

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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WEDNESDAY

JUNE 13, 2012

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The Task Force met in the Washington Ballroom of the Crowne Plaza Old Town Alexandria, 901 North Fairfax 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

JUSTIN CONSTANTINE, J.D., Member

CSM STEVEN D. DEJONG, ARNG, Member

RONALD DRACH, Member

CAPT CONSTANCE J. EVANS, USN, Member

LTCOL SEAN P. K. KEANE, USMC, Member

MSGT CHRISTIAN MACKENZIE, USAF & SOCOM,
Member

KAREN T. MALEBRANCHE, RN, M.S.N., CNS,
Member

STEVEN J. PHILLIPS, M.D., Member

DAVID REHBEIN, M.S., Member

MG RICHARD A. STONE, M.D., USAR, Member

RUSSELL A. TURNER, M.D., Member

ALSO PRESENT

DENISE F. DAILEY, PMP, Executive Director,
ANNE E. SOBOTA, Alternate Executive Officer
JOHN BOOTON, PMP, Operations Staff
LAKIA BROCKENBERRY, Operations Staff

JOHN HEGGESTAD, Operations Staff

PHILIP KARASH, M.A., Operations Staff

STEPHEN LU, Operations Staff

HEATHER JANE MOORE, Operations Staff

DEQUETTA TYREE, Operations Staff

JAMES WOOD, Operations Staff

AMBER BAKEMAN, M.A., Research Staff

KAREN EGAN, M.A., Research Staff

JESSICA JAGGER, Ph.D., M.S.W., Research
Staff

SUZANNE LEDERER, Ph.D., Research Staff

KAREN WESSELS, M.A., Research Staff

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

2 (8:02 a.m.)

3 MS. DAILEY: Good morning, ladies
4 and gentlemen. I'd like to welcome you to
5 this session of the task force. Our first
6 hour is going to be a breakout session, ladies
7 and gentlemen. And so in a minute here, I'll
8 be turning you over to your groups.

9 We have tables in the room set up
10 for each group. To set the tone, the morning
11 will be leisurely, the best way to put it. I
12 have a lot of members who are not here and who
13 informed me they could not be here this
14 morning.

15 The first hour is a breakout
16 session where I think it's a very good
17 opportunity for you to refresh yourself with
18 the recommendations and the findings, get your
19 arms around them, get your arms around them as
20 a group, so that you can come to an agreement
21 or a position on your set of recommendations
22 and findings.

1 At 9 o'clock, Mr. Parker will be
2 here. He's the only speaker we have for the
3 public forum. I have that time period from
4 like 9:00 to 9:45 and I only have one speaker,
5 so that's a large gap of unstructured time.

6 And then at 9:45, we have a
7 session in which you can deliberate as a full
8 group in a public session. And really, what
9 is intended for that period to be is, for you
10 to bring out of those preparatory sessions,
11 the work that you did at 8:00 to 9:00, bring
12 it into the public forum, or bring it into the
13 public for the public to hear, at 9:45.

14 And that session lasts till 12:00,
15 when we have lunch. We can edit during that
16 time if there's definite language you want to
17 change or in your group you see
18 recommendations that you want to combine. I
19 have capabilities here to create new copies
20 once you've made changes.

21 So at 2 o'clock, when we start a
22 voting session, I can have a fresh copy on

1 your table. Doesn't mean we have to do a lot
2 of work before that time period, but I have
3 the capability to edit and to create some new
4 copies for you.

5 Real traction, ladies and
6 gentlemen. I don't think we're going to get
7 any real traction till I get everyone here
8 this afternoon and you all start walking
9 yourselves through every recommendation, how
10 it's phrased, and what you really want it to
11 say.

12 And so, this morning time period,
13 midday, is really your opportunity to get your
14 arms around the whole process and the
15 recommendations.

16 Any questions? Okay. Then what I
17 need to do, ladies and gentlemen, is I need to
18 break you out into your groups and let you sit
19 down and start talking as a group on your
20 topic areas. I need the screen up there that
21 tells them where to go.

22 So I have Command Sergeant Major

1 DeJong, Ms. Crockett-Jones, and Captain Evans
2 over here. And I have Mr. Constantine, Master
3 Sergeant MacKenzie, and Mr. Drach back here.
4 I have one group staying up at the table, so
5 if I don't call your name, you're up at the
6 table.

7 General Stone, Mr. Rehbein, and
8 Ms. Malebranche is back here. Ms. Malebranche
9 said she wouldn't be able to be here this
10 morning, sir. And then my remaining group is
11 at the table up here.

12 (Whereupon, the above-entitled
13 matter went off the record at 8:08 a.m. and
14 resumed at 9:05 a.m.)

15 MS. DAILEY: Welcome back. Have I
16 got everybody? Good.

17 CO-CHAIR CROCKETT-JONES: Okay.
18 Thank you all. Thank you, Ms. Dailey. Our
19 fifth meeting of the second year of effort.
20 I am going to ask our members to introduce
21 themselves at this time. Why don't we start
22 over there, Mr. Rehbein?

1 MR. REHBEIN: Dave Rehbein from
2 Iowa, research scientist, past national
3 commander of the American Legion.

4 CSM DEJONG: Command Sergeant
5 Major Steve DeJong, National Guard Bureau.

6 DR. PHILLIPS: Steve Phillips,
7 physician, retired military, NIH.

8 MR. CONSTANTINE: I'm Justin
9 Constantine. I'm an attorney with the FBI and
10 I'm a Major in the Marine Corps Reserve.

11 MG STONE: Rich Stone, Army Deputy
12 Surgeon General.

13 CAPT EVANS: Captain Constance
14 Evans, Bureau Medicine, Director of Case
15 Management.

16 LTCOL KEANE: Lieutenant Colonel
17 Sean Keane, member of Wounded Warrior
18 Regiment, Marine Corps liaison to the VA,
19 defender of freedom.

20 MSGT MACKENZIE: Master Sergeant
21 Christian MacKenzie, Air Force, U.S. SOCOM,
22 currently working for the U.S. SOCOM Care

1 Coalition, and Wounded Warrior class of 2004.

2 DR. TURNER: Russ Turner,
3 physician, San Antonio.

4 MR. DRACH: Ron Drach, individual
5 member, D.C. area.

6 CO-CHAIR CROCKETT-JONES: And I'm
7 Suzanne Crockett-Jones, civilian co-chair. My
8 co-chair, General Green, will not be here till
9 this afternoon, but we're going to try and
10 manage to carry on without him.

11 We're beginning our public forum
12 and so I would like to hear from Mr. Michael
13 Parker, and we have some information on Tab C
14 for the members.

15 MR. PARKER: Okay. Thank you and
16 good morning. I cannot begin to tell you my
17 disappointment in the task force's IDES
18 recommendations in their FY12 draft report.
19 While the IDES recommendations in this report
20 have merit, they do not address core IDES
21 issues that are cheating our Wounded Warriors
22 out of their proper DoD disability benefits.

1 As you know, the task force did
2 not address IDES issues in their FY11 report.
3 The task force elected to defer IDES
4 recommendations to their FY12 and later
5 reports, yet, despite a multitude of
6 submissions and I&Os presented on DES issues,
7 the FY12 report failed to make any
8 recommendations on these critical IDES issues
9 that have lifetime impacts on Wounded Warriors
10 and their families.

11 Since 2005, I've been in the
12 trenches helping Wounded Warriors obtain their
13 proper DoD disability benefits. During these
14 years, I have uncovered scores of issues that
15 have led to Wounded Warriors being cheated out
16 of their DoD disability benefits.

17 I have relayed many of these
18 unresolved issues to the task force since it's
19 creation. In May 2011, I gave a very detailed
20 brief on these issues to the task force, yet,
21 this brief is not included in the sources for
22 your FY12 report.

1 In fact, I could not find any
2 references in the FY12 report to any of the
3 information or statements I have provided to
4 the task force over the last 18 months. There
5 are way too many issues to cover in this
6 format, but the issues are, by and large,
7 already part of the record from my previous
8 submissions.

9 For the sake of Wounded Warriors,
10 I ask you to act on them. I do have time to
11 make one capstone recommendation: ensure all
12 who are unfit for further military service due
13 to a compensable medical condition receive a
14 DoD disability retirement.

15 After all, federal civil servants
16 who become disabled receive a disability
17 retirement. So why shouldn't our Wounded
18 Warriors and their families have similar
19 disability protection?

20 While this was a key
21 recommendation of the 2007 Dole-Shalala
22 Commission, but Congress has yet to act on it,

1 they need a reminder. I look forward to an
2 information paper on this recommendation soon
3 and I will also continue to forward
4 information papers on other IDES-related
5 issues throughout the summer.

6 That concludes my statement unless
7 there are questions you would like me to
8 answer.

9 MR. REHBEIN: Madam Chairman, if I
10 may for just a minute and I'm sorry, I have to
11 keep my back to you, sir --

12 MR. PARKER: No problem.

13 MR. REHBEIN: -- to use the
14 microphone, but it seems to me that the key to
15 part of what you've spoken to us about in the
16 future is those words compensable medical
17 condition, because a number of the issues that
18 you've raised are in the determination of what
19 is and what is not compensable; service
20 connected. Things like personality disorder.

21 How would you recommend that we --
22 is there a way that we can better define

1 compensable medical condition?

2 MR. PARKER: Yes, and I think
3 that's a couple of fronts. I did submit you
4 guys a case on a POT Kinberg, which I think,
5 if you look at that information, will provide
6 you one aspect of that, and that's them saying
7 that the condition existed prior to service,
8 it was not aggravated, and therefore, not
9 compensable.

10 If you look at his case, they just
11 pencil-whip that as EPTS; done story. Well,
12 Congress, in 2009, required that if you're
13 going to do that, you have to follow the VA
14 standard, which is that there's a presumption
15 that it's service connected and there's a
16 presumption that it's aggravated.

17 To overcome that, you need clear,
18 non-mistakable evidence to the contrary. What
19 would be helpful, if there's a recommendation
20 that says, if you're going to say something is
21 EPTS, then attach to those IPEB findings
22 should be a sheet that says, here's our clear,

1 non-mistakable evidence from which we found
2 this to be EPTS and non-compensable.

3 Then the service member can look
4 at that and have something that he has a basis
5 to either agree with them or to fight them on
6 it. Right now, in the Navy for example, they
7 just said EPTS and didn't tell him why.

8 Now, how do you go to a formal
9 board and then defend yourself when you have
10 no idea what the logic was? The first time
11 you might get a look at what that is is after
12 the formal board when they release the formal
13 board results.

14 It's way too late in the game.
15 They need that information early. And so a
16 simple recommendation that anything that's
17 deemed EPTS without aggravation requires, you
18 know, a PEB decision dash 1 that says,
19 evidence to overcome the presumptions of
20 service connection and aggravation.

21 In terms of personality disorder
22 and adjustment disorder, I recommend that

1 those issues -- when you have personality or
2 adjustment disorder, it doesn't even go into
3 the DES. It gets circumvented around to an
4 admin separation.

5 So my recommendation would be that
6 those type of disorders be required to be
7 vetted by the DES system, and if they're
8 deemed to be pre-existing personality and
9 adjustment disorders, then they follow the
10 same standard of clear and unmistakable
11 evidence to the contrary, having to overcome
12 that presumption to help protect the Wounded
13 Warrior from that stuff.

14 Now, those conditions, there's an
15 eight-year rule that says, if you have a
16 condition that existed prior to service, no
17 doubts, no questions, it's still compensable.
18 That doesn't apply to personality and
19 adjustment disorder.

20 A person can have 19 years in, be
21 deemed adjustment disorder, and they would be
22 booted out without anything. So where you

1 need to look is Enclosure 5 of DoDI 1332.38,
2 which has a list of conditions that are not
3 considered compensable and don't get submitted
4 to the DES.

5 And I would think you need to
6 review those and say, do those still make
7 sense, particularly adjustment disorder and
8 personality order, but other ones as well?

9 I, myself, there's one in there
10 that says, if you cannot take shots,
11 inoculations, to deploy, that's reason to be
12 booted administratively without DES benefits.

13 Well, I came down with an
14 autoimmune disease 13 years into service which
15 is treated with a drug called Enbrel, which is
16 an immune-suppressive drug, which makes me
17 non-deployable.

18 If you read the letter of the law
19 of that thing, I would have been kicked out,
20 not because of the autoimmune disease, because
21 of the shots I had to take, I couldn't take
22 smallpox, for example, makes me non-deployable

1 so I ought to go without benefits.

2 So I think that whole idea of
3 what's on Enclosure 5 of that document has to
4 be looked at, and that's where you'll find
5 personality and adjustment disorder, does that
6 really make sense? Are we really treating the
7 Wounded Warriors? It's an exploitable thing.

8 Personality disorder, we went
9 through a thing where they say you can no
10 longer do that, so they went to adjustment
11 disorder. Personality disorders went like
12 this in lieu of PTSD, and adjustment disorders
13 went like that for PTSD, so lots of loopholes
14 have to be closed in my mind.

15 MG STONE: Mr. Parker, could you
16 spend some time talking about the non-
17 uniformed federal civil servant disability
18 system?

19 MR. PARKER: Sure. Under FERS, if
20 somebody is employed for at least 18 months
21 and they can no longer perform their job, and
22 I think there's some catches in there, you

1 know, if they can't find you a job within 75
2 miles, or something like that, but if at the
3 end of the day, you are deemed that you can no
4 longer do your job, you receive a retirement
5 that is 60 percent of what your current pay is
6 for the first year.

7 After the first year, you receive
8 40 percent of what your compensation was, up
9 until the age of 62. At the age of 62, you
10 receive a FERS retirement as if you never
11 stopped working at all. It's a fairly robust
12 disability protection system.

13 If you have an MP, you have a DoD
14 police officer, manning the same post and they
15 both get whacked by something, and, you know,
16 you can have that MP, basically, get severance
17 pay, which is recouped by his VA pay, while
18 that DoD employee, doing the same job there,
19 is going to have a lifetime disability
20 retirement.

21 So I think that's what Dole-
22 Shalala was getting at. I mean, Secretary

1 Shalala said herself, I don't understand it,
2 these guys should be getting retirements. I
3 got a retirement when I left, why aren't they
4 getting their retirement?

5 And that was a recommendation, I
6 know that Senator Burr and Congressman Buyer
7 both proposed legislation to kind of enact
8 that thing, but it went nowhere. I assume
9 it's a dollar-driven issue, that was probably
10 an obvious assumption, but that, to me, is
11 critical that we are not giving our military
12 members the same level of disability
13 protection to protect that career equity as we
14 are giving federal civil servants that, in
15 often cases, are working side-by-side with
16 them.

17 MSGT MACKENZIE: So the question I
18 have is: is it that the military members are
19 not getting what the civil servants are
20 getting, or is it that the civil servant
21 retirement is unreasonable and the military is
22 still subject to DoD budget cuts which

1 prevents the DoD from doing what civil service
2 is doing?

3 MR. PARKER: Well, I don't know if
4 it's unreasonable or not. I know it was what
5 they signed up for. You know, when you take
6 the job you get certain benefits. You are, in
7 the military's perspective, there are a lot of
8 things that are better than you get in the
9 civil world in terms of your medical benefits
10 and your retirement at an earlier age.

11 But you can't look at that in
12 isolation. You have to look at the other side
13 of the ledger that shows you deploying to God
14 only knows where, you know? Everybody, I
15 think, in uniform knows the right side of the
16 ledger and the bill you pay for those better-
17 than-usual benefits.

18 The key here, and what is
19 fundamental to understand is that, the DoD
20 disability system does not compensate for
21 disabilities. It compensates for the career
22 loss of duty disabilities. The VA is to

1 compensate for the earnings impact of that
2 disability. DoD is to compensate for the lost
3 career.

4 So really what's at issue, and I
5 guess there's some thoughts about how you do
6 this, but what you need to protect is, if I
7 work for ACME Corporation for ten years and I
8 no longer work there, I take with me my
9 retirement equity to date in terms of a 401(k)
10 and stock options, and whatever else I've
11 built.

12 So nowadays, we have portable
13 retirement systems where, I work here for a
14 little while, I move here, I move here, I move
15 here, and I take my 401(k) with me. In the
16 military, your retirement equity comes in a
17 retirement and all that can vanish in a
18 heartbeat because somebody says you have
19 personality disorder.

20 So really, to me, the issue is, if
21 you kick somebody out involuntarily for a
22 benefit, they should walk out with that

1 retirement equity somehow, somehow, be it a
2 retirement, be it a lump sum that's not offset
3 by the VA, by the way, but something akin to
4 that 401, that they've been working for a
5 retirement, they worked up to a certain point,
6 and it all vanishes when they have a service-
7 connected disability.

8 So that's really, I think, the
9 core nugget there is protecting that
10 retirement equity somehow, somehow. Not
11 necessarily by retirement, I suppose we could
12 be open to different solution sets, a lump sum
13 or something like that, but the other side of
14 it is the medical stuff.

15 You're legitimately going to have
16 a guy with 18 years in who only has a 20
17 percent-rated disability. No questions about
18 it. He's going to get severance, and he's
19 going to lose his retirement, and he's going
20 to get a lump sum.

21 But what if that 18-year-in-
22 service man has a daughter with cancer? Well,

1 he just lost his medical coverage as well. He
2 gets it as a retiree, he doesn't get it if
3 he's separated. Now, he's got to go to ACME
4 insurance company and say, can I have
5 insurance and they're going to say, no way.
6 Pre-existing condition, yadda yadda yadda,
7 sucks to be you, kind of a thing.

8 So part of this is also protecting
9 their medical coverage transition. How do we
10 make sure that we're not leaving these guys
11 high and dry? Now, they might be protected
12 under the VA, but their family is not.

13 MR. CONSTANTINE: Mr. Parker, do
14 you see a lot of folks you work with who go
15 through the IDES system, are medical retired,
16 then any compensation they would receive from
17 DoD is completely offset by the VA?

18 MR. PARKER: Oh, absolutely. The
19 way it works now is, if you get severance pay
20 from DoD, I'm rated at 20 percent, they gave
21 me \$50,000, and that condition is compensated
22 by the VA, the VA will collect that \$50,000

1 back by not paying me the compensation for
2 that same condition.

3 So there's an oddity there. If I
4 have a condition that's rated 0 percent, so
5 let's say the Army kicked me out for a knee
6 condition. The VA rates it at 0 percent. My
7 buddy gets kicked out for the same knee
8 condition and the VA rates it at 10 percent.

9 This is a flaw in that system
10 there that, because the VA is paying me 0
11 percent, there's nothing to offset. I'm not
12 being compensated at the VA by that condition,
13 so I keep my severance pay. My buddy with the
14 10 percent, they're going to take back 10
15 percent VA until that \$50,000 is paid back.

16 Does that make sense? Absolutely
17 it doesn't make sense. It doesn't make sense
18 in the first place to take back that
19 compensation because it was designed to offset
20 the loss of their career equity.

21 MR. CONSTANTINE: What about with
22 medical retirement?

1 MR. PARKER: Well, medical
2 retirement, on the severance thing, there is
3 a law that says if the disability occurred in
4 a combat zone, they won't capture the money
5 back again. Why a combat zone, you'd have to
6 ask Congress. I could tell you offline how I
7 think that got screwed up, but it ought to be
8 applied to everybody.

9 Separate the career equity from
10 the VA stuff and don't let one offset the
11 other. In terms of people who are retired,
12 concurrent receipt came out in the 2004 time
13 frame. It came in two flavors; combat-related
14 special compensation and concurrent receipt of
15 disability payments.

16 When they first came out with
17 CRSC, they said you had to have 20 years, no
18 if, ands, or buts. Anybody that didn't have
19 20 years could not get CRSC. They then
20 changed that law and said, no, you no longer
21 need 20 years.

22 So now people who are retired for

1 disability can receive CRSC which will restore
2 the offset. Now, right now, VA will offset
3 your DoD retirement and CRSC will restore all
4 or some of that, depending on what kind your
5 combat condition is.

6 The problem with CRSC is there's a
7 flaw and I submitted to you a thing called DES
8 Outrage Number 8, and the way they calculate
9 it, it basically cheats Wounded Warriors out
10 of all or some of that CRSC payment.

11 Now, if you're retired and you
12 don't have a combat-related condition, you can
13 only get CRDP as a disability retiree if you
14 have 20 years of service. The way the law is
15 written, if you're receiving retirement, and
16 you have a 50 percent VA rating or higher,
17 then you'll get CRDP.

18 But they wrote a special provision
19 that says, unless you're a disability retiree
20 then you need 20 years. Well, the problem
21 with that is, a), it should be going to
22 everybody anyways, in my perspective, but

1 length of service retirees don't necessarily
2 have 20 years.

3 We have around 50,000 TERA
4 retirees, from the last go around, that have
5 less than 15 years. So you have a TERA
6 retiree with 15 years who did not continue his
7 service, either voluntarily or he was told to
8 either get a TERA or we're going to boot you
9 out some other way, they can get both their
10 military retirement and their VA without
11 offset.

12 But a guy with 19 years, with
13 cancer, that's kicked out, cannot. So we've
14 been trying through our efforts to say, hey,
15 CRDP needs to be extended to everybody just
16 like CRSC was. So that, you know, at the
17 bottom-line, and this is part of the Dole-
18 Shalala Commission recommendation, that
19 everybody, if you follow what they were doing,
20 what somebody should get when they get kicked
21 out is all of their VA and a DoD retirement
22 based on their length of service.

1 And that's the same thing that
2 concurrent receipt would do if properly
3 implemented and you got rid of all these other
4 screwy, you're, provisions on it, loopholes
5 that were unintended effects, and things like
6 that.

7 MR. CONSTANTINE: Thank you, but I
8 want to ask more about the folks who are
9 medically retired, who maybe don't have a
10 whole lot of years yet, and how CRSC --

11 MR. PARKER: Okay.

12 MR. CONSTANTINE: -- applies them
13 to make sure that everything's not offset by
14 the VA.

15 MR. PARKER: Right. Well,
16 concurrent receipt, be it CRSC or CRDP, is not
17 disability stuff. It's designed to replace
18 the length of service retirement you had
19 earned to date. So if somebody has two years
20 of service in and has a combat-related injury,
21 his CRSC is going to be limited to what he
22 would have received based off his length of

1 service, which would 2-1/2 percent per year
2 times 2 years, is 5 percent.

3 So you're right, it's going to be
4 a very small amount. But I think the issue is
5 is that, that's what they should get in terms
6 of compensation for their career loss. They
7 only served two years, so you would think that
8 the compensation for the career would be
9 smaller than the guy with 19 years in.

10 Where the issue is in terms of
11 them being compensated is on the VA's side.
12 The VA is the one that needs to compensate
13 them for the disability, that impact to their
14 earnings capacity. So that's the part that
15 needs to be fixed.

16 A 100 percent rated by the VA,
17 it's a difference, there are people at a 100
18 percent that are working full-time. There are
19 people at a 100 percent that are in a coma,
20 you know, that's the difference. So I don't
21 think you can treat those the same.

22 And I think what you're getting to

1 is that, when somebody leaves the military,
2 that VA compensation should be adequate to
3 support them and their family at something
4 other than a level that's been set at the
5 poverty rate. It should be more towards --

6 MR. CONSTANTINE: No, I don't want
7 to get into the VA comp pay, but I've heard a
8 lot of stories about folks who have been
9 medically retired and their medical retirement
10 is being offset by the VA.

11 MR. PARKER: Absolutely. Happens
12 to everybody. Some of them can get it back
13 through concurrent receipt; some or all of it
14 back. And if there's an issue with that, my
15 DES Outrage Number 8 talks about how, even
16 though some people get a small amount, there's
17 a flaw, I call it the CRSC glitch, where they
18 end up kind of double-dipping the offset so
19 you get whacked twice, and people don't get
20 what they're due.

21 Congress understands this, DoD
22 understands this, they've written legislation

1 to fix it, but Congress never seems to get it
2 fixed because they can't find the offset, or
3 it doesn't get in the initial bill, and then
4 it gets thrown in with a bunch of amendments,
5 and one amendment will kill them, all type of
6 thing.

7 You go down and talk to the HASC
8 and SASC staff officers or the staff members,
9 they'll tell you. They know if they got it.
10 You can see that legislation being proposed in
11 at least two different NDAs in the past, but
12 not making it through.

13 MR. CONSTANTINE: Thank you.

14 CO-CHAIR CROCKETT-JONES: Okay.

15 Thank you very much, Mr. Parker.

16 MR. PARKER: Thank you.

17 CO-CHAIR CROCKETT-JONES: We get a
18 short break again and then we will come back
19 and do some more of our preparatory session
20 work all together. Ten minutes?

21 (Whereupon, the above-entitled
22 matter went off the record at 9:25 a.m. and

1 resumed at 9:47 a.m.)

2 MS. DAILEY: Okay. Ladies and
3 gentlemen, we're on schedule, which is always
4 a good thing. 9:45, we are going to start a
5 session and we are going to review the work
6 that you did at the preparatory session.
7 Ma'am, I'm going to turn it over to you.

8 CO-CHAIR CROCKETT-JONES: Okay.
9 This morning, we worked in groups. I'll maybe
10 fine-tune some of the language. I don't know
11 if any of the groups condensed or combined
12 anything, but we need to get to all being on
13 the same sheet of music.

14 So let's look again at the draft
15 recommendations in Tab D. It's
16 recommendations, only the findings, to make it
17 a little bit easier for us to follow along.
18 After lunch, we'll do another breakout session
19 and then come together one more time so that
20 we can all come to some agreement.

21 The first, restoring wellness and
22 function, who would like to speak from that

1 group?

2 DR. PHILLIPS: Recommendation D1,
3 we put a question mark there, basically
4 discussing the fact that the DoDI is written
5 and we assume it will be published, and so we
6 just thought we perhaps don't even need that
7 recommendation.

8 CO-CHAIR CROCKETT-JONES: How long
9 has the DoDI been written and published? Does
10 anybody know?

11 MS. DAILEY: The current DoDI that
12 they've got is expired and so -- ask me the
13 question again?

14 CO-CHAIR CROCKETT-JONES: So how
15 long have they had a DoDI that went
16 unpublished? I mean, this is what I'm --

17 MS. DAILEY: Correct. They have a
18 document called the BGM, it's a directive-type
19 memorandum, in place for three years. They're
20 only good for six months. So they had it
21 extended to the 31st of May, so even the
22 directive-type memorandum is now out of date.

1 You know, everyone still follows
2 it, technically, but it is an out-of-date
3 document and they are making a commitment that
4 they are going to publish the new DoDIs, pass
5 it, and get it through the process.

6 CO-CHAIR CROCKETT-JONES: So
7 because there has been, in the interim, such
8 an amount of delay, I think that that was the
9 thinking behind Recommendation 1 was, so that
10 they would not continue to rely on the DTM, on
11 the expiring documents.

12 MSGT MACKENZIE: And also to
13 alleviate the, for lack of better terms, the
14 empty promise that they're going to get around
15 to doing something. We'll just put it in a
16 recommendation so we can make sure it gets
17 done.

18 LTCOL KEANE: In our discussion, I
19 think Suzanne kind of mentioned that it was
20 pending.

21 CO-CHAIR CROCKETT-JONES: I think
22 it's been pending for a while though. I think

1 that's part of our concern. It should just be
2 published.

3 MSGT MACKENZIE: And as Denise
4 stated, it's pending staffing and
5 finalization. It's not just been written and
6 pending signature. I mean, it hasn't even
7 been done yet and I'm simplifying this
8 significantly, so my choice of words may not
9 be the best, but they need to follow through.

10 CO-CHAIR CROCKETT-JONES: Are we
11 comfortable with leaving it as it stands?

12 MR. REHBEIN: Just for my own
13 clarification, because now I'm a little bit
14 confused by the conversation, there are four
15 recommendations as we go through these that
16 deal with DoDIs, some of them use the word
17 "publish," some of them use the word "write,"
18 are those two words synonymous?

19 What condition is this one in? Is
20 this one written now?

21 CO-CHAIR CROCKETT-JONES: Yes,
22 this one is written. It is not signed and

1 become effective.

2 MR. REHBEIN: Okay. I just wanted
3 to be clear that we weren't using the word
4 "publish" and the word "write" to mean the
5 same thing.

6 CO-CHAIR CROCKETT-JONES: Very
7 good point. They are all in a continuum of
8 points along the process of publication. So
9 some have been written, some are in internal
10 staffing, some are in external staffing, some
11 may be on the publication.

12 None of these have completed
13 external staffing and are pending one
14 signature before publication. Most all of
15 them are in the coordination stage.

16 CO-CHAIR CROCKETT-JONES: Do we
17 want to move on to any discussion on
18 Recommendation 3?

19 DR. PHILLIPS: I think we agreed
20 with that recommendation. Recommendation 3,
21 I think we wanted to have more discussion on.

22 LTCOL KEANE: Yes, Recommendation

1 3 seems to appear to task the unit commanders
2 with finishing this comparative equal
3 opportunity statement regarding the amount of
4 highly targeted Recovering Warriors in WTUs.

5 MR. REHBEIN: As I read these, the
6 question that came to my mind is, this is a
7 problem in the transition units, is it not a
8 bigger problem in the line units that have
9 RWs, Recovering Warriors? Should this be
10 expanded to any unit that has a Recovering
11 Warrior in it?

12 CO-CHAIR CROCKETT-JONES: I think
13 that's a valid question. When we were talking
14 about this, we were trying to find ways to
15 sort of codify the right climate. Some of the
16 things that we had seen in installation visits
17 that were so dependent upon sort of leadership
18 style, that we want to get less dependent on
19 leadership style.

20 What is the military members'
21 feelings about the line unit versus WTU?

22 DR. TURNER: I think I had some

1 disagreement in our group on this, and while
2 we all agree there was a significant
3 documented problem, we had different ideas
4 exactly how to kind of approach it.

5 And so that's why we termed it,
6 well, let's talk about this, because so people
7 don't quite tell the commanders what to do,
8 and some people said, well, the commanders
9 aren't doing what they're supposed to do
10 anyway.

11 So not telling them what to do is
12 not getting us anywhere. And so we're kind of
13 caught in that conundrum. You know, some
14 people think, well, you know, it's a commander
15 issue and then some of us think, well, what
16 we're suggesting is not even strong.

17 MSGT MACKENZIE: The question I
18 have on this was, and when I look at it, at
19 least I know within the Air Force for a fact,
20 there's always a climate assessment. Okay.
21 At every command level there's a climate
22 assessment tool that's already out there.

1 And when I looked at this I was
2 thinking, you know, on the positive aspect,
3 doing a climate assessment, you know, with the
4 Recovering Warriors that was tailored towards
5 that process, I could understand adding that
6 to what's already in place as part of the
7 climate assessment tool.

8 But I wasn't myself very certain
9 as to, does it realistically exist across the
10 services and is it something that we should
11 add to the already in place climate assessment
12 tool or make it a separate climate assessment,
13 was my question on this?

14 DR. TURNER: I would agree with
15 Mac that it should be added to the climate
16 assessment. And I'd also agree with Mr.
17 Rehbein that I think if we're going to do
18 this, it should be expanded, not only to the
19 WTUs, but to the units as well.

20 MSGT MACKENZIE: And I definitely
21 agree with him, because in certain areas of
22 the different DoD branches, there isn't this

1 co-located pool of individuals. And it's
2 about the Recovering Warrior, DoD-wide, is
3 what we're here for --

4 DR. TURNER: Right.

5 MSGT MACKENZIE: -- not just for
6 the WTUs and the Wounded Warrior population,
7 but the Recovering Warrior population as a
8 whole, making sure that they have a way to
9 provide their voice and a way for the
10 individual service branches to modify, provide
11 guidance, so on, and so forth, that they do,
12 like I said, within the Air Force, within
13 those climate assessment tools, to assist the
14 commander.

15 CO-CHAIR CROCKETT-JONES: I think
16 when I was reading it and thinking about its
17 comparison to the equal opportunity
18 statements, I think it would be good for
19 commanders to have some reason to have sight
20 on any Wounded Warriors they're taking care of
21 that are still in their unit.

22 I think that Mr. Rehbein is right.

1 And I think that putting it in that
2 assessment, I think it's a valuable tool. And
3 I'm not sure that it falls under telling
4 commanders what to do any more than having an
5 equal opportunity statement does. It's more
6 about giving them a means to keep sight of a
7 potential issue.

8 DR. TURNER: Then to summarize, I
9 guess what's on the table is: we're going to
10 add Mac's idea that this needs to be included
11 in, you know, a Wounded Warrior section in
12 climate assessments and Mr. Rehbein's
13 suggestion that this should be expanded beyond
14 the transition units to the entire services'
15 units; other units. Is that what you're
16 saying, Mr. Rehbein?

17 LTCOL KEANE: I like the idea of
18 having it in a climate survey. In the Marine
19 Corps, when a new commander takes charge,
20 within the first 60 days, he has to do a
21 climate survey. We have a new commander
22 coming Friday, so that regiment, Wounded

1 Warrior Regiment, there'll be a climate survey
2 done within the first 60 days.

3 Having it in the climate survey
4 realm will capture all units. I think,
5 though, I would rather see wording that says
6 to do it within the climate survey, but not to
7 direct the Army and the Marine Corps
8 commanders to prepare a statement similar to
9 an equal opportunity statement.

10 I like the idea of covering it in
11 a climate survey. What we don't know is, what
12 are the Navy's regulations for climate
13 surveys? Is it optional? Is it required?
14 Are we going to miss units? The same? What's
15 the Air Force's? What's the Army's?

16 MSGT MACKENZIE: The Air Force
17 does have that and it's also a recurring
18 requirement. It's initial and then there's a
19 recurring requirement for that climate
20 assessment. And I know within SOCOM, Admiral
21 Craven, the preservation of the force
22 initiative, does look into those climate

1 surveys more in detail from a command level,
2 to see, you know, how is the force truly
3 doing?

4 And that's why I made -- you know,
5 my recommendation is that the Recovering
6 Warrior piece be added to that recurring
7 climate assessment, as long as the other
8 services follow the same type of requirement
9 on their commanders.

10 LTCOL KEANE: If we have it
11 included as a climate survey, do we need to
12 actually put language in and say it? Because,
13 you know, the commander has the option to
14 construct his own questions. There are
15 standard questions and then there's a space
16 for additional questions.

17 Do we need to go into the detail
18 to have sample questions, like, these five, or
19 these seven, or whatever?

20 CO-CHAIR CROCKETT-JONES: I'm not
21 sure we need sample questions, but we should
22 certainly say what the goal of the questions

1 in a climate survey is, what we'd want them to
2 be looking at. We need to have an idea of why
3 we're asking them to put it in this climate
4 survey.

5 Are they getting access to their
6 medical needs? Are they, you know, being
7 given the resources and support they need?
8 Those questions should target that.

9 DR. TURNER: You know, it'd be
10 interesting if you did have the letter, the
11 statement, that that actually is, you're
12 managing expectations, and you're setting the
13 expectation, and then that actually gives you
14 something to climate survey against.

15 So if the Wounded Warriors and the
16 unit is aware that this is the expectation,
17 then when Mac does his climate survey, then
18 this is the expectation we're surveying the
19 climate against.

20 MR. CONSTANTINE: It seems like
21 we're talking about the climate survey and the
22 commander's letter as if they are similar

1 things, and they're not, or it also sounds
2 like we're talking about it being a command
3 climate somehow replaces the commander letting
4 everyone know where he stands on these issues.

5 And you can survey people all day
6 long and that's all well and good, but that
7 doesn't tell everyone in that company or
8 battalion what the commander's intent is on
9 these issues, it just reflects how they think
10 they're being treated.

11 And I don't think that's a lot to
12 ask the commander because, in the Marine
13 Corps, we all learn how to do this at The
14 Basic School. We have an exercise writing out
15 our commander's intent when we take over that
16 platoon.

17 And it's already mandated under
18 EEO and sexual assault, sexual harassment,
19 because there have been problems with all of
20 those communities. And we've seen plenty of
21 problems within the Wounded Warrior community
22 that these points address about how they're

1 not getting the support.

2 And I obviously understand the
3 importance of the autonomy of the commander,
4 but I don't see how it infringes on him or her
5 at all by saying, you need to address this
6 upfront so everyone in your community knows
7 where you stand on this issue.

8 CO-CHAIR CROCKETT-JONES: Okay.
9 So I'm hearing that Justin's point is the
10 transitioning unit commanders should put their
11 positions upfront.

12 MR. CONSTANTINE: I can say, I'm
13 in support of the recommendation where --

14 CO-CHAIR CROCKETT-JONES: As it's
15 written.

16 MR. CONSTANTINE: Yes.

17 CO-CHAIR CROCKETT-JONES: And so
18 we're hearing -- I hate this when I agree with
19 everyone --

20 MS. DAILEY: I can certainly add a
21 requirement in there for command climates to
22 be assessed and put it in the assessment.

1 That can be added.

2 DR. TURNER: Getting back to Mr.
3 Rehbein's recommendation, do you think we
4 should, again, expand the requirement to other
5 units?

6 CO-CHAIR CROCKETT-JONES: I think
7 the letter of intent is most important in the
8 transition units themselves, but the climate
9 assessment seems like it's also reasonable for
10 others, but you disagree?

11 MSGT MACKENZIE: I completely
12 disagree, and the reason I disagree with that
13 is because there is a significant population
14 of wounded, ill, and injured who are not
15 within these recovering units. And those are
16 the individuals that, at times, can have the
17 most challenges, because they don't have an
18 environment of recovery.

19 So I agree with the
20 recommendation, the thing is, I want it
21 expanded to DoD as a whole. You know, that
22 this is at the lowest, the unit commander

1 level, that this stuff is there.

2 You know, because I don't think
3 it's unreasonable to ask this. And it's the
4 ability of the service member to have a voice
5 as to how they feel that the commander is
6 addressing and assisting them with their needs
7 as a Recovering Warrior.

8 So just as an equal opportunity or
9 sexual harassment or suicide prevention or any
10 of those things that are already in place, I
11 just believe this needs to be another thing in
12 place with that tool for the commanders to do
13 that.

14 Because when you talk to some
15 commanders, they just don't realize that
16 there's an issue and this is a tool that's
17 already in place for them to assess that issue
18 and make sure that they are acquiring the
19 tools and they are acquiring the support they
20 need in order to take care of their Recovering
21 Warriors within the unit.

22 DR. TURNER: So just to further

1 specify, in addition to the Warrior Transition
2 Units, at what unit level do you think the
3 letter should be, you know, placed? Squadron
4 or what unit level?

5 LTCOL KEANE: Can I throw
6 something out there? This thought just came
7 to me. To answer that question, what if those
8 commanders who do an equal opportunity letter,
9 in their equal opportunity letter, they will
10 address the care of their wounded, ill, and
11 injured?

12 You know, let's not create a new
13 policy letter. Within the thing that already
14 exists, they will address the care of wounded,
15 ill, and injured within their unit.

16 MR. CONSTANTINE: That makes sense
17 to me. It's a logical fit. Unless it's
18 mandated that the EEO letter has to have this
19 language and only this language? I don't know
20 that. If it doesn't, I think that's a good
21 place for it to be.

22 And the EEO, is that at the

1 battalion level?

2 LTCOL KEANE: You know, I believe
3 it is, but we don't need to know. Whoever
4 needs to do an EEO will address it. I believe
5 it is at battalion level.

6 MSGT MACKENZIE: I was going to
7 say, I know within the Air Force, I mean, it's
8 at the squadron level, where that squadron
9 commander has to do that and then the
10 recurring responsibility.

11 And I know as a senior NCO, at
12 times, before the commander does that, he
13 comes to us and goes, do I have all the right
14 stuff in here? Because he wants to know the
15 status of his force, and so I think it's very
16 reasonable to put it at that level.

17 CO-CHAIR CROCKETT-JONES: All
18 right. I want to let the folks reword and
19 we'll come back to this. Let's go on to
20 Recommendation 4.

21 DR. PHILLIPS: We concur with
22 Recommendation 4, except we wanted to remove

1 the word "consider."

2 DR. TURNER: Just remove
3 "consider" and make the verb "co-locate."

4 MSGT MACKENZIE: The only problem
5 with that is that, I agree with that, but not
6 all DoD installations have that level of
7 access to where you could co-locate. I mean,
8 although the majority may have, you know, in
9 a perfect world, but the reality to it is, in
10 many locations, they don't have a
11 geographically convenient ability in order to
12 do this.

13 DR. TURNER: Then how would you
14 word it?

15 MSGT MACKENZIE: So, you know, do
16 we want to go so far as to say that they need
17 to bring those who are not co-located, or
18 reasonable co-location, that they have to
19 bring assets to the military? I mean, this
20 sounds like military and VA working together,
21 which I'm totally with, but at what point does
22 the military go to them or does the VA come to

1 us because of geographic separation when
2 you're asking for this?

3 DR. PHILLIPS: And we can just
4 say, when possible.

5 LTCOL KEANE: Well, that gets back
6 to consider, just leave consider in then. It
7 gives them an out.

8 MR. CONSTANTINE: I agree that I
9 think changing the verb to locate, it's still
10 broad, and a lot of times it's not workable,
11 but if had to consider and then we require a
12 report back on that to see what they're doing,
13 because otherwise, Russ is right, they're
14 going to not consider it.

15 MR. DRACH: I disagree with the
16 word consider because they can say, yes, we
17 considered it and we didn't like it, so we're
18 not going to do it. And I understand what Mac
19 is saying, so you just say, where VA rehab
20 hospitals are located. You know, specify the
21 co-location where possible.

22 CO-CHAIR CROCKETT-JONES: I think

1 the reality is that they will do it where it
2 is possible and they won't where it isn't. I
3 don't think that we need to specify that
4 because I think the answer is, we've seen that
5 they will meet -- they're not uncomfortable
6 with partially meeting.

7 MR. DRACH: Well, that was my
8 initial thought and, you know, if there's no
9 VA rehab hospital in Albuquerque, we can't co-
10 locate, so it is what it is.

11 MR. CONSTANTINE: This is raising
12 so many questions. This mandate saying DoD
13 has to co-locate with VA. Well, within how
14 many miles and to what extent? And, you know,
15 there's no burden on the VA to reciprocate.
16 So I don't think there's very many details in
17 here.

18 DR. TURNER: How would you reword
19 it?

20 CO-CHAIR CROCKETT-JONES: I don't
21 think we have the authority to recommend to
22 the VA, do we?

1 MS. DAILEY: No, these
2 recommendations go to the Department of
3 Defense, correct. They have their own task
4 forces, commissions, and however, that doesn't
5 mean that they don't review them and do not --
6 I mean, they do take a look at the report and
7 they do collaborate in the execution of those
8 recommendations that might cross over into
9 their realm.

10 MSGT MACKENZIE: And would that be
11 that we recommend the DoD evaluate the
12 possibility of co-locating, and where
13 feasible, execute a co-location of resources?

14 MR. DRACH: No, evaluate is
15 consider. It's synonymous to consider in my
16 opinion. But let me ask a question, what do
17 we mean by VA rehab hospitals? Are we talking
18 about the polytrauma centers? Do we want to
19 be more specific? I'm not sure what a VA
20 rehab hospital is as opposed to, I think,
21 there's six polytrauma centers now.

22 Is that what we mean, the

1 polytrauma centers? If so, that narrows it
2 down and makes it more specific.

3 DR. PHILLIPS: General Green made
4 this recommendation. I think it was a very
5 good recommendation. It was based on the fact
6 that as we drawdown, that more and more
7 utilization of the VA facilities will be
8 required with less utilization of the DoD and
9 that, to co-locate these, the transition would
10 be much more efficient and use of resources
11 would be much more efficient.

12 Now, he'll be here this afternoon.
13 We could just delay that issue.

14 CO-CHAIR CROCKETT-JONES: Yes.
15 Why don't we hold off and discuss this when
16 he's here so he can be more clear. I think he
17 was talking about increasing the actual
18 sharing of expertise. I think he was less
19 concerned about facility location than he was
20 talking about staff interaction.

21 But since I don't trust my memory,
22 we'll hold off.

1 MS. DAILEY: And you can refresh
2 your memory. The findings, I don't have them
3 here, the findings kind of capture the gist of
4 that conversation.

5 MSGT MACKENZIE: It does, but I
6 guess, when I kind of dumb it down for the
7 helicopter guy here, it's that rehabilitation
8 resources, because if we say rehabilitation
9 hospital, we're looking for a hospital that's
10 referenced as a rehabilitation facility.

11 What we're looking for is that
12 long-term rehabilitation resources at VA
13 medical facilities co-located to work with the
14 DoD in the long-term rehabilitation goals of
15 our Recovering Warriors.

16 CAPT EVANS: Exactly. I don't
17 think he was referring to physical location.
18 I think he was saying that the resources that
19 are currently in the VA system. Prime
20 example, at Walter Reed/Bethesda, we don't
21 have rehab doctors from the VA coming in to
22 the Walter Reed setting until co-location of

1 those providers, those docs, into one setting,
2 which would afford the Wounded Warriors.

3 So when you look at the Recovering
4 Warrior, they have the ability to meet the VA
5 doctor early until that transition, prior to
6 going into that system, so I think that's what
7 he was looking at; the resources; the
8 providers.

9 CO-CHAIR CROCKETT-JONES: And I
10 think he was also looking, as the population
11 wave transitions from DoD to VA, that there's
12 a plenty of staff, resources, and programs
13 within the DoD, that instead of going away,
14 should be able to move a bit and be more
15 available to the wave that's hitting the VA
16 from OIF/OEF.

17 MR. CONSTANTINE: Do you think the
18 DoD would continue to pay people to go work at
19 the VA? Is that what you're saying?

20 CAPT EVANS: So I'll repeat --

21 CO-CHAIR CROCKETT-JONES: I think
22 that we need to hear from General Green what

1 he thought about that.

2 CAPT EVANS: Right.

3 CO-CHAIR CROCKETT-JONES: I think
4 he was talking about the significant number of
5 -- there's a lot of people on active duty
6 getting their services and programs through
7 the VA themselves.

8 MSGT MACKENZIE: What he was
9 getting at was that the DoD has ramped up its
10 medical professionals in a lot of these
11 rehabilitation fields. And as the need draws
12 down, those positions will go away, okay? But
13 there's nothing bridging the gap.

14 So the question is, do we -- I'm
15 trying to think how to word this, but, you
16 know, the reality to it is, if I you have ten
17 physical therapists and your, you know, non-
18 war mandate is two, those eight physical
19 therapists go away.

20 Well, there's no providing
21 additional to the VA, or the VA providing --
22 you know, that connection between the VA and

1 DoD that those resources are still available
2 at the level at which these guys will still
3 need.

4 MR. CONSTANTINE: Well, the onus
5 is on them to look out and say, okay, what
6 kind of manpower am I going to need a year or
7 two from now, and I'll start contracting them
8 and hiring them.

9 DR. TURNER: So I agree. So what
10 you're actually saying, the better wording
11 would be, you would like the DoD to relocate
12 their rehab resources after the drawdown to
13 the VA.

14 CO-CHAIR CROCKETT-JONES: I think
15 the other concern he had was that, inevitably,
16 at some point, you're going to need ten again.
17 You're going to need ten of those physical
18 therapists again, and we shouldn't be starting
19 from zero. We shouldn't be having to retrain.

20 I think that's one of his concerns
21 was the fluidity, but I think that we're going
22 to need to talk to him.

1 MS. DAILEY: Right. But also,
2 ladies and gentlemen, please keep in mind that
3 you are dealing with a future situation. You
4 are asking DoD to consider a future scenario
5 of resource sharing. So since you're dealing
6 with a hypothetical here, words such as
7 consider, evaluate, are appropriate, because
8 they can't do what is not doable in the
9 immediate time.

10 MSGT MACKENZIE: Well, the other
11 thing too is that, where your major facilities
12 are, there's a plethora of personnel. When we
13 look at the Recovering Warrior population as
14 a whole, a lot of these folks are in regions
15 that don't have the expertise, and the sharing
16 of expertise between the VA and DoD in this
17 realm will provide those remoter locations --
18 once you open a doorway for that to happen and
19 to be in place, the stuff becomes more readily
20 available.

21 I mean, the opportunities are more
22 readily available. So we have to make sure

1 that, not only are we looking at major
2 facilities that are manned appropriately, but
3 also our remote facilities. How is this
4 recommendation assisting both locations? We
5 can't just compare against Walter Reed, San
6 Antonio, you know, we need to be looking at
7 Fort Campbell.

8 We need to be looking at, you
9 know, Omaha, Nebraska. I mean, these kind of
10 things, when we make this recommendation, I
11 think it affects across the whole where,
12 somewhere we may need resources from the VA,
13 that collaboration with the VA, and in some
14 areas it's the DoD is providing more and we
15 want to make sure that, maybe we're assisting
16 the VA.

17 I mean, I think, but you're right.
18 I mean, we still need to talk to General
19 Green, but --

20 MS. DAILEY: Yes. Again --

21 MSGT MACKENZIE: -- I don't want
22 to write it off just because we're thinking

1 about Walter Reed.

2 MS. DAILEY: Yes. You're asking
3 DoD to envision a future where they are
4 transitioning these resources to VA, where
5 these resources are being retained where they
6 are needed in remote locations where there may
7 not be VA, you are asking them to envision a
8 future here, which, you can't ask them to do
9 now. You have to ask them to envision it in
10 the future.

11 CO-CHAIR CROCKETT-JONES: Okay. I
12 think we can move on to 5 for now. I think
13 it's pretty clearly stated.

14 DR. PHILLIPS: Yes, we all agreed.

15 CO-CHAIR CROCKETT-JONES: Okay.
16 How about 6?

17 DR. PHILLIPS: 6, we had some
18 discussion and I think we wanted to change the
19 language, and correct me if I read it wrong,
20 "The Recovering Warrior Task Force recommends
21 the Marine Corps provide Air Ground Combat
22 Center Twentynine Palms the needed resources

1 to provide medical and non-medical immediate
2 requirements to meet the needs of RWs on post
3 or at another location."

4 CAPT EVANS: And speaking to it,
5 since here, medicine provides the medical
6 aspect to that, they did provide a response
7 and as far as the medical case managers, they
8 have increased the medical case managers to
9 eight. And they wanted clarification as far
10 as if it was medical case managers or non-
11 medical, that were the concerns for the
12 Warriors there.

13 And they have a caseload of about
14 22 per case manager there. They have funded
15 one PhD psychologist for FY12 to embedded in
16 the medical home port there. And they have
17 also Project FOCUS, which, as of today, has
18 seen 15,000 families and individuals.

19 And Project FOCUS is a -- I think
20 you've heard of Project FOCUS before, so they
21 have looked at Twentynine Palms, and the
22 intent is to go back there to see, this year,

1 what the medical concerns are and how we can
2 improve and meet their needs.

3 LTCOL KEANE: The Marine Corps is
4 also in the process of hiring a VR&E
5 counselor, just waiting for final approval for
6 hiring and workspace.

7 MS. DAILEY: Okay. Dr. Phillips,
8 did you say you all had some specific language
9 you had addressed? Can we have that again?
10 And I'm going to get, Phillip, if you have
11 specific editing, we will do it right now. So
12 slowly again, please.

13 DR. PHILLIPS: Okay. "The RWTF
14 recommends the Marine Corps provide Air Ground
15 Combat Center Twentynine Palms the needed
16 resources to provide medical and non-medical
17 immediate," -- help me here, Russ.

18 LTCOL KEANE: I thought you had
19 immediately provide, but go ahead, ma'am. I
20 think you captured it too.

21 DR. LEDERER: "The RWTF recommends
22 the Navy and Marine Corps provide the

1 Twentynine Palms the needed resources to
2 immediately meet the medical and non-medical
3 requirements of RWs", and then just the final
4 five words are, "on base or at another
5 location."

6 CO-CHAIR CROCKETT-JONES: Okay.
7 I'm going to jump in and say that that,
8 another location, is an issue. That has been
9 the solution at Twentynine Palms is to shuttle
10 them long distances to other locations, which
11 is part of what's driving the problems.

12 Yes, it's remote, and yes, they
13 will have to go to other locations. The
14 problem is that they are doing way more of the
15 distant care than seems workable for the
16 Recovering Warriors.

17 I think we have to find some other
18 way of saying that we understand that they
19 can't do everything on post, but just adding
20 in that, or at another location, that's
21 already the situation.

22 DR. PHILLIPS: Yes. We debated

1 this quite a bit and we went from any category
2 to a 3 not be housed at Twentynine Palms to
3 this language, which is softer.

4 CO-CHAIR CROCKETT-JONES: I don't
5 think they have any Category 3s at this point.

6 DR. PHILLIPS: No, they don't.
7 What I was saying was that, as we know the
8 Category 2s that need specialty care and wait
9 weeks for a test or to be transported to a
10 specialist in San Diego or Pendleton, are not
11 getting the appropriate needs met, and can
12 turn into a Category 3 if their care and
13 treatment is neglected.

14 I think we have to talk more about
15 the wording for this during our next session.

16 CAPT EVANS: Do we know if we
17 have, I don't have the statistics of how many
18 we have, Category 2 and 3s on at Twentynine
19 Palms, so I think that's one, to see how many
20 we have housed there, and to see, what's the -
21 - I know they do provide shuttle back and
22 forth to San Diego, so I guess that's another,

1 to see how many we have to provide services at
2 San Diego and do we need to relocate them, the
3 frequency of them going to San Diego?

4 So I think those are some things
5 that -- I mean, the recommendation, BUMED
6 pretty much concurs, you know, let's go
7 forward with, but I think there's still some
8 questions that we need to just go down there
9 and look to see how we can improve.

10 DR. TURNER: I think she brings up
11 a good point. She brings up a very good
12 point. Perhaps one way, again, to think about
13 wording this in the future whenever we talk
14 about this is, perhaps meet the medical and
15 non-medical requirements of Recovering
16 Warriors stationed at Twentynine Palms.

17 And that way if they can't meet
18 the requirements of people there, then they
19 have to move them, which is what she just
20 said, I believe. So if you're going to have
21 somebody at Twentynine Palms, you doggone
22 better be able to take care of them, and if

1 you can't take care of them, then they don't
2 need to be there.

3 That's what I was hearing the
4 Captain say.

5 CAPT EVANS: I think that's where
6 we need to go back and review to see, if
7 they're there at Twentynine Palms, are they
8 appropriately there? Should they be there?
9 Should we relocate them to San Diego?

10 DR. TURNER: So could we, perhaps,
11 change the language to meet the medical and
12 non-medical requirements of RWs stationed at
13 Twentynine Palms?

14 MR. CONSTANTINE: A lot of people
15 aren't stationed there.

16 DR. TURNER: What would be the
17 correct wording then?

18 LTCOL KEANE: Assigned?

19 DR. TURNER: Assigned? Okay.

20 CO-CHAIR CROCKETT-JONES: Okay.

21 And we'll be coming back to it to be clear.

22 MSGT MACKENZIE: I know one of the

1 other things, too, that was brought up when we
2 were at Twentynine Palms was, some of the
3 folks, if I remember correctly, and I may be
4 totally off-base here, but that discussions
5 had happened about bringing those expertise to
6 Twentynine Palms on a recurring schedule to
7 assist those guys, but that they weren't
8 manned in San Diego in order to provide
9 providers to Twentynine Palms to assist.

10 I mean, some of these things that
11 are recurring on a monthly or biweekly basis,
12 if you have a multiple of individuals that
13 came up for a week, but that was shot down
14 because they didn't have the provider level at
15 San Diego to cut loose a provider to go to
16 Twentynine Palms to do this.

17 So, I mean, that's the other
18 thing, when we looked at this, if that
19 response is then to bring providers on a
20 recurring basis to Twentynine Palms, that, of
21 course, San Diego has to be manned in order to
22 provide that if that becomes a solution as

1 well.

2 CO-CHAIR CROCKETT-JONES: Did we
3 have sight of that in the findings?

4 MS. DAILEY: No.

5 CSM DEJONG: I understand what
6 you're saying, Mac, I like the recommendation
7 as written. It's very to the point. Very
8 specific to something that we've seen over the
9 last two years as a need.

10 How they end up doing that, I
11 understand where we could add to the
12 recommendation, but I don't want to cover up
13 any of the recommendation by adding more.
14 It's pretty cut and dry to meet the immediate
15 needs of who's there. How they do that is
16 going to have to be up to them.

17 CO-CHAIR CROCKETT-JONES: And
18 perhaps we can insert language into the
19 findings to say that we had seen the programs
20 to bring folks from San Diego up to meet the
21 needs intermittently, you know, to provide,
22 but that San Diego -- we can maybe just put

1 that clearly in the findings, that that only
2 works if it's staffed.

3 CSM DEJONG: And there's also some
4 notes in the findings there that we can add
5 into as you go back into some of the focus
6 groups and other things that we had there
7 where, it even comes down to job fairs to
8 where, Twentynine Palms might get one job fair
9 a month, whereas, San Diego is getting one job
10 fair a week.

11 So we can cross-reference the
12 comparables within the findings, I think.

13 MR. CONSTANTINE: That makes me
14 think, what do non-medical requirements, what
15 does that mean? When we say medical, I know
16 what medical requirements are, but what are
17 non-medical ones?

18 MS. DAILEY: The VR&E
19 representative has been in an immediate
20 response to our talking with them after we got
21 back that, job opportunities, the
22 opportunities to look at follow-on employment,

1 own businesses, train themselves, was a non-
2 medical need, and they've been responsive to
3 that.

4 That's the top of the head answer,
5 Justin.

6 DR. TURNER: Just an editing note,
7 I think you need a verb in the recommendation.
8 After Twentynine Palms, the word provide, or
9 is it up there?

10 MR. CONSTANTINE: It's earlier in
11 the sentence.

12 DR. TURNER: Oh, okay. I missed
13 it.

14 MR. CONSTANTINE: It's like the
15 seventh word. I think the findings should say
16 what Denise said about what, as an example,
17 non-medical requirements could say, non-
18 medical requirements include, as an example of
19 something so it's not just out there; in the
20 findings not the recommendations.

21 CO-CHAIR CROCKETT-JONES: Yes,
22 that should be in the findings. And I think

1 that we have an idea of the non-medical
2 programs that are part of our purview when we
3 talk about, you know, RCC training, and the
4 SFAC centers, and the assistance centers. And
5 so I think that there are general examples in
6 the literature, but they should be specified
7 and something should be given as examples in
8 the findings.

9 Okay. Are we comfortable with
10 letting this go for now and moving on to 7?

11 DR. PHILLIPS: 7, we just agreed
12 upon.

13 MR. REHBEIN: Madam Chairman,
14 before you go to 7, this will get somebody
15 throwing rocks at me I know, but I want to
16 back up for a minute, because I was writing a
17 note and I didn't get my finger on the mic
18 switch on 5.

19 We're concerned that we need to
20 codify 5 because the numbers of wounded will
21 be going down, therefore, is it the
22 appropriate time to recommend a name change

1 from Wounded Warrior to Recovering Warrior?

2 To my way of thinking it is.

3 If we're going to be writing
4 legislative language, then it's time for them
5 to make that name change.

6 DR. PHILLIPS: Dave, how about
7 just leaving out the word wounded or
8 recovering, just Warrior Care and Transition
9 Policy?

10 MS. DAILEY: Yes, they've already
11 got a name change. The new name is actually
12 going to be Warrior Care Policy Office? Okay.
13 So that's already an internal DoD event
14 happening as we speak.

15 MR. REHBEIN: Covered, thank you.

16 MS. DAILEY: It's Warrior Care
17 Policy Office. Office of Warrior Care Policy.
18 I got an email on it yesterday. So we'll make
19 that final adjustment on what's the name of
20 the office before we publish. That's the
21 point, frankly, we've got so much transition
22 going over there that names, reorganization,

1 that's why you want to get it codified.

2 CO-CHAIR CROCKETT-JONES: Okay.

3 Shall we move to 8?

4 DR. PHILLIPS: 7.

5 CO-CHAIR CROCKETT-JONES: Oh, 7.

6 DR. PHILLIPS: We agreed with 7.

7 Our question about 7 is, the definition of
8 far. What are we going to consider far? I
9 don't know exactly how to word it yet, but it
10 leaves a large population out. We're either
11 going to give everyone eight visits or --

12 MS. DAILEY: Far is a good point.
13 If you'll also take a look in your left-hand
14 pocket, ladies and gentlemen. This came under
15 a lot of technical scrutiny by the Department
16 of Defense.

17 And I think having our two docs
18 here to talk to us about it, General Green and
19 General Stone, as a matter of managed care,
20 over network care, over TRICARE, over bringing
21 services into the MTF, it could be as simple
22 as letting them figure it out, just like you

1 did with Recommendation 6.

2 How to work it into the TRICARE,
3 managed care, and network care issues, but we
4 should at least consider some of the technical
5 issues that the Department of Defense has
6 brought up.

7 CAPT EVANS: I would have to agree
8 with Denise that, if we could delay this one
9 because even Bureau of Medicine, they had a
10 lengthy conversation about this one, so I
11 think a delay until General Green and General
12 Stone return would be great.

13 MS. DAILEY: But there isn't any
14 prohibiting us from kind of discussing it
15 right now and get your head around some of
16 those recommendations and the input from BUMED
17 and I think the Air Force also. You'll see,
18 I think, the Air Force brought in a same kind
19 of technical, I call it a technical, review.

20 MR. CONSTANTINE: Well, what is
21 the purposes of this recommendation here?
22 Because we're talking about service members,

1 so I guess we're talking about active duty, or
2 Guard, or reservists, they're not veterans,
3 right? So we decided they rate eight free
4 mental health visits.

5 Is there a concern out there that
6 they're not getting that, or is it access to
7 the facilities, or they go to all their visits
8 and that's all they get?

9 CO-CHAIR CROCKETT-JONES: I'm not
10 sure, but I think one of the aspects is that,
11 in order to have them covered, they have to
12 get a referral and I think that might be one
13 of our concerns is that there isn't a way for
14 them to self-refer for a certain number of
15 visits without going through their primary
16 care or their medic to get the referral.

17 I'm not a 100 percent sure that
18 that was one, but I know that that was at
19 least some of the thinking behind this, that
20 there should be, you can go to Military
21 OneSource and get eight visits, but not
22 everyone has success with that.

1 And the idea was that there should
2 be, sort of, an open-door policy for those
3 initial eight visits, that someone doesn't
4 really have to report that they are having
5 problems in order to get treatment.

6 MSGT MACKENZIE: Well, the other
7 thing that was brought up with this too, and
8 that's one of the questions I have is, you
9 know, what is the official considered
10 catchment area of the facility or the
11 headquarters?

12 Because you remember why this
13 brought up was that, we're looking at equal
14 access to services. And when you look at
15 these, you know, some of the Joint Force
16 Headquarters brought up to us was that, when
17 you're an active member, you live on an active
18 duty base, you have X amount of resources
19 right there within that catchment area.

20 But in the case of the National
21 Guard, many of their service members are way
22 outside. I mean, some folks, I mean, I'm an

1 active duty guy, but, I mean, some of the
2 Guard and reserve folks travel hours to go to
3 drill weekend and to other stuff.

4 And that the Joint Force
5 Headquarters relayed to us, in a couple of our
6 visits, that these folks are outside that
7 realm of reasonable travel to get access to
8 care that everybody else has. And that the
9 level of care was based on where you live not
10 based on the availability of it.

11 So the question I have is, what is
12 the reasonable catchment area? Is it, you
13 know, like, TRICARE within a 30-minute drive?
14 Is it, you know, JFTR 50 miles like we do for
15 non-medical attendant orders? What is that
16 catchment area of that regional area?

17 Therefore we can define what means
18 outside of that area versus using just the
19 term far, because 30 minutes could be far to
20 somebody who doesn't like to drive, but that's
21 already been established.

22 But I do know that's what it is,

1 is that, the further away from the facility
2 you live, the less access to the impromptu
3 walk-in-the-door care for their service
4 members and they were concerned with that.

5 MR. CONSTANTINE: I definitely
6 understand that and I think it's important.
7 When we say eight free and confidential mental
8 health visits. Are we contemplating to a
9 private provider? Is that what it is that
10 someone's going to pay for that? Just, what
11 does that mean?

12 MSGT MACKENZIE: For me, that's
13 one I don't remember, specifically, myself.

14 DR. PHILLIPS: One of my wish
15 lists that I sent around would be to have an
16 option for a private provider through
17 Medicare. I don't know if that will fly.

18 MS. DAILEY: To get you out of the
19 TRICARE dilemma as annotated by the BUMED and
20 the Air Force, the Medicare option for this
21 recommendation might be viable. The Medicare
22 option has been on the table, so to speak, for

1 a number of years.

2 We had a presentation at the Dole-
3 Shalala Commission for Medicare access for
4 Wounded Warriors in remote areas. So it's not
5 a new idea, but it might be something that
6 would fit here.

7 MSGT MACKENZIE: The other thing
8 too is, you have to look at the civilian
9 employment of these individuals, because if
10 it's, like, you're back with your civilian
11 employer, just get it through your civilian
12 employer, well, that's not the same rules as
13 far as confidentiality of seeking services as
14 what the military provides.

15 So just saying, well, you can get
16 it through your civilian provider doesn't open
17 that door either, so having -- yes, I think
18 there's still some more discussion here,
19 especially with our two senior medical
20 professionals when they arrive back.

21 DR. PHILLIPS: One thing we can
22 consider, if we just eliminate who lives far,

1 just the option for military or Medicare
2 provider.

3 MSGT MACKENZIE: Well, like, if
4 you look at, you know, Massachusetts, if you
5 live around Hanscom Air Force Base, you have
6 a whole different set of resources available
7 to you than somebody who lives, you know, 50
8 miles from Hanscom Air Force Base.

9 I mean, it's that concept of, you
10 know, I look at some of my National Guard
11 members, they don't live anywhere close to a
12 military facility, you know, that I've worked
13 with at Walter Reed. I mean, you're just not
14 going to find it.

15 So the question is, do they
16 legitimately have access to that level of
17 services because of where they choose to
18 reside? And that's the uniqueness of the
19 reserve component folks is that, they're not
20 required to live near a military installation.
21 They're required to be at home and in their
22 communities, but yet, the resources aren't

1 there.

2 DR. PHILLIPS: That's why I use
3 the term option, you know, they can opt to
4 travel or they can opt to stay local.

5 MR. CONSTANTINE: Can't Military
6 OneSource change from 8 to 16 and then --

7 CO-CHAIR CROCKETT-JONES: I think
8 this was about going outside of Military
9 OneSource. Military OneSource has certain
10 limited providers that they recommend and not
11 everyone has success with getting in. You
12 know, there's time-lapse issues.

13 You know, they have a list of four
14 providers, you go, and all four, not now, is
15 taking new patients. They're a resource that
16 sometimes has some limits. I think we were
17 trying to get this, sort of, something that's
18 a secondary -- not like an extension of the
19 eight visits.

20 MR. CONSTANTINE: Well, I know,
21 like, when I was at Bethesda and the doctors
22 there decided they couldn't fix my problems,

1 they put a referral in to me to Johns Hopkins,
2 and that's where I started going, and TRICARE
3 pays for all that. That required a referral.

4 And can't there be something like
5 this for mental health where someone provides
6 the referral and then it's automatically going
7 to be covered by TRICARE?

8 CO-CHAIR CROCKETT-JONES: They can
9 do that now. I think one of the things that
10 we're concerned about is that some people are
11 not going and seeking care because it would
12 mean having it go in their medical records
13 that they are seeking care.

14 I think that that might have been
15 one of the reasons we were going down this, in
16 the same way that units are having embedded
17 behavioral health that is housed within, you
18 know, the battalion or the -- so that people
19 don't have to tell anyone they're seeking
20 treatment because of the stigma.

21 But someone who isn't in a unit
22 that has an embedded behavioral health --

1 MR. CONSTANTINE: Who are they
2 telling? They're telling their doctor, which
3 is, you know, that's not public information.
4 They're not telling their line commander.
5 They're not telling anyone in their chain of
6 command. They're telling their doctor, and
7 that's private, and he gets a referral, and
8 they go on their own time.

9 MSGT MACKENZIE: However, when you
10 go and do the TRICARE referral it becomes a
11 matter of official record within your medical
12 documentation, which is then accessed by
13 things like security clearances, I mean, it
14 goes on and on.

15 The informal initial --

16 MR. CONSTANTINE: Security
17 clearances are not affected by that.

18 MSGT MACKENZIE: The security
19 clearance aren't affected by the initial
20 seeking behavioral health assistance on your
21 own. It does not require you to go through
22 that. Once you enter into a formal treatment

1 plan, then the severity and the impact could
2 still be assessed for that.

3 I'm trying to think of the wording
4 here --

5 CO-CHAIR CROCKETT-JONES: I think
6 it's more perception than the reality. If
7 someone doesn't go seek help because they're
8 concerned about the repercussions down the
9 line, we'd rather them just go seek help. I
10 think that was what motivated this idea.

11 MR. REHBEIN: I remember some of
12 the discussion too concerning this, I think a
13 fair amount of the people that were, the
14 soldiers, the military members, being
15 addressed here were the less severe cases;
16 folks that, in the course of a few visits, if
17 they can get those few visits at the right
18 time, that the problem can be alleviated,
19 dealt with, learned to live with, wouldn't
20 have to go into long-term treatment.

21 So I think that was part of the
22 motivation for the -- and I don't remember how

1 the eight number came up, nor do I know what
2 eight free visits means, but I do know that
3 when you get out there in some of the more
4 rural areas, finding TRICARE doctors is a
5 challenge because of all of that extra
6 regulatory paperwork that's required to get
7 approved by the system.

8 So I think that was part of the
9 motivation, but like I said, I don't know
10 where the eight comes from; I don't know
11 exactly what free means either.

12 CO-CHAIR CROCKETT-JONES: I think
13 the Air Force was the body that found that
14 eight visits for post-traumatic stress led to,
15 in non-severe cases, return to functionality.
16 I believe that that was -- I don't know if my
17 memory's good, but I think it was an Air Force
18 study that said eight.

19 CAPT EVANS: I believe that eight,
20 when they first started at Military OneSource
21 where the member could call, you could go out
22 in the community and have eight visits without

1 any questions linked back to the facility. So
2 I think the eight, and I believe that's
3 through the Military OneSource, and that's why
4 the link to the eight, have additional eight,
5 that was already approved, increase it to the
6 16.

7 But again, I think they've changed
8 that. I think that's a change through
9 medicine, through the MHS system, where they
10 can go out more, receive more than the eight
11 visits. I guess the question, and again, I
12 think we need to bring in our experts, the
13 recommendation should be, we should allow
14 those members to seek behavioral healthcare in
15 the direct system and in the military.

16 They need to be able to receive
17 that care. I guess the question, how do you
18 link it back to their medical record and
19 knowing that they are receiving care if
20 they're, you know, still active duty, or
21 reservists?

22 So I think that's the question,

1 they should be able to go out and receive
2 behavioral healthcare without there being a
3 limit, somehow connecting it back to the
4 military healthcare system, and so that they
5 can get the care that they need.

6 MSGT MACKENZIE: I just read
7 through all the findings and I think what's
8 happened is, this recommendation has gotten
9 confused, okay? Where it was at eight visits
10 available, because in our recommendation, the
11 stuff that we found was that, Military
12 OneSource was not meeting the eight visit
13 needs with the resources available near to the
14 home of those remotely-located individuals.

15 And unless they got it through
16 Military OneSource, they didn't get it. I'm
17 paraphrasing here a little bit, but I think
18 what the intent was when looking at the
19 findings here was that, they get those eight
20 visits.

21 If Military OneSource can't
22 provide those eight visits, they can still get

1 those eight visits through their community-
2 based stuff; through their local community
3 behavioral health. They weren't limited to
4 the Military OneSource resources, which in
5 some areas, and was expressed to us by the
6 Joint Force Headquarters, that the resources
7 were not available in that area.

8 So I think it might have gotten
9 worded and confused, but I think that's what
10 we were driving on this when looking at the
11 findings was that, those eight visits need to
12 be regardless of whether it comes from
13 Military OneSource or not, that they have to
14 be there and available to the reserve
15 component Warrior.

16 And currently, it's limited to
17 either, you know, active component based on
18 resources, or what Military OneSource
19 provides, and if Military OneSource doesn't
20 find you a provider, you don't get it.

21 So I think that's what we were
22 reaching at with this and I think it just, it

1 may in wording, and whatever, gotten confused,
2 but that's what we were getting at.

3 CO-CHAIR CROCKETT-JONES: Yes.
4 Military OneSource is the only, sort of, self-
5 referral method without going through the
6 Military Health Service and getting a medical
7 referral. And those eight visits shouldn't
8 depend on whether Military OneSource, those
9 self-referred eight visits, has the
10 appropriate resources in your area.

11 MR. CONSTANTINE: So Military
12 OneSource, if you utilize that, and you're a
13 service member, that's nowhere indicated in
14 your medical record that you've gone to
15 counseling?

16 CO-CHAIR CROCKETT-JONES: I
17 believe so.

18 MR. CONSTANTINE: I'm just a
19 little surprised to hear that.

20 MSGT MACKENZIE: And in all the
21 aspects of post-traumatic stress, the look
22 was, you know, it's basically free assistance

1 where you can go and say, hey, I think I have
2 a problem, where am I at? Once you get that
3 diagnosis, obviously there is more follow up
4 if this person legitimately has it, but it's
5 allowing folks to deal with, you know, post-
6 combat stress before that stressors become
7 PTSD.

8 You know, the idea was not to
9 penalize the individual for seeking out
10 behavioral health to ask questions by a
11 professional, but yet, still provide the
12 avenue that if this person actually does need
13 formal treatment and medication, obviously,
14 more actions have to be taken.

15 But we have to start with giving
16 them the freedom to go talk to a professional
17 than talk to a bartender over what they're
18 feeling and their stressors.

19 CO-CHAIR CROCKETT-JONES: And I'm
20 pretty sure, I don't know if it's codified,
21 but I do know that some Military OneSource
22 providers, when you reach those eight visits,

1 then say, we need to continue this. I will
2 bill TRICARE. And then it does go into your
3 regular record.

4 MR. CONSTANTINE: So who pays,
5 right now, for Military OneSource? If you go
6 talk to them, who's paying that provider?

7 CO-CHAIR CROCKETT-JONES: I have
8 no idea.

9 MR. CONSTANTINE: And well, can't
10 we do the same thing? Can't, however they're
11 paying for it now for Military OneSource, that
12 mechanism be used to pay whoever the service
13 member wants to go see?

14 MSGT MACKENZIE: I agree, because,
15 I mean, that's literally what it comes down to
16 is, who's finding the available resources?

17 CO-CHAIR CROCKETT-JONES: Well, I
18 think we're going to move on because we
19 obviously have more questions that need to be
20 answered before we can settle on what to say
21 about 7. Let's look at Recommendation 8.

22 DR. PHILLIPS: We really didn't

1 get there. We just had a quick glance, I
2 think, as we were finishing up. We said it
3 looks good and doesn't seem to have many
4 questions about.

5 CAPT EVANS: Again, Navy Medicine
6 wanted ensure that everyone -- we're currently
7 for a 100 percent of the active duty providers
8 to be trained, as do the vast majority of the
9 civilian providers. They do have a training
10 evidence-based treatment of PTSD at the Center
11 for Deployment Psychological in Bethesda,
12 where they do CPT and PE therapy.

13 Currently, they have the number of
14 providers trained, 479 for the Navy and 55 who
15 are attached to the Marine Corps. Navy
16 Medicine will continue to promote the training
17 of healthcare providers in evidence-based
18 treatment for PTSD. And that's all in the
19 package. You can read the rest.

20 MSGT MACKENZIE: I like the
21 recommendation just because it says it
22 provides, okay, why are you not at a 100

1 percent? You know, I don't believe it's to
2 short-change the efforts that are in place,
3 but to identify, perhaps, a shortfall or
4 perhaps more resources -- whatever the reason
5 may be, it's to say, okay, this is why we're
6 not there yet.

7 And, you know, so it's not to say
8 that no one's making efforts here. It
9 provides that tool to say why we're not there
10 yet.

11 MS. DAILEY: Okay. Real quick,
12 that was General Green. He's in route. He's
13 just a couple of blocks from here.

14 CO-CHAIR CROCKETT-JONES: I think,
15 also, we wanted to get our eyes on
16 incompleteness and program dropouts. So we need
17 to encourage that metric, the measuring, who
18 does not complete the programs. And it seems
19 to be, anecdotally, from some of the places
20 where we have visited, that seems to be a
21 significant problem.

22 Until we know if it's everywhere,

1 we don't know who we need to direct to fix it.

2 CAPT EVANS: The recommendation, I
3 think, are good. I think we need to look at
4 training for the providers and make sure to
5 encourage that it's a 100 percent across DoD.
6 And we should look at a compliance. How many
7 service members we have completing both
8 programs, or that meet the requirement for the
9 programs, so that you can look at, you know,
10 are we meeting the need of the service member?

11 So I think both of them are good
12 recommendations.

13 CSM DEJONG: I agree with the
14 recommendation, I disagree with the
15 compliance. I think we can find that next
16 year. I think we can find that in further
17 research. I think the recommendation should
18 be pretty specific to where you recommend that
19 a 100 percent of all of your providers are
20 trained.

21 I don't think that we're in a
22 capacity to enforce compliance. I think we

1 can find out through the next couple years if
2 compliance has been met.

3 MR. CONSTANTINE: We make
4 recommendations.

5 CSM DEJONG: Correct.

6 MSGT MACKENZIE: But I also, I
7 mean, I'm concerned that, because I read
8 through this twice and hit the first two
9 bullet statements, and I kept missing the
10 third one, but that's an important part. I
11 mean, that's the accountability of the service
12 member as well, where, you know, up until this
13 point, they're not documenting those who never
14 finished these treatment realms.

15 And I know in our original
16 assessment was that, let's not put it all on
17 the providers because there is, still, a level
18 of responsibility that falls back on the
19 service members as well. But I just bring
20 that up for discussion that that Bullet Number
21 3 is about the service members completing
22 treatment and are they documenting who has

1 completed and who has not?

2 So I was just opening that one up
3 for discussion too so it doesn't get missed.

4 CO-CHAIR CROCKETT-JONES: Yes.
5 I'm concerned that if we don't specify that
6 that be tracked that next year, when we visit,
7 we will ask and we'll find out that only some
8 services are tracking them. And then we still
9 won't be able to have the information until
10 the following year when we finally get them to
11 track them.

12 I'm a little worried about how
13 long the timeline would be to getting folks to
14 measure this; the completion rates.

15 MR. CONSTANTINE: Well, what is
16 the purpose of the commander monitoring
17 incompleteness rates?

18 MS. DAILEY: Yes, I do want to say
19 something, if you'll take a look at your
20 notes, and I wasn't in here for the first few
21 minutes of this conversation, so maybe I
22 missed it. We're more than likely going to

1 have to pull that term commander out of there,
2 because of HIPAA.

3 Now, that doesn't mean that the
4 medical community cannot be involved in having
5 a idea of who's completing the programs.

6 CO-CHAIR CROCKETT-JONES: Right.

7 MS. DAILEY: But I do think, for
8 technical reasons, we're going to have to pull
9 the term commander out of there.

10 CAPT EVANS: I think if you're
11 looking at a CPG, it's a Clinical Practice
12 Guideline, you can take that CPG and look at
13 your compliant rate. So it's what we already
14 do with CPGs. So I don't think it's a
15 commander's responsibility, it's the owner of
16 the CPG, which is the medical community.

17 MSGT MACKENZIE: Right, but it's
18 not about compliance of the providers. That
19 third statement is about compliance of the
20 service member, because when we talk to, you
21 know -- sometimes you got to ask the tough
22 questions. And there's a certain amount of

1 behavioral health not being administered
2 because the service members themselves are not
3 being compliant with the treatment schedule.

4 And in order to say that we're
5 meeting the needs of our service members, we
6 also need measured, those service members that
7 refused to finish. You know, it's kind of
8 like the unemployment rate. You can't say
9 people are unemployed until you identify those
10 that refuse to get employment.

11 You know, as we put this
12 responsibility on the behavioral health
13 community, we also need to give them the
14 avenue to say who's actually complying with
15 this.

16 MR. CONSTANTINE: Well, what does
17 this all go to, tracking on whether or not
18 someone goes to all their PTSD appointments or
19 not?

20 CO-CHAIR CROCKETT-JONES: I think
21 in the long term, this is about -- I think it
22 actually gets to compensation for post-

1 traumatic stress. If people are not
2 completing the programs that are standard,
3 it's the same as not going to appointments to
4 fix a broken leg.

5 There's an accountability that we
6 have to start figuring out how to -- providers
7 need to figure out a way to keep people in to
8 complete the programs because they aren't
9 successful at returning to functionality
10 unless they do.

11 MR. CONSTANTINE: If we're talking
12 about compensation as if the VA will consider
13 it if you're going to PTSD counseling before
14 they, you know, award you compensation, that
15 was mentioned, briefly, years ago and kind of
16 got laughed out of Congress.

17 And we don't do that for any other
18 injury, like, oh, did you go to all your back
19 appointments? Yes or no. You're going to get
20 compensation for your back now. We don't do
21 that.

22 And it would be an inhibitor, I

1 would think, to say, okay, if you don't go to
2 these five PTSD appointments, then perhaps
3 you'll get compensation for post-traumatic
4 stress.

5 MS. DAILEY: Yes, Justin, you're
6 right. That's not the intent of this
7 recommendation or the finding. The findings
8 talk about creative ways to re-engage service
9 members who are not able to complete a
10 regimen. And the findings talk about it in a
11 manner that is compassionate to the fact that
12 it might be too stressful for them yet to do
13 it.

14 It might not be the right
15 technique, but the intent of that piece there,
16 and reasons why we included commanders, which
17 we shouldn't have, was that creative
18 opportunities to re-engage service members are
19 actively pursued in order to help relieve them
20 of these symptoms, because that's the intent
21 of the treatment is to relieve the symptoms
22 and create some relief of these symptoms for

1 them through these evidence-based treatments.

2 And the only way you can do that
3 is to know who's not completing, why they're
4 not completing, and how to then reintegrate
5 that information into a new treatment regimen.

6 MSGT MACKENZIE: When we had the
7 behavioral health panel, you know, they
8 encouraged this recommendation for the
9 training and the knowledge of the different
10 processes available, but they also expressed,
11 and actually, in the finding, the Army
12 specifically, with the success of those who
13 had actually completed the program versus the
14 success of those who had dropped out of the
15 program was of great concern to them because
16 they feel that, although they needed the
17 additional exposure and providers that had the
18 training in the different modalities, at the
19 same token though, they needed a way to
20 account for this stuff because they want to
21 help the folks.

22 It's not about the benefit, but

1 like, one of the comments that was brought up
2 was that, if you have, like, in my case, with
3 my back and my neck, you know, I'm on a
4 profile. I have to attend these appointments.
5 There is a commander's no-show list where the
6 medical providers have backup and
7 reinforcement to make sure that I'm attending
8 what I need to attend.

9 But at the same token, it's that
10 that overall treatment plan is based on my
11 ability to show for my treatment. But yet,
12 when this in place with the behavioral health
13 side, there's no way to account for it.

14 So within the medical community,
15 it certainly can be accounted for so at least
16 it's being looked at within the medical
17 community, because you're not going to get a
18 commander's no-show list for behavioral health
19 appointments, but that the behavioral health
20 community should be accounting for completion
21 verse non-completion rates and it will
22 certainly help them evaluate better, the

1 success of the programs.

2 But that was something that was
3 brought up on that.

4 CO-CHAIR CROCKETT-JONES: And the
5 reason why the second try on -- I remember
6 this now, that there is more than one of the
7 empirically-based treatment plans. And if
8 someone restarts the same one more than once,
9 we need to know that.

10 If he drops out, he might actually
11 need to be channeled to a more appropriate
12 treatment plan, that there's some concern
13 about people who restart and drop out, restart
14 and drop out, that they're not in the
15 appropriate program. But until we, sort of,
16 track them, we might not have eyes on that.

17 CAPT EVANS: I'm not sure I would
18 say tracking or looking, again, you want to
19 see if your research-based, your evidence-
20 based, treatment modality is working. And so
21 if it's not working for a particular group, so
22 you can even go back to look at a particular

1 group, location, why isn't it working?

2 Is it because they can't make it
3 to their appointments? Is it because of, you
4 know, lack of support from the command or is
5 it because of, you know, individual reasons?
6 So you need to track compliance just to make
7 sure that the treatment modality is working
8 and that if you need to readjust, then you
9 readjust.

10 And it's not adjustment based on
11 individual, it's based on, you know, why am I
12 readjusting? So I think compliance is good.
13 I mean, we do this all the time with evidence-
14 based treatment plans. We want to check
15 compliance and make sure that we are reaching
16 the mass population based on that CPT.

17 MR. CONSTANTINE: Well, in a
18 previous recommendation, when we're dealing
19 with rural folks, we recognize, apparently,
20 that none of them want to be tracked at all
21 because we're going to make it completely
22 anonymous that they're getting this treatment.

1 But here, we're saying, you know,
2 we're going to track on you and someone's
3 going to come talk to you if you don't get it
4 all done. Those seem disparate to me.

5 CAPT EVANS: That's why I said I'm
6 not sure if tracking is the right word. I
7 think you're looking at overall compliance to
8 -- if it's cognitive therapy, you're looking
9 at making sure that there is a consistency on
10 meeting that need of the individual.

11 So I wouldn't recommend tracking
12 down to the individual, but looking at, if
13 there's a high success rate, what that
14 clinical guideline in that particular area.

15 MS. DAILEY: Yes, and you'll see,
16 we haven't used the word track anywhere in our
17 recommendation or anywhere in our findings.

18 MR. CONSTANTINE: We may not use
19 the word track, but if we're monitoring,
20 keeping a record of that, evaluating it, going
21 back to that person, coming up with better
22 ways to get them in there, that is tracking.

1 CO-CHAIR CROCKETT-JONES: I think
2 that this is driven by there being two,
3 really, separate populations when it comes to
4 post-traumatic stress, but there isn't, yet,
5 in behavioral health, language and literature,
6 but there is a humongous population that is
7 helped by eight visits to return to
8 functionality.

9 There is also a significant
10 population that is not, that needs the
11 evidence-based programs that extend further
12 than eight visits. There are more intensive
13 programs, they require longer time commitment
14 and more appointments.

15 And the folks who are helped by
16 eight visits, I think part of the stigma that
17 prevents folks who would be helped from eight
18 visits is that they don't want to be lumped
19 into a long-term diagnosis.

20 But the folks who are in long-term
21 care, they need a different mode of help, and
22 assistance, and support. And I think that,

1 when we talk about encouraging ways for those
2 eight people to get their visits without the
3 perception of stigma entering, the way they
4 can through Military OneSource, that we're
5 targeting a different community than the folks
6 that we're talking about here who need to be
7 in intensive evidence-based programs and who
8 may be having less success at achieving
9 functionality because they drop out.

10 CSM DEJONG: I like the first part
11 of the recommendation. I agree with Justin
12 that we're kind of contradicting ourselves.
13 The second part of this, I mean, to me, that's
14 why we have a Defense Center of Excellence, is
15 to figure out what the best treatment is,
16 that's why they're provided money, and I just
17 think that we're reaching too far into this
18 one.

19 MSGT MACKENZIE: But also, you
20 know, the other thing too though is that,
21 perhaps it's in the wording of the
22 recommendation, but, you know, the reality to

1 it is is, there's no responsibility of the
2 provider to reach out to those who have
3 dropped out.

4 You came to seek treatment, you
5 started, you left, but there's no real follow
6 up to those who have dropped out of the
7 program. It's just, you went away, you know?
8 And the behavioral health follow up of those
9 who transition from medical facility to
10 medical facility.

11 I mean, where it specifically goes
12 without creating a tracking mechanism is
13 certainly very challenging in this realm, but
14 the reality to it is, is that, you know, you
15 want these people to have the follow up. You
16 want these people to not dissolve away into
17 the background.

18 And right now, if you don't show
19 up for your behavioral health appointments,
20 you just go away, and nobody follows up with
21 you. There's no accountability to once you
22 start that someone follows up with you. And

1 right or wrong decision, I do think that the
2 mental health professionals do have a
3 responsibility to follow up and see how things
4 are going.

5 You know, you go get your annual
6 physical they're going to follow up with you
7 about your knee, about your back, about your
8 whatever, but no one's going to follow up with
9 you about your behavioral health.

10 So, I mean, that's a concern that
11 adds another dynamic to this discussion, but
12 I think that's -- part of it was a particular
13 patient that I was looking after as a liaison,
14 was multiple years of starting and stopping,
15 and there was no accountability anywhere to
16 assisting this individual or trying to find a
17 new way.

18 You know, and it wasn't until
19 things went horribly wrong that it went down
20 the right road. You know, and there's no
21 Magic 8 Ball to say it would have worked, but,
22 you know, as we sat there and talked to the

1 family and so forth, you think back to go, if
2 somebody was responsible to follow up with
3 this individual as to why did you drop out, do
4 we need to look at other things? Would it
5 have gotten that far?

6 So where do you start? And I
7 guess that was my thought process in the
8 behavioral health world, was accounting for
9 those who had started and dropped out,
10 creating a potential follow-up mechanism to
11 see if that individual still required
12 assistance within behavioral health, not
13 reaching outside of behavioral health, within
14 behavioral health where it's a protected
15 environment, that that doesn't have.

16 MR. CONSTANTINE: We're talking
17 about Recovering Warriors here, right? And
18 they all have a case manager, right? Well,
19 they're supposed to.

20 MSGT MACKENZIE: No.

21 MR. CONSTANTINE: No?

22 MSGT MACKENZIE: No.

1 MR. CONSTANTINE: Every Recovering
2 Warrior has a team of some sort, I thought.

3 MSGT MACKENZIE: No.

4 CO-CHAIR CROCKETT-JONES: No.

5 MR. CONSTANTINE: Even on paper?

6 CO-CHAIR CROCKETT-JONES: Even on
7 paper. Not everyone. Only Category 2 and 3,
8 and not all Category 2.

9 MR. CONSTANTINE: That's too bad
10 because I would have been a good person to
11 track on that.

12 MSGT MACKENZIE: But I do believe
13 that our case managers that are here would say
14 that it's also about complexity of the medical
15 case that gets you a case manager, not
16 necessarily -- there's no one identifier. So
17 if you're only being seen for behavioral
18 health, well, you're not going to have a case
19 manager, you know, unless there's more to the
20 case.

21 But you're not going to have a
22 case manager and that's where, within the

1 confines of that protected realm of behavioral
2 health, I think what we were driving at was
3 getting that ability for them to know and a
4 requirement to follow up.

5 And like I said, it's still a
6 discussion point, but I've seen it firsthand,
7 and that's why I'm kind of partial to having
8 a mechanism to do that, because, you know, you
9 tend to wonder how many cases become really,
10 really bad because nobody really bothered to
11 follow up with them.

12 CO-CHAIR CROCKETT-JONES: Well, I
13 think that we've figured out that on
14 Recommendation 8, the small group has to do
15 some work on either breaking this out,
16 reworking the language. I think this needs to
17 go to more small group scrutiny, specifically,
18 before we're ready for all of us together to,
19 sort of, figure out where we stand on it. How
20 about that for now?

21 MS. DAILEY: Okay. And real
22 quick, let me line up Bullet 2. Bullet 2 is

1 an empirical audit, which we described in a
2 briefing. Those individuals who are being
3 audited is really a records audit. If you've
4 been through some of these blind studies
5 you'll understand that no auditing is
6 identifiable to the patient.

7 It is a number of studies in which
8 that type of PII is protected. So that is
9 what we are talking about in the second
10 bullet, and you don't really need to go into
11 detail when you lay that out for them.

12 They know how to do an audit and
13 which PII, and personal information, is
14 protected in the course of trying to determine
15 whether evidence-based processes are being
16 followed and whether they're effective.

17 And so your last bullet there I
18 have is, you want to reword that? I'm okay.
19 That's good. Let's go forward with that. The
20 intent of that bullet though is to envision,
21 for the Department of Defense, creative re-
22 engagement methodologies by the providers for

1 service members.

2 And I'm probably going to have to
3 agree with the service input that the term
4 commander needs to come out of there. I don't
5 know how you can really get your arms around
6 someone without a commander's helping you, but
7 their HIPAA rights cannot be violated.

8 So this has to be a medical
9 community's effort to re-engage, creatively,
10 service members who need follow-on care.

11 MR. CONSTANTINE: But don't
12 commanders, with other injuries, know what the
13 status of all their soldiers are and say, hey,
14 your appointed place of duty is the hospital
15 on Tuesday at 2 o'clock to go get your knee
16 examined?

17 CO-CHAIR CROCKETT-JONES: Yes,
18 that's what I would think. I would think that
19 they would know if they were assigned to a
20 program that was going to last a week if they
21 come back sooner. Wouldn't that just be --

22 CSM DEJONG: All commanders are

1 HIPAA qualified and have to take HIPAA
2 courses.

3 MSGT MACKENZIE: Behavioral
4 health, especially in dealing with post-
5 traumatic stress, is a separate arena, but
6 yes, under normal medical appointments, there
7 is a report that goes out for missed
8 appointments, and commanders are notified that
9 they missed a medical appointment for that
10 kind of stuff.

11 Also the physical profile, duty
12 limitation report, et cetera, et cetera, is
13 signed by the commander, but it's everything
14 other than the dealing with behavioral health.
15 That's a separate entity, if I'm correct, sir.

16 CAPT EVANS: So if you look at the
17 three recommendations, so we're saying a 100
18 percent of the providers should be trained,
19 which I think we all concur on. Again, I go
20 back to my old nursing days when we did a CPG,
21 and we implemented that CPG, we wanted to see
22 how successful we were with that

1 implementation, so we conducted a record
2 review.

3 And so the record review says, oh,
4 we're doing well with that population or we're
5 not. Based on that record review, if we found
6 a patient, or two, or three, that were
7 severely not in complying with the CPG, we
8 would recommend that patient to be case
9 managed by -- you know, we would go to the
10 doctor and say, this is an individual that's
11 not meeting his CPG, are you able to call that
12 individual?

13 We need to get him in. We need to
14 see what's going on. And so the record review
15 just helps us to go back and identify that
16 member that's not in compliance. What are we
17 missing? Assign a case manager, because now
18 they move into that high-risk population that
19 needs to have someone looking into what's
20 going on.

21 So I think, if you go think about
22 it in that process and, you know, you're

1 saying trained, and once we say trained, then
2 we want to see if we're in compliance, and
3 then once we identify that we're in compliance
4 or we're not, and based on that record review,
5 if we find those patients that are not in
6 compliance, then they need to be case managed.

7 MSGT MACKENZIE: But is that a 100
8 percent record review or a sample record
9 review?

10 CAPT EVANS: Again, that's a good
11 question. It depends on your population size.
12 You could do a 100 percent, 100 percent is
13 good, if not, if it's a huge population,
14 you're not going to get a 100 percent.

15 MSGT MACKENZIE: That's part of
16 what generated Statement 3, because, I mean,
17 you know, I am a perfect example of, you know,
18 there's been over a year of "records reviews"
19 and no one has noticed that some of my stuff
20 has not been continued or even been addressed
21 to see if what I did at an outside facility
22 has even worked.

1 So I don't know what it is in the
2 other services, but I can make an assessment
3 based on my own personal experience that it's
4 not a 100 percent review.

5 MR. CONSTANTINE: Seems to me that
6 it's obvious a commander is going to know if
7 one of his soldiers is not -- he knows if a
8 guy didn't show up for work. I mean, he's got
9 to know that. It's got to be approved, all
10 that, so he's there.

11 So why can't the commander say to
12 someone, I see you didn't go to your
13 appointment, you have to go to your
14 appointments, you've been directed to go to
15 eight of them, and then it's just like a
16 physical wound where then you are violating an
17 order if you don't go.

18 I know it sounds Draconian, you
19 know, talking about orders and going, but if
20 we're worried about people who aren't
21 finishing their programs, what options do we
22 have?

1 CO-CHAIR GREEN: Okay. So I'm
2 catching up, but you guys are all over the map
3 here. Okay. So let me kind of come back.
4 The recommendation is talking about making
5 certain that behavioral health people are
6 trained, and yet, you guys are talking about
7 patients that don't complete training, and so
8 I'm confused.

9 MSGT MACKENZIE: But I'm talking
10 about behavioral health re-engaging those
11 patients. I'm not talking about unit
12 commanders ensuring that they go, because
13 behavioral health treatment, if I'm forced to
14 go, it's not going to make any difference
15 either.

16 But the point is, is that, so many
17 people who don't stay in the program, which is
18 what, in the findings that, the Army was
19 pointing out, have less of a success rate of
20 recovering from their symptoms than those who
21 actually do complete the program.

22 But yet, there's no mechanism in

1 place for the behavioral health professionals
2 re-engaging those individuals, whether re-
3 engaging into the same program or perhaps
4 looking for another modality to try to assist
5 them, because no one within that community is
6 actually tracking those that dropped out or
7 did not complete treatment in that program.

8 CO-CHAIR GREEN: So I guess I
9 should be looking at the screen to see how you
10 changed it, but the first two bullets don't
11 make a lot of sense. So the third bullet
12 becomes even more nonsense. And so we need to
13 be a little careful about what we're talking
14 about here.

15 All right. First of all, I can
16 talk Air Force. A 100 percent of my
17 behavioral health providers are indeed trained
18 in evidence-based PTSD treatment, okay? I'm
19 not sure what empirically-based is, but it's
20 called evidence-based. And evidence-based
21 PTSD treatment, a 100 percent of Air Force
22 people -- behavioral health providers are

1 trained.

2 If the question is that not all
3 the services have done that, then okay, I
4 understand where you're going. The secondary
5 thing on here in terms of replicating the Army
6 audit is kind of interesting because that Army
7 audit is ongoing now, right? Are we talking
8 about the same audit?

9 And so why would we tell DoD to
10 replicate that audit with all DoD members when
11 we have no idea what they're going to find?
12 And so I'm just a little confused. And then
13 in the final one, I agree with you that people
14 who complete the training do better, but we
15 also ran into, at Lejeune at least, people who
16 had been through three or more different
17 treatment programs for PTSD.

18 And so, you know, it's one of
19 those things where you say, monitoring and
20 completion rates, all right, so are you
21 talking about incompleteness rates of one form
22 of therapy or another form of therapy?

1 So at what point do you declare
2 victory? Do you say that as long as they
3 complete one form of therapy or do they have
4 to complete every form of therapy they go to,
5 because some things will work for one person
6 and not for another.

7 So that's why I say, you've gone
8 from, we need to train everybody that treats,
9 which I don't disagree with, to saying,
10 because we're not sure if everybody has been
11 trained, we should audit and see what their
12 treatment was, and I go, really, okay.

13 And then finally you say, we want
14 to make sure that a 100 percent of patients
15 actually get the treatment, which, I mean, I'm
16 in favor of someone who has the diagnosis
17 getting the treatment, but, really, the
18 patient always has say over whether they're
19 going to complete or not.

20 So you could monitor people who
21 don't complete and then decide, you know,
22 whether you want to -- but you have to also

1 assume that these folks are getting some type
2 of ongoing, whether primary care, et cetera,
3 and so, you know, if the primary provider, now
4 a family doc, decides that they, you know, are
5 more receptive to therapy, he could put them
6 back in.

7 And so, I'm not sure what you're
8 saying in the last one, efforts to re-engage,
9 because I would think that, you know, I'll use
10 patient-centered medical home, would encourage
11 people to re-engage.

12 So I realize that I'm kind of
13 jumping in here and you guys have been talking
14 about this, and so I apologize, but I'm
15 listening to you and going, okay, one person's
16 talking about, you know, whether commanders
17 should force people to finish therapy, and
18 then we haven't been specific on the therapy,
19 and so I backed up to look at the other two
20 and went, ooh.

21 And I can look at your words and
22 see whether we caught the fact that they

1 didn't even make sense. I don't know what
2 empirically-based PTSD treatment is, but, you
3 know --

4 CAPT EVANS: It's supposed to be
5 evidence-based, sir.

6 CO-CHAIR GREEN: Right.

7 CAPT EVANS: But I think Navy
8 Medicine did say a 100 percent of their active
9 duty providers have received the training, and
10 I think what we were trying to do with Number
11 1, ensure across every service that they have
12 received the training on the evidence-based
13 guidelines, because I'm not sure if we're
14 seeing out in the focus group that --

15 CO-CHAIR CROCKETT-JONES: I think
16 one of the other concerns that drove this was
17 that a lot of people are referred to outside
18 providers for behavioral health and outside
19 providers were inconsistent with sticking to
20 the same training.

21 CO-CHAIR GREEN: Which is the
22 reason for joining forces.

1 MR. REHBEIN: I think we should
2 take that should out of that first line.

3 CO-CHAIR GREEN: Right.

4 MR. REHBEIN: I think DoD should
5 ensure that a 100 percent of them receive
6 training.

7 CO-CHAIR CROCKETT-JONES: Receive
8 training.

9 CO-CHAIR GREEN: Yes. Remember
10 that, what you're talking about now, Suzanne,
11 is what joining forces is about, trying to get
12 all the community to basically have evidence-
13 based treatment for PTSD, for early
14 recognition, et cetera. I said Denise; I'm
15 sorry, Suzanne.

16 Anyway, yes, that will cost me.
17 It's going to cost me on multiple levels too,
18 which is really bad. Anyway, I guess what I'm
19 trying to get to is what the root desire is
20 here. So if the root desire is that all DoD
21 PTSD behavioral health treatment will be given
22 by someone who's been through training, that's

1 a very worthwhile goal.

2 If the goal is to get all
3 providers across the nation, or at least those
4 we refer to, to have that training, you know,
5 DoD will have limited control in that and
6 they'll come back saying, that's what joining
7 forces is about.

8 So, I mean, where do you want to
9 go with the recommendation? We applaud the
10 efforts of joining forces to ensure that all
11 referred, I mean, do you see what I'm -- so
12 which way do you want to go?

13 MS. DAILEY: The intent of this
14 one was, the DoD/MTF treatment scenarios. We
15 are not able to -- well, you can make a
16 recommendation, but the intent of this was to
17 ensure that 100 percent of MTF, mental health,
18 and behavioral health providers have received
19 this training.

20 CO-CHAIR GREEN: Okay. So then,
21 right, the writing, okay, so we're going to
22 wordsmith, DoD must ensure 100 percent of DoD

1 behavioral health providers, get rid of
2 should, receive training in evidence, and it's
3 just a single treatment. There are multiple
4 treatments for PTSD, that's single. So you
5 can get rid of the S.

6 And I have no idea what that next
7 phrase is trying to say, emphasizing both the
8 importance of, it doesn't make sense.

9 MS. DAILEY: Put a period after
10 treatments, Phillip, and erase the rest of it.

11 CO-CHAIR GREEN: And it's
12 confusing, yes.

13 DR. TURNER: I would agree. Let's
14 simplify.

15 CO-CHAIR GREEN: Right. Now it
16 makes sense. So a 100 percent of DoD
17 behavioral health providers, they must ensure
18 a 100 percent receive training in evidence-
19 based PTSD. Now, you say behavioral health,
20 is that where we want it focused; solely on
21 the people who are the specialist?

22 But is it only behavioral health

1 or do we want it to be broader?

2 CAPT EVANS: I think it should be
3 broader because, we're looking at our medical
4 homes model, right, our medical home models,
5 where you have primary care, it should be
6 train those primary care physicians, so I
7 think you should reach outside behavioral
8 health.

9 CO-CHAIR GREEN: Oh, the other way
10 to do it is to leave it that behavioral health
11 providers receive training in evidence-based
12 PTSD treatment and all primary care providers
13 receive treatment in identification. I mean,
14 in other words, you receive training to
15 identify PTSD.

16 So, I mean, you don't necessarily
17 need to train every primary care doc to treat
18 PTSD, but they should identify it. And all
19 primary care providers receive training in
20 identification of PTSD patients.

21 Because now what you're really
22 saying is you want to make certain that, one,

1 the behavioral health people know how to treat
2 it, and two, the primary care people recognize
3 it. Okay. I think that that's clean in terms
4 of where you're trying to go.

5 Tell me what we think the Army
6 audit is going to do. Rich isn't here?

7 MS. DAILEY: Dr. Hoge at the PTSD
8 panel described an audit that they had done
9 and completed in which we have, in the
10 findings, the statistics that were pulled out
11 of that. Now they do them at periodic and
12 multiple times.

13 So what we are crafting there is a
14 recommendation to replicate these types of
15 audits.

16 CO-CHAIR GREEN: But again, I need
17 to know what is it that we want the audit to
18 look at? The Army is in the midst of a 100
19 percent review of all PTSD over an 11-year
20 period. And so, I mean, because of that,
21 people are going to be confused with regards
22 to what we're saying here. We need to be

1 pretty specific.

2 MS. DAILEY: Yes, that's not what
3 we're talking about, because this audit was
4 conducted well before the current situation
5 out in Fort Lewis.

6 MR. CONSTANTINE: It must have a
7 name; that Dr. Hoge's audit, or whatever the
8 Army audit was.

9 DR. TURNER: Just to clarify, is
10 the intent, okay, you know, we're talking
11 about different audits, what is the intent of
12 the audit in the first place? Is the intent
13 of the audit to ensure that proper care is
14 being delivered, or is the intent to ensure
15 access? What is the intent of the audit?

16 MS. DAILEY: It's to assess and
17 optimize the DoD fidelity to evidence-based
18 PTSD treatment methods; period.

19 DR. TURNER: So it's a quality
20 assurance treatment audit.

21 MS. DAILEY: Correct.

22 DR. TURNER: You know, most DoD

1 places do peer review, medical care review
2 anyway.

3 MS. DAILEY: Correct.

4 DR. TURNER: And perhaps if the
5 idea is to add emphasis on the quality
6 assurance of PTSD patients, you may - could
7 work that into the pre-existing peer review
8 medical care system.

9 MS. DAILEY: Okay.

10 CO-CHAIR GREEN: So again, another
11 way to do this, since we have an audit that
12 supports this, is not to replicate an audit,
13 but simply to say, DoD should audit completion
14 rates of evidence-based PTSD treatment, okay,
15 because that completion, you know, has been
16 shown to be associated with a more rapid
17 recovery, okay?

18 If that's what we're trying to say
19 -- so now, we're really saying, you know, find
20 out how many people complete this, because
21 those who don't complete -- because then your
22 third bullet becomes, for those who don't

1 complete, okay, there should be a re-
2 engagement.

3 And now this starts to make sense,
4 okay? The behavioral health people need to be
5 trained, the primary care needs to be trained,
6 they should audit completion of that evidence-
7 based treatment, and for those who don't
8 complete it, they should be re-engaged at, you
9 know --

10 CAPT EVANS: Sir, I wish I could
11 have stated that better, but I think that's
12 what I --

13 MSGT MACKENZIE: And what you
14 missed, sir, prior to your arrival --

15 CO-CHAIR CROCKETT-JONES: That's
16 what we've been trying to do for an hour.

17 MSGT MACKENZIE: -- was our desire
18 for you to be sitting there as we were doing
19 this, because your wordsmithing ability,
20 sometimes of our muddling through stuff, is
21 outstanding. Yes, so that was another thing
22 that you missed prior to arriving, was our

1 request for you.

2 CAPT EVANS: We're saying train,
3 you know, primary care and behavioral health
4 physicians, audit on the success rate,
5 completion, and then those that we find that
6 are not in compliance, let's bring them back
7 in.

8 CO-CHAIR GREEN: And so I'm trying
9 to leave out all the expletives from spending
10 the last three hours in traffic and going to
11 the wrong hotel, so what can I tell you, okay.

12 MS. DAILEY: So are we close there
13 now?

14 CO-CHAIR CROCKETT-JONES: Yes,
15 that's much better.

16 CO-CHAIR GREEN: So basically,
17 let's do the second bullet. So DoD should
18 audit military treatment records, diagnose the
19 PTSD to assess completion rates of evidence-
20 based therapy.

21 MR. CONSTANTINE: And while we're
22 here, 100 should be written out in numerical -

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CO-CHAIR GREEN: Of evidence-based PTSD treatment. That's fine. You can just leave it as treatment, period, after that, yes. That's it. Okay. And then next sentence after that should be: empirical evidence indicates completing evidence-based therapy leads to more rapid recovery.

MS. DAILEY: That would go down in the findings.

CO-CHAIR CROCKETT-JONES: Yes, that's a finding.

CO-CHAIR GREEN: Oh, okay. I see what you're doing. I got it. Okay. And so then I'm not sure you have to say who does it, you simply say, DoD must re-engage patients that have not completed an evidence-based protocol.

Well, and "must" is interesting too. Again, it's back to, what do we want them to do?

CAPT EVANS: You want to make

1 every effort to recapture those patients, so
2 you don't want to lose them. So you want to
3 make that effort, and you want DoD to have
4 some type of means in place to recapture those
5 patients.

6 CO-CHAIR GREEN: The one problem I
7 see is that, you know, the way it's written
8 right now and because of what the Army is
9 doing with their audit - where they're looking
10 at all cases, separated and not - so are we
11 telling DoD to re-engage people who've
12 separated from the military?

13 CSM DEJONG: And again, we're
14 contradicting a couple of recommendations ago
15 to where we're pushing confidential treatment.
16 So what are we really looking for?

17 CAPT EVANS: The treatment is
18 still confidential. I mean, that's a provider
19 -- if I'm working in that clinic with that
20 provider, that's still in the realms of being
21 confidential. So I'm not sure, how are we
22 breaking confidentiality?

1 And I think when you recapture a
2 patient, if I see that that's a retired
3 patient, you know, again, you're making
4 contact and you're saying, it is highly
5 recommended that you continue the treatment,
6 but you're not in our DoD system anymore,
7 you're now into VA or where they're receiving
8 their healthcare.

9 So I think it's still
10 confidential. I'm not sure how we're losing
11 that confidentiality.

12 DR. TURNER: So the re-engagement
13 is more like a re-evaluate and dispose or
14 recommend.

15 CO-CHAIR GREEN: Yes, maybe
16 instead of making separate --

17 MS. DAILEY: And we're not talking
18 about post-DD214, ladies and gentlemen --

19 CO-CHAIR GREEN: Right.

20 MS. DAILEY: -- because these
21 treatments, they've only been trained in these
22 treatments within the last two years. The

1 providers have only been onboard in about the
2 last two years. We're talking about the
3 fidelity of our new trained physicians and
4 these evidence-based modalities for our
5 currently serving service members and going
6 forward.

7 CO-CHAIR CROCKETT-JONES: And I'm
8 pretty sure that these evidence-based
9 treatment programs are only available to those
10 who are being case-managed. I don't know how
11 you'd get access --

12 CO-CHAIR GREEN: No, that's not
13 true, because they cannot even be identified
14 as a Wounded Warrior. Remember, we were
15 trying to rewrite the Level 2s, so that if
16 they were in the disability system and had
17 PTSD, that they had to have a non-medical case
18 manager.

19 But if they are not in the
20 disability system, they're just under
21 treatment from a behavioral health provider.
22 I mean, you see?

1 CO-CHAIR CROCKETT-JONES: Okay.

2 Yes, I see.

3 CO-CHAIR GREEN: So I think that
4 the answer here is not making a third
5 recommendation. I think you can do it on the
6 end of the second one. You can simply say,
7 providers can then offer evidence-based
8 therapy to those who have not completed, those
9 who are having continuing symptoms and have
10 not completed an evidence-based program.

11 Continuing symptoms and have not
12 completed, right, because what you've done
13 then is, when you do the audit, you then
14 provide that information to the provider, who
15 then assesses whether or not they're still
16 having the symptoms.

17 CO-CHAIR CROCKETT-JONES: Can we
18 say should, instead of can?

19 CO-CHAIR GREEN: Continuing
20 symptoms, but have not completed an evidence-
21 based program, right. I think you can get rid
22 of the third line, and that makes it fairly

1 clean. So we're saying you should train
2 people, and once they're trained, you should
3 audit to see who hasn't completed a program.

4 MSGT MACKENZIE: And then in that
5 audit you're going to discover people who
6 haven't, so now you can provide --

7 CO-CHAIR GREEN: And so now it's
8 up to the providers, if they're still
9 symptomatic, to make certain they get back to
10 a program.

11 CAPT EVANS: You're going to have
12 to make contact with those that, I mean --

13 DR. TURNER: Right, exactly. You
14 have to talk to them.

15 CAPT EVANS: Which I think is a
16 really good -- I think that's a best practice
17 in itself, because you're reaching out to
18 service members that may not come back into
19 that healthcare system to engage, you know,
20 just because of the stigma, just because of
21 all the -- and now, we're reaching out, we're
22 being proactive to say, we did the chart

1 review, we noticed that you haven't completed
2 this treatment modality, we would like to
3 bring you back into the system, so I see that
4 as a best practice; proactive.

5 CO-CHAIR GREEN: I don't know who
6 was on the small working group, but I didn't
7 mean to change your thoughts too much.

8 MR. REHBEIN: Question, does this
9 audited data get compiled and passed on up to
10 DCoE? Because that's a good piece of data to
11 have. You can have the world's best treatment
12 program, but if only half the people complete
13 it, it's a 50 percent failure rate.

14 So I'm just asking that question,
15 if we know whether or not this audited data
16 will be compiled and moved up the line.

17 MS. DAILEY: I mean, the one that
18 Dr. Hoge did was published, and that's all I
19 can tell you. How it's integrated throughout
20 the Army and how they re-integrated that data
21 back into their efforts, I don't have
22 visibility yet, but published - and I think it

1 might have even been peer reviewed - yes,
2 published and peer reviewed.

3 MSGT MACKENZIE: No, different.
4 It's not behavioral health.

5 MR. CONSTANTINE: This isn't
6 substantive at all, but I think 100 should be
7 written out numerically to make it consistent
8 with the others.

9 MSGT MACKENZIE: I was going to
10 say, good to have you back, Justin.

11 MS. DAILEY: Okay. One more time
12 on that, Justin. You think it should be
13 written out numerically, not written.

14 CO-CHAIR GREEN: It should just be
15 the number, right. Instead of 100 it should
16 be 100 and the number. Yes.

17 MS. DAILEY: You want the number.
18 Okay. We're on 9, we've got 41, so we're
19 doing fine, but, yes, let's take on 9 here,
20 and we might move this into lunch a little bit
21 also, since we need to, kind of, get as much
22 of this done before the working group.

1 This is much more productive here,
2 frankly, to discuss it because you'll change
3 it, even if you change it in the working
4 group, you'll change it here again, so let's
5 keep moving through these.

6 CO-CHAIR GREEN: Can I ask one
7 question? Did we look at -- I mean, last
8 year, we also started with 41 or 42, so has
9 anybody looked at whether any of these are --
10 are they all separate, or are some of them
11 combinable?

12 CO-CHAIR CROCKETT-JONES: There's
13 been some discussion about leaving them
14 separate, in order to leave them on point and
15 not to have recommendations that become
16 partially met.

17 CO-CHAIR GREEN: All right.
18 Understood.

19 CO-CHAIR CROCKETT-JONES: Okay.
20 Recommendation 9, that was also the same
21 working group, but you all hadn't gotten to 9?

22 DR. TURNER: We didn't make it

1 that far, to that one.

2 MS. DAILEY: We can move into
3 another group with Recommendation Number 10.

4 MSGT MACKENZIE: I mean, where are
5 we at with 9 though? Are we --

6 MS. DAILEY: We're going to let
7 the -- Number 9, we will let the working group
8 look at it from 1:00 until 2:00. We have a
9 preparatory session from 1:00 until 2:00.

10 MSGT MACKENZIE: Roger. Thank
11 you.

12 CO-CHAIR CROCKETT-JONES: All
13 right. For Recommendation 10, Captain Evans,
14 do you want to summarize?

15 CAPT EVANS: So the small group
16 agrees with the recommendation. We wanted to
17 add the language of 24 months. So recommend
18 the service length to 24 months for activated
19 reservists serving as cadre/unit staff and
20 service-level liaisons.

21 And we wanted to keep the wording
22 Landstuhl in, there because that was

1 particularly the one that we found to have the
2 issues, as far as having orders for 12 months
3 vice 24 months, and then the lack of
4 continuity once those orders are up at the 12-
5 month mark.

6 LTCOL KEANE: I'm not sure if
7 limiting it to Landstuhl is good. I think 24
8 months, for any mobilized reservist, would be
9 good across the care. And I would say,
10 lengthen those to a minimum of 24 months,
11 ideally, you want 36 months.

12 CO-CHAIR GREEN: So I guess I have
13 to ask, so when they do an activated tour and
14 assign somebody to a Recovering Warrior Unit,
15 that falls into the deployed time and the
16 restrictions on the amount of time they can be
17 deployed within a five-year period, because
18 they changed the law to where you could only
19 have them activated so much of the time within
20 a five-year period.

21 Have we thought about if we change
22 it to three years or longer, what that does,

1 whether it breaks the law in terms of how much
2 they can be deployed out of any five-year
3 period?

4 LTCOL KEANE: I think the Air
5 Force and Marine Corps have two different
6 understandings of deployed, and I had learned
7 this when I had a Senior Airmen as one of my
8 chiefs when I was in Afghanistan. Deployed in
9 the Marine Corps means you're armed and
10 there's a potential for conflict.

11 And in the Air Force it means
12 you're outside the United States. So I'm not
13 sure how it's interpreted.

14 CO-CHAIR GREEN: So does that mean
15 you could activate them for all five years as
16 long as they're not armed, and that wouldn't
17 count as a deployment; is what I'm saying?

18 LTCOL KEANE: In the Marine Corps,
19 yes, sir.

20 CAPT EVANS: And I have to go back
21 and look. I'm not sure about the Navy because
22 that was our main conversation on Denwick over

1 in Landstuhl, they rotate every 12 months.
2 And so that's a high-utilized area. And so it
3 breaks up the continuity over there when you
4 look at, you know, every 12 months, and out of
5 that 12 months, 2 to 3 months you're training.
6 So you have that huge learning curve.

7 And so I'm not sure if that five-
8 year rule applies to the Navy.

9 MSGT MACKENZIE: Right. And the
10 thing that we brought up with this whole -- I
11 mean, Landstuhl was the perfect example to
12 show where this decision has negative impact
13 on the effectiveness of the units, because of
14 that 12 months, because of the train-up time,
15 the actual effective use of that individual in
16 that role wasn't there because of all those
17 other additional times.

18 So I know that's why we brought up
19 this recommendation of the 24 months, but I do
20 know that, you know, I mean, we could word it
21 multiple ways that, you know, that's 12
22 months, you know, make it 15 months or 18

1 months versus going 24 months, but at least
2 providing that train-up window.

3 Because the other thing we get
4 into here too - and maybe I'm just totally
5 off-base here - is that, regardless of how
6 much time we put these folks on orders for,
7 the actual problem becomes the availability of
8 that person, because in some areas, it's a
9 one-for-one swap.

10 You can't bring somebody on orders
11 to fill a position unless that position is
12 vacant, which is where that disconnect comes
13 to vacant positions, non-manning, and so
14 forth, so as we discuss this, are we looking
15 at that as well? I don't know. I'm an active
16 duty guy.

17 MR. REHBEIN: We heard that at
18 Benning on one of the first trips that I
19 personally was on, because many of the cadre
20 were activated reservists, National Guard, and
21 12-month tours were effectively 9-1/2 to 10-
22 month, not only because of training up to get

1 them in, because of leave time at the end, and
2 because, as Mac said, you couldn't fill the
3 slot until the slot was vacant.

4 So instead of 12 months of an
5 activated reservist's time, it was
6 considerably less than that.

7 CO-CHAIR CROCKETT-JONES: Didn't
8 we also hear this at the community-based
9 Warrior Transition Units?

10 MSGT MACKENZIE: Yes, that is
11 correct. I think the biggest thing is about
12 the effective time. You know, where these
13 individuals are on orders for 12 months, but
14 the amount of actual effective time they're
15 providing is significantly less than the 12
16 months, number one, but most importantly, it's
17 the vacancy.

18 It's the continued operation at
19 less than optimal strength because that person
20 comes onboard, you know, the slot is empty, so
21 the new person is filling that slot, but for
22 those months that they're training, they're

1 either not there or not effective, so
2 virtually, every time they bring a new person
3 on, they take a shortfall.

4 So some of those where, you know,
5 if we could get guys on three orders, then the
6 shortfall wouldn't be so painful. Well, it's
7 not about the three years, it's about, you
8 know, are they getting that full 12 months of
9 effective manning, and are those slots
10 continuously full of trained individuals?

11 And I'm talking in circles, but I
12 think I'm trying to get my point out there.

13 CO-CHAIR GREEN: So as this is
14 written, is there a finding some where that
15 says, based on our observations that between
16 training and continuity, I mean, something
17 that says what the problem is? So is there a
18 problem statement before we get into the
19 recommendation?

20 MS. DAILEY: If you would like to
21 read through the findings you'll see where
22 this is based. All those findings you talked

1 about were captured in last year's findings of
2 Recommendation 11. We also have a different
3 set of findings for this year which is
4 primarily used to capture the Landstuhl.

5 So I'm not adverse to breaking out
6 the Landstuhl into one recommendation, because
7 Recommendation 11 from last year addressed
8 this.

9 CO-CHAIR CROCKETT-JONES: I'm
10 sorry, Denise, I think it was 12 last year,
11 according to the notes.

12 CO-CHAIR GREEN: What I was
13 driving towards is, right now, the problem is,
14 we're trying to solve something across all the
15 services that's manning it somewhat
16 differently.

17 And so when you make the
18 observation that your continuity and your
19 training, essentially, makes it so that you
20 don't have the continuity that's required to
21 care for the Warriors, then the issue is, are
22 we going to tell them how to, basically, cut

1 bait, or are we, you know, going to just
2 identify the problem and tell them that they
3 need to look at all options to extend the
4 period of time that people are in place so
5 that there is, you know, uniformity for the
6 Recovering Warriors?

7 I'm not sure what the words should
8 be, but I'm just a little nervous about saying
9 minimum of 24 months because I don't know, you
10 know, how each service is going to interpret
11 that, or assigning active component personnel,
12 I'm okay with saying that as well.

13 It's just that, I'm not sure what
14 the right answer is. So we're doing, for
15 instance, with our continuity sell, for the
16 guidance to the reservists, we're making those
17 AGR, you know, so they'll be civilians that
18 are also reservists so they kind of
19 understand.

20 So there's a lot of ways to solve
21 this continuity issue and it gets into dollars
22 because these things are all done with man

1 days, and so whether they're counted as
2 deployed, or activation, you're going to get
3 into a lot of dollar issues in terms of the
4 man days.

5 Now, it should be the same dollars
6 if you do it for 24 months versus 2 of them
7 for 12. It may even be cheaper to do them for
8 24 months, unless the law prohibits them from
9 having them, you know, activated for that
10 long.

11 And I just don't know enough to
12 say -- that's why I'm kind of saying, is there
13 a way to generalize this language to where our
14 goal is that they must, okay, improve
15 continuity at the sites? I think that's our
16 goal.

17 CSM DEJONG: This recommendation,
18 sir, was based off of, especially at
19 Landstuhl, it was requested that we make a
20 recommendation to do this. Now, generally,
21 they're on 12-month orders and I don't
22 remember what, a very high percentage of them

1 are extended for another year.

2 So we're looking at the 24-month
3 period anyhow. What they're asking for is to
4 make 24 months across the board, somehow, in
5 some way, a recommendation. Now, I think part
6 of what the services may return with is that
7 they're meeting mission now with the way that
8 they're doing it, so why change it?

9 But this recommendation is driven
10 off the request from the leadership on the
11 ground at Landstuhl.

12 MSGT MACKENZIE: Yes, my apologies
13 for going down a rabbit hole, I was looking
14 more at the findings, and you are correct,
15 because they identified, clearly, a
16 significant shortfall, because I mean, we do
17 three-year assignments at SOCOM over there.

18 I mean, that's a PCS assignment
19 for our liaisons over there. And, you know,
20 I mean, there's such a turnover rate over
21 there it's hard to find experience over the
22 long haul, and the Navy did express to us that

1 there was a significant issue.

2 I mean, if you look at the
3 findings, we laid it out in there, all the
4 stuff that was brought to us because of the
5 situation in Germany.

6 DR. TURNER: In view of that, I
7 would be tending to go more specific.

8 CO-CHAIR GREEN: I'm okay with
9 that. The only other thing I'd point out to
10 you is that the behind the scenes background
11 on this is the argument between the Navy and
12 the Army, for sometime, as to whether or not
13 this is, basically, a day-to-day mission and
14 why is it being filled by deployers?

15 And so, you know, I mean, there
16 may be some aspects that are specific to in-
17 transit patients, but a lot of the manpower
18 that's over there are day-to-day hospital
19 operations. And so the other way to solve a
20 continuity problem is to, basically, assign --
21 you know, so we've been through Six Palms, and
22 so -

1 DR. TURNER: Excellent point, but
2 then I would counter saying, well, if they're
3 fighting about it and we have Six Palms, we
4 also have the track record to predict what
5 their future behavior will be.

6 CO-CHAIR GREEN: Right. It was
7 solved last time at SECDEF level. I mean,
8 really, it couldn't be solved between the
9 services.

10 DR. TURNER: Right. And,
11 basically, that's what we are. So I would,
12 again, underline, let's make a specific
13 recommendation.

14 MS. MALEBRANCHE: So, General
15 Green, just one thing I remember when we were
16 there is, the individuals as well as the
17 leadership asked if they could be there
18 longer.

19 But I think I hear what you're
20 saying is, this is a core function of what's
21 there, then the other issues here are the
22 short time and the reservists may not be --

1 really, their tours of duty don't really
2 matter, it's just getting the work done and
3 that might be a core function.

4 CO-CHAIR GREEN: And I'm okay with
5 being specific. So again, back to what we're
6 talking about is, you know, maybe the
7 recommendation is, adjust the mix of active
8 duty and reserve personnel serving at
9 Landstuhl to ensure continuity of care.

10 I mean, and then you go on to say
11 that the reservists, the reserve mix should be
12 24 months if you want to say it. I mean, I'm
13 not saying no. I'm just looking at it going,
14 right now --

15 CO-CHAIR CROCKETT-JONES: Do we
16 think we should say and/or increase the
17 proportion of AC personnel in these positions?
18 I think we're talking about just saying it a
19 different way, and that's fine. With me, I'm
20 just saying it does say, and/or increase the
21 proportion of AC personnel to reduce turnover
22 rate and increase institutional knowledge.

1 We did build in the either/or
2 whenever this first recommendation was
3 crafted.

4 CO-CHAIR GREEN: I'm okay with the
5 recommendation. Truthfully, as it is, it's
6 okay as long as it's specific to Landstuhl,
7 but this has been an ongoing problem, as I
8 said, for probably six to eight years.

9 MSGT MACKENZIE: And the reality
10 to it is, is that it's a fluid environment.
11 I mean, there needs to be a core group of
12 individuals who do this, but the reality to it
13 is, this will continuously change based on the
14 theater of war and how long things go.

15 I mean, there's no guarantee as to
16 what size conflicts and what duration we're
17 going to have at any point in time, so
18 therefore, you need to have those activated
19 Guard and reserve personnel to plus-up the
20 requirement, but I do believe that the intent
21 behind this is that, when that requirement is
22 plussed-up, that it's on a much longer, more

1 continuum of plus-ups.

2 So it's not these quick one-year
3 turnarounds where you're losing three months
4 to training, but still have enough flexibility
5 while having the active component stability
6 when this needs to grow or this needs to
7 drawdown.

8 DR. TURNER: So I'm hearing accept
9 this as written for Landstuhl?

10 MS. DAILEY: Okay. We have it
11 limited Landstuhl.

12 CO-CHAIR GREEN: I don't know that
13 it can be said any better. Yes, as long as
14 it's limited to Landstuhl, I don't have any
15 problem with it.

16 MS. DAILEY: I think it's cleaner
17 because last year, we tried to address and
18 they responded that the actions that they have
19 taken, which we captured in the findings of
20 this report.

21 CO-CHAIR GREEN: Yes. Suzanne was
22 right. It's written the same way. It's just

1 one in front of the other. It's not a
2 problem. Any objections to leaving this with
3 this specific recommendation? Everybody okay?
4 Okay.

5 CAPT EVANS: Just add that Captain
6 Evans should go over to Landstuhl to make sure
7 we implement this.

8 MS. DAILEY: Okay. So we have,
9 the Recovering Warrior Task Force recommends
10 Landstuhl Regional Medical Center be manned by
11 reserve component serving a minimum of 24
12 months and/or increase the proportion of
13 active component personnel in these positions
14 to reduce, et cetera, et cetera.

15 LTCOL KEANE: You said component,
16 but component's not up there; reserve
17 component. Reserve personnel you have.

18 DR. LEDERER: Is it Landstuhl
19 liaisons and LRMC staff or just liaisons?
20 It's not all of Landstuhl.

21 MSGT MACKENZIE: It's not limited
22 to just -- it's the plus-up within Landstuhl

1 and Germany across the board, because you've
2 got Naval Reserve in the wards, you've got
3 folks scattered throughout the facility to
4 accommodate the increased need that the
5 standard assignment process to Landstuhl does
6 not fill.

7 It's that expansion for time of
8 war, reduction in time of peace, that is
9 covered across the board from all the services
10 in the different areas that does that.

11 CO-CHAIR GREEN: You could solve
12 the problem by changing manned to augmented.
13 So in other words, you don't want to man the
14 whole facility by it, you just want to augment
15 it with reserve component on 24 months,
16 because, technically, if they're manning it
17 with reserve component, you know, then that's
18 forever.

19 CO-CHAIR CROCKETT-JONES: Okay.
20 And I don't know if Justin will pick this up,
21 he probably already has, there's a passive and
22 active voice problem in this sentence.

1 CO-CHAIR GREEN: Yes, it shouldn't
2 be the RWTF recommends, it should just be
3 Landstuhl Regional Medical Center should be
4 augmented.

5 MS. DAILEY: I need you on the
6 mics, please, even for sidebars.

7 MR. CONSTANTINE: To make it
8 active versus passive you would say, reserve
9 component personnel will augment, you know,
10 LRMC, or something along those lines, be
11 augmented is what you're talking about. I'm
12 just explaining, not coming up with an answer.

13 CO-CHAIR GREEN: I kind of like
14 starting with Landstuhl Regional Medical
15 Center because that makes it very specific.
16 As soon as you start with reserve component,
17 then you're going to get lost, but I see where
18 you're going.

19 I'm just trying to figure out how
20 you can -- is there a way to change the
21 wording in the middle to make it so that it's
22 all the same tense or present voice? Should

1 it be augment reserve component personnel
2 serve a minimum of 24 months or the proportion
3 of active personnel in these positions should
4 be increased.

5 And just take out the and, and
6 just make it -- up there where it says and/or
7 the proportion, just say, or the proportion
8 should be increased, so those two are
9 consistent. So or the proportion of active
10 duty personnel in these positions should be
11 increased to reduce turnover rate, increase
12 institutional knowledge, and maximize the
13 number of productive months on the job.

14 MR. CONSTANTINE: It's maximize
15 the number.

16 MS. DAILEY: Say again, what was
17 that about maximize?

18 CO-CHAIR GREEN: He want a the in
19 front of the number; on the next line down.

20 MS. DAILEY: Maximize the number.

21 CO-CHAIR GREEN: T-H-E number.

22 And then the --

1 MR. CONSTANTINE: The last
2 sentence is --

3 CO-CHAIR GREEN: Yes, take out the
4 also and say, staffing overlap is needed, or,
5 you know, if you want to be more active, is
6 required to avoid vacancies. I'd get rid of
7 the also and just make it staffing overlap is.
8 Right.

9 LTCOL KEANE: One more
10 Constantine-like correction. We abbreviate
11 active component and spell out reserve
12 component.

13 CO-CHAIR GREEN: Well, I mean,
14 we're going to be using these all through the
15 thing so it's wherever the first place it was
16 used and then we can make it RC and AC, so we
17 won't have to mess with that.

18 MR. CONSTANTINE: We've already
19 done, so I think we should just say RC and AC.

20 CO-CHAIR GREEN: RC and AC, right.

21 MR. CONSTANTINE: It's just RC,
22 not RC personnel. The way we use it

1 throughout.

2 CO-CHAIR GREEN: Also, get rid of
3 the personnel there. Yes, right, that makes
4 it all nice and neat.

5 DR. LEDERER: And should increased
6 in these positions, what positions?

7 CO-CHAIR GREEN: The augmentation.
8 So in other words, if they're going to augment
9 their staff with reserve component, they
10 should be on 24 months or those same augmented
11 positions.

12 So if you want to say, or the
13 proportion of AC in these augmented positions,
14 if that's what you want to say, if you want to
15 be more specific, augmentation positions. I
16 wouldn't say augmented there. Yes, that would
17 be fine, because that way you don't have to
18 specify it and you won't miss something that's
19 named one thing in one war and something else
20 in another.

21 CO-CHAIR CROCKETT-JONES: Okay.
22 Denise, we're into our lunchtime. Are we

1 eating lunch and working through things here?

2 MS. DAILEY: No. I'm actually not
3 setup to do that. So do you want to hold off
4 on 11 and let the working group -- working
5 group, how did you --

6 CO-CHAIR CROCKETT-JONES: We
7 offered no changes to Recommendation 11. We
8 accepted it as it was standing. So if
9 everyone can agree on that, that would be
10 fairly quick.

11 MR. REHBEIN: Let me ask one
12 question, is that a narrower definition of
13 Category 2?

14 CO-CHAIR CROCKETT-JONES: It's a
15 much more specific definition of Category 2.
16 I think it's not narrower, I think it's more
17 complete.

18 MR. REHBEIN: The recommendation
19 specifically says, more narrowly defined.

20 CO-CHAIR CROCKETT-JONES: Yes, I'm
21 not sure. I think we added something in as
22 well. So more specifically defined.

1 MR. REHBEIN: Yes. I'd say
2 specifically, consistently, whatever, but
3 unless we're really narrowing it.

4 CAPT EVANS: We actually
5 recommended 11 to transfer that one under the
6 wellness and function. Is that not the one we
7 recommended to be transferred under wellness
8 and function?

9 CSM DEJONG: Yes, we did, but --

10 CO-CHAIR CROCKETT-JONES: That's
11 true, and --

12 CSM DEJONG: -- as long as we're
13 on it.

14 CO-CHAIR CROCKETT-JONES: -- we
15 also asked the other group to consider taking
16 a look at this, since we thought it should not
17 be under restoring to society, but under
18 wellness and function, so there's probably a
19 secondary -- I don't know if they go to it.

20 MS. MALEBRANCHE: You know, it
21 makes sense. I guess you are going to
22 transfer, then, into wellness and function,

1 because it makes sense because there is
2 another task force that's looking at RCC/FRCs
3 in these different categories and that'll all
4 be kind of joined, and we need to keep it
5 together, I think, otherwise it's going to get
6 even more confusing.

7 And I'm sorry, because I missed
8 the earlier sessions. I'll try to catch up on
9 --

10 CO-CHAIR GREEN: Now, from our
11 meeting with Congress, they said that it was
12 not Congress who mandated this. They say it's
13 a policy. So are you recommending Congress
14 specifically define or are you recommending
15 that DoD define? Because I mean, again,
16 Congress told us that this was not in the law,
17 that it was policy.

18 CO-CHAIR CROCKETT-JONES: Yes, so
19 I think it actually is in the law.

20 MS. DAILEY: Yes, I didn't want to
21 contradict her, but it has a basis in law and
22 so that's where they drew it from.

1 CO-CHAIR GREEN: And so I'd be
2 more specific, okay? So again, not everything
3 has to start with the RWTF recommends, so we
4 just say, Congress should specifically define
5 Category 2 -- or more specifically define
6 Category 2 designation and direct the services
7 to adopt this definition as criteria for
8 assignment of non-medical case management
9 services.

10 Because I think that all the rest
11 on RCC, that may change based on current work,
12 and then you've got the entry, and the entry
13 is beyond category, unless you're going to put
14 all the new Category 2s into the Wounded
15 Warrior Unit, which wouldn't be typical,
16 because there's people that are staying at
17 their units that are SI/VSI.

18 This is really about assignment of
19 non-medical case managers, right?

20 CO-CHAIR CROCKETT-JONES: Yes, so
21 eliminate everything down to the wounded, ill,
22 and injured service members. Leave that last

1 sentence.

2 CSM DEJONG: But this also was
3 addressed to make it easier for the service
4 member, mainly in the Marine Corps, that
5 wanted to go into a unit, but wasn't being
6 authorized to go into a unit.

7 CO-CHAIR GREEN: I just think
8 there are more criteria in the category that
9 are involved in that decision to move them out
10 of their unit. That's why I'm hesitant to
11 say, do we really think that Category 2s
12 should automatically go to a WTU?

13 CO-CHAIR CROCKETT-JONES: No, I
14 think that we were also concerned, weren't we,
15 about folks who were being kept in medical
16 hold for 12 months, or longer, who were not
17 receiving non-medical case management because
18 they were considered Category 1.

19 CSM DEJONG: Correct. I don't
20 disagree with taking the rest of that out,
21 because I think we're crossing two different
22 lines of thought into one. So to make it a

1 little bit more understandable, if we stop
2 right there, I will agree.

3 CO-CHAIR GREEN: So basically, we
4 just --

5 MS. DAILEY: Stop where?

6 CO-CHAIR GREEN: So Congress
7 should more specifically define Category 2
8 designation and direct the services to adopt
9 this definition as the criteria for assignment
10 of non-medical case management services. And
11 then the rest -- yes.

12 Well, yes, that last line, the WII
13 service members of every service, that states,
14 yes, just like that. Should be entered into
15 Category 2 if they meet any one or more of the
16 following criteria. Yes, I think that
17 captures what we were trying to say.

18 DR. PHILLIPS: I question Bullet
19 1, do we need it? I mean, it's not defined.
20 I mean, if you're in Bullet 2 or Bullet 3,
21 that would certainly imply Bullet 1. I don't
22 really object to it, but I'm not sure it adds

1 anything.

2 CO-CHAIR CROCKETT-JONES: I'm not
3 sure that we'd get that everyone who is
4 referred to IDES for PTSD would have also been
5 a serious illness or injury.

6 MSGT MACKENZIE: The reason for
7 that was, the SI/VSI is a medical
8 documentation, and that level is changed as
9 the medical condition improves. So connected
10 to those other services, an individual,
11 basically, won't have access to that if
12 they're not still SI or -- I mean, you can go
13 from VSI to SI before you ever make it back to
14 D.C.

15 CO-CHAIR GREEN: Yes.

16 MSGT MACKENZIE: And so you can't
17 tie the two together.

18 CO-CHAIR GREEN: Yes, you could
19 have a heart attack, okay, and basically,
20 you're SI overnight, or you could be admitted
21 for chest pain, you're SI overnight, and then
22 it's ruled out in the morning and you're no

1 longer SI, okay?

2 But the trick here is that, the
3 way that they do casualty lists, and I think
4 all services do this, that it cross the
5 services, not just deployed, but if you're
6 injured in a motor vehicle accident in Idaho,
7 and you go into an ICU, and are identified as
8 very seriously injured, or ill, essentially,
9 then you go on the casualty list, which means
10 that they then track you in the personnel
11 system to see what's going to happen.

12 And that's only true for SI/VSI as
13 they're annotated. I mean, many of them, so
14 like the heart attack thing I just gave you,
15 may not make the reporting, but it is where
16 they get their casualty lists today, which is
17 why we included it.

18 So if you're serious illness or
19 injury, and then you can say, as defined, you
20 know, casualty listing of SI/VSI, or, and when
21 you say or, that means you don't have to be
22 the first, the second one also drives it, or

1 the reserve component that come back. You
2 know, basically you're saying, we want non-
3 medical case managers for these things because
4 what we're seeing are, these are the things
5 that are most likely to need non-medical case
6 management.

7 MR. CONSTANTINE: So is the first
8 bullet simply talking about seriously injured
9 or very seriously injured, or that's an
10 example of serious illness or injury? And if
11 it's just SI or VSI, that's what it should
12 say.

13 CO-CHAIR GREEN: So you would make
14 it so that it'd just say, SI or VSI on a
15 casualty list. I agree. That would be
16 clearer, much clearer.

17 MR. CONSTANTINE: Of course, only
18 if we've already used those acronyms earlier,
19 if not, I would spell them out, as you would
20 too, sir.

21 CO-CHAIR GREEN: Right. You're
22 very good, Justin. Thank you. So you

1 probably want to say, identified as SI or VSI
2 on a casualty list. Yes, then I agree. It
3 would have to be written out if we haven't
4 used it before.

5 MS. DAILEY: Okay. Good job.
6 Let's do a wrap and get to lunch, and then you
7 will come back at 1 o'clock, and you'll be in
8 your separate groups.

9 MS. MALEBRANCHE: Okay. Just one
10 last question. I'm sorry. On that second
11 bullet it says, or referred to IDES for PTSD
12 or TBI, why just for those two conditions?
13 And anything else they're referred for doesn't
14 matter?

15 CO-CHAIR GREEN: For non-medical
16 case management, what we found was that the
17 most common thing that was missed was someone
18 who had PTSD, or TBI, because it wasn't
19 identified until, like, six months out, and
20 they weren't on any of the casualty lists.

21 MS. MALEBRANCHE: Oh, the late
22 diagnosis. Got you.

1 CO-CHAIR GREEN: The late
2 diagnosis is what we're trying to catch.

3 MS. MALEBRANCHE: Got you.

4 CO-CHAIR CROCKETT-JONES: Thanks.

5 (Whereupon, the meeting in the
6 above-entitled matter went off the record at
7 12:20 p.m. and resumed at 1:04 p.m.)

8 MS. DAILEY: Ladies and gentlemen,
9 we are back in a preparatory session, so if
10 you would like to save yourself a step, you
11 can go straight to your tables and we will
12 reconvene here at the main table for our open
13 session at 2:00.

14 So, this morning if you didn't
15 have a chance to get through everything, this
16 will be an opportunity to kind of wrap your
17 arms around the rest of the recommendations or
18 to review other ones in other groups that you
19 feel strongly about

20 (Whereupon, the meeting in the
21 above-entitled matter went off the record at
22 1:04 p.m. and resumed at 2:05 p.m.)

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

2 2:05 p.m.

3 MS. DAILEY: We went back and
4 revisited this first one, ladies and
5 gentlemen. Number 4, we can start with D4,
6 you all had requested some assistance from
7 this morning from Lieutenant General Green.
8 Is this, was, kind of your vision back in
9 June, sir, that there be a way to link these
10 types of rehabilitative services, long-term
11 services, with the current expertise of the
12 Department of Defense.

13 CO-CHAIR GREEN: And so just what
14 you see up there is language that was crafted
15 by General Stone and myself changing
16 Recommendation Four to make it a little bit
17 clearer. And so what we really did was change
18 the first part of the sentence so that it now
19 reads, "Substantial rehabilitation expertise
20 has developed over 11 years of war."

21 And then it goes on to say, "DOD
22 should partner with V.A. to further

1 interagency collaboration while continuing to
2 grow DOD capabilities and facilitating the
3 transition of recovering warriors from DOD to
4 the V.A."

5 So in essence it says the same
6 thing in terms of trying to form partnerships,
7 but it says it in a way that is about
8 maintaining the currency and capabilities that
9 we've developed. And so that's where we took
10 it and you guys can decide if we want to put
11 in something more specific.

12 MR. CONSTANTINE: Isn't it already
13 done or mandated through other, with JEC or
14 other vehicles?

15 CO-CHAIR GREEN: Well we may want
16 to be more specific to say, to further
17 interagency collaboration and possibly
18 collocated, okay, rehabilitation centers.
19 Don't leave possibly in there. And just say,
20 and consider collocation.

21 DR. TURNER: We were wondering is
22 consider was a little soft?

1 CO-CHAIR GREEN: All right, and
2 just say, and collocate. I mean, I think that
3 we're okay, I'm trying to make sure I'm not
4 stepping on any toes here, but to further
5 interagency collaboration and collocate rehab
6 capability.

7 And then in terms of saying while
8 continuing, I would just say, to grow, just,
9 yes. Or maybe even just say to sustain. I
10 mean, it's not so much that we're trying to do
11 a lot more now. And facilitate the transition
12 so the other one would be, instead of, yes?

13 MS. MALEBRANCHE: Is this looking
14 at current state and current facilities?
15 Because I think that one thing that's under
16 the, oh, I'm trying to think what umbrella
17 it's under now, but there is that group that's
18 looking at building and whenever there's
19 something that we should look at what our
20 capabilities are in the area before putting
21 new buildings, new structures?

22 CO-CHAIR GREEN: It's honestly

1 going one step beyond that. I mean they made
2 the decision to stand up a separate DOD
3 rehabilitation capability instead of using the
4 V.A. and so now as we, I mean, this has been
5 true in every war.

6 So as the war comes down and then
7 what happens in the past is, you lose that
8 rehabilitation capability because you don't
9 have the patients, whereas the V.A. has the
10 patients. Right.

11 MS. MALEBRANCHE: It is our
12 business.

13 CO-CHAIR GREEN: And that's why we
14 say collocate rehabilitation capability
15 because the idea would be, if you can keep
16 some of the people by having them actually
17 take care of veterans, that's a good thing so
18 we don't have to grow it again the next time
19 we go to war.

20 It was too negative, the way we
21 had it written before, because it was kind of
22 like, you know, an efficiency drill. As we'd

1 see the reduced, reduction in casualties, we
2 must. And so rather than talking about the
3 reduction in casualties, we just talk about
4 sustaining that rehabilitation expertise.

5 DR. TURNER: And you're shifting
6 that capability from the active side to the
7 V.A. side as the population shifts from one to
8 another?

9 CO-CHAIR GREEN: That's what I'm
10 expecting will happen because DOD, other than,
11 perhaps at a couple of sites with the people
12 who have 30 percent or more disability, is
13 probably not going to see these patients.

14 They're going to go back to V.A.
15 hospitals.

16 MS. MALEBRANCHE: This is really
17 supportive of the effort in San Antonio now
18 where we've collocated in some of the, I mean,
19 it's very supportive of and kind of encourages
20 that. I think it's a good one, it states
21 well.

22 MR. CONSTANTINE: So, sir, how

1 will it work for the DOD, these places where
2 you just said they wouldn't normally see
3 patients but the doctors will be on the DOD
4 payroll but will be working on non-DOD people?

5 CO-CHAIR GREEN: I have people
6 working not only in V.A. hospitals but in
7 Scottsdale and U.C. Davis and Baltimore Shock
8 Trauma because I need them to maintain skills.
9 That's exactly right.

10 MR. CONSTANTINE: Great.

11 MS. MALEBRANCHE: There's a lot
12 of, just in sharing agreements and other
13 things occurring back and forth and V.A. does
14 the same thing with academic affiliations that
15 we have. So that's a common thing in that.

16 DR. TURNER: Well I think this is
17 a, you know, I agree with exactly as it
18 written, just in the future, do you think
19 there would be any value added to maybe more
20 codify a relocation of these resources as the
21 DOD draws down to, you know, codify their
22 relocation to the V.A.?

1 CO-CHAIR GREEN: Well remember, we
2 asked last year for them to look at where they
3 wanted to have long-term capability to do this
4 and they really haven't tackled that one. So
5 that's kind of one of the unmet
6 recommendations from last year that I would
7 say we might want to clarify in terms of, so
8 this one doesn't say that you're going to put
9 a WTU at a V.A. hospital.

10 But I'm not sure why you wouldn't
11 put a WTU at a V.A. hospital if it's a place
12 that has a lot of folks that are from that
13 area.

14 DR. TURNER: Or I would say
15 something like, a large, you know, OT/PT
16 department, you know, maybe move that to a
17 V.A. from a DOD facility.

18 CO-CHAIR GREEN: My guess is the
19 V.A. could tell us, you know, even DOD,
20 knowing where they recruit from, people tend
21 to go back to where they were recruited from
22 because that's where families are. And so you

1 may find that there are large accumulations of
2 people that come from certain areas.

3 Texas, California, there may not
4 be a DOD presence there and so the V.A. sees
5 those folks and yet, you know, there's nothing
6 that would keep DOD from maintaining and
7 sustaining their expertise in those hospitals,
8 even though they were going to deploy those
9 folks if we ever went to war again and back
10 into the Walter Reeds and the Fort Lewis' and
11 the Eisenhower's and the, you know, all the
12 places.

13 So, you know, that's, you're
14 right, I mean, we can go farther, it's just as
15 we get more specific it becomes more tenuous
16 in terms of what we're basing this on. This
17 one's pretty easy to support.

18 MS. MALEBRANCHE: Yes, I think the
19 only other thing that I've noticed in some of
20 the things that we're doing together, not just
21 in rehab, but in other areas, this
22 collocation, where they're being strong is,

1 they're saying, before you build anything, you
2 will collaborate with each other before you go
3 to, that's, they're pushing hard there.

4 So you can't just go out V.A. and
5 DOD and build two separate facilities next
6 door to each other. Not necessarily just in
7 rehab, but it certainly would make sense, that
8 is kind of a strong statement, rather than
9 moving what exists, no future activity will
10 occur that has not had some kind of back and
11 forth discussion.

12 MS. DAILEY: Okay, we're moving on
13 to Five. We made some changes here. Very
14 minor changes here. It now reads --

15 CO-CHAIR GREEN: Let me explain.
16 I looked at Five and I said that the problem
17 was that right now there's some politics going
18 on as to whether this works for P&R or Health
19 Affairs or someplace else and so my
20 recommendation was that we take out the A and
21 B and basically just say that permanently
22 preserve, you can take out the A, so

1 permanently preserve the leadership of Wounded
2 Warrior Care and Transition Policy at the
3 level of a Deputy Assistant Secretary within
4 the Undersecretary of Defense for Personnel
5 and Readiness portfolio.

6 So in other words it tells them
7 that they have to keep it in the Personnel
8 Oversight side, they can't put it lower than
9 that. And that then drives the services
10 personnel folks to basically continue to
11 develop policy in this area.

12 So it's a little cleaner than it
13 was before and it has to do with when you say
14 Deputy Assistant Secretary of Defense, Deputy
15 is actually below Assistant, which is weird,
16 but then Deputy is below Assistant and so it
17 would be misread if you left the wording the
18 way it was before.

19 And I don't think we were trying
20 to enter the political fray here. We're just
21 simply saying it needs to be at a high enough
22 level to drive DOD policy.

1 CAPT EVANS: For all of the
2 recommendations, could we just go and just
3 take out the RWTF recommends? Just delete
4 them all?

5 CO-CHAIR GREEN: Yes, I agree with
6 that, too. So then it'll be Congress will or
7 should.

8 MS. MALEBRANCHE: So just so I
9 understand, is this the current group now,
10 where are they now?

11 CO-CHAIR GREEN: It's just moved
12 to the ASD. So it was under P&R directly.
13 Actually, it was under, I think DEPSEC for
14 awhile, but no, so it was under P&R, it just
15 recently shifted to HA and that's fine, okay,
16 but what you don't want is for it to shift,
17 you know, --

18 MS. MALEBRANCHE: Lower, lower?

19 CO-CHAIR GREEN: Yes.

20 MS. MALEBRANCHE: So does this put
21 it back or is it --

22 CO-CHAIR GREEN: No, the goal here

1 is simply --

2 MS. MALEBRANCHE: -- fine where
3 it's at, then?

4 CO-CHAIR GREEN: -- to say it
5 needs to stay at the --

6 MS. MALEBRANCHE: At that level?

7 CO-CHAIR GREEN: At that level.

8 It needs to be at no less than a Deputy
9 Assistant Secretary. That's what.

10 MS. MALEBRANCHE: Oh, okay, I was
11 just thinking, if we were going to move it
12 back, I hope they don't reorganize again.

13 MR. CONSTANTINE: We should say no
14 less than. We should say at the level, or at
15 a level no less than, right? Because this, to
16 move through, it'll always be DASD. But
17 you're saying we're going to Assistant
18 Secretary?

19 CO-CHAIR GREEN: I don't know.

20 MS. DAILEY: This is the correct
21 title and this is where they're at now.

22 CO-CHAIR GREEN: What Justin is

1 saying is, at the level or at a level no less
2 than A, okay, so in other words, they could
3 make it a Principal Deputy if it was a big
4 enough issue. We're not trying to define
5 that.

6 So that's, all he's saying is, no
7 less than a Deputy which is what you'd kind of
8 told me to begin with. I don't know, Denise,
9 do you want to say Deputy? Did you want to
10 make it for Deputy?

11 MS. DAILEY: Yes, we, this is
12 pretty safe the way it is. I mean, if this,
13 the intent is to preserve this policy-making
14 capability in, and I don't care where, but in
15 the personnel and Readiness.

16 It's not to --

17 CO-CHAIR GREEN: Okay so let's
18 just leave it at, you know, at a Deputy
19 Assistant Secretary of Defense. So that's
20 fine. At A, so you can get the level of out
21 of there. At the level of. Yes, it ink it
22 just has to say as a Deputy Assistant

1 Secretary of Defense. I mean, we don't need
2 to say level. We just say as a. Yes.

3 MR. DRACH: Could that language
4 preserve the leadership be interpreted to say
5 that we're supporting the continuation of the
6 incumbent?

7 MS. DAILEY: No because we don't
8 have a name against that Deputy Assistant
9 Secretary of defense and if you're talking
10 about incumbent as in a specific individual,
11 I mean, it can be interpreted many ways and
12 anyone who's got an agenda about this will
13 interpret it their way.

14 But the intent is that a
15 policy-making office for non-clinical wounded
16 warrior issues is sustained in Personnel and
17 Readiness at a level high enough that it is
18 effective. Otherwise there is a good chance,
19 as the war dies down, that everyone says, we
20 don't need this anymore.

21 And you are back to ground zero
22 with the next conflict. Building an office of

1 policy to synchronize nonclinical and clinical
2 management for the incoming wounded.

3 MS. MALEBRANCHE: Denise, I
4 actually like the way you said it better than
5 what we have up here because we have a body or
6 a name here and you actually just stated the
7 function and the importance and the intent is
8 to keep the function at such a level rather
9 than this hierarchy and describing the, what
10 do you call it? The structure or the
11 hierarchy.

12 You discuss the intent of the
13 policy of Wounded Warriors, that seemed to
14 make better sense to me.

15 MS. DAILEY: My intent is easily
16 interpreted in the absence of this language
17 into something else.

18 CO-CHAIR GREEN: I guess the only
19 other thing I would ask is, so enact
20 legislation, I mean if congress takes action,
21 that's how they do it, so should we not just
22 say, congress should permanently preserve the

1 Wounded Warrior Care and Transition Policy at
2 a Deputy Assistant Secretary of defense, I
3 mean, level?

4 What you're really saying is, you
5 want that particular policy-making body --

6 MS. DAILEY: It's already in
7 there. You just have to eliminate enact
8 legislation, too.

9 CO-CHAIR GREEN: Yes, right, so I
10 think you could just do it as, Congress should
11 permanently preserve the leadership of Wounded
12 Warrior care and Transition Policy at a, at
13 would be, yes, at a Deputy Assistant Secretary
14 of defense within the Undersecretary of
15 Personnel and Readiness Portfolio.

16 It says the same thing, just
17 cleaner.

18 MS. DAILEY: We could, come out
19 with those Congressional intent and the sense
20 of congress versus a piece of legislation.

21 CO-CHAIR GREEN: Okay so you think
22 they actually have to enact legislation to, I

1 got it. Enact legislation to permanently
2 present. No?

3 MS. DAILEY: Yes.

4 CO-CHAIR GREEN: Yes. You just
5 got the permanently in the wrong place. That
6 works. Okay. Anybody have any other strong
7 feelings about this thing? D5, done.

8 MS. DAILEY: Yes, let's go into
9 Seven.

10 CO-CHAIR GREEN: I talked with,
11 this one was also given to General Stone and
12 myself. What we looked at was this issue of
13 eight visits or something that was discussed
14 in the earlier meeting in late May. And the
15 problem was that we decided it was better to
16 basically look at TAMP as a potential to start
17 only after their first visit.

18 If you remember, that came from
19 someone here in the group suggesting that.
20 And so as we talked about that and I talked
21 about it with Health Affairs, et cetera, the
22 reality is, there's not an easy way for them

1 to do that.

2 And it might affect different
3 family members differently, et cetera. And so
4 what Rich suggested was, and, he said, why not
5 just expand TAMP to one year post-deployment
6 for a reserve component to simplify access to
7 care for late-arriving health issues such as
8 PTSD?

9 And it's not arriving, it was
10 arising. For late-arising health conditions
11 such as PTSD, which then basically says, look,
12 we'll simplify this. You have a year to get
13 things taken care of. And frankly, you know,
14 the way people are using TAMP right now, it's
15 probably is not a large cost except for those
16 who have PTSD or late-arising conditions.

17 So this would do both. So we
18 thought we could eliminate 28 and basically
19 roll 28 into this and accomplish the same
20 thing.

21 MR. CONSTANTINE: Well then should
22 it be just for behavior health late-arising

1 issues?

2 CO-CHAIR GREEN: Well, but you're
3 going to do TAMP for, if you do TAMP, I don't
4 know that you can limit your TAMP to a
5 certain, you see?

6 MR. CONSTANTINE: Oh, yes.

7 CO-CHAIR GREEN: It'll solve some
8 of the line of duty issues for this kind of
9 stuff. I mean, they may still need it but
10 this allows them to get care while they're
11 pursuing it. Any objection to doing this?

12 MSGT MACKENZIE: No, I mean, I
13 think it works and it's, I mean, TBI is one of
14 those other late-arising things, along with
15 PTSD.

16 CO-CHAIR GREEN: You want to list
17 TBI there?

18 MSGT MACKENZIE: I think we should
19 list TBI as well because I --

20 CO-CHAIR GREEN: Okay, good. I
21 think we're golden. All right, thanks.

22 MS. DAILEY: So up to 11, we had

1 just finished up 11 before we broke for lunch,
2 which was the redefinition of, or a
3 modification of Category 2. I do want to
4 point out one thing on this one ladies and
5 gentlemen, is, you are using the term in this
6 nonmedical case management and in the previous
7 recommendation we had the assignment of an
8 RCC.

9 They are, by the DoDI's
10 definition, two separate individuals. RCC has
11 certain duties, nonmedical case manager has
12 certain duties, so what is your intent? Is it
13 an RCC be assigned? And in which case we need
14 to use the term RCC.

15 DR. TURNER: Yes, we agreed on,
16 the small group looked at it and wanted to
17 bring it to the group for RCC to put in there.
18 And also, Denise, we skipped over D9 that we
19 had not done.

20 MS. DAILEY: Yes, that's right.

21 DR. TURNER: And the group looked
22 at D9 --

1 CO-CHAIR GREEN: Let's finish this
2 one before.

3 DR. TURNER: Okay, go ahead.

4 CO-CHAIR GREEN: So as the
5 criteria for RCC services? Is that what we're
6 going to say?

7 MS. DAILEY: That's fine.

8 DR. TURNER: Yes.

9 CO-CHAIR GREEN: For assigned RCC
10 services. Sign back out of it? Just say RCC?

11 MSGT MACKENZIE: No, if you look
12 at the Air Force model and the RCCs, they're
13 not actually present. The nonmedical case
14 management is still essential to getting some
15 of the services needed in through some of the
16 discussion we were talking about here.

17 CO-CHAIR GREEN: But remember,
18 this is tied to the change in Category 2.

19 MSGT MACKENZIE: Correct.

20 CO-CHAIR GREEN: And so the, I'll
21 use the Air Force. The Air Force does assign
22 an RCC to the SI/VSI. They have a RCC

1 assigned to the RC and the only one that I
2 don't think they've solved yet is the PTSD/TBI
3 that re in the IDES system.

4 But they, you know, this would
5 actually force them to use their RCC system
6 for PTSD and TBI in the IDES system.

7 MSGT MACKENZIE: Correct, which I
8 completely agree with, and I think that's part
9 of what we're trying to say here. Btu I also
10 know that the frequency of contact with the
11 RCC and the, for lack of a better term, the
12 leverage and accountability.

13 Or the leverage and the
14 effectiveness of the RCC with the medical
15 folks where you're at, I don't think they can
16 truly fill the role of that, well, I don't
17 know. I lost my train of thought. My
18 apologies.

19 CO-CHAIR GREEN: Well, let me,
20 let's go back. So as a criteria for
21 assignment of RCC services.

22 MS. DAILEY: For assignment of an

1 RCC.

2 CO-CHAIR GREEN: Of assignment of
3 an RCC? That would be good. Okay, now where
4 I think you were going, Mack, is that each
5 service is using RCCs differently, okay? So
6 you've got the Army who says that they're
7 platoon sergeants, yes, and then you've got
8 the Navy, I think, who's using RCCs, the Air
9 force who's using kind of regionally-based
10 RCCs.

11 I'm not sure what the Marines are
12 doing, but I do think they do use something
13 that's an equivalent of an RCC. But I think
14 we can use this as an, the only reason I
15 didn't put in the RCC in the first language is
16 because this is in flux right now.

17 So the conversations that are
18 going on with regards to whether it's going to
19 be an RCC or whether it was going to be an FRC
20 is making this confusing. But these people
21 need nonmedical case management.

22 So if you prefer it to be RCC and

1 be specific based on the current definition of
2 RCC, I have no objection to that. I'm just a
3 little worried the department's going to
4 redefine an RCC and right now, I mean, so in
5 a way, were saying, so Category 2, as we've
6 defined it, would be, you have to have a
7 service RCC.

8 And Category 3, I think what's
9 going to happen is, you're going to have to
10 have an FRC. Btu they're also redefining FRC
11 and so --

12 MS. MALEBRANCHE: I think you're
13 right and I was just thinking, rather than say
14 RCC, I think the function. You had the
15 function up there. I understand that the
16 function could be a different, I guess a
17 different person, but we are in the midst of
18 this other taskforce.

19 By the time this, it's going to
20 come out about the same time because this
21 other taskforce that's currently ongoing that
22 I was at this morning, we have a due out to

1 the JEC by the 19th of July and they're
2 planning on publishing something in August.

3 But I'm not sure what that's going
4 to look like and I'm like you, if you put this
5 in there, then I don't know if we can't
6 somehow cross level these.

7 CO-CHAIR GREEN: Maybe the other
8 way to do this is somewhere in between. So
9 for assignment of a RCC for nonmedical case
10 management. And that way, however they define
11 nonmedical case management, you're covered.

12 So you've got to assign a Recovery
13 Care Coordinator for nonmedical case
14 management. If you change what an RCC is,
15 then you're going to have to still assign
16 nonmedical case management. Do you see what
17 I'm trying to do?

18 CAPT EVANS: Right, and that's
19 what we really want, we wanted the nonmedical
20 case management component because that's what
21 they were missing. So no matter what the task
22 force.

1 MSGT MACKENZIE: Would you want to
2 do it as that or do it as and/or?

3 CO-CHAIR GREEN: I wouldn't, I
4 think you say for, okay, because the services
5 are already defining RCCs differently, you at
6 least know that they're going to get
7 nonmedical case management.

8 DR. PHILLIPS: We discussed that
9 in somewhat detail and we went with the RCC
10 because that's what's in the DoDI. If we
11 could find another term, that would probably
12 work, but --

13 CO-CHAIR GREEN: I think it's good
14 to include it. I just think we need to be
15 careful because what if they redefine it, then
16 they may ignore our recommendation and I don't
17 want them ignoring this.

18 MS. MALEBRANCHE: Well the other
19 thing that potentially is going to change is
20 the DoDI. So we're looking at the DoDI and
21 the handbook. So the names could be changed.

22 CO-CHAIR GREEN: If it changes

1 perfectly, it would do this, right? Yes.

2 MR. CONSTANTINE: There's a few
3 technical ones on here and so A, RCC, of
4 course it should be in and then I would,
5 instead of, on the next line, oh, you say if
6 they meet any of the following three criteria
7 because it's or, all right?

8 And then in that list, if they
9 meet any --

10 PARTICIPANT: Any of the following
11 three criteria.

12 MS. DAILEY: One or more of. One
13 or more, any of the three of them.

14 CO-CHAIR GREEN: Any.

15 MR. CONSTANTINE: It can be any of
16 the --

17 CO-CHAIR GREEN: Any of the
18 following three criteria.

19 MR. CONSTANTINE: Delete the next
20 four words, and then that, when we have those
21 three bullets, you don't need or at the end of
22 the first one because it's, yes. I always see

1 `title' where it's written out, title is
2 written out, but maybe if it's common to have
3 T? Just T10? Or you have to write out Title
4 10?

5 MS. DAILEY: We'll take care of
6 that, guys. We cannot get through the next
7 three days. We'll take care of it.

8 CO-CHAIR GREEN: I tend to agree
9 with Justin. I'd make it Title 10 so we all
10 understand it. Because I didn't know what T10
11 was, either.

12 MR. CONSTANTINE: The or is --
13 well they are doing it.

14 CO-CHAIR GREEN: You can leave or
15 in all of them, right? You want to take them
16 off at the end of both of those two?

17 MR. CONSTANTINE: After the second
18 on it's okay but there's no reason to have it
19 after the first one.

20 CO-CHAIR GREEN: Oh I see what
21 you're doing, yes, it's comma, comma, yes, I
22 got it. Boy, you're tough on this stuff.

1 Damn, he is tough. D9, let's go to D9.

2 Justin, you're, damn, man, I'd hate to edit
3 for you.

4 DR. TURNER: Our group had looked
5 at D9 and this is one for the DCoE for
6 psychological health. We actually had some
7 input from them and they have, and correct me
8 if I'm wrong, guys.

9 But they already have a CRT
10 research protocol in place and so we, our
11 group was going to recommend dropping this
12 one.

13 CO-CHAIR GREEN: My question was,
14 do you want to take some portion of D9 and
15 make it under D8? Because when we drop that
16 last line on D8 you could put just that the
17 DCoE will continue to, you know, advance
18 research, I don't know, I mean I'd have to
19 look at the wording, but essentially you'd
20 say, conducting a bunch of studies on each of
21 these things.

22 And so I'm wondering if you don't

1 want to have the DCoE share research so that
2 other evidence-based treatment could be
3 applied. I mean, it'd be an easy way to take
4 D9 and make it part of D8.

5 But if you want to just drop it
6 I'm not against that, either.

7 DR. TURNER: Dr. Hanver's input
8 here --

9 CO-CHAIR GREEN: Said that we
10 already have this? Okay, I'm with it. So
11 we're going to drop D9. Good.

12 MS. DAILEY: Okay, so D9 has been
13 eliminated.

14 MSGT MACKENZIE: So that stuff
15 they gave you, they're actually increasing the
16 sizes and expanding all of their stuff or they
17 will just continue to do what they're doing?
18 When you guys said that they responded saying
19 that there was, yes, sorry. Okay, thanks.

20 CO-CHAIR CROCKETT-JONES: Are we
21 ready to move on to Recommendation 12? D12?
22 Do you want to go ahead?

1 CAPT EVANS: D12, we concur, the
2 small group concurs with the recommendation.
3 No editing. I didn't think we did any
4 editing, but now that I'm reading them again,
5 I think we could --

6 CO-CHAIR CROCKETT-JONES: I think
7 it needs better language but I think we
8 weren't, it may need better language, first of
9 all what we're really, I think was being drive
10 at was that it's the CRP or the CPT needs to
11 have more standardization so that, because
12 some services already have a dialogue and a
13 feedback loop if, and that seems to be lacking
14 in the Navy, the Marine Corp and the Air
15 Force's version.

16 The Army's gone electronic. But I
17 don't, we need to discuss this, though, and I
18 think in the larger group. The Marine Corp
19 non-concurs? Is that what?

20 LTCOL KEANE: Yes with, the
21 portion of it having family members inputted.
22 The Marine Corp every two weeks sits down with

1 the family and they have a printout of it, but
2 we don't want them to have access to
3 manipulate it.

4 MR. CONSTANTINE: So sir, how does
5 the family's input translate into the system?
6 Do they sit there and talk with the person and
7 the person types it in right there for them?

8 LTCOL KEANE: It doesn't
9 necessarily happen in front of them, but they
10 sit down, the RCC, the Squad Leader and the
11 family members and the Marine and the RCC
12 updates the CRP.

13 MR. CONSTANTINE: So it's
14 happening?

15 LTCOL KEANE: Right, I mean, they
16 just don't want the family members to be
17 typing on it.

18 CO-CHAIR CROCKETT-JONES: Well
19 that's not what our installation visits come
20 up with, though. Installation visits indicate
21 that it's not actually happening.

22 MR. CONSTANTINE: With the

1 Marines?

2 CO-CHAIR CROCKETT-JONES: With the
3 Marines, yes. That's the theory of how it's
4 supposed to work, but at our installation
5 visits, we had very few Marines who had seen
6 theirs in months. And I don't know if we came
7 up with any family members in the Marines who
8 had seen a CRP at all.

9 CO-CHAIR GREEN: I actually
10 thought this one was good as it was written.

11 MR. CONSTANTINE: Well we need to
12 modify it, just at the beginning of it, like
13 a global change and it ink we should write out
14 CRP the first time.

15 CO-CHAIR GREEN: Well you may also
16 want to make it CTP or, is it CRP, is that the
17 broader term?

18 MS. MALEBRANCHE: Well, I was just
19 trying to figure that out, too. It says CTP
20 at the beginning of the book, we use that, and
21 I think that one service used CRP.

22 CO-CHAIR GREEN: Right now the

1 Army uses CTP and the Navy uses CRP and I
2 don't, I have not seen one of these with the
3 Air Force, so I don't know.

4 MS. DAILEY: Yes, the three
5 services listed under D12 use the CRP. The
6 three services listed under D12 use the CRP.

7 CO-CHAIR GREEN: So I mean, I
8 thought we also had the same feedback from the
9 Army in terms of family members, that they're
10 not actually able to look at the CTP either.
11 That's what I got.

12 MS. DAILEY: We did, however we
13 had a briefing in December in which they said
14 they were making changes. And our agreement
15 at the time was to look at it again next year
16 to see if those changes were taking effect.

17 CO-CHAIR GREEN: I'm not sure that
18 gives them a bye from basically having a
19 feedback loop. I'm not sure why we wouldn't
20 put it in.

21 CO-CHAIR CROCKETT-JONES: Yes, I
22 think the Army should be included in that and

1 we can both say CRP/CTP.

2 MS. DAILEY: Okay, then I
3 recommend it be a separate recommendation.
4 Because the Army is just going to come right
5 back to us and say, we made our changes, we
6 briefed you on our changes and now we'd like
7 to have a chance to see them implemented.

8 So I would like, I don't think we
9 should put them together. They should be
10 separate. If you want to hold the Army
11 accountable, hold them accountable for the
12 CTP.

13 CO-CHAIR GREEN: Well the other
14 way to do it is, so you can leave it just like
15 it is, as facility dialogue and we can
16 actually put there, Army efforts to accomplish
17 the same with the CTP are noted.

18 MS. DAILEY: I believe it's down
19 in the findings. In Chapter 1 also we comment
20 on their briefing to us about how they've
21 changed their CTP.

22 CO-CHAIR GREEN: I don't know, I

1 still struggle. Because I don't think that
2 the Army has arrived in terms of what they're
3 doing, so, I mean, the recommendations is
4 really about the feedback loop for family
5 members and stuff using the CTP or CRP and so
6 I hear you, Denise, but I'm going, so they're
7 telling us the changes they're trying to
8 implement.

9 But I don't know, I just kind of
10 go, why do we give them a bye on this?
11 They'll come back saying they're making
12 effort.

13 CO-CHAIR CROCKETT-JONES: Well
14 it's true, I can say this, though, that the
15 Army does allow the service member to input
16 into their transition plan and the other
17 services do not. So they are already one step
18 closer to that.

19 There is, you know, a segment of
20 their transition plan, you know, of course a
21 segment of it is just for that feedback.

22 CO-CHAIR GREEN: Okay, all right,

1 so the only other thing on this one is that
2 you shouldn't say will insure, it should be
3 should insure. All right, so we can leave
4 this as-is, then? And let it go? I'm still
5 not sure the Army deserves a bye on this, but
6 they are making more effort than anybody else
7 right now.

8 MS. DAILEY: I'm happy to do
9 another recommendation. That's not hard. I
10 just think that we lost a lot of the fidelity
11 of our recommendation last year because we
12 combined CRP and CTP and --

13 CO-CHAIR GREEN: Okay, I got it.
14 Anybody have any objections to 12, then? Let
15 it go this way?

16 LTCOL KEANE: The Marine Corp
17 does, sir, they do not concur with having
18 family members manipulate the CRP.

19 CO-CHAIR GREEN: Manipulate the
20 CRP?

21 LTCOL KEANE: The RCCs are the
22 ones who are trained in working with the CRP,

1 are the ones who go to the week-long Federal
2 RCC course which covers entering the CRP.

3 CO-CHAIR GREEN: Yes, I'm just
4 laughing at your choice of words, so I
5 understand, there's a definitive bias there.

6 LTCOL KEANE: I can jump on the
7 table of you need me to, sir.

8 CO-CHAIR GREEN: Well I guess the
9 question is, okay, right now it says access,
10 so you're objecting only to the directly-input
11 information?

12 LTCOL KEANE: That's correct.

13 MSGT MACKENZIE: I non-concur with
14 that. I have no problem with them putting
15 information on it. As long as they're not
16 authorized to change information that exists
17 in it. I mean there has to be that
18 interaction, there has to be that, they have
19 some kind of input here.

20 CO-CHAIR CROCKETT-JONES: All they
21 need is a comment box. At this point. They
22 don't need --

1 MSGT MACKENZIE: A comment box,
2 or, I mean, there's got to be a --

3 DR. PHILLIPS: Just recommend
4 information. They could recommend inclusion
5 of --

6 LTCOL KEANE: They would need a
7 CAC card, they would need a computer that
8 reads a CAC card, they would need access into
9 MCWIIITS, the tab that has the CRP. There's
10 just more than just giving, you know, it's not
11 a website nor a web-based program.

12 MS. MALEBRANCHE: Could the family
13 members recommend to the RCC as opposed to
14 direct access?

15 LTCOL KEANE: And that's what they
16 do now, ma'am.

17 MS. MALEBRANCHE: Okay so that
18 wouldn't be a change?

19 CO-CHAIR CROCKETT-JONES: No,
20 that's the theory. But family members don't
21 know that and they don't do that.

22 LTCOL KEANE: If you recall the

1 Marine Corps briefed in February that they had
2 intense plans, which started March 10 in
3 utilizing the CRP much more than they had
4 been. So I think what you're basing your
5 information on is pre-March 10.

6 CO-CHAIR CROCKETT-JONES: Yes, our
7 installation visits, sure.

8 CO-CHAIR GREEN: I think that
9 there may be a middle ground here. Because
10 when you say directly input it infers that it
11 has to go into, so you could say that they
12 access their CRP and have ability for written
13 comment on the information on the CRP.

14 That doesn't mean that it has to
15 be in the program itself, but they could
16 comment on something and it would be dealt
17 with. And have ability for written comment on
18 information in the CRP, okay, and then period.

19 And then there must be a feedback
20 loop to ensure the RCC is responsibly, it
21 still says the same thing without forcing you
22 to put the input directly into the form. This

1 is like a personal health record.

2 The problem is that when a patient
3 puts something into an official document, it
4 then makes, it changes that document and so
5 there's another way to do this where the
6 patient information is tracked and it can be
7 kept separately or in a box that's attached to
8 it.

9 But it doesn't have to go directly
10 in, especially if the form for the CRP doesn't
11 restrict you from putting, from changing
12 information, it can be quite the problem. And
13 so I think that if you write it this way, that
14 we get closer to what you're looking for.

15 Because that doesn't say it has to
16 be in the CRP, that written comment doesn't
17 have to be in the CRP but you would expect the
18 team to respond to written comment from the
19 patient.

20 LTCOL KEANE: Do we need to be as
21 specific to say written comment? I mean, do
22 we have to provide, we have to mandate that

1 the family member has to put something in
2 writing? I mean, we could have a discussion
3 --

4 CO-CHAIR GREEN: You have to
5 presume that the RCC, when they talk with a
6 patient, would already be putting things in,
7 so what you're really looking at is something
8 where the patient feels something is not
9 appropriately documented or that there's a
10 variance which probably should be in writing.
11 That's why I said written.

12 LTCOL KEANE: Okay.

13 MSGT MACKENZIE: And hopefully
14 next year you guys can actually get copies of
15 completed ones that are actually filled out.
16 Because unfortunately in our site visits this
17 year, every one we saw was not filled out and
18 didn't meet the standards of the CRP. Yet
19 these were on Marines that had since departed
20 and that was the official record and it was
21 hard to stomach.

22 It was hard to, not stomach, but

1 it was hard to see that that was part of the
2 official record, incomplete in that fashion.

3 CO-CHAIR GREEN: Well the other
4 thing that I'm hearing is that when given, you
5 know, access to write in the official form,
6 then frequently there are four letter comments
7 and other types of things that make entry but
8 then result in other types of action with the
9 recovering warriors.

10 And so it might be --

11 MSGT MACKENZIE: That's why I like
12 the witnesses written, I'm just saying that
13 hopefully --

14 CO-CHAIR GREEN: -- right, it
15 might be very nice to keep it so it's not in
16 the RCC itself. But you understand, I think
17 this is a nice middle ground and so Shawn,
18 this gets you to where you need to be?

19 LTCOL KEANE: Yes sir.

20 CO-CHAIR GREEN: All right.

21 Anybody with any objections?

22 CAPT EVANS: And again, this is

1 one of the twos that we're looking at, we
2 wanted to change because they have two
3 different recovery plans out there. And so
4 this is under a lot of controversy, too, okay?

5 CO-CHAIR GREEN: I don't disagree.
6 I mean I think there should be one that all
7 the services use, that would be much better.
8 But until they kind of agree on that, I guess
9 we're somewhat caught. Now do we, we could
10 say, you know, that they, you know, that the
11 services should move to a common CRP, I mean,
12 but again --

13 CAPT EVANS: It would help --

14 CO-CHAIR GREEN: -- It should
15 adopt, I mean, the services should adopt a
16 common CRP, why don't you just say format?
17 That, then, captures the Army in that, right?

18 MS. DAILEY: Correct sir, it
19 captures the Army's, well, it captures a, yes,
20 I, do you, I think you need to, it is a
21 philosophical discussion, sir, and the task
22 force should be clear and not slide it into

1 another recommendation that they don't think
2 the CTP is a valid document.

3 I mean, that's what we're saying,
4 or that it should be changed along with the
5 CRP. I mean, that's a very valid
6 recommendation of the task force to make, but
7 don't slide it into this one. Make a clear
8 statement that what's out there now is not
9 adequate in either or all of the services.

10 CO-CHAIR CROCKETT-JONES: I would
11 agree. If we're going to make that
12 recommendation I would like it to stand on its
13 own.

14 CO-CHAIR GREEN: I'm okay with
15 that. You know, the Army's been clever
16 because they would say that ours isn't a CRP
17 even though it falls under that criteria, ours
18 is a CTP, it's different, so, you know, that's
19 the one problem you've got.

20 MS. DAILEY: And it's a good
21 statement. It's a good statement if you want
22 to take it on to tell the services to come

1 into compliance with one document. But I
2 think it's a separate recommendation, I need
3 to get, I need to re-jigger findings, which I
4 can probably do, but it's a strong policy
5 statement from you.

6 CO-CHAIR GREEN: Why don't you
7 make it D12, which you make it even an AB
8 because they're so related. So make the
9 services should adopt a common CRP format as
10 Number 1 or as A. And B, the Navy/Marine
11 should ensure that recovering warriors and
12 parents can access their CRP.

13 Do you see? I mean, what that
14 does is, it ties them together and starts off
15 with the stronger one. I mean, the stronger
16 one is, make it a CRP. If you want to make it
17 number, I mean, we can change the numbers,
18 we've eliminated two.

19 So it's easy for you to put them
20 in at the numbers we have.

21 MS. DAILEY: Yes, I'm not worried
22 about numbering, but you need to be able --

1 MSGT MACKENZIE: Yes, I agree with
2 her, it should be a separate recommendation,
3 sir, that way they have to, it's met or not
4 met, there's no partial met, we don't lose it
5 in that, we don't lose it in that aspect, sir.

6 CO-CHAIR GREEN: Oh, I forgot. I
7 wasn't here for that discussion this morning.
8 Okay, I apologize. Separate it is. It's a
9 nice, clean statement. Okay.

10 DR. PHILLIPS: Would it be asking
11 --

12 MS. DAILEY: And I get, yes, go
13 on, sir, go on, sir.

14 DR. PHILLIPS: No I was just going
15 to say, would I be in trouble to suggest that
16 the second sentence, the Navy, Marine Corps
17 and Air Force be eliminated and just put
18 services in? That, maybe?

19 MS. DAILEY: No, no.

20 DR. PHILLIPS: Okay. I was trying
21 to cover the Army.

22 MR. CONSTANTINE: Well the first

1 one should be a CRP/CTP?

2 CO-CHAIR CROCKETT-JONES: I think
3 that it should be CRP/CTP to be able --

4 MSGT MACKENZIE: No, no, no, if we
5 want a common format it's one format.

6 MR. CONSTANTINE: Right, but why
7 is it, why is it CRP and not the CPT if
8 they're going to --

9 MSGT MACKENZIE: Because the
10 legislation of the RCC, does not matter what
11 it is, a comprehensive recovery plan, will be
12 implemented across the, I mean, isn't that how
13 it came out was is --

14 CO-CHAIR CROCKETT-JONES: Maybe we
15 shouldn't use an acronym. Maybe we should
16 eliminate the acronym.

17 MS. MALEBRANCHE: Well let me just
18 say this, too. The task force that's looking
19 at that we want to be congruent with, is,
20 they're looking at another, they're looking at
21 a comprehensive plan. It's not been specified
22 as a recovery or transition plan.

1 And if we want to be congruent,
2 because we're trying to get there, a
3 comprehensive plan --

4 CO-CHAIR GREEN: So let's just
5 change this and put a common, comprehensive
6 plan, don't, yes, just like that, don't
7 capitalize it, plan, and then put in
8 parentheses around it, CRP, CTP, et cetera.

9 MS. MALEBRANCHE: That would,
10 then, that would nicely dovetail together
11 because that's what they're looking for. And
12 then we keep it all in one place.

13 MSGT MACKENZIE: I was going to
14 say, because actually, recovery doesn't fit
15 because most of this document is used to
16 transition someone, not to do recovery.
17 That's medical case management and your
18 medical records is part of your recovery.

19 CO-CHAIR GREEN: Yes, so it
20 probably needs a common, comprehensive plan,
21 format for recovery. Okay? Just to make sure
22 they know what we're talking about. We're

1 good. Thank you, guys.

2 MS. MALEBRANCHE: Recovery and
3 transition?

4 CO-CHAIR GREEN: For recovery and
5 transition. I am corrected. And transition
6 add at the end, there. Good, thank you.

7 CAPT EVANS: D13. The first three
8 words are out, delete it. DOD should conduct
9 joint training to include RCC, squad leaders,
10 platoon sergeants, AW2 advocates, squadron
11 section leaders and AFW2 nonmedical case
12 managers.

13 MS. DAILEY: So did you change
14 that in any way other than to take the first
15 three words out?

16 CAPT EVANS: I just took the,
17 moved it around a little.

18 MS. DAILEY: Okay then you'll need
19 to slow down.

20 CAPT EVANS: Okay. Conduct, host,
21 joint training. I don't, I mean, RCC
22 training, RCC is a function so I think they

1 are included in the group of people that
2 should be in that training, that function is
3 included, right?

4 So it's not RCC training, is it?

5 MS. DAILEY: No. The original
6 intent of this question was that these
7 individuals attend the DOD RCC training.

8 CAPT EVANS: Okay so we'll go
9 back, so we'll leave it as it is, joint RCC
10 training of squad leaders, platoon sergeants,
11 AW2 Advocates, dot, dot, dot.

12 CO-CHAIR GREEN: So just some
13 clarification, so DOD should conduct joint RCC
14 training for, okay, recovering warrior squad
15 leader and platoon sergeants because there's
16 others. It's RW, yes, squad leader, yes, you
17 could do RW. Sorry.

18 Squad leaders, platoon sergeants,
19 AW2 advocates, section leaders and AFW2.
20 Perfect. I think that gets us there.

21 MR. CONSTANTINE: Does that
22 include the Marine equivalent of AW2 advocate?

1 I can't remember what the person's --

2 CAPT EVANS: Well, Safe Harbor?

3 They're the wounded warrior regiment, Navy is
4 Safe Harbor.

5 MR. CONSTANTINE: I know it's the
6 regiment, but what's the person? Is it a
7 squad leader or is it --

8 CAPT EVANS: Section leader.

9 MR. CONSTANTINE: Okay, so then
10 that will --

11 MSGT MACKENZIE: Before we go too
12 far, guys, if I can interrupt, I believe this
13 was joint training across the board, not RCC
14 training as in there's working in a joint, I
15 mean, this was the training we were talking
16 about where some people get some training,
17 some people get other training.

18 Why are we creating all these
19 different training elements when a
20 collaborative joint school on training in the
21 support of these positions?

22 MR. CONSTANTINE: So is, these are

1 saying all these different people are going to
2 get that same joint RCC training. You're
3 going to have folks in the Marine Corps who
4 are section leaders, you're going to have Army
5 folks.

6 MSGT MACKENZIE: If you look at
7 the findings, I believe it misses a big chunk
8 of what's in the findings.

9 MS. MALEBRANCHE: Is this the
10 world of RCCs, this group that's getting the
11 training, or is this RCC training for others
12 that are not RCCs? That's --

13 MR. CONSTANTINE: The latter.

14 MS. MALEBRANCHE: That are not
15 RCCs?

16 CO-CHAIR CROCKETT-JONES: It's
17 including some who are not RCCs.

18 MS. MALEBRANCHE: But some are?

19 CO-CHAIR CROCKETT-JONES: But some
20 are. Because in some places, platoon
21 sergeants aren't functioning as RCCs.

22 CO-CHAIR GREEN: I suggest that, I

1 mean, I'm hearing a dichotomy here. So I'm
2 hearing Denise say that this was to get them
3 to all attend a joint course that already
4 exists. And then I'm hearing you say that
5 it's not just that course, that it's beyond
6 that.

7 And so if that's, because the way
8 this reads, it could be that the RCC trained
9 these other people and that would meet the
10 intent. So the way this reads, you could have
11 said, I'll say it a little differently,
12 conduct joint RCC training on nonmedical case
13 management for all of those people.

14 Don't insert it yet. But you see
15 what I'm saying? Because if that's true, then
16 what I just inserted would pick up on what
17 you're saying, Mack. But if it's a specific
18 course, we might be better off just saying
19 that all these people will attend that course.

20 And I don't know the name of that
21 course, so if we don't --

22 MS. DAILEY: RCC training is the

1 name of the course.

2 CO-CHAIR GREEN: But see, that's,
3 the way this reads right now, it could be
4 interpreted that the RCC will provide training
5 for these other people instead of them going
6 to the RCC training.

7 MR. CONSTANTINE: Maybe we just
8 turn the sentence around and say all those
9 people will attend the DOD's joint RCC
10 training course, or --

11 CO-CHAIR GREEN: That would be
12 cleaner if that's what we're trying to do, but
13 that's still different than what you said.

14 MSGT MACKENZIE: Right, and that's
15 the, I mean, we send, SOCOM sends their folks
16 to RCC training in order for us to meet the
17 intent of providing RCC services to our
18 recovering warriors. Okay? But that only
19 covers that one aspect.

20 I mean, one of the, if you look at
21 the findings under this, you know, the other
22 big thing that we saw, like especially at

1 Landstuhl, you know, the lack of training of
2 those individuals, that it was on the job, it
3 was on the fly, I mean, there was quite a bit
4 of discussion amongst the task force about the
5 amount of training that was provided and as,
6 you know, the Army is building this fantastic
7 training school of all the personnel involved
8 with working with their recovering warriors.

9 You know, why is this, why is not
10 that same effort provided across the services?
11 You know, a section leader in the Marine Corps
12 doesn't need any less training than a squad
13 leader in the Army.

14 You know, so the squad leader
15 training in the Army, you have to be in a WTU
16 is X amount of time long, but, you know, some
17 of those fundamental training courses are
18 still the same, so I guess I --

19 (Simultaneous speaking.)

20 MSGT MACKENZIE: -- some of the
21 supporting documentation out of, the findings
22 out of this recommendation.

1 Because the findings talk about
2 this, that other training.

3 CO-CHAIR GREEN: Well, they can
4 always update the RCC training course to
5 include anything in that. So when we say a
6 DoD RCC training course, we're trying to
7 specify a common training for them rather than
8 setting up all these other things.

9 But then they could always expand
10 or improve upon the RCC training course. So
11 I don't think we have to take the findings
12 out, I think we just say that they need to go
13 to the joint DoD RCC training course and then
14 our findings tell them that they may want to
15 update the RCC training course.

16 Because what you're trying to do
17 is not get every service training their people
18 separate and then not, you know, doing the
19 right thing.

20 MSGT MACKENZIE: Well, correct, and
21 that's why when I was looking at this, I'm
22 looking at the, you know, we've moved a lot of

1 the medical training down to San Antonio, you
2 know, that joint training facility there at
3 SAMMC and you look at the, because Paragraph
4 Number 2 under the findings of this talks
5 about that joint training environment that we
6 were talking about through our findings.

7 Because RCC training doesn't do
8 anything for liaisons in Germany. RCC
9 training doesn't do anything for that whole
10 process at all. So sending an Air Force
11 person that's going to be a liaison in Germany
12 to RCC training is, quite frankly, a waste of
13 money.

14 And a waste of time. But yet
15 having a joint, that liaison, having a joint
16 liaison course or that, you know, we were
17 talking about the two-week course, so many
18 people are in Germany with no training, you
19 know I spent two weeks with my liaisons going
20 to Germany, but it's but anyway all I'm saying
21 is that --

22 CO-CHAIR GREEN: Let me try and

1 help.

2 MSGT MACKENZIE: -- the joint
3 training environment.

4 CO-CHAIR GREEN: On the, first of
5 all it shouldn't say well it should say
6 should, okay? And then at the end of that
7 line, after training course after the period
8 a new sentence, the DoD RCC training course
9 must be continuously updated with new
10 materials to improve the care for recovering
11 warriors.

12 Now your findings fit. Okay? All
13 right, does that help you?

14 MSGT MACKENZIE: I will concur.

15 CO-CHAIR GREEN: No? Take it
16 change it fix it so it'll work. How do you
17 make it so that that course is giving you what
18 you want? Because the problem is if the
19 Army's developing a course you can't say send
20 them all to the Army course that we think
21 they're going to develop which we think will
22 be better.

1 Okay, until you have a course to
2 say we're going to send them to you need a
3 baseline and then the following question is
4 how do you improve on the baseline?

5 MSGT MACKENZIE: And that was the
6 discussion. I mean that was the discussion
7 throughout the year was that who's got the, I
8 mean, because what you're saying you know,
9 you're saying that the WTU cadre course now,
10 doesn't need to be done?

11 It needs to be part of the RCC
12 course?

13 MR. CONSTANTINE: No, the Army can
14 make them go to that cadre course but they
15 have to go to the RCC course as well.

16 CO-CHAIR GREEN: We're
17 establishing a minimum, not the maximum. So
18 they can send them to anything they want to
19 after that.

20 MSGT MACKENZIE: Okay, so services
21 can still conduct their own training however
22 they want to, but --

1 CO-CHAIR GREEN: Right.

2 MSGT MACKENZIE: -- it's just
3 everybody has to have RCC training?

4 CO-CHAIR GREEN: They're going to
5 have to have the common minimum baseline. One
6 more comment on the structure of this. I
7 don't know that you need the the in before
8 care on this one. Now Justin may kill me on
9 this but I think it can be just, "to improve
10 care for recovering warriors".

11 MR. CONSTANTINE: I think that's
12 right. And in the findings instead of having
13 a long list of the -- for several different
14 agents, just call them transition unit staff.
15 Is that appropriate instead of this, in case
16 we miss somebody?

17 Like from Safe Harbor I don't know
18 what those people are called, you know what I
19 mean? So maybe, is transition unit staff a
20 good catchall or do we want to have them all
21 listed out, all those different people?

22 CAPT EVANS: Fleet liaisons are

1 equivalent to the squad leaders for the Navy
2 Safe Harbor, for the navy side so fleet
3 liaison. So you can still keep the section
4 leaders because they serve as section leaders
5 on the Navy side.

6 MR. CONSTANTINE: Okay, my
7 question is just, should we have transition
8 unit staff or list every position out?
9 Because what if there's a new title change or
10 something like that?

11 CO-CHAIR GREEN: Yes the problem
12 with, this is about nonmedical case managers
13 and management and so if you say transition
14 assistance, then that could include case
15 managers and nurses and, you know, even some
16 of your other benefits advisors.

17 So I think you need to be specific
18 because what we're looking for is those people
19 who are primarily responsible for nonmedical
20 case management advising.

21 MS. DAILEY: Correct. But I do
22 agree with Justin, we should put a Navy flavor

1 in here, a Navy nonmedical case management.
2 They are designated positions, so and you're
3 saying, ma'am, also, that the term section
4 leader will also cover any Navy individuals
5 providing nonmedical case management?

6 CAPT EVANS: Right.

7 MS. DAILEY: Okay, all right, I
8 think we can put a Navy flavor in there, too,
9 to capture the Navy.

10 CAPT EVANS: Right, and I may need
11 to come back and let me just make sure I got
12 the right terminology in there.

13 MS. DAILEY: We have it. We have,
14 we, it's probably just an oversight on our
15 part --

16 CAPT EVANS: Okay, is that
17 correct? Fleet liaisons would be the correct
18 --

19 MS. DAILEY: -- we didn't put a
20 Navy flavor in there. Now again, I just want
21 to be careful. If your intent in June was,
22 okay, we've got this RCC training, it's a

1 joint training, it would benefit this
2 community to do a joint training, that was the
3 intent.

4 The second part of this which you
5 just added is now a different recommendation
6 which says we're not sure you're updating it
7 on a timely enough basis. Make sure you do
8 that. So what is it?

9 Do we want another recommendation?
10 Is the intent here that RCC training is not
11 meeting requirements for updating and
12 adequacy?

13 CO-CHAIR GREEN: the truth is, I
14 don't know enough about the content of the
15 course, but if they are, if people are adding
16 a lot of training beyond this, then the
17 question would be, what can be done, if this
18 is going to be the minimum?

19 So if we take the second line off,
20 because I really am not commenting on the
21 quality of the course, I intended this just to
22 be, rather than people developing separate

1 courses, if there was a way to insert things
2 into the curriculum to meet needs.

3 That basically means that your
4 joint course is the course you need. So
5 again, I'm not commenting, I had no intent on
6 commenting on the content of the course other
7 than to say these things, you know, need to be
8 continuously working to improve care.

9 So if you think that's a separate
10 recommendation and that's a negative comment
11 on the course, that was not my intent. I was
12 trying to capture Mack's comments, which are,
13 there's a lot of other training that's out
14 there right now and we'd like for it to be
15 joint, but, you know, not everybody's going to
16 go to two months worth of training.

17 So again, I'm not hard over on
18 this second line, I'm just trying to capture
19 what Mack was working towards.

20 MSGT MACKENZIE: And that's fine,
21 we can remove that. The only thing I would,
22 I mean, and then in the findings I'd just

1 remove, my recommendation in the findings are
2 to remove the patient liaison at Landstuhl
3 comment.

4 Because that does not coincide
5 with RCC training. And that was not what was
6 brought up to us at Landstuhl or looked at,
7 was, RCC training has nothing to do with being
8 a liaison, nor does it have anything to do
9 with, certainly at Landstuhl.

10 So that statement would need to be
11 removed because it's talking about two
12 different types of training.

13 CO-CHAIR GREEN: Okay so basically
14 the family liaisons we have not included in
15 this, they have a different training?

16 MSGT MACKENZIE: Well it's a whole
17 different theory.

18 CO-CHAIR GREEN: Right.

19 MSGT MACKENZIE: It's a whole
20 different experience and responsibility, you
21 know, because it's, that's a totally different
22 world than RCC training.

1 CO-CHAIR GREEN: Let's just take
2 the Landstuhl comment out and eliminate the
3 second line, then. I got it. Yes, that's
4 fine. Let's just do that now and be done with
5 it. Okay. Got it. Any further comment on
6 this? Does anybody have any problems? Okay.

7 Thanks, Mack. I just didn't, I'm
8 not as familiar with what you're referring to
9 on the Landstuhl comment. Now I --

10 MSGT MACKENZIE: And that's,
11 between the findings and some of the wording,
12 it was attacking both of those topics. And
13 certainly we found that in many areas those
14 who were supposed to be filling the roles of
15 the RCC didn't have any of the training, which
16 was what was driving that training about the
17 RCC that we were talking about before.

18 But it's just the, now that we've
19 removed that other piece, then it's strictly
20 focused towards that RCC training, which is
21 good as it is now.

22 MR. CONSTANTINE: Mack, you're

1 saying the patient liaisons would not benefit
2 from RCC?

3 MSGT MACKENZIE: Absolutely not.

4 CO-CHAIR GREEN: So let's go to
5 14. Who's got it?

6 CAPT EVANS: I guess I'm in the
7 hot chair today. Continue? So we did not
8 change the wording, again. We just need to
9 eliminate the first three and I'm torn between
10 will and should.

11 Services will provide caregiver
12 services, so again, you have big letter
13 service and you have little letter, little s
14 service. Services. Without requiring
15 permission.

16 CO-CHAIR GREEN: I would change
17 that a little bit. What you're really saying
18 is provide services to caregivers, right? So
19 the services, I think, should provide services
20 to caregivers would be a little clearer.

21 Because of the recommendation I've
22 been changing them to should. Because will is

1 kind of a compliance thing and we're not
2 writing the regulations, here, we're kind of
3 giving recommendations.

4 And then when they put it in
5 policy it becomes will, if you see what --

6 CAPT EVANS: Yes, we need a word
7 other than services. They should provide.

8 MSGT MACKENZIE: Wouldn't that be
9 DoD?

10 CO-CHAIR CROCKETT-JONES:
11 Supports.

12 CO-CHAIR GREEN: Yes, it should
13 provide support to caregivers. Support is not
14 bad. I guess the question is that --

15 CO-CHAIR CROCKETT-JONES: And then
16 support should include --

17 MR. CONSTANTINE: some of those
18 things in that list --

19 CO-CHAIR CROCKETT-JONES: I don't
20 know about assessment. I think we can
21 eliminate assessment.

22 MS. DAILEY: Okay, the, you don't

1 want to run that sentence on. That sentence
2 has that first intent, which is without
3 requesting permission, so we don't want to
4 include, and those should, and without
5 permission.

6 CO-CHAIR CROCKETT-JONES: Yes.

7 MS. DAILEY: Discrete?

8 CO-CHAIR CROCKETT-JONES: Yes.

9 CO-CHAIR GREEN: What does
10 assessment mean?

11 CO-CHAIR CROCKETT-JONES: I don't
12 know. We think we can remove assessment
13 because I'm not sure what we were --

14 PARTICIPANT: Evaluation?

15 CO-CHAIR GREEN: But evaluation of
16 what?

17 MR. CONSTANTINE: Of what?

18 CO-CHAIR GREEN: Are we talking --
19 intake for the caregiver or intake for the
20 patient? For the recovering warrior?

21 CO-CHAIR CROCKETT-JONES: The
22 caregiver.

1 MR. CONSTANTINE: But what?

2 Mental, physical? How much do they know?

3 CO-CHAIR CROCKETT-JONES: What
4 resources they need.

5 MS. DAILEY: It's a holistic look.

6 CO-CHAIR GREEN: So maybe it
7 should include a needs assessment? Is that
8 what? I mean, I'm trying to figure out,
9 assessment is just too broad, so?

10 CO-CHAIR CROCKETT-JONES: I would
11 say needs assessment is, would be fine.

12 MSGT MACKENZIE: One of the terms
13 that was used was a comprehensive in
14 processing. Their coming-on orders to be the
15 caregiver for them, you know, you go through
16 that whole laundry list of, you know, do they
17 have the finances, do they have the, you know,
18 there's all this. But that was just something
19 that was brought up.

20 CO-CHAIR GREEN: One of the
21 problems is, you're kind of going from what
22 the caregiver needs to what the, so what's

1 counseling for recovering warriors' children
2 got to do with the caregiver?

3 CO-CHAIR CROCKETT-JONES:
4 Resources for them. And it's not just, this
5 is one of those area where we're not just
6 talking about assigned caregivers. It's
7 family members who are part of the recovery.
8 It's not assigned caregivers.

9 Not every spouse is assigned as a
10 caregiver. But they still don't need
11 permission to talk to her and give her an
12 avenue for finding resources.

13 CSM DEJONG: So do we change that
14 to family member?

15 MS. MALEBRANCHE: Support to
16 caregivers or support to family member or
17 spouse, then?

18 CO-CHAIR CROCKETT-JONES: I think
19 we want to say family member because sometimes
20 we've got someone, a child, mother, father,
21 a sibling.

22 CO-CHAIR GREEN: Yes, but don't

1 eliminate caregiver because it should be
2 family member/caregiver.

3 MR. CONSTANTINE: We used, let me
4 make a recommendation, where it says family
5 member and/or caregiver. Maybe we should
6 consider that.

7 CO-CHAIR GREEN: Yes. And so if
8 you say family members, okay, you could,
9 and/or caregivers without requiring, I still
10 think that it's odd saying counseling for the,
11 because RW's children are family members. Do
12 you know what I'm saying?

13 CO-CHAIR CROCKETT-JONES: And
14 really we don't necessarily, well.

15 MR. CONSTANTINE: Counseling
16 covers RW's children.

17 CO-CHAIR CROCKETT-JONES: Yes, we
18 can leave counseling for the children out,
19 it's all counseling that we might need.

20 MR. REHBEIN: How is financial
21 assistance different from financial
22 management? Financial assistance, to me,

1 sounds like if somebody's got financial
2 problems you come up with some money for them.

3 CO-CHAIR CROCKETT-JONES: And that
4 might be ACS loans or --

5 CO-CHAIR GREEN: But financial
6 assistance would cover all those.

7 CO-CHAIR CROCKETT-JONES: -- NGO.
8 Yes.

9 CO-CHAIR GREEN: Yes, so you can
10 take out financial management.

11 MS. DAILEY: Difference between
12 financial management and financial assistance?
13 Financial management is helping them if
14 they've got a budget that they need to align.
15 If they do have credit that needs to be
16 managed and how to pay it off and what
17 sequencing they do that in.

18 Financial assistance is about, I'm
19 about ready to get foreclosed on my house, I
20 need money.

21 CO-CHAIR GREEN: So just make it
22 financial management/assistance, okay, so that

1 you're not going to put another and in there.

2 MR. REHBEIN: That question is
3 simply an artifact of my unfamiliarity of some
4 of what goes on at those levels.

5 MSGT MACKENZIE: No, you're
6 absolutely correct because the management
7 piece is a huge thing, especially when you
8 deal with a new normal and the individual's
9 losing special pays, the financial, the family
10 member can't work.

11 There's a lot of financial impact
12 that's not necessarily addressed because
13 they're not counseled on how to we manage the
14 new financial status of this family.

15 CO-CHAIR GREEN: And that last
16 line is problematic, guys. This support
17 should meet the caregiver's needs that, and
18 are not tied? One, it's not grammatically
19 correct, but two, the, I mean, so the service
20 member does have HIPAA and Privacy Act
21 protection, so -

22 CO-CHAIR CROCKETT-JONES: This

1 one, I know why this was interjected. It was
2 because the reason for requiring permission
3 was given as concerns about HIPAA. But there
4 is nothing in violation of a recovering
5 warrior's HIPAA-protected information in
6 providing support services to a family member.

7 We wanted to reiterate that, but
8 if it doesn't need to be said, then it
9 doesn't.

10 CO-CHAIR GREEN: I think --

11 MR. REHBEIN: The way you think,
12 that case needs to be made in the findings,
13 not in the recommendation itself?

14 CO-CHAIR CROCKETT-JONES: That
15 would be fine.

16 CO-CHAIR GREEN: Well, wait, there
17 may be a better recommendation here. So when
18 does the RW, is unable to make HIPAA and
19 Privacy Act decisions, a principal caregiver
20 should be given that authority. Do you see
21 what, the difference?

22 CO-CHAIR CROCKETT-JONES: No, no,

1 that's a separate thing and that's, I think,
2 already in place.

3 CO-CHAIR GREEN: Okay, so I guess,
4 then, I don't understand your sentence.

5 MR. CONSTANTINE: Not talking
6 about, this is making sure that their
7 permission is not precluded by HIPAA, someone
8 saying, we'd like to give you that permission,
9 we'd like to let you do that, but we're
10 precluded by HIPAA from doing that.

11 CO-CHAIR GREEN: But what I'm
12 saying is, when the member cannot make a
13 decision as to who to designate.

14 MR. CONSTANTINE: We're not even
15 getting to it.

16 CO-CHAIR CROCKETT-JONES: We're
17 not even getting there.

18 MR. CONSTANTINE: That problem
19 exists, but the problem we've seen is someone
20 not, that scenario. Not that scenario. Just
21 someone saying, I would like to help you, but
22 it's a HIPAA. Just throws out there. It's a

1 HIPAA thing.

2 CO-CHAIR CROCKETT-JONES: Yes,
3 we've seen it at more than one installation
4 that the reason for not contacting any family
5 member to give them information on, say, how
6 to get in touch with, that the SFAC exists,
7 the reason for not making that phone call is
8 because you need permission.

9 And the reason for getting
10 permission is because you, somehow it would
11 violate HIPAA.

12 CO-CHAIR GREEN: So then you could
13 say, HIPAA and Privacy Act should not
14 interfere with providing required services to
15 the family member/caregiver. I mean, so your
16 recommendation can be very clear.

17 Support to family
18 member/caregivers.

19 MS. MALEBRANCHE: Because the
20 intent was not to keep information. It's not
21 going to work. We're not thinking that long.

22 CO-CHAIR GREEN: Right, so in

1 other words, we're not trying to give them all
2 the patient data, we're just simply saying
3 don't use HIPAA and Privacy Act to not provide
4 services? Right. So now get rid of the rest
5 of that. This support should meet the, get
6 rid of all that, that last sentence.

7 CO-CHAIR CROCKETT-JONES: And you
8 can eliminate the last sentence.

9 MS. DAILEY: I need you to be
10 clear. Is that what you want eliminated?

11 CO-CHAIR GREEN: Yes.

12 MS. DAILEY: All right.

13 MR. CONSTANTINE: In that list of
14 support, what is referral mean? Is that just
15 you letting people know about outside agencies
16 and stuff like that?

17 CO-CHAIR CROCKETT-JONES: Yes.

18 MR. CONSTANTINE: I think it
19 should be plural then or maybe appropriate
20 referrals.

21 CO-CHAIR CROCKETT-JONES: It says
22 as needed. You've got --

1 MR. CONSTANTINE: Then at least it
2 should be plural, then. It would make sense
3 if it's referrals.

4 CO-CHAIR GREEN: It's 2:20. I
5 vote for a bathroom break. Let's take five,
6 okay?

7 MS. DAILEY: Actually, isn't it
8 3:20?

9 CO-CHAIR GREEN: 3:20, let's take
10 five anyway.

11 MS. DAILEY: okay and just a
12 cautionary note, yes, take a break, come on
13 back. We do a lot of wordsmithing. We have
14 not voted on anything. If you come back
15 tomorrow and want to vote, you cannot
16 wordsmith again.

17 And we will be wordsmithing for
18 the next three days.

19 CO-CHAIR GREEN: We're very good
20 at wordsmithing.

21 MS. DAILEY: You're the best of all
22 that I've seen in my 10 years. But you'll

1 never get through the say, based on my
2 experience in 10 years, of wordsmithing again
3 before you vote.

4 (Whereupon this matter went off
5 the record at 3:21 p.m. and resumed at 3:33
6 p.m.)

7 MS. DAILEY: Okay, where are we at
8 here? D15.

9 CO-CHAIR CROCKETT-JONES: There is
10 a possibility that if we can get the language
11 right that 15 can be added on to 14. I don't
12 want to lose any of the intent.

13 But we've just talked about that
14 the family members need to get information
15 without worrying about permission and this is
16 just basically saying that someone needs to be
17 designated within each unit to do so.

18 LTCOL KEANE: The Marine Corps's
19 identified a person to do that and the DoDI
20 identifies a person to do that, the RCC.

21 CO-CHAIR CROCKETT-JONES: This
22 goes back to that whole changing RCC status

1 again and not everyone having an RCC.

2 LTCOL KEANE: If I could read one
3 of the findings. "Recovering Warrior Task
4 Force believes that having multiple points of
5 contact for family member needs can be
6 confusing for family members and defuses the
7 responsibility for ensuring these needs are
8 met." I don't think the answer is creating
9 another person.

10 CO-CHAIR CROCKETT-JONES: Yes, I
11 know. That definitely was not the intent.
12 The intent was that someone within the
13 structure needs to be the accountable person.

14 If it is the RCC -- I wouldn't
15 like to just say that we need to say the RCC
16 or the person identified as fulfilling that
17 job because if we say the RCC and family
18 members look and find they don't have an RCC
19 that will just make for more confusion.

20 MS. MALEBRANCHE: You know, one
21 thing that this group is looking at with the
22 comprehensive plan, they were talking about

1 some of their frustration. Captain Evans and
2 I were on yesterday about, you know, the FRC,
3 the RCC.

4 Regardless of who it is, they said
5 they need to have one point of contact on this
6 continuum and that that person should be known
7 by the recovering warrior and/or the family,
8 I mean, both. They should be known.

9 And that person may not always be
10 the same. At the acute phase it'll be one,
11 but then, you know, then it'll be someone
12 else.

13 And it's kind of hard to figure in
14 this setting, but part of this I think needs
15 to be in concert or allow that to happen, but
16 that's the essence of the very same thing
17 you're talking about.

18 This group has been talking more
19 about the recovering warrior, but that person
20 should be the same for the family. It
21 shouldn't be two different people, in my
22 estimation.

1 So I think it's still that single
2 point of contact we're looking for and in that
3 respect I understand what Colonel Keane's
4 saying. You don't want to create another
5 person.

6 But that one person has never been
7 there to begin with so that's what I think
8 this is looking for. I'm not quite sure how
9 we want to phrase that so.

10 CO-CHAIR CROCKETT-JONES: I know
11 that when we've gone to installations, the
12 problem that's trying to be fixed with this
13 recommendation, it comes from both sides of
14 the house.

15 Family members don't know who they
16 should call. They don't know who their
17 contact is.

18 And the folks that we talk to who
19 brief us never seem to have it in their
20 sights, unless we query, that this is
21 something for which they're accountable. It
22 seems pretty low on their radar.

1 I don't want to create a new
2 person. I just want their accountability
3 clarified.

4 MS. MALEBRANCHE: So how about we
5 say just something similar to that, that the
6 single point of contact or person responsible
7 for care should be identified clearly to the
8 family member, service member, at whatever
9 point, but it should be clear as to who the
10 single person is.

11 CO-CHAIR CROCKETT-JONES: And if
12 we can find a single sentence, we can actually
13 add that on to our Recommendation 14 and
14 eliminate 15.

15 MS. DAILEY: And I have to tell
16 you, ladies and gentlemen, they slid through
17 this one last year, all the services, so you
18 can do whatever you want. I don't think you
19 should combine them.

20 MSGT MACKENZIE: Let me provide an
21 example to help with this discussion. You
22 know, as I look back through my follow-up,

1 like right now I have an AFW2 advocate.

2 And although I'm very pro-active
3 and very informed, I'm the exception to the
4 rule.

5 But as I sat here as we were
6 looking at this and I read through it and then
7 I thought to myself, I was like, okay, who
8 follows up with my family?

9 Okay, I'm eight years post-injury
10 and then I realize that, you know, part of
11 that communication from my AFW2 advocate is
12 how's the family? Family's fine. And we
13 proceed on.

14 Okay, if my family wasn't fine,
15 there's no accountability to my AFW2 advocate
16 or requiring my AFW2 advocate to communicate
17 with my spouse.

18 So, you know, and it doesn't hurt
19 anything by them establishing that
20 relationship. But you're right, you know, at
21 one point it would be this person.

22 And as my single focal point of

1 contact as a recovering warrior changes, that
2 same person should also have the
3 responsibility of direct communication with
4 the family member, not through the recovering
5 warrior but directly with.

6 So his responsibility to me once a
7 quarter should also be the same responsibility
8 to my family member once a quarter. You know,
9 it's as simple as two phone calls or two
10 emails.

11 But the reality to it is that at
12 this point in time so far post-injury, I am
13 accountable for my family member. There's no
14 accountability for anybody else to check on my
15 family.

16 CO-CHAIR GREEN: I think we need
17 to be much more specific here because I think
18 we're going to get lost if we try to pick up
19 on what the AFW2 does.

20 And so I would not even say the
21 single point of contact. I think we're on the
22 right track. I'd say the principal point of

1 contact, okay?

2 So in other words, who is the --
3 it's not single because you're going to have
4 a thousand people that talk to you in these
5 things, but the principal point of contact
6 should be clearly identified to the family and
7 I wouldn't say member. I'd just say
8 family/caregivers, okay?

9 For RWs, both when, I wouldn't say
10 both, but when hospitalized or in a WTU. So
11 when they're out of the WTU, I think that the
12 system has a whole host of ways they provide
13 information.

14 But when they're in the WTU, the
15 problem is they're inundated by too many
16 helping hands and they need a principal point
17 of contact.

18 And so whether it's social worker
19 or RCC or platoon sergeant, whoever, that
20 principal point of contact has to be
21 identified, and that's the problem.

22 And I think the findings support

1 that, that people had who's the person we're
2 talking to? And so I think if we just say
3 that as a recommendation, then all the rest of
4 the stuff is kind of, you know, not necessary.

5 The findings support that and I,
6 Denise, think we should keep it separate from
7 the one above at least.

8 CO-CHAIR CROCKETT-JONES: Okay,
9 I'm happy to keep it separate and I know that
10 people are worried about, you know, this sort
11 of cacophony of too many helping hands.

12 But, you know, my husband's been
13 in a WTU for 450 days and I have never been
14 contacted by one single person in any shape or
15 form in any place from that WTU, not his AW2,
16 not any of the cadre, not any non-medical case
17 management, nothing.

18 So there might be some places
19 where the cacophony is from too many helping
20 hands, but I think that there's also plenty
21 who just never get any contact whatsoever.

22 CO-CHAIR GREEN: But I still think

1 that that's different than what Mac was
2 referring to when you're not in a WTU and the
3 AW2 representative is calling you on a
4 quarterly basis.

5 I mean, you could say that the AW2
6 is your principal point of contact but I think
7 the people who are having troubles with this
8 aren't people who are out in the follow on.

9 MSGT MACKENZIE: But what I was
10 getting at is that the principal point of
11 contact for the RW should be the principal
12 point of contact for the family member as
13 well, because I think if you add a different
14 person in here, you have potential
15 misinformation or two different scripts going
16 on.

17 All I was trying to say was that
18 whatever that, now that I've gotten some more
19 words from you guys, that principal point of
20 contact for the recovering warrior should also
21 be the principal point of contact for the
22 family and directly interacting with the

1 family so does that --

2 CO-CHAIR GREEN: So you would
3 change this to say the principal point of
4 contact should be clearly identified to the
5 RW/family/caregiver? Okay.

6 CO-CHAIR CROCKETT-JONES: No I
7 think that dilutes it can we not say it that
8 way? How about say the principal point of
9 contact for the family/caregivers and then in
10 parentheses say the principal contact for the
11 RW, the same --

12 DR. TURNER: So what you're saying
13 is there should be one principal contact for
14 both the caregivers/family and RW clearly
15 identified.

16 CO-CHAIR CROCKETT-JONES: Clearly
17 identified to the family members.

18 DR. TURNER: Right.

19 CO-CHAIR CROCKETT-JONES: Yes.

20 DR. TURNER: So just you're
21 identifying there is the principal contact is
22 for everybody and they're clearly identified.

1 That is the person that shepherds this RW and
2 this family through the process?

3 CO-CHAIR GREEN: Yes, I mean, I
4 think everybody thought that that was going to
5 be the RCC and so, you know, for those --

6 But the problem is that those
7 definitions and RCCs have made it really
8 confusing.

9 MSGT MACKENZIE: And that's like
10 the example that I gave before and I'll
11 present that example again.

12 When I was a liaison and I was
13 dealing with my guys in the facility, I was
14 that principal point of contact.

15 I was communicating with all the
16 resources but talking to both the service
17 member, the recovering warrior, but I was also
18 the principal point of contact to the family
19 for these resources, okay, which was, it was
20 a matter of liaising all the resources.

21 You know, I'm not doing
22 everybody's job. I was just if the family

1 member picked up the phone and call one
2 person, they contacted me and I would clear up
3 or leverage the resources to make sure that
4 was getting done.

5 And throughout the process, there
6 always should be one principal point of
7 contact.

8 You know, if you got 100 business
9 cards, there's got to be at least one that you
10 can call that's always going to get you
11 straight and I think that's what we were
12 trying to get to.

13 But that same point of contact
14 should be the same for the family and
15 caregivers as well, and they should be
16 accountable to those folks.

17 CO-CHAIR GREEN: From a wording
18 standpoint, there should be one principal
19 point of contact for the RW which should be
20 clearly identified with easy contact
21 information.

22 MSGT MACKENZIE: And that

1 principal point of contact should also be for
2 the family.

3 DR. TURNER: Who is also the
4 principal contact.

5 CO-CHAIR GREEN: Who is also the
6 principal contact for the family/caregiver,
7 okay?

8 MR. CONSTANTINE: One principal
9 point of contact for RW when? For everything?

10 CO-CHAIR CROCKETT-JONES: Whatever
11 their principal point of contact is at
12 whatever stage they are.

13 So if they're still in the
14 hospital and their principal point of contact
15 is their nurse case manager, then it makes
16 sense that if --

17 MS. MALEBRANCHE: All right, so
18 when you're in the acute phase in the ICU, you
19 might have an acute care manager.

20 When you are released from the
21 facility, you'll have a different person but
22 that person will be the same for your family,

1 so it's one person.

2 You know, we're already having
3 trouble with transitioning from the recovering
4 warrior so now we're going to have the family
5 too but they should be a unit. I mean, they
6 should all know --

7 CO-CHAIR CROCKETT-JONES: Exactly.

8 MS. MALEBRANCHE: -- the same
9 person, same information at the same point in
10 time.

11 So I think that's what we're
12 trying to get to also with this comprehensive
13 plan. At different points in the plan, it'll
14 be different people.

15 But it shouldn't matter to the
16 service member. They should just know, I used
17 to work with you and now I'm going to be
18 working with you and my family will come to
19 you.

20 CO-CHAIR GREEN: So why don't we
21 add there should be one principal point of
22 contact for the recovering warrior in every

1 phase of recovery, okay?

2 And then make it a separate
3 sentence, okay? This principal point of
4 contact should also be -- should also serve as
5 the principal for the family/caregiver.

6 MSGT MACKENZIE: Or just put this
7 person also serves as the principal point of
8 contact for the family/caregiver.

9 CO-CHAIR GREEN: Yes, also serves.
10 So this individual also serves as the
11 principal point of contact for the
12 family/caregiver.

13 MSGT MACKENZIE: It will be this
14 individual also serves. So get rid of
15 principal point of -- right, there you go.
16 Then put in individual.

17 CO-CHAIR GREEN: And then just end
18 the sentence by saying principal point of
19 contact for the family/caregivers. We need to
20 talk about easy access but I guess that's good
21 enough.

22 PARTICIPANT: That's good.

1 CO-CHAIR GREEN: Yes, that may be
2 good enough.

3 CO-CHAIR CROCKETT-JONES: We
4 should also probably indicate that they have
5 to proactively contact.

6 CO-CHAIR GREEN: Okay, so
7 family/caregivers and proactively --

8 MSGT MACKENZIE: And have a
9 proactive engagement plan.

10 CO-CHAIR GREEN: Yes, engage the
11 family/caregiver. You had it right. You just
12 want it to be the principal point of contact
13 for the family/caregiver.

14 But I'm not sure about the
15 proactive. This individual also serves the
16 principal point of contact for the
17 family/caregiver and should proactively engage
18 the family/caregiver.

19 MS. MALEBRANCHE: Maybe make a
20 third sentence. The individual should
21 proactively engage.

22 CO-CHAIR GREEN: That would be

1 okay too.

2 MR. CONSTANTINE: Well, that is a
3 nebulous statement because you mean every time
4 something comes up they reach out to the
5 family? Every ten days? Whenever they feel
6 like it? What does that mean? And we
7 shouldn't have language that leaves a lot to
8 interpretation.

9 CSM DEJONG: I would leave that
10 last sentence out.

11 CO-CHAIR GREEN: Okay, so do we
12 need to say anything about easy access or
13 contact information? That's the only other
14 question.

15 CO-CHAIR CROCKETT-JONES: My only
16 concern, and maybe we can come up with the
17 right language for this, is that as we leave
18 it, they don't have to do anything. They
19 don't ever have to contact.

20 CO-CHAIR GREEN: Yes, my worry too
21 is that essentially the hospital will know who
22 that principal point of contact is but the

1 family/caregivers won't.

2 DR. TURNER: Well, this gets back
3 to what she was saying about her experience.
4 No one contacted her and she didn't know who
5 to talk to.

6 So I think clearly identified,
7 which was up there before, you know, they need
8 to be clearly identified who the point of
9 contact is and very easily accessible to that
10 person.

11 And if you want to put a minimum
12 recurring contact on it, you could do that.
13 You don't think that works?

14 MSGT MACKENZIE: I agree with what
15 you're saying where they were about to tie up,
16 which was it should be one easily identified,
17 readily available principal point of contact
18 for the recovering warrior in every phase of
19 recovery.

20 So there should be one easily
21 identified, readily available principal point
22 of contact for the recovering warrior in every

1 phase.

2 CSM DEJONG: I think clearly
3 identified.

4 DR. TURNER: Clearly.

5 MSGT MACKENZIE: I mean, does that
6 meet it because it's --

7 CO-CHAIR CROCKETT-JONES: We still
8 aren't saying anything about them establishing
9 their availability to the family member.

10 MR. CONSTANTINE: In the
11 recommendation before this, we said they have
12 to do a whole bunch of things.

13 CO-CHAIR CROCKETT-JONES: In the
14 recommendation before this, we said they don't
15 need permission to do those things.

16 DR. TURNER: So you want to say
17 something, initial contact is the
18 responsibility of this principal individual.

19 CO-CHAIR CROCKETT-JONES: Yes, I
20 think we should. I think we --

21 MS. MALEBRANCHE: Well, you know
22 what, part of this individual who's taking

1 care of the recovering warrior, part of the
2 plan is they have to engage at different
3 points.

4 I mean, I guess we can't assume
5 that, but part of the plan is to engage the
6 recovering warrior and/or the family and that
7 might be something we need. The family should
8 be in the plan.

9 CO-CHAIR CROCKETT-JONES: Well, I
10 know that the family is in the plan already
11 and, like I've said, 450 days and, you know,
12 and I'm available, yes.

13 CO-CHAIR GREEN: Initial and
14 ongoing?

15 CO-CHAIR CROCKETT-JONES: They
16 need to at least establish an initial contact
17 and if you want to say initial and ongoing
18 that sounds good too.

19 CO-CHAIR GREEN: Let's simplify
20 this. The individual also serves as the
21 principal point of contact for the
22 family/caregivers and should ensure they have

1 easy contact information.

2 CO-CHAIR CROCKETT-JONES: Okay,
3 they could meet that by giving a paper to the
4 RW which never, ever goes home.

5 MS. MALEBRANCHE: I actually have
6 a copy of something I'm going to just show you
7 from Massachusetts General Hospital that does
8 exactly that.

9 I just happened to get this from a
10 patient the other day and I think that that's
11 one of those clearly identified.

12 I know we can't put that specific
13 of something, but that I'm going to start
14 working with our folks to use as who should I
15 contact?

16 CO-CHAIR CROCKETT-JONES: That's
17 great, and I'm telling you that this doesn't
18 happen. And also, even with the best
19 intentions, if you've got a guy with severe
20 TBI, this paper might never get there. This
21 person needs to --

22 CO-CHAIR GREEN: Okay, I

1 understand what you're trying to do but, you
2 know, you're not going to be able to get
3 everybody to do this.

4 So if they have contact
5 information and if your initial and ongoing
6 contact with the family/caregiver is the
7 responsibility of this individual, then you've
8 actually said what you're asking, right? I
9 mean --

10 CO-CHAIR CROCKETT-JONES: I
11 thought someone was going to, they were
12 eliminating initial and ongoing contact. If
13 we leave initial and ongoing contact in, then
14 we're fine.

15 CO-CHAIR GREEN: Okay, so let's
16 take out the "easy" on contact information,
17 and ensure they have contact information,
18 okay?

19 And then finally you say initial
20 and ongoing contact with family/caregiver is
21 the responsibility of this individual.

22 Now, is caregivers always plural

1 or is it singular? I thought it was a single
2 person that was a caregiver. Is it more than
3 one?

4 MR. CONSTANTINE: I think
5 generally should be one because one person is
6 designated.

7 CO-CHAIR GREEN: That's what I
8 thought. So I'd make your caregiver singular
9 in these things because there's only going to
10 be one designated time. There may be more
11 than one over time, but there's typically only
12 one if they're --

13 CAPT EVANS: So did we agree to
14 leave 14, 15 as separate recommendations?

15 CO-CHAIR GREEN: Right. Now, that
16 second paragraph kind of gets eliminated,
17 right?

18 CAPT EVANS: Right. That's why I
19 was going to, okay, although I do like the
20 fact that we kind of asked for a
21 professionally trained individual but I know
22 that's --

1 CO-CHAIR CROCKETT-JONES: If it's
2 the person who's principal for the RWs, they
3 will be trained.

4 MR. CONSTANTINE: When we say and
5 should ensure their contact information, what
6 does that mean? Are we ensuring your family
7 members have the contact information for this
8 person or vice versa or what?

9 LTCOL KEANE: If we're getting rid
10 of that second paragraph, are we kind of
11 leaving this out there without actually
12 tasking or making a recommendation of who
13 should clearly identify?

14 CSM DEJONG: That should be
15 identified in 14.

16 CO-CHAIR CROCKETT-JONES: Well, I
17 think when we identify it as the same person
18 who is the contact for the recovering warrior,
19 they are identified at this point in the
20 various stages, correct?

21 LTCOL KEANE: Correct.

22 MSGT MACKENZIE: You know, the

1 same level of requirement and accountability
2 to recovering warrior, by connecting the two
3 pieces, that same level of accountability and
4 requirement to the family member.

5 CO-CHAIR GREEN: We're all over
6 this thing so let's come back to Justin's
7 comment. Justin, you're right. We don't need
8 and should ensure they have contact
9 information. That can come out, okay, because
10 the last line gives us that.

11 The other piece of this in terms
12 of each service should identify one
13 professionally trained individual, you know,
14 the question is is Suzanne right?

15 So if it's the person who's also
16 the principal contact to the recovering
17 warrior, do we need this? That's what we need
18 to hear from you guys because we're basically
19 defining it for the family members as somewhat
20 different.

21 But here, is there someone who's
22 not professionally trained that's going to be

1 the principal contact to the recovering
2 warrior? If not, then you probably don't need
3 the first line.

4 CAPT EVANS: Right. When you read
5 on, you know, lately, because of all these
6 task forces and groups, I've been just doing
7 a lot of reading on care transition and care
8 coordination.

9 And I tell you, there's a solid
10 handoff from either case manager/social
11 worker, social worker/social worker, case
12 manager/case manager. We have so many layers
13 in there that we need to really define.

14 And I don't want to tell the
15 services. I don't want to get into the
16 services telling them who should be the lead.

17 But, again, there's a difference
18 between a case manager, licensed, practical,
19 you know, or a licensed nurse that's trained
20 as a case manager and RCC.

21 There's a major difference and
22 those folks have to follow, you know, they

1 have organization standards that they have to
2 follow. RCCs, they don't.

3 So when I look at a case manager
4 to say the coordination of care, I know the
5 standards that they have to follow. I don't
6 know the standards of a RCC other than they've
7 been trained by the DoDI.

8 At some point we have to say
9 professionally trained means that I have a
10 nurse handing off to a nurse, I have a social
11 worker handing off to a nurse or I have a
12 social worker, and it's the same for the
13 social workers. They do the same. They have
14 a standard that they have to follow.

15 CO-CHAIR GREEN: That all makes
16 sense when you're talking the clinical care,
17 okay? It doesn't make sense when you're
18 talking about financial assistance or other
19 things.

20 And so I hear you but I'm kind of
21 going, you know, the case manager may or may
22 not choose to get involved in that, knowing

1 that there's all these other resources that
2 are available.

3 So assigning one principal -- I
4 mean, it may make sense for the case manager
5 to be the one when they're in the hospital.

6 It may make sense for, depending
7 on the diagnosis, for the case manager, the
8 medical person, because of the number of
9 medical appointments and what's going on, to
10 be the one in that phase of therapy. But then
11 there's a period of time when it's not a case
12 manager anymore and so --

13 CAPT EVANS: I agree, sir. And
14 what I see though, that case manager should be
15 able to reach down to that non-medical person
16 to ask the question what's going on
17 financially for those non-medical?

18 I don't know if that person really
19 should have to go to a non-medical person for
20 those, you know, and I understand. I mean,
21 there's the argument right there that we're
22 having at these different groups, but you got

1 to have one person.

2 In the Army they have case
3 manager/case manager, although their single
4 point of contact is their squad leader, or is
5 it squad leader?

6 CO-CHAIR GREEN: The only
7 difference between what you're saying and what
8 we're saying is we didn't specify who it
9 should be.

10 By saying one clearly identified
11 in each phase of recovery, then they can pick
12 the case manager to be the principal person or
13 in a different phase of recovery they can pick
14 the RCC to be the principal person, if you see
15 what we're saying.

16 So I think we're okay on this
17 because we don't want to say this person has
18 the top authority in terms of what's going on
19 because it may be different in different
20 phases of recovery.

21 As soon as you say professionally
22 trained individual, you know, you say, okay,

1 do we have anybody who's not a professionally
2 trained individual who becomes a principal
3 contact to a recovering warrior?

4 And if the answer is yes, then we
5 can put that line back in and we can keep that
6 second paragraph.

7 If the recovering warrior's always
8 going to have a professionally trained
9 individual, then it's redundant and so that's
10 the question.

11 If it's going to be the same one
12 the recovering warrior has, then it should be
13 appropriate to their phase of recovery and
14 that should be enough.

15 But if you think we need to say
16 professionally trained, then we need to put
17 this other paragraph back in.

18 And by the way, I think that the
19 second line after, the ones that are scratched
20 out, I would take the rest of that paragraph
21 and leave it in there.

22 Provide this individual the

1 requisite tools and equipment to help meet the
2 caregiver's needs, for the needs of the family
3 members as opposed to caregivers. Ensure the
4 NMCM is specified in DoDI.

5 I'd leave that all in. I think
6 that that actually adds to this. It makes it
7 much more specific.

8 And I just don't know whether I
9 need the first line because I think as soon as
10 we made it the same principal point of contact
11 as the recovering warrior has, by definition,
12 it's already trained.

13 MR. CONSTANTINE: Captain Evans,
14 you said that it's also for the principal
15 point of contact to be a RCC and you don't
16 think RCCs should say professionally trained,
17 right?

18 CAPT EVANS: Okay, that's a good
19 argument. Well, I'm going to say, yes, they
20 are because they receive standard training.
21 When I see professionally trained, again, I'm
22 a nurse, you know --

1 MR. CONSTANTINE: You think a
2 degree is coming after that name.

3 CAPT EVANS: Exactly, right.

4 MR. CONSTANTINE: Right, a one-
5 week course doesn't cut it, right.

6 CAPT EVANS: So, you know, you can
7 argue, say, yes, they were professionally
8 trained.

9 Not only do they do the one-week
10 course but they also have to work with that
11 service to do training to learn the service
12 that they RCC for so, again, you can argue
13 that they are professionally trained.

14 I think we're going to have to
15 look at the standard that we want to set for
16 our warriors. And the standard, do we want to
17 say we're okay with the RCC?

18 And I can tell you, there's a big
19 fight out there right now between RCCs and the
20 case managers because the case manager is
21 saying you don't tell me what to do because I
22 am a certified case manager.

1 And the RCC says we own the DoDI.
2 We own the recovery care plan and we do tell
3 you what to do as far as non-medical so, I
4 mean, it's just a huge ongoing issue.

5 CO-CHAIR CROCKETT-JONES: But I
6 think that we don't have to tackle that issue
7 on this recommendation.

8 We're saying however that pans
9 out, whoever winds up being the principal for
10 the recovering warrior, that's also a
11 principal for family members and I think that
12 we tackle that with this.

13 CAPT EVANS: Right. And if you
14 look at it right now, it is the RCC for one
15 service. They are the principal point of
16 contact for the warrior and for the family
17 member.

18 And they kind of manage some of
19 the issues that the case managers, you know,
20 they reach back to the case managers in
21 telling them we need to make sure this is done
22 or have they been to their medical

1 appointments?

2 So, you know, again, we can go
3 with the wording. That's fine. But I think
4 the service is going to come back and tell us,
5 well, here's who we want it to be and this is
6 who we define. They're going to define that
7 for us.

8 MR. CONSTANTINE: That's a good
9 point and I guess if we say that every RW
10 deserves a professionally trained individual
11 and by that we mean someone who's gone to
12 school and has an acronym after her name,
13 whether it's social worker or caregiver, that
14 we're doing a disservice to them by letting
15 the RCC substitute as that.

16 However, if we're all convinced
17 that an RCC provides enough services that we
18 are comfortable with, then it's a moot point.

19 MSGT MACKENZIE: The thing about
20 this recommendation as written, okay, this
21 provides the flexibility.

22 I mean, trust me when I say that

1 through personal experience, you know, when I
2 had a recovering warrior and family that had
3 a nurse case manager with 20 years of
4 experience, okay, I did a whole lot less in
5 that aspect than I did with the one who had a
6 case manager with five years of experience.

7 The flexibility of that single
8 point of contact and the amount of work, the
9 amount of advocacy and leveraging of resources
10 changes based on these other professionals
11 that are involved at the different continuums
12 of care.

13 And what it does is it creates a
14 point of contact to get things done. This
15 point of contact is not necessarily the one
16 making the decisions.

17 It is this is somebody that they
18 trust that's continuously communicating with
19 them, that is working through all of this
20 stuff, okay? It's not the person doing the
21 work.

22 I mean, very often I was the

1 principal point of contact but I'm not a nurse
2 case manager. I'm just simply the guy they
3 can always get a hold of and I can go talk to
4 their nurse case manager and say here are some
5 of the concerns.

6 CO-CHAIR GREEN: Yes, and my
7 problem with what's going on here is so, Mac,
8 you're really effective and so is Constance,
9 okay?

10 MSGT MACKENZIE: Right.

11 CO-CHAIR GREEN: And so the trick
12 here is that I don't want to decide who's best
13 for a family.

14 MSGT MACKENZIE: Exactly and this
15 allows it to be the right person.

16 CO-CHAIR GREEN: Right, I really
17 think the family should decide and so I think
18 we should leave it as is with this cut out and
19 I think we've got it covered, okay?

20 DR. TURNER: So this is basically
21 whoever's on the team already, one of those
22 people is the wrangler that goes and makes

1 sure, the expediter if you're a ramp guy like
2 me. You know, they're the ones that make sure
3 the mission gets off.

4 CO-CHAIR GREEN: And by the way,
5 the family or the patient is going to have a
6 lot of say in this because if they really like
7 working with a nurse, then that's maybe their
8 principal point of contact.

9 And if they really like working
10 with the non-medical case manager, that may be
11 their point. And that's okay, okay? That's
12 okay. This becomes about communication
13 skills, not about professional skills.

14 MS. MALEBRANCHE: That last
15 sentence, though, where it says for the needs
16 of family members as opposed to caregivers
17 ensure the non-medical case manager as
18 specified provides similar services and
19 outreach, does that imply the other one's a
20 medical case manager? No?

21 CO-CHAIR GREEN: Didn't catch
22 that. You're right. So just take out that

1 line. You're right.

2 That's actually the counterbalance
3 to the professionally trained, isn't it? So
4 you guys wrote this so that it covered both.
5 I got it. Yes, this was the battle of the
6 non-medical versus the, yes, I got it.

7 Okay, provides them the requisite
8 tools and equipment to help meet the
9 caregiver's needs. This individual must be
10 provided, is that what you want?

11 MR. CONSTANTINE: Never mind, I'm
12 sorry. That's good to go.

13 CO-CHAIR GREEN: Okay, good.
14 Thanks. Anybody with anything else on this
15 one? Done.

16 MSGT MACKENZIE: Who's the
17 recommendation to?

18 CO-CHAIR GREEN: What's that?

19 MSGT MACKENZIE: Who's the
20 recommendation to?

21 LTCOL KEANE: Thank you. That's
22 what I was going to say. It looks like a

1 statement, not a recommendation. We need to
2 add the services.

3 MSGT MACKENZIE: Like services,
4 DoD, the hospital?

5 MS. MALEBRANCHE: At some point
6 it's going to be VA too, is it not? In every
7 phase of recovery.

8 MS. DAILEY: This one would be a
9 services recommendation. This needs to go to
10 the services to accomplish this.

11 CO-CHAIR CROCKETT-JONES: So each
12 service should clearly identify.

13 CO-CHAIR GREEN: Right. Good.
14 Each service should clearly identify a readily
15 available principal point of contact. That's
16 good. I think we stop while we're ahead.

17 CO-CHAIR CROCKETT-JONES: Do we
18 want to consider going back and voting on this
19 first 15 or do we want to continue?

20 MSGT MACKENZIE: I say we continue
21 because we've got time to vote tomorrow. I
22 mean, there's a lot of wordsmithing that has

1 to happen. I'm not going to vote on anything
2 that's not been wordsmithed.

3 So we might as well continue in
4 the wordsmith spirit and knock out as much as
5 possible because, I think a lot of these
6 recommendations it is a simple voting process
7 -- we're going to burn through the voting
8 because the recommendations are clearly
9 supported as standing for a vote.

10 CO-CHAIR GREEN: Okay, why don't
11 we do this, okay? I don't know if we have the
12 ability to print the ones that we've got.

13 But we would see if we could give
14 everybody a copy of 1 through 15 or whatever
15 the numbers are so that tomorrow first thing
16 we're going to vote on the ones that are done,
17 see if we can't put them aside, okay?

18 And that way we don't have to keep
19 revisiting, all right? So let's see if we can
20 get a written copy. That way we don't have to
21 go back and wordsmith them.

22 We just give you something to look

1 at tonight and you can jot down if you're
2 uncomfortable with something and then anybody
3 who's uncomfortable with something, we'll talk
4 that tomorrow.

5 And then we'll vote however many
6 we get through today so that we're kind of
7 done with those unless we see something that
8 can be combined. Is that okay?

9 MS. DAILEY: I can do anything you
10 want but I'm not clear on what you want so.

11 CO-CHAIR GREEN: The ones we
12 wordsmithed, so we're through 15 now? Yes.
13 So when we finish today, if we could get 1
14 through 15 printed so people can look at them
15 and that way tomorrow we'll just go 1, 2, 3,
16 4, whatever they are, that we've gone through
17 today and see if we can't get those off our
18 plate.

19 MS. DAILEY: Okay. Are we
20 planning on continuing and you want me to do
21 all of them?

22 CO-CHAIR GREEN: We're going to

1 continue and see how far we get and however
2 many we get through is what we'll print out
3 and try to give people to take home to look at
4 tonight.

5 MS. DAILEY: Yes, okay, good. I
6 got.

7 CO-CHAIR GREEN: All right, 16.

8 MS. DAILEY: And one more
9 question. I'm sorry, I've just got to be
10 clear.

11 If we get through 16, you're happy
12 to wait for whatever it takes for me to print
13 them out for you, right? Or do you just want
14 me to start printing now 1 through 15?

15 CO-CHAIR GREEN: How late are we
16 going tonight?

17 MS. DAILEY: I was going to go to
18 6:00 at this rate, two more hours.

19 CO-CHAIR GREEN: We've got 42, is
20 that correct? Forty-one?

21 MS. DAILEY: Forty now, yes, 40.

22 CO-CHAIR GREEN: So we've got 40?

1 MS. DAILEY: Correct.

2 CO-CHAIR GREEN: So I'd say we
3 need to get through 20 today.

4 MS. DAILEY: Okay.

5 CO-CHAIR GREEN: All right? So
6 let's get through 20 and then we'll print out
7 those 20 and let you look at them tonight and
8 call it a day for today and see if we can't
9 get the other 20 tomorrow, okay?

10 MS. DAILEY: Okay.

11 CO-CHAIR GREEN: Sixteen.

12 MR. CONSTANTINE: We may not even
13 need to print them out. We could email them.

14 CO-CHAIR GREEN: That'd be even
15 better if everybody has email access, but just
16 in case, okay? Yes, if you want to email them
17 to us or print them out, whichever way.
18 Sixteen, let's keep going.

19 CSM DEJONG: Sixteen, we didn't
20 change much other than after process, CRP/CTP
21 process and upon entrance into the IDES the
22 services should educate.

1 Basically what we were trying to
2 wrap up there is that at different phases of
3 their care and as they enter different things
4 you're going to get potential benefit changes,
5 potential income changes, potential access to
6 resources that you didn't have before.

7 CO-CHAIR CROCKETT-JONES: The idea
8 was that if they're not entering IDES, it
9 would be bad timing for resources.

10 CO-CHAIR GREEN: I guess my
11 question is why do you need as part of the
12 CRP/CTP process?

13 Why don't you just say upon
14 entrance into the IDES systems, the services
15 should educate family members and caregivers
16 on potential benefit changes?

17 CSM DEJONG: That's fine too.

18 CO-CHAIR GREEN: So do it at the
19 outset, you see what I'm saying?

20 CSM DEJONG: That's fine.

21 CO-CHAIR GREEN: Because otherwise
22 you'd have to do it, you know, early on when

1 they're still thinking they're going to stay
2 on active duty so.

3 MR. CONSTANTINE: What about that
4 last sentence? Is that necessary?

5 CSM DEJONG: No.

6 CO-CHAIR CROCKETT-JONES: Go
7 ahead, Denise.

8 MS. DAILEY: Yes, I think it's
9 important that instead of saying we're already
10 doing this, which is what we get, that they
11 can start pointing to their products that do
12 this.

13 I mean, we're using the Marine
14 Corps example of the color pages that they are
15 disseminating to all their service members as
16 the model actually or the apps.

17 DR. PHILLIPS: I might suggest
18 that we expand apps then to other social media
19 resources.

20 CO-CHAIR GREEN: Yes, or just put
21 social media in front of apps. It would have
22 been fine.

1 MS. DAILEY: The real intent is
2 that it's about family services, not services.
3 It's about the family services, not just VA
4 services, that these are specifically tailored
5 to family services.

6 MR. CONSTANTINE: So are you
7 saying right now there's apps out there that
8 are just for family services?

9 MS. DAILEY: I'm saying there are
10 not.

11 CO-CHAIR GREEN: Yes, but just put
12 a comma before apps. Okay, we're okay with
13 all the different things you want to put in
14 there. We're going to come back to it.

15 There's another problem with this
16 which says that informational briefing early
17 in the recovery process. What do we mean by
18 that?

19 Do we want them to get an
20 informational briefing early in the recovery
21 process that's separate from what they get
22 when they're in IDES?

1 So I have to come back to the
2 briefers. I had to take out that phrase but
3 are you wanting them to do it, you know, like
4 so somebody's in the hospital. You want them
5 to know what the differences are if they
6 separate?

7 MS. MALEBRANCHE: Well, you know,
8 one of the things they do, and I don't know if
9 this was thought about, but it's like the DTAP
10 and the TAP and so when they're in the
11 hospital they do get that transitional
12 assistance briefing.

13 And if this is for family members
14 and not just VA, it's all listed in that first
15 sentence as VA, you would have to put, "comma
16 VA resources and others," because there's also
17 some state resources that families need to be
18 made aware of if they're in that process.

19 If they're going to be going to a
20 certain state and if they've got a child with
21 certain needs, there are other things that
22 need to be in there as well.

1 CO-CHAIR GREEN: But make it other
2 VA/state resources.

3 MS. MALEBRANCHE: It could be,
4 right. It could be just VA resources and
5 other resources, but there are state things
6 that I know are important.

7 Some families choose to go to
8 certain states because of the benefits that
9 they can get, particularly if they're
10 residents.

11 But for the informational briefing
12 part then, informational briefings could be
13 that transition assistance, the DTAP and the
14 TAP.

15 MSGT MACKENZIE: I disagree, and
16 the only reason I do that is because when you
17 look at the recommendation as a whole, okay,
18 there are people in phases of their recovery
19 where this is an absolute waste of time.

20 As a matter of fact, family
21 members and others don't even go to it or tell
22 them not to bother them because they're so

1 early in the process, thinking about
2 transition is irrelevant.

3 But I do strongly, you know,
4 support the IDES process because what we're
5 doing is, that's a 300-day window. That's
6 when the magic's really going to happen.

7 And those individuals going into
8 IDES are, you know, the services are achieving
9 that 90, 95 percent entry into IDES that are
10 going out.

11 You know, they're beginning to,
12 you know, professionally find ways where
13 they're not putting people into IDES that are
14 going to stay on active duty.

15 And the preponderance of people
16 going into IDES will be going out and that is
17 the time when these people are striving for
18 this information and they're striving for the
19 currency and relevance of the information.

20 If you've got an individual with a
21 severe TBI and it's going to be a year and a
22 half before he goes through IDES, whatever you

1 provide them early on is going to change
2 between now and then and what that recovery
3 plan's going to be.

4 So, I mean, it could be in there
5 but I don't think it's really necessary
6 because I don't find it to be effective.

7 CO-CHAIR CROCKETT-JONES: I think
8 we want to make it early in the IDES process,
9 not in their recovery probably.

10 CO-CHAIR GREEN: Yes, let me make
11 a suggestion. So because of that last line,
12 we really don't need anything after
13 "entitled," okay?

14 So put a period after "entitled,"
15 and take that line, don't, yes, I was going to
16 tell you to, never mind. Go ahead. Yes, put
17 that down at the end for just a second before
18 the new. That's good.

19 And so now the final question on
20 this is, you know, informational briefings
21 early in the recovery process are encouraged.
22 Do you see what I'm saying? So right now what

1 we took out of this is anything that's earlier
2 than IDES.

3 And so anything that you could
4 provide to somebody earlier in the process,
5 especially if they go to apps and social media
6 and things, to tell them the things they could
7 be looking at would be very useful to someone
8 who's trying to make a decision on whether
9 they're going to separate or not. And so
10 informational briefings on, what's the --

11 MS. DAILEY: Family-specific VA
12 services.

13 MS. MALEBRANCHE: Yes, I think
14 because not everybody's in IDES the 300 days
15 but I think just offered in that time if they
16 want them, because if they have to establish
17 residency in a state and that's going to take
18 six months, they need to know that some point
19 earlier than the last day of the IDES.

20 CO-CHAIR GREEN: I think that what
21 that does is it gets back to what they put in
22 this at the beginning where they said, so this

1 now basically says do this stuff with social
2 media apps, fact sheets, pamphlets and then
3 provide informational briefings on where they
4 can get information if they're interested.

5 MSGT MACKENZIE: And not just VA
6 resources but I'm talking about the beginning
7 of the IDES process.

8 I'm a big fan of once you are
9 identified as beginning the IDES process, this
10 begins your transition. All this stuff should
11 start happening at that point, not at the end
12 of IDES, not anywhere later in that.

13 This is part of that beginning to
14 me, is that if you're going to IDES, you know,
15 this is transition minded. You know, if
16 something's determined that you can stay on
17 active duty, yes, that's different.

18 But I do agree with the last
19 statement that these briefings on family-
20 specific services early in the recovery
21 process.

22 I don't think we should just limit

1 it to VA. I mean, state service, I mean, all
2 this information should be encouraged.

3 MR. CONSTANTINE: SSDI.

4 MR. REHBEIN: Mac, I'd be very
5 careful about promising them state
6 information.

7 There is no single resource that I
8 know of to go to get information on a given
9 state except that state, so you wind up going
10 to all 50 states and trying to analyze what it
11 is they offer. It's very difficult.

12 I've had the governor ask us to
13 find out where we stand as opposed to some of
14 the other states in veterans benefits and it's
15 a very difficult process.

16 MS. MALEBRANCHE: Well, and it's
17 not just veteran benefits. I understand what
18 you're saying, Dave, so maybe we say other
19 resources.

20 But I know that our VA liaisons in
21 the different facilities get a release form
22 and they get it signed and they send it to the

1 state and the state reaches out, sometimes
2 through these transition assistance advisors.

3 But that's, you know, that's not
4 everybody, but they do have that ability, so
5 other resources.

6 But there's also Department of
7 Labor, Social Security, I mean, there's a
8 number of other resources and usually the case
9 manager care coordinator helps them with that
10 so it's not just a single one I guess.

11 CO-CHAIR CROCKETT-JONES: So I
12 think that if we just say family-specific
13 services, then we've covered it.

14 CO-CHAIR GREEN: Services, right.
15 Take out the VA. And honestly, Mac, I think
16 we covered yours when we put in the upon
17 entrance to IDES. So in other words, we're
18 trying to get it right after they enter, okay?

19 MSGT MACKENZIE: Correction, the
20 only thing I request is that when those
21 resources to which they may be qualified for,
22 and take out the word entitled.

1 MS. DAILEY: And we should also
2 take out that "they" and put the word families
3 in there so that we keep the attention on the
4 family services.

5 CO-CHAIR GREEN: For which they
6 are qualified.

7 MR. REHBEIN: Or for which they
8 are eligible.

9 MS. DAILEY: For which families
10 may be eligible.

11 MS. MALEBRANCHE: But we're saying
12 upon entrance into the IDES and the recovering
13 warrior is one who enters the IDES.

14 CO-CHAIR CROCKETT-JONES: For
15 which families may become eligible or --

16 MS. MALEBRANCHE: Yes, because the
17 warrior is the one going in the IDES, not the
18 family. So, I mean, we just have to be
19 consistent.

20 CO-CHAIR GREEN: Yes. You're
21 going to have to change it. You're going to
22 say may be eligible to receive, okay? So,

1 yes, so be eligible to receive. I think that
2 captures it.

3 MSGT MACKENZIE: I just wanted the
4 word entitled removed. Whatever you come up
5 with.

6 CO-CHAIR CROCKETT-JONES: And it's
7 still for, resources for which.

8 MR. CONSTANTINE: No, just take
9 out completely. Resources which families --

10 CO-CHAIR CROCKETT-JONES: Yes,
11 just eliminate, there we go.

12 MSGT MACKENZIE: So we can just
13 put upon recovering warrior entrance into
14 IDES.

15 MR. DRACH: Resources is a very
16 big term, or it's a very broad term. We don't
17 talk here about all the non-profit
18 organizations that are out there providing
19 things.

20 As Karen mentioned, you've got
21 OPM, you've got DOL, you've got HHS, you've
22 got HUD and you've got a whole plethora of

1 federal agencies that may touch these
2 individuals.

3 And as for the state benefits, it
4 may not be all inclusive but the National
5 Resource Directory is certainly a template to
6 start with in terms of looking at all of the
7 benefits and all of the services and all of
8 the resources that are out there.

9 And if you saw some of the
10 discussion on some of these recommendations,
11 the National Resource Directory is under-
12 utilized tremendously.

13 And if you recall, about a year or
14 so ago former Chairman of the Joint Chiefs
15 Admiral Mullen mentioned how important it was
16 for the service members and the services to
17 emphasize the use of the National Resource
18 Directory.

19 CO-CHAIR GREEN: I think you're
20 right. We just take out the VA/state and just
21 make it and other resources.

22 MR. CONSTANTINE: I agree with

1 that. But resources which they may be
2 eligible to receive. You don't receive
3 resources, right?

4 CO-CHAIR GREEN: Okay, so then
5 you're back to "for which families may be
6 eligible," period, so the "for" makes it work.
7 Going, going --

8 MSGT MACKENZIE: The --

9 CO-CHAIR GREEN: Oh, so close. So
10 close.

11 MSGT MACKENZIE: Mr. Drach doesn't
12 always catch everything so I just want to make
13 sure his comment is being addressed which is,
14 you know, should that just quite simply be VA,
15 federal, state and other resources?

16 I mean, why do we have to
17 specifically mention caregiver program and vet
18 centers?

19 It should just be VA, federal,
20 state and other resources and that way it's
21 flexible but yet the compartments are
22 directed, you know.

1 MS. DAILEY: And it's too broad.
2 They end up trying to cover too many bases and
3 miss them all. I mean, there are some
4 specific hand offs to the VA that caregivers
5 aren't receiving and families know nothing
6 about.

7 CO-CHAIR GREEN: So leave it VA
8 caregiver programs, vet centers and other
9 federal and state resources for which they may
10 be eligible.

11 That covers the gamut, federal and
12 state, unless there's any international things
13 out there I don't know about, okay?

14 MSGT MACKENZIE: The thing is for
15 which they may be eligible. What that does is
16 the person that is providing this briefing
17 must now determine and work with them to
18 determine what is eligible.

19 MS. DAILEY: And we're asking the
20 services here to do pamphlets and apps, so
21 we're asking them to dig into their pocket.

22 The bottom line is you're going to

1 have to draw some priorities here on where
2 they're going to spend that money to get the
3 families transitioned to another phase of
4 their life.

5 And so maybe you don't want it to
6 be the VA, but if you want that transition to
7 happen to the VA, you're basically asking them
8 to invest in information, briefings, apps,
9 paper, to get them to the VA.

10 CO-CHAIR GREEN: Yes, and I think,
11 Mac, you're over-reading for which families
12 may.

13 You could be at a broad-level
14 briefing talking about types of federal and
15 state resources without necessarily talking to
16 them about specifics unless they have the
17 right injury or something and then you can
18 talk to them about specifics.

19 So we're just talking about giving
20 them information right now, so I think we're
21 okay.

22 MSGT MACKENZIE: Okay, I just, I

1 guess, and I'm not wording this correctly and
2 I'm taking up a lot of time so forgive me.

3 But it's just the generalized
4 briefings, the generalized information go into
5 a box or into the circular file because it's
6 just too much information to try to sit down
7 and read while kids are crying, things are
8 happening, guys are going back and forth to
9 appointments.

10 You know, if we're going to
11 provide these folks information, let's provide
12 them the information that's valuable to them
13 and not just provide them information.

14 Otherwise, this can all be
15 encompassed by here's the website to the
16 National Resource Directory.

17 MS. MALEBRANCHE: Well, the
18 reality is it should be part of that
19 comprehensive care plan too.

20 I mean, that should be all part of
21 it and that point of contact should know you
22 have this issue. You have a special child.

1 You need this. There are no international
2 ones.

3 But just as a technicality, as
4 we're writing this report when you talk about
5 vet centers I think we should address them,
6 their technical name is Readjustment
7 Counseling Centers so just so people know that
8 that is one and the same.

9 So at some point we have to just
10 annotate that. I don't know if we do it at
11 the beginning or whatever. But I do think,
12 Mac, the comprehensive care plan --

13 CO-CHAIR GREEN: You can make it
14 Readjustment Counseling Centers. That's more
15 specific. Is that what you want it to be?

16 MS. MALEBRANCHE: That is more
17 specific but that is what a vet center is just
18 so people are aware. I don't know if people
19 are aware of either/or. You could put it in
20 parens or something.

21 CO-CHAIR GREEN: Well, I'm not
22 sure it adds much. That's okay, just leave it

1 vet.

2 The other question I have is if
3 you're interested, Mac, in taking this one
4 step further because this one was really about
5 making sure they got briefed on potential
6 things out there.

7 But if you look at what we did in
8 the last one, you could actually say the
9 principal -- I don't remember how we worded
10 it.

11 But the principal point of contact
12 in this phase of therapy should target
13 services and talk with the family about
14 targeted services, right?

15 I mean, so this may be somebody
16 completely different that essentially now is
17 going to help them get through the IDES.

18 MS. DAILEY: Well, then that last
19 line is about the services making this
20 information available in a variety of
21 information delivery systems.

22 So if you're holding that

1 individual responsible, who's got the ball
2 here for --

3 CO-CHAIR GREEN: Well, if we're
4 going to go this way and put the principal
5 point of contact should discuss targeted
6 resources, then I would take out the
7 informational briefings on family-specific
8 services because that becomes confusing.

9 So I'd take out that sentence if
10 we're going to go after targeted. Originally
11 I thought we were trying to just make certain
12 that they had information.

13 But, Mac, you're taking it to a
14 different level so is this what you want?

15 MSGT MACKENZIE: I mean, I may be
16 wrong. You know, when I get ready to
17 transition, you know, there's about 45 states
18 that I really don't care what their services
19 are because I'm not going to go to any one of
20 those 45 states.

21 So getting a briefing on
22 generalized information isn't going to assist

1 me and my family as much as this is my
2 transition plan. This is where I intend to
3 go. Let's talk about where I'm going, not
4 necessarily where I could potentially go.

5 I mean, it can be generalized
6 early on but as you get to that transition
7 plan, I mean, you're looking to help them find
8 an idea as to where they're going, where
9 they're transitioning to.

10 And so, I mean, it's a point of
11 discussion. I mean, if that's not where we're
12 going, that's fine.

13 CO-CHAIR GREEN: But do you like
14 this one better? Do you like it ending this
15 way?

16 MSGT MACKENZIE: I don't because
17 the flexibility of the previous
18 recommendation, it provides that point of
19 contact to leverage resources.

20 It doesn't insist that that point
21 of contact be educated in all the information
22 and deliver that information.

1 You know, because if the RCC is
2 the principal point of contact, he doesn't
3 know what a nurse case manager does but he
4 knows how to get a hold of the nurse case
5 manager working with that patient to make sure
6 that the family knows what's going on.

7 So it's, you know, the principal
8 point of contact isn't responsible for knowing
9 everything. They're responsible for knowing
10 who in each question is the person they need
11 to talk to.

12 CO-CHAIR GREEN: Okay, I got it.
13 So let's get rid of the principal point of
14 contact for this phase of recovery and make it
15 legal and PEBLO, okay, should discuss targeted
16 resources.

17 I mean, I'm not even sure PEBLO is
18 the right -- legal and VA representatives at
19 this point, right, because at this point
20 they'd have access to VA representatives.

21 MSGT MACKENZIE: I mean, am I
22 taking everybody down a rabbit hole? I mean,

1 I need more input here.

2 I don't want people to be just
3 saying, okay, you know, because I talk louder
4 that everybody's going my way. I mean, are we
5 meeting the intent of this or.

6 CO-CHAIR GREEN: Yes, get rid of
7 for this phase of recovery. So legal and VA
8 representatives should discuss targeted
9 resources with individual families.

10 Okay, so now it's not part of the
11 briefing. This is about getting to, these are
12 the things that probably apply to us.

13 CAPT EVANS: I thought I was on.
14 I'm sorry. That RCC shouldn't be providing
15 that education, that information.

16 They should be referring to the VA
17 liaison, to that person who knows the
18 information, so they should not be providing.
19 So I think this covers the intent of it.

20 CO-CHAIR GREEN: Going, gone.

21 Okay, 17.

22 CSM DEJONG: Other than changing

1 the beginning to "the services should require
2 that upon," I think it's pretty
3 straightforward. You know, we did not change
4 a whole lot of this in our small group.

5 CO-CHAIR GREEN: Okay, Justin, I
6 like this one. What are you going to change?

7 MR. CONSTANTINE: With that kind
8 of introduction --

9 MSGT MACKENZIE: Do you need the
10 word "that" or should it just be "services
11 should require?"

12 (No response.)

13 CO-CHAIR GREEN: Going, going,
14 gone. We got it. Justin, you can look at it
15 tonight. We'll check it out tomorrow. He
16 reserved the right. Number 18.

17 CSM DEJONG: Eighteen we made no
18 changes to.

19 CO-CHAIR GREEN: Need to change
20 the front of it again, the services should.

21 CSM DEJONG: Right.

22 MR. CONSTANTINE: There's a policy

1 now that's outstanding on invitational travel
2 orders, right?

3 I mean, there's guidance already
4 and so aren't the services, they have to
5 comply with those policies, right, or is there
6 a lot of flexibility in there?

7 CO-CHAIR GREEN: The problem, as I
8 understand this one, we're seeing very high
9 divorce rates in some of the reservists
10 because of long times in WTUs, WWRs.

11 Since they can't PCS them,
12 evidently by law, the question is how do we
13 solve this so?

14 CSM DEJONG: This was targeting
15 the Navy, sir, to where they have east and
16 west.

17 And out of some of the focus
18 groups that came out of there from the
19 discussions, I was not in the focus groups
20 specifically, but it was a 50 percent or
21 higher rate of divorce due to the separation.

22 MR. CONSTANTINE: Well, are the

1 service members saying, hey, I want my wife to
2 be here and they're saying no?

3 CO-CHAIR CROCKETT-JONES: Yes,
4 specifically at Portsmouth there was no place
5 to locate those family members.

6 The only available accommodations
7 were bachelor quarters and they weren't
8 letting families come and visit reservists in
9 med hold in Portsmouth.

10 And they had no place to put
11 families if they came to visit. They needed
12 to have invitational travel orders in order to
13 get hotel accommodations.

14 MS. DAILEY: But the discussion
15 broadened into also getting people down to
16 WTUs and --

17 CO-CHAIR CROCKETT-JONES: Yes,
18 that was just the extreme sort of example.
19 This was also the case in other places.

20 MSGT MACKENZIE: The question is
21 how much time is a trigger to liberally use
22 ITOs, you know, because it says "who cannot be

1 treated in the home community are delayed at
2 the MTF" for 5 days, 10 days, 100 days?

3 I mean, there has to be a point,
4 otherwise they could say unless it's greater
5 than 365 days.

6 I mean, there's too much leeway in
7 this recommendation for that timeline. Do we
8 know what we learned from those visits to tell
9 us what's a reasonable delay time?

10 CO-CHAIR GREEN: Yes, the other
11 problem with this one on the same line is
12 delayed at the MTF. What if they're delayed
13 in the WWR or the WTU?

14 In other words, you know, keeping
15 reservists, this isn't always the MTF. It's
16 sometimes about long periods of time at the --
17 so you may want to not be as specific at the
18 MTF.

19 Who cannot be treated in the home
20 community and are delayed for greater than 30
21 days. Do you see what I'm saying?

22 MSGT MACKENZIE: In a post-

1 deployment health or a post-deployment
2 recovery cycle or --

3 CO-CHAIR GREEN: Yes, and are
4 delayed greater than 30 days.

5 MSGT MACKENZIE: Sergeant Major,
6 what is the normal time frame on redeployment
7 without any medical issue whatsoever?

8 CSM DEJONG: Generally looking at
9 14 days.

10 MSGT MACKENZIE: So anything
11 greater than 14 days or 30 days. Like it
12 can't be less than 14 days because that's a
13 standard part of the deployment process.

14 MS. DAILEY: Yes, we're not
15 talking about that time period. We're talking
16 about people brought back on active duty,
17 centrally located away from home getting
18 conjugal visits essentially.

19 MSGT MACKENZIE: So that's delayed
20 greater than 30 days? I mean, I just want to
21 make sure we're putting the right time frame
22 on there.

1 And the reasons for seeing my wife
2 and my children are, although different,
3 they're still valuable so.

4 MR. CONSTANTINE: I wonder if we
5 ought to say and are delayed greater than 30
6 days. It's kind of awkward language.

7 CO-CHAIR GREEN: Why don't we say
8 are delayed greater than 30 days for medical
9 treatment or disability processing.

10 That would cover pretty much
11 everything. And then I think that's a period
12 at the end of that, okay?

13 And then we start a new sentence
14 that says is important to preserve family
15 dynamics and keep family members engaged in
16 the recovery process.

17 LTCOL KEANE: I'm sorry, sir.
18 Could you repeat that?

19 CO-CHAIR GREEN: It is important
20 to preserve family relationships or dynamics,
21 I'd say family dynamics, and keep family
22 members engaged in the recovery process. Yes,

1 that would do it.

2 That's much better than conjugal
3 visits. I'm not sure it's better than
4 conjugal visit but it sounds better on paper.
5 All right, take a peak at it. Justin, help me
6 out.

7 MR. CONSTANTINE: If somebody's on
8 active duty, they don't need ITOs or --

9 CO-CHAIR GREEN: They actually can
10 be --

11 MR. CONSTANTINE: There's some
12 other process, right.

13 CO-CHAIR GREEN: They can actually
14 be PCS so there's lots of ways for the active
15 duty members, but for the reservists they
16 haven't been using invitational travel orders
17 and that's one of the things we're
18 highlighting.

19 MSGT MACKENZIE: Or they're at
20 their home duty station receiving care but --

21 MR. CONSTANTINE: Looks good.

22 CO-CHAIR GREEN: Number 18 are we

1 on board, reasonable words? Okay, 19.

2 CO-CHAIR CROCKETT-JONES: Okay, we
3 struggled. Well, we looked at this one and we
4 were good with the intent, although I have to
5 say if I had my way I would not worry about
6 this recommendation as much as a
7 recommendation to change the name of the
8 National Resource Directory.

9 I believe one of the reasons it's
10 not utilized is because its name has
11 absolutely nothing to do with wounded warriors
12 or recovering warriors or soldiers or service
13 members or anything. National Resource
14 Directory is totally, it's off --

15 MR. CONSTANTINE: Sounds like a
16 government clearinghouse.

17 CO-CHAIR CROCKETT-JONES: Yes, it
18 sounds like it's just a federal information
19 center for any citizen.

20 I think that the intent that
21 started for this was that we were talking
22 about that there needs to be a DoDI to make

1 the websites clear on their purpose and to
2 designate a portal so that something with high
3 visibility can lead to the proper resources
4 and call centers and information.

5 So there, I threw that out to
6 everybody because I think we need to work on
7 this.

8 DR. PHILLIPS: Is there any reason
9 why we can't recommend the name change?

10 MS. DAILEY: We're happy to do
11 that. That's well within your purview.

12 DR. PHILLIPS: Recovering Warriors
13 Resource Directory.

14 MSGT MACKENZIE: I go back to I'm
15 not as much concerned about the name because
16 it's a very valuable website. Regardless of
17 what you call it, it's still a direction that
18 you send these folks to.

19 My problem with these websites is
20 there is no way, they have not created and
21 adamantly oppose any way of validating that
22 this actually works for recovering warriors

1 and their family members.

2 I mean, it's not that it's not a
3 valuable tool. There's no feedback loop and
4 there's no way of saying that this stuff
5 really works for those that it was intended
6 for.

7 You know, some of the things that
8 we run into when you're looking at these
9 things that we're doing for our recovering
10 warriors, they bleed over to the force as a
11 whole which National Resource Directory has
12 done.

13 But at the end of the day, it was
14 designed for recovering warriors. You know,
15 are we seeing to it that it's meeting those
16 needs?

17 CO-CHAIR CROCKETT-JONES: Have we
18 not heard briefings saying that they are
19 working on a way to categorize the users?

20 CSM DEJONG: I don't know if we
21 can ever truly capture that, but what we have
22 captured in the focus groups is that the

1 National Resource Directory is not the first
2 place that anyone goes because they really
3 don't know what it means. They don't know.

4 If you line five resources up on a
5 board and ask family members which one are you
6 going to go to, the National Resource
7 Directory is not the first one that they're
8 going to go to because they can't identify
9 what resources they're going to get from that.

10 MR. DRACH: I think, you know,
11 there's a couple of comments on the table
12 about that and I think they're all right and
13 you made a very good point, that NRD or
14 National Resource Directory.

15 But I think, you know, we've come
16 to use the NRD as a generic term. Like a
17 Xerox machine is, you know, it doesn't matter
18 whether it's a Canon or whatever it is. It's
19 a Xerox machine.

20 I was just looking and I couldn't
21 find it but I think the subtitle is a handbook
22 for, you know, wounded, ill and injured or

1 something like that so, yes.

2 But the other thing is and I saw
3 in some of the comments that those that did
4 use the NRD found it to be pretty useful. The
5 high percentage found it useful.

6 But the NRD folks can tell us how
7 many unique hits they get monthly but I don't
8 know if they can, I can find out, whether or
9 not they can tell you what subject areas were
10 sought after or what links they went to.

11 But I know they can tell you how
12 many unique hits they're getting but it's down
13 right now.

14 CO-CHAIR CROCKETT-JONES: What we
15 don't know right now is if the hits that they
16 get come from recovering warriors or their
17 family members.

18 There is a way for people entering
19 into use of a website to designate their --
20 like a category of person. And there was --
21 I'm not positive, but I believe it was
22 Military OneSource. We do know that one of

1 the websites was going to create a method for
2 people entering to indicate who they are, not
3 specifically, but what type of user they are.

4 Are they a service member, a
5 family member, unrelated user? And I think
6 that that would be helpful on all these
7 websites so that we can track how much use
8 they are.

9 But I also think that the name
10 change is important, because -- you said it
11 perfectly. If you look at a list of websites,
12 National Resource Directory does not sound
13 like one that is targeted for recovering
14 warriors, and yet you go to it and it's really
15 easy to use.

16 And some of the others, like
17 Military OneSource, are not targeted for
18 recovering warriors. They have a broader base
19 and they have a lot more information that can
20 make it harder to get to what you need. So I
21 see both points. I think they're two separate
22 issues.

1 DR. PHILLIPS: Let me just add, I
2 mean, our findings show very little use of the
3 National Resource Directory.

4 I agree with everything that's
5 been said but perhaps we need to recommend a
6 campaign of awareness. Name change, fine.
7 But somehow educate people that this is out
8 there for them to use.

9 MSGT MACKENZIE: Let me throw this
10 out there too. The websites that are on the
11 National Resource Directory, you can get to
12 those resources without going through the NRD,
13 okay?

14 So you get on the NRD once, write
15 down 20 websites. You never go back to NRD
16 again because the 20 websites you want you
17 already have.

18 MR. CONSTANTINE: Can we consider
19 maybe scrapping this recommendation because -
20 - I don't even understand what it means on the
21 rules and responsibilities of it.

22 CO-CHAIR GREEN: If I can try one,

1 because I was thinking the same thing, Justin,
2 but I think there may be some value here.

3 How about if we make it WWCTP
4 should codify, we won't say DoDI, but they
5 should codify a process to clear online sites
6 and informational resources that should be
7 available through a single portal to
8 recovering warriors, families and caregivers.

9 So in other words, they need to
10 get a single portal that they say these are
11 approved sites, things that we know you're
12 going to get accurate information. And people
13 come through us to get their stuff listed in
14 that portal. That would actually serve people
15 very well.

16 MS. DAILEY: That is what the NRD
17 does, sir. That's exactly what it does.
18 Everyone who's listed on there has gone
19 through a vetting process and is certified to
20 be there.

21 MR. CONSTANTINE: Mr. Burdette
22 came up here gave us his spiel and he said,

1 you know, all those numbers and they can track
2 those analytics.

3 They know people don't feel
4 comfortable saying I'm here as a wounded
5 warrior. They don't -- never going to
6 identify that. But they have the information
7 already so I don't really see what this adds.

8 CO-CHAIR GREEN: So the easier
9 way, then, if we say that that's what the NRD
10 is, then the other recommendation that would
11 make sense here is rename the National
12 Resource Directory to X. So Recovering
13 Warrior Portal, okay? I mean, whatever, RWP.
14 I mean, you know, and name it whatever.

15 Be clever, but we can just get rid
16 of everything and say rename the National
17 Resource Directory to more effectively reach
18 recovering warriors.

19 MS. DAILEY: Okay, and we'll do
20 that. That's a great recommendation. I just
21 want to remind you of your legislative
22 mandate.

1 The legislative mandate is
2 information resources and it lists
3 specifically five or six items, only one of
4 which is the National Resource Directory.
5 Websites, call-ins and so -- what's that?

6 PARTICIPANT: Hotlines.

7 MS. DAILEY: Hotlines. So your
8 legislative mandate is to look at all these
9 items and to, you know, see if these resources
10 are being used efficiently, to -- what are the
11 redundancies, again, the efficiencies of all
12 these resources.

13 And so the intent of this
14 particular recommendation, which we talked
15 about in June and I walked you through what
16 the legislative mandate says, was to make DoD
17 get their arms around all of these resources,
18 try and eliminate redundancies, try and
19 streamline these information resources, so
20 that's the intent.

21 I'm happy to pull this out. That
22 was the intent and that's why it's here. And,

1 yes, you know, a recommendation that tells DoD
2 to market NRD more aggressively is very easy.
3 But that's not the mandate.

4 And last year on recommendation --
5 we slid into this information resources piece
6 by mentioning the NRD with the keeping it all
7 together package and that's the only place you
8 touched it.

9 And so this year, in an effort to
10 kind of get a better, more comprehensive look
11 at this legislative requirement, we're in this
12 camp. But I'm happy to either pull it or we
13 can just deal with the NRD.

14 CO-CHAIR CROCKETT-JONES: Are the
15 SFACs -- are those part of the same, because
16 we do have several TAPs on the Assistance
17 Centers as well in this information resource
18 topic.

19 MS. DAILEY: Correct. Congress
20 listed the information, the SFACs and the
21 Family Assistance Centers, in the legislative
22 mandate to review information resources. Now,

1 I'm happy to pull it.

2 CO-CHAIR GREEN: Denise, I don't
3 know where you're taking this, because the
4 problem is that what was defined in the
5 original recommendation you're telling us is
6 already done by the National Resource
7 Directory.

8 And so then the other side of the
9 discussion is, well, we don't like the
10 National Resource Directory because people
11 aren't using it because it's not named well.

12 So I guess, I mean, I'm kind of
13 like are we -- is the problem that we're not
14 seeing the, you know, the screening of the
15 sites that makes the -- or is it just that
16 nobody's using it? Because if nobody's using
17 it, you're right, we can just go after
18 marketing. But that's the question.

19 So, I mean, as it's written here,
20 essentially it says WWCTP write a DoDI on
21 rules and responsibilities and dissemination
22 of information by websites, online resources,

1 call centers and other information.

2 Well, DoDI will not affect a lot
3 of these things because too many of them are
4 done by outside agencies.

5 And so what you really need is a
6 clearinghouse that says this is good
7 information, it's been approved to be on. And
8 that's why I kind of went the next level.

9 But if you tell me the NRD is
10 already doing that, that they already have a
11 codified process for how they do that, then
12 it's just a marketing problem.

13 MS. DAILEY: It's just not about
14 the NRD, sir. I mean, Congress asked us --

15 CO-CHAIR CROCKETT-JONES: Congress
16 also asked us about streamlining and
17 redundancies, which is not covered by this
18 recommendation.

19 CO-CHAIR GREEN: Right, so, I
20 mean, you're not covering screening or
21 redundancies here. There's nothing in here --
22 rules and responsibilities and dissemination

1 of information by websites, online resources,
2 call centers -- I mean, so we're not tackling
3 what you're saying based on what the words
4 are.

5 That's all I'm saying. I mean,
6 I'm not arguing for or against one or the
7 other, I'm just saying the words aren't
8 helping us with what you're saying our charter
9 is.

10 MSGT MACKENZIE: I think, just to
11 use an example, you know, when you use the
12 term portal, you know, and I think of the Air
13 Force Portal, I literally take all of this
14 information that's available for an Air Force
15 member and I literally create my own page with
16 the information that applies to me, you know.

17 And I know at times I've run
18 across something and I forget about it. Two
19 months later, I'm like, where did I find that?

20 You know, instead of trying to
21 create a one size fits all area, how about we
22 create an area where each individual has

1 access to the information and creates their
2 specific information, you know, where I can
3 take and pull in these different sites into my
4 page and go, I get in, I log in and boom,
5 here's all my stuff that I found thus far.

6 CO-CHAIR GREEN: But the Air Force
7 Portal is restrictive on what you can link to,
8 okay, based on their codified rules.

9 MSGT MACKENZIE: But I'm just
10 saying that's an example.

11 CO-CHAIR GREEN: No, no. It's a
12 good example because that's what I thought we
13 were moving towards is -- so give me a portal
14 that I can say this is the stuff I want out of
15 the National Resource Directory or this is the
16 stuff I want to show up on my computer when I
17 look at it.

18 MSGT MACKENZIE: Like Military
19 OneSource and contact centers and all that
20 stuff.

21 CO-CHAIR GREEN: Right, whatever
22 they are. But then what Denise said was that

1 that already exists.

2 MSGT MACKENZIE: No, no, no. It
3 doesn't.

4 CAPT EVANS: So do we have a list
5 of everything that, according to our mandate,
6 do we have --

7 MS. DAILEY: Yes, we've been over
8 it. Can we go back to your question about
9 what is the National Resource Directory
10 providing?

11 I'm sorry, ma'am, to cut you off.
12 I need to stay on track with the line of
13 questioning that Mac is on and that General
14 Green is on.

15 What is the National Resource
16 Directory doing? It is vetting everyone who
17 comes and wants to list their agency on the
18 National Resource Directory.

19 That is a function of the National
20 Resource Directory. Now, how does that differ
21 from what you're talking about?

22 MSGT MACKENZIE: What I'm talking

1 about is, okay, so now there's 20,000 pieces
2 of information that have been vetted by the
3 National Resource Directory.

4 MS. DAILEY: Correct.

5 MSGT MACKENZIE: And I'm using a
6 fictitious number.

7 MS. DAILEY: No, actually, that's
8 correct.

9 MSGT MACKENZIE: And I want 5000
10 of that. But if I access the National
11 Resource Directory, I find some things I like.
12 I get distracted.

13 Two months later I go back to do
14 it again, all of that process to find and
15 whittle down those things I was looking at two
16 months ago, I must do again.

17 If I have a portal, a place where
18 I create my environment, where once I pull
19 that into, every time I log into that
20 environment -- and that can be inside the
21 National Resource Directory -- but once I
22 create that environment, all that information

1 is there for me.

2 That's what I think we have
3 realized, is that there's very positive, very
4 quality information, it is all there. It is
5 all available to the recovering warrior.

6 The question is are we looking at
7 this where we should be, you know, providing
8 a portal site that the recovering warrior and
9 their family create an environment connecting
10 all the pieces?

11 MS. DAILEY: And I think it's a
12 fabulous idea. I'm not sure I can gather
13 enough data for you all to make a
14 recommendation, bring in other people to talk
15 about how those resources are done, or bring
16 in WWCTP, to walk down that road of their
17 capability. I can't do that at this stage of
18 our deliberative processes.

19 CO-CHAIR GREEN: Let's come back
20 to where I started. So let's just change it
21 around.

22 WWCTP, okay, should establish a

1 single portal for recovering warrior, families
2 and caregivers and with the processes codified
3 to clear online sites and informational
4 resources. Because what we're trying to get
5 them to do, and so we're just being more
6 specific in how to market this, is give them
7 a portal that they can then look at the
8 National Resource Directory stuff and all the
9 other things so that they can basically say I
10 want this in my portal. I want this to be my
11 home page because that's the way I want to
12 look at this information.

13 So if I want to know about left
14 leg amputations, that would be the first thing
15 that comes up in my portal.

16 And so why don't we just make this
17 specific in terms of, "WWCTP should establish
18 a portal," it doesn't have to say single
19 anymore, "a portal for recovering warrior,
20 comma, families, comma, and caregivers for
21 them to organize informational resources of
22 value," and then period.

1 A clear process just to codify
2 online and informational resources that would
3 be available to the portal. Let's see.

4 PARTICIPANT: It's not a sentence.

5 CO-CHAIR GREEN: I know. But I'm
6 trying to figure out how to use the next
7 sentence. Yes, so then take out from WWCTP
8 down to dissemination.

9 Resources that would be available
10 to portal will improve, just say will improve
11 dissemination of information and other
12 information resources and just put a period,
13 or actually it's -- you guys can look at it.

14 We can get ready of renaming the
15 National Resource Directory, because when they
16 establish a portal you have to name it. And
17 so if they just make a recovering warrior
18 portal, if they have a process for how they're
19 going to screen what's available on the
20 portal, we'd be there and essentially it's a
21 new marketing tool.

22 DR. PHILLIPS: I don't know if

1 this is an issue. I just went to the website
2 and went to about five different categories
3 and I got page not found. So that might be --

4 CO-CHAIR CROCKETT-JONES: National
5 Resource Directory, I believe, is going
6 through some changes right now, isn't it? Is
7 it down?

8 DR. PHILLIPS: Oh, okay, all
9 right.

10 ((Off-microphone comments.))

11 MS. DAILEY: Okay, let me keep
12 this on the record. Dr. Phillips, I don't
13 know why you didn't get to the location, but
14 the site --

15 DR. PHILLIPS: Well, I got to the
16 location. It just wouldn't, when I hit --

17 MS. DAILEY: The site is not down.
18 The contract has changed but they are still
19 manning it. It is still active. It has
20 different people working it. It is not down
21 and it -- there has been changes in the
22 contract but it is still a functioning

1 website.

2 DR. PHILLIPS: Let me clarify. I
3 got to the website. I got to the home page,
4 and the home page on the left-hand side lists
5 about 10 or 15 different categories that you
6 can access, jobs, health, et cetera, et
7 cetera. I went through about five of those
8 and it just said page not found.

9 What I'm saying is before we make
10 a recommendation, we should just perhaps make
11 sure that this thing is functional.

12 CO-CHAIR GREEN: Yes, but see, I'm
13 trying to stay away from -- so whether NRD or
14 call centers or whatever, I mean, all of them
15 -- or basically they have something on the
16 web.

17 And if you know where to go, you
18 can find them. If you Google the right thing
19 and put in the right parameters you can
20 probably find them, but you have to do that
21 every time you want it.

22 And so why not give them a portal

1 to where they could organize it so that I need
2 access to PTSD or I need access to whatever,
3 and when they go to the computer, then they'd
4 see on the portal just like we do now.

5 CO-CHAIR CROCKETT-JONES: Okay,
6 maybe I'm an outlier here, but that is what
7 most of your internet service provider home
8 pages already provide you.

9 Most people already have a method
10 by which they save the important links they
11 need and they don't need an extra portal to do
12 so.

13 MR. CONSTANTINE: The point is,
14 though, if you go in through the Resource
15 Directory, now you have a limited world and
16 you can pick and choose.

17 If you're just going through
18 Google and setting up bookmarks, it's up to
19 your imagination to figure out what those
20 things are. If you go to National Resources
21 Directory and then --

22 CO-CHAIR CROCKETT-JONES: No, if

1 you go through National Resource Directory,
2 any page you get in there or link you access
3 is also able to be bookmarked into your own
4 folder or set to your own --

5 MSGT MACKENZIE: On your system.
6 If I work at the library, if I go to work, if
7 I go anywhere else, none of that's available
8 to me.

9 CO-CHAIR CROCKETT-JONES: That
10 shouldn't be true. That's what I'm saying.
11 Anytime you go online into any computer, if
12 you sign into your own access, that shouldn't
13 be computer --

14 MSGT MACKENZIE: My favorites at
15 work aren't the same as the favorites at home.

16 MR. CONSTANTINE: Bookmarks are to
17 your computer.

18 CO-CHAIR CROCKETT-JONES: Okay.

19 LTCOL KEANE: Can I say one thing?

20 CO-CHAIR GREEN: Go ahead.

21 LTCOL KEANE: I think we should
22 scratch this one.

1 CO-CHAIR GREEN: Yes, that's where
2 I was at the beginning.

3 LTCOL KEANE: I think we're
4 spending a lot of time on National Resource
5 Directory.

6 The fact is, people aren't using
7 the website. They're using Facebook. They're
8 using their iPad. They're using their
9 handheld device and searchable websites aren't
10 what they want.

11 They like the Wounded Warrior
12 Regiment. They get information pushed to
13 their phone by likes. The bottom line is
14 websites aren't that current technology. It's
15 Facebook and likes, tweets, blogs.

16 You know, they put on their phone.
17 They're getting the alert of the Marine Corps
18 one, the Warrior Games again this year, third
19 time in a row.

20 MS. DAILEY: Yes, and the National
21 Resource Directory has all those features. It
22 has Likes. It has tweets so.

1 CSM DEJONG: I think the reason
2 that we kind of get stuck on Military
3 OneSource and National Resource Directory is
4 through all the focus groups that I've been
5 part of that is the two main things that we
6 actually get feedback on, which is why I think
7 that we continuously stop short of what would
8 be a full legislative mandate because that's
9 really all we're getting feedback on.

10 We're not getting feedback on call
11 centers. We're getting feedback on Military
12 OneSource and we're asking questions
13 specifically guided towards the National
14 Resource Directory.

15 We may want to look at changing
16 some questioning of when we get into the
17 surveys and some other things.

18 DR. LEDERER: Your findings also
19 point out an issue with a lack of parity in
20 the information resources across the services,
21 different levels and qualities of websites and
22 information services.

1 And CFP DoD thinks that they're
2 playing a secondary role and the services are
3 playing a primary. One of the motivations for
4 this recommendation was to ask them to
5 reconcile that question.

6 CO-CHAIR CROCKETT-JONES: I still
7 want to rename the National Resource
8 Directory. I still feel really strongly about
9 that recommendation.

10 CO-CHAIR GREEN: Our problem is
11 we've got a very vague recommendation that
12 everybody who adds to it is --

13 CO-CHAIR CROCKETT-JONES: I just
14 want to recommend that the National Resource
15 Directory have the name changed to the
16 Recovering Warriors Resource Directory or the
17 Recovering Warriors Directory.

18 MR. CONSTANTINE: Why Recovering
19 Warrior when it could be WWI? We could have
20 a long conversation right now about what it
21 would be. I don't think we have time.

22 CO-CHAIR CROCKETT-JONES: That's

1 true, we could, but do we want to leave it up
2 to them? I know that National Resource
3 Directory is a terrible name.

4 MR. REHBEIN: Across the board, as
5 you go through the findings, you see the same
6 thing, lack of usage, we don't know about it.
7 The usage percentages are down and it's not
8 just National Resource Directory.

9 It's the whole thing, except the
10 SFAC, except the Family Assistance Centers,
11 and that's because you can see the Family
12 Assistance Center. When you walk by, there it
13 is. You can't walk by a website. You can't
14 walk by a hotline.

15 If you're going to talk about
16 renaming something, I think rather than us
17 trying to determine the best name, we set a
18 goal for them to rename the National Resource
19 Directory to something that would double the
20 existing usage. Set a goal for them.

21 I think if we're going to make a
22 recommendation here on how to get more

1 information out there, the services need to
2 more aggressively market what information
3 resources they have.

4 I'm not sure that writing a DoDI
5 on most of the subjects that are specified
6 there is really going to increase usage of
7 those informational resources.

8 DR. PHILLIPS: I agree with
9 Lieutenant Colonel Keane. My reason to scrap
10 it is because I've been playing with it and
11 two thirds of the pages are not found so it's
12 not --

13 MSGT MACKENZIE: Actually, sir,
14 it's the way you're doing it.

15 CO-CHAIR GREEN: All right, all
16 right. We've really got to go on.

17 MSGT MACKENZIE: It's the way
18 you're doing it because I can get into every
19 one of them. I can get into every one of
20 them. It's the way you're doing it and I know
21 what you're seeing. You're just not seeing
22 the full thing.

1 CO-CHAIR GREEN: How about a
2 different recommendation, okay? Rename the
3 National Resource Directory and market the new
4 resource with a goal to double usage, okay?

5 MS. DAILEY: Rename the National
6 Resource Directory.

7 CO-CHAIR GREEN: And market the
8 new resource with a goal to double the usage.

9 MS. DAILEY: Good.

10 LTCOL KEANE: Sir, why didn't you
11 say that an hour ago?

12 (Laughter.)

13 CO-CHAIR GREEN: What is that
14 suicide line again? Tell me. Can you look it
15 up for me, Steve, on National Resource
16 Directory?

17 (Laughter.)

18 MS. DAILEY: And so we'll take the
19 rest out. And maybe one of these days I'll
20 get your arms around all the legislative
21 mandate, but this is fine. This is fine.

22 CO-CHAIR GREEN: Twenty.

1 CSM DEJONG: Sir, 20, the only
2 note that I have next to it is to clarify and
3 I'm going to refer to your expertise and the
4 Air Force Instruction.

5 CO-CHAIR CROCKETT-JONES: Our
6 understanding was that the Air Force in
7 practice is giving priority to AFW2 program
8 participants but that they don't have it as a
9 documented written policy.

10 CO-CHAIR GREEN: I don't know
11 exactly what you're saying but, I mean, if you
12 want to tell the Air Force to publish their
13 AFI guiding the management of wounded
14 warriors, I would go, yay, do it.

15 (Laughter.)

16 MS. DAILEY: Yes, sir, that's it.

17 CO-CHAIR CROCKETT-JONES: Yes, I
18 think that basically might be what we're
19 saying.

20 MSGT MACKENZIE: That's what we
21 need is --

22 CO-CHAIR GREEN: Yes.

1 MSGT MACKENZIE: It would be about
2 time that that gets done and, yes, please.

3 CO-CHAIR GREEN: Yes, I mean,
4 because I don't know. When you go into the
5 details of it, since it hasn't been published,
6 I don't know.

7 I think that you just want to say
8 the Air Force should publish its guidance on
9 the -- you know, publish AFI 34-1101 to
10 establish guidance for the wounded warrior
11 program. I think that that's important.

12 CO-CHAIR CROCKETT-JONES: Right,
13 because if we suggest they change something,
14 it would just delay publishing, wouldn't it?

15 CO-CHAIR GREEN: Correct.

16 CO-CHAIR CROCKETT-JONES: So, yes,
17 I guess we should just --

18 CO-CHAIR GREEN: And I can't tell
19 you whether what you're saying is in there or
20 not in there because it hadn't been published.
21 So once it's published, then we could go,
22 change that.

1 (Off-microphone comments.)

2 CO-CHAIR GREEN: Mic.

3 MS. DAILEY: I need you on the mic
4 please, sir.

5 DR. TURNER: Why don't you just,
6 you know -- like, I agree with you. Why don't
7 you say the Air Force should publish AFI 34-
8 1101, the AFI for wounded warriors, and
9 document the relationship between the Air
10 Force Airman and Family Readiness Center,
11 period?

12 MS. SOBOTA: It is published.

13 PARTICIPANT: Did they publish it?

14 MS. SOBOTA: Well, 34-1101 is
15 published but it's the Assistance to Survivors
16 of Persons Killed in --

17 MS. DAILEY: Yes, they have an old
18 one from 2001 which they're updating so we're
19 still --

20 PARTICIPANT: Updating?

21 MS. DAILEY: Correct, publish the
22 updated.

1 MSGT MACKENZIE: If you read the
2 findings, I believe this was information that
3 was provided to us, that the relationship
4 between the two, even when this is published,
5 is not clearly identified and so, therefore,
6 we need to have this --

7 CO-CHAIR GREEN: Why don't we keep
8 this real simple? The Air Force should update
9 and publish -- well, just say update and
10 publish AFI 34-1101 to document their wounded
11 warrior programs. AFI 34-101, right, to
12 document their wounded warrior program.

13 Now, I don't know what that other
14 one means, the relationship between Air Force
15 Airman and Family Readiness Center and AFW2.

16 MS. DAILEY: We had a lot of
17 discussion about this at the last meeting and
18 I can see where, if it's captured in the new
19 update, that we might not need to call it out.

20 But this is the part of where the
21 family centers are providing services to
22 wounded warriors. And as we move down the

1 road where more and more of these services are
2 not needed, they're moving into these family
3 centers and depending on them to provide these
4 services.

5 CO-CHAIR GREEN: And so my
6 recommendation would be that you put that in
7 the findings because that's what we saw.

8 And so the recommendation is the
9 Air Force should update and publish AFI 34-
10 1101 to document their wounded warrior
11 program, period.

12 Right, and so then the findings
13 will identify this. So once they publish it,
14 then we'll know how they've dealt with it, so
15 the findings would say why we need to see what
16 they really mean to do.

17 (Off-microphone comments.)

18 CO-CHAIR GREEN: Yes, the other
19 thing is take out the "the" before the AFI, so
20 just publish AFI. Get rid of that. And it's
21 not "s" on programs, to document their wounded
22 warrior program, period, at the end of the

1 sentence.

2 MS. DAILEY: Okay, what's that
3 again, sir?

4 CO-CHAIR GREEN: Instead of the
5 "s." At the very end, it's not "programs."
6 It's "program," okay? That's fine. That's
7 very clean. The findings will support that
8 and we'll be all set.

9 Yee-haw, that's 20. I think we're
10 ready. Does everybody have access to email or
11 do we need to get them to print these 1
12 through 20 now?

13 PARTICIPANT: I prefer email.

14 DR. PHILLIPS: Do we need to print
15 the findings because we already have those so
16 make it easy, yes. Make it easy just --

17 CO-CHAIR GREEN: Yes, I think you
18 have findings in your book, okay, and so we'll
19 tie the findings.

20 Is there any renumbering that's
21 going to cause a problem? When we dropped the
22 one, did that eliminate the finding to go with

1 it?

2 MS. DAILEY: Yes, that took the
3 finding out on that one. We'll work it out,
4 sir. We'll work it out.

5 CO-CHAIR GREEN: Okay. All right,
6 so everybody has access to email if they send
7 them to you so we can try and do this in the
8 morning.

9 All right, that'll save you guys
10 some printing time. So I'll let you guys
11 email them to us. All right?

12 MS. DAILEY: One thing -- and my
13 staff just brought this up. Please read 21.
14 They're inter-related to 20. So you might
15 want to just be careful about voting on 20
16 without having knowledge of 21.

17 CO-CHAIR GREEN: Let's tackle it
18 tomorrow and take the Airman and Family
19 Readiness Center and include it into 21. So
20 the first one is just, you know, to get the
21 Air Force to publish their AFI.

22 And the second one will be to

1 basically link what are the relationships in
2 the wounded warrior program to all the fleet
3 and family and the army -- I don't know the
4 name of it, and the Airman and Family
5 Readiness Centers.

6 MS. DAILEY: Okay, good.

7 CO-CHAIR GREEN: So we'll just
8 tackle that tomorrow.

9 MS. DAILEY: Good, good, good.
10 All right, email. Anyone want a hard copy
11 tonight, because that will be about 10 or 15,
12 20 minutes?

13 MSGT MACKENZIE: I'd like to
14 provide a different email address.

15 MS. DAILEY: Is there any
16 different emails than what I already have?
17 All right, then I need you to talk to LaKia
18 and I need you to give LaKia right now the
19 email that you want.

20 CO-CHAIR GREEN: So I think with
21 that we're going to stand down for this
22 evening. Any administrative announcements in

1 terms of what time we start in the morning?

2 MS. DAILEY: We're going to start
3 at 8 o'clock tomorrow morning. We are going
4 to have group photos at 8:00, so I need --

5 CO-CHAIR GREEN: So everybody try
6 and be here maybe about 10 minutes to 8:00
7 tomorrow, okay?

8 MS. DAILEY: Right. We're going
9 to kick off with group photos. But I don't
10 have any other administrative comments other
11 than that.

12 CO-CHAIR GREEN: All right, thank
13 you, everybody. Appreciate your patience.

14 MS. DAILEY: Okay. LaKia's here.
15 If you have a different address than what we
16 send your information to, I need it now. I
17 need her to collect it.

18 (Whereupon, the meeting in the
19 above-entitled matter was concluded at 5:17
20 p.m.)

21
22

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Task Force on Recovering Wounded

Before: US DOD

Date: 06-13-12

Place: Alexandria, VA

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