OFFICE OF
WOUNDED WARRIOR
CARE & TRANSITION POLICY

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# MARTIN ARMY COMMUNITY HOSPITAL (MACH) TRIP REPORT

**SITE VISIT:** Fort Benning, Columbus, GA

**DATES:** 16 December 2009

**HOST ORGANIZATION POINTS OF CONTACT:**
Brigadier General Gary H. Cheek, Commander, WTC
(b)(6) Commander, MACH
(b)(6) Commander, WTB

**VISIT OVERVIEW:**
Briefing at Fort Benning and a simulation of the Comprehensive Transition Plan (CTP) including:

- Warrior Transition Battalion (WTB)
- Soldier Family Assistance Center (SFAC)

**WWCTP STAFF ATTENDING:**

- Noel Koch, Deputy Under Secretary of Defense for Wounded Warrior Care and Transition Policy
- Al Bruner, Deputy Director for Disability Policy
- (b)(6), Military Assistant
- (b)(6) Special Assistant to the Chairman of the Joint Chiefs of Staff for Warrior and Family Care
- (b)(6) Disability Evaluation System Consultant

**COMMAND BRIEF**
Provided by COL Nishimura

- DES Pilot Discussion:
  - Scheduled to begin on 28 February 2010.
  - Dr. Jim Hege briefed importance of an initial screening through doctors prior to being referred to a Medical Evaluation Board (MEB) to ensure there are no "misfires".
  - Ft Benning processes 500 TDRL cases and 2,500 Existed Prior to Service (EPTS) boards per year.
  - 30% of MEB boards are Soldiers who were injured during basic training. Expressed a need to come up with an expedited process for Service members injured during basic training. WWCTP staff members assured the group that Working Group was formed to address this need.
  - Lead PEBLO, Lisa Lay, stated the current DES average MEB processing time is approximately 22 days.
  - Already a BDD site with established relationships between the Physical Evaluation Board Laision Officers (PEBLOs) and VA Military Service Coordinators (MSCs).

  - Building on lessons learned from other DES Pilot facilities by co-locating PEBLOs and MSCs to facilitate coordination.
  - MACH currently meets the Army ratio requirement of 1:30. DoD policy requires a 1:20 patient to PEBLO ratio.
  - Anticipate about 100 cases to continue to process through the legacy DES system once the DES Pilot has started.
  - Doctors at MACH are already doing holistic general examinations.
  - VA doctors will be co-located with DoD physicians.
- Cross-Service MEBs:
  - Service members from all Services have the ability to go through MEB processing at MACH. Note: This is consistent with DoD revised policy, currently in coordination, for processing MEBs for all Service members located at the MTF for which they are receiving treatment.
  - MACH PEBLO will do referral and case file workup; VHA will handle the general medical exam, and the MEB results will be sent to the Service member's Service PEB.
  - At present, all Service MEB are "worked-up" by MACH and mailed to the appropriate PEB.
- Future possibilities for disability processing:
  - BG Cheek introduced the idea of a single, centralized MEB facility that would process all DES referrals from all Army medical facilities.
  - Air Force is also exploring a similar single MEB site at Lackland Air Force Base, San Antonio, TX.
- For Soldiers who are transitioning, important to bring back to WTU to share experiences.
  - The community is currently linked with the treatment facility, WTU, and the Family but do not have an Outreach program to ensure Service members and Veterans are receiving care post-separation. MACH is having difficulty bringing former WTs back to share their experiences in the WTU—good and bad experience as motivation to current WTs.
- For Reserve and Guard members, there is a problem getting complete medical treatment records, getting scheduled for initial workups, and completing medical examinations.
- Reservists are spending their own money to come in for medical appointments.
- Central management is critical; unsure of number of Reservists processing through MACH.
- Currently have a shortage of primary care managers and doctors on staff; likely due to lower cost of living in this locality, resulting in overall lower take-home pay.
- 9th floor of the hospital has been made available to house VA doctors; discussions are ongoing to assign VA physicians to practice at MACH.
- BG Cheek notes that (Army-wide) 829 Service members have applied for COAD / COAR; 329 Service members have been approved. Objective should be to retain as many people as possible, i.e. anyone who wants to stay in the Army should be offered the ability to do so.
- Military Occupation Code (MOS) / Medical Retention Board (MMRB) allows the Service member to change MOS in order to remain on active duty; many Service members who get a change to their MOS still go through a MEB.

- "Continuing on Duty as an Active Civilian (CODAC)" is another possible avenue for transitioning soldiers; the option is almost impossible to implement due to the current practices of hiring federal civilians.
- Retention NCOs have been part of the WTB for about 3 months; they are still trying to train and define roles.

**LUNCH WITH WOUNDED WARRIORS**

- Met with many Wounded Warriors and their Families for lunch at Uchee Creek Campground and Marina.
- Nothing significant to report.

**WARRIOR TRANSITION BATTALION (WTB)**

Brief provided by (b)(6)

- The WTB tracks Service members through an automated web-based tracking tool, hosted on Army Knowledge Online (AKO).
- The WTB at Fort Benning has been working on the tracking tool for over a year and is the first Army base to track Warriors in Transition (WTs) in an automated system.
- The tracking tool continues to be a work in progress with the ultimate goal of a automated system that is standardized and employed by the Warrior Transition Command (WTC).
- 50% of soldiers in the WTU at Fort Benning are reservists.
- A Soldier with a 30-50% disability qualifies for the Army's Wounded Warrior Program (AW2). There have been 48 AW2 severely injured Service members processed through the WTB; 12 AW2 soldiers are currently in the WTB.
- WTs with a CTP are not necessarily in AW2 status.

**COMPREHENSIVE TRANSITION PLAN (CTP)**

Mr. Koch and BG Cheek had the opportunity to go through a simulation of a Warrior in Transition (WT) populating a CTP. They were both given real-life scenarios and went through the process of self and risk assessments, goal setting, and management of expectations. Simulation led by LTC Sean Mulcahey.

- Every WTB member has a CTP. A CTP is assigned after the WT is given an in-briefing and assigned a cellphone.
- Within 24 hours of the soldier's arrival to the WTB, their initial self assessment and risk assessment is completed.
- Once a soldier is assigned a CTP in the database, they are also assigned to the TRIAD of Care, which consists of a Case Manager, Primary Care Manager (PCM), and Squad Leader.
- Approximately 50% of WTs return to duty from the WTB. Goal is to retain on active duty as many WTs as possible.
- Case Managers and squad leaders are available to WTs 24 hours a day, 7 days a week.
- The CTP self-assessment is based on a 14 part questionnaire which covers medical care, behavioral health, activities of daily living, pain thresholds, care coordination and management, housing, educational goals, transition information, finance, family issues, and transportation.

- Weekly self assessments, completed by the WT, and risk assessments, completed by the PCM are available to the squad leader for review.
- The tracking tool uses a stoplight approach to track the progress and risk of the WT. Green (low), yellow (medium), and red (high) are risk factors assigned to each question which allows the commander to focus on WT needs.
- After in-processing has been completed, the WT is afforded the opportunity to set goals. In-processing for a soldier assigned to the WTB averages 30 days.
- As part of the CTP, the WT sets goals with an occupational therapist, which includes setting a long-term goal and then setting milestones to reach the long-term goal.
- Many WTs choose a goal of "staying in the military". Focus is on re-integration, not separation.
- According to the WTB, less than 10% of soldiers assigned to the WTB at Ft Benning are unrecoverable, uncooperative, or unmotivated.
- The WT meets with the company commander weekly if they show high risk in one or more areas of their weekly assessments.
- As part of goal setting, BG Cheek expressed interest in making an adaptive sport mandatory for WTs in the WTB.
- Plan on testing the web-based tool at several Pilot sites including Ft Bragg, Ft Sam Houston, Ft Riley, Ft Campbell, and Ft Carson.
- The CTP measures its success based on 5 factors: accountability, risk management, CTP effectiveness, internal development, and morale and well-being.
- Every 180 days, the WT appears before the transition board to review his/her self-assessment and go over diagnosis with his/her medical provider. This review board is intended to be informative for the way ahead for the WT.
- Next project is to include a Family Module in the automated web tracking tool. The module will have the ability for family members of the WTs to set goals, reveal issues, and track milestones to ensure they are meeting goals.

**WHAT WE LEARNED:**

- Appears there are long in-processing procedures for WTs and duplicative services offered by medical and non-medical case managers, chaplains, social workers, Advocates, program staff.
- It is understood that the in-processing and on-going assessments will be less onerous when undertaken over an extended period (vice the experience of the simulation provided to Mr. Koch and BG Cheek). We recognize this is a process still in development, but there is a sense of the ideal (the apparent objective of the CTP program) being the enemy of the sufficient. This may be counter-productive in the present work-up of the evolving program, and may be equally so in the long term, i.e. the anticipated increase in Wounded Warriors returning from the latest surge may continue to push the problem ahead of the ideal solution: a fully-found CTP.
- The WTUs are burdened with soldiers placed in them by Commanders as an expedient means by which to rid their units of their "undesirables". This is counter to the fundamental objective of providing the best possible care for Wounded Warriors.

**RECOMMENDATIONS:**

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# IRWIN ARMY COMMUNITY HOSPITAL (IACH) TRIP REPORT

**SITE VISIT:** Fort Riley, Manhattan, KS

**DATES:** 18 December 2009

**HOST ORGANIZATION POINTS OF CONTACT:**
(b)(6) Commander WTB
(b)(6) Executive Officer, WTB

**VISIT OVERVIEW:**
Briefing at Fort Riley, tour of facilities, and sensing sessions with members of the WTB:

- Irwin Army Community Hospital (IACH)
- Warrior Transition Battalion (WTB)
- Sensing Session with Wounded Warriors
- Sensing Session with CADRE
- VA One-Stop Facility

**WWCTP STAFF ATTENDING:**

- Noel Koch, Deputy Under Secretary of Defense for Wounded Warrior Care and Transition Policy
- Al Bruner, Deputy Director for Disability Policy
- (b)(6) Military Assistant
- (b)(6) Disability Evaluation System Consultant

**DES PILOT BRIEF**
Briefing by (b)(6)

- Developed standard operating procedures in November to prepare for DES Pilot program.
- Use stoplight assessment chart to track progress of DES Pilot readiness prior to implementation, with monthly teleconferences held for DES Pilot Standup with emphasis on issues and showstoppers.
- Start date for the DES Pilot was 4 January 2010 but has been moved to 1 February 2010. New procedural changes as well as lack of training cited as the cause of the delay.
    - DES Pilot training to be completed 4-6 January 2010. Originally scheduled for week of 18 December 2009.
    - This change has not been briefed to the SOC OIPT.
- VA Compensation and Pension (C&P) exams will be completed at IACH by VHA.
- VHA will conduct general medical exams in VA One-Stop center. VHA will conduct Mental Health exams at the VA Community Base Out-patient Health Clinic (OBOHC) in Junction City.

- VA recommends Traumatic Brain Injury (TBI) specialty examinations be completed in Topeka, KS. There have been discussions about completing examinations on site at IACH to eliminate unnecessary travel for WT. There is no TBI clinic currently at IACH.
  - Need to get DoD physician VA (C&P) certified to do examination.
  - DUSD emphasized limiting movement of TBI patients because of high mortality rates when transporting.
- VA / DoD will jointly conduct audiology exams at IACH.
- Sleep studies will not be done at IACH. Potential to build a sleep lab in the new hospital, scheduled to complete in 2013.
- Procedures need to be in place so that VHA does not do unnecessary examinations.
  - DoD providers are undergoing C&P training and certification through MHS Learn. Scheduled to complete 10 January 2010.
- PEBLOs and MSCs are currently located within the same building.
- New hospital will be available for use in 2013. PEBLOs and MSCs will be co-located in the same wing.
- Generally processes only Army cases. However, they have the capability and expressed the desire to do disability processing for all Services within the catchment area.
- Currently processing 99 TDRL cases; some are Navy / Marine Corps members.
- Average 30-35 MEBs per month, average 300 MEBs per year. Currently processing 337 Active cases. 1 case has been in the Legacy system for 360 days.
- Currently taking an average of 80 days for a soldier at IACH to reach the PEB from point of referral into the DES; average 4-6 weeks at PEB due to backlog of cases.
- 8 PEBLOs on hand. 3 additional hiring actions submitted; 2 hiring actions approved, 1 hiring action still needed.
- For VA staffing, 4 MSCs, 3 general medical providers, 1 behavioral health provider, and an administrative support clerk are on hand. VHA/VBA facilities have been made available to them; 1 workstation is still needed for VA admin support.
- All IT and equipment needs have been met for both DoD and VA.
- Memorandum of Agreement (MoA) between DoD and VA has not been signed. VA has the lead and development is ongoing. This is a critical requirement before DES Pilot initial operating capability (IOC).

Prior to the Command Brief with (b)(6) Mr. Koch had the opportunity to speak with a few Service members who are undergoing treatment at IACH:

- Male NCO is a WT in the AW2 program. He was injured in Iraq in 2004 and has traveled between Walter Reed Army Medical Center (WRAMC) and Fort Riley for treatment.
- Male NCO was hit by a drunk driver which resulted in a broken femur, and some paralysis of the left leg. He speaks out against Drunk Driving and the impact it has on lives.
- Male NCO had a cataract and detached retina in the right eye. Since his injury, he has been cleared and returned to duty.

**COMMAND BRIEF**
Briefed by (b)(6) and (b)(6)

- Warrior Transition Battalion (WTB)
  - Originally an aircraft hanger, the WTB Complex has undergone a million dollar renovation of the facility to include a food court, lounge, gymnasium and auditorium.
  - 156 barracks rooms will be made available to WTs.
  - Soldier Family Assistance Center (SFAC) will include services such as child care, education, finance, Traumatic Service Members Group Life Insurance (TSGLI), legal assistance, community outreach, military benefits.
  - The updated Warrior Transition Barracks is scheduled to complete in March 2010 with a formal opening in June 2010; Will be the first WTB built to Army standards
  - With BRAC, Fort Riley is expected to gain an additional 12,000 soldiers and 50,000 family members.
  - Currently 250 WTs in the WTB, with a peak of 432 in July 2008.
- Comprehensive Transition Plan (CTP)
  - Does not currently have an automated process for the CTP.
  - Reception, Staging, Onward Movement, Integration (RSOI), in-processes Soldiers into the WTB. Currently is a thorough but arduous process.
- Mental health characterizations of injuries at the WTB include the following: PTSD, TBI, and Other Mental Health.
  - "Other Mental Health" is characterized as any psychological conditions that are not classified under PTSD or TBI such as anxiety disorders, mood disorders, personality disorders, etc.
    - "Other Mental health" issues are attributed to the delay of significant stressors, soldiers who do not display mental and behavioral problems until they have reached a certain age can make it through recruiting, testing and training without exhibiting mental health symptoms.
  - Median age of community under the "other mental health" categories is 20-25 years of age.
  - Possible to have an underlying mental illness as well as PTSD.
  - Most of the WTs in this category have never deployed.
- Recruiting standards are changing; currently, 67% of American youth are not physically qualified for Army recruitment.
- The Army can deal with physical injuries ; PTSD is a more complex and challenging issue.
- Takes more manpower to deal with a Soldier with PTSD.
- 6 suicides over the past year; 1 soldier was part of the WTB.
- Behavioral health specialists are hard to hire and burn out quickly; Squad leaders are spending 10+ hours daily with WTs; should be spending no more than 8 hours.
- Many soldiers are MEDEVAC'd to Fort Riley without their Family.
  - Family outreach includes local newspapers, radio ads, Family support meetings, Family oriented events, etc.
  - Spouses Understanding Needs (SUN) Program available to Family members of WTs experiencing PTSD; Meets weekly.

- Currently, the WTB does not have room for additional family members for WTs. They are attempting to work with command to provide housing and hoping to involve Fisher House for additional assistance; repurposing the WTB is a possibility.
- Financial Support to Caregivers
  - Approved by Congress; WWCTP is writing the policy now to disseminate.
  - Issue remains how to ensure that care and financial support is given to the right people.
- "Operation Enduring [redacted]
  - Introduced [redacted]
  - Process assessments of Warrior/Family issues 30 days prior to separation; first Army facility to come up with concept.
  - WT can choose how they want to be contacted. Possible avenues include phone, email, facebook, twitter, etc.
  - Goal is to set WTs up for success; whether they are retained in the Service or separate to become a civilian.
  - The purpose is to assist soldiers who do not qualify for the AW2 Severely Injured program.
  - Initial questionnaire given to WT to establish the baseline. Track issues through five pillars: financial, social, employment, education, and physical.
  - Emotional and social interaction is key to success.
  - Email contacts have been set up to see how the WT is doing after they leave the WTB.
  - Mission is to collect data from WTs who have transitioned and automate the process.
  - DUSD recommends a pilot process to include a phone bank operation much like the Marines operate at Quantico.
  - Best practice at Fort Riley but has not been adopted by the Army as a whole.
- After PEB results, AW2 soldiers are going into internships then becoming federal employees; 15 AW2 soldiers were placed in civilian jobs since 2008 at Fort Riley.
- While internships are not allowed under DoDI 1000.17, providing job experience under occupational therapy is accepted (they do not get compensation and have the opportunity to work with the general population).
- Focus is to heal and transition and still be able to participate in society.
- Do not have Recovery Care Coordinators at Fort Riley.
- [redacted] expressed an interest in Service Dog Programs and Equine Therapy for [redacted]

**SENSING SESSION WITH WARRIORS IN TRANSITION**

Sensing Session with 10 wounded, ill, and injured WTs currently residing in the WTU at Fort Riley and DUSD, WTB Executive Officer attending. (Note: Opinions expressed are those of the WTs.)

- Male NCO was deployed in Iraq when he experienced back issues and had to be evacuated. He had a positive experience getting through the disability system and felt the medical care at Fort Riley was above and beyond his expectations. He plans on staying in

the service but is confused as to the avenue to rejoin his company. He would be the first WT to return to full active duty from IACH.

- Male NCO was deployed in Kuwait when he experienced a heart attack. After being returned to IACH, which is the closest medical facility to his home in Iowa, he was told by his cardiologist he could not deploy and had to stay at Fort Riley for 180 days. He has been expressing unhappiness to his doctor and his command, but no action has been taken to send him home or return him to duty. There is no cardiology rehabilitation at Fort Riley. WT left DUSD with background information to review.
- Male NCO was diagnosed with cancer in his neck and has had multiple surgeries. He was concerned that Traumatic Service member's Group Life Insurance (TSGLI), a VA program administered by DoD, is not available to Service member's who are diagnosed with cancer. He also is concerned that burn pits causing cancers in young service members are not being recognized. He is planning on separating from Service.
- Female Officer was a CADRE nurse case manager prior to transferring to the WTU. She was diagnosed with a heart condition after experiencing a mild heart attack and is scheduled for surgery next week. She has not had a smooth transition and has experienced many obstacles through her command. She had no contact with her command during her hospitalization and originally was told she would not be put into the WTU and therefore would not be eligible for benefits, aid, and assistance. Although her command was not helpful, the squad leadership at the WTU has been compassionate and competent.
- Male NCO has had a very good experience at the WTU. He was MEDEVAC'd from Iraq and has been in the WTU for one month.
- Female NCO has female issues that were aggravated by deployment to Iraq. She stated the in- processing procedures at the WTU were long but painless. The accountability of the command has been good. She will be going through a MEB.
- Female NCO was deployed to Iraq in September 2009. She was MEDEVAC'd out of Iraq for mental health issues. Since joining the WTU, she sees a psychologist every week and there are discussions about sending her to an inpatient facility for further treatment. She does not want to separate but feels she does not have an advocate for her to stay in the Service. She is currently undergoing a MEB.
- Male Enlisted has "space" in his left shoulder that causes instability. He is scheduled for surgery which should result in full recovery. He has been well treated and is planning on staying in the Service.

**SENSING SESSION WITH WTB CADRE (SQUAD LEADERS):**

Led by (b)(6) (Opinions expressed are those of the SLs.)

- 8 CADRE, all Squad Leaders (SL) in sensing session with DUSD, WTB Executive Officer attending.
- 50% of Service members in the WTU are Active Component; 25% are National Guard members; and 25% are Army Reserve.
- The WTB is almost exclusively AC centered in its operation; SL stated that more training and emphasis should be centered on RC case management.
- SL stated selection for CADRE duty takes too long thereby requiring the command to compress training to keep required ratios.

  - Report virtually no formal training; mostly On the Job Training (OJT).
  - Believe some formal training is best but value "right seat/left seat" training most so that learning can be "every day" until they are mission ready.
- SLs assess SL to WT ratio to be inadequate. Stated ratio is 1:10 but SLs recommend a ratio of 1:6 due to "high-risk" cases (i.e. suicidal intentions, mental, etc.) require more attention. Headquarters (HQs) note that the WTB is approximately 135% of authorization but SL state that this is still not enough to deal with normal and high-risk WTs.
- SLs assess recent Army MEDCOM study on SL duties as flawed. According to SLs, study revealed SLs average 60-70 hours per week of non-standard hours.
- SLs report high ratio of "malingerers" to legitimate WTs. SL assesses ratio to be 3:1. SLs recommend the Army toughen WTU entry standards to weed out malingerers. Malingerers sometimes turn into "high-risk" because of trouble and disciplinary issues.
- Malingerers become "barracks lawyers" and "barracks doctors" who help WTs to remain in the WTB the maximum time in order to avoid separation, re-deployment, or attain maximum Government payouts.
- Several SLs reported a lack of general discipline within squads. SLs assess some WTs use the "claim PTSD/TBI" as a "free pass" to abuse drugs, alcohol, family members, and be general bad actors.
- SLs report fewer disciplinary infractions amongst genuine combat wounded because they seem to seek help more and segregate with other combat wounded and thus become their own support groups.
- SLs are concerned that normal line NCOs being recruited into the SL CADRE need to learn old "cold-war" leader management techniques to deal with WT—less rigid styles. Combat arms techniques from a war time environment do not work with WTs. Another reason for formal training and "right seat/left seat" training.
- SL "Burnout"
  - According to SLs, burnout is becoming a major issue. SL should be on a controlled 24 month tour. For the majority of CADRE, this is the burnout threshold.
  - Managing the burnout is doable with offsite and garrison teambuilding and professional development.
  - Lowering ratios of WT to SL is critical for SL to routinely take leave and pass time.
  - Respite time; SLs need decompression.
  - CADRE should have access to mental health counselors periodically, at least once per quarter.
  - SLs report a natural tendency to identify and bond with WTs; SLs are not trained on keeping separation from WT; need similar training as health care providers.
- Fort Riley is understaffed for JAGs. Need at least one legal person assigned to the WTU.
- SLs appreciate the opportunity to take care of WTs; morale is high but frustrations with institutional boundaries within MEDCOM are present.
  - There is a natural and healthy friction between medical civilians and WTB CADRE. Medical civilians want to provide exhaustive care and WTB CADRE is oriented to transition WTs quickly.
  - WTB XO reports that most SL request extensions to their standard tour lengths.

**VA ONE-STOP**

Brief by (b)(6) Clinical Operations Staff and (b)(6) Veterans Health Affairs (VHA) transitional social worker

- Service members can be offered many benefits prior to receiving a DD 214.
- IACH planning on integrating the one-stop into the DES Pilot.

(b)(6) American Legion Veterans Service Representative

- Manages 3 funds for Veterans
  - American Legion Fund for needy children
  - Wounded Warrior Fund
  - VFW Un-met Needs Fund – which includes rent / auto
- Did not seem familiar with the Heroes to Hometown program.
- (b)(6) assured him that VSOs have access to Service members in the DES Pilot. There will a procedural update available shortly outlining the roles of VSOs during the claim development stage of the Pilot.

**MEETING WITH MAJOR GENERAL HOROHO**

In a one-on-one meeting with General Horoho, Commander of the Western Regional Medical Command and Chief of the Army Nurse Corps, Mr. Koch raised the subject of cross-service MEBs. General Horoho said she will support this initiative without reservation.

**WHAT WE LEARNED**

- In the WTB, combat related and non-combat related wounds, illnesses, and injuries are segregated from one another. There is a marketing challenge is to ensure all Service members view themselves as being treated fairly.
- It is noted that, despite the complaints of CADRE, each has requested to extend. This apparent contradiction, we believe, is attributable to their dedication to duty and devotion to the Wounded Warriors with whom they are working.
- Need to monitor TBI discussions between DoD / VA at IACH to allow DoD Physicians to administer VA TBI specialty examinations at IACH, thereby reducing unnecessary travel for WTs.
- To ensure the program is being offered to all who qualify, more research Traumatic Service member's Group Life Insurance (TSGLI) needs to be done for who is eligible under the program.
- Need to expedite policy for Financial Support to Caregivers within the next month to provide benefits for family members of WTs.

**RECOMMENDATIONS**

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