue together as well. But
17 they're all just variable stacked in that
18 table and then you present them in different
19 ways.
20 CO-CHAIR GREEN: One of the things
21 we struggle with; now back to the task force,
22 is as you come up with a need for a new

application; so this comprehensive transition plan or the comprehensive recovery plan that are being used by the services, much of that information should be able to be populated from an existing database. So in other words, you always kind of -- my reality is anything that you don't have to put in the computer again that could come from someplace else is a good thing.

DR. McDONALD: That's absolutely right. There's a limit to that though, and this is the -- everything isn't stored in a way you want it. In fact, you know, the few things we -- we store maybe -- there's 40,000 LOINC variables, so maybe we store -- and that's not all there are. So maybe there's 100,000-200,000 variables. But we keep inventing new ones, you know, every -- these -- any time you ask a new questions, a new survey instrument, or develop something, ask some more questions. And I think we ought to control our urge to invent new things because

1 of the work loads involved, which we don't
2 think about.
3 So you won't always have what you
4 want in a structured way. So a physician
5 will, you know, do the physical exam, but
6 they're not going to put in separate fields
7 for diastolic blow and, you know, all the
8 different things you could say. When you
9 think -- in the computer world people start to
10 think, well, we want all that, but then that's
11 20 minutes of entry for the physician. So it
12 depends on what the content is.
13 Now you got special things you're
14 dealing with, so psychology and mental trauma
15 and lots of other things in the wounded
16 warriors and some neurologic things that may
17 not be routinely recorded. You probably will
18 have to invent or discover, create some new
19 structures, new data to enter.
20 CO-CHAIR GREEN: And so the other
21 question I would ask then is one of the newer
22 concepts is federated databases where you link

1 different databases together. And so when you
2 have a new app; I'll use a CTP or CRP, you
3 could actually build the database for the new
4 elements that you can't get from somewhere
5 else and keep it as a federated database until
6 the decision was made that you actually do
7 want to collect that every time, correct?
8 DR. McDONALD: I don't know. I've
9 seen too many fad names of new things that
10 solve all the problems and they hardly ever
11 have. You know, it ends up being work.
12 Someone's got to think about what you really
13 need and how is it represented and is it
14 really any good at all ever?
15 CO-CHAIR GREEN: The only
16 advantage is you wouldn't have to bring that
17 into a master database until you kind of
18 figured out --
19 DR. McDONALD: Well, there's
20 something to be said for stalling. When you
21 don't know what to do, don't do it yet, yes.
22 Yes.

1 CO-CHAIR GREEN: I would love for
2 you to meet with a couple of my experts. I
3 represent all three of the service surgeons on
4 the DoD/VA. And so, I think that your
5 conversations with one of my people; Al Bonham
6 is his name, would actually be very useful in
7 terms of helping to shape some of the ways
8 we're thinking about data. Everything that
9 you're talking about we're dealing with, and
10 the question is are we thinking too
11 simplistically, which is what you really have
12 based on four years of experience with this.
13 DR. McDONALD: It's a hard haul.
14 So I'd be happy to.
15 CO-CHAIR GREEN: I'll set that up.
16 DR. McDONALD: Anything to be of
17 service.
18 CO-CHAIR GREEN: Yes, I'll set
19 that up. I don't want to hog this. Obviously
20 I have a lot of interest in where this is
21 going, but I don't want to -- so is there
22 anything that the members would really like to

1 know? I think if nothing else this helps you
2 understand the complexity of why we don't
3 simply have a CTP that now could be looked at
4 by patients and by -- I mean, it's just --
5 it's not -- it doesn't happen over night, is
6 the problem.
7 MSGT MacKENZIE: It just seems
8 like with every new thing they come up with
9 everybody's trying to create their own empire
10 and the empires are clashing and let's just
11 simplify it. I mean, things need to be
12 created within a structure that's already in
13 place. It's that structure that's missing
14 that prevents these new great designs that
15 can't interface with anything else.
16 CO-CHAIR GREEN: The interesting
17 part is that the structure that actually
18 exists becomes resistant to change and
19 resistant to additions. And so, sometimes the
20 structure you create becomes your own worst
21 nightmare. I mean, to do an upgrade to AHLTA
22 right now can take as long as two years to get

1 it across the large system. Not quite that
2 long to develop it, but it takes forever to
3 make sure there aren't conflicts within MUMPS
4 or et cetera. And so, sometimes the structure
5 you build becomes the things that delay you.
6 Doctor, am I -- do you disagree?
7 DR. McDONALD: Yes. Well, life is
8 hard. That's the basic rule. Life is
9 basically just hard. But, you know, I guess
10 I think you'd want to think hard about -- and
11 maybe you could think of it different ways.
12 If we call it HIE temporarily -- is hard about
13 something that's -- the structure -- you've
14 got a message between the structure that it
15 comes from and the structure that it goes to.
16 That message makes you free. See, once you
17 have the structures thing, everything gets
18 tied into the structure. And if you have a
19 simple generic message, it basically makes you
20 free.
21 And you could then -- you know,
22 you could have all those messages accumulated

1 in some file and you have your new, say,
2 central database. And then you go I don't
3 want that anymore. Well, you could build a
4 new one. So, but just the one lesson would be
5 -- now, when you get to transaction
6 processing, it really gets way more
7 complicated. When you get to -- you know, I'm
8 trying to schedule appointments and all that
9 kind of stuff, it does get more complicated.
10 And I think I -- the lessons for keeping
11 medical record data around are not as
12 applicable to that. That's harder.
13 But I think you do the same with
14 personal health records. And you might think
15 more about just plain dumb documents, you
16 know, not so smart and not so coded, you know?
17 But then be careful you don't pile -- you
18 know, no one wants to look through 500 pages
19 of stuff. So keeping everything can be bad,
20 or at least make getting it in -- it could be
21 somewhere, but keeping everything without any
22 selection can be bad. And, you know, if

1 you've got -- you could probably pick out like
2 the lab reports, the X-ray reports. You could
3 pick out a whole bunch of stuff for clinical
4 care that -- and maybe some images, because
5 they're fairly easy to manage now, too. And
6 you'd be able to send them somewhere and you
7 get them into a personal health record, or
8 into a viewer, a portal viewer, or whatever
9 you want to call it, someplace that the
10 individual could look at some stuff and you
11 might be able to interact with them a little
12 bit.
13 DR. PHILLIPS: Just a quick
14 comment just for the committee. I mean,
15 having a robust and flexible IT system allows
16 research and it will allow us or others to
17 solve some of the problems that we have to
18 deal with.
19 Two questions perhaps you can
20 address. APIs. I hear a lot of people say,
21 oh, that's the solution, including some very
22 high-level, you know, people in our industry.

1 Plus, is there anything to do with all the
2 scanned documents, because a lot of documents
3 now just are being scanned and sent?
4 DR. McDONALD: Yes. Okay. APIs I
5 think are another one of these, you know,
6 cover -- it's -- they don't solve anything.
7 I mean, you need an API, but if they're all
8 different, you got the same reality as you got
9 with totally different systems. So I come at
10 you the standard message that you can -- you
11 don't have to figure out what the API is. How
12 is it different than this one? How do this.
13 You just -- I know what it's going to be and
14 I can take it in. I'm not saying APIs are
15 bad, but they're not magic. They don't --
16 they're just sort of an interface. So it's
17 like saying you got to have an interface.
18 Yes, but you don't want to have 100 different
19 ones.
20 Regarding the -- scanned documents
21 are beautiful and I love them. I scan
22 everything now and I OCR it. And, you know,

1 regular Adobe. You put it in and, you know,
2 you get a skew and a this and that, and it
3 goes -- it says de-skewing, and you see the
4 image turn and then you can find all the words
5 on it, 98 percent of them, you know, so that
6 you can search it. So I think they're great.
7 The challenge from healthcare is
8 labeling them. So if you get -- you know, you
9 got a hospital discharge and you take, you
10 know, the -- sometimes it's this thick and you
11 just run them all through. You got to -- it's
12 -- they're -- they can be -- you know, PDF can
13 take two, four, five, ten seconds to pull up
14 and you're going "uhn, uhn" to scan it.
15 So you got to label them. And
16 there's two ways to do it. If you got a
17 system, you got an operating system, what you
18 do is you make sure the handwritten stuff in
19 a form that has bar codes on it that says
20 that, and you maybe put a label on it that
21 says who the patient is, or somehow. Or you
22 have sections in the chart and you take your

1 whole chart and you put this is X-ray, this is
2 this, this so people can get to the parts they
3 want to get to. Otherwise, it's a bog. You
4 know, you've got way too much.
5 But otherwise they're gorgeous.
6 And you're selecting what you want to do and
7 then labeling them. You know, this is a chest
8 X-ray done on this date. That would be great.
9 MR. REHBEIN: Steve, there some
10 other work. In the other part of life I deal
11 with scientific research, and many of those
12 older publications have been scanned and are
13 available. There is some work going on now.
14 Folks that are -- we're working with a group
15 translating those old scans, because those old
16 scans are not text. They're pictures. And
17 trying to --
18 DR. McDONALD: It's tougher.
19 MR. REHBEIN: -- turn that back
20 into text and then work with the syntax of the
21 language in order to not just go through and
22 search for specific instances of a word, but

1 to do semantics. And there's a lot of that
2 work going on now and it's now, frankly,
3 extending into some of the pictographic
4 languages, the Chinese and the Japanese, to be
5 able to give us access to some of their
6 research publications, too. So there's a lot
7 of that kind of thing going on out there in
8 other areas.
9 DR. McDONALD: Well, I mean, a
10 comment on that though. It's industrial now.
11 I mean, what Google's doing is just searching
12 for words. I don't think you have to get
13 deeply smart to find a lot of stuff that you
14 want to find. I don't think we need a huge
15 research breakthrough to be able to find stuff
16 in a file of files with even -- you know, with
17 the available technology. I'm not saying you
18 don't want to do more research, but we don't
19 need a breakthrough. We need to find a way to
20 label these buggers to know -- you know, so
21 you don't have to -- you know, well, yes, I
22 guess if you had the words "chest X-ray"

1 inside, you might find them that way, too.
2 So, you know, as long as they're typed
3 documents. Anywhere in the last 20 years the
4 typed documents are all OCR find.
5 DR. PHILLIPS: But that's where
6 one of the real challenges comes, because as
7 a research scientist, when I read a paper, so
8 much of the information I'm looking for is not
9 in the text; it's in the figures --
10 DR. McDONALD: Yes.
11 DR. PHILLIPS: -- and to try to go
12 back through several hundred documents and
13 interpret those figures and draw the relevant
14 information out of them.
15 DR. McDONALD: Yes.
16 DR. PHILLIPS: That's a challenge
17 that's beginning to be met.
18 DR. McDONALD: Okay.
19 DR. PHILLIPS: There really are
20 some creative people out there that are doing
21 those kinds of things.
22 DR. McDONALD: But you mean the

1 drawings or the tables with numbers in it when
2 you say "figures?"
3 DR. PHILLIPS: Graphs.
4 CO-CHAIR GREEN: So I'm doing some
5 work with Open Source, and one of the things
6 that was talked about was kind of this system
7 where they have kind of started with health
8 information exchange and people hook up to it
9 and have to meet certain standards. Are you
10 optimistic that in this country efforts like
11 the National Health Information Network -- are
12 we going to see -- and the National Health
13 Information Exchange, that allows us to stop
14 being hospital islands, I'll call them. Okay.
15 Basically, everybody who has Epic still can't
16 talk with each other through different
17 hospital systems. Do you think we're going to
18 get there with the NHIN, or is there something
19 else coming?
20 DR. McDONALD: Oh, boy. Okay.
21 You can get there, and we've done it in
22 Indiana. The place in Canada that gets no

1 publicity is ECHIN. It's the children's
2 network in Ontario. They got everything and
3 every pediatrician can look at any result from
4 any hospital.
5 The health info ways is really
6 kind of younger. And they now have all their
7 lab codes in the country, the LOINC. So I
8 don't know really though really they are
9 shipping them in high volumes yet. So I think
10 it's the only possible solution. You know, if
11 you look at messaging inside of an operating
12 system, it's the answer. It's just the thing.
13 Now this is about -- everybody
14 wants to -- it's interesting, I know more than
15 I can talk about. But it's the combination of
16 everybody wants to do their own way, but
17 there's also -- sometimes vendors don't
18 encourage the sharing within two different --
19 you know, one hospital and another hospital.
20 So that problem, if -- the surge we've seen in
21 instrument vendors since last September is
22 spectacular.

1 So there's a -- TAP today is a big
2 format magazine for laboratories and it's kind
3 of -- it's just popular news and stuff. They
4 do reviews of laboratory instruments and they
5 -- for 15 years this guy Ray Aller has a
6 questionnaire. It says do you support LOINC?
7 And, you know, people would say no and some
8 would say yes, and we'd call them. They were
9 lying. They didn't really support it. So
10 that they weren't -- just weren't doing
11 anything. And then, "boom," it just went like
12 this. So that will make a difference, you
13 know, if the market's paying attention. So if
14 ONC holds the pedal to the metal and holds
15 that they have send stuff in a standard way,
16 not just be able to store it, send it the
17 other guy in a standard way, I think that will
18 be a game changer.
19 And if that model -- if that
20 works, why not -- I mean, everyone will go,
21 well, shoot, an X-ray's got a label on it.
22 You got a thing -- it goes through an HL7.

1 Why not -- what are we waiting for? It's not
2 that hard. X-ray is actually easy because
3 they got long names. You can tell what they
4 mean on an X-ray.
5 (Off mic question.)
6 DR. McDONALD: Well, and -- okay.
7 No, I didn't mean to avoid it. I have --
8 there's two HINs. There's a Direct and a
9 CONNECT, and they've kind of dropped the word
10 NHIN in some of these things and they -- and
11 the NHIN is -- the CONNECT has actually been
12 simplified a little bit. I think the national
13 infrastructure is really a tough, tough nut to
14 crack. And the central core problem is that
15 we're America and no one wants to have all
16 their data in a central database. I mean, you
17 know, there's a political -- whatever it is.
18 And so, once you go national, you got to put
19 so much security on it that it makes it really
20 hard to use. So inside of -- in CONNECT or in
21 NHIN is this thing where patients can specify
22 you can send my chest X-ray if it's done on an

1 angle, but not if it's, you know, done PA
2 lateral. You can do this if that. Who's
3 going to ever -- how are we going to ever
4 manage that? It won't happen. It will just
5 clog everything up.
6 So, you know, what I already
7 urged, just do it locally and then we can find
8 easy ways to say, hey, forward it to the other
9 local thing, you know, in a national -- at
10 least to start with so we can prove it all
11 works.
12 CONNECT though has a simpler model
13 now where you can kind of connect up local
14 things.
15 And Direct, I'm very enthusiastic
16 about, but someone says I'm wrong. A good
17 friend of mine. But because that really says
18 you're going to basically take standard
19 Internet technology and you're going to get a
20 group of guys in a city or a community, or
21 whatever, and you're going to say we're going
22 to give out a certificate server here and

1 we're all going to use the same certificate
2 server, and we can do just through email,
3 encrypted email, all the stuff we ever want to
4 do. So and that's pushed. They have to
5 support both of those models, the CONNECT
6 model and the Direct model in the NPRN. So I
7 think there is hope there. That's sort of the
8 smaller part of the problem.
9 So I think Regenstreif now has
10 3,000 interfaces in Indiana. And, you know,
11 it takes someone half a day to build an
12 interface. It uses VPN IP6, I think, with
13 security in it. So it's not a huge leap over
14 that, but I think it will be an advance.
15 MS. DAILEY: We should try and
16 wrap here, ladies and gentlemen. I don't have
17 a briefer in this hour, so there are some
18 other things we should talk about, and I just
19 want to kind of bring us back to the task
20 force's charter also.
21 The Interagency Program Office,
22 which is now charged with overseeing the

1 development of these two new systems for VA
2 and DoD, is part of our charter. And I think
3 that Dr. McDonald has been helpful in laying
4 out how complex it is. They had an initial
5 push in one course of action. And then just
6 this last briefing we heard that they've
7 started the new push, which is to combine
8 these systems and to make new ones. And so
9 our charter goes down the road with observing
10 how they're going to manage this new path
11 between the two agencies.
12 Any more questions?
13 CO-CHAIR GREEN: I would encourage
14 us as we look at the IPO to not necessarily
15 get into the IT technology piece and focus a
16 lot on the governance, whether or not they're
17 being given the authority to truly make
18 decisions for both departments. I think that
19 from a task force standpoint we'll survive if
20 we do it that way.
21 (Laughter.)
22 CO-CHAIR CROCKETT-JONES: Thank

1 you very much, Dr. McDonald. You've helped me
2 personally, but with some -- understanding
3 some things. And, yes, I do think it's time
4 for us to move on. Thank you.
5 DR. McDONALD: Thank you.
6 MS. DAILEY: Let's do a quick
7 break and then I do have an item in the tab
8 that we can go over.
9 (Whereupon, at 11:17 a.m., the
10 above-entitled matter went off the record and
11 resumed at 11:28 a.m.)
12 MS. DAILEY: I'm going to do about
13 20 more minutes of business, then I will
14 adjourn you for lunch at 11:45.
15 I'm going to turn your attention
16 to tab D, ladies and gentlemen.
17 I am right on top of the next
18 meeting, ladies and gentlemen. We have less
19 than a month. I have to publish a Federal
20 Register notice for our next meeting. And
21 normally I'll send it out and give you all a
22 time period to kind of gnash it over, and then

1 I get the Federal Register notice out. But as
2 I am a month away from the next meeting, I
3 thought I would take this five minutes to just
4 kind of give you a quick overview of the next
5 meeting, which is essentially your voting
6 session, ladies and gentlemen. It's your
7 voting session and it is your last meeting of
8 this fiscal year.
9 I have structured it somewhat
10 similar to last year. Last year -- and the
11 major difference I want to talk with you
12 about, for those of you that were here last
13 year, was I had a lot of breakout sessions
14 last year, and the next agenda I'm hoping not
15 to do that. I think this time period here
16 will suffice for that.
17 We'll get to the end of these next
18 days where we're doing a lot of discussion and
19 I think that will -- once we give you the
20 results of your discussions, drafted
21 recommendations, you will feel comfortable
22 enough to edit them in open sessions and then

move right into your votes. So I had at least a day-and-a-half of the last meetings, almost a day-and-a-half of sessions that were preparatory that I think we're eliminating. So the big change in this is that I really have one preparatory session and the rest of it is your editing, crafting your recommendation and then moving into a vote on it.

CO-CHAIR GREEN: My only concern, Denise, is that the members who aren't here -- and so, there will be strong feelings. And we've got what, four people missing?

MS. DAILEY: Three active participants; yes, sir.

CO-CHAIR GREEN: Okay. And so, I am a little concerned that right now they don't have quite that same opportunity to contribute to the language, especially within their work groups, if there's other things that come out of it. Now we'll probably have a good understanding of that as we go forward

1 over the next two days, but just understand
2 that if we find that the people have strong
3 objections, the question will be do we solve
4 those strong objections in a large session, or
5 do we give them an opportunity -- you're
6 thinking it can be done in just a half day?
7 Actually -- and what I'm looking at here is I
8 see basically an hour-and-a-half session.
9 MS. DAILEY: Yes, sir. I have an
10 hour-and-a-half session on the first morning
11 to recraft any recommendations and then bring
12 them back before the Board for a deliberation
13 effort, yes. And if there are strong
14 feelings, I think that over the document --
15 covering the document that we give you -- I
16 mean, if they feel strongly about 40
17 recommendations, then we'll have problems,
18 right? I'm hoping that if there are strong
19 feelings, we're only going to be talking about
20 one or two that may really trip someone's
21 trigger.
22 CO-CHAIR GREEN: Yes, I just --

1 MS. DAILEY: Okay.
2 CO-CHAIR GREEN: Maybe the way to
3 deal with it is to have the preparatory
4 session breakout groups meet before the task
5 force members review the draft
6 recommendations. Okay? So let each of the
7 smaller groups look and see if there's
8 anything that they want to recommend, and then
9 when we come together, let them present the
10 recommendations that fall in their areas. So
11 maybe if you just reverse this.
12 MS. DAILEY: Okay, sir.
13 CO-CHAIR GREEN: Okay.
14 MSGT MacKENZIE: That's what I was
15 going to say. And then the only thing I was
16 thinking was -- I know you have to do this in
17 the Federal Register, but, you know, is it
18 possible to either, you know, have a session
19 that could be either/or, public or private
20 based on the needs of the task force? If we
21 need to go back into another breakout, that we
22 could change something that's -- you know,

1 could we schedule it so it could be either/or?
2 Is that possible?
3 MS. DAILEY: No.
4 MSGT MacKENZIE: It has to be one
5 or the other?
6 MS. DAILEY: Correct. And I'm
7 having preparatory sessions and I need to make
8 sure everyone's language is correct here. I
9 can't have a private session. I can't have a
10 closed session. So I have to clearly
11 delineate in the Federal Register a session
12 which is open to the public or a session in
13 which is not required to be open to the public
14 because it's a preparatory session.
15 CO-CHAIR GREEN: I think if you do
16 the preparatory session first, then that
17 allows people and their smaller groups to see
18 if there are any recommendations they want to
19 make to the larger group. And then when you
20 open it to everybody so it's a public session,
21 when they present those recommended changes --
22 and that way we've captured what needs to be

1 done and still gives -- some work can be done
2 in a smaller group before they come in and
3 represent that to the larger group. There may
4 be nothing that's presented from the smaller
5 group to the larger group. Everyone may be
6 happy. It's just that's not my usual
7 experience.
8 MS. DAILEY: Okay. Fundamental
9 disagreements would be captured there. The
10 actual wordsmithing is going to go on in the
11 open session. But, no, I apologize. I am
12 constrained by -- and we are -- you know, have
13 a richer product because the product is open
14 to the public, and I have requirements to do
15 that.
16 CO-CHAIR GREEN: Yes, I guess and
17 then if -- that probably will do it. And then
18 the session just after lunch where you're
19 saying -- I guess you started consolidated at
20 1:00. And so, you might want to make it so
21 that from 1:00 to 2:30 or something could be
22 if we wanted to refer something back to a

small group, we could. I don't think that will happen. But again, if the larger session says we need to have a small group, it gives us the ability to do something, or even link up something where we do it through lunch. So the 12:00 on lunch you could do potential for a small group session if there's rework that the large group sends back to the small group.

MS. DAILEY: Okay. I can put another preparatory session in after lunch. Again, I'm constrained to identify it as such.

CO-CHAIR GREEN: Yes, so --

MS. DAILEY: Shouldn't be any off-record discussion.

CO-CHAIR GREEN: Why don't we just say that lunch --

MS. DAILEY: Okay.

CO-CHAIR GREEN: Make a little bit more of an extended lunch. So make it from 12:00 to 1:30. And so the lunch would not be a public session and if there's a small group -- so just put after the lunch potential for

1 preparatory final work by groups. Okay?
2 MS. DAILEY: Okay. So you want
3 one of those early -- first thing in the
4 morning, pretty much, and then one right after
5 lunch. Okay.
6 CO-CHAIR GREEN: Yes, so just
7 reverse it. So preparatory session would be
8 from 8:00 to what -- yes, 8:30 to 10:00.
9 MS. DAILEY: Okay.
10 CO-CHAIR GREEN: And then 10:30 to
11 lunch would be your review of draft
12 recommendations. And then just at lunch time
13 you would put there lunch and then in
14 parentheses potential preparatory session if
15 needed from 12:00 to 1:30.
16 MS. DAILEY: Okay. Good.
17 CO-CHAIR GREEN: Okay.
18 MS. DAILEY: That's the first day.
19 And then the next day is almost all a voting
20 session. And the last day, there are more
21 pieces and parts to the task force report.
22 And the chapter 1 is -- I'm now on page 3, day

4, June 14th -- or day 3. So pretty much on the last day we would look at the other pieces and parts, the foreword, the introduction, chapter 1.

And then last year we did a matrix breakout. We spent some time on trying to identify locations where each one of the recommendations would go. That's the matrix.

We have a requirement to have a best practices in the task force report, so we need to spend some time looking at that. I'll be able to get all of these to you in advance. But your eyes on in the meeting is important.

And then we have some extensive appendices that you should put eyes on before we go to print. So that would be your last day.

So depending on how rapidly you get through your voting session -- and I've had task forces that -- you know, the third year or so. It's really moving along. Everyone's got the process down. But we're

doing three days this time and I do believe that we will probably still take up all three days. But if it compresses, that means the process is working well for you.

CO-CHAIR GREEN: I know that I have a conflict on the 12th. I'll have to see if I can resolve that. But I'm supposed to be doing a change of command on the 12th, so I'll take a peek to see if I can change that.

Anybody else have any conflicts with these dates?

MSGT MacKENZIE: No, sir, I'm good.

CO-CHAIR GREEN: Okay.

MS. DAILEY: And then the last thing I have is one of our appendices is the biographies. We have sent out biographies. Some of yours have been updated. We need to take one last look at them, because that's what goes in the report and that is the product that represents you in the report. So Philip is your point of contact on that. And

1 at some point in time I do this. I mean, I
2 have to print. So you don't get anymore
3 input. So just your biographies are
4 important. And I think I've only got minor
5 changes.
6 My concern is, Captain Evans, is
7 there anything you want changed in yours?
8 You're new. You're the only new member.
9 And, Ms. Malebranche, I think --
10 did we get something from Ms. Malebranche?
11 Were you okay with that?
12 Those would be my two what I call
13 high-risk ones, because -- Okay. All right.
14 So since you are my two new members, yours are
15 the ones that would not have been reviewed and
16 vetted, at least by one report.
17 And, Mr. Drach, you've changed
18 positions in the Wounded Warrior Project.
19 You've changed positions in Wounded Warrior
20 Project?
21 MR. DRACH: I'm no longer the
22 president of the board.

1 MS. DAILEY: Okay.
2 MR. DRACH: But I'm still on the
3 board.
4 MS. DAILEY: Okay. We want to
5 capture that in your bio as a past position,
6 not current.
7 Anything else? New jobs? New
8 titles?
9 (No response.)
10 MS. DAILEY: Okay. That will help
11 us knock out that appendices.
12 Okay. Thank goodness for Dr.
13 McDonald taking up almost half an hour, 45
14 minutes of this time period. I apologize, my
15 briefer in this time period was not able to
16 make it. Her material, the Transition
17 Assistant Program is still basically
18 embargoed. There's many new initiatives.
19 It's going to be announced. We tried. This
20 is the second time I've had to take her off
21 the agenda. The material remains embargoed.
22 So am I'm ready to release the

task force members for lunch. The task force will be back at -- what's my return time? I believe it's

CO-CHAIR CROCKETT-JONES: You have it down as 12:45?

MS. DAILEY: 12:45, yes. And I have briefers coming in. The next set of briefers is the Air Force and they will be in at 12:45.

CO-CHAIR CROCKETT-JONES: We'll be back at 12:45.

MS. DAILEY: What's that?

CO-CHAIR CROCKETT-JONES: Then we'll be back at 12:45.

MS. DAILEY: For the task force members eating lunch here, out the door, to the right, hard right where we were last year in June, up to the platformed area for lunch.

Thank you all. Be back at 12:45.

(Whereupon, at 11:42 a.m., the above-entitled matter went off the record and resumed at 12:45 p.m.)

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

12:46 p.m.

CO-CHAIR GREEN: Okay, ladies and gentlemen. Welcome back.

I think that our next briefer is General Eden Murrie. Welcome. And so, she's the Director of Air Forces. She'll brief us on some actions discussed in the February meeting. You can find General Murrie's information along with that of her team in tab E.

On a personal note, after our conversations previously I felt there was much confusion regarding Air Force programs, and so I have asked General Eden Murrie if she could come and brief and Denise approved them coming back to give us a little bit more insight into Air Force programs. So thank you for your indulgence and, General Eden Murrie, thank you for coming back to kind of help clarify issues for us.

B. GEN. MURRIE: Yes, sir.

1 Well, good afternoon, ladies and
2 gentlemen. I'm honored to be here. My
3 briefing mate, Colonel Gianna Zeh. We're
4 going to break this briefing up into fields of
5 expertise, but for when I'm not ready for the
6 hard questions, you can see I have brought an
7 entire panel of experts. They have obviously
8 been with me before when I've briefed and knew
9 what to start out with.
10 Gianna and I are just going to
11 give you an overview of our program. I'm
12 really proud of it. This is new for me. I've
13 only been in this job for a year, so coming
14 into Warrior and Survivor Care Policy was new.
15 I have learned a lot. Asked some questions.
16 And I think we've made some improvements way
17 before I got here and we continue to improve
18 everyday. We're going to show you that today,
19 the dynamics of our program as we go forward.
20 Next slide. Oh, I've got the
21 slides. I forgot. There we go.
22 Okay. This is the overview that

1 we're going to talk about. Talk about our
2 mission, you know, the difference between war
3 time and peace time as we go forward and the
4 fact that we have an adaptable system, we
5 feel. Program overview. I'm going to be
6 talking to you about the non-medical needs and
7 Colonel Zeh will be talking to you about the
8 medical needs of our wounded, ill and injured.
9 And then where are we going? And we'll talk
10 a little bit about that, too, as we go through
11 the slides.
12 Okay. So this is our mission. We
13 want to provide the best non-clinical and best
14 clinical care for our wounded, ill and injured
15 in the entire system. We have a centralized
16 management and more of a decentralized
17 execution. In that regard I think we're a
18 little bit different from some of the other
19 services, which is maybe where some of the
20 confusion came in, and we're hoping to clear
21 up that up today.
22 For the non-clinical piece, this

1 is what we're looking at for our Air Force
2 warrior and survivor care. You have the
3 Survivor Assistance Program, the Recovery Care
4 Program and then our Air Force Wounded Warrior
5 Program. And then across the bottom you can
6 see all of the kind of pieces that play into
7 that with the family liaison officer, the
8 recovery care coordinator, our non-medical
9 consultants and AFW2, and our community
10 readiness consultants, which are at the
11 installation level. So everybody is focused
12 on the wounded, ill and injured for their
13 recovery, their rehabilitation and their
14 reintegration.
15 And I'm going to show on this next
16 slide, which I know is very busy, and we're
17 going talk through that, but I think it's a
18 really good example of how we have turned the
19 care for our wounded, ill and injured into a
20 continuum and we try and show where all the
21 pieces and parts fit together as we take care
22 of the one person.

1 Up at the very top -- I'm going to
2 make sure I'm doing the right thing here.
3 Okay. That wasn't it. Oh, there it is.
4 Okay. Up at the very top up here, we're
5 looking at this from the perspective of the
6 airman. Okay? So if you're an airman who's
7 injured, ill, combat wounded, what does that
8 mean to you? Well, that's across the spectrum
9 there. And then how are we going to take care
10 of you? There's pretty much three basic
11 streams. You've got the medical case manager
12 of course the medical team that's treating the
13 injury. Then you've got your recovery care
14 coordinator. And then if you're combat
15 wounded, that's where we're doing the AFW2 for
16 the non-medical care manager there. You can
17 see that we're looking at the continuum of
18 care for our wounded, ill and injured, you
19 know, what they're facing.
20 And then we've tried to show with
21 these diagrams -- and they're not perfect
22 where the arrows lay on the chart, but we're

1 trying to show where people come in and out.
2 You can see up here concentrated involvement
3 with the medical case manager right after the
4 injury. You can see continuous involvement
5 from the recovery care coordinator from the
6 time that we're notified of a casualty,
7 whether it's combat or otherwise, that that
8 recovery care coordinator is going to do a
9 comprehensive care program with that person
10 and then a warm hand-off to the VA. You're
11 looking here for limited involvement until
12 they're ready to be reintegrated or
13 transitioned to service. And that's when your
14 non-medical case manager for AFW2 is going to
15 be coming into place with all the folks that
16 are down here.
17 And then a couple other things.
18 I've talked about the community readiness
19 consultant at the base level. If that person
20 can't be retained in the service and they're
21 going to be transitioned out, that's at that
22 base level. And that's part of the

1 decentralized execution part we're looking at,
2 because the base support there is for our
3 wounded, ill and injured. And so, if you're
4 not in rehab or something like that and you go
5 back to the unit level, then that person's
6 going to help you. And of course we have
7 those everywhere depending on where you are.
8 One of the things that we've
9 really tried to beef up for ourselves now is
10 the adaptive sports piece. We partnered
11 through the money that OSD has gotten a grant
12 for, hosted an adaptive sports camp this past
13 year. We're active participants in the
14 warrior games. But it's not about the games.
15 It's about teaching our wounded, ill and
16 injured that they can be active in sports and
17 then that can contribute to their
18 rehabilitation. And we had a lot of good
19 success at our first sports camp, and we've
20 been sending a lot of our athletes no matter
21 whether you're combat wounded or otherwise, to
22 camps sponsored by the other services.

1 So I apologize for the busyness of
2 the slide, but once we put this together --
3 and I say "we" loosely because I'm not this
4 good at graphics, but once we put this
5 together, I think it really shows how we're
6 following our wounded, ill and injured from
7 the time that they're injured; once again,
8 whether it's combat or not, all the way
9 through their continuum of care until they
10 decide or we decide what they're going to do,
11 whether they're retained in the service or
12 they're transitioned out, making sure that we
13 partner with the VA, making sure that we work
14 a transition plan with those folks and help
15 them transition to the outside world, if
16 that's what they choose to do.
17 I'm going to build this slide. I
18 just wanted to show a little bit what happens
19 if you're wounded in the AOR. Here's if your
20 injury occurs, a casualty report is generated.
21 All those other people on the side that you
22 saw before; your AFW2, your non-medical case

1 manager and an RCC, are going to get that and
2 we're going to start those processes right
3 away, along with the medical team who's
4 following that.
5 Most likely you're going to go to
6 Landstuhl. Some casualties come straight
7 through the States, but lots of times there's
8 a stop in Landstuhl. You'll see that they're
9 met by an RCC and a family liaison officer
10 there. Usually the family's not there unless
11 there's a longer stay at Landstuhl. Normally
12 the transition time is so quick we don't fly
13 the families over. But if we should for a
14 longer stay, there's a family liaison officer
15 there.
16 As you know probably, at Landstuhl
17 there's a Fisher House, all of that. There's
18 an RCC that meets them there. If that wounded
19 airman stays there a day or an hour, there's
20 going to be an RCC who meets the airplane, is
21 with them and helps them get back on the
22 airplane, is in constant contact with the

1 States saying where they're going to be. I
2 get the reports on my email saying so-and-so's
3 landed here, they're going to take off from
4 here, they're going to be here, they're going
5 to be met by so-and-so, all of that. So
6 they're being constantly tracked.
7 Then they're probably going to
8 come to Walter Reed or Bethesda, which means
9 they're going to land at Andrews. Once again,
10 an RCC and a FLO-er are going to be assigned.
11 More than likely the family's going to be
12 there, so that FLO is going to be more
13 interactive, as long with the RCC, with the
14 families, tracking that person. Some of the
15 casualties are going to go straight down to
16 San Antonio. Once again, you got a FLO and an
17 RCC there. That's where our team is, too,
18 primary down there at AFPC. So that just kind
19 of gives you a view of what happens from a
20 combat injury when they're coming home, just
21 to kind of tie in.
22 And when you talk about those

1 terms; a FLO and an RCC and our non-medical
2 case manager, where are they? Where are they
3 interacting? How do they get notified? Who's
4 taking care of who? Who's tracking it? How
5 are we following it? And you can see this
6 team of experts over here is all part of that
7 system. And we're going to talk about some
8 improvements that we've made.
9 This is our current organization
10 and I guess this is where I came in and I
11 asked some questions, because I had some folks
12 on my staff that were doing operational things
13 and I'm like why are we doing operational
14 things at the air staff when we should be
15 doing policy? Where should that sit? How can
16 we interact better? While this was working,
17 it required a lot of coordination that I think
18 we could do better.
19 And so, we have a new organization
20 that we're working toward. This will be in
21 place probably I'd say by 1 July. We're
22 working there and getting the pieces in that.

1 So pretty much I'm going to do policy with my
2 folks at the staff and oversight of what's
3 going to happen in San Antonio in this new
4 directorate that will be stood up under the
5 two-star down there, General A.J. Stewart.
6 That's the Airman and Family Care Directorate.
7 This is brand new.
8 Let me break it down a little bit
9 more for you here. This breaks out that
10 directorate and what's going to be put in
11 there, and it's pretty different. In the Air
12 Force our casualty and our mortuary cells were
13 separate. Casualty was done more by the
14 Personnel Command. Mortuary was done more by
15 the Services Command. But either way you're
16 a casualty and so let's put all those folks
17 together. The entitlements, you know, come
18 together. Let's have smart people in all of
19 that. So that's one thing we did.
20 Then Warrior and Survivor Care and
21 Airman and Family Readiness. I talked about
22 the community readiness consultant who sits at

1 the installation level. That is governed by
2 the Airman and Family Readiness Center at the
3 installation level. And the operational arm
4 of that is in San Antonio. So let's put that
5 under this directorate and mirror it with
6 Warrior and Survivor Care because I just
7 showed you on the continuum of care how those
8 people interact all the time as we deal with
9 wounds, ill and injured, you know, as we deal
10 with an airman who has an issue. And so
11 that's what we're doing there, airman and
12 families there.
13 You can see I've kind of broken
14 airman and family up. The top part above that
15 blue line right here, this is kind of what
16 more deals with Warrior and Survivor Care.
17 This is more what the Airman and Family
18 Readiness does all the time. But I'm going to
19 talk a little bit else about something that
20 ties in there.
21 This right here is our military
22 family life consultant. And you could see the

1 community readiness consultant. Those people
2 are all going to be sitting now at the
3 operational arm of oversight for the wings and
4 are going to help them deal. So if you have
5 a wounded airman who's at your installation,
6 then they're probably meeting with that
7 community readiness consultant and they may
8 have some issues and she can put them in touch
9 with the military family life consultant. Or
10 if they're not at an installation, these two
11 folks can talk and reach out in the region in
12 that they're in through the RCC and figure out
13 how to get them the help they need. So these
14 people are constantly talking.
15 And then they're constantly
16 talking to the folks here who are working all
17 of this. What are our benefits? How do I get
18 them? How do I get employed? All of that.
19 The RCCs are regionally distributed throughout
20 the United States.
21 This video service delivery here,
22 we just got some money to execute this which

1 will -- if you're not at MTF or you're not at
2 a base, you're reserve or Guard and you need
3 some help, this is kind of -- I'm not very
4 technically-oriented, so I call it Skype on
5 steroids. Because not only are you going to
6 have a picture of the airman that you're
7 talking to, but it's going to be secure so
8 that you can talk about Privacy Act data, you
9 know, the medical pieces, whatever the RCC
10 needs to talk about with that person. You're
11 not quite so much over an over line. And the
12 RCCs will have access to that.
13 And so, you know, it won't be in
14 the home individually of the people, but it
15 will be more spread out so that they -- we're
16 not flying in RCC to their location and maybe
17 they can go to their reserve unit that doesn't
18 have an RCC and connect with them. So we have
19 a lot of improvements that are going to tie in
20 here.
21 And then, Colonel Zeh will talk a
22 little bit more about this part over here.

1 But this was all separate. First of all, the
2 directorate didn't exist and these were all
3 split out all over San Antonio. So we brought
4 them all together. So not only do we have the
5 non-medical care under the same directorate,
6 but now we've put the medical team in here,
7 you know, not the people who are treating them
8 in the hospital, but the folks that are
9 dealing with what's going to happen to you.
10 What's going to happen with reintegration?
11 Are you going to be kept in the service? Are
12 you going to be transitioned out? What about
13 the boards you have to meet? What do we have
14 to do with that? That's all right here. And
15 Colonel Zeh will go into a little bit more
16 detail.
17 But the beauty of this is it's at
18 one location. They're all going to sit -- I
19 won't say in one room, but in a variety of
20 rooms and one hallway. And so, instead of
21 having to reach somebody on the phone, you
22 might actually talk to someone; there's an

idea, face-to-face. So we really want to do that and work on that.

And so, I think this will really improve. I mean, our system is good now. We've made a lot of improvements, but I think this is really going to take us to the next level where we have all the people, the synergy for that one airman, they're all talking at the same place. They're all tracking him. The folks, the non-medical case managers and the Air Force Wounded Warrior Program, if it's a combat injury, everybody's going to know where that combat injury is. Have you done this for him, RCC? Well, what about this? And so, they're all going to be talking.

So in case you can't tell, I'm really excited about this. So I think this is a really good deal and I think we're going to make some improvements, not only for the folks who have to work this, for the folks we are dedicated to the airman, but for the airman

1 and the families themselves. So I think it'll
2 be a win/win for everyone.
3 Talking about our case load, you
4 can see over there the current case load shows
5 that the 1 to 40 ratio for the RCCs is pretty
6 consistent. We're about 1 to 53 for the AFW2.
7 But as we looked into this a little bit more,
8 there's two things we noticed. First of all;
9 and I showed you on that continuum of care,
10 the RCC is continuous involvement and the non-
11 medical case manager kind of gets involved as
12 the airman transitions into whether they're
13 going to be retained in the service or whether
14 they're going to go to the PEB portion and all
15 of that. We were sort of double counting.
16 The AFW2 was counting and once they started
17 tracking them -- but they're really not
18 dealing with the airman until they get more
19 into the system.
20 And the other piece we'd look at
21 as we go forward with this on the 1 to 40
22 ratio is we need to look at the acuity of

1 need. You can have an RCC or an AFW2 person
2 dealing with an airman that maybe just needs
3 -- is waiting on one piece of paper. So
4 you're doing a phone call a month. Otherwise,
5 you might have an airman who really needs
6 constant care, a phone call a day or visiting
7 them, whatever. So we have to look at the
8 case load on that.
9 The DoDI gives us a little room
10 for that. When I was reading through the DoDI
11 to make sure that I was remembering what I had
12 read before, it does talk about the acuity of
13 need when you look at RCCs and that. And so,
14 that's something that we need to factor as we
15 go in. But you can see here, as we adjust the
16 case load based on those two, we're going to
17 be pretty much right at the 1 to 40 piece that
18 we're looking at for the -- that the
19 Department of Defense is looking at.
20 The graph over here, what this
21 shows is we really didn't have our non-medical
22 case managers in place for the Air Force. You

1 know, we had -- our casualties grew a little
2 bit more of time, different from the Army and
3 the Marines. So 2005, that went into place.
4 And then our RCC Program, all the services
5 started the RCC Program in 2008. So the graph
6 doesn't really depict that we had all these
7 injuries happen in 2005 or 2008. What it
8 depicts is we started accounting for them
9 better.
10 And you can see here that it
11 started to taper off a little bit. We're sort
12 of catching up. We've got everything in line.
13 We've put everything in place. We started
14 tracking better. And that's what you see here
15 on this graph.
16 So I know, you know, this is a
17 constant concern of folks, and you guys or
18 your folks who are overseeing us, I think that
19 we are managing our cases very well and we'll
20 continue to do that. And I think the synergy
21 on this will only improve as we do this new
22 organization.

1 These are testimonials. Of
2 course, I only put the good ones up here
3 because, you know, I didn't want to put --
4 that was a joke. Come on, it's my best one.
5 Work with me.
6 (Laughter.)
7 B. GEN. MURRIE: We do have good
8 testimonials. We talk to our wounded, ill and
9 injured all the time, and I think that's
10 important. It's wounded, ill and injured. I
11 mean, you can have an airman in your unit. I
12 do right now whose wife is dying of cancer.
13 What kind of care are we providing him? How
14 are we taking care of him? Who's briefing on
15 the benefits that he has for his wife? You
16 know, all those other things. If it was a
17 reverse, who's taking care of that? So that's
18 kind of one extreme.
19 We focus a lot of that on the
20 combat piece, and of course that's totally
21 important, and we're taking care of that, too.
22 That's almost easier than following up on an

ill or injured person in your unit. And so, we want to make sure that the system we have in place, like I briefed you at the beginning, is just as good for peace time as it is for war time. And that's what we're working forward.

MSGT MacKENZIE: General?

B. GEN. MURRIE: Yes?

MSGT MacKENZIE: Sorry to interrupt, and unfortunately my other job took me out of the loop too quickly. On the previous slide those cases you were managing under your current case load, where are they going under your adjusted case load?

B. GEN. MURRIE: It's not so much that they're going anywhere. It's where we're accounting for them differently. You can track something, but that doesn't -- as soon as your injured, you're going to be entered -- as soon as your combat wounded for AFW2, you're going to be entered into the system. But they're not really dealing with you as a

1 case. They're only tracking you, the AFW2
2 consultants.
3 Let me go back to this continuum
4 of care. Sorry. That slide builds.
5 MSGT MacKENZIE: No, that's okay.
6 I'm familiar with the continuum of care sheet.
7 B. GEN. MURRIE: Right.
8 MSGT MacKENZIE: That's what I was
9 getting at, was a little more fidelity. And
10 that comment was that you're still tracking
11 them, that that case load of the AFW2 is now
12 -- those active cases, not those like myself
13 who are inactive, don't require the follow up,
14 but I'm still on your books?
15 B. GEN. MURRIE: Yes.
16 MSGT MacKENZIE: I just don't do
17 that? Okay.
18 B. GEN. MURRIE: Until you
19 transition out over here at the end. Yes,
20 absolutely.
21 Sorry. I got to go all the way
22 back through. I'll be here. Obviously I'm

here all day to answer questions. That was -- come on, that was another really good joke. You guys work with me on this. All right?

(Laughter.)

B. GEN. MURRIE: I'm going to let Colonel Zeh talk about the rest of that, and then of course we'll address any questions you have. I do want to foot stomp though. There's always room for improvement. We've done that. I really see that. And having come from the outside and had to ask questions just to get familiar with this, I've seen a lot just change in the past year. And we continue to evaluate these processes. This organization we set up, if it's not the right organization, then we'll move people around.

You know, we had some issues when we took some cuts, civilian cuts. We've reevaluated those. We're putting those people back on the books to make sure that we have the care managers that we need. But then we're going to evaluate that based, I said, on

the acuity of need. I don't need too many people on the books. I need enough people to take care of the current -- you know, the wounded, ill and injured. And as we draw down, then that combat wounded piece is going to get less. Figuring in the PTS piece that we'll start to recognize more as people come home, we'll make sure we're ready for that. We need to have the peace time set up and we need to have a surge capability for war time when that happens again. And so, we're working toward that, too.

So I'll entertain any questions, but I'll let Colonel Zeh talk unless somebody has something right away. Sir?

CO-CHAIR GREEN: Yes, let me ask just a couple of clarifications. So one of the things that on the visit in December was a concern from the folks who briefed was that they were taking some manpower cuts. And so, I think you just answered that.

B. GEN. MURRIE: Yes, sir.

1 CO-CHAIR GREEN: So you've
2 basically kept those positions on board right
3 now as you look at your work load?
4 B. GEN. MURRIE: Yes, sir, we did.
5 We kept the positions that I think you were
6 briefed. There were six of them. Three
7 remain. We're going to have to hire three
8 more people. We're working through the hiring
9 piece to do that, but we have three right now.
10 CO-CHAIR GREEN: The other
11 question that has been kind of tops on our
12 list this year is looking at how the services
13 are provided to reservists. So you mentioned
14 the reservists in terms of the new
15 technologies that are available, but do you --
16 I think I know the answer, but I'd like to
17 hear it from you. Do you treat this as a
18 total force? So these centralized assets are
19 really available to reservists and guardsmen
20 the same?
21 B. GEN. MURRIE: I think so, sir.
22 You know, once again, we have some notes, the

1 testimonials from the Guard and reserves. So,
2 you know, if you're a guardsman or reserve and
3 you're wounded, ill or injured, you know,
4 would you answer the same way? I hope you
5 would. Because I believe we have the
6 processes and procedures in place to do that.
7 It is total force. We recognize
8 our guardsman and our reservists are hurt just
9 as much as anyone else. The RCCs being
10 regional, gives us kind of the flexibility to
11 move them around to where the need is. In our
12 contract we have the ability to flex. For
13 instance, if we figure out that we need
14 another RCC for a different region or, you
15 know, the one RCC, that they can't carry the
16 case load, then we'll hire another one.
17 That's our flexibility in the current contract
18 we have.
19 So it's definitely total force and
20 you don't really notice the difference almost
21 -- I mean, you don't notice the difference in
22 wounded, ill or injured airman in the medical

1 piece and through the transition. It's once
2 the transition and you start to get in -- and
3 that's what Colonel Zeh I think is going to
4 talk a little bit about. You start to -- I
5 don't know if you're a guardsman or reservist
6 when you're laying in the hospital. But as
7 you start to transition out, that's where we
8 need to make sure that we have the continuity.
9 And that's why the regional care coordinators
10 and the non-medical case managers are so
11 important. And I think the synergies will get
12 there. We'll improve that. But I think we
13 have a pretty good system in place.
14 CO-CHAIR GREEN: So one final
15 question and then I'll pass. But we heard
16 this morning as we listened to the Navy
17 program some issues that are going on with
18 INCAP versus Title 10 orders for some reserve
19 casualties. And so, I know that the Air Force
20 has also struggled with that a little bit. In
21 your new central office who will make -- the
22 line of duty is still done by the reserves or

1 the Guard, but once a decision is made in
2 terms of payment on INCAP versus actually
3 being on orders, Title 10 orders and getting
4 full active duty pay, where will those
5 decisions be made now? Is that part of the
6 central office?
7 B. GEN. MURRIE: Gianna? Yes, go
8 ahead.
9 CO-CHAIR GREEN: Okay.
10 B. GEN. MURRIE: Do you want to
11 wait for that, sir? She's got really pretty
12 slides, too, so she'll tell you all about
13 that.
14 MSGT MacKENZIE: Ma'am, one other
15 question. Part of what generated the
16 questions for us in San Antonio was a visit to
17 the Air National Guard in Massachusetts.
18 B. GEN. MURRIE: Okay.
19 MSGT MacKENZIE: So the question I
20 have is are you convinced that everything's
21 going well, or are you sending folks out to
22 the individual Guard locations to make sure

1 that they're getting the kind of contact and
2 resources that they need?
3 B. GEN. MURRIE: I don't know that
4 we have sent anyone out to the individual
5 Guard units. So we could certainly do that.
6 I mean, I am relying on the command structure.
7 Actually, that's -- I was just looking at Mr.
8 Gonzalez. That's true. Mr. Gonzalez has been
9 out to the SAC, for the Secretary of Air
10 Force. He's been out to several of the Guard
11 units and brings information back and issues
12 back. And so, now that I think about that,
13 that's true. I was thinking more on the SG
14 side. I can't answer that for sure for the
15 Surgeon General side, on the medical side.
16 But, you know, it's interesting the way you
17 ask. Are you assured you're doing it right?
18 I'm assured we're doing it right now, and I
19 mentioned to you we can always improve it.
20 And so, that's certainly something we can take
21 for action, too, to make sure we're reaching
22 out to those units.

1 MSGT MacKENZIE: Thank you. Yes,
2 because it was benefits, it was right along
3 the line with that non-medical care that was
4 the issues we saw out there. It wasn't so
5 much the medical care.
6 B. GEN. MURRIE: Right.
7 MSGT MacKENZIE: It was that non-
8 medical piece, the lack of information. I
9 mean, when I show up as part of a DoD task
10 force and I'm providing them information that
11 they should already have --
12 B. GEN. MURRIE: Right.
13 MSGT MacKENZIE: -- that's where I
14 -- that's what generates the questions of are
15 we doing that, and I just -- you know, you
16 guys have done such and amazing job with
17 reaching out to figure out how to do this
18 right. I just want to make sure that doesn't
19 get overlooked because there are issues out
20 there.
21 B. GEN. MURRIE: Okay. We'll make
22 sure. I was just thinking, too, I know Mr.

1 Ginsberg just got back from Pease and
2 someplace else. So, yes, we obviously took
3 that as an action and we'll go forward and
4 we'll make sure we look at that more.
5 LT. COL. WYATT: Just to add real
6 quick, that video service delivery system, we
7 sent out -- there are RCCs and staff members
8 from our office that have gone out to
9 different Guard bases. And when we go install
10 that system, there's a process where we go
11 make sure that the wing leadership knows
12 what's going on, the communications, and FSS,
13 everybody is aware. And we take that
14 opportunity to also, you know, educate the
15 base population leadership about what we do.
16 So, and that's the whole point
17 behind the VSD is to get that -- to have that
18 presence and to make sure that anyone in the
19 region knows that they have just as much of an
20 opportunity to have that face-to-face
21 interaction and also the opportunity to go
22 through that comprehensive recovery care plan

1 in a secure atmosphere with an RCC as someone
2 that's in the same MTF or in the same area, or
3 location. So that's really been our focus, is
4 making sure we have that available so that
5 they get equivalent care, you know, to an
6 active duty.
7 B. GEN. MURRIE: One other piece
8 -- oh, sorry. Go ahead.
9 CAPT EVANS: Oh, I'm just
10 wondering, is that every airman, every
11 recovering service member you assign an RCC,
12 so at the beginning inpatient until they
13 transition to -- they have an RCC?
14 B. GEN. MURRIE: Well, based on
15 the category of care. We do it mainly --
16 CAPT EVANS: So it is based on
17 category?
18 B. GEN. MURRIE: Category 2 and 3.
19 But, you know, that's unit-specific, too. If
20 you're going to need an RCC, you're going to
21 reach out to us and we're going to help you.
22 We're going to start at the category 2 and 3

level. And I'm looking at my experts over here to make sure I'm saying that right.

But for instance, having been a former commander, if I saw somebody in need at my wing, then I'm going to get a family liaison. I've got the community readiness consultant. If someone goes in the hospital, we're using that piece there, you know, depending on whether category 2 or 3. But it's mainly -- the RCCs are for that.

CAPT EVANS: Okay.

B. GEN. MURRIE: One other piece, too, I wanted to mention, and it kind of ties into what Lieutenant Colonel Wyatt was talking about and kind of ties into your question, too.

Part of the education is not only a member, because you can tell the member something, but they may not remember that you told them, because they're getting 1,000 pieces of data a minute. So what we are doing a better job of, I think, is when I go and I

1 speak to the wing commanders, the new wing
2 commanders, the wing commander of course at
3 Maxwell Air Force Base, I'm educating them.
4 And I have a slide that says to them, you may
5 have a recovery care coordinator at your base.
6 You're not paying for them, but I expect you
7 to give them an office and a computer, and
8 take care of them and bring them into your
9 staff meetings, and make sure they're
10 educating what they do and where your wounded,
11 ill and injured population is around that
12 region, because obviously they're there for a
13 reason. So that's one step we do.
14 I also brief the group commanders
15 and the wing commanders and their spouses
16 about what is out there. And these are the
17 new folks coming in, so we're growing a new
18 crop now. These are the new commanders coming
19 in. Saying, you know, you could have a combat
20 death, or you could have a combat wound, or
21 you just have somebody ill and injured, or you
22 have a suicide, or whatever you have at your

1 base. What is in place for you? What is your
2 reach back? What should you do? And so we've
3 really beefed up our education on that, all
4 the way down to the squadron level. And we're
5 working on the MAJCOMs, the Major Commands,
6 also starting to include in the squadron
7 commanders' courses. And I think that will
8 buy us some benefit, too.
9 COLONEL ZEH: Good afternoon. I'm
10 Gianna Zeh. I'm currently stationed at the
11 Air Force Medical Operations Agency in San
12 Antonio. And so I just want to jump right in
13 there and talk to you about how we're caring
14 for our wounded, ill and injured under
15 specifically our reserve and Guards units for
16 our MEDCON.
17 And so the task force asked
18 specifically who's on MEDCON orders, how long
19 are they on, and how are we following them?
20 And so, to begin our conversation, I want to
21 spend some time about the background of
22 medical continuation orders.

1 So in 2004, our situation is we
2 had increased need for medical evaluation of
3 our ARC, our Air Reserve Component members
4 requiring medical evaluation and treatment.
5 So we stood up three MAJCOM, specifically
6 stood up case management offices to help
7 facilitate the medical evaluation of these
8 folks. Unfortunately, there was disparity on
9 who received medical care and then how the pay
10 and allowance were associated with the
11 financial allocation piece.
12 And so, our task them became in
13 2006 how to centralize this. How are we going
14 to make sure that we're validating
15 appropriately? So as AFMOA stood up in San
16 Antonio, we stood up or MEDCON cell. And this
17 cell actually provided centralized management
18 of our validation piece.
19 Our task then became that we
20 needed to incorporate the financial
21 management, so in 2008 we actually centralized
22 the allocation piece. So as we begin 2010, we

1 had both centralized allocation and validation
2 of our MPA medical continuation orders. And
3 this resulted in a standardization and
4 efficiency in accountability on how we
5 provided MEDCON to our ARC servicemen and
6 women.
7 Our current process -- I want to
8 make sure -- so it starts initially at the
9 unit level. MEDCON starts with a line of duty
10 determination. We need the medical condition
11 identified by the unit. Once the LOD is
12 established, we have a credentialed healthcare
13 provider then assess whether the airman is
14 able to perform military duties. We have a
15 treatment plan. So we have a line of duty, a
16 469, which is our profile, and then our
17 treatment plan.
18 Now the unit is ready to actually
19 request medical continuation orders. The
20 medical continuation orders go through CMAS,
21 which is our Command Mandate Allocation
22 System, and that actually is forwarded to our

1 headquarters ARC. Here eligibility is
2 determined.
3 Once eligibility is determined for
4 MEDCON, it is not forwarded to AFMOA. AFMOA
5 has three tasks. The first task is to
6 validate the medical condition. Our second
7 task is to provide recommendations on the time
8 frame of how long folks will be on MEDCON
9 orders. And then our third task is our
10 monitoring phase. Our goal is to make sure
11 that our folks got to their appointments, that
12 the treatment plan hasn't changed, the profile
13 is still good. So we have a monitoring piece,
14 really a care coordination piece at AFMOA as
15 well. We don't allocate the benefit though.
16 That is our Air Force A1, A1M. They are the
17 allocators.
18 So three phases for MEDCON.
19 There's an eligibility, a validation and an
20 allocation of MEDCON.
21 So you guys wanted to know how
22 we're doing. So I just want to spend a little

1 bit of time talking to you about who's on
2 MEDCON.
3 CSM DeJONG: Ma'am, on that slide
4 prior --
5 COL. ZEH: Yes, sergeant major?
6 CSM DeJONG: -- one of the things
7 that we had been briefed on is that
8 traditionally with Air National Guard the LODs
9 are not done until they return home from
10 theater. So that's where we get that gap.
11 And that's what General Green was talking
12 about. That's traditionally right now being
13 filled in with INCAP pay, which is technically
14 not what INCAP pay is there for, but has there
15 been any changes to that, where the LODs are
16 done prior to leaving theater, any changes to
17 streamlining that system to identify these
18 airmen prior to coming off of Title 10 orders
19 to expedite the continuation?
20 COL. ZEH: The change is the 30
21 days that the unit can actually extend their
22 mobility orders while we at least are able to

1 initiate the line of duty. And in that time
2 frame then we at least understand the medical
3 condition that we're addressing. And for
4 anything emergent, we'll put folks on MEDCON
5 orders until those line of duties are
6 established, sergeant major. Absolutely an
7 important part and piece.
8 So who do we have on MEDCON? So
9 last year at this time we actually had 525
10 folks on MEDCON. This table actually goes
11 through this past year. And now we are
12 actually managing 288 folks on MEDCON.
13 What's the difference? Well, we
14 still have the same cases. The green bar
15 graphs talk to us about the 30 to 40 new cases
16 each month. What's different is our ability
17 to close cases. And we're closing cases and
18 getting rid of our backlog for two reasons.
19 The first one is we're evaluating and treating
20 our folks more promptly, more efficiently and
21 we're getting them returned to duty.
22 Or the second reason we're closing

1 cases is we're actually expediting folks
2 through the IDES process, the disabilities
3 evaluation system. So I think this is a
4 success story for our ability to make sure our
5 ARC servicemen and women are receiving the
6 care they need and getting them either
7 returned to duty or entered into the IDES
8 system.
9 My second graph is my Christmas
10 tree graph. And this is your laugh. You're
11 supposed to laugh at my Christmas tree colors.
12 The 2011 data is in red and the
13 2012 data is in green. And this is really
14 talking to you about how long folks are on
15 MEDCON.
16 And so, do we have folks in MEDCON
17 for 1,000 days? The answer is yes, we do, and
18 we'll get to that in a minute. But I want to
19 focus our attention on the first year folks
20 are on MEDCON, and that kind of is this period
21 right here. And the sergeant major in
22 February discussed when do we talk to our

1 folks about transitioning or potentially
2 cross-training? Well, we talk to them in this
3 period when we're medically evaluating and
4 treating them.
5 And if we have our security forces
6 airman who cannot shoot anymore or carry a
7 weapon, this is a good time for us to spend
8 with our services members saying, okay, we
9 have this medical condition we're treating the
10 first 365 days. And this might be an
11 unfitting condition, especially if we get to
12 the 365 day. So this period of transition,
13 our treatment period, the 365 days, is all
14 about evaluating and treating and thinking
15 about potentially cross-training all those
16 other services that we need to do for our
17 airman.
18 As we enter 365 and we talk about
19 who will enter into our disabilities
20 evaluation system; and the first case is if we
21 have identified a condition that is
22 potentially unfitting, those folks will be

1 considered entering into the IDES. And then
2 when we hit the 365 day, you know, we are now
3 entering the IDES time frame.
4 So the graph in duration talks
5 about the first year is about treating and
6 evaluating. The second year is about entering
7 our folks into the disabilities evaluation
8 system.
9 And then I just want to spend a
10 moment talking about folks who have been on
11 MEDCON for 1,000 days. First off, you notice
12 a difference from last year and this year.
13 We've made strides in who we're keeping on
14 that long. And I'll focus your attention that
15 actually two of these four folks actually have
16 data separation dates, and they're in May. I
17 was trying to get them off the books before
18 this brief, but it didn't happen. But these
19 folks are on administrative hold right now.
20 They're either in an appeal process to the
21 Secretary of the Air Force related to their
22 PEB or they actually have data separation.

1 So we are treating our folks. I
2 think this is appropriate, the duration that
3 folks are on MEDCON, and we're making progress
4 on how we're returning them to duty or getting
5 through the IDES system.
6 So what does this picture show
7 you? It talks to you about two things: The
8 first philosophy is that we want to care for
9 our folks on MEDCON at their unit station
10 where their support system is intact, where
11 their RCCs are, where their units are. And
12 so, our system allows for that about half the
13 time. So we have 288 folks in MEDCON orders
14 right now and 58 percent of them are in our
15 IDES system receiving an MEB. And half of
16 those folks are able to stay within our sub-
17 specialty or specialty hospital platforms and
18 get MEB'ed at that unit.
19 Our system is flexible enough
20 though when our services are not available
21 specifically in our network that we have a
22 process where we can bring our folks to

1 Lackland, down to San Antonio to get their
2 MEBs. And so, I just wanted to highlight to
3 you that if we're able to, we will facilitate
4 their MEBs at their home station. If not, if
5 we need to expedite medical care and get them
6 through their MEB process, we bring them to
7 San Antonio.
8 MS. DAILEY: And real quick;
9 excuse me, ma'am, your Christmas tree slide,
10 all those individuals, if they're not in IDES,
11 they're in their home station? And if they're
12 not in IDES at Lackland, they're at their home
13 station?
14 COL. ZEH: I can't speak for every
15 specific one, but that is our goal and our
16 intent; yes, ma'am, if network availability
17 supports that.
18 MS. DAILEY: Okay.
19 COL. ZEH: So who helps coordinate
20 our care for our ARC servicemen and women?
21 And this kind of touches on do we actually go
22 out to ever Guard unit, every reserve unit?

1 We will leverage our case managers in our MTFs
2 right here to help facilitate coordination of
3 care. And so, for our numbers, our medical
4 case managers, we have 131 in the Air Force
5 right now at our MTFs caring for 2,500
6 wounded, ill and injured monthly. So our
7 ratios of medical case managers are 20 to 1.
8 And I'll just foot stomp. Our case managers
9 are our safety net to make sure we're getting
10 the right care to our folks at the right time.
11 And also this graph kind of
12 demonstrates our communication path to our
13 RCCs. We consider our RCCs part of your
14 medical home, and our medical home is all
15 about making sure our patient is at the center
16 and the focus of our care. So much so that
17 where is the Air Force investing? We're
18 investing in our case managers specifically
19 for the care of our ARC, or Air Reserve
20 component members.
21 And General Murrie kind of stole
22 my thunder a little bit about our move. So we

1 are moving to San Antonio, to AFPC. And we
2 actually get a new name, too. Our new name is
3 going to be the ARC Case Management Office.
4 And our focus will be case management of ARC
5 servicemen and women who are not stationed at
6 MTFs. So the folks out at main that need help
7 and need help with care coordination. We are
8 piloting 12 new case managers to help
9 facilitate that care coordination.
10 Besides case management, that cell
11 will also work on all order statutes. So to
12 stop the disclaimer that we're doing only MPA
13 MEDCON, we're also going to do Title 10 RPA
14 days, as well as our Title 32. They'll all be
15 incorporated centrally and centrally managed.
16 So as I close my information
17 regarding MEDCON, our focus is really to
18 expedite medical care for our servicemen and
19 women, to get them to return to duty status or
20 entered into the IDES system.
21 CAPT EVANS: You will have case
22 managers working in San Antonio specifically

1 for the warriors that are not in the hospital
2 or not -- that are out in the community?
3 COL. ZEH: At the Guard units.
4 CAPT EVANS: At the Guard units?
5 COL. ZEH: Eighty-five percent of
6 our Guard units are not associated with a
7 fixed MTF. And so, we need to help facilitate
8 and help coordinate that care as well, ma'am.
9 CAPT EVANS: Okay. So the case
10 managers that are working with the warriors at
11 the hospital, will they also fall under you,
12 or is that a different -- do they fall
13 specifically under the hospital?
14 COL. ZEH: No, they will follow at
15 the MTF level.
16 CAPT EVANS: MTF?
17 COL. ZEH: Yes.
18 CAPT EVANS: Okay. RCCs will fall
19 --
20 B. GEN. MURRIE: Under the
21 structure that you saw before, the RCCs will
22 fall under the central RCC management there.

1 CAPT EVANS: Okay.
2 B. GEN. MURRIE: Because they're a
3 regional also, like the MTFs are.
4 CAPT EVANS: Okay. Thank you.
5 MR. REHBEIN: Colonel, if I may,
6 you just said the words "return to duty," and
7 on an earlier graph you were talking about the
8 cases that you've closed. Can you speculate
9 on what your return to duty rate is, what kind
10 of percentage? Five percent? Twenty percent?
11 As opposed to people processing out.
12 COL. ZEH: Right. So 58 percent
13 of our folks actually enter in -- that are on
14 MEDCON go through the IDES system. So 42
15 percent are returned to duty, sir.
16 MR. REHBEIN: Okay.
17 COL. ZEH: In the Air Force.
18 So I heard you were curious about
19 our screening process for IDES. Yes? Yes?
20 A little bit? Okay. And so we wanted to
21 spend some time talking to you about our
22 screening process for folks we've identified

1 that need to enter IDES. So specifically
2 who's doing the screening, what are the
3 outcomes of that screen and then officially
4 how a member gets entered into IDES?
5 A discussion about IDES wouldn't
6 be complete unless you talked about the
7 timeline. So our DoD timeline I wanted to
8 highlight for you. We need to do our screen
9 here before the member enters into the MEB
10 phase. And the reason is is we've already
11 started to begin allocating, you know, VA
12 resources of the claims development. The C&P
13 exam happens at the medical evaluation. And
14 then we're already at 100 days. And so, we're
15 going to use resources and time at the MEB
16 phase. We need to screen prior to the MEB
17 phase. And that was the point of showing the
18 timeline.
19 As the Air Force has worked
20 towards meeting our DoD goals on timeliness;
21 and I just want to foot stomp, we did actually
22 meet our MEB goal in March for the first time,

1 so we're excited about that, we also
2 identified other opportunities to improve
3 efficiencies. Some would say our surgeon
4 general identified those for us, but I'll
5 leave that to you to make that determination.
6 (Laughter.)
7 COL. ZEH: So I want to start off
8 with our screening process. And the box in
9 the green is our Medical Standards Branch.
10 And it's not for General Green. It's actually
11 for Dr. Green who's sitting there at the end
12 who's going to answer any questions that you
13 have about your screening process.
14 But we have identified that our 75
15 MTFs will diagnose or actually find a
16 potential disqualifying condition that will
17 need to be determined whether it's unfit or
18 not. The MTFs will now forward all of those
19 decision to Medical Standards, which is
20 located at AFPC. It's going to fall under
21 General Murrie, the family and --
22 CO-CHAIR GREEN: Can you explain

1 the DAWG to them?
2 COL. ZEH: Yes, sir. The DAWG is
3 the Deployment Availability Working Group.
4 And so whenever a condition is identified as
5 potentially unfit, the DAWG at the MTF makes
6 a determination about whether we need to
7 pursue that as being disqualifying condition.
8 And they will send this decision now to
9 Medical Standards. And our screening process
10 is, 100 percent of our screens will go through
11 Medical Standards to make the determination of
12 whether we're going to do an MEB or not.
13 And Dr. Green's staff is our
14 subject matter experts in this, and they've
15 really standardized our process for that. And
16 their goal is if they make the decision that
17 someone needs to go through an MEB is that,
18 you know, you are thinking that this member's
19 going to be separated or retired.
20 The second decision that our
21 Medical Screening Branch can do at AFPC is
22 they can make a decision to return to duty.

1 And this is the path we want for any return to
2 duty, and that's through a potential
3 assignment limitation code. And we don't want
4 our member to go through IDES and then get
5 returned to duty this way. Our goal for our
6 return to duty rate through IDES is less than
7 five percent.
8 So these are the words to go with
9 the diagram that we just talked about. What
10 are our drivers behind a screen? Our drivers
11 behind a screen is we actually had a return to
12 duty rate through IDES of up to 19 percent.
13 And unfortunately that's a waste of time for
14 our airmen and our staff, as well as
15 resources. And so, we can do better than
16 that. And that's why we developed the screen.
17 And the screen is two ways. It's
18 a two-step process. We still want our MTFs,
19 the Deployment Availability Working Group, to
20 make that decision, because we want to educate
21 them on the proper mechanism for that. But
22 the decision to process through an MEB will be

1 made at Medical Standards.
2 There are four outcomes of our
3 screen. The first one is a return to duty.
4 The second one is directing an MEB. The third
5 one is administrative actions. Potentially
6 the commander letter wasn't written or the
7 referrals are outdated. And then finally,
8 Medical Standards can also make the decision
9 to actually medically observe the patient as
10 not quite time for the MEB. So to foot stomp
11 our goal for the screen, it's really to reduce
12 our members that present to PEB that are
13 return to duty, as we want a less than five-
14 percent return to duty rate.
15 Once our Medical Standards Branch
16 does direct an MEB, who's responsible for
17 communicating to the member? We want to make
18 sure that our members are educated about the
19 process, the disabilities evaluation process.
20 And what's so great about the prescreen is it
21 gives the member opportunities to think about,
22 okay, am I going to get an MEB or not?

1 And so, our PEBLO officer, our
2 liaison officer, is responsible for counseling
3 our members on the disability evaluation
4 system, very specifically the decision from
5 Medical Standards whether an MEB is going to
6 be done or not. The PEBLO's also responsible
7 for communicating with a provider and getting
8 a signature for the VA form. And then
9 finally, the PEBLO, in conjunction with our
10 case manager is helping our members navigate
11 the system.
12 And this slide I just want to
13 highlight is that our case managers -- and
14 we're really working in conjunction with our
15 services to -- that we have case managers at
16 each step of the way. At the time of
17 diagnosis our case managers sit on our
18 Deployment Health Availability Working Groups.
19 They're with them through the MEB phase. And
20 then also when they get final disposition of
21 a separate, a retire or return to duty. And
22 our case managers actually -- there's another

1 box over here which should be the VA box, that
2 they're actually helping them navigate that
3 system as well.
4 And so as I conclude my brief
5 today, I just want to communicate and connect
6 with you on our message, and our message is
7 that we care about our wounded, ill and
8 injured and we're committed to caring for
9 them. And our focus is to get them healthy,
10 to them to return to duty or entered through
11 the IDES system. And we think we're ready for
12 questions.
13 MR. REHBEIN: When you go through
14 the retention standards prescreen and the
15 evaluation comes back that the airman should
16 go to the MEB, is there an appeal process for
17 that airman? Can that airman ask that that
18 case be reexamined because they really want to
19 stay on active duty?
20 COL. ZEH: Yes, sir. And I'll let
21 -- Dr. Green, do you want to --
22 LT. COL. GREEN: The initial

1 screening portion, the appeal comes later,
2 because they enter into the PEB process and
3 then they're able to appeal of course the same
4 way that they do now through the formal board
5 and through the Secretary of the Air Force.
6 So our screen is simply a screen to say we
7 think you need an MEB. They do not appeal at
8 our level. That level is through the formal
9 system where we're hoping to get that down to
10 a less than a five percent.
11 Now, we don't take it lightly.
12 What we do basically is we have the benefit of
13 sitting in the same office close to the PEB.
14 So what our doctors do is we will look at the
15 commander's letter. We will prescreen. We
16 know about the manning and what is needed and
17 how people can do their duty. And then we
18 will actually discuss with the PEB before we
19 make that decision. But the appeal process
20 comes at the very end through the same process
21 as all MEB processes.
22 MR. REHBEIN: Wouldn't having an

1 earlier appeal process help you achieve that
2 five-percent goal?
3 LT. COL. GREEN: Well, I think
4 what -- our screening is just the regular
5 physician screening. We do not have a board
6 that does the screening. So what we have is
7 we have 70 years of experience between three
8 physicians that basically we discuss. But in
9 order to have a formal appeal process through
10 the system, they would have to go through the
11 PEB and then the formal board.
12 CO-CHAIR GREEN: The medical board
13 is really designed not to -- it's an issue of
14 whether or not they meet standards. And so,
15 when you look at it, you're really making a
16 medical judgment as to whether or not this
17 person meets medical standards. So there's
18 not necessarily an appeal as to whether or not
19 you meet standards or not. The appeal process
20 comes a little later, but there is the
21 advantage. And the system is that we do send
22 a commander's letter up when it goes to the

more senior physician who's adjudicating whether the person can be retained in their specialty, whether they can be retrained, or do they have to go to IDES?

But there's not really a reason that I can think of for an appeal at that level, especially since there's a commander's letter. In essence, the things that are going up are all the information that's available, including what the manning is in that specialty, if there's going to be any special dispensation with a code C. So the goal was to eliminate some of the waste by sending 20 -- you know, if you're going to make a decision to retain them, do it up front.

DR. PHILLIPS: There was just something I didn't understand on the slide that talked about the centralized execution of MEB. You have a list of Air Force bases, but then there's non-specialty MTFs. Where are those?

COL. ZEH: Yes, sir. So we

1 currently in the Air Force have many
2 outpatient clinics. And so, those are our
3 outpatient clinics, Dr. Phillips. Yes.
4 MS. MALEBRANCHE: I had one
5 question. This is interesting to me, the DAWG
6 here, this Deployment Availability Working
7 Group.
8 COL. ZEH: Yes.
9 MS. MALEBRANCHE: Who is on that
10 group? Are they all medical folks? Are there
11 personnel people?
12 COL. ZEH: I think that's a great
13 question. And so, we have -- as I noticed
14 that we have our case managers on it. So we
15 have Medical Branch, but we also have A1 that
16 comes over, which is our personnel side, to
17 actually help as we're working through
18 decisions that potentially would be, you know,
19 benefits. And so, and then we have our chief
20 of medical staff, as well as our SGP, which is
21 the operational side of the house. And then
22 we have our physicians within the facilities.

1 MS. MALEBRANCHE: I don't know if
2 you know this or not, but do the other
3 services do anything similar?
4 COL. ZEH: I don't know. General
5 Green, do they any of the --
6 COL. POINDEXTER: No, they do not.
7 COL. ZEH: That's an interesting
8 concept.
9 COL. POINDEXTER: At this point
10 the other services are not. The Navy has been
11 very interested in the DAWG process and is
12 actually considering adopting, but I've not
13 heard at this point that they have moved that
14 direction.
15 MS. MALEBRANCHE: Thank you.
16 MSGT MacKENZIE: Okay. So I'm
17 going to try to explain this. Hopefully I
18 don't confuse myself while I'm trying to
19 explain this, but you take an individual -- I
20 mean, obviously with this pre-IDES screening
21 process, a lot of it falls on the individual's
22 desire to continue to serve. Because if

1 you're -- I mean, are you looking at this
2 review process where you're allowed to retrain
3 this individual? Is that mandatory retraining
4 to keep them in, or is that retraining based
5 on their request to prevent them from going
6 through the IDES system if they're going to be
7 retained on active duty in a different career
8 field?
9 CO-CHAIR GREEN: I think that any
10 issue with retraining is going to be decided
11 at AFPC. And so, really it's going to be
12 whether a -- so think if you're a fireman but
13 you can't lift the weight anymore, and yet
14 there are enough crossover skills between a
15 fireman and some other specialty. Then they
16 can make a recommendation for cross-training,
17 at which place it comes back and the member
18 has to say he's interested or not interested.
19 Does that make sense, Mac?
20 MSGT MacKENZIE: That's what I was
21 getting at, sir, was that, you know, if you've
22 got two identical injuries, one chooses to

1 cross-train and one does not. You know, that
2 one that does not is now going to go through
3 med board, medical retirement. The other's
4 going to retain on active duty. Then you
5 reach a situation where that individual may or
6 may not have what it takes to continue and
7 chooses to say, you know, enough, no mas, I
8 can't continue to do this.
9 Now, which would generate into --
10 my second question is does that member now go
11 through the med board process that he earlier
12 did not do because of retraining, or are they
13 just allowed to separate?
14 CO-CHAIR GREEN: The system is set
15 up so that it's trying to give people every
16 opportunity to stay on active duty. If they
17 choose not to retrain, then it would go back
18 through the process for the med board if they
19 can't be retained in their specialty. If they
20 choose to retrain, go into a new specialty but
21 their medical condition is still not allowing
22 them to basically do the job, then it would go

1 through the DAWG and back up through the
2 system again. And so, essentially they'd go
3 through the IDES. It just would be after
4 they've been given every chance to stay in
5 with a different specialty.
6 MSGT MacKENZIE: Okay, sir.
7 Thanks. Because previously that's happened,
8 so that's why I was curious if that was in
9 there just to prevent that from happening
10 again.
11 LT. COL. GREEN: Yes, and that's
12 an excellent point. We have spent a lot of
13 time between the informal board, the formal
14 board and Medical Standards redesigning our
15 narrative summary template. And one of the
16 questions that we added was exactly that:
17 What does the member desire? What is the
18 member's desire. And that's been added to the
19 end of the new template, so exactly for that
20 reason.
21 MSGT MacKENZIE: And that's kind
22 of a follow up to last year where that was

1 attempting to be prevented, but yet, you know,
2 one of -- the guy who started me down my path
3 was allowed to just walk out of the Air Force
4 and was never med boarded. And so, I was
5 curious if this process was fixing that giant
6 gap. Thank you.
7 CSM DeJONG: Ma'am, regarding your
8 reserve components, do they all have RCCs
9 also? Do they have that same --
10 B. GEN. MURRIE: Yes. Yes. And
11 I've got the experts over here, but yes. Tier
12 1 and tier 2. I mean, the seriously injured.
13 CSM DeJONG: Okay. Is it
14 equivalent to active duty?
15 B. GEN. MURRIE: Yes.
16 CSM DeJONG: Okay.
17 B. GEN. MURRIE: Yes, there's no
18 difference. You're assigned an RCC right at
19 the beginning.
20 CSM DeJONG: And with that, can
21 you tell me how they're being managed now with
22 the INCAP pay versus spec and orders? Do you

1 know how many are out there that are on INCAP
2 pay right now?
3 B. GEN. MURRIE: Anybody? No.
4 CSM DeJONG: And is thee anything
5 -- I mean, I understand that there's a fix
6 coming, but I'm just trying to figure out how
7 many you're still managing through that.
8 MS. FEARRINGTON: No, we tracked
9 how many on MPA that get Title 10 dollars, but
10 the ARC component really tracks INCAP pay.
11 CO-CHAIR GREEN: My impression,
12 Steve, is that the difference in terms of what
13 would happen with ARC is that they may not --
14 unless they're at one of our facilities,
15 especially the Guard, because the reserve
16 bases tend to be -- the reserves tend to be
17 associated with our units. And so, they would
18 have the same access to case management.
19 If you're in the Guard at one of
20 the 39 locations where you're not near one of
21 our MTFs, then the MEDCON cell basically
22 serves as the case management. So it's

1 centralized for them. Okay? Whereas in large
2 part we can use local case managers for the
3 reservists and for the active duty that are at
4 the base. It's just that for the guardsmen,
5 when we don't have an MTF anywhere close, the
6 only case management they have, medical case
7 management, is probably through the MEDCON.
8 COL. ZEH: Yes, sir.
9 CAPT EVANS: So for the RCC
10 component -- and this was service-wide. I
11 keep hearing that it's category, based on tier
12 and category. I thought the DoDI read to that
13 all service members will have no matter what
14 the category. So I'm a little confused with
15 that. Is it based on category or should every
16 service member that's been injured/ill have an
17 RCC with a recovery care plan?
18 MS. DAILEY: It's category 2s and
19 3s only.
20 CAPT EVANS: It is 2s and 3s only?
21 MS. DAILEY: Wounded, ill and
22 injured are broken down into three. The first

1 category is someone anticipating a very short
2 term. Second category, category 2s, there are
3 some criteria, but they are required -- if you
4 categorize your service member as a category
5 2, they are required to have an RCC. And then
6 severely wounded is -- generally there's not
7 a lot of, you know, ambiguity about category
8 3s, but there is some ambiguity about category
9 2s. But if you are categorized as category 2,
10 the DoDI states you are to have an RCC.
11 CO-CHAIR GREEN: And so the
12 category 1; just to kind of take this the
13 other phase, is really managed by the local
14 Airman and Family Readiness Center in terms of
15 benefits and questions they may have. And
16 they're also dealt with by their local case
17 management, Patient-Centered Medical Home
18 System. So they have medical and they still
19 have access to information on benefits,
20 etcetera. It's just done at the local level.
21 B. GEN. MURRIE: And that's where
22 the -- on the slide I showed you, the

1 community readiness consultant who sits at the
2 Airman and Family Readiness Center can assist
3 with that. You have in the Airman and Family
4 -- well, in the structure, the organizational
5 structure of the squadron, the force support
6 squadron, you have your casualty folks who can
7 answer those questions. And if -- you know,
8 in that case you have mortuary in there, too,
9 but you wouldn't need that in this case. The
10 casualty folks at the local level that --
11 And, you know, and I mentioned
12 that I told the commanders, the wing
13 commanders, you know, to make sure that they
14 got in touch with all of these procedures and
15 programs, but I always caution them. I always
16 say to them don't over-promise something the
17 Air Force can't deliver on. So you all have
18 all of these experts, just like I do. If you
19 get a question from airman that your folks on
20 the base don't know what it is, pick up the
21 phone and call and do not over-promise. And
22 so that's there, too. That's why this

structure that brings it all together I think will really help.

CO-CHAIR GREEN: So we wanted you folks to know the Air Force really does have a program. Okay? So, General Murrie, thank you so much. Okay. Colonel Zeh, thank you.

And I think that brings us to a break. And so, we'll come back at 2:00. Thank you, everybody.

(Whereupon, at 1:42 p.m., the above-entitled matter went off the record and resumed at 2:04 p.m.)

MS. DAILEY: Ladies and gentlemen, if I could get everybody to return to their seats, please.

CO-CHAIR GREEN: Ladies and gentlemen, if I could take a moment before we pass this over to Suzanne. So I looked at my schedule and I really cannot make it on the 12th. And so, they've looked and it's possible for us to shift the June meeting to the 13th, 14th and 15th, which would be

1 Wednesday, Thursday and Friday. But I don't
2 know what anyone else's schedule is. Does
3 anybody have things hardwired on that Friday
4 that we couldn't shift it by one day?
5 MSGT MacKENZIE: Sir, I'm
6 available that whole week, so as long as we
7 keep it within that week. I'm not available
8 the week prior or the week after.
9 CO-CHAIR GREEN: Karen, do you
10 know?
11 MS. MALEBRANCHE: Today I'm good.
12 CO-CHAIR GREEN: Today you're
13 good. Okay. So I think that we're going to
14 make a task force decision that we will make
15 it the 13th, 14th and 15th, which would be
16 Wednesday through Friday instead of starting
17 on the 12th of June.
18 Denise, is that satisfactory?
19 MS. DAILEY: Yes, sir. The
20 contract was our only hang-up, the contract
21 with the Crowne right down the street here
22 said Friday's good. Wednesday, Thursday and

1 Friday of that week is good. And I'll send
2 out the Federal Register notice. That will
3 pretty much lock us in.
4 CO-CHAIR GREEN: That will lock us
5 in. And thank you very much. I had a change
6 of command I just could not get out of. So
7 very good.
8 MS. DAILEY: So we'll get that
9 word out to our other four members. And who
10 was I talking with? I was talking with
11 Command Sergeant DeJong. We can start sending
12 out calendar updates. We'll get it on your
13 Outlook calendars. We notice that some of
14 these things kind of fall off every once in
15 awhile. Our changes don't get into the system
16 that you work in, and Outlook is good for
17 that. So we'll work with either the product
18 on your desk or your staff to get your dates
19 shifted. You can de-conflict your calendars.
20 CO-CHAIR CROCKETT-JONES: Okay.
21 Very good. Then we're going to begin a
22 discussion of the status of last year's

recommendations. They are in tab F. And if anyone is missing a tab F, I have an extra tab F. And, Ms. Dailey, you're going to walk us through the status?

MS. DAILEY: Yes.

CO-CHAIR CROCKETT-JONES: Thank you.

MS. DAILEY: All right. I'm going to have a discussion with you. My staff and I broke out the recommendations like this: Now, all that means is is that's me and my staff's work. What we hope to do -- and it's an hour and there are 21 recommendations here. What I really need you to do is help me move the recommendations around and I need you to tell me whether you think the Department of Defense has met them, not them or partially met them.

Now, I want everyone to understand the protocol. The protocol is is that the Department of Defense reports -- we provide this set of recommendations to the Department

1 of Defense. The Department of Defense has a
2 requirement to do an evaluation at 90 days and
3 an implementation plan at 120 days. They
4 forward that to Congress. So ultimately the
5 report is not in this -- both the
6 implementation plan and the evaluation are not
7 to us, the task force. Our responsibilities
8 pretty much ended when we turned it over to
9 DoD. That's the protocol. And then they have
10 requirements to report back through DoD to
11 Congress.
12 I think it's important for us to
13 go through their implementation plan, which is
14 what you'll see excerpts for. Go through the
15 implementation plan and for us to look at what
16 we can take off the table, what we think needs
17 to be re-crafted or rejiggered into this
18 year's recommendations. That's kind of where
19 we need to understand what still needs to be
20 worked in this next set of recommendations
21 that we're doing to the Department of Defense.
22 And there are going to be some in a category

of partially met. Some things have happened. Some things have not.

So when I went through this with my staff, my count -- and let's keep this in mind, this is my count. It's not the task force's count. And that's what we're going to make your product out of this. My count is that they have met five of them, that there are 14 that are not met and there are two that are partially met. And we'll go through each one. And I need you to weigh in and say yes, no, yes.

The best document to do that is the Word document in this file. I have a PowerPoint in there. I've had to truncate it so much that it's just -- it's almost not usable. So there's a Word document in there and I'd like to start with that Word document.

Any questions?

(No response.)

MS. DAILEY: Couple more slides, Word document. Okay. The first

1 recommendation was a standardization request
2 to go over the terms, go over the definitions.
3 And I think our expectation, which is what I'm
4 extrapolating more than anything else from the
5 work that we did last year. Our expectation
6 was that Department of Defense wound engage in
7 a pretty active review of the terms set forth
8 in 2007 and 2008 and re-look and try and
9 standardize them across the departments.
10 Based on the information we
11 received in the implementation plan, we didn't
12 get that response from them and they would be
13 looking at them was the closest we could come
14 in the implementation plan to accomplish that
15 expectation. So I consider it unmet, but --
16 yes, sir?
17 CO-CHAIR GREEN: So the way this
18 is written is the expectation is how you're
19 interpreting what we think, and when it says
20 "DoD 1 March Implementation Plan," that was
21 DoD's answer?
22 MS. DAILEY: Correct.

1 CO-CHAIR GREEN: Okay. I just
2 need to be sure. Thanks.
3 MS. DAILEY: So I've essentially
4 left this one open as unmet.
5 Now, and let me then bring this
6 back around.
7 CO-CHAIR GREEN: So let me --
8 MS. DAILEY: Go on.
9 CO-CHAIR GREEN: -- that question.
10 MS. DAILEY: Go ahead, sir.
11 CO-CHAIR GREEN: So in their
12 answer they say DoD will review these terms to
13 assess what impact if any these varied terms
14 have on our wounded, ill and injured service
15 members. Have they done that? They say that
16 they'll do it. The question is have they done
17 it?
18 MS. DAILEY: No, sir.
19 CO-CHAIR GREEN: Okay. So the
20 easy way to deal with this is to basically say
21 that they've partially met because they're in
22 -- by the intent to review what impact these

1 had. But until the review occurs, it's not
2 met, right?
3 MS. DAILEY: Correct, sir.
4 CO-CHAIR GREEN: Yes. Okay. Got
5 it.
6 MSGT MacKENZIE: And that's one of
7 the things is there's a huge impact, as we all
8 know, and those of us in the business see it
9 every day, but there's been no inkling of,
10 hey, we're trying to see how this affected us.
11 I mean, one perfect example is the Wounded
12 Warrior Assistance Act that came out of the
13 DoD. You know, once again they're trying to
14 wrap it all into this wounded warrior term.
15 But with what I do everyday, I have a major
16 problem, because the term "wounded warrior,"
17 not only to the DoD, but to America as a
18 whole, are two totally different meanings. I
19 mean, the Wounded Warrior Assistance Act came
20 out after we made this recommendation and it's
21 still the same.
22 CO-CHAIR CROCKETT-JONES: Yes, and

1 we've encountered -- the NGOs that are working
2 with this population believe that wounded
3 warrior indicates combat wounds only, and
4 that's their expectation, so that their
5 ability to get services from other agencies is
6 kind of impacted. There's an expectation that
7 they might not meet if they are in a wounded
8 warrior transition unit but they were not
9 combat injured.
10 CO-CHAIR GREEN: One of the
11 questions I have is in our -- when we say it's
12 partially met and we look -- and, you know,
13 once they complete the review, do we want to
14 say that special emphasis should be placed on
15 wounded warrior versus recovering warrior, or
16 do we want to give them any suggestions for
17 language, if you know what I'm saying?
18 MSGT MacKENZIE: Yes, I know when
19 the service chiefs got together --
20 MS. DAILEY: We can do that in --
21 I do have a place for that in -- when we do
22 recommendations. If you feel that we want to

re-craft a recommendation, I can do that in the recommendations.

MS. MALEBRANCHE: I'm not even sure this is partially met, because in the recommendation it was DoD should define and adopt common standards and nomenclature. And then it says the services have defined in varied ways. So already there, that's not common nomenclature. I mean, in the response that says we have done it partially. But I don't think there is.

PARTICIPANTS: I was being really kind.

MS. MALEBRANCHE: Yes, you were being really nice.

MS. DAILEY: On the record, sir, please.

(Laughter.)

MS. DAILEY: Okay.

DR. PHILLIPS: I would just like to add, I think Mac's point is very important, and I think we need to emphasize that because

1 of the different -- and the way different
2 groups look at these folks. And I remember
3 when we met with the, I guess, Assistant
4 Secretary of the Army, who said if they're in
5 green, they're all the same. And I don't want
6 to do -- even though there's a different
7 category and I don't want to talk about the
8 differences, I don't want to do a disservice
9 for those who are not combat wounded and let
10 them fall between the cracks, because it will
11 just come back to bite us in the long run. I
12 think we need to --
13 MSGT MacKENZIE: And I understand
14 what Denise is saying, so I'll throw this
15 comment out there: I recommend that we look
16 at this during our recommendation session, to
17 rewrite it and put it up again.
18 CO-CHAIR GREEN: Don't disagree.
19 I think we may need to be more specific if
20 there's a couple of areas we truly want them
21 to tackle, because we gave them broad guidance
22 since we had such a short time. We now have

1 two years of looking at this and see some
2 things very specifically that would help.
3 MS. DAILEY: Okay. Good. Good.
4 Sir, I'm happy to move it out of the not met
5 into the met. I just need consensus. I
6 generally don't like to vote on anything
7 accept a recommendation. You want to have
8 consensus to move it out of the not met into
9 the partial, or you want to keep it in the not
10 met? CO-CHAIR GREEN: So everything
11 we're going to be looking at are not met? Is
12 that what these are?
13 MS. DAILEY: No, I'm going through
14 the whole list.
15 CO-CHAIR GREEN: You're going
16 through the whole list?
17 MS. DAILEY: Yes.
18 CO-CHAIR GREEN: All right. So
19 number one, we're all in agreement it's not
20 met and we will give more --
21 CO-CHAIR CROCKETT-JONES: And
22 needs to be -- yes, not met and to be

1 revisited.

2 MS. DAILEY: Okay. Good. Good.

3 I mean, that's what the rhythm of this needs

4 to be over the next 45 minutes. Thank you.

5 Excellent. All right.

6 We're now onto recommendation No.

7 2, which has to do with the population-based

8 standards criteria to drive decisions about

9 location, establishment, expansion of

10 transition units.

11 And succinctly, I believed our

12 expectation was we wanted them to kind of

13 establish some metrics for setting up

14 recovering warrior units for closing them

15 down, for where they were going to have unit-

16 based operations. And as populations grew,

17 where they could build a recovering warrior

18 unit. And around the robustness or the lack

19 thereof of the military treatment facility and

20 the location. I don't think we got any buy in

21 into that concept at all.

22 MR. REHBEIN: I frankly have a

1 hard time thinking that our expectation and
2 their implementation, we're talking about the
3 same subjects.
4 (Laughter.)
5 CO-CHAIR GREEN: I think we're not
6 going to be kind at all. Okay. I got it.
7 (Laughter.)
8 CO-CHAIR GREEN: I actually agree
9 with you on this one. I think that they
10 didn't even catch that we're trying to get
11 them to tell us when they're going to bring
12 one down and how they're going to bring one
13 up, what the criteria are going to be. So I
14 think that they kind of missed the boat on
15 this one. That's my impression.
16 DR. PHILLIPS: Can we recommend
17 criteria? I mean, just recommend next to
18 major treatment facilities, things -- I know
19 we say that, but is it within our purview to
20 even do that?
21 MS. DAILEY: Your purview is to
22 make recommendations. You have to come to a

1 consensus and vote on it to go forward.
2 That's your criteria ultimately.
3 You had a relatively robust debate
4 on this last year. You debated large
5 facilities. You debated centralized
6 locations. And this was your final wording.
7 CO-CHAIR CROCKETT-JONES: I think
8 perhaps we just maybe need more emphatic or
9 specific language. You know, it's hard to
10 know -- with this response being so non-
11 responsive, it's hard to know exactly where we
12 missed, but it seems like we missed it
13 completely. So I guess can we put this again
14 into the category of not met and needs to be
15 revisited?
16 MS. DAILEY: Okay.
17 MS. MALEBRANCHE: And with
18 definitive recommendation, maybe more
19 definitive or specificity.
20 MS. DAILEY: Okay.
21 MS. MALEBRANCHE: That'll help.
22 MS. DAILEY: Okay. Good. All

1 right. No. 3. Our third recommendation.
2 This was more on the medical side, which was
3 to develop the data-driven protocols,
4 standardize, focused on condition-specific
5 medical conditions. Now what we have found is
6 that there has been a lot of work in this
7 area. There are a lot of clinical practice
8 guidelines out there developed jointly by DoD
9 and VA.
10 MR. REHBEIN: As I read the
11 implementation plan for this, it's an exact
12 match for the implementation plan for 2. Did
13 we wind up with some transcription errors
14 MS. DAILEY: What is that?
15 MR. REHBEIN: The --
16 MS. DAILEY: No.
17 MR. REHBEIN: What's shown here in
18 the implementation plan for recommendation 3
19 is exactly the same as what's in here for the
20 implementation plan for recommendation 2.
21 MS. DAILEY: Correct. That's what
22 DoD put in there.

1 MR. REHBEIN: Okay.
2 MS. DAILEY: Yes.
3 CO-CHAIR GREEN: So we need to
4 vote on No. 2, but on No. 3 I do think they've
5 initiated a process to do clinical practice
6 guidelines by using data-driven information.
7 So I think they've started the process on
8 this, so I would give them some credit in
9 terms of, you know, moving towards capturing
10 this in clinical practice guidelines, which is
11 what we want them to do.
12 CAPT EVANS: I would think
13 partially met.
14 MS. MALEBRANCHE: Yes, I would say
15 so, because they have done since then. I
16 think the only piece in here where we talked
17 about the VA and DoD should use population-
18 based data, I think they're starting on that,
19 but that's not responded to in the limitation
20 plan. But the clinical practice guidelines
21 are.
22 MS. DAILEY: Not a problem. I'm

1 happy to move it into the partially met piece.
2 And I'll just -- let have Philip flag it. I
3 do have the complete implementation plan. I
4 can go back and check exactly what the wording
5 was, but I thought we were pretty careful
6 about making sure we pulled it directly out of
7 their document.
8 Okay. All right. I have it here.
9 When we get a little farther down the road,
10 let me just cross-check.
11 All right. No. 4. Are we on 4?
12 Yes, 4. This had to do with the CRP, ladies
13 and gentlemen. We were -- at the time had
14 some concerns about its standardized
15 implementation across all the services. Now
16 the CTP applies to the Army. The CRP applies
17 to all the other services, and CRP is run by
18 the RCCs.
19 So what we -- our expectation is
20 here. The Army can -- we found that they were
21 given credit where credit's due. The Army
22 gave us a very big briefing in December about

1 the major revisions they've made to the CTP,
2 and the Marine Corps has also briefed us on --
3 in February about their renewed interest in
4 implementation of that CRP and the RCC --
5 basically the contractors came on line in the
6 Marine Corps meeting and said, yes, we're
7 quality controlling these RCPs. We're doing
8 spot checks on them. So not only giving them
9 credit for their responses to the DoD
10 implementation plan, but when they briefed us
11 on these topics, I've incorporated that
12 information in here also.
13 I think we still have some
14 concerns about the Navy. Again, we didn't see
15 any at the Norfolk. And people we talked to
16 with the Air Force were mostly already out,
17 had left the AFW2 program. And so, that was
18 not good information. But we'd gotten good
19 information from RCCs the year before.
20 And then the final concern --
21 CO-CHAIR GREEN: My personal take
22 on this is that each of the services has made

the RCC responsible for it. So I think there is a consistency in terms of the RCC being responsible for it, but the thing that's not consistent then that we've seen in every site visit is the last piece, which says we're concerned about the service member ability to access the CRP or CTP. And that remains true regardless of service.

So again, I kind of feel like serious progress has been made in standardizing that the RCC is responsible for the CTP/CRP. But then, we remain concerned that the service members don't have access to seeing what's actually being put into this. It's not a living document in most of the places we went to.

MSGT MacKENZIE: It certainly is not. And it's also the oversight of the completion of this form. I mean, I know we're going to talk about Twentynine Palms at a later time, but that was one of those prime examples of the information contained therein

1 on seven packages I was shown was not even
2 close to meeting the required data to be
3 placed into a CRP. So I mean, we've seen
4 evidence this year that although they're
5 trying to do that, there's no interface or
6 accountability for the actual execution of
7 this form on behalf of the service members and
8 their families.
9 CO-CHAIR GREEN: Well, I think --
10 I guess I look at this in kind of phases here.
11 So standardize and provide oversight and
12 guidance for the implementation. I don't know
13 whether that's been done or not. Clarify
14 which member of the team is responsible. I
15 think all the services said the RCC's
16 responsible. And so, ensure the plan is a
17 meaningful tool utilized for positive
18 meaningful dialogue. That really comes down
19 to the family members and not having access to
20 it, right?
21 CO-CHAIR CROCKETT-JONES: And some
22 places service members didn't have access to

1 it. So I think this is definitely partially
2 met. I mean, they are -- you know, they've
3 gotten clarity on who's responsible. They're
4 not necessarily standardized and it's
5 definitely something -- as long as this is to
6 be the keystone of tracking care, I think we
7 might put this in the revisit in order to
8 emphasize its use as an interactive tool, not
9 just a generated document.
10 MS. DAILEY: And real quick, let
11 me discrete -- let me provide some discrete
12 definitions here. The CTP is the Army tool.
13 It is online. It's accessible to service
14 members. They still have technology problems
15 to get timely access to it. But not only does
16 that service member have access to it, but the
17 medical care side has access to the Army's
18 CTP. So it's online, interactive by all the
19 transition teams.
20 CO-CHAIR CROCKETT-JONES: The CTP
21 is interactive, yes.
22 MS. DAILEY: Right. The CRP is a

1 DoD document executed at service level and
2 they have not had that resource to make it
3 online, to make it interactive. So there are
4 two types of documents here we're talking
5 about. We got a briefing on CTP in December.
6 CO-CHAIR GREEN: Oh, so I guess
7 that it really depends. Okay? It is the Army
8 who made the change. Okay? Technically the
9 CRP was what was required and the CRP run by
10 the RCCs is supposed to be where they're
11 tracking progress of recovering warriors. The
12 Army took it one step further and said we're
13 going to make this an interactive document so
14 the whole team can basically look at it, call
15 it a CTP. And at least at the places where
16 we've looked at right now, the CTP has not
17 been necessarily the thing that's kind of the
18 key to managing this. Well, at least that's
19 not what I've seen.
20 DR. PHILLIPS: Could I perhaps
21 suggest summarizing it by saying in theory
22 it's excellent, but the application of it has

1 not worked for a whole host of different
2 reasons? There are technology problems and --
3 CO-CHAIR GREEN: Can I point out
4 though that I think -- you know, if you read
5 the guidance on the CRP, the CRP was something
6 that the RCC was supposed to basically be
7 keeping track of where everybody was. And so,
8 it wasn't -- never -- nothing really said that
9 it was an interactive document that everybody
10 would put information into. Until the Army
11 briefed us that that's the way they were going
12 to use it, there wasn't an expectation that it
13 -- it was really supposed to be the
14 comprehensive recovery plan put together by
15 the RCC for their own purposes to make certain
16 they didn't lose anybody.
17 MS. DAILEY: There's supposed to
18 be interaction with that service member to
19 transition them along, let them set the goals.
20 The RCC is getting them resources so they can
21 meet those goals.
22 CO-CHAIR GREEN: But there's

1 nothing that says that they can't be verbal
2 between the RCC and the service member under
3 the CRP. It's simply a tracking tool for the
4 RCC. So I mean, the problem here is that
5 there's a mixed expectation. The CRP was
6 supposed to be the way the RCC basically
7 documented and showed how they were going to
8 move people forward. And then -- but it
9 didn't say that there was going to be anything
10 other than the RCC putting things into the
11 CRP. And now, the Army took that one step
12 further and said we want this to be an
13 interactive tool that all of the different
14 case managers, et cetera, can put information
15 into and that the -- it will be the primary
16 tool for the soldier to essentially look and
17 follow their care. But that wasn't what DoD
18 said the CRP was.
19 MR. REHBEIN: Should we then be
20 holding up the Army example as a best
21 practice? Do we think it's --
22 CO-CHAIR CROCKETT-JONES:

1 Something --

2 MR. REHBEIN: Do I think it's as

3 good as it could be? No. But I think

4 involving -- having that active involvement of

5 the service member in it, I think, has the

6 potential of providing more value than just a

7 verbal conversation between the RCC and the

8 service member. I think there's a little more

9 ownership there.

10 CO-CHAIR CROCKETT-JONES: Yes, and

11 not only that, but when you're dealing with a

12 population with a lot of TBI and PTS on paper

13 or on access over the Internet is important.

14 Not verbal. Verbal goes is lost. You know,

15 a lot of these guys, you can tell them things,

16 but -- but I would want to say -- the other

17 thing I wanted to say about this is we did

18 also hear from WTU chain of commands in more

19 than one place that their having access to the

20 CTP was useful to them in determining risk

21 assessment, that input on that CTP gave them

22 an idea of who needed more contact and who

needed less.

MS. DAILEY: Good.

CO-CHAIR CROCKETT-JONES: And who was at risk.

MS. DAILEY: Good.

CO-CHAIR CROCKETT-JONES: So actually, I would say yes the Army CTP is a best practice, not maybe best potential -- meeting its potential, but I can say that eyes on that from chain of command was useful to the chain of command.

MS. DAILEY: Okay. Ladies and gentlemen, we're on No. 4 of 21 with 30 minutes left. I have two days in which you can talk about the very topics we're into. A conversation that says met, not met, we'll talk about in units of programs. We'll talk about it in the reserve component piece. I have an hour devoted to each one of these discreetly.

CAPT EVANS: So I think we all agree partially met, need revisit.

1 MS. DAILEY: Okay. Partially met,
2 revisited.
3 Command climate was the fifth one.
4 We put this in the not met category.
5 CO-CHAIR GREEN: From my
6 perspective, I mean, everybody was pretty
7 sensitive to this in terms of what the command
8 climate was going to be. So are we sure it
9 hadn't been met? I mean, what is it that's
10 driving you to say not met?
11 MS. DAILEY: Well, I think in the
12 implementation plan --
13 CO-CHAIR GREEN: In essence,
14 you've got the Army and the Navy, Marine Corps
15 who saying this is what our expectations are
16 and you've got the Air Force saying we expect
17 this to be managed by the chain of command,
18 you know, at their normal bases. So this is
19 only really for the WTCs and WWRs. At least
20 what I saw at the WWR, there was a clear
21 expectation of the command climate. So I
22 don't know. I mean, what would you look at

and say that it wasn't? Did we had a visit this year that was really a negative command climate? We had one last year. I don't know we had one this year.

CSM DeJONG: I think that's what drove this recommendation, was that visit from the first year.

CO-CHAIR GREEN: The first year?

CO-CHAIR CROCKETT-JONES: And I said we had at least one visit from this year with a fairly negative command climate, yes.

CO-CHAIR GREEN: Okay.

CO-CHAIR CROCKETT-JONES: At least -- on mine I'd say actually two.

CAPT EVANS: My only visit was definitely a command climate. Portsmouth.

CO-CHAIR CROCKETT-JONES: Then let's make it three for mine.

CO-CHAIR GREEN: Okay.

CO-CHAIR CROCKETT-JONES: Because if I add Portsmouth to it, because --

CO-CHAIR GREEN: Which ones did

1 you have problems?
2 CO-CHAIR CROCKETT-JONES: I think
3 Fort Carson was a glaring issue. And
4 Twentynine Palms remained partially an issue.
5 LTCOL KEANE: But the issue you
6 had at Twentynine Palms, were those Marines
7 who weren't part of the Wounded Warrior
8 Regiment? The 22 Marines that were part of
9 the Wounded Warrior Regiment, they seemed --
10 everything was hunky-dory. Is it the other
11 278 Marines who were still part of the units?
12 So that wouldn't be --
13 CO-CHAIR CROCKETT-JONES: Yes,
14 that --
15 LTCOL KEANE: -- that wouldn't
16 come under Wounded Warrior Regiment.
17 CO-CHAIR CROCKETT-JONES: Yes,
18 that's -- it's because of the odd setup with
19 them. Navy BUMED and so many folks in --
20 MSGT MacKENZIE: I don't think we
21 can --
22 CO-CHAIR CROCKETT-JONES: It's

1 complicated.
2 MSGT MacKENZIE: -- keep
3 Twentynine Palms under this recommendation.
4 CO-CHAIR CROCKETT-JONES: Yes, it
5 might not be under this one anymore, really.
6 MSGT MacKENZIE: Because one of
7 the things that we've -- the things that we
8 found there were different than this.
9 CO-CHAIR CROCKETT-JONES: You're
10 right. Yes.
11 MSGT MacKENZIE: I think this was
12 fixed.
13 CO-CHAIR CROCKETT-JONES: Yes.
14 MSGT MacKENZIE: It's the other
15 two involved.
16 CO-CHAIR CROCKETT-JONES: It's the
17 other two. Okay.
18 MSGT MacKENZIE: The other
19 involvements that causes --
20 CO-CHAIR CROCKETT-JONES: It's the
21 other involvements. So I'll let it down to
22 two.

1 MSGT MacKENZIE: -- the problems.
2 Which certainly need to be addressed, but
3 that's not this.
4 CO-CHAIR GREEN: So I'm just
5 trying to make certain that the two sites
6 we're talking about were either WTC or WWRs.
7 CO-CHAIR CROCKETT-JONES: Yes.
8 CO-CHAIR GREEN: So Portsmouth and
9 Carson are both WTCs or WWRs. Portsmouth?
10 CO-CHAIR CROCKETT-JONES:
11 Portsmouth was a med hold.
12 CO-CHAIR GREEN: Yes, see, that
13 doesn't -- unless you're that --
14 CO-CHAIR CROCKETT-JONES:
15 Portsmouth's a med hold.
16 CO-CHAIR GREEN: Does that count
17 in this?
18 MSGT MacKENZIE: I think this has
19 been met, sir. I just think we need to get
20 full consensus that we're not missing
21 something before we say this has been met. I
22 don't think it needs to be -- you know, I

1 think by throwing this out there, it's opened
2 up other issues, but --
3 CO-CHAIR GREEN: I feel that
4 the --
5 MSGT MacKENZIE: -- based on what
6 it is, I think it's been met.
7 CO-CHAIR GREEN: I feel that their
8 implementation plan saying the Marine Corps
9 will do this and the ARMY WTC will provide
10 guidance, they've actually done what we asked
11 them to do. Whether or not we're still seeing
12 some command climate things is a different --
13 but it's not necessarily WTC and WWR. It's at
14 some of the smaller units now.
15 CO-CHAIR CROCKETT-JONES: Okay. I
16 agree that the implementation actually sounds
17 like it's -- they've understood the
18 recommendation and they're -- so met is fine.
19 The topic may need to be revisited, but the
20 recommendation was met.
21 CO-CHAIR GREEN: Yes, that's what
22 I think, too. Anybody who objects to that?

1 MSGT MacKENZIE: No, sir.
2 CO-CHAIR GREEN: So I think we
3 move this one to the met column.
4 MS. DAILEY: Okay. This one goes
5 to the met column.
6 The No. 6 had to do with entrance
7 criteria, the enforcement of the entrance
8 criteria and standardization.
9 CO-CHAIR GREEN: I only have
10 experience at the one side, but I thought the
11 Marines did a good job with this when we
12 visited down at Lejeune. So I was impressed
13 that they'd actually dealt with this one. But
14 I don't know about all the other sites in
15 terms of case manager ability to move people,
16 you know?
17 CAPT EVANS: I think at Portsmouth
18 it was clearly defined who would go into a
19 service program. So I didn't see that as an
20 issue. And even at the campus, I don't -- I
21 really don't see this as -- they understand --
22 each service is clearly defined. I think

1 maybe one program, as far as Safe Harbor --
2 that's the only one that I'm still -- and it's
3 not so more in the wounded warrior categories,
4 the non-battle injury.
5 CO-CHAIR GREEN: Even the Iowa
6 situation, they seem to have clear criteria.
7 And when they enforced it, they didn't bring
8 all those people in. I'm not sure that we
9 agree with the criteria, but that's a
10 different story.
11 CO-CHAIR CROCKETT-JONES: Yes, I'm
12 going to say that I actually think I have a
13 grasp on criteria and have been able to find
14 clearly what the criteria are. I'm not sure
15 that the implementation plan actually is very
16 clear. It necessarily was responsive to our
17 concern in the recommendation, but I think
18 actually our recommendation has been met. I
19 think that it has brought us to perhaps once
20 again a need for more specific recommendation,
21 for instance, if entrance criteria are trumped
22 by bed availability.

1 MS. DAILEY: Okay.
2 CO-CHAIR CROCKETT-JONES: Yes,
3 things like that.
4 MS. DAILEY: Yes.
5 CO-CHAIR CROCKETT-JONES: But
6 within the recommendation we made I actually
7 think that they've met the criteria, not
8 necessarily with their implementation plan,
9 but just in reality.
10 MS. DAILEY: Okay. So we're going
11 to move 6 to the met category.
12 Onto 7. This is the nurse case
13 manager availability at the WTUs, the WRRs and
14 the community-based warrior transition units.
15 We have assessed this one as being met. We
16 have a very large nurse case management
17 inventory these days and clearly they've been
18 identified as principals in recovery programs.
19 Where we are running into problems
20 is the transition between case managers turn
21 that's occurring, under-laps. But everywhere
22 we go, they're 90 percent filled.

1 CO-CHAIR GREEN: I think everybody
2 -- any objections? I think they met this one
3 with their implementation plan. Yes. They've
4 all talked about acuity. They're all talking
5 about the ratios. So we got their attention.
6 Yes, met. Good.
7 MS. DAILEY: No. 8 was the reserve
8 component. Shape strategic solutions to the
9 reserve component issues. And actually, I'm
10 not even sure this got kind of even pushed
11 down to the right people for an answer to it.
12 I'm actually going to have a meeting with
13 Reserve Affairs to talk about recommendation
14 8 specifically. So we have this in the not
15 met category.
16 MSGT MacKENZIE: I would concur
17 that it's not met. And I think we need to, if
18 we're going to revisit this, be more specific
19 in what it is we're asking for because it's
20 pretty obvious to us, but it's obviously not
21 obvious to them.
22 CO-CHAIR GREEN: Any objections?

1 Not met and we'll be more specific? Agreed.
2 MS. DAILEY: No. 9. This was the
3 Centers of Excellence. We have put this in
4 the met category. Doesn't mean we might not
5 make more recommendations on it. But this one
6 is about aligning them with the services. The
7 issues of funding. And we did get some more
8 briefings this year about funding and
9 personnel and all of seemed to be centering
10 around fiscal constraints and caps on
11 personnel hiring actions. We can re-craft to
12 keep the attention on that. We have more data
13 this year for a different recommendation if we
14 want to go there.
15 MSGT MacKENZIE: I did like the
16 Division Center of Excellence response to them
17 becoming that central location of expertise
18 for the outlying medical facilities to call
19 upon. I think they took our recommendations
20 very seriously. However, you're right; they
21 got lots of funding. They just can't spend it
22 because nobody allowed them to hire the people

1 they need to actually fulfill the mission
2 they're trying to take on.
3 MS. DAILEY: And just keep
4 something in mind; we're going to move this
5 into the met category, I have to put this in
6 the FACA database that no one looks at. But
7 when we go up and talk to Congress, sir,
8 ma'am, they ask us, well, your recommendations
9 for the Centers of Excellence, you've felt DoD
10 took your recommendation. I mean, we do end
11 up defending them in certain categories.
12 CO-CHAIR CROCKETT-JONES: I think
13 that, yes, the recommendation as we wrote
14 it --
15 MS. DAILEY: Okay.
16 CO-CHAIR CROCKETT-JONES: -- they
17 did meet it.
18 CO-CHAIR GREEN: Yes, they met it.
19 The other thing is that it's not
20 too hard to be -- DoD at the same time would
21 support them, because they have taken more
22 than two years to get to a place where they're

1 aligned with the service where they could
2 executed. So I mean, I can handle that.
3 MS. DAILEY: All right, sir. All
4 right. I'm on it.
5 All right. Next one. Doing good
6 everybody. Doing good.
7 Recommendation 10. PTSD care.
8 Access to it across the continuum. Access to
9 routine care at the time was the thrust of our
10 intent here. I had this in the met column and
11 then I moved it into the not met column and
12 back and forth. Ladies and gentlemen, here's
13 been a lot of work done on PTSD, but any --
14 who's -- how do we --
15 CO-CHAIR GREEN: I think we give
16 them a partially met and our concerns remain
17 with the reserve side of the house. I'm just
18 not certain that we're offering timely PTS
19 services to the reservists based on line of
20 duty and other things. But that's my two
21 cents.
22 CO-CHAIR CROCKETT-JONES:

1 Definitely partially met. I'm not even sure
2 they're meeting timeliness for regular active
3 duty. I think that we're --
4 CO-CHAIR GREEN: Well, you could
5 also -- it may be easier to just say not met
6 on this one based on what's going on at
7 Madigan right now as well. So I mean, I'd
8 just leave that. Rich isn't here to cringe
9 when I say that, but --
10 CO-CHAIR CROCKETT-JONES: Then
11 partially.
12 MS. DAILEY: Yes, you know, I
13 moved it out of the met into not met because
14 of General Stone's recommendation.
15 CO-CHAIR GREEN: I think that
16 that's wise right now.
17 MS. DAILEY: Okay. We will keep
18 it in the not met and -- yes?
19 LTCOL KEANE: One comment. The VA
20 has identified 1,900 PTSD healthcare providers
21 that they will be hiring over the next years.
22 MS. DAILEY: Correct.

1 LTCOL KEANE: That's another --
2 MS. DAILEY: I do think you have
3 credit and I think we captured it in the
4 expectation. There's a lot of hiring. DoD's
5 brought on over 2,000, according to their own
6 numbers.
7 CO-CHAIR GREEN: Yes, I think the
8 way to do -- although significant progress has
9 been made, it's still not met based on reserve
10 and other issues that have evolved over the
11 year. I think that's the way to work it.
12 MS. DAILEY: Okay.
13 MSGT MacKENZIE: I also think that
14 any further recommendations that we sit down
15 as a group.
16 MS. DAILEY: Yes.
17 MSGT MacKENZIE: We need to
18 identify that difference between PTS and PTSD,
19 because it's not all about PTSD. So if we're
20 going to look at this, let's make sure we're
21 looking at both of those.
22 MS. DAILEY: No. 11. Still

1 concerns about the various rules. FRCs, RCCs
2 seem to be the topic of the day, but we also
3 expanded this last year into the VA liaisons,
4 the poly-trauma, the nurse case managers.
5 This also has to do with the definitions.
6 CO-CHAIR GREEN: This one is in
7 progress, and so I think we give them a
8 partially met. There's actually been a
9 meeting called by Health Affairs between both
10 VA and DoD to try and do exactly what we've
11 asked them to do. And so, it's one of those
12 things that I think we give a partially met
13 and say that we recognize the efforts are
14 ongoing to clarify these roles. I mean, I've
15 seen the charter that they've put out, so I
16 know that they took us very seriously on this.
17 MS. DAILEY: Good. All right.
18 Yes, even ongoing actions and we'll throw them
19 in the credit category. Very good.
20 All right. Twelve. This was
21 about training of cadre, ladies and gentlemen.
22 This is dealing specifically with the Army

1 unit and the cadre that are taking care of
2 Army and young Marines. How are they trained?
3 How are they prepared for this job? Can we
4 enhance it? Can we provide them continue
5 career growth and still be in these types of
6 jobs?
7 CAPT EVANS: I believe they're
8 providing some training to the cadre and the
9 section leaders in the Wounded Warrior
10 Regiment. So I know they have looked at this
11 one, because I've seen the training myself.
12 My only concern is that training
13 -- we really have segregated training. So
14 there's section leader training, RCC training,
15 FRC training. So I would like to -- I think
16 we can move into the partially met, but then
17 we need to revisit this one to encompass
18 training across the board.
19 CO-CHAIR GREEN: So another one
20 that we'd say significant progress has been
21 made based on briefings we've taken at all the
22 different locations, but you know, we still

1 feel that there are training gaps?
2 CAPT EVANS: We still have
3 training gaps.
4 MSGT MacKENZIE: I wouldn't say
5 that they've met it because they haven't done
6 anything with what they've told us yet. I
7 mean, it hasn't been implemented. They got a
8 lot of great ideas, but it hasn't actually
9 been implemented yet.
10 CO-CHAIR GREEN: Based on what
11 they say here, that's true. Based on what we
12 saw, it actually is in the implementation
13 process, at least for the Army and the Marines
14 that I saw.
15 CO-CHAIR CROCKETT-JONES: So I
16 guess it's another partially met and revisit?
17 MS. DAILEY: Okay. Yes, I mean,
18 the Army's whole briefing in December was
19 about this new training program. Ten days.
20 All the compartments. All --
21 MS. MALEBRANCHE: And the Iowa
22 group, when we went there, there wasn't

1 training. I mean, we were talking with those
2 NCOs. I don't know if this is related to this
3 particular one, but there was not training --
4 MS. DAILEY: Yes.
5 MS. MALEBRANCHE: -- for those
6 NCOs at all.
7 MS. DAILEY: Yes. No, we're
8 talking about the WTU cadres.
9 MS. MALEBRANCHE: Okay. You're
10 talking about --
11 MS. DAILEY: But, yes, to your
12 point, ma'am, a kind of more overarching
13 training. It talks about integration of these
14 skills would be a good way to go.
15 CO-CHAIR GREEN: And that's a nice
16 way for us to evolve this one, too.
17 Significant progress has been made. We still
18 identify training gaps. Use some of the
19 examples from site visits this year.
20 MS. DAILEY: Okay. Good. Next
21 one is the ongoing -- excuse me. This one was
22 really directed at families, but it was

1 information dissemination. And it was
2 designed to kind of focus and direct
3 information to family members. We've kind of
4 expanded it to include recovering warriors.
5 MR. DRACH: Just a point of
6 information on the NRD. They got a stop work
7 order at the end of April. So the NRD is not
8 currently being updated. I think it's status
9 quo as of April 30th. There's no work being
10 done on it. Well, what I heard was that
11 they're going to re-compete it. So the
12 question is when?
13 MS. DAILEY: This also had to do
14 with the Keeping It All Together package. We
15 found it to be a best practice. We wanted
16 them to get it out in bulk, make it more
17 accessible. I think that piece of that has
18 been met. Most of our concerns actually are
19 now really down into recommendation 14, which
20 is empowering caregivers. So they kind of run
21 together.
22 CO-CHAIR GREEN: So are you

suggesting we say met on that one? I'm missing --

MS. DAILEY: I know.

CO-CHAIR GREEN: Don't want to on 13?

MS. DAILEY: I know.

MR. REHBEIN: I think one of the other things we discussed as far as 13 is concerned a lot of these folks had been briefed on National Resource Directory and keeping it all together, but very early in the process. And when they needed it a year from then, they'd forgotten that was why we said regular and recurring. And so, I don't know if that's being done.

CO-CHAIR GREEN: Well, I love the WRR app. I mean, you know, you're talking about pushing something with people. I mean, so they actually had the app to pull it up. So I don't know that you can give them full credit for having met this one, but again, it's one of those that there's some effort to

1 improve this.

2 CO-CHAIR CROCKETT-JONES: Yes,

3 once again I'd say as it was written they have

4 made significant progress. The topic itself,

5 when it comes to information access and

6 getting to the family members and -- is that

7 -- that's a topic that needs to be revisited,

8 but I think this recommendation as it was

9 written is mostly met.

10 MS. DAILEY: Okay.

11 CO-CHAIR CROCKETT-JONES: But

12 recurring might not be, but some are actually

13 doing that.

14 CO-CHAIR GREEN: So maybe we could

15 say met and then focus on a different aspect

16 of information still not getting to them, or

17 we can say significant progress but still work

18 to be done. I mean, whichever way you want to

19 go.

20 CSM DeJONG: Yes, we've also

21 changed technologies since writing this to

22 where the Keeping It All Together folder is

now available through an app and the rest of the thing. So we got to take that into consideration.

MS. DAILEY: So I'm happy to move this one to the met category.

The next one, which is 14, is --

CO-CHAIR GREEN: Before you say the next words --

MS. DAILEY: Okay.

CO-CHAIR GREEN: So everybody's okay with that saying met, because we're actually -- I think we'll use the app as a best practice in the next one. And so, what she's about to say is by closing this one, by saying it was met, then we can actually capture some of this in the next one.

MS. DAILEY: We would revamp it --

CO-CHAIR GREEN: Right.

MS. DAILEY: -- and do another. Fourteen is more focused on family caregivers. I have this as a not met. I think we might still feel pretty strongly that the

1 empowerment of the caregiver is still a
2 significant issue.
3 DR. PHILLIPS: I hesitate to say
4 this, but so much of this -- all of these are
5 dynamic and they're ongoing. And I just throw
6 this out as a met or not met, adequate. I
7 mean, should it be successful or implemented
8 or -- I just want to be fair.
9 CO-CHAIR GREEN: I kind of agree.
10 I think on almost all these where we say it's
11 met, we're almost better off saying a
12 significant effort and progress has been made
13 in trying to implement this and go from there.
14 So, yes, I know why you're doing met and not
15 met, but on all of them I think the wording
16 would be significant progress and then even
17 use a best practice.
18 And so, it will help our report.
19 It'll make it easier because we can give
20 examples of what we've seen that show that
21 they've made significant progress and then use
22 examples of where more effort is needed. So

1 I kind of agree with you. It may well not be
2 that we can simply say, yes, that one's
3 closed. Gone. And you don't have to worry
4 about education of family members anymore.
5 Oops.
6 CO-CHAIR CROCKETT-JONES: Yes, and
7 I also want to point out that we can't really
8 roll education and information resources for
9 family members into a discussion of the
10 empowerment of family caregivers, because that
11 is a strictly defined role.
12 LTCOL KEANE: I think we've come a
13 long way since last year with the SCAADL and
14 the VA's Caregiver Program, if that's what
15 you're hitting on.
16 MS. DAILEY: Well, that's 15, and
17 15 is a solid met.
18 CO-CHAIR CROCKETT-JONES: Yes, now
19 I'm saying that when we say "empower family
20 caregivers," we're talking about a subgroup of
21 family members. Family caregivers is a
22 defined term regarding the amount of care

1 someone who is wounded, ill and injured
2 requires and the family caregiver is a defined
3 role, saying that they require a caregiver, an
4 in-home caregiver. Information resources to
5 family members is a larger group of people.
6 And if we eliminate the concept of information
7 resources to family members and rename it
8 giving it to family caregivers, we're talking
9 about a much smaller group of people that we
10 are expecting to have information resources.
11 CO-CHAIR GREEN: And so my way
12 forward is that I think we talk about
13 significant progress in 13. I think in 14
14 right now, I mean, my impression is not met.
15 Okay? I'm not even sure they understood it,
16 based on their response. And so, that makes
17 it a little easier. Then 15, based on what
18 they've done with SCAADL and some of the other
19 things, I think 15 is met.
20 So essentially it would be 13,
21 significant progress; 14 not met; 15, met.
22 Anybody with any big objections to --

1 CAPT EVANS: With the revisit to
2 14. And I would say 13 and 14 revisit.
3 CO-CHAIR GREEN: Right. Right.
4 CAPT EVANS: Okay.
5 CO-CHAIR GREEN: Okay.
6 MS. DAILEY: Sixteen had very
7 specific focus on the SFACs with the Army. I
8 did talk with General Stone. He was
9 comfortable with leaving it as a not met. He
10 says there is some pressure to reduce the
11 staffs in the SFACs. And they're not a part
12 of the WTC or the MEDCOM. He was asking for
13 the task force's support to allow the MEDCOM
14 and the WTCs to leverage task force's
15 recommendation for these facilities.
16 CO-CHAIR GREEN: And see, I agree
17 with Rich. I think one of the problems is is
18 that as they have to come out of their WTCs,
19 that they're going to need the SFACs. And so,
20 if they close down the SFACs before they shut
21 down the WTCs as their numbers come down,
22 they're going to be in big, big trouble. So,

1 yes, I agree with keeping it open. And I
2 don't know how to work in terms of met, not
3 met, progress, not progress, but I don't think
4 they can close it. This one's tightly tied to
5 that one about population-based decisions on
6 where you're going to set things up.
7 CAPT EVANS: So right now, with
8 the exception of Walter Reed/Bethesda, all the
9 SFACs, they belong to the garrison.
10 MS. DAILEY: Correct. They belong
11 to --
12 CAPT EVANS: With the exception of
13 the one, and the one belong to MEDCOM. So
14 with the numbers, I think what we're seeing
15 across the board, especially as we move
16 towards integrating more facilities, the focus
17 should be how can we not only have Soldier
18 Family Assistance Center, but how could we
19 integrate those services across where we have
20 different entities on board one campus? How
21 can we make that as one? Prime example, you
22 have 28 staff members in the Soldier Family

1 Assistance Center at Walter Reed, on top of
2 the 52 Marine Corps MCLOB providing similar
3 services, on top of hospital staff providing
4 similar services. So the goal I think we need
5 to try -- how could we not -- we need to, as
6 far as wounded warrior, integrate as much as
7 those services to the families as possible.
8 I just see a lot of redundancy out there with
9 this type of --
10 CO-CHAIR CROCKETT-JONES: But I
11 think that we can tackle that with the next
12 recommendation cycle. And for now, let's
13 leave this as not exactly met. Open somehow.
14 MS. DAILEY: Okay. I'm going to
15 leave it as not met.
16 CO-CHAIR GREEN: Well, leave it as
17 not met. My recommendation would be we look
18 at how we tie 16 and No. 2 together, because
19 they clearly didn't understand our No. 2,
20 which was about the population-based standards
21 and criteria to drive decision about location
22 establishment, which drives to your efficiency

1 issue. So I think we could kind of roll them
2 together and see if we could help them
3 understand what we're trying to get at.
4 CAPT EVANS: I agree.
5 MSGT MacKENZIE: Right, and that's
6 the thing, because, I mean, Walter Reed's a
7 unique area where the unit-specific expertise
8 can be rolled together into one office that's
9 doing all the stuff at the same time. But
10 also where this comes into play, too, was the
11 -- you know, where you had a significant
12 population of wounded, ill and injured, where
13 the SFAC was trying to stand up, but you know,
14 people were like, well, it's over here. Why
15 are you -- you know, that decision to put a
16 centrally located area for these networks to
17 work out of was being overrun by the -- you
18 know, the in-place establishment, but yet that
19 in-place establishment had no plans to provide
20 the level of services that the SFAC model is
21 designed to do. So that's, I think, with it.
22 MS. DAILEY: Okay. Good.

1 Transition Assistance Program No. 17. I
2 listed this as met, met through legislation.
3 The Vow to Hire Heroes Act makes it mandatory,
4 however, the Vow to Hire Heroes Act does have
5 exemptions and I think we'll need to monitor
6 the DoD on how they apply those exemptions.
7 CO-CHAIR GREEN: This is another
8 one that because it hadn't actually been
9 implemented yet, you want to not say met as
10 much as you want to say clear progress has
11 been made. But I agree with -- I mean, yes.
12 MS. DAILEY: I mean, I --
13 CO-CHAIR GREEN: It's the same
14 thing. I mean, I think you're right about it
15 being met. I just don't want it to be a met
16 and a check mark there. We don't watch it.
17 I think it needs to be significant progress is
18 made by the law of doing this and once
19 implemented, it will indeed meet the intent.
20 I mean, that's --
21 MS. DAILEY: Okay. I see.
22 CO-CHAIR GREEN: You see?

1 MS. DAILEY: Yes. Eighteen.
2 Eighteen was centered around better
3 availability to service members for the VR&E
4 Program. We did see also in the most recent
5 legislation the relieving of the sun set on
6 December 12th of 2012. The R&E access prior
7 to DD214 was due to end in December of this
8 year. Congress relieved that. Took it off.
9 Actually, they put it out to 2014. This was
10 about allowing more access, more involvement
11 to get people into the VR&E Program earlier.
12 CO-CHAIR GREEN: So again, I think
13 we say progress was made with the
14 congressional action to extend it to '14 and
15 that we will continue to monitor.
16 MS. DAILEY: Right, sir.
17 MSGT MacKENZIE: Yes, but do we --
18 yes, I mean, still with every installation we
19 go to they either don't have a VR&E counselor
20 or the VR&E counselor doesn't realize they can
21 start 365 days prior to getting out.
22 CO-CHAIR GREEN: But the nice

1 thing is because the new is out there, we
2 should expect to see that there will be
3 progress made on it. And so, that's why when
4 I say "monitor," we could even mention the
5 fact that in our facility visits we have not
6 yet seen, you know, this being implemented, so
7 we're going to monitor it closely.
8 MS. DAILEY: And I capture a
9 little bit of that in our -- you know, we see
10 that it's -- we've got some going on, but some
11 places it's not. So we'll put progress to be
12 monitored. Progress to be moved forward.
13 Partially met. Partially met.
14 Okay. Nineteen. This was a
15 continue to monitor. I'm sure I have it in
16 the not met category. I have it in the met
17 category? Okay. Second to the last line.
18 Task force will continue to monitor how the
19 legal support requirements are being met. The
20 PEBLO. I have, let me see, the PEBLO ratios
21 are continuing to be monitored. But we gave
22 them -- my recommendation was to give them a

1 met on the legal requirements. Again, you've
2 got a whole day to talk about legal. We can
3 craft another recommendation if we still need
4 a point in that area.
5 CO-CHAIR GREEN: No, I agree. I
6 think we can give them a met on the legal and
7 basically on the PEBLO as we continue to
8 monitor. The problem is the PEBLOs are --
9 it's very fluid in terms of the numbers. And
10 so, not only because it's going up right now
11 for the Army, but because it's coming down for
12 the other services. So I think we'd have to
13 say that we'll continue to monitor PEBLO
14 support.
15 MS. DAILEY: Good. Okay.
16 Nineteen. Two left. This is the electronic
17 health records recommendation. I'm on 20?
18 Yes, that's right. Pending implementation of
19 the electronic health records. Twenty.
20 Our thrust here, ladies and
21 gentlemen, was about interim solutions. They
22 went from the interim solution to the big

1 solution.

2 CO-CHAIR CROCKETT-JONES: They did

3 brief us on a couple of interim pilots with

4 some -- they have at least one site where

5 they've managed to merge and they had some

6 interim -- and then another site that they

7 were piloting --

8 MS. DAILEY: Correct.

9 CO-CHAIR CROCKETT-JONES: -- a

10 whole new system. But I'm not sure that what

11 they briefed us on their interim solutions was

12 really effective for any number of the people

13 that we are covering.

14 MS. DAILEY: Correct.

15 CO-CHAIR CROCKETT-JONES: So, yes,

16 they have not met interim solutions for the

17 wounded warrior population. So I can see that

18 as being not met.

19 MS. DAILEY: Yes, and I don't

20 think they get this one either. Again, I

21 think; correct me if I'm wrong, your focus was

22 on capturing some of the faxing, copying,

1 encrypting and sending via email processes
2 that we've seen. I thought that's where you
3 were going with this recommendation. Don't
4 see a lot of that happening either. But this
5 is one I think is almost already become
6 overcome by events. Monitoring, and as you
7 said this morning with the IPO, sir, keeping
8 track of their ability to provide the
9 management of this big new initiative is
10 probably more in our lane.
11 CO-CHAIR GREEN: I think that the
12 way to tackle this one is say that the task
13 force has seen progress in the formation and
14 manning of the IPO to oversee the record.
15 There also has been progress in terms of some
16 of the integration in terms of records
17 availability to the VA, especially North
18 Chicago, the way they're leveraging BHIE and
19 the single sign-on context management. And
20 the formation of e-benefits actually has been
21 pretty positive over the last few months in
22 terms of its availability to veterans to give

1 them access to services. And so I think we
2 give them a we're seeing progress and I don't
3 think we even talk about met or not met. We
4 just say we're seeing progress and we'll
5 continue to watch this one.
6 MS. DAILEY: Okay. Good, sir.
7 DR. PHILLIPS: Yes, I'd say I
8 think we've seen a lot more improved
9 efficiency in the actual existing process,
10 which I would encourage. I mean, even though
11 there hasn't been alternative solutions.
12 MSGT MacKENZIE: Maybe an
13 opportunity to highlight some of their best
14 practices where different facilities are
15 getting these guys through this -- the records
16 through this system with correctness and
17 accuracy that is not seen in other locations.
18 This would be an opportunity for us to
19 highlight some of those and -- definitely.
20 MS. DAILEY: I have to add, didn't
21 get any best practices when we talked to the
22 VAs. They are really still struggling with

1 trying to reach into the electronic health
2 record system. That's not a slam on them.
3 I'm just saying I don't really have any data
4 to validate best practices on records transfer
5 out there.
6 MS. MALEBRANCHE: Yes, I'm not
7 sure, but I don't think -- we didn't talk
8 about some of the things you mentioned like
9 the bilateral health information exchange --
10 MS. DAILEY: Yes.
11 MS. MALEBRANCHE: -- that's
12 occurring.
13 MS. DAILEY: Yes.
14 MS. MALEBRANCHE: North Chicago's
15 been the test bed. They're already doing some
16 things. Pharmacy's ongoing. But that's not
17 captured yet.
18 CO-CHAIR GREEN: I think that I'd
19 probably say --
20 MS. MALEBRANCHE: Ongoing?
21 CO-CHAIR GREEN: That's why we say
22 we've seen progress with the -- and then list

1 a host of initiatives, but that we -- you
2 know, until we actually see a reduction in the
3 paper transfer for the actual disability
4 evaluation, they won't have reached what we're
5 really looking for.
6 And if we can go on to No. 21, 21
7 is interesting because you'd like to say it
8 was met because they did do it except for one
9 thing, that DoD persisted in not necessarily
10 putting the deputy on there. And so, how do
11 we deal with that one?
12 MS. DAILEY: We tied that
13 specifically to a congressional -- that
14 Congress has to kind of rejigger the JEC
15 legislation, sir. And so, that was DoD's out,
16 but believe it or not, you knew that last
17 year --
18 CO-CHAIR GREEN: I know.
19 MS. DAILEY: -- when you said --
20 so you wanted that in there. And I agree. We
21 just have to get up and talk to Congress, and
22 we'll have that opportunity in June. And

1 we'll take the opportunity to say we need you
2 to rejigger, as per our recommendation; the
3 task force's recommendation, to put the deputy
4 secretary in the lineup for the JEC as a
5 co-chair.
6 CO-CHAIR GREEN: So give them
7 credit for consolidating the --
8 MS. DAILEY: Correct.
9 CO-CHAIR GREEN: -- SOC with the
10 JEC. And then we say we'll work with Congress
11 to help you actually reach the ultimate
12 objective?
13 MS. DAILEY: Right. Right. And
14 we'll have a window of opportunity to do that.
15 And it's important to these other big
16 programs. Like the IPO, if they really want
17 to get down the road, they're going to need
18 that level of leadership at the JEC. The IDES
19 system is going to need that level of
20 leadership at the JEC.
21 Okay. Good. Thank you very much.
22 Good job, everybody.

1 CO-CHAIR GREEN: Was there a
2 second one? Was there one other one that --
3 I thought there were 22.
4 MS. DAILEY: No, sir, 21. Good
5 job.
6 CO-CHAIR GREEN: We did better
7 than I thought.
8 CO-CHAIR CROCKETT-JONES: Yes.
9 MR. REHBEIN: Denise, could you
10 run back through the list just for
11 clarification, just to make sure I got my
12 notes right.
13 MS. DAILEY: Okay.
14 CO-CHAIR CROCKETT-JONES: Okay. A
15 short break everybody, and 10 minutes.
16 MS. DAILEY: Wait a minute. Mr.
17 Rehbein asked for kind of a quick recap.
18 CO-CHAIR CROCKETT-JONES: Oh, I'm
19 sorry. I didn't hear that.
20 MR. REHBEIN: If we could just run
21 back through the list of which ones fall into
22 which categories so that my notes are --

1 MS. DAILEY: Okay. This is -- I
2 can rejigger them based on some of the change
3 in language at about 15, but up to 15 this is
4 what we had done: No. 1, not met; to be
5 revisited. No. 2, not met; to be revisited
6 with some more specificity. No. 3, partially
7 met. No. 4, partially met; to be revisited.
8 No. 5, met. No. 6, met and specifics. No. 7,
9 met. No. 8, not met. No. 9, met. No. 10,
10 not met. No. 11, partially met. No. 12,
11 partially met. No. 13, met. No. 14, not met.
12 We had a met at 15. And in about 16 we
13 started inserting languages of not met but to
14 consider this. Look at tying 16 and 2
15 together. And 17 we have a met with clear
16 progress made; must be monitored. Eighteen we
17 had a partial met with progress made and
18 monitoring. Nineteen, I have a met with
19 continue to monitor particularly the PEBLO
20 support. Twenty, met. Excuse me. Twenty,
21 not met. Will monitor. Look for progress.
22 This is the IPO one. And 21, partially met.

1 CO-CHAIR GREEN: We'd just like to
2 have that list. I guess everybody's got it,
3 but if we're going to revisit them in our
4 findings this year, it would be nice to have
5 that as a starting point for tomorrow.
6 MS. DAILEY: Good.
7 CO-CHAIR GREEN: Okay.
8 MS. DAILEY: Okay. I'll have this
9 list and we will incorporate them into our
10 discussions when we talk about units,
11 programs, medical care management, non-medical
12 care management, IPO, yes. Now break or --
13 we've got -- yes?
14 CO-CHAIR CROCKETT-JONES: Yes, I
15 was going to say 10 minutes to --
16 (Whereupon, at 3:13 p.m., the
17 above-entitled matter went off the record and
18 resumed at 3:34 p.m.)
19 MS. DAILEY: Thank you, ladies and
20 gentlemen. Happy to have you back here.
21 If you would, sir, and then I'm
22 going to pick it up after you go through the

1 script.

2 CO-CHAIR GREEN: Okay. I'm not

3 doing well on my part here. I apologize.

4 MS. DAILEY: Page 4.

5 CO-CHAIR GREEN: We'll now review

6 the topics of transition outcomes and the

7 DoD/VA/Senior Oversight Committee

8 coordination.

9 Last year we created

10 recommendations 3, 10, 18, 20 and 21, which

11 related to these topics. As we discussed

12 earlier, the SOC has become the Wounded, Ill

13 and Injured Committee of the Joint Executive

14 Council, which we're all very pleased with.

15 Effective documents for these topics can be

16 found in tab G.

17 This topic falls under the

18 enabling a better future, so I'll turn this

19 over to Mr. Malebranche and Mr. Rehbein.

20 MS. DAILEY: And I'm going to help

21 them out a little bit on this first one,

22 ladies and gentlemen.

1 So we're on tab G. So as I said
2 in the email, this will pick up a rhythm just
3 like it did in the recommendation review. The
4 reason we're starting with these topics is
5 that they're some overarching. They're
6 interagency activities.
7 The Transition Outcomes Effective
8 Document in particular is an outcome document,
9 ladies and gentlemen. It is all the touch
10 points who deal with wounded warriors after
11 the DD214. So it is the data gathered from
12 discs. It's the data gathered from AFW2s, who
13 most of their clientele are retired or out of
14 the Air Force. It's data gathered from AW2s,
15 the Army equivalents who are transitioning
16 people seriously wounded 30 percent and above
17 outside the military. It's data gathered from
18 our visits. Do you remember our visits to the
19 VAs, the OEF/OIF program managers.
20 And so this kind of gives you an
21 overarching look at the service member after
22 the DD214 with the intent that you can take

1 this information and you can roll it back into
2 our programs and say where do the pre-DD214
3 services benefit for improvement based on this
4 outcome information? So if we see a lot of
5 data that talks about service members being
6 financially handicapped, unable to get -- and
7 we access VA.
8 You kind of take that data. You
9 kind of roll it back in and say, okay, we need
10 to beef up financial programs so that they've
11 got better budgets going out the door. And
12 that's the intent of the Transition Outcomes
13 Effective Document. It touches that
14 transition between DoD and VA, that warm hand-
15 off between a case manager, the DES, PEBLO or
16 the MSC working in the DES program to an
17 OEF/OIF program manager. And we want to kind
18 of work that piece. It's part of our
19 oversight and it is the end product, and the
20 efficiency of those is the end product that we
21 want our service members to do successfully.
22 Overall over the next two days

1 what is to be accomplished is for you to kind
2 of convey among yourselves where you want to
3 take a recommendation in any one of these
4 areas. So if you feel, having looked through
5 these documents, that you have strong evidence
6 that a recommendation is supported, discussion
7 among you all, agreement that you want the
8 research staff to craft a recommendation
9 around it, and pull in the findings.
10 And then I give you a document on
11 or about two, two-and-a-half weeks from now
12 which has your thoughts about what area needs
13 a recommendation. And it has wording that --
14 not specific wording, but the intent of the
15 wording of the recommendation and passing it
16 to the research staff. They'll pull the
17 findings in and they'll come back to you with
18 recommendations.
19 Your next meeting you will massage
20 those, you'll go over them and you will come
21 to final wording and you vote.
22 Next two days is our opportunity to discuss

1 each topic area.
2 CO-CHAIR GREEN: I'm sure glad
3 your group is ready to talk about this,
4 because I'm looking and I'm a little
5 overwhelmed with the amount of stuff that
6 we've got kind of linked here. So what are
7 you folks thinking?
8 MR. REHBEIN: I'm going to just
9 make a couple of remarks here, and it comes as
10 much from experience as it does from the
11 outcomes document, but it's -- my experience
12 is reinforced by the outcomes document.
13 I think the one thing, the one
14 overarching thing, if I can use that word,
15 that I see as people attempt to transition out
16 of the military back to civilian life -- it's
17 as much a culture change to them as it was
18 when they first put on the uniform, but
19 they're not provided with the guidance that
20 the drill sergeant gave them when they first
21 put on the uniform, and I think they feel like
22 they're out there alone. Not sure how to

1 navigate these systems, even if they know what
2 the systems are.
3 You know, I think about -- it's
4 reinforced by your remark a few minutes ago,
5 sir, about your exam at the VA. The
6 perception of what's there as opposed to the
7 reality of what's there, they don't match. We
8 try to develop information and resources for
9 the recovering warriors going through
10 recovery, but yet it's very difficult. I wish
11 we could develop those kinds of resources for
12 people coming out of the military, except that
13 experiences are so much different that it
14 almost has to be individualized.
15 And I think of some of the things
16 that I've seen out there in the apps area,
17 because I know there are apps being created to
18 help a person walk through a VA claim, where
19 you can make choices, and in that the choices
20 you make help guide you to the next set of
21 decisions. And I don't know if something like
22 that is possible for someone coming out of the

1 military or not.

2 Karen, you want to --

3 MS. MALEBRANCHE: Well, actually

4 because of a number of things besides the

5 visits, I do think that's possible. I mean,

6 they've done a PTSD app. The VA's done that,

7 and that started out to be a pilot. And

8 that's turned out to be a total program. I

9 mean, they're fully invested in that and doing

10 more on other things.

11 I think from the -- just the few,

12 the couple of visits that I did for this

13 year's and from looking at last year's report,

14 there is definitely some improvements,

15 especially in terms of caregivers. What I'm

16 really surprised and I guess just personally

17 disappointed, and I think as an agency, that

18 the wounded warriors still have the 35 or 50

19 refrigerator magnets with I'm a single case

20 manager. They still have so much out there,

21 but they don't know where to go to first. I

22 mean, that seemed to be consistent even to

1 this point in time. So when we talk about
2 some of the things, I think it kind of -- to
3 Mr. Rehbein's point, is like, you know, the
4 resources are there, but they don't know
5 they're there, so what good are they if you
6 don't know that they're there?
7 I think that we have to maybe
8 provide some more specificity. I'm not sure
9 what's part of the TAP and some of the other
10 things that have come out. There are some
11 good things. There is definite progress. But
12 now I'm thinking there are some more things
13 that have to be worked on maybe, now I have
14 better clarity on after having talked to --
15 so --
16 MR. REHBEIN: So much of what I
17 see here in the transitions outcome section
18 isn't just limited to recovering warriors.
19 It's generalized to everybody that's coming
20 out, except some specific sections here; for
21 example, the problems related to PTSD and TBI.
22 But so many of the others, like financial

1 hardship and lack of financial preparation,
2 employment issues, complex rules and systems
3 -- but the question that arises in my mind --
4 yes, in the case of the recovering warrior I
5 think DoD has a responsibility and obligation
6 to prepare them for civilian life, because
7 their civilian life is not what it's going --
8 what it would have been. But the question
9 that comes to my mind is just how much
10 obligation does DoD have in preparing the
11 individual military member in their
12 transition? You know, you can't guarantee
13 success. You can drive yourself nuts and go
14 broke trying to guarantee success for people.
15 MS. DAILEY: Good. Good. With
16 that in mind, page 10 of your transition
17 outcomes. You can look at the third bullet
18 there. Those are kind of the findings from
19 the DoD transition process from an
20 installation to a OEF/OIF/VA program manager.
21 And I think we need to kind of limit our
22 transitions, because we are talking -- you

1 could possibly be talking about 250,000 people
2 that transition out of the military a year --
3 to the people that we want to move into this
4 type of organization. They are specifically
5 designed to absorb this population, to
6 integrate the warrior into the VA system. How
7 do we get them to this office? Who does that?
8 MS. MALEBRANCHE: Well, you know,
9 partially what General Green alluded to
10 before, there is this other task force,
11 because this whole recovering care coordinator
12 and the Federal Recovery Coordinator Program,
13 this has been ongoing for a couple of years.
14 There still is not the warm hand-off from one
15 to the other. And now, this mini federal
16 agency, if you will, I think has about a six-
17 week charge to come back with a plan and
18 timeline, because we still -- it seems like we
19 keep reworking it and reworking it. When I
20 say "we," I mean DoD and VA. As an agency we
21 keep reworking these things and numbers. And
22 we have numbers just as though -- just as the

1 mental health folks that are out there for the
2 TBI/PTSD, which you've got to find them.
3 You've got to train them. And now we're
4 reworking it.
5 So that's something that's in
6 progress that wasn't earlier, that now in this
7 new entity the JEC, now the SOC no longer
8 exists. That whole case management piece was
9 a part of the SOC. That's now transferred to
10 the JEC. It's gotten a work group. And that
11 work group is looking at some of these
12 outcomes, that I think part of this will need
13 to work into one of our recommendations as to
14 how that's going to be and have specific
15 timelines, because it's been pretty vague, I
16 think, in the past.
17 DR. PHILLIPS: I would ask a
18 research question. Of this 15 to 30 percent
19 that were partially satisfied or dissatisfied,
20 who are these people? Are they combat
21 wounded? Are they just ill? Are they people
22 perhaps that had preexisting conditions before

they came in which maybe added to their confusion? I don't know that we can answer that at all, but I think it would be a research question as to what this group is. Then you can drill down perhaps into why didn't it work for them?

CO-CHAIR CROCKETT-JONES: You're on a different page 10 from the rest of us.

DR. PHILLIPS: I thought I was on page 10.

CO-CHAIR CROCKETT-JONES: There's another page 10 about 10 pages --

MR. REHBEIN: There are several page 10s.

CO-CHAIR CROCKETT-JONES: -- earlier.

MS. DAILEY: The first -- yes.

DR. PHILLIPS: Story of my life.

CO-CHAIR CROCKETT-JONES: The first page 10.

DR. PHILLIPS: The other page 10?

MS. DAILEY: The first page 10 on

1 the --

2 DR. PHILLIPS: Sorry.

3 MS. DAILEY: -- first about

4 transition outcomes.

5 MSGT MacKENZIE: One of the things

6 in this topic though that we may want to look

7 at is -- because I know my group's looking at

8 it, is the accountability of information flow

9 and information retention at certain phases

10 through this process. You now, I mean, it's

11 not that the information's not there and that

12 we don't have great people doing this. It's

13 that nobody -- you know, in different

14 situations nobody goes back to make sure that

15 they have the information. It's we presented

16 this. We presented that. Check the block,

17 check the block, check the block.

18 And then questions get asked like,

19 okay, do you have any questions for us? You

20 know, periodically through there, we stop and

21 go do you have any questions, but we never

22 stop to make sure -- to rehash that

1 information to find out if they have
2 questions. Because if they don't remember
3 what we presented them three months ago,
4 they're certainly not going to have questions
5 for us three months later. But, you know, are
6 we re-presenting the information as these
7 recovering warriors go through this process?
8 And as information providers are we being
9 accountable to the warrior to make sure that
10 we've re-presented that information so that
11 they can generate questions for us?
12 CO-CHAIR GREEN: If I may, I think
13 I'd like to go back to where David was before
14 we go too far off beam here. When you look at
15 what it's saying here on DoD/VA coordination;
16 I'm going to use my own experience, okay, I
17 would have never believed after spending all
18 the time I have in our system how focused we
19 are on returning people to the job. Okay? I
20 don't -- I mean, I realize we have an
21 occupational component, but I always think of
22 us as just practicing basic medicine.

1 But my own experience going
2 through some of the VA work, you realize
3 immediately as you go through the VA, one is
4 the quality of the exams; and two is that they
5 are very focused on long-term implications of
6 things that our system basically simply is
7 looking at as how do I solve this to get you
8 back to duty? It's a very interesting
9 difference. It's a very cultural difference,
10 because we basically look at things as to how
11 do I return you to duty, and the VA looks at
12 it as what's going to happen with this
13 individual, okay, in 20 years, in 30 years, in
14 whatever?
15 And so, I don't know that the DoD
16 system can actually prepare people for the VA
17 culture. It's a very interesting dynamic. So
18 how do you do -- should it be that DoD, where
19 you've got people who have always been focused
20 on returning to duty and being able to return
21 to flying status or to return to your unit,
22 your band of brothers -- are they really the

1 ones that are going to be able to take you to
2 these are the long-term implications you need
3 to be thinking about? Okay? And who is it in
4 DoD that can train to that new culture? I'm
5 not sure that DoD has the ability to do it.
6 So the question becomes how do you
7 get VA -- and the IDES may get us started on
8 this, but how do you get VA to say welcome,
9 okay, to what's next? Okay. I mean, that's
10 really -- so this is truly a cultural issue.
11 It's probably much more of a cultural issue
12 than most people believe.
13 But my own experience -- and so
14 I'll just share. My own experience was that
15 as I set this up, I simply -- I thought I'm
16 healthy, I'm fine, you know, I'm a fire -- and
17 then I just put down the things that had
18 happened over a career, and the VSO
19 highlighted those things. And so, I went in
20 and saw multiple specialties and it was like,
21 uh-oh. But I mean, it's just --
22 Yes. Well, I don't know. I mean,

1 but it was a very different experience, a very
2 thorough and enlightening experience. I'm
3 just saying that I would not have gotten that
4 even in my top medical center. That's not the
5 way we think. We think about how to get
6 people back to duty. How to help them -- I'm
7 not saying this right, because it sounds
8 negative when I say it. It's really facing
9 the realities of the things that are to come.
10 And so, I don't know how to say it even.
11 MR. REHBEIN: It's the difference
12 in medicine when you're 25 and the expected
13 result of going to the doctor as opposed to
14 when you're 50. Because when you're 25, all
15 you care about is getting better and getting
16 back to work.
17 CO-CHAIR GREEN: I'm still 25.
18 What are you talking about?
19 MR. REHBEIN: And I want to bring
20 up one other thing here, too, because as we
21 talk about transition outside of the folks
22 that are seriously enough injured to have an

1 FRC, once someone leaves the military, DoD
2 loses that touch, except in the case of the
3 reserve component, because they're going
4 through a transition at the same time DoD
5 still retains the ability to touch. And I'm
6 wondering if you can't use some of that
7 experience as they transition, if there's ways
8 we can put together studies or gain data that
9 would help us understand better about what's
10 going on with the people that we can't touch
11 anymore. Because once they're gone, they're
12 gone. Once they're out, they're out.
13 But those issues that are unique
14 to the reserve component, there's an advantage
15 also I think that's unique to the reserve
16 component, that they're still -- they're in
17 transition, but they're still involved with
18 the unit. There's still a way for DoD to
19 reach out and help and understand, learn
20 what's going on. So that's just something
21 that occurred to me as I was going through
22 here, that it's not all problems as far as the

1 reserve component is concerned. Maybe there's
2 an advantage there that we can take advantage
3 of.
4 CO-CHAIR CROCKETT-JONES: Well,
5 just the things that you're saying make me
6 want to point out that we have heard at
7 installation visits and from focus groups that
8 there is a sense that recovering service
9 members somewhere along the way start
10 realizing they are leaving and they talk about
11 why doesn't their chain of command let them go
12 more, let them make that change? So this is
13 -- actually this transition is something --
14 there comes a time when people become ready
15 for the cultural change.
16 And I don't -- you know, in my
17 head it should be -- there should be a way for
18 reality to slowly transition. As it is, they
19 are 100 percent in the DoD and then one day
20 they become 100 percent VA. And transition --
21 that's not actually transition. That is
22 change. And if -- you know, we envision this

1 transition. They should be being introduced
2 slowly to that.
3 The more we have VA reach into
4 those folks who we know are getting out -- if
5 someone is already in the IDES process and if
6 we know -- if we have a pretty good idea
7 they're getting out, the more VA can reach
8 backwards into that process before they're out
9 of DoD, the better that transition, the easier
10 it would be if they had days where they could
11 be at the VA and starting that connection
12 before they are finally out.
13 Now it might not be --
14 legislatively or funding-wise, that might not
15 be possible, but to my mind what we're calling
16 a transition is really just a change. If we
17 want it to be a transition, it would have to
18 be way more meshed.
19 CSM DeJONG: And that's where we
20 talked about once that medical decision point
21 is reached, we've got a year, and a year is
22 more of a transition than -- just how do we

1 wordsmith that? How do we make that happen?
2 How do we make that year the warm hand-off?
3 MS. MALEBRANCHE: You know, one
4 thing that occurred to me as we were talking
5 this, and Dave, too, with -- the reserves I
6 think is a piece that maybe we haven't done
7 real well with, but on some places we have.
8 But the other thing, when you were
9 talking about culture and VA, I would like to
10 see as a group -- and I've brought this up I
11 think to a different group, but for the VA to
12 be able to go in and talk to commanders and
13 sergeant majors and places to get them
14 understanding the culture of the VA, maybe in
15 a -- you know, I don't know, advance course or
16 something. Somebody told me -- I went and
17 talked to actually some young troops and they
18 said don't talk to us in basic. We're too
19 busy. But, you know, later we'd like to know
20 a little bit about, you know, what it is that
21 the VA does, especially they're looking at
22 training and for when they get out. Now these

1 are healthy folks.
2 For the recovering warriors, maybe
3 if they've been exposed to something, and we
4 usually tell them; it's the whole idea even
5 with this IDES that, you know, the military is
6 looking to return you to duty and you yourself
7 may be wanting to return to duty. We're
8 looking at you in a whole person concept,
9 which is why it's different. And we haven't
10 done real well I think on education of those
11 concepts to people which is still part of the
12 whole issue. So that might be helpful to look
13 at something and --
14 CSM DeJONG: And it's still shown
15 in the difference between the two different
16 physicals. Right now we're using the VA's
17 rating, which is fine with IDES. But it was
18 completely -- it was apparent to me that --
19 and I've used the example in the past; over
20 the last year-and-a-half, two years that the
21 hearing test in the Army versus the hearing
22 test at the VA are two considerably different

1 tests. And the Army can tell you that, yes,
2 you've lost some hearing in your ear. When
3 you get to the VA, the test is so much more
4 complex that they can say, yes, you've lost
5 some hearing, but you don't rate anything on
6 it because you haven't lost enough.
7 CO-CHAIR GREEN: More importantly
8 they say you can't discriminate in these
9 letters and you're probably having trouble
10 when you listen not just to your wife, but to
11 other people.
12 (Laughter.)
13 MSGT MacKENZIE: And I think we
14 have the data. Because I know when we were
15 looking at stuff this year and we were going
16 to the different VA facilities, some of those
17 key questions; you know, the whole new, you
18 know, VA being TRICARE providers, you know, it
19 was all, well, the VA can't provide the level
20 of medical care that the military needs. And
21 we're all looking at it because you're not
22 capable -- your mindset is not to return guys

1 to duty. It's sustainment.
2 You know, and we asked those
3 questions at several of these VA facilities
4 and I think our focus was wrong, where it was
5 like, well, they're not designed to do that
6 because they're designed to help us
7 transition. So let's stop looking at it from
8 are you providing us the care that we need to
9 stay on active duty versus interfacing with
10 the VA to facilitate that transition into that
11 world? You know, because they -- was it three
12 or four different facilities we asked a series
13 of three identical questions and at every
14 location it was no. And the -- you know, so
15 that's an interesting -- you know, we were
16 looking at in one direction, but it actually
17 showed us something in a totally different
18 light.
19 DR. PHILLIPS: Being on the
20 correct page 10 this time, it still brings up
21 all these research questions related to some
22 -- can we identify some very specific areas

1 that make the transition or the change
2 difficult? I'm just using some examples.
3 Delays in getting appointments, distance from
4 a VA, getting prescriptions refilled from one
5 versus the other. I'm not saying these are
6 problems. I'm just using those as examples.
7 Would that be helpful if we could identify
8 large groups that have difficulties in
9 specific areas and maybe suggest corrections?
10 Education, as you say.
11 MS. MALEBRANCHE: Yes, I think --
12 I mean, there are some of those large groups,
13 but sometimes I think it would be helpful to
14 have some of the specificity, too. You know,
15 we're looking more at rural health and tele-
16 health and those sorts of things, so that
17 might be helpful as well. But you're right,
18 we could frame this, because the liaisons are
19 not at every facility. Where they're at it
20 seems like we're doing okay. So do we need to
21 do liaisons at more facilities? I mean,
22 that's a good question.

1 DR. PHILLIPS: Maybe this
2 questionnaire. I mean, what troubles did you
3 have, if any? I mean, get specific and --
4 CO-CHAIR GREEN: One of the
5 problems with the military is that they really
6 react much better to just-in-time training.
7 So if you are going to give people training;
8 and I'll use chemical training -- when you're
9 getting ready to go over to the war, okay,
10 when we were going into Iraq, people were very
11 interested and paid a lot of attention to your
12 training on chemical tactics. Okay. But
13 prior to that, it became almost a -- you know,
14 a paper exercise to see -- finish it and make
15 sure you have the background, but not
16 necessarily -- and so, one of the problems you
17 have is how you would target your training.
18 So I can tell you in our system
19 people are not ready to hear about VA. In
20 fact, even the transition. I mean, so in our
21 service they had to mandate that two-stars
22 would go to the TAP class, because you had to

1 realize that eventually you have to get out.
2 Okay? And so, you know, think about it. So
3 by the time you make two-star, you're probably
4 about 30 years and eventually you're going to
5 have to get out. So you have to go take TAP.
6 And people still don't go and sign up for TAP.
7 And so it's just one of those things.
8 So how are you going to -- when
9 you think you want to reach in to provide some
10 training on VA services, the reality is you
11 need to -- we need to think about where and --
12 where is it that we find that magic point
13 where people are ready to receive information,
14 which is a bit of a problem.
15 DR. PHILLIPS: Could the VA
16 possibly -- I mean, you have patients that are
17 there a week, a month or a year. Pick a
18 group. And since they're in the hospital
19 getting -- going to clinic or getting care,
20 could you develop a simple questionnaire to
21 ask them across the board, from the good
22 locations to the remote locations, what

1 difficulties have you had or would you help us
2 out? Maybe there might be something that
3 comes out of that.
4 MS. MALEBRANCHE: Well, we do an
5 annual survey that we send out to everybody,
6 that SHEP survey. I don't know if that --
7 this task force looked at it. But there is an
8 annual survey. And there's, I think, some
9 time for qualitative as well as just the
10 quantitative piece. So that would see -- you
11 know, that's plausible.
12 When you asked about the or
13 mentioned the just-in-time, one of the reasons
14 I was thinking of senior leaders is because it
15 affects them and it's kind of like when you
16 try to teach those younger than you coming up
17 like the good things to know. I think the VA
18 people come for the hearing when they realize
19 as they're getting older that, gee, my friend
20 who is 65 does not get hearings through
21 Medicare, but if you had a service connection
22 with the military, you can get them through

1 the VA. Did you get a hearing disability or
2 any kind of piece through that? So it's kind
3 of your -- that is maybe a -- it's what does
4 it mean to me?
5 For the younger folks, too, as
6 they're transitioning out, if there is
7 positions or jobs, people are looking to that.
8 So I think you have to very much hone it to a
9 group. You know, you target your audience and
10 your group of what you're doing. But I think
11 to Dr. Phillips' point, too, we probably could
12 do some more with survey pieces. I'm not
13 sure. But the outreach is we are really
14 expanding a lot in outreach. And I think
15 we're reaching -- I know with the recovering
16 warriors we're also reaching out to family
17 members.
18 And one of the good pieces of
19 legislation that occurred -- I think it was
20 NDA last year or the year before, with the vet
21 centers, for reaching out for families,
22 because the VA has not been taking care of

1 families. And that does seem now with
2 caregivers, families can go to vet centers in
3 conjunction with the veteran care. I think
4 that has helped tremendously to those that we
5 spoke to. When we were out -- I know when we
6 were overseas here and talking with the family
7 members, they were able to go to vet centers.
8 And that also -- they felt pretty safe or
9 comfortable there. And that was outside.
10 That was kind of a -- enlightening for me. I
11 was surprised at how much they really seemed
12 to focus on vet centers, which is a different
13 way of looking.
14 MR. DRACH: I think we're talking
15 about a couple different things here. When
16 you say or we say "transitioning," I think a
17 lot of the discussion we've had in the last
18 half hour or so has been there's two areas of
19 transition. Transitioning back to their job,
20 back to active duty, or transitioning into the
21 civilian world, back into -- to being a
22 veteran.

1 Then you talk about TAP. TAP is
2 the Transition Assistance Program, and it's
3 five parts, and it's done -- and it's
4 conducted by the services, VA and Department
5 of Labor. And of course TSA has their -- or,
6 yes, not TSA, DHS has their component for the
7 Coast Guard. So there you're talking about
8 transitioning from military service; as you
9 mentioned, general, to civilian life and
10 trying to prepare them; r,sum, writing, so
11 forth, with the employment workshop.
12 But the other components, the --
13 well, now it's all mandatory, but the precept
14 counseling is taking care of all your work for
15 the service. Then you got the Department of
16 Labor two-and-a-half day employment work shop
17 and you got two -- four hours of VA briefing
18 and then two hours of disabled voc rehab, if
19 you're lucky.
20 From what I've seen from our site
21 visits and from what I've just seen in general
22 is that a lot of the wounded, ill and injured

1 do not get TAP. They do not go through the
2 formal -- they may get the precept counseling
3 because that was mandated. Now the whole
4 thing's going to be mandated. But a lot of
5 them -- and those that did get the Transition
6 Assistance Program had no idea what they were
7 getting. So if you were to survey them and
8 said did you go through a TAP, a lot of them
9 wouldn't have any clue what TAP was, because
10 they just didn't understand what they were
11 going through at the time they went through
12 it.
13 So, you know, it gets confusing
14 because of, you know, what are we as a task
15 force looking at? Are we looking at the two
16 areas of transition back to active duty or
17 discharge? Because TAP in general is not
18 focused on the wounded, ill and injured,
19 whereas the other two are.
20 CO-CHAIR GREEN: You know, and may
21 confuse things just by talking about my
22 experience, but I think it's probably the same

1 and maybe even more difficult for someone
2 who's young in their career, has certain
3 expectations of what they're going to be doing
4 in their career and then finds themselves
5 where they may not be able to continue that
6 career. And so -- you know, so I don't mean
7 to confuse things.
8 The question becomes; and I think
9 Suzanne may have hit on it -- is when you
10 watch, what you see with the wounded warriors,
11 recovering warriors is that they have a very
12 difficult time going from I'm going back to
13 I'm not going to go back. And so -- and it's
14 a -- and I think it's because of the two
15 cultures. And so, now the question becomes
16 how do you -- what is it you do -- so we focus
17 now solely on the recovering warriors, what is
18 it that you do that helps them make that leap?
19 Okay.
20 And from -- and what I was trying
21 to get at in my comments is DoD, who really
22 focuses almost entirely on getting you back to

duty, may not be the right people to help you make that leap. Very hard for us. It's like you failed when you can't get them back to where they were able to, you know, go back to the job they want to go do. And so -- you know, or when you have to tell them they're not going to be part of that band of brothers because they're not going to have the capability to do that. So, you know, how do you help?

And the other thing is; and this is the opposite side of that, many times the system in DoD will keep people. Okay? I mean, some of the people that we've actually kept on active duty, their benefits and their lives might well be improved by taking the next steps in terms of what's going on, but they don't realize that because they're so tied to that culture of returning to the unit. And so, I don't know how to help with that. I mean, they just -- they don't understand this whole world out here.

1 And so, that's -- you know, and
2 honestly, DoD doesn't want them -- I don't
3 mean it negatively as it may sound, but DoD
4 really wants them to return to duty if they're
5 at all capable. So there's not an incentive
6 to help them understand, you know, how you
7 make that transition. So that makes this
8 doubly hard to figure out, because DoD's
9 system is the one that needs to help them make
10 that realization, and yet all the incentives
11 are the other way. All the incentives are to
12 keep you -- you know, what -- even look at
13 some of the programs that have been
14 implemented. All of the programs in large
15 part have been implemented to try and -- to
16 keep you.
17 CAPT EVANS: So do we go back to
18 DoD to say; just as what the legal system and
19 the IDES program, you have to -- we require a
20 lawyer to be there to speak with that member?
21 Do we institute that through the VA system,
22 because regardless of the results of the

1 outcome, we need to have that member educated
2 on that system?
3 MS. MALEBRANCHE: You know, one of
4 the things that just struck me when Ron was
5 talking, too, is, you know, there's that DTAP
6 program. And at that point, when they talk
7 with that in families; and a little bit of
8 what you're saying, like in the DES, it seemed
9 like for those members that maybe would have
10 been better off financially and for their
11 family, because they knew they weren't going
12 back. Once they made the decision, if they
13 knew what they were going to have for benefits
14 and their family knew that they were going to
15 be taken care -- one of the things in the
16 IDES, I think they get that benefits letter
17 fairly earlier. This is what you can expect.
18 Isn't that right, Colonel Keane?
19 LTCOL KEANE: They do. And it
20 gives them an opportunity to make sure that
21 they've captured everything.
22 MS. MALEBRANCHE: Right, and they

1 make choices based on knowing -- you know,
2 knowing what's going to happen. I mean, if
3 it's going to happen eventually and this is
4 what's going to happen, or should I go forward
5 and -- with the rest of the things? Because,
6 you know, it's all based on what the
7 individual claims, too, for a lot of the
8 disabilities. And they may not claim and
9 there it is. I think it's true that when they
10 want to go back, they hold on some things. So
11 maybe it's just educating folks for awareness
12 and they don't know what they're benefits are
13 or could be and what the outcomes could be.
14 And once they know that, and/or with the
15 family member, that helps them make this
16 decision. It's time to transition or not. But
17 you're right, some of it's culture and it's
18 going to take time. But I'm not sure about
19 the lawyer, but I think knowing what your
20 benefits are going to be could be helpful.
21 CAPT EVANS: Right, and it doesn't
22 -- I mean, so we have a VA liaison. We have

1 a position for the VA. And I assume the VA
2 liaison is the one we refer our warriors to as
3 far as here's what you expect when you cross
4 over into that VA system. I'm not sure if
5 that VA liaison is well integrated into our
6 process. At some point in time we -- until --
7 I think the gap -- again we have TAPs. We
8 have mandated -- it's not written right now,
9 but all -- anyone, anyone of the warriors,
10 they have to go through TAPs before they sign
11 any paperwork. So TAPs is being mandated.
12 There's still a gap. So even with TAPs
13 there's still a gap. So at some point we have
14 to bring the VA into the system early just
15 specifically for education on going through
16 that VA process. Because it's two different
17 systems that they're working with.
18 MS. DAILEY: A lot of papers here.
19 Can I get your attention possibly to page 8 of
20 the discussion points. Discussion points.
21 It's in your folders, page 8. Discussion
22 points, in the folder. Page 8.

1 Now although this comes under the
2 discussion points of reserve component, No. 4
3 might capture some of your thoughts. And I
4 use the term MOA. It might be a DTM. But
5 something that formalizes getting into the VA,
6 getting a warm hand-off to the VA, to the
7 OEF/OIF program managers. Formalizes the
8 requirement that you interface with the VA.
9 MS. MALEBRANCHE: Actually, I
10 don't know where this came from, but there is
11 an MOA now that does some of these things, but
12 not all specifically for reserve. But right
13 now the social work liaisons --
14 MS. DAILEY: Yes, I would expand
15 this to both reserve and active duty --
16 MS. MALEBRANCHE: Right.
17 MS. DAILEY: -- and but limit it
18 to wounded warriors.
19 MS. MALEBRANCHE: But that is the
20 right term. The social work liaisons in the
21 MTFs where they're at do get a paper signed by
22 the service member to -- for the state,

1 actually. Because the state has -- I think
2 all but one state has signed that they would
3 like the information in advance, that you have
4 a service member that's severely injured and
5 coming back to civilian life so that they know
6 who's potentially coming back to their state
7 and what they offer them. So pieces of this
8 are done.
9 MS. DAILEY: And I need this
10 actually to be in like DoD language. DoD
11 doesn't do MOAs. I mean, that doesn't compel
12 a commander. It's a DoDI, it's an Army reg,
13 it's an AFI that filters its way down, that
14 these types of steps would be incorporated in
15 on the DoD side to get them across that line.
16 MSGT MacKENZIE: I definitely
17 agree with that. And if we look at what the
18 Air Force is trying to implement, you know,
19 where they're talking about less than five
20 percent of those they put into the IDES system
21 will be returned to duty, I mean, that's a
22 whole year of going, hey, it's time to go hang

1 out with the VA and figure out where you're
2 going. I mean, it's -- you have -- there's
3 going to be very little funding expended if
4 less than five percent of those entering the
5 IDES system are actually going to returned to
6 duty. And it creates an opportunity for that
7 cultural shift to begin and for the focus to
8 begin in that realm.
9 I mean, we're talking about people
10 who think they're going to spend six months in
11 the system still hoping to return to duty and
12 it's while they're going through this IDES
13 system that's -- or eight months. It's a
14 whole wasted opportunity because people are
15 going into IDES thinking they still might have
16 a shot at returning to duty. Whereas if we
17 re-look at this and perhaps recommend that
18 what the Air Force is looking at going to this
19 review board, the pre-IDES certification
20 process that goes does this person really need
21 to go through this entire system, or do we
22 have the opportunity to return them to duty

1 and make that clear-cut call before we put
2 them into the IDES system so then we can
3 focus?
4 MS. MALEBRANCHE: You know, I
5 really was intrigued by that DAWG part of the
6 Air Force piece. And I was wondering when
7 they talked about -- I thought that that was
8 such a great idea and practice of healthcare
9 and personnel. And I think as I look at this,
10 I want to make that distinction here so that
11 you're all aware. When we say a VA liaison,
12 and it says from DoD healthcare to VA
13 healthcare, sometimes the person is more
14 interested in the benefits issues and the
15 benefits piece. And the VBA is very distinct
16 and separate from the VHA, all under the big
17 VA umbrella.
18 So we need to -- when we talk
19 about VA liaisons, that's not necessarily the
20 VA healthcare person in a facility. But that
21 concept that the Air Force has put together in
22 they're new organization, a VA person may be

1 healthcare and/or benefits could be part. I'm
2 not sure where, but I sure do like that. I
3 think that's something that is overdue. But,
4 gosh, it was just nice to see that in there.
5 And maybe somewhere along that line when
6 people are thinking about if they're no longer
7 deployable -- I mean, maybe that's even late,
8 but if they're no longer deployable, they're
9 probably not going to have a future in the
10 service, this might be the time. They'll be
11 ready to listen. You know, so when you talk
12 about just in time, somehow in that cell, I
13 thought that was really intriguing. I really
14 liked that.
15 MS. DAILEY: It's true, but
16 they're into -- they've gotten a NARSUM within
17 about 45 days of that DAWG, correct, sir? So
18 they're already going to be seeing the MSC
19 within 45 days of the DAWG, more than likely.
20 CO-CHAIR GREEN: When the AFPC
21 surgeon makes a decision. So then they'll see
22 definitely within 45 days of that. So, yes,

1 I guess the -- I'm going to throw something
2 out and it's a little controversial, but one
3 of my concerns from the get-go, going back
4 several years, was DoD's decision to build
5 large rehab capabilities. And so, we knew in
6 the '90s we couldn't sustain them, and so a
7 lot of that went away. And so, the Air Force
8 really did not have rehab hospitals, with the
9 one probable exception of Wilford Hall, and of
10 course now SAMMC. When we started seeing the
11 influx of casualties, there was a -- it was a
12 very, you know, well discussed decision for
13 DoD to rebuild their rehab capability as we
14 brought the casualties back, and so especially
15 at Walter Reed.
16 But across the Army in particular,
17 they put a lot of rehab capabilities into
18 multiple facilities based on the numbers
19 coming back. And a lot of that has to do with
20 the two systems not being more integrated at
21 the hospital level. Because DoD will not be
22 able to maintain that once the flow of

1 casualties ends. And so, there's always --
2 and if you look at every war, there's always
3 this same thing where it builds up and then it
4 comes back down and the country spends huge
5 amounts of money to take care of their
6 warriors and their heroes.
7 And I'm not against, you know, the
8 expenditure to take care of our service men
9 and women. But because we can't maintain it,
10 the question is is there a way that basically
11 you would put the DoD rehabilitative assets in
12 the things that are basically your
13 augmentation into the hospitals that will
14 continue to be rehab hospitals? And then
15 basically what happens is you would get the
16 mixing of cultures in those larger rehab
17 hospitals.
18 Now I don't know that that's
19 necessarily in the purview of something like
20 this group, but understand what I'm saying:
21 Because you can't sustain it, there's a huge
22 expense to build it up and to take it down

1 versus building up at a place that will
2 sustain a rehab capability and then bringing
3 it back down to a level where you're basically
4 integrating VA, some VA and DoD, at least at
5 the rehab level, because then you can maintain
6 the skill sets as well. So if I put a
7 rehabilitation doctor into a VA hospital, you
8 know, it basically is the same federal
9 dollars. It's just across departments. And
10 it's the across departments that makes it so
11 difficult.
12 But there's a problem here, and
13 the problem is that as our system is organized
14 today, we rebuild the rehab hospitals trying
15 to bring everybody back to duty knowing full
16 well that many of them will not make it and
17 then we basically -- even in the disability
18 system now, we then give them as they get
19 disability -- if they get 30 percent, right,
20 they get TRICARE benefits. But they're also
21 going to get VA benefits. And so, there's a
22 duplication. And so, it's very expensive for

1 the country.
2 Now exactly to look at that. So
3 Congress has been very interested in -- not as
4 interested in going after revamping
5 disability, the disability system, how things
6 are rated, etcetera. But it's an interesting
7 difference when you talk about how things are
8 cared for regardless of the disability rating.
9 And so, why didn't we put the WTUs at VA
10 hospitals? Okay. And then the idea of being
11 the decisions made then at this combination
12 rehab hospital that basically -- and there's
13 the tension then as at the medical side saying
14 we can bring them back and, no, this is what's
15 -- but then the decision is kind of made and
16 you see it would be much easier to sustain.
17 So I don't know if this is in the
18 purview, but I just -- I mean, if you think
19 about it in a much broader sense, part of the
20 problem right now with the culture is that
21 we've kept them in our own rehab hospitals
22 knowing full well that eventually the rehab

1 hospitals have to come down. Well, maybe as
2 they come down is the time to look at
3 integration.
4 MSGT MacKENZIE: But that takes
5 you back to my original point though. Those
6 that -- you know if we look at the percentage
7 across the board, you're right, a significant
8 number won't come back. But it's that
9 percentage that will come back that if they go
10 to a facility that's not designed to return
11 them to duty, it's designed to sustain them,
12 they're not getting the same level of care.
13 And that was the very specific questions that
14 we asked, because it is a different mind set.
15 You know, a guy who's trying to return to duty
16 is going to do significantly more things on a
17 regular basis than a guy who's going to just
18 transition back and do something completely
19 different than what they were doing before.
20 There's a difference in level of care. So you
21 can't send --
22 CO-CHAIR GREEN: The

1 commonality --

2 MSGT MacKENZIE: The military

3 should not have their own rehab; I get that

4 direction, but at the same token, we have to

5 look at it from --

6 CO-CHAIR GREEN: The commonality

7 that should drive both sides is that the

8 individual wants to get back as much as they

9 can. If duty drives them a little harder to

10 get back to it, that's great. That's why I

11 don't say send them all to VA hospitals. I

12 actually say send them to an integrated

13 hospital where you've got people in uniform

14 who are keeping them motivated to get back.

15 Okay? I mean, I think that that's a realistic

16 expectation. If you simply sent them to the

17 VA hospital, you're right, I'm not sure --

18 yes. Well -- yes, but -- yes, I'm not certain

19 that even that's true, but I understand the

20 concern from the active duty side of the

21 house.

22 If you release them out of your

1 system, then there's the focus as much on
2 getting them back into your system. I don't
3 know. But I do think that there's an argument
4 to be made on the integration of the system
5 for twofold: One, DoD needs to maintain some
6 of these skills when we go to war. And, two,
7 it actually would help with the culture
8 development that needs to happen to help
9 people understand that there's life beyond
10 active duty.
11 CSM DeJONG: But then again, even
12 if we took that year; and I'm thinking way
13 outside the box right now, so don't throw
14 anything at me -- but we're already using VA
15 doctors for IDES. So why not do the IDES and
16 transition the care at the medical decision
17 point to the VA system and do it all at a VA
18 center instead of bringing these docs and
19 building new centers? You look at Fort Know.
20 They have a completely separate center that
21 they decided to put up, or that they put up
22 and they're utilizing. Why not look at -- I

1 mean, has the thought been out there to use a
2 VA hospital for that and transition the care
3 to there once that medical decision point has
4 been made?
5 CO-CHAIR GREEN: The problem today
6 would be that while the resources that went
7 into housing for the families and housing for
8 the troops are all at DoD facilities. And so,
9 VA has not been created in a way that they
10 have the ability to house and to support these
11 folks. So when we were building WTUs, the
12 question would have been should you do an
13 experiment with a WTU at a VA hospital where
14 you're basically providing the same level of
15 active duty support in the WTU, but the care
16 is being provided by the VA or by some
17 combination of VA/DoD.
18 Even today it still may be
19 possible to do something like this, but it
20 would require VA to move some of their people
21 into DoD's rehab hospitals and DoD to move
22 people in terms of the backfill into VA

1 hospitals. That would be a pretty significant
2 issue, and tough culture change for the docs
3 that did it. Now it's not a problem to work
4 and do clinical work in the VA hospital, but
5 there's a different approach on both sides.
6 So, you know, it's kind of like, you know,
7 we're living -- we're doing very well right
8 now with integrating Army, Navy, Air Force
9 hospitals in D.C. and down in San Antonio, but
10 we -- and I don't know how the Navy effort is
11 going out with Great Lakes, but I mean, there
12 is an effort right now with Great Lakes where
13 you've got a combination hospital. And so --
14 MR. REHBEIN: Yes, we were
15 fortunate there that there was both the DoD
16 facility and the VA hospital that needed to be
17 upgraded close together, so that when they
18 built the new hospital they could do that,
19 they could build it to do that combination.
20 Yes, that's an ongoing project. I'm very
21 interested to see how that turns out.
22 If I may, general, I'd like to

1 deflect the conversation somewhere else for a
2 moment.
3 With the exception of the
4 healthcare, the DoD/VA, I think we can smooth
5 that transition. For the rest of it, I think
6 what we're -- all we can do is help the
7 recovering warrior prepare for transition,
8 because transition really starts the day you
9 know longer put the uniform on. I've been
10 through a couple of transitions in my life;
11 one out of the military and one into
12 retirement. You know, and both times you look
13 around and you say to yourself, wow, this is
14 different.
15 Every place I think all of us have
16 been in our lives, there's been a mentor.
17 There's been someone we could go to to talk to
18 if we ran into a situation. Now I'm not
19 saying that we can provide mentors for all of
20 the transitioning military members. I'm not
21 even saying we can provide mentors for all of
22 the recovering warriors, but I look at the

1 Marine DISC system and the safety net that
2 they provide, because all of the people -- the
3 population we're concerned with, the
4 recovering warriors, are going to be going
5 through the VA system.
6 And with those DISC Marines being
7 able to maintain that communication into the
8 VA system to find the people that need help,
9 maybe the best we can provide is a safety net.
10 Maybe we can't guarantee help for everybody,
11 but maybe we can find a way to provide a
12 safety net for those that need it the most.
13 I don't know. I was impressed both with the
14 system and with the Marines that I've talked
15 to that are involved in that.
16 MS. DAILEY: Every service does
17 have its safety net right now. The AFW2 that
18 -- Mr. Rehbein, Mr. Drach, Master Sergeant
19 MacKenzie, you all talk to the AFW2 citizens
20 after their transition, and they -- this is
21 kind of what solidified this, that focus
22 group, which most of those individuals from

1 the AFW2 program were, were now citizens.
2 They're retirees. They spoke very well of the
3 VA once they got there and they spoke very
4 well of their mentor, the AFW2 program,
5 getting them there. So we do hear that.
6 Once they get there, the services
7 are working for them. They have become
8 integrated. The culture has changed. The
9 AFW2 program does that. DISC program does
10 that. The AW2 program for the Army does that.
11 We really haven't had a chance to look at the
12 Navy's program that's mentoring people, but
13 they have a mentor program that also is their
14 safety net. Getting them through that point,
15 getting the DoD to formalized a process to get
16 them through that needle pinhole is -- might
17 be an area we could look at on the DoD side.
18 MR. REHBEIN: I think the -- if I
19 understand the DISC program correct, colonel;
20 correct me if I'm wrong, I think it's a little
21 broader than that, because in my conversations
22 with Major Burkhart, he's got contacts into

1 the VA hospitals. And if the VA hospital sees
2 a Marine in trouble, they know enough -- they
3 know to contact Major Burkhart and get him
4 involved?
5 LTCOL KEANE: That's correct.
6 Two-way street. That's correct.
7 MR. REHBEIN: So it's not
8 something -- the Marine doesn't necessarily
9 leave the Corps with Major Burkhart already
10 assigned, but Major Burkhart's out there
11 trying to catch as many as he can, that the VA
12 or someone else is letting him know that
13 here's a Marine in trouble.
14 LTCOL KEANE: And more times than
15 not that's a one-time assist. He may not
16 necessarily need to add that person to the
17 case load, but that is correct. I'm not sure
18 if any other of the services are actually
19 picking Marines up at their house, bringing
20 them to doctor's appointments, calling them,
21 making sure they're taking medications,
22 checking with their parents. I don't know if

1 the other services are doing that.
2 MR. REHBEIN: I don't know how many
3 Marines are out there acting as DISCs. I know
4 we had that number, but you know it's --
5 LTCOL KEANE: Thirty right now.
6 MR. REHBEIN: -- I think it's a
7 significant safety net for the Marines that
8 are out there.
9 CO-CHAIR GREEN: So when you come
10 to a recommendation on something this -- so
11 where are you going? How do we tie in this
12 timing issue with the need for enculturation
13 to what may be next without necessarily going
14 to TAP? I mean, TAP may be the answer, but I
15 mean, now we're talking recovering warriors.
16 How do you get them ready for that transition?
17 So what -- let me ask -- so you're
18 married obviously to someone who's been
19 through this. How did they get your husband
20 ready?
21 CO-CHAIR CROCKETT-JONES: They
22 haven't. I'm sorry to burst your bubble on

1 this. The only thing that hasn't prepared him
2 for his upcoming like more intense encounters
3 with the VA has been the appointments he needs
4 to go through the IDES process. That's pretty
5 much been it. And he needs -- this is -- it's
6 a culture change that I don't think he is
7 actually prepared for.
8 And, you know, maybe it's because
9 I'm a mom, but I feel like he needs a field
10 trip to the VA. And I don't know how to put
11 it in terms that would make it applicable to
12 transition units, but it's as if they need an
13 assembly and then a field trip, and then an
14 assembly and then a field trip sometime over
15 that almost year of IDES where they start to
16 get their toe in the water of that cultural
17 change.
18 And while I don't necessarily
19 think this is the -- this cultural change is
20 the thing that's pressing on him -- so I don't
21 think he'd pursue it on his own, like figuring
22 this out. I don't think that's the fear

1 that's pressing on him the most in this
2 process. It's more of that, you know, where-
3 am-I-landing kind of a thing. But I think
4 that he greatly underestimates how much of a
5 cultural change he's going to experience.
6 CSM DeJONG: I'm trying to figure
7 out how on the active side to do what Indiana
8 is doing for the National Guard Reserve
9 soldiers that go through. And when they do
10 their demobilization and their post-deployment
11 health assessment, it's done at the VA
12 hospital. How do you integrate that into the
13 active component? Because then they've got
14 the Seamless Transition Center right there
15 that picks up and carries you and answers your
16 questions and you walk out of there with
17 answers, names, numbers to call and you've got
18 five years of seamless transition. I don't
19 know how to take something similar to that
20 into the active component, into the IDES
21 system and make it work in that manner.
22 MS. MALEBRANCHE: You know, it's

1 interesting that you just mentioned that,
2 sergeant major. I was just thinking -- and it
3 was Indiana, but the post-deployment health
4 reassessment, the VA has offered; and you were
5 talking about the field trip, to have those at
6 VA facilities. And I think as often as you
7 can they go, oh, well, this -- you know,
8 there's something about familiarity. You do
9 it once, you do it twice, just going back
10 there. And that has proven to be very, very
11 successful. And particularly Indiana has done
12 that.
13 So we've encouraged that and we
14 encourage our VAs in areas where they can to
15 reach out to volunteer their places for that,
16 like on weekends as much as possible. And it
17 does seem to -- you're right, when you walk
18 out of the door with the appointment -- and
19 they've also had some events that occur at the
20 time where they can actually see people all
21 the time. It wasn't intended that they did,
22 but they had some critical need. That was

1 very helpful.
2 So I think that as much as
3 possible, you know, we've encouraged that. I
4 don't know how else you can do that, because
5 obviously it has to do with the facility, the
6 timing, the dates that they're coming back.
7 But that's huge.
8 CSM DeJONG: And it also has to do
9 with the fact that a reserve component soldier
10 can walk out and still be part of the reserve
11 component, but get VA care. So you're
12 crossing lines there, but you need to do
13 something similar to give that experience and
14 that exposure.
15 DR. PHILLIPS: Can we possibly
16 frame the recommendation into short, medium
17 and long-term recommendations, both narrow and
18 broad? I mean, General Green's comments were
19 brilliant about the integration, and that's a
20 long-term -- you know, perhaps that should
21 start now, but it could be long term.
22 Short-term type things are the

1 site visits, and maybe that's the way we can
2 think about short, medium and long term broad
3 and narrow recommendations.
4 MS. MALEBRANCHE: You know, Dr.
5 Phillips, the other thing -- and just when I
6 was thinking about you, too, the PDHRA is the
7 other thing that they do for soldiers, they
8 register them on site so that you start the
9 record if they don't already have one, and so
10 they're in the system. And, you know, one of
11 the things you want to know in medical care or
12 any kind of care is like who your population
13 is. And then when it's time then and they do
14 actually the formal transition, they're
15 already in and then they enroll in the system
16 if they're able. And that -- getting them on
17 site and doing it right there without saying,
18 well, send in this form or come back later is
19 such a big difference.
20 DR. PHILLIPS: That's brilliant,
21 because I know I've gone online to register
22 and I give up. I occasionally go back. I

1 forget one number. I don't know the answer.
2 It's over. So that's brilliant. That takes
3 so much away from the stress of doing that.
4 MSGT MacKENZIE: Yes, but that
5 will only work if the VA medical centers
6 across the country are integrated and the
7 same. And the active component, unlike the
8 reserve component, when you retire chances are
9 you're not staying in that state. You're
10 going to another location whereas a reserve
11 component is interfacing with the VA system,
12 the VA hospitals, the VA doctors that are
13 going to be the VA folks that are going to
14 take care of them. And so therefore, there's
15 a difference there. I mean, why do I want to
16 build a relationship with a group of people
17 that aren't going to take care of me or even
18 have anything to do with me when I walk out,
19 because I'm moving thousands of miles away
20 from the state that I'm in.
21 DR. PHILLIPS: Before you
22 discharge is it possible to have someone at

1 your location, if you're in Texas still on
2 active duty, but you know you're transitioning
3 out, to do that for you at the VA where you're
4 going to be in Illinois?
5 MSGT MacKENZIE: But that's where
6 that goes to the field trip or whatever else.
7 Which also brings me back to if you're going
8 to stay in -- let's focus on if you're staying
9 in. If you're going to be going through the
10 IDES and chances are you're getting out --
11 greater than 95 percent of those folks in that
12 IDES system are going to get out. If you
13 filter that at the beginning, then you create
14 an environment where that's the focus.
15 Because I'll tell you right now,
16 from dealing with folks even into their 30s
17 and 40s and 18-19 years in the service, if
18 they're staying in, they don't listen, they
19 don't retain and it's not -- that's not
20 important to them at that time. So, you know,
21 that transition needs to be focused on a
22 specific group of folks where that call is

1 being made.

2 But you're right, it's where I get

3 back to that interface with folks. I mean, we

4 visited multiple VA hospitals and they're not

5 all the same.

6 MS. MALEBRANCHE: The VA hospitals

7 aren't the same; you're right, and the

8 relationships aren't. Getting them in the

9 system and registering them, however though,

10 does afford you that. If they're in

11 California or here, you can pull up a record

12 should they come in, and active duty are seen

13 in some cases.

14 One thing, in North Chicago they

15 are doing; because I was just up there a

16 couple weeks ago, is the recruits are all

17 registered in the system. So they have a

18 record day one of -- in the electronic health

19 record. And that's where they're also

20 piloting this joint virtual lifetime

21 electronic record. So there are some

22 potentials here, good things that are coming

1 down the line.
2 I hear you about the relationship,
3 Mac, but I also know that even active duty-
4 wise or civilian-wise people are transient.
5 So, you know, they are moving around. So you
6 are building -- depending I guess on your
7 injuries and issues, you're building some
8 different relationships. And the ones that I
9 think that I notice that do well are VA
10 doctors that are former military doctors.
11 They really connect well with the patients.
12 And I think that's been somewhat helpful. So
13 we, you know, do try to create jobs in that --
14 CO-CHAIR CROCKETT-JONES: I also
15 want to say this concept of exposure during
16 the IDES process, even if it isn't going to be
17 with a specific VA hospital it is still an
18 exposure to the cultural shift, to the concept
19 shift. I mean, you know, I have a spouse who
20 took years to accept the reality that he was
21 going to have to get out, that he was going to
22 face a medical retirement. It took him years.

1 And given there were no supports when he was
2 injured, it's -- length of that, you know?
3 But I really think we ought to
4 consider the idea of just some visits to
5 reduce the fear that the VA is not going to --
6 is a zero. I think that there is -- that
7 people assuming that the VA is not going to
8 help them at all drives them to not access
9 benefits that are available for them,
10 resources that they should have. And if we
11 eliminate some of that fear of the cultural
12 change, they might be more likely to at least
13 look for the resources that they can get.
14 MSGT MacKENZIE: But we're also
15 going to have to coincide the resources
16 available to the same extent. There are
17 things when I retire that I can get at the VA
18 that I can't get on active duty. Okay. So it
19 doesn't do me any good in some areas of my
20 recovery to go to the VA because I can't
21 receive the -- it would be like, well, if you
22 were on active duty right now, you could get

1 this, but you can't. And --
2 CO-CHAIR CROCKETT-JONES: Yes, I'm
3 not saying to --
4 MSGT MacKENZIE: -- so it's --
5 CO-CHAIR CROCKETT-JONES: We're
6 not saying go to the VA for anything.
7 MSGT MacKENZIE: But I mean that's
8 --
9 CO-CHAIR CROCKETT-JONES: We're
10 just saying familiarity with what is going to
11 be available to them.
12 MSGT MacKENZIE: Right, but then
13 that's --
14 CO-CHAIR CROCKETT-JONES: And also
15 we've also been saying we should encourage
16 some more back reach to say once they're in
17 IDES and they know they're getting out we
18 should make more of what is at the VA
19 available to them while they're in transition.
20 MSGT MacKENZIE: But I'm just
21 pointing out one of the challenges because,
22 you know, if I was to go for a field trip to

1 the VA and talk about what I'm going to get
2 when I get out in two -- you know, in a year-
3 and-a-half, it's kind of frustrating to hear
4 about things that you can't get right now that
5 you can get later. See, so what I'm saying is
6 is that there is some frustration there as
7 well where you have those challenges. So it's
8 not as easy as that interface.
9 CO-CHAIR CROCKETT-JONES: Sure,
10 there's that frustration, but we're also
11 getting IDES down to being less than a year.
12 So it's not like these are long-term waits.
13 MSGT MacKENZIE: Right. I
14 think --
15 CO-CHAIR CROCKETT-JONES: I mean,
16 this is changing. This is a dynamic thing.
17 MR. REHBEIN: I think just seeing
18 the VA medical centers, VA has a hurdle to
19 overcome that no other medical system does,
20 because VA is a very open system, willing to
21 admit their mistakes publicly. And so,
22 periodically you hear -- you read those news

1 stories about a VA hospital that messed up.
2 And we've all heard stories from people whose
3 father had a horrible experience there 25
4 years ago and will never go back.
5 And so just that -- I think just
6 that familiarization of going to the --
7 walking through the door of the VA hospital
8 and saying, gee, this looks like a pretty
9 nice, clean, well-run place. You know, I
10 think some of those first impressions are
11 important as well as, you know, knowing the
12 kind of healthcare you get there and what the
13 benefits might be, yes. But just that first
14 impression that this isn't a place that I
15 would be afraid to walk into and it's
16 generally not a place that's going to harm my
17 health rather than help it.
18 DR. PHILLIPS: I agree. I know
19 there are a whole host of issues and there are
20 challenges, but just knowing that you're going
21 to go to the VA in three months or two months
22 and having someone, an expert help you get

1 online and register or process that takes away
2 so much burden. I mean, I've tried it myself,
3 as I mentioned. If there's an expert sitting
4 with you and can help you do that, and then of
5 course, when you get there, a lot of that is
6 done and you just know.
7 CO-CHAIR GREEN: Just be aware,
8 that works when we talk about the medical
9 culture and the availability of treatment, but
10 it really doesn't address probably what is a
11 greater fear, which is that coming out of
12 uniform and the transition. And so, one of
13 the things I think -- actually another best
14 practice perhaps with something was the
15 clerkships that they're allowing people to do
16 so that they can find jobs that they're going
17 to be doing next, because that's kind of the
18 other part of this. Once you kind of know
19 this is what I want to do, then it -- you
20 know, it turns around. Instead of it being
21 don't hurry me, don't hurry me, it becomes I
22 need to get there so I can get this job. And

1 so there's a secondary -- actually probably a
2 more primary piece of this and the medical
3 care is probably a secondary piece.
4 MR. REHBEIN: And that addresses
5 something that's out there in the higher
6 education community now. The people, the kids
7 are coming out of high school. The advice is
8 pick a major that provides some internships
9 because internships lead to employment. You
10 don't have to go into that job search cold.
11 So that same sort of thing that's happening
12 there, yes, that smooths the transition and
13 helps ensure the success. So I think maybe
14 there's another thing that we need to do that
15 we need to do there is make some kind of a
16 recommendation to promote as many of those
17 kinds of internships. I know there are some
18 geographical constraints put on those. Maybe
19 we need to take a second look at that, see
20 what we can do.
21 CO-CHAIR GREEN: Yes, let me
22 just --

1 CSM DeJONG: No, it's not a
2 concern. I know Mac's concerned. We've
3 spoken that many times about how in his
4 position it keeps him from accessing some VA,
5 but part of our mandate is to talk about a
6 warm hand-off to the VA. So we're still
7 separating the two. General Stone said a
8 couple meetings ago it's all the same pot of
9 money. So what is stopping us from looking at
10 making recommendations of melding the two
11 together at a medical decision point and
12 transitioning that healthcare? But we're
13 still talking around the table and we're
14 keeping them separate. What's stopping us
15 from putting them together?
16 MS. MALEBRANCHE: Captain Evans
17 and I had a little discussion before this
18 meeting. And one of the things with the FRCs
19 and the RCCs that we've been talking about,
20 you're right, they're two different systems.
21 What if it was one? What if in that area it
22 was one office, federal? I mean, I hate to

say it, kind of like the IPO. But what if that was something out there? And then certainly you'd be looking at a lot of this transition piece that would be, because it's not a warm hand-off. You're right. You don't even know the case manager you're talking to.

And I was looking -- and again, kind of referring to that Air Force model, I was seeing some of that potential in that model, and that might be something that we want to take a look at, seriously consider.

LTCOL KEANE: If I could just make everybody aware of what the Marine Corps's doing with the FRC program, as a Marine is identified to have an FRC, or even if a Marine's being evaluated to have an FRC, I'm notified and I tell the regiment. When a Marine gets an FRC assigned, I notify the regiment and they assign the RCC. The Marine already has an RCC, but the RCC then contacts the FRC. That's been going on since the beginning of March.

1 CO-CHAIR GREEN: Now you could
2 take this back one step further, which is if
3 you actually could predict which people are
4 least likely to return to an active duty
5 position, you could make decisions on where
6 they get their rehabilitative care. So just,
7 you know, take it one step further. But I
8 like the idea about the FRCs and the RCCs --
9 I think that's a very reasonable way.
10 I need to bring us back to some
11 process issues, and so let me just -- I had to
12 take a quick phone call. I apologize. But if
13 we're going to do all of these issues in the
14 larger forum, we're going to have a very hard
15 time getting to where we need to be in the
16 next two days. And so, some of the work that
17 needs to be done is in those smaller groups
18 again to try and bring together those things
19 that we want to capture and then let the
20 larger group talk about how we're doing to do
21 it. Because otherwise, I'm not sure we're
22 going to get through all the issues.

1 Denise, how are you thinking about
2 doing this?
3 MS. DAILEY: Sir, I can't create
4 smaller groups. I don't have it published.
5 I designed all three days for an open
6 discussion. That's all I can do, sir. I
7 can't close off any of this meeting.
8 CO-CHAIR GREEN: It's not so much
9 that I'm trying to close it off as I'm trying
10 to figure out how we're going to get around
11 the things that -- I mean, in the last time
12 around we actually took these issues, because
13 we established those four work groups to
14 essentially look at items from different
15 visits that came together into common areas,
16 those four common areas we talked about. And
17 so, I guess my question is right now you've
18 got the people who are in that one common area
19 talking kind of in the open forum about this,
20 but they haven't had really any time to think
21 about how they would like to make
22 recommendations to us.

1 MS. DAILEY: Okay.
2 CO-CHAIR GREEN: And so, I mean,
3 whether we do it in the open forum and break
4 into smaller elements so that just we can talk
5 between ourselves -- I mean, right now we're
6 all kind of all over the map on how we're
7 going to get to a recommendation. And I'm not
8 even sure who's capturing what the possible --
9 MS. DAILEY: Yes, sir. My
10 researchers are capturing it, sir. And at the
11 end of each one of these hours -- and, yes, we
12 moved and rambled here, but that's kind of
13 what today is about, to kind of get the feel
14 for it. The rest of these topics, some have
15 an hour, some have an hour and fifteen. So,
16 yes, you will need to kind of come to three or
17 four points by the end of an hour and say --
18 you know, turn around to these guys.
19 We talked about, and I took some
20 notes. I think you all resonated on
21 education. Ms. Malebranche was saying let's
22 get into the senior leaders and talk to them

1 about VA. That was one of the points.
2 The other piece that we talked
3 about with some length was a trip, so to
4 speak, some requirements to put service
5 members in a VA for some time period. We'd
6 craft some language that wouldn't be field
7 trip, so to speak. But to get into an OEF/OIF
8 program manager's facility and culturalize the
9 individuals. That would be two.
10 Then I'd pointed out some language
11 on page 8 of your discussion points that is a
12 formal process for doing this hand-off.
13 So Suzanne, Jess -- at the end of
14 each one of these periods, sir, Suzanne and
15 Jess would kind of formalize three or four of
16 the points that you all resonated most clearly
17 with. And they you would give them feedback
18 and say, yes, no, take that one off the table.
19 We don't really want to do that. Go build a
20 recommendation and put the findings behind
21 those top two. That's the process.
22 Now we've kind of had some time to

kind of talk here. I think it's good, but, yes, tomorrow and the next few days a little more focus and a little more discipline to kind of come to two or three points that you really want them to bring the data in behind and bring the recommendation to the table for you next time will be required.

CO-CHAIR GREEN: Okay. I mean, that's fine. I'm not trying to keep anything hidden here. I'm just trying to handle a lot of information, and typically you can have a smaller group basically help refine the information so that when it's presented here people can add and subtract from it. But we can do it the other way. It's just that I'm afraid that we're going to find at the end of the -- depends on when they're going to show us what they've captured from this. When do you expect for the people to see it?

CO-CHAIR CROCKETT-JONES: Well, that's what I was just going to ask. Can they present to us now what they captured from our

1 discussion?
2 MS. DAILEY: Yes. Yes, they would
3 spend --
4 CO-CHAIR CROCKETT-JONES: Do they
5 need a break --
6 MS. DAILEY: No.
7 CO-CHAIR CROCKETT-JONES: -- to do
8 that, or are they ready?
9 MS. DAILEY: They're ready.
10 DR. LEDERER: It'll be rough, but
11 I'm happy to share with you now.
12 You did say a lot. I've tried --
13 while you were talking I've tried to pull
14 together the threads and the themes, and there
15 are about maybe three large buckets, I think,
16 I hope.
17 One of them is this concept of
18 culture change. Actually, Mr. Rehbein, you
19 led with this culture change. When they get
20 out, just like when they get in there's this
21 culture change. And then General Green talked
22 about the culture change he experienced when

1 he went to the VA and realized how the whole
2 model is different.
3 More focus on the long-term
4 implications versus the DoD focus on getting
5 the recovering warrior returned to duty. VA's
6 looking at what's going to happen to the
7 individual in 20 to 30 years. Ms. Malebranche
8 said that's because they're looking at the
9 whole person concept. General Green asked who
10 within the VA system can prepare people for
11 this culture change within the DoD system? Is
12 the DoD really equipped to facilitate this
13 educational experience given that the DoD is
14 traditionally so focused on retaining and
15 returning to duty?
16 Ms. Malebranche, it was at that
17 point that you talked about how you'd love to
18 see the VA go and enlighten and train DoD
19 leaders, commanders, senior enlisted personnel
20 about the VA so that they can be spokespersons
21 and advocates for the VA with their soldiers
22 and other service members, perhaps at the

1 advance courses. This notion of
2 enculturation. General Green talked about,
3 well, except that the military likes just-in-
4 time training, so that could be a little bit
5 of a rub there. What can we do to help them
6 make this leap when all the incentives are to
7 retain them?
8 And then General Green did talk
9 about how the -- when the war was gearing up
10 and the influx of casualties was very obvious
11 we had -- facilities were built on the DoD
12 side as opposed to on the VA side. And he
13 sees an opportunity as the war effort draws
14 down and the VA -- the rehab facilities are
15 dismantled to integrate them at VA sites which
16 could help to promote that enculturation of
17 military personnel to the VA system. So that
18 whole recommendation is about facilitating
19 that cultural transition.
20 Ms. Crockett-Jones talked about
21 the field trips, that early exposure, which
22 also Ms. Dailey highlighted as well. That

1 would be one recommendation that I heard you
2 all talk about at some length.
3 The next thing, I heard you talk
4 about a need to emphasize and reinforce the VA
5 programs and assets that already exist, like
6 the VA OEF/OIF program and the VA liaisons for
7 healthcare, and the military service
8 coordinator, and all of these assets that
9 perhaps DoD is not taking as much advantage of
10 as it could. Is there some way that we can
11 better mobilize those resources? Ms.
12 Malebranche talked about how we're doing
13 better at facilities with VA liaisons -- I
14 believe you said.
15 Mr. Drach talked about a lot of
16 wounded, ill and injured don't get TAP, but
17 there is DTAP. Perhaps we're not maximizing
18 that. There's that benefits letter again
19 trying to capitalize on the resources and
20 processes, assets that all can help recovering
21 warriors maneuver through that transition.
22 And Ms. Dailey talked about page 8 of the

1 discussion points that starts to get at some
2 of this, that business about an MOA or some
3 such policy, written policy that would
4 document and formalize this transition.
5 I think I just have one major
6 large one, which was Ms. Crockett-Jones talked
7 about we use the word "transition," but it's
8 really not necessarily a transition that's
9 happening from these recovering warriors'
10 standpoint. One day they're in and another
11 day they're out.
12 And there was some discussion I
13 think, perhaps sergeant major, about making
14 better use of these 365 days to allow them
15 really -- those in particular who are in IDES
16 and we know are not going to return to duty,
17 how they can better be helped to prepare for
18 this transition.
19 Once the medical retention
20 decision point is reached, we've got a year.
21 How do we make this happen, make the year more
22 productive for them? You all talked about

1 that pre-IDES screen, the DAWG that the Air
2 Force is using, and how you might perhaps be
3 able to leverage that in a new model. Ms.
4 Malebranche talked about -- I think perhaps
5 you also. It was a little bit toward the end
6 of this hour. What was it, combining the DAWG
7 and -- okay. Okay. Thank you. There was
8 some discussion about how do you do this for
9 the AC when these systems are there for the
10 RC?
11 MS. DAILEY: So four groupings and
12 the process would be, you know, kind of listen
13 to this. Okay. Pull out No. 2, pull out No.
14 1, focus on 1 and 2. So that's the process.
15 CO-CHAIR CROCKETT-JONES: Okay.
16 From having been retold back, I picked up on
17 sort of six things in those buckets. I picked
18 up on six things that sounded like
19 recommendations, potential recommendations.
20 Can I offer those as sort of a clarification
21 of what you just did?
22 One, more VA outreach and training

1 and education both at the basic level and of
2 specific resources like OIF/OEF.
3 Two, long-term rehab integration.
4 Three, field trip replication of
5 the Yellow Ribbon or PDHRA program that
6 reservists get, but a -- I know "field trip"
7 is the wrong word, but you know, some sort of
8 way to bring that to the active component.
9 More VA in TAP. More VA -- or
10 emphasis in TAP.
11 Prescreen to make IDES more
12 clearly focused in separation outcome, to
13 clarify why someone is in IDES and make that
14 year more productive.
15 Combining the RCC and FRC
16 programs.
17 Those were the six sort of
18 discrete ideas that I heard. The DAWG was
19 part of the -- as a model for the prescreen.
20 MR. REHBEIN: The one other thing
21 that I'd like to add and we didn't spend much
22 time, on and maybe we should have spent more

1 time on it, was the employment issues. And I
2 think if we can encourage DoD to expand the
3 opportunities for internships, I think that's
4 the one big step that could be made, is to
5 remove all of the barriers, remove as many
6 barriers as possible to internships, whether
7 -- for the recovering warriors.
8 MS. DAILEY: There is a real
9 discrete recommendation on that, which is they
10 need to publish the DoDI. They made a
11 commitment to publish the DoDI. That's in
12 consonance with the new language of the
13 legislation. And so that's a discrete, you
14 know, met/not met-kind of recommendation that
15 you can make. And that can languish because
16 DoDIs are hard to push out unless there's
17 someone with -- you know, providing them the
18 requirement.
19 MR. DRACH: David, excuse me, when
20 you say "provide internships," are you talking
21 about for the recovering warrior?
22 MR. REHBEIN: Steve says -- Steve,

1 you're going to be getting deeper into this
2 subject?
3 CSM DeJONG: I'm not saying we
4 can't. I'm just saying we ran out of the hour
5 for -- right now for enabling a better future.
6 So we can look at restoring into society for
7 the internships.
8 MR. REHBEIN: Well, the short
9 answer to your question, Ron, is yes, for the
10 recovering warriors.
11 MR. DRACH: Well, currently DoD
12 operates the Operation Warfighter. Operation
13 Warfighter, they have very, very consciously
14 said that it's not an internship. They didn't
15 want to call it an internship. Theoretically
16 I think it is an internship because it gives
17 them these experiences.
18 I think Operation Warfighter thus
19 far has been very, very successful. It was
20 never intended to be a placement program, but
21 it kind of has morphed into that. Because a
22 lot of these recovering warriors, they get

1 assigned to a federal agency as part of their
2 recovery and it's intended to be get them out
3 of the hospital setting, get them into the
4 work environment, and the unintended
5 consequence was that these agencies said, hey,
6 this guy is really good or this gal's really
7 good. So when they do finally get discharged,
8 the agencies are hiring that individual.
9 DHS has been probably the most active. VA and
10 DoD has also been very, very active in the
11 military services.
12 The criticism that I personally
13 have with Operation Warfighter is they haven't
14 expanded it to the private sector yet. Now
15 there is a lot of talk going on to expand it
16 to the private sector. Is that something that
17 we should entertain as a recommendation?
18 CO-CHAIR CROCKETT-JONES: Is that
19 what the DoDI -- yes, there is. And there is
20 another chance where we're going to hit this,
21 isn't that correct? Or it's in the --
22 MS. DAILEY: We'll put it on the

1 table for you, whether we get there or not.
2 CO-CHAIR CROCKETT-JONES: It'll be
3 part of our --
4 MS. DAILEY: Yes.
5 CO-CHAIR CROCKETT-JONES: Yes,
6 tackled.
7 MS. DAILEY: Again, so five, six
8 points here, ladies and gentlemen. You know
9 you're going to have to edit it down. You had
10 almost two hours on this topic. You're going
11 to have to bring it down. But very good.
12 Very good.
13 CO-CHAIR GREEN: The other thing
14 is that because of our experience with last
15 year where there was some confusion I think
16 with some of the recommendations not being
17 understood fully -- one of the other things to
18 do here is Suzanne has given us, you know, six
19 or perhaps seven with the one you've added --
20 the other question would be are they all
21 recommendations or are they all part of a
22 greater whole?

1 And so, do you talk to -- for
2 instance, is the culture issue -- do we talk
3 to the recommendation as being, you know,
4 under the heading -- is it one or two things
5 that talk about breaking the barriers of
6 culture between DoD and VA to enhance the
7 transition? And then talk to specific things
8 underneath that so that it's not seven
9 recommendations. It's essentially -- you
10 know, it's one or two or three under an
11 umbrella.
12 I don't know the answer. I'm just
13 saying we need to think about those issues as
14 we write this, because especially when we go
15 back and look at the ones that are already
16 there with 22, or 21, then when we come back
17 to this one, if we add seven with each of the
18 four groups, we're talking now in the 40s or
19 50s. And so, I'm sensitive to not providing
20 too many overarching recommendations and
21 basically giving them specifics under a
22 heading, if you will, that may make sense.

1 So I'm not sure what that heading
2 is and I'm not sure that we want to -- I'm not
3 trying to demean any of the seven. I'm just
4 thinking there may some that fall together and
5 we need to have you thinking about that a
6 little bit.
7 MR. REHBEIN: If I remember last
8 year, I believe we started with 40 and
9 essentially cut it in half.
10 CO-CHAIR GREEN: I think it's a
11 green box to say we've reached the magic
12 bewitching hour. Okay? And so, I think that
13 we've done some good work today. We'll
14 adjourn for the day and reconvene tomorrow
15 morning I believe at 8:00 again.
16 Is that right, Denise?
17 MS. DAILEY: Yes, sir. Just heads
18 up on the morning. So you have situational
19 awareness, we do have a public forum. Mr.
20 Parker will talk to us for two minutes. He
21 gets two minutes. I'll manage that. That's
22 what the Public Register says.

1 You will have a minute to ask a
2 question, if you'd like. The presentations
3 are in tab H. So those are the presentations
4 tomorrow. That's only going to take five or
5 10 minutes.
6 Following that, Colonel Mayer from
7 the Wounded Warrior Regiment will be here to
8 talk to us about Twentynine Palms. Ms.
9 Crockett-Jones is going to lead that
10 discussion, but it's another part of our
11 interactive site visit reviews. That will take
12 up the first half hour. Yes, that will take up
13 the first half hour. Then at 8:30 or
14 thereabouts we start with non-medical case
15 management.
16 I highly recommend a review of the
17 discussion points and your part of the
18 integrated documents that lay out your topic
19 areas. You have homework, ladies and
20 gentlemen.
21 (Whereupon, the meeting was
22 adjourned at 5:12 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: Wounded Armed Forces Members Task Force

Before: DoD

Date: 05-15-12

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