UNITED STATES DEPARTMENT OF DEFENSE

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

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BUSINESS MEETING

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TUESDAY
JANUARY 15, 2013

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The Task Force met in the Washington Ballroom of the Doubletree Hotel Washington, D.C., Crystal City, 300 Army Navy Drive, Arlington, Virginia, at 8:00 a.m., Suzanne Crockett-Jones and Vice Admiral Matthew Nathan, Co-Chairs, presiding.

PRESENT:

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
VADM MATTHEW L. NATHAN, MD, USN, DoD Co-Chair
JUSTIN CONSTANTINE, JD, Member
RONALD DRACH, Member
TSGT ALEX T. EUDY, USAF & SOCOM, Member
CAPT CONSTANCE J. EVANS, USN, Member
LTCOL SEAN P.K. KEANE, USMC, Member
KAREN T. MALEBRANCHE, RN, MSN, CNS, Member
MG RICHARD P. MUSTION, USA, Member
STEVEN J. PHILLIPS, MD, Member
DAVID REHBEIN, MS, Member

ALSO PRESENT:

DENISE F. DAILEY, PMP, Executive Director
ALISON CERNICH, PhD, Deputy Director, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
KENNETH C. CURLEY, MD, U.S. Army Medical Research and Materiel Command
MARGARITA DEVLIN, Veterans Affairs Vocational Rehabilitation & Employment Service
CAPTAIN PAUL S. HAMMER, MC, USN, Director, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
JAMES P. KELLY, MD, FAAN, Director, NICoE
DERENDA LOVELACE, Office of the Assistant Secretary of Defense for Health Affairs
MICHAEL A. PARKER, LTC, USA (retired), Wounded Warrior Advocate
GINNEAN QUISENBERRY, Office of the Assistant Secretary of Defense for Health Affairs
CAROL A. WEESE, Veterans Affairs Federal Recovery Coordination Program

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

8:07 a.m.

CO-CHAIR CROCKETT-JONES: Okay, we're starting this morning with our public forum section of the meeting.

With us this morning to provide an oral statement, we have Mr. Michael Parker, a Retired Lieutenant Colonel and Wounded Warrior Advocate.

Members, you can find supporting information in Tab H in your briefing book.

Welcome back, Mr. Parker. I'm turning it over to you.

MR. PARKER: Thank you and good morning.

Over the past two years, I've presented a common theme to the Task Force. There is inadequate enforcement and oversight of well-established disability laws, policies, and regulations. This cheats our Wounded Warriors out of proper DoD disability benefits.

The case of Sergeant Lynn Jarvis is a prime example of this problem. Sergeant Jarvis, a member of the Ohio National Guard, deployed to Iraq in 2005 for a 15-month combat tour. While there, his duties included monitoring and guarding burn pits.

In December of 2009, he was diagnosed with an inoperable and terminal malignant brain tumor. The VA service connected his brain tumor and rated it at 100 percent disabling.

His command found that the brain tumor was in the line of duty. His oncologist estimated his tumor began three to five years prior to discovery, and Sergeant Jarvis was on active duty 18 of the 24 months of that two-year onset window.

In 2012, Sergeant Jarvis underwent DES evaluation, where his Medical Board declared his brain tumor incurred while entitled to basic pay.

However, his Informal Physical

Evaluation Board declared the condition was not connected to his active duty, and ordered him to be separated without disability benefits.

So much for the VA and DoD operating on the same service connection standards, as required by law.

The PEB violated several laws and policies when they adjudicated Sergeant Jarvis's case.

Key violations included: the PEB failed to adjudicate the case based on the favorable line of duty determination as required by DoD policy and Army regulations.

The PEB failed to adjudicate the case under the line of duty standard, vice the much more restrictive proximate result standard.

The PEB failed to provide clear and unmistakable evidence to overcome the presumption of service connection and service aggravation as required by law, and the PEB

failed to address the issues raised by Sergeant Jarvis's IPEB appeal in an itemized and orderly fashion, as required by 10 USC 1222(a), thus leaving him blind as to their decision rationale.

Our Wounded Warriors deserve fair disability evaluation, conducted to the required standards. DoD must enforce these standards.

Again, I ask the Task Force to address these concerns with concrete recommendations to DoD and Congress. Our Wounded Warriors deserve nothing less. And this concludes my statement, absent any questions or comments.

MEMBER MUSTION: Can I make a comment?

I mentioned to Mr. Parker this morning that after reading this case, I went back to the PDA last night, to ask them to revisit.

I mean, it's clear, if the line

of duty determination found the soldier to be in the line of duty, than that should be the overriding factor in the PEB's determination, and I'll get resolution on this case and push it back to the Task Force, as well as Mr. Parker, probably in the next 24 to 48 hours.

MS. DAILEY: Thank you, sir.

MEMBER PHILLIPS: Colonel, just as a physician, I was just asking, has another oncologist reviewed this?

I mean, I'm not a neurologist or a brain surgeon, but I don't know how anyone can say when something like this started.

I'm just wondering if you had other experts.

MR. PARKER: He, as a Reservist, he's being treated by a private oncologist who had done all the diagnostic and the biopsy type of work.

It did go through a Medical Evaluation Board, and I presume that the doctor who did that is an oncologist or

related field, but I couldn't verify that.

But there is a medical doctor involved in the Medical Evaluation Board process, which in turn, found that the condition incurred while entitled to basic pay.

Again, he also went to the VA, who -- well, he went through a CMP exam. Again, I don't know the background of the doctor who conducted it, but their assessment was, you know, we're talking causality, for one thing.

If causality is the burn pit, there certainly is evidence that there are carcinogenic elements that were exposed there. There's been a lot on the burn pits in the media and with Congress and registries that they just recently passed, as well.

The onset is -- again, I am not a doctor, you are, but you know, I assume that they made some type of a linear regression, based on the size and nature of that tumor,

to say that it didn't start yesterday, based on, you know, experience or whatever, that it started during this time period.

MEMBER PHILLIPS: Yes, I'm not discussing the technical aspects of the Board review.

MR. PARKER: Okay.

MEMBER PHILLIPS: But we start developing atherosclerosis in our teenage years, or a little later.

So, it's kind of a slippery slope, if you have a heart attack at the age of 50, is it work related because you're on the assembly line and lifting something heavy, or did it start when you were, you know, 19 years old, because we know historically by autopsies, atherosclerosis can do that.

So, I think it's kind of a slippery slope, and I think it would be important to kind of get a definitive response to this, because it can have far-

reaching implications.

MR. PARKER: But if there is a definitive response, I don't know if the science would support that.

I do know that the law states that if you come into the military and your physical states there is no conditions, and then a condition is discovered afterwards, then the presumption is it began while on active duty, and then there is a requirement that there is clear and unmistakable evidence to overcome that.

So, if there was clear and unmistakable evidence to say that this was not related to his service or it began while he was on active duty, that's what they would or should come forward with.

MEMBER MUSTION: This is unusual, Steve, that both there is a line of duty -- at least according to what Mr. Parker has provided, there is a line of duty that says it was in the line of duty.

There is supporting MEB evaluation that says it's an unfitting condition that was found also in the line of duty, and then -- so, I'm struggling to figure out what the logic is and the rationale for the PEB to make that decision.

So, we'll run that to ground and we'll report back out, hopefully in the next couple of days.

MEMBER PHILLIPS: Thank you. I agree with that. I was just talking a broader point about science and trying to support the actual technical decision as well that it should be reversed.

CO-CHAIR CROCKETT-JONES: Thank you very much, Mr. Parker.

Okay, I didn't actually see any other statements in Tab H.

MS. DAILEY: Correct.

CO-CHAIR CROCKETT-JONES: So, since our business meeting in December, we've conducted two site visits to Navy Safe Harbor

and to Fort Carson, Colorado.

This marked our first visit to the Navy Safe Harbor and our second visit to Fort Carson.

The Navy Safe Harbor visit focused on Navy's non-medical case management. We also took the opportunity to visit the Navy Yard and receive briefings from Commander Webster and Mr. Powers on the Navy PEB process.

The Fort Carson visit followed up last year's concerns on care-giver support and non-medical case management.

Focus groups were conducted at both site visits. We will use this session now to review the site visits and discuss lessons learned, as well as best practices found by those who attended.

So, I want to ask the folks who were at Navy Safe Harbor -- it's all blending together. You were at Navy Safe Harbor, correct?

MEMBER REHBEIN: Yes, I was, and I will kick this off, although I regret to tell you that the majority of the visiting group of Navy Safe Harbor was not able to be with us this morning: Captain Evans, Sergeant DeJong, Dr. Turner.

So, Tech Sergeant Eudy and I seem to be the only two remaining survivors of that group.

CO-CHAIR CROCKETT-JONES: Mr. Drach was there too, correct? No, he was not?

MEMBER REHBEIN: Ron, were you there?

MEMBER DRACH: No.

MEMBER REHBEIN: You weren't there at Safe Harbor?

CO-CHAIR CROCKETT-JONES: You were at Safe Harbor.

MEMBER DRACH: I'm sorry?

MEMBER REHBEIN: After the last business meeting, were you part of the visit

to Navy Safe Harbor?

MEMBER DRACH: Oh, I'm sorry, yes, Navy Safe Harbor, yes.

MEMBER REHBEIN: Okay, so you were not.

So, please bear with me. I am going to focus my remarks on the focus groups that we conducted, because that was where I took my notes, and I'm frankly, not going to depend on memory for many of the other things.

But I want to start off with something, now that I've said that, I want to start off with just one note of commendation to the Navy.

We were privileged to be introduced to a couple of their non-medical care case managers. These were both Master Chief, very senior NCOs, very qualified, very quality individuals.

I think the Navy is to be commended for devoting that quality of

individual to that particular position.

I can only imagine, if I were a Recovering Warrior, becoming acquainted with one of those individuals.

Not only did they carry the rank and the qualifications to do the job, but they also carried the right mindset, I think that they really felt like they were there to advocate for the Recovering Warrior and make sure that the recovery went as well as it could.

I can only try to feel the reassurance that those Recovering Warriors must feel, as they met those -- as they became acquainted and met those folks.

As far as focus groups, I conducted one of them with lower-ranking enlisted. We only had two on that group, and I'll be honest with you, I become so immersed in making sure that we get through the protocol and understand the remarks that they're making, that I don't -- a lot of it

does not -- it's in the ears and out the mouth. It doesn't retain.

I made some notes on the higher, the more senior NCO group, and it was a number of recurring themes that we heard.

As far as the CRP, there was much lack of knowledge there. Either they didn't know they had one, or they had never seen it. They didn't know that -- they didn't know what input they had to it, and that's a recurring theme we've heard in a number of places over the years.

CO-CHAIR NATHAN: Do you recall the make-up of the focus group of the senior personnel, in general, either by service or by disability or by injury or by illness?

MEMBER REHBEIN: By service, they were all Navy.

CO-CHAIR NATHAN: Okay.

MEMBER REHBEIN: No, I do not, but I think that information would be available.

MS. DAILEY: Yes, sir, they were E-5's to E-7's, this particular group is E-5 to E-7. The other group was E-1s to E-4s, and the makeup of the majority of the both groups was "ill," in the category of "ill," cancer or other disease, heart disease.

So, you had a one to four enlisted. We had a five to seven more senior enlisted, and most of the population of the Navy Safe Harbor is "ill" category.

CO-CHAIR NATHAN: Thank you. I only bring that up because we have, just speaking on behalf of Navy and Navy Safe Harbor, which has been realigned, as you know, recently under Commander Naval Installations Command, removed from the personnel AGs, and moved over to the installation's AGs, and that is, I think, then to create better linkage between the facility's personnel and who resides there.

But there has been -- I have had to insert myself at the advocacy at the Chief

of Naval Operations, into looking at policies that are congruent not only for injured and severely injured, who automatically get thrown into the Safe Harbor Program, and especially if they're category two or higher Wounded Warriors at Walter Reed or other places, they're automatically assigned case mangers.

But not all the ill Warriors were being given that same opportunity, and that's why I asked the question, and it sounds like if there was a disconnect there, because these people were primarily ill, severely ill, or had chronically ill disease, it doesn't surprise me that we may hear from you, that they weren't well invested or situationally aware of what was available to them.

The Navy, I believe, has recognized that and is rectifying it, so, that we're doing a better job of getting case management, visiting nurses, and finding

those folks who are not near the medical centers, but are now back out in the interstitial space of the country, so we can do it.

So, I didn't mean to interrupt, but I was curious about the demographics.

MEMBER REHBEIN: No, and I appreciate that. That is important information to have.

Another piece of information that the group should have, this was a telephone focus group.

So, these folks were spread throughout the country. That eliminates the possibility of an installation-specific problem, and it makes things look more like systematic system-wide issues that need to be addressed.

That is just a piece of information that needs to be on the record.

A couple of other places that that same theme occurs, they expressed the

desire to know more about where they stood in transition and the DES process. That is -- I think part of that is just human nature.

At this point in my life, I am waiting on information on a VA claim, and as most humans would, I wish I knew more about where those pieces of paper were, too.

I don't know if we can supply enough information, but we need to have some sort of mechanism by which people feel like they are connected into a process like that.

The other place that they expressed a lack of knowledge was information on retraining into a different job or returning to duty. It seemed like they felt they were all on a path to discharge, and they didn't have any options, on whether or not they could choose a path to return to duty.

So, they seem to -- and I don't know if this was a function of them being spread around the country, but they seem to

all agree on those areas of insufficient knowledge, that they wished they were tied, connected into what was -- into the process tighter, so that they knew what was -- they knew what was going on.

I have some other -- well, I made some other notes, but I'm not going to get into them, because they're less clear to me than they were at the time. You know how it is, when you make notes and then you look at them two months later, and what does that mean?

So, I think the primary thing there was they expressed lack of knowledge on the process that they were going through.

CO-CHAIR CROCKETT-JONES: That's how I remember it, too.

I'd also say that when we talked to those senior NCOs who were functioning as non-medical case management, they felt that their rank allowed them to intervene as advocates in hospital issues, with more --

they had more authority to intervene and to act on behalf of the wounded, ill or injured that they were taking care of, and so, they felt it was a concrete advantage.

I also would say that, yes, those were the main themes that I recall, as well.

I think that we are -- they are persistent themes. We saw this at Navy Safe Harbor, but that we see also, a similar -- especially the desire to understand where people are in the transition process.

We see that almost everywhere, that people feel very blind to where they are in a time line sense.

MEMBER REHBEIN: One other thing that I'm going to mention, and I don't know if we can draw conclusions from it, although I tend to think I can, personally.

The other focus group was the more junior enlisted. We only had two of the group that actually participated.

I don't know if that is an

indication, because it seems like as we conduct focus groups, as we get to folks with more experience in the military, they're more willing to participate, and I don't know if that's an indication that they're better able to advocate for themselves, that they feel like their voice should be heard.

You know, I tend to think that there is a lesson to be drawn there, that the lower-ranking enlisted folks are more attuned to listening than they are to speaking, and so, to me, that means that they're also much less attuned to advocating for themselves, and that we need to look at. Is there a need for a stronger support system for them than there might be for say, an E-7 or as you move into the officer ranks?

That is the supposition on my part. I am not going to -- I think there needs to be some more work done. I draw that from limited data, participation rates and focus groups, and you have to work harder in

the lower-ranking enlisted focus groups, to draw them out, to get them talking.

MEMBER STONE: This was the nidus of our recommendation last year, that when anyone starts the disability system, that they receive legal counsel.

If I remember correctly from yesterday, the Department had non-concurred in that. Is that a correct statement?

MS. DAILEY: On the MEB, they concurred, sir. However, we didn't really have a lay-down, other than to say, we'll provide this guidance to the services and allow them to allocate as their resources allow.

MEMBER STONE: I think it -- these are very complicated systems, as we've all figured out. The idea of having advocacy is what we were looking for in that recommendation.

It will be interesting, then, to see how the Department really works its way

through, both with legal advocacy, as well as case management advocacy, and the service member may not be able to understand exactly where they are in a 55- or 60-step process.

But certainly, their advocate should understand on their behalf.

CO-CHAIR CROCKETT-JONES: I also think that this concept of not having information about: could they return to duty? Could they change their MOS? Could they be retrained to a different job?

It concerns me that -- and it's certainly not limited to one service or another. I'm wondering, you know, if there is any way to do a better job of identifying the folks who are seriously in need of transition out of the military, because they need a very different set of supports than those who are going to -- who want to stay, who, you know, can adapt.

I mean, I know that there is a grey area in there. There are going to be

folks who want to stay who cannot, and folks who could stay who aren't going to advocate for themselves and aren't going to -- would rather be out.

I just don't want the process to create folks who could stay, who have been all -- you know, money and time has been invested in training them, and have the process create a desire for them to get out.

So, hearing it at Navy Safe Harbor, we hear it in sometimes, less clearly or less emphatically, but the lack of information on staying, the sort of, "Where am I? What is going to happen to me?" that seems to be everywhere we go, to one degree or another.

MEMBER REHBEIN: And I agree with you, we don't want a process that creates the desire to leave the military, but at the same time, we don't want a process that creates false expectations of being able to stay in the military, either.

It's a very narrow path. You know, it's a very -- there is not a lot of variation that can be done, to stay off of one extreme -- to stay between those two, because it's a very narrow path between those two.

CO-CHAIR NATHAN: It's reliant on the local expertise of the medical personnel who are dictating the narrative summaries, and who are evaluating the disease and/or injury.

In theory, they are the ones who should be brokering whether the individual is fit for continued duty or not, and many of the things we're discussing right now have to do with local capability, and you just expressed, I think, Suzanne, the unevenness that we find.

You may go to one facility where the case managers, the PEBLOs, the physicians, the Federal care coordinators are all invested, have all been experienced, and

can answer everybody's questions, and people feel like they are seamlessly being taken through the system and have very little complaints, other than maybe they didn't get the answer they were hoping to get, but they got the answers.

You can go 100 miles away to another facility, and people are lost. They're in a complete quandary. They don't know what their appeal rights are. They don't know where if -- who they talk to about trying to stay on active duty, because all they've been told is, "You have an injury that is not consistent with that."

They don't know about VA disability. They have no idea what their rating is going to be, or should they accept this or should they accept that, and so, that is what I have found in my experience, is this tremendous inconsistency, and I still contend that the system got pretty overwhelmed, pretty fast with the degree of

injuries and the longevity of the conflict and the veterans returning.

The thing that I think we have to recognize is, as I look at my good friend here, Major General Stone, there is going to be thousands and thousands and thousands of people coming off the rolls in the next few years, Marine Corps and Army alike, and so, this isn't going to get better. This is going to get worse, before it gets better.

I think the services recognize that, and the Army is looking very hard at what they can do to try to steel themselves for the new wave of veterans who want to go through IDES or the normal disability evaluation system.

But I think that we're still a little bit on the cusp of the tsunami here that is coming.

The question I've always wondered, and I'm thinking out loud now, because I think we have a few minutes, given

the agenda, and I would be interested in the Task Force's Gestalt on this.

As I've always felt from the very first time I've encountered Wounded Warriors and their families and the recovering and the non-medical support genre, that there should be a central resource that people can reach out to, to get advocacy, to get information, to get expertise.

A, if that were the case, would provide a consistent answer to everybody, so, that the person talking to the case manager at Fort Hood doesn't get a different answer than the person talking to the case manager at Fort Campbell.

Secondly, I think it would instill confidence in our Recovering Warriors, that they had a place to call, where they got their call answered pretty quickly and accurately.

As I said before, 10 years ago, the complaints that I would encounter, Rich

and others, was, "I don't know who to call."

The complaint I encounter now is, "I've got too many people to call. I've now got a stack of business cards, you know, Admiral Nathan, at my desk, at the bed-side here, of my loved one, my injured loved one. I've got a stack of business cards here," and I have a Federal -- and I'm glad to see we're going to have a Federal care coordinator come in and speak to us this afternoon, I'd be interested in hearing their perspective on this.

But when I ask people, "Who is the one person who has come in and said, "If you have any questions about the process, if you're concerned about what is happening to you -- if it's medical, ask your doctor." But if it's not medical, who is the one person who is steering you through the shoals, who is navigating you through this very complex myriad of bureaucratic logistical entanglements, to get you there,

all by good-meaning people, who want to see you fairly treated, but who is navigating you through this?

If you talk to the Army, as a rule, it's somebody in the chain of command, who has been assigned as their advocate. If you talk to the Navy, it's often a case manager or a Federal care coordinator, and so, we have different systems who do it, and some of them do it very well.

You encountered a couple of Master Chiefs who you would want on your team, if you were ill and trying to get through the system. Not all of them are that good.

So, again, I just bring it up as a question that we need to think about. You know, we're investing so much resource and money and material and personnel into the local facilities, and that needs to be done, so people can have a human being they can talk to locally about this or get on the

phone with.

But what have we done to consolidate and to make a comprehensive resource facility?

You know, if you have a problem with your computer, there is an 800 number that you call, and they'll eventually get you to where you need to be, and they'll stay on the phone with you and work through it with you, regardless of whether it doesn't work right, it doesn't come on or off, you can't get the program loaded.

You know, we don't have something like that, and so, or we have certain one-stop shopping websites, but again, we're either not advertising them well enough and our families aren't aware of where to go.

So, you've been doing this, looking at these issues strategically longer than I have. I've just had the tactical issues. So, I'm very curious as to what your thoughts are on that.

CO-CHAIR CROCKETT-JONES: I just want to say -- I wanted to say one thing that actually, in the installation visits that we've gone to, even for non-medical issues, we find that Army Recovering Warriors tend to turn to their nurse case manager for information.

Family members, almost everywhere, say that the first person they'd call regarding any of the issues, is the nurse case manager. There is not --

CO-CHAIR NATHAN: Who is mostly there to broker the clinical.

CO-CHAIR CROCKETT-JONES: Yes, but she winds up being -- or he --

CO-CHAIR NATHAN: Right.

CO-CHAIR CROCKETT-JONES: -- winds up being sort of the portal to: who do you need to call? That is one thing.

The second thing is, when we first started going on installation visits, the most commonly used of the, you know, 800

number or one-stop resources was Military One Source.

People in focus groups were more likely to have used it. They knew about it. They've used it and they were happy with it.

The past few focus groups that I've done, I was surprised that people knew about Military One Source. They're not as across the board as they did a couple of years ago.

They were less likely to have used it, and those who did were not satisfied.

So, it's been a change, and we have a number of other general resources, and most of them are not -- they're not even saying the name does not -- asking for them doesn't get any response. Saying the names of a number of them still gets no response, except for possibly still Military One Source.

So, you're right, there are a lot

of go-to choices that are built as the resource that will guide you to the information you need, but they are not known and they're not being used.

Like I said, I was really disturbed that we heard in focus groups, that people were very unsatisfied with their experience at Military One Source, because they did not get any answers, and they did not get support. They didn't even feel like they were being given a fair hearing for what they did need.

So, I just wanted to interject that in this discussion.

MEMBER PHILLIPS: I don't want to be too redundant, but I want to emphasize the fact that it's universal.

Everywhere we go, we hear, "I don't know what is going on," whether it's from the service member, and especially from the family, or the support team, which is another issue that we're working on, trying

to get the families more involved.

We know that in doing anything, preparation is critical, whether it's preparing for surgery, driving to the meeting or waiting for Hurricane Katrina.

A key issue in preparation is information about, "What do I have to prepare for and what do I do?"

I am just saying that because from the point of view of the Task Force, is there something we can do to stimulate the development of a document, of a videotape, of a Facebook page, that is simple but scalable, that goes through five or ten bullet points of the steps that you will be going through and, "This is what you have to do."

I mean, really, a robust drill-down, because they're not going to the sites. There is too much information.

It may not be perfect, but at least it would jump-start, and you can connect this to all of the different

frustrations that the service members have, whether they're enlisted or higher ranked.

I mean, maybe that is something from the Task Force, that we say, "We need to drill down and we need to identify the critical issues, which we know we're not getting enough information," and then sub-categories related to those critical issues. Publish it on a pocket card or using social media. I mean, really focus on something like that. It's doable.

CO-CHAIR CROCKETT-JONES: I also want to throw out one more thing.

Consistently, everywhere we've gone, the one-stop shop that has the highest rate of satisfaction are the Army SFACs.

They have knowledge. The people who do utilize them are supported, not only in what they seek, but they are often guided to things they didn't know they needed, and I just want to throw that out, that if we need to be talking to people about that one-stop

shop concept, we need to talk to those SFAC folks about, you know, how to do it right. They're doing it right, from what I can tell.

MEMBER DRACH: Just following up on the one-stop, from my notes, this is not a direct quote, but: "The whole medical group, including VA, has made it into a one-stop shop, and it is very good." Now, this was at Navy Safe Harbor. So, there is some validity there.

A couple of other comments from Navy Safe Harbor.

One of the comments was that -- and you could sense the frustration from -- I believe it was one of the people, one of the sailors, very frustrated that there was no electronic system where records could be available to anyone.

Every time he saw a physician or therapist or whomever, he had to answer the same questions over and over again, and he was saying, "Why can't they just have an

electronic system, so they know what medication I am on, who I saw, what the doctor said?" so forth and so on.

Another comment was: "The process takes too long," and I know that we've talked to some people around the country, that are still in the process three years post-injury.

Now, this individual, my notes don't indicate how long that person has been on, but the comment was that the process takes too long.

The TRICARE appointment system takes weeks, sometimes months, and the comment was, "It's not the people, it's the system that takes -- the TRICARE system makes it so bad."

One comment was: they're not confident in the transition to the VA. A few did not have a PEBLO assigned. Those that did, the PEBLO was very helpful.

One other comment, and some of my notes are kind of hard for me to understand,

they're overwhelmed by so much support, you know, they're being inundated with offers of help.

The mentoring program seemed to be working very, very well, and one other comment was, and I think it was one of the presenters, I wrote down the name, but I don't want to repeat it.

His comment was, "The Recovering Warriors should be made to work," and the context of that was that sometimes, they have too much time on their hands and they don't have anything to do, and they should be given some kind of work, not necessarily make-work, but give them something that could -- this is my interpretation, anyway, some kind of work that could be meaningful to them and could help them, when they transition into the civilian economy, by gaining some practical experience, but it also, in my mind, is therapeutic.

So, rather than sitting around

all day, maybe watching soap operas or whatever else, give them something, put them to work in the library, put them to work in the record center, put them to work somewhere.

So, those are some of the comments, the highlights that I have.

MEMBER MUSTION: Of course, I'm new to the Task Force, so I'd just make an observation, and I've been working with the disability process and warriors in transition for close to four years, in my prior assignments.

But what I'm hearing in the discussion really beckons two things. One is the training education of the force providers and one is training education of the soldiers, or those that are undergoing, as warriors in transition or Wounded Warriors.

And each service has made a concerted effort to try to train and educate both the providers and train and educate

those that are undergoing the system, but I think we've all done that in a piecemeal manner.

At the Department of Defense level, I don't think we've really made a concerted effort, just as Steve pointed out, as a comprehensive standardized training strategy. We don't have that.

I mean, I don't know, as we go out and do our site visits, how much we talk to the members that are providing support about the training and education that they've received from the soup to nuts, from where it starts to where it ends.

I know what the Army's program is, and I know that we probably are not as wholly consistent as we need to be, in some cases, and the Army's resource, the SFACs, is kind of a -- is fail-safe, for lack of a better term.

But that just kind of resonates. I think the comment was made, "inundated

with information." I made a comment that we have soldiers and providers in this system that are both drowning in information and starving at the same time, because we have a whole bunch of information, but yet, not enough specific information, and the inconsistency across the force, I think really has come to light in the discussions here, and what I've seen in the past.

MEMBER EUDY: Dr. Phillips, just something that I was thinking about. You were talking about an all-encompassing resource, and I just thought of the Wounded, Ill and Injured Compensation and Benefits Handbook.

Although it is quite large, as the updates do come out, that is handed out to families, at least at our in-patient facilities, in order for them to, you know, use that as a resource, whether it's referencing financing issues, you know, whether it's the disability evaluation

system, treatment plans, basic knowledge of drugs, prescriptions, things like that.

But I think, you know, that resource could be evaluated further. I agree with what you're saying though, having a smaller footprint -- or a large footprint, but a smaller manual would make things a lot easier.

In regards to your comment, Admiral Nathan, how do we get families to really connect and see, you know, who is the go-to? And I'll take my Air Force hat off, and I'll put my special operations hat on.

Our population, unique in our size and agility and movement. Key successes would be your low amount of Wounded Warriors to case manager or our case liaisons.

Being that, you know, our large forces, I think of First and Second Marine Division, the 82nd 173rd Airborne are going to remove from Afghanistan here, and we're going to see, you know, the long term installations

like Fort Carson with 4th ID, needing the W2 establishment for quite some time.

But to have that low ratio of let's say, you know -- we talk about it all the time, what is the magic number? Is it one to 12? One to 10? One to eight? If you can get it down as low as, you know, in our case, it's sometimes one to five, you're really developing those relationships with family members.

Also, shortening that, the amount of people that are available to you, from your in-patient to out-patient movement of our most seriously wounded.

Common complaint that I remember, again, this has only been my first installation visit, but having years in direct family care and experience, if you're moving from a different social worker and a different nurse case manager, a different liaison or cadre member, from both your in-patient and out-patient movements, whether

that is moving inside, you know, a higher headquarters company, to you know, your line WTU unit, I'll use it just as a general term to base across all the services, that direct one-on-one communication, you're missing that, as you have to re-establish that relationship with the new nurse case manager, with the new social worker, so you don't feel them as your direct go-to.

So, I think key things are, you know, getting those numbers down, placing key individuals in those spots, and again, holding them long-term. When it comes down to our cadre members, our section leaders, you know, again, across the services, having that continuity of years of experience pays dividends.

We talk about them receiving continuing, you know, medical education, at those sites, in order to stay updated with current policies and procedures. But if those low level, you know, NCOs, those who

are deemed as the POCs for families who, they're suppose to be the go-to, instead of the nurse case managers, or just the social workers, having that continuity of two or three years of experience, I think is key for, you know, taking care of those families.

MEMBER KEANE: I have a few comments.

Mr. Rehbein, I want to get back to your original question about the focus groups, the E-1, 3 and 4.

I agree whole-heartedly, that they're a harder group, to get them talking, but I would suppose that it's a more simple thing, that we have two paragraphs in our script that discuss voluntary information, input what you want to.

I wouldn't change that script, but I think it's more of a technique of, as you go along and you find three of the 10 are talking, you say, hey, you call on someone as a technique and say, "What do you think?" and

more times than not, you'll end up getting eight or nine of the 10 talking towards the end.

It's still voluntary, and still comes to a point where some of them don't volunteer any information, but you can get them, as a technique, to talking.

The second thing I want to -- do you have a comment?

MEMBER REHBEIN: No, go ahead.

MEMBER KEANE: I have a separate topic.

MEMBER REHBEIN: Well, then let me simply respond.

Yes, and I understand and those techniques work well face-to-face.

But this sort of telephone group, where the first step is to get them on the telephone, that is strictly of their own volition, and if they choose not to punch the first number on the telephone dial, there is no way we can reach out. There is no way we

can reach out and touch them, like we can face-to-face, and I appreciate what you're saying, yes.

MEMBER KEANE: The other thing, Admiral, is the VA/DoD's IC3 Task Force that they have, three major topics that I am aware of, that they're working on is the relationship between the FRC and the RCC roles, trying to define them.

A universal CRP, as you know, the Army doesn't even call it CRP, as the DoDI discusses, the CTP. So, having one, that's another big topic.

But the third thing that relates to our discussion is a pilot for a lead coordinator, and Ms. Malebranche is probably a better person to ask. She is a Co-Chair of one of the tiger teams that I'm on. She may have more specifics. I don't want to misspeak.

But there is -- if it hasn't started, starting soon at Walter Reed, of

having -- I believe it's 90-day pilot of having a lead coordinator, someone who has got the belly-button. That person is the lead coordinator for the families.

CO-CHAIR NATHAN: Right, that is the program where the person stays with the family through the entire process, because we were handing off to different case managers and social workers, and now, you assign a lead coordinator, which I think is all goodness, and it sounds like there is some trajectory here, which is helpful.

Again, my concern is that there is an ambient loss of confidence and/or trust in the system, because families and Warriors perceive variability in it, depending on where you are, who you are, what service you work for, and who is holding your hand through the process.

I don't like variability. I don't like the perception of it, as no one would like it in their medical care, if I

went to the doctor and said, "I'm having chest pains," and somebody said, "Well, my doctor put me in the hospital, did a cardiac catheterization," or whatever, and, "Well, all my doctor said to do was take some Pepto-Bismol."

"Why is your doctor treating you differently than my doctor?" and they both may be very appropriate, but when the two people talk in the lay terms, they get nervous, and then one says, "Well, maybe I didn't even need a catheterization. Maybe I should have just taken Pepto-Bismol, because it cost me $4,000."

You know, so variability is a very difficult thing. So, communication and transparency are key.

I am concerned, as well, about Military One Source, and again, I think, and Rich, I'd be interested in your comments on this, because I think we've really worried about saturation bombing of the local

facilities with expertise, and trying to ramp those up.

We've created, to some extent, some stove-pipes of expertise that vary and are not necessarily connected at the common center, and so, in our efforts to avoid -- because all politics are local, and if there is a yaw-yaw that comes out of Walter Reed Bethesda, we immediately all -- everybody runs to the left side of the ship, and tries to put the fire out.

We hire more people. We hire PEBLOs. We throw the SFAC in there. We amp it up. We have a focus group, and we massage that hiccup until it's gone.

But we haven't looked at it from a systems approach to say, "Should we have something that rises above all of this, that those people could simply call, and say, 'here is my situation. I am an Army Wounded Warrior. Here is my family situation. I've been hurt. This is my diagnosis. I am being

told this, but what do you think?'" and then somebody centrally could say, "This should be what is occurring to you and the time frame it should be occurring."

Armed with that information, you could go to your local experts, you could go to your local points of contact and say, "This is what," I can't remember what Boris Badenov used to call the -- but anyway, this is something central, you know, and this is where you should be, to provide some sort of congruency across the spectrum.

I don't think it's a disaster, but I think it's suboptimal, where we are, and that is my vent. Rich, what do you think?

MEMBER STONE: First of all, let me respond to a number of things that have been said over the last half-hour or so.

Sir, I think you are correct; we're on the bow-rail of this.

As we draw down the Marine Corps

and the Army, I think we have many Marines and soldiers who have soldiered through their injuries from 12 years of warfare and multiple deployments, and when the Department of Defense looks at them and says, "Thank you very much, we appreciate the 12 or 14 years and multiple deployments that you've given us, but it's time for you to go home," those service members rightly, will say, "It's now time for me to take care of my healthcare need that I have put on the back burner," and therefore, I do expect, as we bring the Army down by something like 80,000 people, and the Marine Corps down, we will see a substantial number of individuals reporting healthcare needs, that will then need to go through the system.

I think that most of the discussion that we hear in our visits, as well as all of our visits to visiting wounded, ill and injured in various institutions, mainly goes from the fact that

we, as a community, are pretty concrete individuals.

When we joined the military, we know that if we're an E-4, exactly what we earn. We know what our benefit for housing is. We know what our healthcare benefit is, and when in fact, we begin to go through the transition process that we term IDES to process out of the system, there is tremendous unknown, and almost everything we've been talking is not about healthcare, because the decisions on healthcare are really pretty much known.

But I would challenge each of us, that -- what Colonel (Retired) Parker discussed in a very difficult case, where the service member receives 100 percent from the VA and zero from DoD, I don't think many of us can really articulate exactly what that means to that service member, because of the access to either healthcare or commissary privileges, before retirement, various access

to where: am I on the prioritization list in the VA system versus can I still go to DoD for my healthcare? It's really confusing.

Almost all of this relates to administrative unknown, what is going to happen to me and what is going to happen to my life and my ability to care for my family, that I thought was pretty set, because I can open up Army Times, Navy Times, I can see what my pay is this year, what my BAH is, what my BAS is. I know what every single piece is in my life, but now, I'm on this unknown. I know I am getting out of the military. The medical decision has been made, but what is going to happen?

As such, because we are, I believe, a compassionate and caring organization, we have 25 different groups that will come to your advocacy, including a number of our advocate groups who work on behalf of veterans, everyone, well-intentioned.

But then we get into the unknown, and Suzanne, I can remember a year ago, you discussing very articulately, that you got so sick of it, as you recovered your husband, that it became the social networking group that really gave you better information than almost anything else.

I think if we do recommend a centralized repository of, "Here is where you should be," I think we need to recognize the fact that our service members will still be in that unknown phase, and until we simplify this system into a single adjudication, where the services say, "You are no longer fit for duty. We have made a decision, we can't get you medically better and we can't retrain you," we now hand you off for that administrative portion to the VA, whose responsibility it is to care for you in perpetuity, then we will have a much simpler system that is easier for service members to negotiate their way through.

I submit again, what we did probably six or nine months ago, when we had some people from the Department of Defense talking about single adjudication, and the fact that it was just too difficult.

This is about pots of money that benefits come from and neither the VA pot or the DoD pot, but cost to the American people is exactly the same, other than a few access issues to commissary privileges, things like that. The cost to the American people is the same.

We really need a simpler system, and this is a discussion was had last year, as we began to get our recommendations together, do we go small tweaking the system, or do we go big, and I remain convinced that this system is archaic. It's a 1940s-era system.

Colonel Parker has been absolutely a gem for us, in bringing forward to us difficult cases where people get caught

in these very difficult areas administratively, and we need a simpler system, in order to accomplish, sir, what you're asking for.

But we will live this for at least another five years, as we draw down the size of the force, unless the country decides to take a different direction.

MEMBER REHBEIN: I agree with most of the -- the gist of the General's comments. I want to make one other point though, and yes, we are looking at this next five years and the draw down.

But I find this group that we spoke to at Safe Harbor very valuable, because groups like this are going to continue to exist indefinitely.

We are always going to have the ill and the injured. It may be a smaller number than we're currently dealing with right now, but I think we need to spend some portion of our attention on remembering that

the processes we set up now, will need to be sufficient for them 10 years down the road, because this is not a problem that will go away with the draw-down. This is a problem that may become smaller and less critical, and probably much less visible, and that diminished visibility, I hope, doesn't turn into diminished resources.

So, if we can make intelligent decisions and begin to do some of -- begin to change, create some of the processes to address that more distant future problem, let's not lose sight of that.

MEMBER PHILLIPS: I think that's all very well said, and I think from the very beginning of this Task Force, Dr. Turner and myself and many others questioned the lack of standardization and consistency and terminology across the different services, which is very confusing, even to us, let alone an E-3 or an E-4, trying to get through this process, and I think it was

paraphrasing.

One of our recommendations to create standardization of terminology, whether it be for the service member or for the facilitator, and yet, the response that we got back was, it just can't happen.

I mean, the Marines are going to call "x" x and the Army is going to call "y" y and that is the way it's always going to be, but I think if we're going to try and solve these issues, we have to create some sort of standardization.

When you take off an airplane, you go through the standard steps, no matter where you are, to get the plane off the ground, and if not, it's going to continue to be confusing.

MEMBER REHBEIN: You know, it may be that we have the opportunity to go back to -- maybe we can create some progress there, because what I hear you saying about the Defense Health Agency seems to me to be a

step, a real step towards standardization.

And so, maybe stay encouraged on that point, that maybe we can build on what they're -- what the services are doing there, what the DoD is doing there with the Defense Health Agency.

CO-CHAIR CROCKETT-JONES: I want to jump in here, while we have just a couple of minutes left, to ask the members who went to Fort Carson, if they have anything that they want to share about that site visit, while we still have time to bring it forward.

MEMBER KEANE: To echo what you mentioned, regarding the SFAC, that was, in all three focus groups, the place to go to.

They needed -- you were there. They needed some help in getting even more people to use it, getting the word out there, but in the focus groups that we spoke to, unanimous that that was the go-to place.

I don't know if you were going to go through best practices, if you want to go

through all of that.

They had a best practice of reducing dependency on requiring prescriptions for oxy and opiate drugs, and I guess that was a more recent best practice, and it echoed a concern that the family focus group had of dependency on drugs.

So, it seems like, I think they were independent of each other, in my mind, but definitely a best practice of trying to minimize the need for drugs.

CO-CHAIR CROCKETT-JONES: I do want to say that we saw one thing that -- we see a perpetual problem with a sort of time lag issue for transitioning folks who want to get -- have potential to get a job, and they want to start a job, but they can't, because they don't know when they're getting their DD-214, and, you know, they can't do an internship because they're too close.

They can't get the job because it's too far. It's going to go to somebody

else in the interim, and there is this time line hiccup that we've seen in a number of places, and they have created a work-around.

It's the first place we've seen where someone said, "You know what? If we pull together the VA, voc rehab connection and all of these folks," instead of sort of staying in their own lane, which as you mentioned, stove-pipes of expertise, that they have -- they've collaborated down at Fort Carson in a way that we had not seen in other places, and a person had a way to be in a VA stipend internship at the job, so that the job could be basically held for him.

It was a unique situation, and they'd only talked to us about doing it that once, but when we've seen this perpetual issue come up everywhere we go, and to finally see a group independently create a solution by working together, where in other places, their territories had seemed very separate, that was very encouraging. I was

glad to see that.

MEMBER EUDY: I'd just like to remark. Yes, that was the OWF, the E2I, the VR&E, all sitting together at the same table, saying the talk on a regular basis, about all issues of coming service members, so, they were able to save face with every single one.

When you mentioned -- back to the best practice portion, high marks on the behavioral health access. That was something, through all the focus groups, both junior and senior enlisted, felt that they had great access to behavioral health.

We'd even discussed down at the battalion level, how they had placed behavioral health assets throughout the post, and the downturn of certain behavior related incidents of all varying degrees that had decreased, and so, that was something quite high.

But high marks to the behavioral health department for all of that, positive

remarks from all of that.

Again, yes, the delineation that we had mentioned between the RTD track, the return to duty track and the MEB or transition portion, the high from the focus groups have, you know, why are we all bundled together, if I know that, you know, these three soldiers are looking at turning back to duty, and are reclassifying their MOS, versus all of those that are placed on long term MEB process.

They felt like they were further delayed in the process, because of having to follow it as one solid track, instead of two separate groups.

MEMBER KEANE: There was some confusion of how soon a service member could get Legal involved, and a little education there.

They thought it wasn't until much later in the process with the NARSUM.

Also, the majority, they had some

good luck with the PEBLOs. The majority of the PEBLOs were very engaged, contacting service members weekly, even if it was to say that there wasn't an update, but that was a good practice.

They had an IDES tracking database, a local IDES tracking base that the PEBLOs used, that seemed to be working well locally, helping them on their way to -- they still have some work to do, to get the timing down, but that seemed to be a good tool to help them.

CO-CHAIR CROCKETT-JONES: Unless anyone has questions about our Fort Carson visit, I just wanted to get some of that information out there, and Denise, did we have anything that we needed to do on our site visit schedule, or is that going to be later, are we going to discuss that?

MEMBER REHBEIN: Suzanne?

CO-CHAIR CROCKETT-JONES: Yes.

MEMBER REHBEIN: Could I just ask

a question for the staff, please?

CO-CHAIR CROCKETT-JONES: Yes.

MEMBER REHBEIN: I am very interested in what the Colonel was just talking about, with that local IDES tracking mechanism.

Can we get some information on that distributed to the rest of us that weren't on that particular site visit? That sounds very intriguing.

CO-CHAIR CROCKETT-JONES: We got a hard copy from one of the PEBLOs, correct, and so, they had created a template. So, I'm sure we can all -- the staff can get us all a copy.

MS. DAILEY: I'm sorry, get a copy of what?

CO-CHAIR CROCKETT-JONES: The local tracking template that they had created for their IDES process.

MS. DAILEY: Okay.

CO-CHAIR NATHAN: So, we're just

heading now into a break. Again, I appreciate --

MS. DAILEY: Sir, I would like to cover one more topic, before we take a break.

CO-CHAIR NATHAN: Okay.

MS. DAILEY: Okay, sorry. We are at 9:15, and our briefers have called. They say they're stuck in traffic, however, they aren't due here until 9:30. So, I do think they'll be on time.

So, let me just take your time real quickly, ladies and gentlemen. I want to indicate some changes in our schedule. This is in Tab B.

We are rescheduling the North Carolina Joint Forces Headquarters Installation visit. It had been scheduled for the 29th. It had been scheduled for the 29th through 30th of January.

We are rescheduling it for the 28th and 1st, 28th of February to the 1st of March.

So, if you were on the North Carolina Joint Forces Headquarters Focus Group and site visit, we have rescheduled that.

All right, and Stephen, go to the next page of this.

I do want to discuss with you, in particular, the 25th and 26th March business meeting.

We have a good number of individuals out in California.

If you can see the sequence there, the 19th of March we are in Camp Pendleton. We'll move up the coast and we hope to visit the Naval Reserve MedHold West in San Diego, and then, and that is about five or six of our members, and then, I have a business meeting Monday and Tuesday of that week.

We then return to the West Coast on the 28th and 29th of March, for Fort Lewis, and then up the coast to Alaska.

So, that is a two-week session, and this 28th and 29th March -- excuse me, the 25th and 26th March business meeting requires some inter-coastal flying for our members.

One option we have is to hold that business meeting out on the West Coast, which basically requires everyone to go to the West Coast, and I wanted to discuss that with you.

It's a Monday and a Tuesday. You would be flying on Sunday, and if you're very eager to get back, we could fly you back out on a red-eye that night, and so you'd be back to work on Wednesday.

It's a tough schedule to do that, or I can do it here, and the con of doing it on the West Coast is, we're identifying individuals to brief us, most of them are on the East Coast, and we when do these, what we do is, we like to bring the locals in.

So, we'd bring the local individuals to brief us, like we did in San

Antonio a year ago.

So, an off D.C. briefing/business meeting consists a lot of the local players in the San Diego area, and I do have DoD briefings that would have to be piped in, so to speak. We would Skype them, probably over non-DoD systems. I'd use my contractors and Skyping capability for them to brief us.

So, like WTC, I don't think -- and I don't think I should require, for example, WTC to fly out to the West Coast to brief us, but we want WTC to brief us, and this will be the last meeting they can do it. They're an example. I'm going to have to Skype them in.

Locally, I can bring non-profits. I can bring the VSOs in. I bring FRCs, RCCs, this would be the same, if you were here in San Antonio. We bring a lot of local to the table, when we do off site briefings.

So, that is how -- that is the dilemma with the March 25th and 26th business

meetings.

It is -- I am not sure I can get my East Coast briefers to the West Coast, except by Skyping them in, and but we do get the benefit of a local briefing, local experiences, and we basically are keeping that West Coast line up on the West Coast, those individuals going to the West Coast.

CO-CHAIR NATHAN: So, you wouldn't have folks -- let's say the business meeting weren't occurring at that time, you're not postulating that the folks who are out in San Diego would stay there until they moved up to the Fort, right?

MS. DAILEY: Yes, sir. That was the original intent, was that I had one day of travel in between each one of those visits.

CO-CHAIR NATHAN: So, they would finish on the 22nd, and they would start again on the 28th of March?

MS. DAILEY: If we don't have

that business meeting there, I would move Joint Base McChord into those two dates.

CO-CHAIR NATHAN: Right, I mean, from a fiscal services standpoint, it seems to make more sense to consolidate the West Coast visits, if that is possible.

MS. DAILEY: Correct, sir.

CO-CHAIR NATHAN: So, that there is --

MEMBER REHBEIN: Sir, your microphone.

MS. DAILEY: Sorry.

CO-CHAIR NATHAN: I'm trying to get this on.

I think it makes -- from a fiscal conservancy standpoint, if you can consolidate the West Coast visits, to save time, travel, and money, that would be the way to go.

I see where you could fill the -- you could fill the white space there with the business meeting on the West Coast, but now

you've got a majority of people who are back here, who won't be going on those trips, flying back to the West Coast, and as you said, it may be hard to get the briefers that you're looking for on the West Coast.

MS. DAILEY: Correct.

CO-CHAIR NATHAN: So, I am thinking out loud, I'm just wondering, should we figure out a different time for the business meeting?

MS. DAILEY: Okay.

CO-CHAIR NATHAN: And then consolidate the West Coast visits.

MS. DAILEY: Correct, I'm happy to do that, sir. I am really probably going to have to go back with your staff.

I did have you here on the -- I did have it on the 2nd and 3rd, and your staff says you're not available on the 2nd and 3rd of April.

CO-CHAIR NATHAN: Well, it's testimony season, and so, you may be able to

watch me on TV.

But I think it's open for discussion. I mean, this isn't a -- I mean, whatever you all think. I am just trying to look at a way to decrease the wear and tear on the members, and try to avoid too much layover, a non-productive layover in one duty area.

MS. DAILEY: Okay, again, I see the constraint now, in April.

I'm happy to reconnect these two trips, without having a business meeting in the middle. Maybe we can bring this business meeting down to one day versus two, because of the testimony season. That is the constraint, as we move into April. People just aren't available too far into April, for participation in the business meeting.

So, we're trying to keep it in March.

CO-CHAIR NATHAN: Other thoughts from the members, Task Force?

MEMBER PHILLIPS: Would it be impossible to have a business meeting with the testifying on a weekend? Is that just a no-no?

MS. DAILEY: It's not a no-no, sir.

MEMBER PHILLIPS: I am just wondering if we did it on the weekend of the -- or right following the Navy, the San Diego trip, it's Friday, Saturday and Sunday, 23rd and 24th.

I mean, if we stayed out on the West Coast, we could just all continue right through and then come back and then, go to McChord.

MEMBER EVANS: This way, we'd be able to get the briefers on the weekend.

MEMBER PHILLIPS: That's what I was thinking.

MS. DAILEY: Well, there is no rules against it. It's just bad form, frankly.

CO-CHAIR CROCKETT-JONES: All right.

MEMBER KEANE: I think it would make sense to have a one-day business meeting, and it will be focused on all of the recent trips that we've had. Have it after the Alaska trip.

MS. DAILEY: Yes, no, we have DoD briefers that we've got to get in. We have the East Coast briefers that we've got to get in. For sure, Warrior Care Policy needs to brief us.

You expressed a significant amount of interest in -- I need to track down that COE Advisory Board, and I think bringing them in is important, and then I have another of DoD entities that have to brief us.

MEMBER KEANE: Are we not going to have -- I'm sorry, sir, go ahead.

CO-CHAIR NATHAN: I guess the question the Colonel is asking, though is, is it prohibitive to try to have a one-day

business meeting somewhere around the first week of April, after the Elmendorf trip? Do we know that people are not --

MS. DAILEY: Absolutely.

CO-CHAIR NATHAN: People are not -- isn't that what I hear you saying?

MEMBER KEANE: Yes.

CO-CHAIR NATHAN: Having a one-day, or ideally two-day, but if necessary, a one-day business meeting, somewhere in the first week of April, following all the trips, so that we can compare notes about the trips, hear from the people who went, who didn't go.

MS. DAILEY: Absolutely, I can do it sir. I need you to pressure your staff a little bit, sir.

CO-CHAIR NATHAN: Well, easier -- I guess there is always first time. I guess easier said than done. No, I'll certainly look at it.

MS. DAILEY: Okay, all right, because I can basically flip-flop that

meeting, the 25th and 26th of March, to 2nd and 3rd of April, and push everything to the left and then, do the business meeting on 2nd and 3rd of April.

But I definitely think, sir, you've got a commitment on the 2nd and 3rd, that bumped me out of it.

CO-CHAIR NATHAN: I'll check and see.

CO-CHAIR CROCKETT-JONES: Can I throw out one other concern?

MS. DAILEY: Yes, ma'am, okay.

CO-CHAIR CROCKETT-JONES: The Rock Island CBWTU?

MS. DAILEY: Right.

CO-CHAIR CROCKETT-JONES: And the Arkansas CBWTU?

MS. DAILEY: Yes.

CO-CHAIR CROCKETT-JONES: We have only two members scheduled.

MS. DAILEY: Correct.

CO-CHAIR CROCKETT-JONES: I'm

just a little concerned that these are our RC component visits.

MS. DAILEY: Right.

CO-CHAIR CROCKETT-JONES: And they are more a source of information to us, even than our JFHQ, which you know, because we don't do focus groups at the JFHQ.

So, I would like people to just look at their schedules to consider if we could get a third person on there, you know, running the multiple focus groups.

Now, it's true that we also have less likelihood of a family member focus group of any size, if at all, at the CBWTUs, since people are remote.

But I would just like us to consider the optics, as well as the reality of the importance of those visits.

The 5th and 6th of February?

MS. DAILEY: Is Joint Forces Headquarters and the Rock Island is the 12th and 13th of March, and right now, we haven't

-- we have the request from the Army to cancel that.

So, that one, it might be off the table.

CO-CHAIR NATHAN: Can it be replaced by something else?

MS. DAILEY: No, sir, generally, at this stage, you know, business meeting, there is a thought. There is a thought. But that is pretty quick. It's tough to orchestrate a business meeting on -- okay, let me look at that.

But generally, I schedule 15. I generally have to do this to one of them. So, it might be the CBWTU, but we also cancelled them last year. This will be the second time we've cancelled Rock Island.

So, I will -- I can look at that, but I do agree, I would like someone to put their name down for the two community-based warrior transition units, and we will try and beef up that attendance, basically, yes,

ma'am.

All right. Are my briefers here yet? Are my briefers here yet? Okay, they're not.

CO-CHAIR CROCKETT-JONES: Okay, so can we take a brief break?

MS. DAILEY: Yes, I'm going to break until my briefers get here, please.

CO-CHAIR CROCKETT-JONES: Okay, thank you.

MS. DAILEY: Ladies and gentlemen, thank you.

(Whereupon, the above-entitled matter went off the record at 9:26 a.m. and resumed at 9:46 a.m.)

CO-CHAIR CROCKETT-JONES: Okay, we will now receive a presentation from Margarita Devlin, the Deputy Director of the Vocational Rehabilitation Services.

The Veterans Affairs Vocational Rehabilitation and Employment Program is Congressionally authorized to assist veterans

with service connected disabilities to prepare for, find and keep employment.

For those veterans with severe service connected disabilities that affect their ability to work, the program also offers services to improve their ability to live as independently as possible.

If you would please refer to Tab K for the briefing information, and I'm going to turn it over to you, Ms. Devlin. Thank you for coming, and for jumping in, too.

MS. DEVLIN: Thank you. Good morning, everyone, and thank you for having me here.

We've got a pretty healthy slide deck here. I am going to -- for those of you who were here last time I briefed, some of this information will be review, but I understand there are some new members. So, I will go over everything, so bear with me, if you've heard this once.

We're going to talk about the

mission, which you've already captured, the general mission for me, thank you, and the overview and process of how the VR&E program works and what benefits are provided, VR&E performance, the IDES involvement that VR&E has in the IDES process, a little bit of information about our satisfaction surveys, our Vet success on campus initiative and Vetsuccess.gov initiative.

So, our mission statement, which has already been mentioned, I won't repeat.

I do want to talk about eligibility and entitlement in two categories, service members and Veterans.

A common myth about our program that I like to dispel is that it is only for service connected disabled Veterans.

That is not true. It's also accessible to service members, with disabilities and injuries, which will become service connected.

So, I'd like -- I'll go over the

eligibility.

If the service member is active duty and is expecting an honorable discharge, has either a VA memorandum rating or an IDES rating of 20 percent or more, so, if you're familiar with the IDES process, they get a proposed rating, which isn't actually promulgated for payment until they're discharged.

That rating gets them in the door to a voc-rehab evaluation, or if the service member is participating in the IDES program, and has been referred to a physical evaluation board, and there is evidence of that referral, they are eligible for VR&E. No memorandum rating is required.

For Veterans who have an honorable or other than dishonorable discharge, and either a VA memorandum or IDES rating of 20 percent or more, so even if it hasn't been promulgated yet and they're already a Veteran, they are eligible, or if

they have a VA service connected disability of 10 percent with a serious employment handicap or 20 percent with an employment handicap, and I'll go over what a serious employment handicap and an employment handicap means.

CO-CHAIR CROCKETT-JONES: Can I ask you a quick question about eligibility?

Something that is never talked about, if you have 100 percent disability, opening this program to the spouses or sources, if they're not going to be employable, just wondering if that has ever come up in discussion?

MS. DEVLIN: Not to my knowledge, although we do provide counseling to eligible dependents, if the Veteran has Chapter 35 eligibility, based on permanent total disability.

We can provide counseling related to employment and education benefits usage to the dependents, but we don't provide the full

scope of services that we provide to service members and Veterans.

CO-CHAIR CROCKETT-JONES: Okay, thank you.

MS. DEVLIN: So, this chart gives you an overview and a visual sense of the VR&E process. I did want to go over this, so that you have an understanding of how the process works.

So, this is a program that has to be applied to. So, the Veteran or service member must submit an application.

However, as part of our outreach, if we're doing outreach to service members and Veterans and telling them about our program, we always have applications with us. It's very brief. It's one page. It's a series of a very few brief questions. So, it's very easy to fill out.

Once the Veteran applies, we establish their basic eligibility. There are really two adjudicative decisions in this

process.

The first is basic eligibility, which is what we talked about earlier, about the disability status, Veteran status and service member and discharge status.

Then the next thing is, we schedule the Veteran with a vocational rehabilitation counselor, to get a comprehensive assessment of their interests, aptitudes, and abilities.

So, we look at their educational history, work history, their disability conditions, the skills that they already bring to the table, their Military background, transferable skills, what their potential for learning is, the type of learning environment they work best in, and then we look at whether they have an employment handicap or a serious employment handicap, which is the second adjudicative decision that we make, and that determines whether, based on that decision, whether they

are entitled to receive the full scope of benefits or not.

MEMBER EVANS: So, let me ask you, isn't this -- why do they have to fill out an application? Isn't this a benefit that you're entitled to? So, what is the purpose of the application?

MS. DEVLIN: It is an entitlement program, but not everybody -- not every Veteran or service member is entitled. It's based on their need, based on an employment handicap.

So, they may come out of the Military and have a great job that pays them $100,000 year and don't need the benefits.

So, rather than expending resources on those individuals who have no need or interest in the program, we ask that they apply, if they have an interest, so that we know that they need an evaluation.

Like I said, the application is very simple and can even be filled out by a

counselor on their behalf, as long as they're able to sign when they come in for the first appointment.

So, we have taken informal claims and we can take informal claims, based on a phone call, a chance encounter at an outreach event.

An employment handicap, in layman's terms, is basically the Veteran or service member is unable to perform suitable employment, meaning it's consistent with their interests, aptitudes and abilities, in some part, because of their service connected disability, or disability that will become service connected.

But we also take a holistic approach, so, we do look at the entire picture, including non-service connected disabilities, but the service connected disability has to have some substantial impact on their ability to achieve suitable work.

So, a Veteran can be employed, but under-employed in a job that is not suitable for them, and they can be entitled, or they can be unemployed, and be entitled.

So, their employment status in this determination is not a direct indicator of whether they would be entitled, but it's that, the nature of that employment and whether it's consistent with their interests, aptitudes, and abilities.

A serious employment handicap, in addition, once that first decision of employment handicap has been made, the second decision is whether that employment handicap is serious in nature.

So, this would be an individual who needs above and beyond services, above and beyond the basic rehabilitative services of obtaining the skills that they need to compete for employment, but they will need other supportive services, to overcome their employment handicap.

Some examples I like to give of this are a visual disability, where they may encounter negative attitudes on the part of employers, because it's a visible disability, or disabilities that may have negative connotations to employers, if they don't understand, such as PTSD, TBI or other neuropsychiatric conditions.

Also, substance abuse tends to be an issue that requires additional rehabilitative and supportive services.

Once those decisions have been made, the counselor will look at what the Veteran's potential for employment is. If the Veteran's potential for employment looks very feasible, they will develop a rehabilitation plan for employment being the goal.

If employment is not currently feasible, because the Veteran is too severely disabled and has not really reached that point of maximum rehabilitation gain to move

on to preparing for employment, the voc rehab counselor will prepare what is called an independent living plan, and I am going to go over both plans.

There are basically five tracks to employment, which you will see in that light blue area. Re-employment is really the use of USERRA to help a Veteran who comes back from Guard and Reserves, to re-engage with their previous employer.

We provide adaptive equipment, if needed. We provide any accommodations needed to help them stay in either the same job they were in, same employer/different job, or even the same employer, totally different career field, with some training.

Rapid access to employment would be that individual who has training already, that may help them compete for employment, for example, a Bachelor's degree, Master's degree, Associates degree, technical degree, any kind of training that, they don't need

additional training to compete for employment, but they do need other services.

They need help with a resume. They need help with job seeking skills, how to interview, how to find the jobs. They may even need help with certification, exams, and such.

So, this would be the -- the rapid access to employment means they don't need to go to school or to a training facility, but they need some other credentialing that is short term, or they need the actual assistance to bridge the gap from that unemployed status to employed status, using their existing skills.

Self-employment track, this is for the individual who, because of their need for flexible work environment or just because of their interests, they don't want to work for an employer, but they want to be self-employed.

There are two categories for

self-employment. Under category one, if they have a serious employment handicap and very severe disabilities, VR&E can actually provide not just the employment -- the assistance to develop the business plan through the help of SBA and other partners, but also, the funding for a large part of establishing that business.

We cannot pay for certain things, such as real estate, vehicles, there are certain preclusions, but we can stock them up for their initial business.

The example we like to give is a Veteran that goes to school to become a barber.

He can either go to work in a barber shop, or he can set up his own barber shop, and if he meets the criteria for category one, he will have to fund his own space using other resources, but we will stock him up with the necessary supplies to stock up his entire barber shop, and help him

with marketing and other training on how to run a business.

Category two is that Veteran who is not so severely disabled, but chooses self-employment, and we will help with our partners to help them develop a viable business plan, and then at the end of their training, example of the barber, they can either choose to go to work for an employer or they can set up their own business, but VR&E would not fund that business. They would need to find other resources to fund that business.

Employment through long term services is what you'll see the bulk of our Veterans participating in.

These are Veterans who come in, who do not have the educational accomplishments to compete for employment that is suitable. They may come to us with some education completed, but they may not have the right level of education or in the

right field, to be consistent with a job that fits their disability conditions and their interest and their aptitudes.

So, in the employment through long term services track, the plan will call for a specific training facility, a specific training program, and upon completion of that program, we will assist the Veteran with obtaining the employment that they set out as their goal.

Then the independent living plan would be the individual who is -- for whom employment is not currently feasible, and we will help them with any accommodations they need to be independent in their activities of daily living, including taking care of their bathing, their grooming, their cooking, cleaning, any kinds of activities that many of us do independently, that they might need the assistance of a family member or a dependent to enable them to not have to rely on those individuals, but to be able to do

those things on their own.

We can also help them with community access.

A lot of times, if a Veteran can't work, but they can volunteer part-time, it gives them a sense of being involved in their community, it increases their self-confidence, and it can also help them to lessen symptoms, for example, of depression and isolation and hopefully, we always hope that at the end of an independent living program, when they achieve their goals, that we can re-assess and that maybe they are, at that point, ready to pursue employment.

But if they're not, and they achieve all of their goals for being more independent in daily living, then they will be considered a successful rehabilitation.

For the other four tracks, successful rehabilitation is defined as, they achieved their employment goal.

So, for traditional employment,

once they've achieved their employment goal, so they started a job, we monitor them for a minimum of 60 days, and I want to stress the word minimum, because we have had questions before about, is 60 days enough, and 60 days is the minimum. The maximum is 18 months. Statutorily, we can only provide employment services for 18 months.

So, somewhere between 60 days and 18 months, the counselor will determine that that Veteran has no further needs, that they are suitably and stably employed, and they have no further needs to adjust to that employment.

However, if the Veteran chooses self-employment or has a temporary job that is not temporary in nature, such as a contract-type position, but more of a temporary job that has a distinct beginning and end date, and at that end date, there is no assurance that that job will continue.

If it's a temporary or self-

employment, we do follow them for a minimum of one year from the date they began that employment, and not to exceed 18 months.

So, those are the basic criteria for rehabilitation through those five tracks.

During the time that the Veteran is in one of the tracks, they receive case management services from the voc rehab counselor.

That voc rehab counselor will meet with the Veteran in person, from the point of evaluation and plan development, all the way through to rehabilitation, a minimum of once per year, but most of our Veterans are assigned what we call a category two, which is once per term.

If they're not in a standard term training program, such as semesters, if they're in a semester program, it's typically three times per year. So, Spring, Summer, and Fall.

If they are in a quarter type

program, it would be four times a year. If they're in a non-standard program, the typical is quarterly.

So, once per quarter, they have a face-to-face meeting with their counselor. Go ahead.

MEMBER DRACH: Yes, can I get clarification on the case management?

I choose employment through a long term service, and I go to college and I go four years and I get a degree, and then at the -- upon graduation, I say, "I need some employment services help."

Does the 18 month of case -- months of case management start when I enroll in college, or when I start the employment services?

MS. DEVLIN: That is a very good question.

The entitlement for the training part of the program is 48 months, but that can be extended with a serious employment

handicap to more than 48 months, and they have 12 years from when they got the service connected disability, to use the program, or it can be extended if they have a serious employment handicap.

The statutory 18 months begins from the decision the counselor -- the date the counselor makes a decision that the Veteran is job-ready.

So, they've finished their training. They've got a resume. Job seeking skills have been learned. They are ready to hit the ground running and seek a job. That is the day it starts.

So, that is why one of the things we focus on in case management is to enable the Veteran to get a job, before they graduate, because that gives us -- first of all, it's easier to find a job if you're either already employed or if you can say you're a full-time student, and second of all, it helps them to not have very much time

between when they're receiving subsistence allowance and training, to when they're receiving a salary.

So, yes, 18 months from the day they are job-ready.

During the time they're in training, in addition to getting case management services, they get full funding, 100 percent funding for their tuition, books, fees, supplies, adaptive equipment, technology that they need to support their training program, or also, any kind of independent living supports.

That is fully funded. No out-of-pocket expenses for the Veteran. There is no limit. There is no dollar limit. There are funding approval level limits, for example, that VRC, the counselor can approve up to $25,000. Above that, it has to go to different levels of management for approval.

But there is no funding limit, statutorily speaking, for how much could be

spent on a Veteran's program. It's based on their individual need, what their track is, what their training requirements are, and the other services that are required for them to achieve rehabilitation. Do you have a question?

MEMBER EVANS: So, are you the only case manager working with that Veteran at the time, or do they have other case managers assigned to them, also?

MS. DEVLIN: There is typically one voc rehab counselor that is assigned to each Veteran, and they will have a case load of a number of Veterans assigned to them.

In most regional offices, we have at least one employment coordinator. Voc rehab counselors are Master's level trained professional counselors. Employment coordinators, some of them are also trained rehab counselors who chose the employment coordinator position, and some of them are not. They usually have experience in HR and

other recruitment and other such employment backgrounds, and their job is really to help the Veteran find the job.

So, sometimes the voc rehab counselor will transition the Veteran to the employment coordinator, for intensive employment services. But it depends on the regional office, what their staffing levels are, whether they get transitioned or whether the employment coordinator teams up with the voc rehab counselor, to help a series -- a number of Veterans together.

MEMBER EVANS: So, they may have multiple case managers working with them?

MS. DEVLIN: They have one voc rehab counselor assigned to them at any given time.

MEMBER EVANS: One voc rehab?

MS. DEVLIN: Yes.

MEMBER EVANS: Okay.

MS. DEVLIN: They can transfer from one to another, depending on whether

they move, change training programs or if we have staffing losses.

Okay, so, that is the overall process, and the one thing I would mention, again, I wanted to dispel the myth about active duty service members, they can receive the full range of benefits that I just described, with the exception of subsistence allowance.

So, they can get tuition, books, fees, supplies, equipment, everything, except the subsistence allowance.

So, if they begin a training plan, while they're active duty, they'll receive all those benefits and the day they get discharged, they will start receiving subsistence allowance at that point, as well.

One other point I'd like to make, related to subsistence allowance is that previous to 2010, the subsistence allowance was significantly less than the post-9/11 GI Bill, and a law was passed that enabled us

to, if the Veteran is eligible for post-9/11 GI Bill and is also eligible for voc rehab, they cannot pursue both benefits at the same time, that is against the law.

They have to choose one, but if they choose voc rehab, which is the more robust, because we have no limits on what they can receive, they also get to receive the higher post-9/11 subsistence rate.

If they're not eligible for post-9/11 GI Bill, they do not get that additional benefit.

MEMBER REHBEIN: But if they use the VA and our benefit, they don't lose the post-9/11, is that correct?

MS. DEVLIN: That's a really good question. The entitlement is what we call the same pot of entitlement.

So, they do use the entitlement. So, if they choose VR&E and they use -- now, under post-9/11, they get 36 months. Under VR&E, they get 48. They could use 48 months

under VR&E, and it will use up their GI Bill benefits, as well.

However, it doesn't work the other way exactly, because of the extensions that our program allows.

So, if they use 36 months under GI Bill, and they still require additional education to be competitively employed, and they apply for VR&E, there is a stipulation in the law and in the regulations, that allows us to extend their entitlement for an additional -- up to a maximum of 48 months. So, we can extend and basically, recoup some of the entitlement they've used.

MEMBER DRACH: When you declare somebody rehabilitated, it's determined that they've held suitable employment or improved ability to live independently.

At what point in time do you measure that? Is it one month post rehabilitated, or you do it at 18 months?

MS. DEVLIN: A decision is made

by the voc rehab counselor, that the Veteran no longer needs additional services, and that would be at that point, where they've been suitably employed for a minimum of 60 days or longer.

So, the voc rehab counselor is following up with the Veteran to verify, you know, what their needs are.

For example, if the Veteran says, "You know, I love my job. Everything is going great. However, my back condition is really flaring up. They have really terrible chairs here, and it's a really small business and I really don't want to ask my employer to buy me another chair."

So, what we could do is purchase a special lumbar support chair for that Veteran, even if it's been 65 days, since they started the job, and then we would wait until they got the chair, they tried it out, they verified that it's working, their pain symptoms have subsided, and then we would

say, "Okay, are you good? You don't need anything else? Everything is going great? Okay, we'll go ahead and propose that your case is rehabilitated."

MEMBER DRACH: I'm not sure that that actually answers my concern.

I've heard a lot of criticism lately, that VA and Department of Labor and other Government agencies, do not adequately track or have adequate metrics in place to measure success.

So, if I am declared rehabilitated, October 1, 2012, what system is in place to track me, say for 30 days, 60 days, 90 days, 180 days, to find out if I'm still successfully rehabilitated, because I may not come back to you. I may be unhappy. You mentioned the chair. I may just say, "I am going to go home and not do anything."

So, is there any metrics in place, or any system in place that measures that?

MS. DEVLIN: Actually, there are two things that are going on right now, that address that.

The first is more of a long term project, and that is the longitudinal study. Public Law 110.389 mandated the voc rehab and employment conduct a longitudinal study of three cohorts of Veterans, 2010, Veterans entering the program in 2010, 2012 and 2014.

We will be tracking those Veterans for 20 years, from the moment that they enter the program, 20 years.

So, we've got our first cohort underway. We've prepare our report to Congress every July.

So, that is more of a long term view of three cohorts.

In the more short term, what we're doing is, and this is a fairly new initiative, we're still working on getting off the ground, is what we call post-rehabilitation and post-discontinued follow

up.

So, the law says, and the Code of Federal Regulations says this is when you rehabilitate a Veteran.

So, you declare them rehabilitated. You send them their letter. You say, "Thank you, you're successful, you know, see you later. Let us know if you need anything else in the future," kind of thing. It's a nice letter, but it has Appellate rights. Your case is closed. That will not change.

What will change is that at certain periods of time post-closure, and I'm going on memory here, because I don't have the information in front of me, but I believe it's at six months, 12 months and 18 months, if my memory serves me correctly.

We will be doing follow up. The follow up will consist of a survey, a short survey, that will ask them, if they were employed -- are they still employed, are they

doing well, do they need additional services?

It will be pretty short, because we don't want it to be cumbersome for the Veteran, and then based on them returning that survey, if it says, "Hey, I'm doing great. I don't need anything. Thank you very much," then we will file it down and we'll do it again at the next point, to verify that they're still doing okay.

If they come back and say, "No, I need some help or I need something," we will bring them in for an appointment and discuss what those service needs are and provide as the law allows, whatever follow up services they need.

For the discontinued Veterans, which are those who closed out of the program without achieving and maintaining suitable employment that met the criteria, we will do the same follow up, but with slightly different questions about, are you ready to re-engage in the program? How are you doing?

You know, can we bring you back in to see if we can help you to achieve your goals?

Same thing, at those points, where we've already made the decision to close because we've tried all the follow up. We will still do follow up for another, I believe it's 18 months.

This is an overview of our workload in 2012, fiscal year 2012. The number there that you see for participants, those are individuals who began a rehabilitation plan. So, they were found entitled and actually participated in the rehabilitation plan during fiscal `12.

So, that includes Veterans who began in previous fiscal years. They might have begun in fiscal year 2009, and were finishing in 2012, or they might have begun their plan in 2012.

It also includes Veterans whose cases were closed during fiscal year 2012, but they participated in a plan during that

year, prior to their rehabilitation or discontinuance.

We received 72,605 applicants in fiscal year `12, and we rehabilitated -- I'm sorry, we received 13,284 Chapter 36 applicants.

Chapter 36 is educational and vocational counseling for service members who are six months pre or 12 months post discharge, who may not have a service connected disability, and also, for any beneficiaries of any education programs.

So, if they have post-9/11 GI Bill, but no disability, and they want to receive counseling on vocational direction, planning how to use their benefits effectively, or if they come into problems while they're using their GI Bill benefits, and they need help to get back on track, we can provide that counseling, too.

We have 56 regional offices and over 100 satellite offices where these

benefits are administered.

As I mentioned previously, this is a face-to-face process. It's not a telephone. It's not a paper trail, where we are making decisions on paper. These are people. We are looking into the eyes of the person, as we're working with them. So, we have to be everywhere.

So, we have a pretty high access level.

MEMBER MUSTION: Can I ask you to clarify the 72,000 number? Is that new applicants during fiscal year 2012?

MS. DEVLIN: Right, we received their application from October 1st to September 30th, and of those 72,000, and I don't have the numbers in the slide deck, it wasn't included, but just to give you a general idea, about -- a large percentage of those are entitled.

So, we entitle a large percentage, you know, of our Veterans, but

some percentage of those Veterans choose not to participate in the VR&E program. They choose to participate in Montgomery GI Bill, post-9/11 GI Bill, or they may not be ready at all.

They may not be ready and they may not want to participate now, but they got the information that they needed through the comprehensive assessment, and they may choose to delay their entry until later, and then some of them will actually enter a plan, and some of those individuals will not be entitled.

MS. DAILEY: So, those are just that application that -- I'm over here, sorry, ma'am.

MS. DEVLIN: Okay.

MS. DAILEY: So, that is just the application?

MS. DEVLIN: Correct.

MS. DAILEY: That very small, quick application that you have asked them to

fill out --

MS. DEVLIN: Correct.

MS. DAILEY: -- and to assess their status?

MS. DEVLIN: Correct.

MS. DAILEY: Okay.

MS. DEVLIN: And then you see the number of benefits paid in 2012, which includes benefits from the readjustment benefits fund, not GOE.

I wanted to talk about our placements, and I've got two slides on this that take a slightly different view.

One of the things that is unique about our vocational rehabilitation program in VA, that is different than the State vocational rehabilitation programs, is that because our goal is to enable the Veteran to enter the most suitable employment situation for that Veteran, that unique individual Veteran, that we can provide the level of training that they need to become career

ready.

It's not just a job, it is a career. So, we enable them to achieve the level of education, as you can see from the placements, you're going to see in the next slide, this slide talks about the types of employers.

About half of our Veterans are employed in private sector, but you can also see that about 30 percent are employed in Federal sector.

We have great partnerships with VA regional offices and VA Chase Centers, and with DoD, to employ our Veterans, and we use a lot of different initiatives, such as the non-paid work experience program, which allows the Federal agency to bring the Veteran in, sort of as a student trainee, but it doesn't count against that agency's ceiling for FTE, and we, VR&E, pays the Veteran a stipend.

It's a training stipend. So, it

is not a lot. It's not a salary, during the time they're placed in that agency, and during that time, they're getting trained in a specific job with that agency, and at the end of that training, if the agency feels the Veteran did a good job and is a good fit, they can non-competitively appoint the Veteran into a job if they have an FTE slot.

MEMBER DRACH: Quick question. That is a significant increase, which is very, very good, on the average salary before rehab, and the average beginning professional salary. Is professional salary meaning average across the board of all rehabilitated successfully employed?

MS. DEVLIN: Right, so, that would exclude two categories in the average. It excludes the independent living rehabilitation, because they are not employed.

MEMBER DRACH: Right.

MS. DEVLIN: And it also excludes

those Veterans who choose not to become employed at the end, but choose additional education.

So, they can be rehabilitated, because they made a choice not to become employed, but to go on for higher education. They might seek their PhD, and we can rehabilitate those Veterans, too. Those aren't included in there.

MEMBER DRACH: So, it would include the self-employed?

MS. DEVLIN: Yes.

MEMBER DRACH: And it would include somebody who went through an OJT or apprenticeship program and became a welder?

MS. DEVLIN: Yes.

MEMBER PHILLIPS: The graph, I just wonder, I mean, my way of thinking, I could include the 12 percent of self-employed and the five percent of faith-based into the private sector, which would increase that number.

MS. DEVLIN: We could have. There is a couple of reasons we do that. One is because we do have a strong partnership with faith-based organizations.

So, we do like to show that we do have an emphasis in that area, and also, for self-employment, there is typically a lot of interest in how many self-employments we have.

So, yes, there are technically all three private sector.

MEMBER PHILLIPS: Yes, I agree with that, I just wonder if it would be helpful for you, as far as whoever you have to present to and get funding from, to show that sub-category within the private sector being, you know, almost 65 percent or so.

MEMBER REHBEIN: Just a clarification, is self-employed 12 percent or one percent?

MS. DEVLIN: Based on this chart, it is 12 percent.

MEMBER REHBEIN: Then the state and local Government is one percent?

MS. DEVLIN: Sorry, no, I'm sorry, I have that backwards. No, it is one percent for self-employment and state and local is 12 percent. Thank you.

One other initiative that I wanted to talk about, well, it's not an initiative. It's part of our program, is the special employer incentive, and the special employer incentive allows the VR&E counselor to provide an incentive to an employer to hire a Veteran who may have been out of work for a long time, and may have just recently graduated with a new skill, but doesn't have any experience.

If they have those kinds of obstacles to employment, they can go to an employer and say, "If you will agree to hire this Veteran, because I believe in this Veteran's skill sets, but I understand the limitation in experience, but I know that

this Veteran can do a great job for you, so, I will agree to reimburse 50 percent of the Veteran's salary, for six months, while you train them and while you take one of your other employees and dedicate them to training this person," because I realize that is a productivity loss for the company, while you're bringing this person up to speed, but the reward at the end will be worthwhile.

So, it's an incentive for an employer to hire, and it's a contract that gets entered into, before the employer hires the Veteran. They get the reimbursement of salary and the Veteran is expected to maintain that employment because they are hiring this Veteran. So, it is a full-time FTE on their private -- it's a private company, not a Government.

But so, and that is another initiative that we can use with private sector employers, and it's recently been expanded.

Previously, you could only provide that benefit to a Veteran who had graduated through training in the VR&E program, and that was recently expanded with the VOW Act, to allow Veterans who -- right in the door from application status, if they're entitled, we can use those special employer incentives, even if they didn't train through our program.

The other chart about employment will talk about where the Veterans are getting -- what type of categories.

As you can see, 70 percent of the jobs are professional. We find a lot of our Veterans get into management jobs right off the bat, but they are typically professional categories. We've got a smaller percentage in clerical services, the building, sales, or other trade types of jobs.

Some of that too, will reflect the fact that our Veterans do have disabilities, so, some of the trade

occupations that may be in high demand, might also be very physically demanding. So, they may not be able to choose those.

So, most of the jobs that our Veterans enter into are going to be sedentary. So, they're going to be typically in a sedentary environment, typically an office environment, a lot of white collar type of jobs.

This is some data about our participants, that shows you a comparison between 2011 and 2012. You can see, we've had some growth in our participants, and this gives you an idea also, of how many service members participated in the two years.

I do want to point out that for each fiscal year, if a Veteran enters -- if a service member enters the program, let's say in fiscal year `11, and they're counted as a service member then, but by the time fiscal year `12 rolls around, they've been discharged and they are now a Veteran, they

will not continue to be counted as a service member.

So, this gives you a snapshot of how many individuals we're serving at any given time, that are in active duty status.

MEMBER MUSTION: So, can I ask a question about that? Maybe I'm the only guy who can't work the numbers. Can you go back?

So, in 2012, you had 121,000 participants in the program, and I assume that number is still tracking, and about 9,900 that completed the program, and went into employment?

MS. DEVLIN: The 9,949 rehabilitations include independent living and employment rehabs. It does not show you the other exits.

So, Veterans who exited the program because they chose not to complete their rehabilitation plan or they encountered health issues and couldn't, or they achieved

what we call maximum rehabilitation gain.

So, maybe they graduated with their training, decided to start a family and be a stay-at-home dad, or a stay-at-home mom, those kinds of exits are not shown in this number. This only shows you those that by law, meet the criteria as rehabilitated.

So, we probably had an additional somewhere around, I think it's 60,000-ish that would have exited in different categories.

MEMBER MUSTION: So, in your earlier charts concerning employment and jobs, what is the actual number of soldiers, or service members or Veterans who were employed, ended up with employment?

MS. DEVLIN: The 9,989 minus about 1,200 that were independent living. So, about 8,000.

MEMBER DRACH: If a service member starts under VR&E, while still on active duty, transitions out, continues on

the program that he or she started while on active duty, where would they show up in the rehabilitation, once they get rehabilitated? Would they be -- would they show up as an overall or participated in Gulf War or service member? Which category?

MS. DEVLIN: They are going to show up in the overall rehabilitation number.

The ones that you see that are service members, that are rehabilitated, we sometimes encounter that a Veteran, actually a Veteran, will be in our program, and then be recalled to active duty.

And so, if they are recalled into a position that is now suitable, either because their disabilities have improved or because it's a more sedentary job in the Military, we can actually rehabilitate them into an active duty status.

MEMBER DRACH: And when you say participated in Gulf War, do you mean they actually were wounded or were injured while

either in Iraq or Afghanistan or served during the era?

MS. DEVLIN: They served during the era.

MEMBER DRACH: During the era, okay.

MS. DEVLIN: Okay, this slide shows you sort of our -- all of our different methods of outreach and early intervention, and there are a lot of slides subsequent to this. I am going to summarize, so that I don't run out of time.

We do perform outreach, both in the hospitals. We go bed-side and we'll send a voc rehab counselor to meet with the service member, if they're severely injured, to make sure that they're getting the services they need for independent living, as they approach that medical rehabilitation point.

So, prior to separation, we participate in disabled transition assistance

program. We are now in the IDES, many of the IDES installations, which I'll talk a little bit more in depth about.

We use Chapter 36 educational vocational counseling to provide early intervention counseling to the service members, and at that point, they get a better understanding of what the different benefits are that they might be entitled to. So, if they have a disability, we'll tell them about that during the ed/voc counseling.

We also work through the -- we have OEF/OIF coordinators that perform outreach and we case manage, even if they're not in our program, we participate in follow up for those severely injured to make sure that if they're not ready for voc rehab now, that we keep following up, so that we know when they are ready.

We work closely with DoD in a lot of different ways, which I'll talk a little bit more about.

We also do what we call, if you look at the fourth bubble, the third and fourth bubble, with every disability compensation rating that enables the Veteran to become eligible when they previously were not eligible for VR&E, we send them, VBA sends them a -- with their rating notification, an application for voc rehab and a fact sheet that explains the program to them, because maybe when they got out of the Military, maybe they had a zero percent, and now, they have a 10 percent. So, it's been increased.

That enables them to become eligible. They may have had rehabilitation needs before, but they weren't eligible.

So, if they had a 10 percent previously and now, they get an increase to 20 percent, they also get a letter with an application, because they might not have had a serious employment handicap and not been eligible with a 10 percent.

Then with the rating increases, if they get a new disability rated that wasn't previously rated, so, let's say, they were rated for 10 percent for a scar previously, and now, they just received a rating for 20 percent for a knee condition, they are now eligible in a different way because maybe that scar was not in any way preventing them from achieving suitable employment, but the knee condition might be.

So, any time there is a new condition that is awarded disability comp, they get an application and a fact sheet.

So, we try and perform as much outreach as we can.

If they're a VSI/SI severely injured when the disability compensation rating process begins, there is an end product established for outreach for VR&E, as well, and so, the VR&E division can get involved early on, to provide outreach to that service member or Veteran, to make sure

they know about our program.

So, we perform outreach at a lot of different venues. We also try to involve ourselves as much as possible, in Yellow Ribbon and PDHRA events.

So, these next slides are going to go into a little bit more detail about the types of outreach programs.

'Coming Home to Work' is VR&E's outreach to service members, which is now, being somewhat combined with the new IDES initiative, and I have several slides on that, so, I'm going to skip past that and come back to it.

The VA assistance program VAP is a program in San Diego that involves multiple VA/VBA employees, both from the comp side and the VR&E side, who are physically onsite.

They do an in depth assessment and provide in depth services onsite for about a week-long program. It's a really great program, if you've never heard about

it, it would be worthwhile to get a briefing on it.

The Vets Success on Campus Program is another place that we do outreach. We're on several campuses, and I have a list of the campuses. It's not in the slide deck, but I have a list of the sites, if you are interested, I can leave that here.

So, this talks about Yellow Ribbon and PDHRA, where we try and send counselors as much as possible, to be at those events, to tell the folks about the VR&E program, and try and get them engaged if they need it.

We, of course, work with the recovery care coordinators, various support service agencies and Military services coordinators, and we educate, not just service members, but a lot of times, it's as much about educating the other providers, the VHA providers, the DoD providers, about our program, so that as they encounter service

members who are going through problems and issues, that they are able to direct them to us, and say, "Hey, there is a program that can probably help you," and send them in our direction.

MEMBER DRACH: Excuse me, another question.

I know there's an MOU between VR&E and Department of Labor Vets, which is about six or seven years old, since -- as I recall, since the signing of that MOU, the DoD has set up the EPO, Employer Partnership Office, and the Military Services Wounded Warrior Programs have pretty much, all established some sort of an employment initiative.

The MOU that makes -- you make reference to here, is that the MOU between VR&E and DoL, or is there a new MOU, or are you considering a new MOU, with DoD and with the Military Services?

MS. DEVLIN: There is a new MOU.

It was signed in February, and that MOU is an agreement between DoD and VA, to place voc rehab counselors onsite at the IDES installations, to provide space and provide access to the service members and in fact, not just access, but to require every service member who is going through the IDES process, to meet with a counselor, at least once, to get a full chance to ask questions about sort of the, "What's in it for me," about the VR&E program, and to get information that will enable them to make a more informed decision about whether they need the program.

So, and I have another slide that talks a little bit about the MOU, but we also -- the Physical Evaluation Board, one of the key things about our MOU with DoD is that at the point of referral to a PEB, that is the point at which they will mandate, that they get this briefing with the VR&E counselor, and at that point, it's the service members choice, if they want to continue for a full

fledged evaluation and see what kind of plan can be developed for them.

The plan can be developed and should be developed as much as possible, while they're still going through that IDES process.

It doesn't slow the process down, because we take moments in time, when they're not participating in other parts of the IDES process, to meet with them, and if they don't finish the process with their VR&E counselor, but they finish the rest of the IDES process, related to their disability compensation, and they're ready to move on, they can move on, and whatever town they end up in when they're discharged, they will get a warm hand-off to a voc rehab counselor in that town.

So, I think I kind of spoke ahead. This is what this slide talks about, in terms of the referral to the PEB, the comprehensive evaluation.

One of the other things that we

clarified is that not all service members going through IDES are interested in being discharged and becoming Veterans.

So, that is another thing that the counselor can help them with, in terms of assessing, if you do stay in, you know, what are your options? What happens if later, you know, you get discharged, if you do want to come out, here is what you're looking at, in terms of career options, educational requirements to prepare.

So, that counseling can help them with that decision making, if they have a choice.

MEMBER REHBEIN: That mandatory meeting with the counselor, is that mandatory one-on-one?

MS. DEVLIN: Yes.

MEMBER REHBEIN: Okay, so, it's not, we'll gather up everybody that started the PEB process this month and have a group meeting, and that fulfills the requirement?

MS. DEVLIN: No, it is one-on-one, so that that way, they can address that person's specific questions, and you know, their injuries and what their personal circumstances are in a private environment, in a private office.

So, this slide kind of talks about what we've done already with the IDES program.

In 2011, we started testing the concept and then in 2012, we added 48 sites, which will serve about 12,000 service members and Guard and Reserves.

I don't have any statistics for you on how many individuals have been served in 2012. We didn't put all the counselors onsite on October 1, 2012. They were put in place throughout the year. So, we hope to have some information next year.

Then this current year, we're adding 95 additional staff to serve an additional 10,000 service members at the

largest of the remaining staff, of the remaining sites.

So, we're focusing on the sites that have the largest number of service members coming through, and also, trying to -- because the draw-down will, you know, eminently, at some point, reduce the workload, trying to keep those close enough to a regional office, that you know, if need be, we can always shift resources, but we do anticipate that there is going to be enough workload for the voc rehab counselors who are going to be onsite.

Again, they provide -- those voc rehab counselors will provide the full scope of benefits, as long as the service member is still going through the IDES process, and perform a warm hand-off to a counselor at a regional office, if they relocate to another area, so that the process can continue.

This is really information that I've already covered. So, I'm going to skip

over this slide.

So, this talks about the memorandum of understanding, between Department of Defense and Department of VA. It talks about if it's been determined that the service member has an injury or illness that could lead to a referral to IDES, and this -- you mentioned, Mr. Drach, the other Wounded Warrior employment related programs.

If they do have -- if at the facility that we're at, an installation we're at, they have another program, we will collaborate with that program, as well, because under Chapter 36, even if the service member is not injured, under Chapter 36, we can provide the same counseling and evaluation services to help them with their transition. We just can't provide the educational services.

But if they're eligible for post-9/11 GI Bill, which typically they are, then that can help them with using their benefits

most effectively.

So, the E2I is the example on here that is actually named in the MOU.

I did want to talk a bit about the satisfaction survey, the next 'Voice of the Veteran' survey, which is actually going on right now, so, we should have results in the near future.

It actually looks at several categories of Veterans, Veterans who have just applied to our program, Veterans who are in the middle of their program, so, have received enough benefits to be able to tell us what their experience is, and Veterans who have already exited our program, so that they can look back and tell us what their experience was. So, we're very excited about getting those results.

The other thing that I mentioned, which isn't in the slide deck, is the longitudinal study, and I would encourage you to take a look at that.

The longitudinal study is out there on the web, the VR&E longitudinal study. The first report came out in 2011, and so, we put out a report in 2012, and we're working on our third report.

I would caution you, when you look at the report, that our program typically takes somewhere between one to five to six years to rehabilitate a Veteran. So, that cohort began in 2010.

So, it will take a while to see what really happens with all those individuals, but we already can see some patterns, in terms of which types of Veterans exit early in a good sense, being rehabilitated, and which types of Veterans exit early without being rehabilitated.

So, that gives us a little bit of information already, and I think in the next few years, it's going to be really interesting to see how that cohort progresses.

The Vet Success on Campus Initiative is an initiative where we put a voc rehab counselor in campus locations. These voc rehab counselors are not there to provide VR&E services. They are there under the Chapter 36 authority, to provide services to post-9/11 GI Bill students and other Veteran students who are pursuing training at that facility.

Now, they may get individuals. They met get Veteran students with disabilities, who they will refer to the VR&E program, and help them even by conducting their evaluation onsite, or they might get VR&E Veteran participant who comes to them with a question, and they will serve them, as well, and then refer them to their voc rehab counselor that is assigned to them.

But the purpose is really to ease the transition and to help those Veterans become integrated into the school, and to successfully graduate and obtain employment.

We began this pilot in June 2009, at the University of South Florida in Tampa, and we've expanded, in 2011, seven additional sites and then 32 sites in fiscal year 2012, and then we're also adding an additional number of sites in 2013.

I can't tell you how many campuses we're going to be adding in 2013, because what we're trying to do is focus on the largest universities and community colleges, to try and get the most access to the most Veteran students.

But in some cases, we've had high level of interest from states, where they may not have such large universities, but they have smaller campuses that we can group together with one counselor.

So, we're looking at the benefits of doing some of that, where there is a high level of interest in smaller colleges and banding two or three colleges together, so that there is one counselor serving multiple

campuses.

CO-CHAIR CROCKETT-JONES: On a related topic, not this exactly, what proportion of your benefits paid are education benefits, like the Choice benefits between Montgomery GI Bill or your program, or the post-9/11 GI Bill and your program, things like that?

What portion is education benefits and what portion is non-education benefits, the supplies for self-employment, the assessment, pre-employment assessment, things like that?

MS. DEVLIN: So, I don't have those statistics with me, but I will tell you that the annual benefits report does go into some detail with that. It does give you an idea of how much subsistence allowance is paid and how many Veterans received subsistence allowance in the program.

In terms of the post-9/11 GI Bill rate of subsistence, is that what you're

referencing?

We do have some information on how many elect that rate, but I don't have that with me. And then, there are, of course, a number of Veterans that receive services, that receive the lower rate because they're not post-9/11 GI Bill.

So, I don't have that statistic -- those statistics with me, but we can certainly get them for you.

CO-CHAIR CROCKETT-JONES: I am just trying to understand what portion of the benefits you pay are winding up, going to an institution, you know, going out to an institution to cover education benefits versus those that are services you provide that are unique.

MS. DEVLIN: So, the tuition versus special adaptive equipment and things like that?

CO-CHAIR CROCKETT-JONES: Yes.

MS. DEVLIN: No, I don't have a

break-down on that.

CO-CHAIR CROCKETT-JONES: Okay.

MEMBER REHBEIN: Many, I won't say the majority, but many universities already have some sort of a Veteran's benefits coordinator on campus. How do you interact with them to prevent duplication, competition, all of those kinds of things?

MS. DEVLIN: Actually, interestingly enough, the University of South Florida, when we talked to them about beginning this pilot, they already had a veteran's center, and they were looking to improve it, and they said, "Wouldn't it be great, if we had a VA staff person here, who knows all the benefits and can actually answer those questions that we get, that we don't know how to answer."

Like, "Why am I not getting my check? How do I get a disability rating increase? Why, you know, how do I know if I'm eligible for specially adaptive housing?"

So, it's a very collaborative relationship and a lot of schools that are either in the process of establishing Veteran's support centers or already have them, are actually reaching out to us, asking us to become a part of that.

So, it works really nicely, when they either have one already or they're working on establishing one.

MEMBER REHBEIN: And so, my next question is then, of all of the universities across the country, how are you choosing which ones to go into as your program grows in size?

MS. DEVLIN: Well, what our criteria was, prior to fiscal year 2013, is that the university -- the school had to have a population of veterans, veteran students of 800 to 1,200, or in partnership with another school, for example, in Rhode Island, we have two, a college and a community college that are partnered, and between the two of them,

they have been 800 and 1,000.

So, we had enough veterans to support having a full-time person there, providing counseling.

They had also had to be near enough to a regional office or a out-based VBA location, so that we could move a counselor who was already experienced and seasoned and knowledgeable about VBA benefits, to the campus, rather than having to hire somebody new, who was inexperience and didn't know, didn't have the historical knowledge.

So, they had to be close enough, within a 50 mile radius, so that we could actually do that.

Now, in the current year, as we're moving towards higher level expansion, we're looking at the size of the colleges and making sure that we can reach the most Veteran students this year.

But like I said, we've had, you

know, for example, one college that was establishing a veteran's support center and they said, "We really need a VBA person there. We really want you there," but they were really small, and they -- we really couldn't support putting a full-time person there.

So, we're looking at those colleges that come to us, that don't meet that criteria, and figuring out how much we can include them too, either as an itinerant function, so, for example, the voc rehab counselor at the nearest location might go to that college one day a week, for example, and have office hours that day, or they could partner with another college that is nearby and we could give them a full-time counselor.

MEMBER REHBEIN: And finally, have you given any thought to all of those hundreds, thousands of students that are pursuing their education online? How are you going to access that, that student

population?

MS. DEVLIN: We have given a lot of thought to that, and it is a more challenging -- a more challenging assignment to take on, because with any online community, they live in, of course, multiple locations. They may not go to one location on a regular basis, because they don't need to.

So, we've looked at online software for things like chatting and those kinds of things, but of course, the security issues that have to be overcome with that, have not been taken care of yet.

So, until we can address those issues, we're focusing on the face-to-face interactions that we can have on campuses, as we look at the opportunities for virtual type of support.

MS. DAILEY: And I can only give you five more minutes or less, so, let's wrap, and if you've got questions, ladies and

gentlemen, you need to get them out, so we can discuss them and then roll into our next briefing, please.

MS. DEVLIN: So, in the last five minutes, what I'll do is, I'll tell you about our vetsuccess.gov website.

It actually started out as a VR&E initiative to serve the VR&E Veterans, to get them to create a job board for employers who were specifically seeking to hire disabled Veterans.

But it has since grown and it is no longer a disabled veteran job portal. It is now for all veterans, and it has been for quite some time.

What it does is, it allows employers to register their jobs, and it allows Veterans to register themselves, register their resumes, search jobs that are available or post their resume to be searchable by employers.

The employers do have to be

vetted by our employment coordinator, so we do verify that they are legitimate. We have, as you can see, over 190,000 veterans registered, with over 5,000 registered employers, and we also have access to other jobs where we're connected to other job boards.

But primarily, we focus on getting veterans -- or getting employers to be interesting in hiring veterans, to post their jobs here.

We're working on enhancements. We're working on things like -- we've got currently, Military skills translator, but they're very basic.

So, we've currently contracted out to improve the site and make it more robust and have more sort of transitional assistance, resume assistance and things like that for veterans, so, that even if they're not eligible for any other program, they could come to this website and get some

online virtual assistance.

MS. DAILEY: Now, is this hung off the NRD? Is this what's on the National, NRD?

MS. DEVLIN: The National Resource Directory? Yes, they are connected.

MS. DAILEY: Okay, all right, so, this is -- if I go to the National Resource Directory, I can click on 'Vet Success'?

MS. DEVLIN: Yes.

MS. DAILEY: And find jobs, and this was an initiative launched by the White House in November 2011 or 2010, in collaboration with DOL and DoD.

MS. DEVLIN: Vetsuccess.gov has actually been around since before then, but the collaboration with the NRD and other programs, yes.

We are also connected to VA for Vets and we are also connected through e-benefits.

So, as a veteran goes into e-

benefits, they can connect directly into Vetsuccess.gov, as well.

So, that is my presentation, and I am going to not go into great lengths, because you have the PowerPoint on the (dot)gov redesign that we're working on.

But what questions do you have for me about anything that I didn't already cover?

MEMBER EVANS: Are you going to -- so, when you say you go to the bed-side, you have one of you, a VRE counselor to go to the bed-side, is that in the DoD side or the VA side?

MS. DEVLIN: Mostly, in the VA side.

MEMBER EVANS: Okay.

MS. DEVLIN: We have, for example, at the poly-trauma units, in some of them, we have VRE's, that's their work site. That's their duty location.

MEMBER EVANS: Okay.

MS. DEVLIN: So, that they can be there when the service member or Veteran is ready to receive rehabilitation services.

MEMBER EVANS: Okay, and so, are they explained, because one of the things that we keep getting beat up on is that, who is managing the case managers?

So, are they brought in and introduced by their OEF/OIF case manager?

MS. DEVLIN: Yes, they are --

MEMBER EVANS: Or the poly-trauma --

MS. DEVLIN: -- in with the VHA staff, yes. They don't impose themselves in the process. They are invited into the process.

MEMBER EVANS: Okay.

MS. DEVLIN: When the service member or Veteran is ready, and we'll be educating them too, on sort of the lead coordinator process that we're working on.

MEMBER EVANS: Okay.

MEMBER MALEBRANCHE: Margarita, how long does it take for a counselor to be trained? What is the normal training cycle, because I know you're hiring a lot of new people, and it's hard to get all of this, so much, so quickly. What is that average time, would you say?

MS. DEVLIN: The counselors are hired, already having the educational background of the Master's degree, and some of them come in with certifications.

But the actual sort of on-the-job training of the VA policies and procedures takes about two years.

So, the career track is GS-9, 11 and 12, and so, they've got to two years to get to journeymen, and what we're doing with the initiative such as IDES and Vet Success on Campus, is we're putting our more seasoned and experienced counselors, as much as possible, at those sites, although at some IDES locations, because of the volume, we

might have five counselors, for example, at that site.

So, we might put one senior counselor and four new ones, so, that that is -- they at least have somebody that can help train and support them.

But yes, it's about a two-year process to really learn the ins and outs of the policies and procedures, but the counseling piece, they come fully equipped with.

MEMBER CONSTANTINE: Do the PEBLO's fall underneath you?

MS. DEVLIN: I'm sorry?

MEMBER CONSTANTINE: Do the PEBLO's fall underneath you?

MS. DEVLIN: The PEBLO's? Do they have an issue with --

MEMBER CONSTANTINE: Are you in charge of the PEBLO's?

MS. DEVLIN: No, we're not in charge of the PEBLO's. We do work with the

PEBLO's and -- when we're at, like for example, in San Diego, we work very closely with the PEBLO's.

Other questions? I'll leave the list of facilities where we're already at, in terms of IDES, the IDES installations and school campuses. I'm sorry, I didn't bring enough copies, but I'll leave it here, in case anybody is interested.

CO-CHAIR CROCKETT-JONES: Thank you very much, Ms. Devlin.

MS. DEVLIN: Thank you.

CO-CHAIR CROCKETT-JONES: And I think we have another set of briefers that are here. We want to give them just a minute or two to set up, and then we'll --

MS. DAILEY: Yes, Colonel Curley and the team is here. We're going to get their briefing up.

Thank you very much, and I'd like a relatively quick turnaround, if you need a break.

But I do want to assure this team that you have an hour, and we don't want you to short-change that time, okay.

(Whereupon, the above-entitled matter went off the record at 10:50 a.m. and resumed at 10:55 a.m.)

MS. DAILEY: Okay, ladies and gentlemen, can I get my Task Force members to return to their seats, please?

CO-CHAIR CROCKETT-JONES: Okay, thank you.

We will now welcome -- actually, let me give my Task Force members one more minute to get back to the table.

All right, then we will now welcome Dr. Kenneth Curley, the Traumatic Brain Injury Portfolio Manager for the Combat Casualty Care Research Program.

Under the Army Medical Research and Material Command, the Combat Casualty Research Program leads studies on TBI, through their research and development

program, in order to develop new treatments and to arrive at evidence-based solutions.

We have the briefing under Tab J. I'm going to turn it over to you, Dr. Curley.

DR. CURLEY: Thank you. Thank you for the opportunity to brief. This is the first time that MRMC has briefed this group. I thank you for your forbearance, schedule-wise. It drizzled, as you know, and turned our Frederick to Washington ride, into a Pittsburgh to Washington ride.

So, my background is in clinical and research neurology, neuro-science. I was an active duty medical officer, graduated Uniform Services University in 1993, had an incomplete spinal cord injury, and so, I myself, this is more like the Hair Club for Men's commercial, I work here, but I'm also a member.

I've been through the PEB

process, and the VA process, and I was sort of saddened to see with the discussion with Sergeant Jarvis in one of the hand-outs, that some things haven't changed in 13 years.

I'll explain a little bit about MRMC.

When we first talked about presenting here, I think the difference is, a lot of what you've been presented in past meetings has been on things that are related to what we call P8 Program 8 operations and maintenance stuff, or how to run hospitals, how to run clinical programs.

We do RDT&E, Research Development Tests and Evaluations, and we also do product development, and MRMC is unique among the services. It's been -- it's probably the -- it is the largest such organization in the Department of Defense and it's also the oldest.

This is just a little look at MRMC, more to -- I want to show you the size

of the organization. It's quite huge and it's worldwide.

We have labs all over the planet, and we have laboratories all over the United States. So, it's quite a bit of work for our Commanding Generals and senior executives, and it's challenge enough, at the level of the research directorates, which is where I work for Colonel Dallas Hecht, who is here in the back. He is the Director of Combat Casualty Care Research Program. He's program manager for TBI, for the joint program, Joint Program Committee 6, which I'll explain in a few minutes.

So, this is just another example of all the different inner-relationships that we have. We have close relationships with our sister agencies, the VA in particular, NINDS improving, and more close relationships with NIDR at the Department of Education, and I'm speaking specifically from the TBI standpoint. We also work closely with the

FDA, as well.

Here, I want to get into a little bit of discussion of mission, because one of the things I was asked to talk about was cognitive rehabilitation.

You see civilian focus versus Military focus here. Some things are fairly similar in line across. You get down to trauma, you see septic shock, and then down here rehab. You don't see rehab over here.

That doesn't mean we don't do rehab research. We do. It just means that our goal is to preserve the fighting strength and conserve the fighting strength, and baring that, put the person in the best condition they can be in, before they're moved into the VA system, where they get definitive rehab, and in fact, especially with the expected cuts in research, one of the things we've been doing is trying to align our research pathways, so that we and the VA are not doing things that the other

group should be doing, necessarily.

The VA should be focusing more on the rehab. We should be focusing more acute care, en route care and initial management, and that is what we've begun to do.

Joint program committees manage TBI research. There are three involved in TBI research. Joint Program Committee 5 is Military and operational medicine, Colonel Carl Castro.

They deal with basically, mild TBI with comorbidities, whether it's PTSD or depression or other comorbidities.

JPC 6 is where I actually live, although I keep watch over all the three JPC's. We manage the spectrum of TBI from mild to severe and penetrating, and we deal with it from the point of injury to the initial weeks within U.S. facilities, and Joint Program Committee 8 is clinical and rehabilitative medicine. That is Colonel John Scherer, and their goal is to deal with

research within the medical treatment facilities, until someone's return to duty medically bordered or transferred to VA care, as I discussed.

This is a little diagram of how the Defense Medical Research and Development Program works. It's basically the direction we're heading, jointness.

There is sort of a mirror program on the Army side like this, that has different names, we call them Research Directorates and in any event, the funding, the great deal of funding for TBI research for our annual budget and through Congressional special interests, flows through the Defense Medical Research and Development Program, which is part of the Force Health Protection and Readiness Directorate.

Now, this drills down a bit. This gets into what I do. This is how we run the Joint Program Committees.

Where we spend most of our time is down here in review and analysis. We're going tech watch. We're investigating new solutions, as they come up. We're planning program announcements. We are reviewing proposals on past program announcements, and we're working budgets for out-year funding, so on and so forth, and that portfolio analysis is an iterative process.

Each year, I give a formal briefing to the Defense Health Program on our status and basically, where we're planning to go over the next two to five years.

Mission within JPC 6, because it's combat casualty care, it's a lot broader than just TBI, but TBI happens to be our largest area.

We have closing in on 600 projects that have been funded since 2007, and that brings us to about $650 million, I believe.

Within the combat casualty care

arena itself, we have two big areas that we're concerned with, one being non-compressible hemorrhage and the other being traumatic brain injury.

As you can see, we follow these with other -- we follow these different things with other Joint Program Committees, the TBI with JPC 5 and 8, and then spinal cord injury, burn and facial trauma and pain with JPC 8.

At this point, I'd get into TBI itself. You might have seen this slide or a variation of it, because a lot of the folks in the R&D side use it, use variations of this slide.

Basically, it shows both the public health component, as well as the component of comorbidities associated in TBI, especially mild TBI.

As you see here, there is quite a bit of overlap of pain and PTSD, and you get other disorders, sleep disorders, substance

abuse, vestibular disorders, visual disorders in some cases, and in some case, cognitive disorders.

These are just to focus us on our DoD definition. This is the DoD/VA definition of TBI. These are also -- this is a graphic of diagnoses.

The is a little bit older, and I think now, we're standing around 230,000 or 233,000 total, and that is just ones we've identified, and then down below, we have things broken out by service and by type of injury.

This just shows our integrated research approach and how we work with other agencies.

For example, as people are coming of age and wanting to join the Military, NIH and Department of Education's NIDR would be engaged in doing research that would be helpful to us there, you know, trauma data banks, especially for pediatric neuro-trauma.

Another thing we're finding is just one's social milieu use can have an impact on how much resilience one has to these kinds of injuries. So, they can be a source of information on those types of things, as well.

Once you get into the DoD circle, it's pretty much the Defense Health Program, and as you get towards separation, the VA gets involved and post-Military surveillance is a combination of all four agencies.

MEMBER MALEBRANCHE: Excuse me, do you have registries? Does your area have registries of the TBI, the PTSD and do you have any sort of -- you mentioned comorbidities. Do you have any sort of overlap or connection of those?

DR. CURLEY: There are registries, but the registries are done on the clinical side. It's more along the lines of something that the DVBIC takes care of, Defense Veteran's Brain Injury Center.

Those are kinds of things we might fund, for example. So, yes, we're engaged in funding those kinds of projects, but the actual execution of them, digestion and dissemination of information, should progress up from DVBIC and NICoE, through DCoE and out through DoD, as guidelines and policies.

MEMBER MALEBRANCHE: Do you --

DR. CURLEY: At least ideally, that's what we're aiming for.

MEMBER MALEBRANCHE: Do you have -- I mean, because I would think that you would want utilization or access to those, or you do not need those, for what you're doing?

DR. CURLEY: Oh, we do, but the -- I guess, the way I'll put it is that right now, the -- a lot of these are just getting started.

So, it's hard to make -- it's hard to make broad type, you know, population based -- population based decisions on

research trajectory based on that.

A lot of what we do is having the -- just out of necessity, come from the smaller end studies, you know, ends of 20, ends of 50, and part of that is simply because it's difficult to get -- and you can have a registry of people with TBI, but the problem is, you need to keep it up.

You need to be able to follow it from DoD to VA. The same person needs to be picked up in VA and identified. We still have a problem with people, although this is being addressed, the number of people who go out of DoD, for example, with mild TBI, who are able to get VA healthcare, but choose not to or don't, for one reason or another, can cause some problems in making assessments of what issues are really important.

You know, one of the things I was going to talk about a little later on, and I'll talk about it now, is with the World War II population, for example.

World War II was not unusual for there to be short-drops of bombs. There were also large local populations exposed to bombs, and kind of not -- well, once you get to World War I, prior to World War I, the types of blasts people were exposed to are relatively mild in respect to the things that came in World War I and beyond.

By the time you get to World War II, you're dropping 500 and 1,000 pound bombs and it's being done within 500 yards or less sometimes, of where the troops are, and like I said, you do get short-drops or you get situations like Anzio, where you had entire divisions that were like fish in a bowl, getting shot at with 88's for over a month.

It would be interesting to be able to see, gee, you know, what happened to all of those people? You know, have we had a huge number of people turn up, for example, with chronic effects, such as Alzheimer's disease or chronic traumatic encephalopathy,

in that population. Is it something we missed? Is the signal not high enough?

Those are the kinds of things that we can do now, so that in the future, we can come back and answer.

So, like for example, in Million Veteran Program, where they're collecting all the blood, that would be really helpful in 10 or 15 years, when we come upon a new finding in neuro-science, to be able to go back and check, "Well, what were these people exposed to and did they manifest this particular finding," and so, it's -- you know, this is -- it's a work in progress, and we're working with DCoE and the and the services themselves, trying to help with putting together these different registries and how they're managed.

We actually have a program we funded at NINDS, which I think might be coming up shortly. I'll get into that. I'll explain what we're doing on that part, and I

think you'll be interested.

This just shows the continuing --

MEMBER PHILLIPS: Dr. Curley, I'm sorry.

DR. CURLEY: Yes?

MEMBER PHILLIPS: Could you just say a tiny bit more about two areas, neuro-plasticity and the K through 12 effort at the NIH?

Neuro-plasticity, is it a big program? Is it helpful?

DR. CURLEY: That is what I was going to get into, in the main body of the discussion.

MEMBER PHILLIPS: Okay.

DR. CURLEY: It's helpful, but it's something that we're still learning about.

MEMBER PHILLIPS: How about the K through 12?

DR. CURLEY: The K through 12, I have seen very little of that, and it's

something that I've only started to get briefed on, and in fact, we're going to be having meetings with NINDS, and other parts of NICHD, as a matter of fact, are doing something like that on the NIH side, and we'll be getting together and finding more out.

At this time, a larger study on that side was proposed by NICHD, although I don't know if that's been picked up for funding. I think it will be, but I am not positive at this time.

This just shows how we try to visualize our portfolio, what we call buckets here, starting with basic science and epidemiology, over on your left, and then moving all the way to return to duty.

Fairly busy slide. If you have any questions, feel free to ask me after the briefing.

The current assessment of mild TBI and concussion research, right now, we

still lack a validated clinically useful case definition.

There is 41, probably more than 41 now, definitions and guidelines identified by World Health Organization.

We have a work group that had been working between Brain Trauma Foundation and CDC, to try to identify a useful, clinically useful definition, and of the literature they found that qualified to be examined, only .5 percent of that literature was of moderate quality to be included in their assessment, which was very concerning.

A lot of what they found were papers that had circular arguments. They were using the test that they were assessing, as its own gold standard, and you can't really do that, and really, we don't necessarily have a gold standard per se yet, for mild TBI.

The other issue is the heterogeneity injury. I wrote a paper with

Paul Rapp that was -- that said it's basically a category error.

It's like someone having mild TBI and the surgeon comes out, like in a Monty Python show, and says, "Your wife has had a motor vehicle accident." Well, what does that mean? We don't -- you know, we don't know. I can mean all kinds of things, and the injuries can be unique to each person.

The high frequency of exposure to blast related impact and non-impact, and multiple exposures to war fighter, and that was what I was starting to get into, as far as my history digression went.

We're seeing more and faster, both in the military and in the sports side. Thirty years ago, you didn't have high school teams with 300 pound lines. Now, you do. You didn't have wide receivers and safety's that were able to run four or five 40's. Now, you do.

In the military, we're dealing

with the IED issue. It's a huge amount of explosives that can be funneled in a specific direction, and cause what you already have seen in past discussions, a great deal of horrible injury.

Also, the issue of comorbidity with other behavioral health concerns, whether it's PTSD, this sort of running argument between us and our military operational medicine folks. JPC 5, who would do the psychological health part of our business, is what came first, the PTSD or TBI?

I mean, it really is a scientific argument. It's like, what we got, what we got?

Does having traumatic stress put you at risk for having a worse effect, if you're exposed to a mild head injury? Does having a mild head injury put you at more risk of having post-traumatic stress, and these questions might seem like they're

relatively simple to answer, but they're not, because there is so much overlap and symptomatology.

Finally, multiple factors can complicate recovery, those being risk of repeated head injuries, and mis-diagnosis or other diagnosis, and that can actually also be due to the War fighters themselves, not wanting to go sit down, and there were points at which they were trying to figure out how -- what all of the right answers were on the MACE cards, and we had to make several versions of the MACE, so that they couldn't game their way through the MACE.

Some of the -- I've heard reports back of some of these guys, that you ask them to do the reading part of a neuro-cognitive test, pre-morbid, before they go on deployment, and they'd say, "Current assessment of MT," you know, all right, what can you do with that?

So, that is why we're looking for

more objective ways to base line and then diagnose people.

This just is a graphic of the study I talked to you about already, for trying to come up with a -- come up with a clinically useful definition of mild TBI.

This gets into the heterogeneity. This is a more severe injury, you know, GCS of six, basically, and we like using this because it is six ways to the same injury, and these people have completely different outcomes. They have completely different prognoses, and the same goes when you're dealing with a mild TBI, where you can't see anything wrong at all on an image, at least on a CT.

So, in mild to severe is on whole, one of the things that we're working on is standardization of blast and impact models. That got a little bit out of hand after 2007. Once the Joint Program Committees were formed and we were

able to start having assessments of military relevance and in-process reviews, and once we were able to set a process for ensuring quality of research, things began to improve that way, and I am hoping that we can eventually get something like a NATO standard for how to do a shock to experiment, because there is a huge difference.

You can't just go to Billy Bob, the gun-smith, and ask him to set up a rig, and it's going to work the way -- and it's going to work the way you think it is, and the blast physicist always asks that the neuro-scientists, they say, "We don't practice neuro-science, so, please, neuro-scientists, don't practice blast physics."

So, I spend a lot of time doing team building because of that.

So, mild repetitive mild TBI models require validation, and we're doing that right now.

Blast effects may have unique

signature of injury, but it's difficult to isolate what is called a primary effect, or effect from the shock front itself, just from effects caused by acceleration. So, what would be a tertiary effect, so, my body getting thrown back.

In animal models, we're able to do this. Basically, you have to tape the rat's head down if you're using rodents, but the question comes up, is that our soldiers aren't having their heads taped to the inside of wherever they're sitting, so, how valid is that?

Screening and assessment development has been showing a lot of promise. We have a very large serum biomarker program going on. It's in, how many hospitals are we up to, sir? Hundred?

Forty-one. Physiologic assessments, using quantitative EEG smooth pursuit eye-tracking, pupilometry.

Imaging is sort of the third

prong here. Diffusion sensor imaging and then something called high definition fiber tractography. It's very interesting.

Positron emission tomography, functional MRI, MR spectroscopy and so on. There is a myriad of imaging types that we're looking at, and neuro-psychological assessment tools, which we continue to look at.

The other issue is that there have been over 30 clinical trials on treatments for TBI, and zero, if translated, zero worked.

We've got a couple going right now, one with progesterone in phase three. That one, I would -- my impression was that it basically squeaked in to phase three. I think there is a little push-down from above, that got it -- got the phase three trial going in the way it did, and we're doing some phase two trials with some other drugs, which I'll show you on this screen.

These are the drugs that were either in advanced animal research or working in phase one or phase two trials, and progesterone is in phase three.

The other issue is, because of this failure to translate, I mean, here we have a bunch of rats who, you know, the rats of the world are rejoicing, because we've solved their problems in TBI. We've solved their problems in spinal cord injury. We've solved their problems in peripheral nerve injury. But none of it is translating to humans. Why? And that 'why' is something that we're working on a great deal with NIH, for example.

One of the ways we're working on that is through this data repository. It's called the Federal Interagency TBI Research Infomatics System. It's a requirement now, for anyone who gets Defense Health Program funding.

If they're doing Defense Health

Program funding with humans, that data gets plugged into here. We're also working on ways to back up and get research that was already done with DoD funding, and even research that was done with NIH funding, where the people want to put their information in here.

Through these kind of databases and coupling this with the VINCI system at the VA, we think we'll be able to start getting some answers by working backwards from what we're analyzing from these clinical trials, to help us refine the models that we use, because that is part -- we think that is part of the problem.

The other part of the problem is outcomes assessments. Right now, people tend to use outcomes assessments that were developed for stroke. Stroke is a focal injury. TBI is not a focal injury necessarily.

Obviously, when you get into

severe TBI, we're penetrating components that has focal components, but in general, it's a more defuse injury, and it might not be that the assessments that we're using are sensitive enough to pick up change.

So, we're looking at ways of identifying assessments that might be more sensitive, whether that's biomarkers of the metabolic processes that are involved with that particular treatment, or whether it's a functional assessment.

The common data on this program is something that came out of collaboration between DoD, NIH and other agencies. This was -- and the VA, as well.

This allows us to have a frame work, an ontology, common ontology for our clinical trials, so that we all know that we're talking about the same thing, and again, that gets back to the fact that neuro-trauma, relatively speaking, is a newer area of research, and it was actually a back-water

area of research before about 2000.

A lot of people, before that period, would be, you know, "You're doing neuro-trauma? Well, I guess you don't want to make full professor," and that is -- you know, very much like that in some places.

So, what happened was, everybody was working in little cells, but the irony was, if you sort of did a family tree of everybody, turns out, everybody was second cousins.

So, we all got together and decided we're going to speak the Queen's English, as far as how we describe injuries goes.

Rehabilitation. Again, this is something that we are more and more working with the VA on, and it is a primary responsibility of VA rehab research and development. We do some of this work. Much of what we use, again, was developed in the stroke and spinal cord rehab arenas, and I

already talked about the vocality of stroke.

The other issue is the definition of recovered. Some of the information that we're seeing out of people like David Hobda's lab, in California and places like that, cause us to ask, "Do we really get better, or are we just able to compensate," and at a certain point, we're not longer able to compensate.

CO-CHAIR CROCKETT-JONES: I have a question for you.

DR. CURLEY: Yes?

CO-CHAIR CROCKETT-JONES: I'm wondering, do you have -- are we getting any research into the diagnosis of chronic traumatic encephalopathy that, you know, my understanding is, it can't be diagnosed until post-mortem. Is that correct, and is there anything to try and nail down what rates really are?

DR. CURLEY: So, right now, we have a program announcement that is in full

proposal review, to address sort of, ways of assessing, to include things like in-vivo or in-living systems measurements, because we don't have that. You're right.

I don't know how many people with concussions are going to volunteer for brain biopsies. I don't know. Some of my friends in the infantry might, but I'm joking.

But the -- the other aspect of this is that we have a $60-plus million program going on right now, that we've just gotten the full proposals back on, chronic -- the chronic effects of neuro-trauma consortia, and the goal of that is the VA/DoD collaboration to support a consortia that includes VA centers and also, civilian and industry -- civilian, academic and industry partners, to look at the epidemiology, to look at the pathobiology, to look at -- to try to determine cause and effect with relation to this, because right now, we can't say with certainty, as much as what we're

seeing with the football players.

We can't stand up and say, "Well, this is because of that." It might look like it, but as you know, you can fall into some dangerous land, if you don't do that very carefully.

Moving on to rehabilitation after TBI.

In general, we have assistive technologies, cuing and reminder systems, touch systems, which are more for more severely injured people.

Assistive animals, don't get me started. I was very -- you know, I think the assistive animal is great, whether it's PTSD or TBI. That is my personal opinion, not the DoD's. Speech synthesizers and special eye-wear.

Rehabilitation technologies. There, we get into plasticity, and actually, the idea of plasticity has been around since the 60's.

Paul Bach-y-Rita is one of the pioneers of that, and I'll actually be showing something that his lab designed in a little bit.

There is only so many ways you can go after it, at this point. You can use physical therapy, repetition, speech therapy for swallowing issues that more severely injured people get, occupational therapy, vision therapy, and then we have neural modulation, which is sort of the next step.

Cranial nerve stimulation, which is non-invasive. That was what Bach-y-Rita's group discovered, and deep brain stimulation, which is quite invasive.

My colleagues in that arena will argue that, that is not so invasive, but when you're diving, I don't care how skinny it is, but when you're pushing it into the center of my brain, it's invasive.

So, these are just some examples of some of the types of projects that we

have, and I won't go through every one, necessarily.

This is the project out of Bach-y-Rita's group, and initially, they had developed a technology that helped people with balance disorders, and you put the mouth-piece in, and the electrical charge moved, based on where you were moving.

So, if you were moving to the left, the charge would go to the left. If you moved to the right, the right side would start zapping, and then there was a point at which they had a system that was tied into a camera, to allow blind people to navigate.

I used the thing, and it was creepy. Within 10 minutes, I was able to navigate a room, and what you saw was sort of like a very poor black and white TV, and again, that was just 10 minutes.

So, we have these inherent capabilities, and we're trying to leverage these.

This is different, in that rather than giving you any -- a large signal, the way the older device did, this new device called the PoNS uses very low frequency -- low voltage, high frequency pattern pulses, and it turns out that you can have someone do this, and over time, they need to do it less and less.

So, they can start off doing it ever day, but then they can do it every other day, every week, and eventually, they can go off of it, in some of these cases, and not necessarily have to go back on it.

We've been looking at in MS patients, and interestingly, that is what they did before they became engaged with us, and it would be hard to fake the data that they got with that. These people had improvements across the board in pain cognition balance.

So, it's something that we're taking a very close look at right now. We're

looking at it at Fort Campbell, and we might be -- might be adding some other sites on over the ensuing few months.

This is more along the lines of what you might see on the TV commercials, that you know, make your brain smart, brain trainer. This actually, this group came out, spun out of Mike Merzenich's work and he is sort of the godfather of this type of cognitive plasticity work. He is out of San Francisco area.

So, the goal here is to make an engaging type of game system, that while you're playing it, is retraining your brain without you necessarily knowing it, and that is one of the key parts, is making it fun, so that it doesn't seem like drudgery.

This project, using -- the goal here is that they're using functional brain imaging and structural brain imaging to try to see if they can use that to assess the functionality of these computer-based type

training devices.

This project, neural markers and rehabilitation, they're using functional MRI, which again, it basically tells you what parts of the brain are active, based on what parts of the brain are consuming more oxygen than others, and we can get that and change it into a color image, and map it to the person's MRI, and it's fairly accurate within a few seconds.

You have to be very careful with your methodology, however, and they are combining that with EEG, because another issue here has to do with dis-synchrony that develops between different parts of the brain sometimes, after these head injuries.

So, they're seeing if they can assess the executive functioning, which is basically frontal lobe, by using these two modalities combined with these computer-based systems.

This project is based on a system

called Strategic Memory and Advanced Reasoning Training, and again, they're trying to look at patients with comorbid TBI and PTSD.

This particular project is another spin-off from the type of work that Mike Merzenich had done originally, and so, it's basically another computer-based system, and in this case, they are doing a randomized control trial, which is really what we need.

It's frustrating to have a bunch of small proof of concept studies, because you can't really -- you know, that is not evidence. You need blinded, randomized controlled trials, as much as they can be done, and with that first device you saw, the PoNS device, that did the stimulation of the cranial nerve, that is where we're going with that particular device.

This brain training to enhance functional lobe function, again, that is using the smart tool that I had talked about

a couple of slides ago, and there is two slides, and they look similar because this is -- this type of award is one where there is two primary investigators, it's sort of a co-PI process, and so, there are two different places, doing similar work.

Now, I'll deviate into some of our sister agencies, and things that they're doing, because some of the things that they do, in turn, are funded by us.

The Defense and Veterans Brain Injury Center, I think you're familiar with. A study of cognitive rehabilitation effectiveness, it's a fairly big study using self-directed computerized cognitive rehab and therapy -- versus therapist directed individualized cognitive rehab.

They want to compare and contrast that, and they have another project called I-SCORE, which is the imaging component of that study, and the important thing for us here is sort of a new area of neuro-science called

connectonics, and where we're able to start trying to make connections between different networks in the brain, and learn what that tells us about what someone's condition is at the time they started a training process, and the time they finished it.

So, this kind of work will help us determine whether people are truly recovering from an injury, or are just shuffling functions to other parts of the brain, so that other parts of the brain are subsuming the functions.

You might have heard this in amputee discussions, with respect to people who have lost an arm or a leg, and the brain still acts like the arm is there, and then you get phantom pain, and it's a similar type of process going on.

MS. DAILEY: So, Dr. Curley, you posed an interesting question, do we get better or do we just compensate until we cannot compensate anymore?

This particular study is trying to answer that question?

DR. CURLEY: Well, this particular study is trying to see how that compensation goes on. That is what we're going to be looking at, is change over time.

The "perfect study" would be to have these people imaged before they got hurt, having never had a head injury before, then unfortunately, they get injured and then they go into a study like this.

That is what we need to do on a national level. That is the kind of stuff that we're going to have to focus on nationally, and it's going to take time, because until we can have that kind of information, it's going to be a little bit more difficult to again, prove causality.

I mean, we might see some interesting patterns, but we won't be able to say, "That is it," until we can do that kind of study.

This, I'm going to bring up, because just driving simulators. If you've been in some of the larger VA's in the rehab building, you walk passed -- I was walking passed the room and driving simulator, I'm like, "Why do they have driving simulators here?"

Well, turns out, driving simulators are great for dealing with executive function. Everybody knows about how we like to screw with our phones and talk to our friends and mess with the radio and drive off the road.

Well, if you have a mild head injury, your brain is already acting like it's -- acting like it's texting, without you having to even do it, and so, that -- one of the tools they've started to use is the driving simulator, to help assess these patients.

This study was done at Fort Carson, again, DVBIC inter-active metronome

technology. This -- there is a half-hour or hour discussion of inter-active metronome. The 10 second discussion is timing, literally brain timing, timing of the firing of neurons and trying to synchronize that within a person's brain.

MS. DAILEY: We did hear about this.

DR. CURLEY: Yes.

MS. DAILEY: When we were at Fort Carson, the TBI doc mentioned it.

DR. CURLEY: So, and actually, this has been pretty promising. So, the initial results of this have been promising.

Have I been going the wrong way or something?

MS. DAILEY: Yes, Commander has briefed us.

DR. CURLEY: There we go. So, this one, this one is fairly long large study, and what they were looking at were cognitive rehab interventions along with

giving someone SSRI's, which are selective serotonin reuptake inhibitors, an example of which is Zoloft, anti-depressants in the parlance.

Their initial results are that there -- they aren't finding a whole lot of difference.

I go back to my argument of our assessment tools are too dull, because what we're starting to learn plasticity and how the brain acts and responds, whether it's animals or humans, in response to different stressors or injury regimes, I think that our assessment tools are too dull.

Application of instructional technology software is a cognitive and vocational rehab tool. This is another computerized tool assessment.

Then on to the National Intrepid Center of Excellence, Dr. Kelly is out there today. Hello, Dr. Kelly.

The project I wanted to point out

here is, I think really cool. It's called Assessing the Impact of Mild TBI on Multi-Sensory Integration While Maneuvering on Foot.

They have this big simulator system that was brought in to do the amputee rehab. Well, figured out that we could do -- several years ago, a few of us said, "Well, gee, you know, let's put spinal cord patients on it. Let's put TBI patients on it. Let's see what happens."

We were using it with moderate and severe injuries, and then someone said, "Oh, let's put some mild's on it," and one of the interesting initial findings here is that this might not only be able to help people recover from some of these sensory integration problems, but it could help us diagnose the problems, as well, because it really -- I've actually been on this thing and if you've got a sensory problem -- integration problem, whether it's peripheral

or central, this will bring it out for you, and so, I was really excited to see that.

This is out of Uniform Services University, the Center for Neuro-Science Degenerative Medicine. It's a USUHS/NINDS partnership, and I just have a couple of abstracts here.

This first one goes back to the type of technology that I just showed you, and Leighton Chan is at NIH Clinical Center, head of physical medicine rehab there, very bright physician, and then the next project, effects of rapid reciprocal exercise versus light therapy by Dr. Damiano.

Their conclusions in our -- in the MHS, we focus on TBI in a relatively short term window, about a year, such time that we're able to determine whether someone can return to duty, needs to MOS, have their MOS's changed, or they need to go through a PEB process.

More severely injured service

members move to the VA Poly-Trauma Center, as soon as they're clinically stable in many cases.

We support cognitive rehab research, which I've shown you. The issues, such as clinical definitions, evolving understanding of the natural history of the disease, pathobiology of the disease, and our evolving understanding of the need for accurate and specific outcome measures currently drive our research focus.

Cog-rehab and mild TBI remains a challenge to assess, because of the heterogeneity of the injury and its comorbidities, as well as the huge number of confounding variables induced by the out-patient setting, and that is something that -- you know, it's always frustrating to me, you can't -- you know, we, unfortunately, aren't rats and we can't live in little cages that all look the same.

But even with the rats, we found

out, oh, if you give them an injury and you put them in a cage that has toys, they get better faster.

So, if you have someone that is in their normal social milieu, and you're adding different kinds of interventions, how do you know what is causing what, and that is a challenge that we have to deal with.

Our understanding of plasticity continues to improve and gives us a sense of optimism, gives me a sense of optimism, as we move forward, and imaging especially, a lot of the -- a lot of the fiber-tracked imaging technologies, I think is that combined with functional MR and PET are going to be tools that we really lean on, to find the answers.

They might or might not necessarily become part of the diagnostic armamentarium at the level of concussion, but as far as getting answers, I think those technologies are really going to help us.

With that, I thank you very much,

and will answer any questions.

CO-CHAIR CROCKETT-JONES: Well, thank you, Dr. Curley. There might be questions that bubble up later, but I think we're pretty overwhelmed by all that is being done right now.

So, I'd like to tell us all, we're getting ready to go to lunch, correct?

MS. DAILEY: Correct.

DR. CURLEY: There is a book I want to recommend, and I didn't write it. I don't know the author. It's called 'The Brain that Changes Itself' by Norman Doidge, D-O-I-D-G-E, and if you want to read about some applications -- the history of and applications of neuro-plasticity, that is a must read.

CO-CHAIR CROCKETT-JONES: Can you give me the author, one more time?

DR. CURLEY: Pardon me?

CO-CHAIR CROCKETT-JONES: Can you give me the author one more time?

DR. CURLEY: Norman Doidge, D-O-I-D-G-E. He's a neurologist who writes a lot of these kinds of books for public consumption and he's very good at it. Thank you very much.

MS. DAILEY: Thank you, Dr. Curley. Really appreciate you being here.

(Whereupon, the above-entitled matter went off the record at 11:50 a.m. and resumed at 12:50 p.m.)

MS. DAILEY: Ladies and gentlemen, I do -- we will be starting a briefing here with Carol Weese, who has been a regular at our meetings.

I also want to note that we have provided you an updated schedule. It's in black and white. It's on your desk, now. We changed some dates around.

So, for those of you who committed to the -- for those of you who committed to the west coast trip to Joint Base Lewis McChord and Joint Base Elmendorf-

Richardson, those dates have moved back into to 25th and 26th of March, and 28th and 29th of March, and so, you'll need to work with your executive assistants and your staff, to re-clear those dates.

MEMBER EUDY: Ma'am, was there any clarification regarding the Joint Forces Headquarters for North Carolina visit, that was cancelled?

MS. DAILEY: Yes, not cancelled. Right now, it is scheduled for 28 February and 1 March. Sorry, we'll update it and get you another copy.

CO-CHAIR CROCKETT-JONES: Okay, are we ready? Welcome back.

We'll be hearing from Ms. Carol Weese, Acting Executive Director of the Federal Recovery Coordination Program.

The FRCP is a joint program of Veterans Affairs and Department of Defense, established to provide care coordination for severely wounded, ill and injured service

members, veterans and their families.

Ms. Weese will updating the Task Force from her briefing in February 2012. Please find the information under Tab L of our binders, and I'm going to turn it over to you. Thank you for coming back to talk to us.

MS. WEESE: Well, thank you for inviting me to come back again, and I know many of you here in the room, and it is great to see all of you again, and to be invited to come back and talk about the Federal Recovery Coordination Program.

Today, I also brought Michael McDonald with me, and I'll ask Mike to wave. Mike is the Deputy Director for Benefits in the Federal Recovery Coordination Program.

So, we're here, and happy to give you an update on where we are currently with the program.

I thought that it would just be helpful to give a quick overview of what the

program is about, as I get into this.

The Federal Recovery Coordination Program is a joint DoD/VA program, established back in 2008. As a matter of fact, when I was sitting down and thinking about it, it was five years ago this month, that the program initially enrolled its first clients.

We are focused on those service members and veterans that are the most severely wounded, injured, and ill. The Federal Recovery Coordinators themselves are Master's prepared, registered nurses or licensed clinical social workers.

We are authorized 25 FRC's and we currently have 24 FRC's that are onboard, and we have one who is out on detail, currently.

But the Federal Recovery Coordinators are highly trained clinical folks that really spend a lot of time working on care, services and benefits across Department of Defense, Veterans Affairs,

other Federal agencies, and the private sector, as well.

We have clients that receive care and benefits in all of those different realms.

The whole reason that the program stood up to begin with was for the creation of the Recovery Plan, and it's lovingly known as the FIRP, the Federal Individual Recovery Plan. You always have to be careful in the Government, what you call something because it's going to turn into an acronym.

So, I had one of my FRC's write me the other day and says, "I've got to go FIRP'ing." So, I said, "Okay, good."

Then the FRC's stay with the client throughout all of their transitions, throughout recovery, reintegration and rehabilitation. This is one of the things that is different about the FRC program versus some of other programs that are out there.

So, once we assign a client to an FRC, that FRC will remain -- maintain contact with that individual throughout all of the transition, and then as long as that client needs the services of the program, itself.

These are the criteria for the program, itself. These criteria were given to the program by the senior oversight committee, back in 2007, when the original MOUs were developed, and then the program kicked off back in 2008.

You will notice that the criteria for the program are very broad. They were written that way on purpose, because what they wanted to do was to be able to get the maximum number of folks who could be eligible for the program, actually referred into the program, itself.

So, that is why the criteria were certainly -- were written in the fashion that they were, at that time. These are still the criteria that are used by the program today.

I thought you might be interested to know, kind of where we were -- excuse me, where we are now, in terms of the demographics of our client population, and these are the numbers as of December 3rd, when we submitted.

We had currently 902 active clients. Those are clients that we are currently providing care coordination services for, and that represents about a five to seven percent increase over when I was here last year, seven percent total year, and when I was here last time, it was five percent.

Out of our client -- active client load, currently 55 percent of those are still on active duty. The 45 percent balance then are veterans, and that has pretty much been a constant factor that we've seen throughout the life time of the program itself.

Then you'll see the break-down

versus the components of the Military services, then 87 percent are active component, 73 percent are attached to one of the Wounded Warrior programs, which is important to us, because a large part of our work is in conjunction with our DoD counterparts, and the work that is going on, on the Military side of the house, in addition to on the VA side of the house.

MEMBER MALEBRANCHE: Carol, can you --

MS. WEESE: Yes?

MEMBER MALEBRANCHE: The last time you were here, I don't recall, but what is the change in the number of Federal Recovery Coordinators from last year to now?

MS. WEESE: We have been authorized 25 FRC's since 2010. So, we have not had any increase in the number that we have.

So, I will delve into the questions then, that were presented to the --

just that were of interest to the Task Force, and get going with that.

First up was to talk about the multiple recovery plans, and certainly, this has been a topic that has been discussed largely, and has been a focus of what has been going on for care of the Recovering Warriors now, for quite some time.

My focus of what I have been working on since I have been acting as the Executive Director is in opening up what we are doing with our documentation system, with our recovery plans, and really focusing and working with the recovery teams, with the healthcare teams, the multi-disciplinary teams, to make sure that we are all synchronized and that we are working towards a common goal.

So, this is a large part of what I have been driving in the program.

To do that, one of the things that we did was that the Federal Recovery

Coordination Program is the pilot program going into the Federal Case Management Tool. It's called FCMT.

So, that is where the FIRP currently resides. So, the FIRP is designed by the Federal Recovery Coordinator, in conjunction with our client, either a service member or veteran and their family, and the teams that are working with them.

We were previously housed in the veteran's tracking application, and we had an opportunity that presented itself, to move into a new arena.

What this is going to be able to give us to do over time is flexibility now, to be able to share the information that we've got, with other programs in VA, and down the road in DoD, so, that we can get the information out to the folks that really need it, that are working on designing care plans, tracking goals and things like that.

So, the Federal Recovery

Coordination Program moved into FCMT in June of 2010. Currently on the --

MS. DAILEY: Can you give me that acronym again? FCMT?

MS. WEESE: Yes, Federal Case Management Tool.

MS. DAILEY: Okay, thank you.

MS. WEESE: Okay, so, Federal Recovery Coordination Program moved into the tool in June of 2010.

Currently, the VHA -- excuse me, 2012, not 2010. The VA --

MS. DAILEY: I was going to say, you didn't mention it last year.

MS. WEESE: Sorry about that. The VHA liaison program is currently working, and will be transitioning on to this platform with us, as well as the VBA programs of Chapter 63 and outreach.

This is a Microsoft CRM platform that is being used, and we are on one end of the platform and on the other end of the

platform is VBMS, which is Veteran Benefits Management System.

So, what we're really looking at doing now is the opportunity, as the programs are coming in to this, is how we are going to be able then to share important pieces of information that we are all collecting.

Now, there is also an initiative on the DoD side of the house, that has been spearheaded under the IC3, which is the Interagency Care Coordination Committee, and Military Services and Department of Defense are also looking at opportunities and FCMT has been out to talk with them about what is going on with that, as well.

So, I'm excited about the opportunity to be able to work in this arena.

The other thing that we have been doing related to this as well is in ISI, and ISI is the Information Sharing Initiative, and the ISI project got going back in 2008, and was recently launched and the Federal

Recovery Coordination Program got capabilities in ISI back in November of 2012.

What is currently happening in the Information Sharing Initiative is the ability to be able to see case manager and care coordination, or care coordinator information through the applications of VTA, which is the Veterans Tracking Application, through FCMT and through the Army system of AWIKETS.

So, those folks that are involved in taking care of service members and Veterans in those different programs, all have the capability through the new Information Sharing Initiative, to go in and see who are the other care coordinators that are taking care of folks, and then what is their contact information.

So, this has been part of my overall strategy of helping us to make sure that we are connected and that we're sharing the information about what we're doing from

an FRC perspective, with all of the other counterparts, RCC's, non-medical case managers, case managers, so forth and so on, that are taking care of this population, as well.

Talk about this a little bit, as well. The last bullet here on the bottom is about VA and DoD working to develop a single comprehensive common plan, and this is part of the overall work that is being done by the Interagency Care Coordination Committee, and the first areas that are being identified for work are development of the lead coordinator role, and a single comprehensive plan for folks that are taking care of this population, to have a single plan, and so, that is where we're really driving all of the work towards, with all of this, is in that direction.

MEMBER REHBEIN: Is there any kind of a time line on when that common plan would be finished?

MS. WEESE: Yes. So, the training for the lead coordinator role actually is this week, and this is the beginning of the process for that, and the single comprehensive plan is due to roll out next year in 2014. So, it is actively underway.

Okay, issues in transitioning. I think it's summed up and I spent a lot of time talking to the FRC's about, you know, what are the common issues that you are seeing, as you are transitioning folks between DoD facilities, DoD to VA, so forth and so on, and every single one of them will tell me is, each and every case is different.

There is not a cookie cutter model for figuring out what it is for each individual that is going to be working for the next individual, then to come down the line, and I think a lot of that has to do with the fact that we are taking care of the folks that have the most serious injuries.

We're also taking care of folks that have some very complex support system and family issues, that are coming from all over, and so, we spent a lot of time with folks, trying to figure out what is the best mix.

So, there really is a lot of work from an FRC perspective, that goes into making sure that we have everything synchronized.

You know, we're not the boots on the ground. We're not the ones that are actually the ones that are doing the bulk of the work. It's the case managers. It's the care coordinators. It's the folks that are at the individual MTF's and the different areas that are doing that.

What we're doing is, we're making sure that those pieces are all in play, and making sure that those teams have everything underway.

There is a lot of education that

goes into that. There is a lot of making sure that from the clients, to the families, to the folks that we're transitioning the care between, that everybody is educated, everybody is communicated with, everybody knows what is going on, so that these transitions are going well.

You know, we do still see that there are visibility issues, that there are differences in how things are conducted by different Military services, by individual VA's, and so, a large part of the time of the FRC's is spent in looking at that.

So, as we -- you know, as we talk about that and we looked at that, and so forth, there has been a lot of discussion about, you know, who are all of the players that are out there? What are all the key components and aspects? You know, how does this all work?

So, back in June/July time frame of 2011, we started having this discussion in

the VA, about what programs are touching service members and veterans, and the VA Chief of Staff got very interested in what this was.

And so, in July of 2011, the VA started what they called the Wounded, Ill and Injured Task Force, and started really delving into who are all of these different programs that are out there, and who is touching who, when, and how is this, you know, process all working?

So, we got down the road in doing all of this, and we surveyed a lot of the different programs within the VA, and then the Chief of Staff started sharing that information that we had gathered, with counterparts in the Military Services and Department of Defense.

Then out of that, grew the Warrior Care Coordination Task Force, which stood up in May of 2012.

So, now, on the DoD and on the VA

side of the house, everybody started to take a look at, gee, you know, what do we have going on?

You know, we've been at this now, for quite a period of time, and we have a lot of people that are doing a lot of really great work out there, but is it all synchronized, and what, you know, is there an overarching plan?

So, that is what really then led to the Interagency Care Coordination Committee, that was formed and was stood up by the JEC, the Joint Executive Committee, in September of 2012.

It is Chaired by the Chief of Staff of the VA, and the Principal Deputy Assistant Secretary of Defense for Health Affairs, and what they're really looking at is the synchronization across both departments.

We've identified that there are over 48 programs that are touching these

individuals, that there are over 127 policies that are guiding all of this. So, that is what the IC3 is really focused and working on.

That is where we come then, to the first of what is the real beginning of how to look at a common operating picture, and focusing everybody on what is the synchronization across the departments, and the creation of the lead coordinator role, and getting that underway.

The first sites for the phased implementation of that are Walter Reed National Military Medical Center, the D.C. VA and the Richmond VA, and like I said, the initial training for that is starting this week.

Okay, moving onto pre-DD214 problems. You know, the Federal Recovery Coordination Program spans the DD214.

One of the things that we know from working with our clients and we know

from working with case managers and care coordinators is that the earlier that a transitioning service member is identified to the program, the better it is for the individual because we can begin that process of starting to get them connected into services and benefits across all of the different domains.

So, that is something that I really work on, when I talk with groups and individuals, it's part of the education and training that I do, in terms of doing that.

It's certainly not that, you know, Military Services or individual programs aren't taking care of folks. What we're trying to do is, we're trying to forecast and span for what it is that folks are going to eventually need down the road, as we begin to do that.

We spent a lot of time working with the Military Services and the Wounded Warrior Programs. We had a Navy Commander

that was assigned to work in the FRC program and he certainly, spent a lot of time forging a lot of the relationships and helping with the DoD component and the DoD end of the Federal Recovery Coordination Program.

We have Lieutenant Colonel Keane, who is embedded with us in the VA, from the Marine Corps. We have Jane Dulin, who is assigned to work with us in the VA from AW2.

Those of us that are working on case management and care coordination in the VA are all pretty centrally located, and on any one given day, you'll find us up and down the hallways and in and out of each other's offices, working on complex cases and such.

So, I think we've really spent a lot of time on an individual level, working on that.

We have placed Federal Recovery Coordinators in with the Military Services.

The first Federal Recovery Coordinator to do that went into SOCOM, down

in Tampa, and then we were asked by Navy Safe Harbor, for a Federal Recovery Coordinator, and we are now in the process of placing one at the Wounded Warrior Regiment in Quantico, and we will have that Federal Recovery Coordinator in place here soon.

So, I think that part of what makes it a success for the service member and Veteran is the collaborative relationship across the programs, and really forging those relationships between the Military, DoD and VA, to make sure that we're centered on taking care of folks, and that has been a high priority.

So, what are some of the issues that are impacting folks?

One of the things that we are faced with, because we are dealing with folks for long term, is helping folks to adjust to their new normal, and this is certainly not an easy task.

We all know that when individuals

entered into the service, and then were injured or became very ill, this was not how they thought that their life was going to progress, and so, now, one of the important functions that we help them to do is to get adjusted back to what that new normal is going to be, and back in home town America, where that is.

We transition folks back all over the United States, and that is one of the reasons why we have been a virtual program, is because we are taking care of folks throughout all of these transitions, and what not.

We are working across the United States, as we are doing this, and so, what we're really doing is connecting these people back into home town America, and so, that is kind of getting me back to what I said to begin with, about every situation being different, because depending on where folks are going, the services and benefits that are

available to them in those particular areas are going to be different.

How close are they to a VA medical center or to one of our CBOC's? What are the providers -- who are the providers in the area? Who is accepting TRICARE and Medicare, and so forth and so on?

So, those kinds of things are going to be different in the different areas of the country, of where we're working.

We're helping folks to, when they're able to work, what is the meaningful activity going to be? It wasn't what they thought they were going to be doing. It was not what they thought their life career was going to be. So, you know, we're helping to identify that.

Again, their access to healthcare. Housing and housing adaptations are obviously a big portion of what is very important to these folks, because of the nature of the injuries, making sure that

their houses are ready for them when they return, and helping them with finances and financial counseling.

We certainly heard a lot about that throughout the course of the War, on what's going on with all of that, and it's managing expectations.

We spend a lot of time with our clients and their families, in helping them to manage their expectations, across the entire continuum.

So, when they go from a DoD facility into a VA facility, there is going to be a change, since there are different cultures. You know, what are those kinds of things? What are the differences then, when you're transitioning out of the Military and into civilian life, and managing those, and what those adjustments are going to be for their different wants.

We spend a lot of time educating and working on resources that are available

and getting them into the National Resource Directory, connecting them with the Veteran's jobs bank, and those kinds of things.

Then I think, you know, really in conclusion is that we've spent a lot of time in helping folks in transitioning, and there is still, I think, a lot of work to be done, and I am excited about the work that we are engaging in across DoD and VA, because there are a lot of programs out there.

But I think we have some renewed opportunities to really address focusing on the synchronization of those programs, and getting all of that underway, and that is what I have.

CO-CHAIR CROCKETT-JONES: Let me ask you.

MS. WEESE: Questions?

CO-CHAIR CROCKETT-JONES: Because I think I'm not understanding something.

MS. WEESE: Yes?

CO-CHAIR CROCKETT-JONES: The

lead coordinator that rolls out soon, correct?

MS. WEESE: Yes.

CO-CHAIR CROCKETT-JONES: Is this a new job description? Is this a designated position among the team members that already exist? I'm not understanding who --

MS. DAILEY: Can I get the DoD to come in and brief us on that new program?

CO-CHAIR CROCKETT-JONES: Okay, so, it's a DoD position?

MEMBER EVANS: It's not, no, it's a VA/DoD. So, it's a joint.

CO-CHAIR CROCKETT-JONES: It's a joint?

MEMBER EVANS: Right, and I think the IC3 should come in, so, I'm the Co-Chair for implementation, but I'm not going to speak on it, because we actually should have the Chairs for the IC3 to come in and talk about it.

But it is a -- it's not a new

job. We specifically said no hire. We didn't -- you know, because there is no resources, but it is a function that --

CO-CHAIR CROCKETT-JONES: It's an assigned function, not a new hire?

MEMBER EVANS: Right.

CO-CHAIR CROCKETT-JONES: Okay, that is --

MEMBER EVANS: Then adding the tool kit to assist the case managers and the RCC's, in coordination of care. So, it's not an added role.

But I do -- one of the things that we haven't answered, and I think we keep seeing in the GAO reports, and I know we have not had a brief on the roles of the RCC's and the FRC's, and it sounds like -- it sounds as though we are assigning FRC's to the headquarters, which is good, but then they have a case load out there.

So, what is going on with the case load? Are they going to continue to

carry a case load? Is that going to be shifted to case mangers?

So, we're just -- I don't think that question was ever resolved, as to the case load they have.

MS. WEESE: No, so, there is a -- the proposal that came out of the Warrior Care Coordination Task Force was to align the Federal Recovery Coordination Program to the Headquarters of the Military Services and the Wounded Warrior Programs.

There has been no final determination made on that. The new IC3, this will go to the new IC3 that stood up the Interagency Care Coordination Task Force, and it's on the agenda, for the first project that they are undertaking is that of the lead coordinator.

MS. DAILEY: Carol, on page eight, you've listed 'engaging in meaningful activities, health care access, employment, housing adaptation, finances and financial

counseling'.

MS. WEESE: Yes.

MS. DAILEY: So, these are what impact recovering Warriors after they leave, when you've got them in the civilian world?

MS. WEESE: Yes.

MS. DAILEY: So, then those are things that we, pre-DD214, Department of Defense should be working on preparing service members for, correct?

MS. WEESE: Yes.

MS. DAILEY: So, this is kind of -- we could do these things better before they leave the Military?

MS. WEESE: I think I wouldn't say necessarily better, but what I would say is that we need to work together, to make sure that we are addressing these areas and introducing them to folks at the right time, so that as we know that folks are going to be transitioning, that what we're doing is, we're planning for that up front, so that we

have a coordinated effort for how that can work for folks, as they are drawing across the DD214. Anything else?

MEMBER EVANS: I just have one more.

MS. WEESE: Okay.

MEMBER EVANS: It's partly because Carol and I work closely.

But going back to the recommendation, as far as if that decision -- so, I'm not sure what the recommendation that's going to be to the IC3, for the case load, but I think when you report it, you had about 900 Category 3 patients that fall into the FRC program, is that correct?

MS. WEESE: Yes.

MEMBER EVANS: About 900.

MS. WEESE: Nine-hundred-two.

MEMBER EVANS: Nine-hundred-two, so, they're all Category 3?

MS. WEESE: Yes.

MEMBER EVANS: Okay, so, I think

it would be interesting to see what you recommend because the question, who will have the ability to re-absorb that 900 Category 3 patients, if they're removed from the FR -- under the FRC case management program.

So, they have to be followed by some entity, and so, I think would that go back to the service leads, or would that go back to the medical case managers?

So, I'd like to see where that -- I have a special interest in it, because I, you know, Navy case managers, but definitely want to see where that population, if it's recommended.

CO-CHAIR CROCKETT-JONES: Yes, who --

MEMBER EVANS: Who?

CO-CHAIR CROCKETT-JONES: If they already have assigned AW2's --

MEMBER EVANS: Right.

CO-CHAIR CROCKETT-JONES: -- Safe Harbor, those folks, you know, to see if

they've got anything.

MEMBER EVANS: Right, and how that transition is going to be made, where that service member is educated on, you now have a new lead case manager, it's no longer going to be the FRC, and how that process is going to work.

MS. WEESE: Right, so, they would have -- so, if the determination is made that we truly move into a consultant role, and that we're not longer going to carry an active case load, then we would have to sit down on a case by case basis, and then take a look at where we would place those individual clients, in terms of where their case management and care coordination needs would fall into.

And so, that would be a collective effort, you know, led by the program, but certainly, in conjunction with the Military Services and the VA, especially for those that would be in a Veteran status.

So, you know, they would have to be networked and knitted into the fabric of the processes that are in place.

MEMBER MALEBRANCHE: Carol, another thing. You said they're all Cat 3, but do they stay Cat 3 forever?

MS. WEESE: No, and you know, we have had a few clients that have gone back to active duty service.

You know, once -- you know, just because you were severely wounded, injured and ill, you can progress, you can get better. People, you know, we've seen this across the board.

Some people are going back. You know, if they do go back to an active duty status, we disengage at that point, and we have had clients that have gotten better, that have inactivated from the program itself.

Originally, when the program stood up, it was envisioned that we would be

care coordinators for life, but really, what we have found over time is that not everybody needs us for life, and that is okay, because we're not trying to develop a dependency on the program, itself. We're trying to get people back to their new normal, what it's going to be.

MEMBER MALEBRANCHE: Well, I think we'll understand it when we get the IC3 briefing, but do you have the statistics of were Category 3, who are Category 3, how many have gone back to active duty, how many now are lesser Categories?

Do you have those -- that group of statistics on this group of 902?

MS. WEESE: I would be able to tell you over the life time of the program, who has been enrolled in the program. I can tell you who has been inactivated under certain Category assignments, and so, I can answer part of that.

MEMBER MALEBRANCHE: I think that

would be interesting to see, because as we're going forward and doing these new things, it would be interesting, because this was the group that started out to have the most need, and it would be helpful, as we progress, to know how that has happened.

MS. WEESE: Yes, okay. Anything else?

CO-CHAIR NATHAN: Earlier today, we were speaking to the topic of central coordination, central repository of expertise. There was anecdotal stories told, by various members of the Task Force, who had visited focus groups or had personal experience where they didn't know how the system worked, they couldn't find the right person, they -- one service does it different than another service, and they were somewhat befuddled by it, and that in certain localities where there is expertise and corporate memory and very competent professional personnel, those folks get

wickered through the -- hit the gates all very nicely and feel like they're well cared for.

Others may feel a little more disparate from the system, and not in the know and sort of at the mercy of people who are trying to figure it out at the same time they are.

Do you have any comments on that, from your experience now, and the years that you've done this, and from the time that you were clinically invested at Bethesda and now, working in this capacity, and the AG's of care coordination between the two systems?

What would you see as the best mouse trap to build? If somebody came to you, and said, "Resources are unlimited, the sky is the limit," how would you -- do you have frustrations with the system or do you constantly say, "Boy, if I were Queen or King for a day, this is what I would do."

MS. WEESE: I'll tell you, from a

program perspective, one of the most frustrating things to me is, I don't know what I don't know, and I always think that sounds like an oxymoron.

But let's talk about the service member or the Veteran that gets lost in the system and people don't know where they were. You know, one of these came across the desk last week.

From an FRC perspective, I don't know who is out there, because I am totally a referral based program.

So, this is where there has been the drive to look at aligning us in with the heads of the Military Services and the Wounded Warrior Programs, so that we have better visibility over, you know, the folks that are out there.

From a program perspective, that would make a tremendous impact, I think, in what we're able to do, not necessarily that everybody needs a Federal Recovery

Coordinator.

Again, I go back to the synchronization, the coordination of what the programs are doing and what not, but helping direct all of that.

So, where I sit in the VA, I don't have visibility over, you know, the incoming wounded Warriors. So, I see that as an issue or a problem.

What I think that we are doing, in terms of VLER and the Virtual Lifetime Electronic Record, and looking at how we -- where we have data and medical records and in care plans, and recovery plans and all of that, I think that can only help to expand our ability to be able to help these folks that are out there, because I do believe that we've got a lot of programs that are all doing a lot of work, and a lot of us are all in individual stove-pipes, and so, I think that when we get that information out and about, that that would help a lot of that,

too.

I think that we've spent a lot of time working on that with the most severely wounded, injured, and ill. Where I'm hearing these, a lot of these things, is with the folks who are not considered to be Category 3s, those who are considered to be less injured or ill. So, I see problems there.

So, you know, from program perspective, I think it's a good idea to align us more closely with the Military Services. There are differences in how things get done, service by service by service. Everybody knows that.

But there is also differences in the VA, as to how things get done, too. So, one VA medical center isn't necessarily doing things the same way that another VA medical center is doing it.

So, you know, I want to put that out there because, you know, we work on that, on that side, too.

CO-CHAIR NATHAN: Thank you. Other questions? Comments? Concerns?

Thank you very much, Ms. Weese. We really appreciate the update.

MS. WEESE: Thanks again, for the opportunity.

CO-CHAIR NATHAN: Denise, have you had -- has the Task Force had briefings on medical home, per se, on what medical home is, and how it's being implemented in the DoD?

MS. DAILEY: Just from the Air Force, sir.

CO-CHAIR NATHAN: All right, because I think that fundamental understanding is going to be important to discussions that we're going to have now, and maybe we can talk a little bit about that, as Ms. Quisenberry gets going.

But please, let us welcome Ms. Ginnean Quisenberry who is the Director of the Population Health Medical Management and

Patient Center of the Medical Home Division, with the TRICARE Management Activity.

Ms. Quisenberry will discuss the status of new clinical case management, Department of Defense instruction, which is to follow the clinical case management directive of type memorandum 08.033, which expired in January 11th, well, actually, expired, I guess a couple of days ago, in 2013.

This is a follow up briefing from one provided to the Task Force in February 2012. You can find Ms. Quisenberry's updates in Tab M of our binders.

Ms. Quisenberry, thank you very much for coming, and we're all ears, as to the DoD directive and how it dovetails with patients entering medical home and clinical case management.

MS. QUISENBERRY: Well, good afternoon. Thank you, everyone, for welcoming me back. I will just say at the

outset that patient centered medical home is now run by Gina Julian.

So, I have the population health and medical management with case management that falls under that.

So, as to the specifics of patient center medical home, I would just probably ask that, you know, we coordinate that and how they're being rolled into that, because there is certainly staffing issues and looking a patient center care directly with that, because certainly, our service members are at and are in those places where we do have the patient center medical homes and where they're moving to.

So, before I get started today, what I wanted to do was again, thank everyone for welcoming TMA Health Affairs back to address and update you on the efforts where we currently are, with the implementation and moving forward with the case management, and just reintroduce you to Ms. Derenda Lovelace.

MS. LOVELACE: Hi, I am Derenda Lovelace, and I am the case management nurse consultant in the population health and medical management division.

MS. QUISENBERRY: And new with us here today is Lieutenant Commander Collins.

COMMANDER COLLINS: Hi, good afternoon. Lieutenant Commander Collins. Thank you for having us here today.

Just a quick background. Prior to becoming part of the United States Public Health Service, I spent 15 years in the United States Air Force, 10 years of which I was security forces enlisted and the last five as an ICU trauma nurse, with several deployments under my belt.

So, I am excited to be here, working with TMA, specifically as a Branch Chief and helping forge the way forward for case managements, providing care and services to our wounded and ill Warriors. Thank you.

MS. QUISENBERRY: Thank you. So,

today, what we've been asked to do, come and address, and I would like to update everybody on, is specifically and primarily, where our publication for Department of Defense instruction currently is, in moving through our transition from our directive type memo that specifically addresses case management, and rolling that under the full cadre of care coordination within our medical management efforts.

Also, talk about any publication challenges that we faced, with the implementation of this new instruction, looking at our case load management and limits, as well as any changes that may have occurred in our transition to this instruction, for both our qualifications, as well as our training for case managers, as well as looking at the status of where we are today, and where we are moving forward in case management.

So, specifically, I wanted to

take the opportunity to let you know with our Department of Defense instruction, we are looking to have that published any time now. We have not quite gotten the thumbs up from our directive division, from the Department of Defense.

Where we have completed, and what I wanted to highlight off the bat is the extensive internal and formal communication and coordination required for this effort, specifically, in the fact that when we went forward with this effort, we made sure that our partners were at the table and discussing this.

All of our services were in the revision of this transition, as well as going through our own internal TRICARE management activity, in moving it up through our General Counsel, as well as up through our P&R, our personnel and readiness division.

As you can see, it then moves into the formal coordination where we have

our service representatives involved. We did include the VA, as well as making sure that our definitions and what we identified for their programs were crisp and were on target, and that were well understood and accepted within the Department of Defense instructions.

Currently, we are awaiting the directives division to do their final adjudication through the OGC, or our General Counsel, and then we will be able to move through the publication of the formal Department of Defense instruction.

We have talked to them in the fact that our directive type memo is currently expired. We spoke to them, and they are not pulling that off, offline, until we have from them, the directive's portal confirming that our instruction will be formally in place and active, before we are removing anything.

One thing I wanted to highlight,

because a question asked is what challenges did you face with moving through this formal publication of this instruction?

I think it's important to note that what challenges we face are probably not uncommon from any other Department of Defense instruction that is being formally put through, but what we identified at the outset was trying to get our services and all of our partners at the table.

Last I addressed the committee, I was able to highlight how we would affect and interact with case management, because a lot of times, I think we are just looking at that strictly at a Military treatment facility aspect and a VA facility aspect.

With my hat over at the TRICARE management activity, I am cognizant of the fact that these individuals are also out in our purchase care platform, and they are interacting with our providers in the TRICARE sector, and making sure that we are working

with regional partners.

For those, just to let you know the update, TRICARE has three separate regions. So, we work with a north, south, and west. So, we made sure that our TRICARE regional partners were at the table, as well as our services in the VA.

When you're looking at the challenges normally on average, it takes approximately 18 months to get a Department of Defense instruction put through.

Thanks to the services and the pre-coordination and extensive time taken by all of our partners, we've been able to meet and exceed this deadline, looking at having this publication now, a little bit early. We're looking at about the 13 to 14 month mark, as opposed to the 18 month mark.

So, again, it's just the complex, and mainly it's complex, as many of you are aware, and probably not uncommon, as to the many questions that we get, making sure that

we are coordinating and integrating with the policies that exist, and reflecting what individual services want to make sure that we're identifying within the requirements of the instruction itself.

I thought it would also help for everybody to kind of see a visual of this. Right now, again, it goes back to what I had just discussed.

We have moved all the way through and are currently at the stage four process, specifically, when we're looking at the legal sufficiency review.

So, right now, we have submitted that action memo and we are looking at that formal adjudication through the General Counsel, and we have given them our clean comments, and how we have responded to all of our partners, received concurrence on that.

So, again, we are just simply waiting for their thumbs up on getting -- making sure we have the correct formatting

and we have met our due diligence to what we need to place forward.

Also, I've been asked to address the case load considerations, as far as management and limits within this new Department of Defense instruction, and specifically, I would like to go ahead and point out that when we're looking at identifying such case loads, we have to consider all of the many facets that go into dealing with these service members.

So, looking at our national guidelines, that drives case management requirements and the standards of practice put forth by this national committee, and looking at, in the fact that they have historically worked with the national standards and our social workers out there, know, even our case management society of America, our national that drives our standards has not identified a case load by case manager.

As many of you have learned, as many of you have seen and heard the feedback of, a lot of factors go into that. This being the process of moving through a very specific evaluation on what individuals require and need, moving through this assessment, planning, implementing, coordinating type of process, moving through that.

So, many factors, some time are obvious to us on the types of support a service member would require and some times, not so obvious, or those hidden ones.

So, we have not specifically identified how many per case manager, but are certainly trying to continue to work forward, in looking at that, working hand in hand with our services, as well as they are working to identify those -- helping to again, identify personnel required and things like that.

CO-CHAIR NATHAN: So, there is no industry standard? There is no --

MS. QUISENBERRY: No, sir, none that I have been able to find, and I've personally called Case Management Society of America, the Vice President over there, and I said, "You, setting the standard, is there anybody that is saying, is there one standard that would identify," and in looking even at the civilian sector, when they identify case managers, they'll even do it by possibly one case manager covering for another, maybe a neuro and an ortho, and looking at how many patients per facility beds they would have.

But none that I have been able to find, none in working with our service partners, that have been able to identify one standard that has been a hard and fast standard, that we can we stand on.

Another, just trying to give you a visual of how we are trying to move towards this, and possibly identifying, maybe even being a leader to the Department of Defense, and being able to identify a national

standard, is utilizing a tool.

So, again, trying to put a tool out there, when our individuals or our case management, my case management colleagues are in different platforms, being at a Military treatment facility where our members move through and may receive their acute care, moving out into out-patient or those geographically separated sites, and what considerations or what might help you get to be able to identify what would make sense, as what would be a proper case load for us, in our different settings.

So, this just gives you an example of a tool that we've moved forward in trying to put out there, to help determine for those case managers, how much time you would be spending and how you identify -- I'm sure you've heard conversations with the identification of the type of category being one to three. This helps also, as a tool to identify what would constitute a low to a

moderate to a severe to a high, and the amount of time and what it would take.

Again, developing this with our service partners and what would make the most sense, as we're identifying those service members in need.

Any questions on that? Again, this is just a tool in helping individuals identify that.

MS. DAILEY: Is it in the new DoDI, as an exhibit or diagram or --

MS. QUISENBERRY: What this was developed in was in the Department of Defense Appendix E, as -- and what that puts out is helping us identify how they document or capture, where an individual is getting case management, and helping us, you know, identify by what site and what code that they're at.

So, this helps them identify how many cases, when they're starting to code, I have this many at say, Fort Belvoir. So,

when I'm coding this, they can then go to their leads and say, "This is the amount of time that is being taken."

So, what we're doing is, since this is being developed, and it takes so long to change a Department of Defense instruction, we have this in our living document that is codified and approved through the Department of Defense, through our Appendix E that helps identify that.

So, as we move and change, we'll be able to update this.

MS. DAILEY: Okay, so, Appendix E of the TMA operations manual?

MS. QUISENBERRY: It's Appendix E, and I have that right here.

It's in the 'coding and clinical case management' for health affairs that the services can utilize, and I can certainly share that and get that over for everybody to see.

MEMBER EVANS: So, I think one of

the things that we've been doing, as all the lead case managers or director case managers with the -- we've been working collaboratively together, to talk about work load, and how -- what is a -- so, prime example, you know, you just completed a visit over at Walter Reed and Navy had a different case load than Army.

And so, we're utilizing this, the acuity level, but then we're also saying, based on the type of injuries at Walter Reed, you know, maybe 20 should be the max, because of the level of acuity, and based on acuity, you may have less than 20.

So, you have to -- we have to establish a max, and then looking at the acuity, assign less or more, and you know, there is no right or wrong, you have to listen to the workload of the case managers. You have to listen to them, but at the same time, you have to look at the acuity level of the Warriors they're working with, and we

need to standardize it across all three -- all four branches, because I don't think that we should have Navy saying, "I have 30," and then in the same facility, another service saying, "Well, I take care of 20."

So, we are looking at that magic number. We've been working hard, but then we're also factoring in the acuity level.

So, when you go out to the site visit, you may hear a case manager say, "Well, I have 30," but then the question, the next question, are they all category one, 30?

So, are you just on the phone with them once a month, you know, once every two months? What is the workload, and so, that is how we make the determination, if they have too many or not enough.

So, we are looking at what is an accurate number, standardized number against for all services, and then based on the acuity, what is their assigned workload? Am I correct on that?

MS. QUISENBERRY: You are correct, and then going back to being able to identify those minutes, and things like that, that help you drive to the amount of time that these individuals are taking in coordinating their care, as well.

So, not only can you look at the diagnoses and the acuity level of the individual, as far as the requirements, and this injury sustained, but again, you could have an individual that is not so obvious, but takes an extensive amount of time, to be able to help with care coordination activities.

So, again, this is just a tool, trying to help drive and that acuity level.

MEMBER PHILLIPS: Two questions. Do you sub-categorize? I mean, do you have care coordinators that specialize in high acuity or medium acuity?

I mean, can you identify -- is that a worthwhile thing, to identify and who

makes the decision to move people between different levels, or how often do you do that?

MS. QUISENBERRY: Well, none that I know of, as far as -- when I look at the civilian sector, just coming from that, I kind of worked in the civilian sector, grouping the MTF's, and now, looking at case management at this level.

Case management is looked at and done very differently in the civilian sector, because when you are accessing a case manager, you're really accessing a very high level type of need, because they will utilize discharge planners, before they're going to move to a case manager.

Now, normally, it will depend again, on those care needs and they will sub-categorize by how you may have a prenatal with a neo-natal intensive care type of nurses. You might have orthopedic and neurologic together. It just depends on how

that specific organization sets those up.

As far as in the service level, I am not aware that they do that within the military treatment facilities, and that might be primarily because we don't have -- you know, we have different services at different sites. We have different services that are moving towards bedded facilities versus non-bedded facilities.

So, it's a good point, and it is something that I know we've kind of broached, but being able to identify that is a little tougher within the service sector.

MEMBER PHILLIPS: And how do you move between the different levels? I mean, do you meet periodically and --

MS. QUISENBERRY: Well, and that will go in -- I am kind of jumping ahead in my slides.

So, I, at TMA -- that's okay, sir. I am at TMA, am not going to make a service level decision and driving even

further down to a Military treatment facility level decision, as to where I would identify an individual or wounded member, as far as what category.

Certainly, do individuals move within that category? Yes, we would hope that they would move to the positive.

It would be up to the individual service to identify then, how they would then utilize their available resources and how they would treat that and how they would move those members.

Again, that goes hand in hand with the care coordination techniques that they would employ.

MEMBER MALEBRANCHE: For purposes of what you're doing here, when you talk about case managers, are you talking specifically about nurse case managers and/or social work, because I know Case Management Society of America recognizes both.

But in terms of the Military

service, is it nurse case managers?

MS. QUISENBERRY: Yes, ma'am.

MEMBER MALEBRANCHE: Okay.

MS. QUISENBERRY: That is a great question.

MEMBER MALEBRANCHE: Okay.

MS. QUISENBERRY: We, in the DoD, recognize nurse case managers, but we also recognize our licensed social workers.

So, we do have both. We certainly don't have as many social workers at the VA. I believe when I left, you guys had like 5,000, but we don't have as many social workers.

So, the nurses will take on that role, but we do recognize both, and it is identified within our Department of Defense instruction.

So, again, I really wanted to be able to give you a visual of what we are using, as well. Sometimes, it's different when you talk it, and now, you're thinking at

what you may have seen earlier.

With the Department of Defense instruction, looking at the certification requirements that are now identified, we have not taken the step to require a case management certification, and what we have done, and what I know the services are doing is, it's a highly desired certification to have, but we are not requiring it.

Interestingly enough, I went and looked at the American Nurses Association and just looked at the amount of nurses.

So, right now, we have 3.1, according to their report, 3.1 nurses across the United States, 2.6 of those are practicing at an average age of about 45 to 50 years old.

I was interested to see, well, how many case managers do we have? Has that been growing?

Correlated that over to the Commission on Certification for Case

Management, and this entity has been certifying case managers since 2007, and has had a growing certification since 2007, and is at 35,000 case managers.

So, it is something that is highly desired out there, certainly, something that my colleagues are working towards, a certification we would want to see, but requiring it within our Department of Defense instruction, requiring that with an individual position description, we may find ourselves, or existing with the nursing shortage, again, only about 538,000 individuals going into a nursing program every year, U.S. wide, we may find ourselves short of certified case managers.

Again, it's not that we don't want to drive towards that certification and certainly, that specialty. That is a highly desired thing, where we want to continue to work towards, but we did not specifically require that within our Department of Defense

instruction.

Also, looking at our training, I can tell you when I joined TMA, I really look at training in a way of how I came up within the military treatment facilities, and my colleagues and how they're identified as case managers, and I really go on this through a nursing ferris. I am a nurse.

So, going at this in a nurse ferris type approach, specifically Pat Benner, when she looks at a novice to expert type of approach.

Our education and training that we have set up specifically does that. We have the newest of new, that may not have the institutional knowledge of a case manager, and then we have truly, our true experts out there.

So, when looking at our original directive type memo training, we have a smattering that identifies the basics, and understanding what is TRICARE? You may be

brand new.

We certainly don't want a case manager, armed and required to take care of these members, and not realizing what a certified case manager is, having them out there in a civilian sector, and now, we've just added to another problem that we have, debt collection or some type of cost associated with using a non-authorized TRICARE provider. We are not helping them doing that.

So, we have moved in our training, in having just basic understanding of TRICARE, basic understanding of case management, bringing in that service specific type of basic training, moving all the way up to the specialty type of training, for our TBI, as well as our PTSD.

One thing that we have now formally implemented and what we were able to move over to our Department of Defense instruction training is the new addition of

our disability evaluation module.

Again, that was built not solely in TMA in a silo, but working at the table with our partners, at the services VA level, as well as our TRICARE regional providers, out there, as well, regional offices.

MEMBER PHILLIPS: Related to the shortages and the certification issues, is there a consideration or perhaps, you do already contracting out to the civilian sector to do some of this?

MS. QUISENBERRY: If I'm not mistaken, and I don't want to speak out of turn, I think our Air Force partners do have medical management, where they are primarily supported with contract.

I would -- I don't want to go on the record and say anything for our Air Force partners that may not be correct, but I believe in working in the medical management aspects that I do, that is contracted efforts.

As far as the percent of what the ratio is to GS to contracted type of support, I'm sure there is definitely a mix of that throughout the services.

But my question then, are you driving to possibly contracted, as far as an analogy would be if you needed coverage in a hospital and so, you would contract out specifically for shift type of work.

MEMBER PHILLIPS: I was thinking in those terms, just like hospitals doing in the civilian sector, either as an interim bridge or as the numbers change, that we're dealing with.

MS. QUISENBERRY: Right.

MEMBER PHILLIPS: We're going to have a big increase soon, and then we'll have a decrease, hopefully.

MS. QUISENBERRY: Right, and so, what I did, in bringing those numbers, just specifically looking at nursing today, it was meant to be kind of an idea of where we are.

I don't specifically know of any type of contracting out for that, because the continuity associated with that would suffer, I think severely, because you wouldn't be able to have that rapport with that individual.

So, none that I know of, but I think they all have a smattering of GS and contract based personnel.

MEMBER EVANS: Right, we all contract, we have contracts.

MS. QUISENBERRY: So, moving to again, the existing status, just trying to give you the here today, of where we are, and making sure in the mechanisms that we work is, we work very, very hard, and I asked my consultant within my office, to make sure that we are concentrically moving out with our case management, as far as not working at it through a strictly Health Affairs TMA type of approach, and looking at what case management is and our requirements within the

Department of Defenses instruction, but concentrically reaching out to making sure the various platforms --

MS. DAILEY: Okay, I'm sorry, I've got to hold you, stop. I don't have these pages in my book. We either missed them or did you update this with some additional pages?

Okay, so, these last few pages are not in your books. Your books end at page eight. Please, now go.

MS. QUISENBERRY: I'm sorry, should I -- just let me know if I should re-send them over, but they were -- you've got them?

MS. DAILEY: Yes.

MS. QUISENBERRY: Okay, so, just working out concentrically again, to making sure that we are including all of our partners, in moving forward, and we've now even extended out and we are working out with our Wounded Warrior care policy program, and

making sure we have a representative from that office.

Partnership engagement, again, working with that, and I even have -- try to insert myself within the medical director type of conversations, within our office.

So, I go sit with the docs and try and make sure that if I am hearing any type of gaps, type of feedback, anything associated with case management, that I'm hearing it right back from the provider population out in our Military Health System overall, as well.

I believe I heard before I came up, the introduction of the new collaboration that is going on with the community of practice, with our DoD/VA partners, and how they are working towards the overarching type of policy.

I know we are very engaged in looking at our tracking systems. I know for all of us, and certainly for our service

members, the ability to share the information across in a very seamless and a bi-directional fashion, so, all individuals who are involved with this type of care, have the ability to see it's something that we continue to work towards.

We are certainly not satisfied with coming up on the inability to be able to do that and simply saying we can't do it. We continue and we will continue to make efforts to try and find a way around that, and try to jump that hurdle.

Also, the satisfaction type of review, or the effectiveness, how do we know at TMA, if we're being effective or not, and so, what we did, and certainly, we looked at the 2011 Task Force book that was put together, and we identified that case management certainly was getting reviews, good reviews.

We went ahead and we have a wounded, ill and injured survey that goes out

to our healthcare survey of DoD beneficiaries through that avenue, to identify what is the feedback for our case managers?

So, we quickly took the opportunity to get inserted in that, and the feedback from that was positive overall, and I'll be able to give you a little bit of an idea of that in the next slide.

But again, where are we today, continuing to make sure we're systematically looking at those gaps. Again, getting with those providers and hearing back, looking at what action or action plans we need to take when we do hear of a problem, having everybody there at the table, certainly makes that much easier to be able to move forward on in an immediate fashion, and okay, how do we solve this? What can we do? What are the limitations? Where do we go?

Partnership and engagement, again, very involved in the community of practice. We have -- we attend those

regularly and are certainly an active partner within those, and then finally, looking at going forward.

We're all in a cost-constrained environment. So, how do we stay involved in getting that feedback on our effectiveness?

So, what we've done is, we again, have gone back and looked at the wounded, ill and injured. I believe you had Dr. Bannick previously here from Defense Health Cost Program, that came in and talked to you.

He has graciously allowed us to piggy-back again, on that wounded, ill, and injured survey. I can let you know that that survey reaches out with over -- since I have 2007, over 200,000 individuals surveyed, with 80,000 individual response, giving it a 41 percent response rate.

So, in looking at a response rate of that, that is pretty impressive today.

So, he has graciously allowed us to get in there. We are meeting with them

tomorrow and looking at how can we get questions put back in the survey, so we again, are utilizing every avenue that we possibly can, to make sure we do not miss any type of feedback that we can possibly obtain, in how we are doing.

So, that concludes what I was going to present today.

CO-CHAIR NATHAN: So, if I could ask you to sum up to the layperson, once the instruction gets through the wickets, and is ready for prime time, if the instruction is adopted successfully and fairly universally, what would you tell the layperson that will -- how will that change the way care is rendered in our facilities?

MS. QUISENBERRY: I would let them know that we would -- this would help us move forward in a de-conflicting, in the siloed approach that we sometimes fall into.

Having everybody at the table and being able to come to consensus on what has

been identified in here, and moving this forward and having this approved, would allow us to move forward in a very organized fashion, in where we were moving with case management.

In doing so, having the services agreement on this, having our definitions identified will then be a platform that will let us be able to step forward when we are working with our VA partners on that community of practice, and having a very clear direction forward.

So, we've had our previous Department of Defense instruction. We had all the Dole Shalala on all of the IRG with the previous things that happened in 2007. We've had that feedback. We've now been able to take our DTM, have that in place, meet, clean this up and move now, forward to a very integrated Department of Defense instruction to allow our care coordination to be more focused.

CO-CHAIR NATHAN: What do you say to the family member who lives -- whose DoD beneficiary lives in Wisconsin, and is navigating the Wisconsin healthcare system, far from -- although I'm never surprised where the Air Force has bases, but far from a probable base or MTF, that has direct oversight?

MS. QUISENBERRY: I would be able to, with confidence, be able to say, I realize that you're geographically separated, and are in that purchase care sector, and so, what we would do is, we have avenues through this Department of Defense instruction, that we have readily recognized the platform, and not only in the instruction, have had them be part of that, but we also work, since they are not as far as the Department of Defense instruction, in that, but we work regularly and routinely with your TRICARE regional offices.

So, we have that life-line there,

and we have active engagement for that care coordination identified with active coordination and discussions going on, with that managed care support contractor.

The managed care support contractors certainly are required by contract to have certain things, but they are all readily engaged and recognize the importance of this and many of them are retired members and understand the issues associated with that.

CO-CHAIR NATHAN: So, then, and I don't know all the intricacies of the instruction, but since you are Health Affairs TMA and you do broker the benefit and you do write the contracts with Health Net, United, Humana, et cetera, this instruction in -- there will be contractual language, which requires the managed care partner to meet at least the minimums of this instruction?

MS. QUISENBERRY: Well, this is a Department of Defense instruction.

CO-CHAIR NATHAN: Right.

MS. QUISENBERRY: So, our contract language, certainly, we would try to incorporate the aspects of case management that we would want to have with that care coordination.

So, we definitely have, not getting into anything procurement sensitive, the recognition of case management, and how we work with them in identification of these members, out in their regional areas.

CO-CHAIR NATHAN: So, we do have a hammer, based on contractual language.

MS. QUISENBERRY: We do have case management, yes, sir.

CO-CHAIR NATHAN: Okay.

MS. QUISENBERRY: Identified within our regional contractors.

CO-CHAIR NATHAN: And the last comment I'd make would be on, where medical home inserts itself, I think we've learned through the years, that the worst thing we

can do to a recovering Warrior or any patient who has a complicated or complex issue, behaviorally, emotionally, physically, is sort of cast them adrift from specialist to specialist, or person to person.

Primary care becomes critical in managing these people, creating a primary care reservoir that knows what one hand is doing on the other, and that is the medical organization of it.

The case management oversees, as they move from primary care to specialist, to outside the hospital for a consult, that is where that takes place.

So, the primary care generates that and medical home, ideally when it works well, is a way of creating more continuity of care in the military, which is the one thing we lack.

Most patients are very happy with the care they get, but they don't like the revolving door, and they don't like the

revolving primary care, they don't like having to reinvent the wheel, and that becomes inconvenient for the average patient. It becomes failure, in many cases, for the recovering Warrior.

And so, medical home, then I think dovetails with this, because it allows a more continuity of care, it allows patients to feel that they are home with their medical care, and then the case management then bridges that when they leave the medical home genre and they go to other care pods, it bridges that.

So, I see all goodness here, and as long as I think that we can make sure that this isn't lost, as we leave the MTF's, I think it's good news.

MS. QUISENBERRY: Yes, and I would say a basic tenet of patient center medical home is the fact that it is patient centric, patient centered. So, the needs are identified in a very holistic manner.

CO-CHAIR NATHAN: Right, I mean, that is the idea.

MS. QUISENBERRY: Correct.

CO-CHAIR NATHAN: We find some place that they simply take the sign down that says 'internal medicine', and put a new one up that says 'patient centered medical home', and we're working very hard now, to actually change the culture of primary care, and the MHS, to be one that -- actually, it's probably going to be the game changer.

I mean, it's probably -- it's probably the one thing that is going to allow us to decrease MHS cost, is medical home, is being able to provide health as opposed to healthcare, to provide preventative medicine, as opposed to healthcare reactionary medicine. So, I think the two dovetail very nicely.

MS. QUISENBERRY: Yes, and it's certainly a priority, as our Assistant Secretary of Defense identified where we want

to move is healthcare to health.

I'm very much a part of the National Prevention Strategy and Executive Order, by the President, identified in June 2011, in trying to move our system from one of sickness to one of health, and in looking at what we do in our division of those population health efforts.

But a very good point raised is, what happens when they move outside those Military treatment facilities, and they become geographically separated?

CO-CHAIR NATHAN: And they explore it to a primarily fee for service environment, and that is where we also lose control of the patient.

So, I don't want to belabor it, but no, I'm a big believer in healthcare to health. We should do it like the 15th century Chinese did, and they paid their physicians while they were well.

So, your doctor was very

concerned with your overall health, and didn't want to get you -- see you become ill.

Other questions? Concerns?

MS. DAILEY: Ginnean and Ms. Lovelace, I want to congratulate you guys on pushing this DoDI through as aggressively as you have.

It's been a big concern for the Task Force, that medical case management, which we consistently see as a success out in the wounded Warrior units and in the field, that it not lose its importance, and one way to do that is the Department of Defense instruction.

The Task Force has repeatedly said, Department of Defense instructions are an important part of institutionalizing these practices, and you were at the top of our list last year.

So, and I know how far you are in the process with the pre-signature review, and it takes a little while, but the hard

part is over. All of those coordination's and getting your service and partners to buy in is over.

So, thank you. Good job. Having done it and having my assistant DFO or alternate DFO do it, it is a significant accomplishment.

I did also want to ask you to clarify, and I know this is a good move also.

We do have -- have had Dr. Bannick in to talk to us about the wounded, ill and injured survey that has been ongoing since 2005, I think. It's a very in depth -- I'll just make sure I understand what you were telling us.

You've had questions in there or you're re-inserting questions? Now, you've established this new policy. You're measuring its effectiveness by re-inserting questions?

MS. QUISENBERRY: Yes, because I am taking the opportunity, you know, we're

all told cost constraint, cost constraint, cost constraint.

So, trying to get a survey started, I think when you go -- not knowing the process specifically, but certainly, when you look at putting a survey in place, the Department of Defense, our population is considered an at-risk population.

So, you have to go through all the IRB's. You have to have everything approved. You have to go through OMB. That is a pretty extensive type of process.

Dr. Bannick allowed us to quickly get some questions, last year, on that, and so, I became a little bit of a badger, and he allowed me to -- graciously allowed us to go ahead and put that in, and so, we were able to re-insert questions, because I think it's an opportunity that is available to us, and we certainly don't want to lose that feedback loop.

So, we are trying to get more

questions re-inserted.

MS. DAILEY: Good, thank you.

CO-CHAIR CROCKETT-JONES: Thank you, Ms. Quisenberry. It's good to see you again.

MS. QUISENBERRY: Good to see you.

CO-CHAIR CROCKETT-JONES: We'll take a break, now.

(Whereupon, the above-entitled matter went off the record at 2:15 p.m. and resumed at 2:35 p.m.)

MS. DAILEY: Okay, so, if I have all my members here, we can start early.

This isn't -- we do have another 10 minutes. So, if I have everyone here, I'm happy to give that over to Captain Hammer.

No, Dr. Phillips is right here. So, I'm going to turn it over to you, Captain Hammer.

CAPT. HAMMER: Is that it? Okay, good afternoon, members of the Task Force.

My name is Captain Paul Hammer. I am the Director of the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, that is DCoE, and I'm here, yet again, to provide you with an update, and I appreciate the opportunity to do so.

I've divided my talk into two major portions here. The first is to -- some of you may either have forgotten or be new and unfamiliar with what DCoE is.

So, I thought I would very quickly, go through a background, talk about what we did in the last year, and then where we're headed in the way ahead, and then respond to the specific Task Force questions that were posed to us, and then take any questions and discussion that you might have.

So, a little bit of background about what is DCoE and what are we about, and I won't belabor this, because I understand you've also heard from the other Centers of Excellence, throughout the course of this,

and I am also painfully aware that I am the last thing standing between all of you and 'happy hour', and there is a bar about 20 yards outside the door there.

So, DCoE is the Defense Center of Excellence for Psychological Health and TBI, its mission is to improve the lives of our nation's service members, families and veterans, by advancing excellence in psychological health and traumatic brain injury prevention and care.

Our job is to make the system better, so, that our service members, their families and veterans get better care.

Our vision is to be DoD's trusted source and advocate for psych health and TBI knowledge, standards and profoundly improve the system of care.

What we did recently was really re-tool our mission vision, as well as get some sort of organizational values, to really describe what we do, and improve what we do

as an organization.

This is the important thing, is our value proposition, and that is one of the things that we look at, in terms of our strategic planning, was to talk about why should DoD give us money to exist? Who are we and what do we do and what do we provide to the organization, as a whole, that really provides value?

We believe that by serving as the principal integrator and authority on psychological health and traumatic brain injury knowledge and standards for DoD, we're uniquely positioned to accelerate improvement in care and affect and impact the continuum of care and reduce variability across the services.

One of the important things to realize is everywhere on this continuum of care, from surveillance and prevention, all the way through treatment, diagnosis treatment, to rehabilitation and re-

integration, are things that can be done to improve the system of care, and in keeping with what has been going on within DoD, to understand what the Centers of Excellence are, you know, one of the things we really focused on is our sweet spot is in the middle there.

What are we doing to improve diagnosis and treatment for these particular conditions?

This is the Star Trek slide. If you notice, it looks kind of like the Star Ship Enterprise, you know, there is sort of the main part, and these are the thrusters, and sort of the bottom part there.

The idea behind this is sort of graphically describe what we do there, and I'm going to spend a little bit of time walking through this, because I think it's important to understand what is the Center of Excellence and what is it suppose to be doing.

You see here, on the right-hand side, is the sort of diagrammatic system of care.

What happens at the initial care level or the medic record, what happens in theater, and the treatment entities there, whereas, what happens with definitive care at level four and five, all the way, if somebody needs it, to long term care and rehabilitation through the VA.

What we want to do is to be able to extract data out of the system and then put it into our system here, where we identify, evaluate, analyze information, best practices, all sorts of things, and eventually, produce good clinical guidance that gets back into the system, and integrated wherever it needs to be in that system.

The idea behind us and DCoE is a headquarters with three centers, the National Center for Technology, the Defense Health --

the Clinical -- the Defense -- Deployment Health Clinical Center and DVBIC, the Defense and Veteran's Brain Injury Center, and the idea is to have connections with what is going on with the services, what goes in professional organizations, what is happening in various parts of the VA, what is happening in academic institutions?

What are we doing with partner centers? What is going on in military treatment facilities, as well as research?

Organize that, synthesize that with the data that comes out and produce knowledge, and knowledge gets fed back into the system.

So, we're not exactly in the system, but we're outside of it, and serve as an integrator for a number of entities that need to interact within that system.

So, at this point, let's talk a little bit about what have we accomplished in the last year.

So, in 2012, and I'd like to sort of look, to make sure that we're matching up with various aspects of what is happening at continuum of care, some of the highlights of some of the things that we've done in 2012.

We had the fourth revision of the military acute concussion evaluation, the MACE. We published deployed clinical guidelines, and those are actually in practice in theater, throughout Afghanistan at this time.

We published a couple of new clinical recommendations. We published a couple of different new tools kits, substance use disorder and major depressive disorders, substance abuse disorders and a co-occurring conditions toolkit.

We continue to be and make progress, as the DoD lead for 18 of the 26 integrated mental health strategies.

We put out in August, we published a special military medicine

supplemental issue, and the entire issue was edited and curetted by us, and discussed everything related to psychological health and TBI.

We held a number of key conferences and monthly webinars. We have anywhere from 400 to 700 people participating in our webinars monthly, on various aspects of psychological health and TBI topics.

We instituted the Institute of Medicine Phase 1 Study that was completed this past year, and they're now, working on Phase 2. We have a number of RAND studies.

We were able to get the directive type memorandum, published as a DoD instruction, that was converted. We are working on the blast event concussion inventory incident report. These are theater reports, and developing that system.

Actually, it refines some of the 2011 data with service-specific reports on what they're experiencing.

We did a collaborative curriculum review with the medical education training campus in San Antonio. We did a very rapid evaluation of National Guard and International Guard psychological health programs studies.

Our RESPECT-Mil program has screened over 2.5 million soldiers. It's largely focused on Army sites, and we have a couple of new mobile apps, and if you're interested in seeing the mobile apps, I have them on my iPhone, and they're easily downloadable.

So, there is a lot that we've been doing to try to get various information, knowledge, best practices, clinical recommendations, tools, things that help clinicians, patients, family members and improve, generally, the system of care.

One of the major things we also did was a stakeholders survey, and I'd like to talk briefly about that.

We decided that one of the things we needed to do was survey our stakeholders. So, from July to August of 2012, we surveyed the senior Military Medical Advisory Council. We got about a 36 percent response rate, and we also surveyed a number of other key stakeholders within the Assistant Secretary of Defense for Health Affairs, the services and the VA.

We were able to obtain some feedback, and it consisted of 10 questions, getting feedback on clinical recommendations and tools and resources. How are we doing, in terms of our effectiveness at getting the word out, and then what are the emerging needs of stakeholders that we need to be focused on?

Again, this is what organizations do that are more mature, and really want to understand what their major stakeholders are looking for.

So, the toolkits received very

high votes, which is consistent with our website statistics.

Now, product downloads, over there on the far left-hand corner, on the bottom, you can see the co-occurring -- or the mild TBI pocket guide.

We have a co-occurring conditions toolkit, which is also very popular. The website gets a lot of downloads, as well as the apps from T2.

So, a lot of the things that people thought were really good were our -- some of the downloads that we talked about, some of the clinical recommendations.

Products that didn't score so high were clinical guidance that people weren't quite so hot on, and then some of our social media, our briefings to higher authorities and TBI guide for care givers of service members and Veterans did not receive such high scores.

But in any case, we're trying to

look at what do some of our key stakeholders want and what do they need?

Some areas for improvement. The number one area for improvement that our stakeholders really said was, they want us to be more aggressive and more active, as the integrator role.

They want to utilize a collaborative network to identify and assess programs, and really get the word out.

They want to hear more about and have us communicate better about what we're doing, in terms of the products that we provide and how well we do that, and there was a lot of misunderstanding about what do we do to disseminate our products.

So, their awareness of what we do was not as great as we would have liked.

So, those are a lot of things that we're going to be working on in the coming year, and I also included some of the positive comments that we have there, as

well.

MEMBER PHILLIPS: Captain?

CAPT. HAMMER: Sir?

MEMBER PHILLIPS: Along the lines of what you've been talking about, and they're wonderful applications, a bit of an obtuse question, but I'll ask it anyway.

Are you involved at all or do you look at recruitment standards, as an expert, related to psychological profiles and perhaps, pre-existing conditions related to substance abuse?

Are you or anybody involved in that area?

CAPT. HAMMER: Not so much.

MEMBER PHILLIPS: Either on the record or off the record, would that be something that would be helpful downstream, if the standards were different?

CAPT. HAMMER: Possibly, but you -- historically, that has not done well, at least in terms of when you look at combat

stress and PTSD and that kind of literature.

Screening, traditional psychological sorts of screening, other than, you know, "Do you have a major mental illness," and the normal recruit training or recruit screening, better screening generally does not -- is not a good predictor for performance later on, or you know, high stress combat performance.

That said, yes, you do want to do some screening, but we have not been involved in that.

It's more focused on, how do we treat it and how do we do better, and looking at also, the researchers, there is a lot of research looking at biomarkers and pre-disposing factors, genetic factors, that sort of thing. But that has yet to be born out in such a way that's practically useful. That's still in its early stages.

So, let's talk now a little bit about, okay, we are we going from here in

2013. I'm going to talk a little bit about our governance and our alignment with the medical research and material command, the Army's medical research and material command.

We've also done some internal reorganization and are finalizing that, as well as some of the key emerging products that we have working.

So, we were directed, when I first came onboard, to go ahead and get started with -- there were two actual things that were going on.

One was the Under Secretary for Personnel and Readiness established a COE Advisory Board, which was responsible for providing policy guidance and oversight of all of the COE's, and in addition to that, we were also tasked with realigning from under TRICARE management activity to the U.S. Army medical research and material command, and we spent a lot of time addressing all the various details involved with that.

I can report that as of December 28th, the DoD directive was signed and making us an Army Executive Agent, as of 2 January 2013.

So, we continue, however, to carry out our mission as defined by Dr. Woodson and as legislated by Congress, and we're working to ensure that we meet in a timely manner and identify potential barriers to fully integrate.

So, we expect that by the end of this fiscal year, 1 October 2013, we should have full operational capability, but right now, there are still a number of things that we're working on.

CO-CHAIR NATHAN: Paul, let me ask you, once you facilitate and migrate under MRMC, how will you -- and I apologize if I'm getting ahead of your brief, but what do you see then as the change in your deliverables and your ability to perform your mission, or in the change of your mission?

CAPT. HAMMER: I don't think the mission changes at all, sir. I think it continues to be a joint mission, that we look at improving care in all the services.

I think the challenge or difficulty, and I talk about it a little bit, is ensuring that we have -- that we're clear on what our role is, and what role we play and what the relationships are with the services, and I'll talk a little more about that later on, when we discuss -- and I understand there were some questions about addressing the COE's ability to have an effect within the services, since the services actually own the Military treatment system.

I don't think it's going to change at all. The difficulty is going to be how we communicate both from the policy and overall guidance side with HA-TMA, as well with the SMMAC and the other service -- and the service leadership.

I think in terms of what we do day to day, in developing clinical guidance, reviewing the literature, trying to get data and that sort of thing, is not going to change.

I think what's going to change is more the process issues, like how taskers are assigned or -- and in some cases, how we get work assigned to us, and those are the things that, the sort of details that we still have to work out.

So, for example, this week, even though we're now an Army EA, we were tasked as part of HA-TMA to develop and edit hearing papers for the new SEC DEF nominee.

So, okay, do we still do that, or can we now offload that work to now, focus on the other work that we're suppose to do?

Policy development and educating on how are we going to communicate with the various entities and TMA, and I'll talk more -- one of the questions was on how do we

integrate with the SMMAC and integrate with Counsel, and I can talk more about that and we can discuss more on that, as well.

So, the big thing for next -- and I apologize, this sort of just happened. This is going to be February of 2013, is when we actually have funding and personnel transfers to the Army, but we anticipate, like I said, full operating capability by October.

So, this is the organizational alignment, and this may speak to answering some of your questions, sir.

So, as an EA, we're under the Department of the Army. There is the Surgeon General of the Army, MEDCOM, U.S. Army medical research and material command is one of the major MEDCOM subordinate commands, and then we would be, as an EA, one of the subordinates here, and then that is DCoE's structure there.

But we'd still have the dotted

lines over to the SMAC and the COE oversight board, in terms of overall guidance regarding what we're doing.

But again, a lot of what that actual dotted line consists of, both sides still has yet to be determined and clarified.

As part of one of the things we looked at throughout 2012 and noted, that we needed to also do some internal reorganization for ourselves.

So, the purpose was to get a more unified DCoE with effective and efficient streamline functions. One of the things we had was a lot of redundancy working inside DCoE with multiple TBI places, multiple psych-health, PTSD, focused places, and so, wanted to get them all in one place.

So, over the course of the past year, we looked at, you know, did some tiger team, work with looking at our organization and structure, did several deep dives to really understand some of the issues, and the

finally, made some decisions at the end of this last fiscal year and began implementing them.

So, if you look, this is the new DCoE, and I won't belabor you with the old one, because it's more complicated. It is a director, we have the Deputy Director who is from the VA. That's Dr. Allison Cernich, she is here with me today, some special staff as usual.

We have a Chief of Staff that has all the business operations with the usual Military G-shop type organization.

We have an Office of Integration and everything related to TBI is with DVBIC. Our psych-health center is DHCC, and our tele-health and technology center is T2, and all of everything TBI located here, psych-health located here, tele-health technology located here, with a few here for integration purposes, and to provide some shared services across our organization.

Also wanted to highlight some of the key emerging projects that we have coming up this year, some of which are pretty significant.

The first one is our program evaluation effort. This is an enterprise-wide, and that is MHS enterprise-wide initiative to determine the impact of clinical and non-clinical psych-health programs.

It initially started out as an OSD CAPE, and OSD cost assessment and program evaluation effort, that gradually got morphed into an agency priority goal and then, was taken up with the President's recent Executive Order on mental health.

So, it's a very key part of the -- of what we're doing, in terms of how things are going to happen over the next several years.

One of the other things we're working on is metrics and pathways. We need

to develop an enterprise level dashboard of psychological health measures, so that we can ensure that programs are meeting the intent and ensuring our patients are getting effective care.

We're also looking at clinical pathways and patient level outcomes, and again, looking at how do we measure what we do and how do we look at, as an enterprise, how well we're doing it.

The other thing that we're working on is a joint mental trauma registry and this parallels or is a part of what the surgical community has already done with the joint theater trauma registry.

There is a module, a TBI module there, and neuro-trauma module that there that we're looking at trying to get real-time data-driven clinical processes to improve concussion care, both in theater and in CONUS, but again, based on the joint theater trauma registry.

So, at this point, that is sort of just a sampling of background of DCoE. I can pause and ask if there are any questions, before launching into the actual specific Recovering Warrior Task Force questions that you all had.

CO-CHAIR NATHAN: So, I think you're going to get into -- as a byproduct of the questions, you'll get into a little bit of how we get more traction out of our Centers of Excellence --

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: -- and how we connect them to an execution arm of the MHS.

But going back to the reorganization, and my question should not be construed as service centric or anti-service centric, but you talked about how you have yet to determine how the dotted lines, once you fully vest yourselves under MRMC, so, you'll be an Army subordinate command.

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: And you have yet to figure out exactly how the dotted lines to Health Affairs works.

I have not been shy in my concern of the DCoE over the last few years, in that -- many years really, in that it does great policy and finds and cultivates great science, but doesn't do a great job of creating execution.

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: This may help create execution, being under a service branch, but how does that protect you and/or the enterprise from other ideas, coming from other services or academia or whatever, that have to be filtered through a service, in this case the Army, to get traction?

CAPT. HAMMER: Well, hopefully, if all works well, that process of having good ideas or best practices that come out of academia, that is part of that whole --

CO-CHAIR NATHAN: I'll give you a

tactical example, and I may be all wet, because maybe I'm reading the dialogue.

Right now, if somebody comes to you, if Jim Kelly from NICoE comes to you, if Hobda from UCLA comes to you and says, "I've got this great idea. I think it's really good. Look at the science," you flip through it and Paul Hammer says, "This is tremendous."

You go to Dr. Woodson, who is the AG's of us, who can then implement policy, sometimes effectively, sometimes not, but can implement it through the services.

Now, you sort of go to the Army, and the Army goes, "Never mind." Not that they would.

CAPT. HAMMER: Right.

CO-CHAIR NATHAN: You could be working for the Navy, and we might do the same thing. We might say, "Not important to us."

How do we protect ourselves from

a service parochial, when we don't know exactly how those dotted lines are going to work?

CAPT. HAMMER: Well, we still have the dotted lines to the COE oversight board and we still have the dotted lines into the SMMAC, as well as to the integrating counsels that feed into the SMMAC.

And so, we still have this relationship here. The idea behind here is, this is an executive agent.

So, they basically take care of our personnel and money and IMIT and logistics and you know, do you have a building that you can sit in and offices and that sort of thing.

I think the policy guidance, mission guidance, like we say here, joint mission guidance, still comes from over here.

But to your point, we don't have that codified in a DoDI yet, and that is the next step, and what we're doing is to lay out

in a DoDI, as you know, here is the entities, here are your responsibilities.

So, MRMC, you're responsible for care and feeding of DCoE. TMA, you're responsible for providing, you know, policy guidance or assistance in implementing policy, whatever. We go down through that and actually outline that.

Our goal this year, and I'm sort of jumping ahead to one of the questions, where we talk about that, but the goal this year is to get that DoDI done this year, with the idea that you can always go back and revise it later on, but get the basic markers down on who is responsible for what, so that we clarify some of these things, and we can move on, and we're not stuck, you know, every couple of months, having a new problem crop up and go, "Wow, we hadn't thought of that one. Who has got that one for action, or who is responsible for that."

CO-CHAIR NATHAN: Right, I

understand.

CAPT. HAMMER: So, trying to get that, you know, nubed out and sorted through, to figure that out is the next task.

CO-CHAIR NATHAN: I like the execution aspect of being under a service.

My concern is, and this is full disclosure, I was the guy who had to bring Walter Reed and Bethesda together, and so, I'm a true believer in the synergy of the best ideas from the services, coming together and making a better product, because it's no question that it did.

The greatness that the Army brought with it from Walter Reed, combined with the good things at Bethesda have made the two organizations synergistic into a composite.

That said, I always worry about one service. I used to tease my counterpart Patty, I used to tease her that the world's greatest Army, which occupy Valley Forge, Da

Nang, Tokyo, Berlin, now occupies Bethesda, Maryland, and what I don't want to see happen is, either the Navy or the Army or the Air Force stilt what should be an open completely transparent organization to filter all the best ideas, without any service parochial, the Navy, it may be no better than the Army in that.

CAPT. HAMMER: Right.

CO-CHAIR NATHAN: Okay, I like the Macy's and Gimbels sort of across the street from each other, trying to make the better product together. So, that is my point in this.

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: Okay.

CAPT. HAMMER: Okay, so, I'll move on to going through and specifically answering the questions.

So, question number 1A, you brief the status of the customized evaluations of 20 psych-health and TBI programs being

conducted as part of the 2011 land study. What is the current status of these programs and their evaluations?

So, RAND, in 2011, or actually prior to that, but in 2011, RAND published a study and they originally did some of the ground work for our program evaluation studies and they originally determined as part of that, was that up to 20 programs would be further evaluated in a more in depth study.

As we got into it, both DCoE and RAND collaboratively looked at the money that was left on the contract and determined that the project budget could support a rigorous evaluation for 13 programs.

We thought that a smaller number of -- or a smaller number of larger size and scientifically rigorous evaluations would be preferred to doing all 20.

RAND initiated 13 program evaluations. Eleven of them are ongoing or

have been completed. Two program evaluations were initiated and then terminated before completion, one of which -- one study, one program was actually eliminated, so that DoD is no longer funding that program, and the other one was taken over by another entity.

So, the current status of this is that we have a catalogue of programs and a data base completed. As part of our ongoing program evaluation that rose out of that, that data base has been constantly culled and refined to get a complete list of programs.

Three program evaluations are completed, one is under security review and eight remaining to be conducted or are currently in the process of getting there.

Question 1B, you indicated that you were working to standardize TBI outcome measures, in order to better analyze effectiveness of care. What is the status of DCoE's efforts to develop standardized outcome measures for TBI treatment?

So, the outcome desired is development of a dashboard of standardized outcome measures for TBI care that are reliable, ecology valid, clinically useful. So, we have three phases that we want to go through to do this.

We are currently in phase one, concept development and initial planning activities. We had a RAND study to establish the frame work for quality assessment of our TBI care. They went through a number of different measures from a lot of different entities, including some common data elements from the National Institute for Neurologic Diseases and Stroke, and the National Institute for Disability and Recovery Research, as well as the concussion clinical care measures, rehab measures database.

We have a PH and TBI registry. We have TBI model systems. There an NIH toolbox. We looked at a lot of different things, to look at measures, to begin to

select measures for this.

Phase two is a dashboard design. We'll be going into that later this year, and select a web-based platform, customize data elements and the beta test it, and then implement that by the end of this year, roll it out to selected sites and then look at some initial data collection to see how well we were doing.

Question 1C, regarding the Task Force's year-one recommendation that DoD and VA ensure timely access to routine PTSD care, we noted that DoD is partnering with VA, to ensure all deployed service members, Veterans and families can receive readjustment counseling and mental health services for three years.

You guys wanted some elaboration on that partnership, and which part of VA was providing these services.

So, looking at this, we collaborate quite heavily with VA and in

fact, one key thing as part of our reorganization was to actually do what the other COE's have done, and formally establish one Deputy Director, and that is Alison here, as the VA person in our organization.

We are also key in terms of implementing the DoD and VA's integrated mental health strategy, and in particular, in looking at the transition issues, IMHS number 13 and 23 are important, and we have been working with the VA, as well, both within transition for service members, to ensure that they are -- if they are relocating, or they're getting out, going through the VA, or whether the PCS to go to another command, that they're able to get the care that they need.

We're also looking at collaborating with the VA and Chaplains to look at the Chaplain's role.

More specifically, to answer the specific question, which part of VA is doing

that?

As you note, all deployed service members and Veterans get cost-free VA readjustment counseling, and that is done in a variety of settings, but the Vet centers are the ones that actually provide the readjustment counseling services.

I think that was covered in one of the other presentations, as well.

Question 1D, in February of 2011, you identified the challenge of lacking authority over how clinical services are delivered. As a strategy for mitigating this challenge, you described engaging with SMMAC and its integrated counsels for leveraging influence. How effective has this strategy been?

We were just talking about that a little bit. I think that has improved our ability to engage with the SMMAC, as well as the integrating counsel has been helpful. It does involve us intimately with what is going

on, in HA-TMA, in terms of policy development and execution.

We have been heavily engaging with them regarding the dashboard and measures, the clinical pathways. We're very much engaged in program evaluation, as well as recently, telehealth strategy.

We tried to integrate with them, in order to gain guidance for getting support from the services, program evaluation capability, and we're working with them also, in defining requirements for the PH and TBI registry, and as well as developing best solutions regarding centralized institutional review board and other issues.

It is a challenge though, to have that integration and I think we already talked about that before in the question and answer.

Number 2, what changes are needed outside DCoE, for example, legislation and policy, to enable us to better fulfill our

mission?

So, as mentioned earlier in the brief, the DoD designated us as an executive agent, or designated the Army with MRMC as our executive agent.

Following on that DoDD with an instruction to specify roles and responsibilities is going to be very important.

What we need is leadership to really clarify expectations on what they want for us, in terms of our roles and functions, so that we can be coordinating entities for our specific clinical areas.

We also, one specific thing that we're really, I think hopeful of, is that each of the COE's, when you look at their legislation, has a slightly different sort of a mandate. Each little piece of legislation that established the COE's is slightly different.

One of the things that we think

is important for all of us is the establishment of a registry function, and so, enabling us to have authorizing language that says, you're responsible, much like what the Vision Center of Excellence has, I think might be helpful for us, and enable us to work collaboratively with the services.

But I think the biggest thing is, is what can we do to further cement our role as an advisor and to assist the services that are actually responsible for executing the care?

MS. DAILEY: Captain Hammer, who is writing the DoDI? Did I hear you earlier say that you are writing the DoDI?

CAPT. HAMMER: Well, we will write a draft and then of course, circulate it through all the various organizations to staff it.

So, we will write a draft, put up a straw man, and then send it through all the various entities in HA-TMA, as well as the

services and get their take on it, and then you know, staff it through in that respect.

MS. DAILEY: Okay, so, the normal --

CAPT. HAMMER: The normal process.

MS. DAILEY: The normal process?

CAPT. HAMMER: Yes.

MS. DAILEY: So, you'll have your input to it, basically?

CAPT. HAMMER: Yes.

MS. DAILEY: Yes, and so, the leadership, the DoD leadership must clarify expectations and roles? What does that statement mean? Are you clarifying it in the -- your draft, and you really need buy-in to that vision?

CAPT. HAMMER: I think it's important, and I don't think I'm -- I don't want to talk out of school too much, but at the recent SMAC R&A, where I was presenting on the pathways, for example, one of the

frustrations that we had was trying to get work groups, in order to do some of the good things that we do.

Right now, it's a very ad hoc process. So, I'll give you a success story.

When I talked about the MACE and deployed guidelines, we actually have a very mature TBI working group. It's very collegial. They work very well together. They have both CONUS and theater participation in these halls. We had the theater neurologist onboard, so that when we came out with the mason deployed guidelines, the theater neurologist had a bunch of his folks on those calls. We developed training materials for them. We helped develop the things they needed, so that the theater neurologist, who is the guy over there who is going to actually execute it and responsible for it, was able to get all the materials he needed and say, "Go forth." He is the one saying it, "Thou shalt use the MACE this way.

You're going to use this AHLTA," what is the -- I'm blocking on the name of the form, the AIMs form, they had developed and AIMs form in AHLTA, they put the form in there.

You know, so, he is responsible for making that happen, but we supported him in providing that to do it, but it was all done as a very ad hoc sort of thing.

They tried to get the working group developed, in order to start looking at dashboards and measures, got a lot of push-back, "Oh, we got too many people doing work groups, and it's hard, you know."

So, we got to be clear on what is our responsibility and how do we get supported, in order to enable to do that, and it's tough, because there is -- we need to de-conflict a lot of demands on everybody, and I feel for a lot of the services, because I'm in the same work groups and the same meetings that everybody else is, and I don't have to see lots of clinical patients who do

a lot of other work, like they have to do.

So, it's a tough problem, but part of that is, is that the leadership understands who are we as COE's, and what are we suppose to be doing, and they understand, this is your job, this is your role, this is where you fit in the grand scheme of things.

I think there is still a little bit of misunderstanding, and we end up having to make it up as we go along, and the difficulty in that is, I don't want to get too far out in front, where I am making a decision that probably ought to be made at a higher level than my pay grade.

I don't know if that is articulating that well or not.

Any other questions on that or should I proceed?

MS. DAILEY: And your last one, because these kind of make good recommendations, but in the effort to be cryptic and not give us 300 slides, the last

bullet, you feel that the National Defense authorization, you need a National Defense authorization Act to do a cross-agency registry for TBI and PTSD?

CAPT. HAMMER: It may not require legislation, but the mandate for the vision center is that they do a registry.

Now, we've been very collaborative with the vision center, in terms of setting up or cooperating with them, so that they help us. You know, they've fenced off area for us to have a module. It's very modular, so that, you know, you want to have a PH and TBI registry as part of this thing? Sure, we'll plug it right in, you know.

But ultimately, I think there needs to be some higher mandate other than Paul Hammer at DCoE thinks there needs to be a registry, and you know, it's very easy for people to say, "Well, who the heck are you, and no," when that's a core piece, in terms

of looking at data.

If you go back to the original legislation that established DCoE back in the 2008 NDAA, it basically said, "Thou shalt have a program," and you can assign people up to the program, and the very first thing about signing people up to the program is, where am I going to put that information, in a safe, secure way that we can all access it, and that if I have a guy with a TBI and PTSD, and he has an amputation, that the amputation center and the PH and TBI center, and maybe the vision guys and the hearing guy, we can all work off the same information.

So, that is where that is coming from. It may not take legislation. It may take a decision from on-high, in some other mechanism, but you ask for, "What do you want," I'm going to give you something.

Okay, number three, what can DoD and the services do to better meet the needs of recovering Warriors with PTSD and reserve

component recovering Warriors with PTSD?

So, the biggest thing is -- there are a number of things. I'll get my notes here.

Increasing direct clinical outreach by screening and early identification and referral. There are a number of folks that are experiencing PTSD symptoms, that are not currently receiving care, and we have to find a way to reach those folks, and provide better care for them or provide care, period, to them.

We need to improve strategies to recognize PTSD, overcome stigma and get folks into health seeking, rather than avoiding treatment until it becomes catastrophic or critical.

We need to increase efforts to ensure treatment continuity and completion. One of the things that the literature does support and we know, is that there is a huge drop-out rate, in terms of the care and

treatment for PTSD, and if people can stick with their care and complete treatment, they do better than when they drop out.

So, finding ways to engage the patients and therapy better, and get them into the therapy that they need, is important.

CO-CHAIR NATHAN: I'll add to that. At least talking to the Navy and the Marine Corps leadership hierarchy, they feel they've made good -- the good news is, they feel they've made good strides in stigma reduction, not great, but good strides in stigma reduction, and people are coming to see the providers now, who believe that they have some behavioral manifestation or affectation of stress, post-traumatic stress depression, whatever.

The bad news is that they're coming to you thinking that in one or two shots, they can get the cure.

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: You know, a pill, a magic hypnosis thing, whatever, and be done, when they're told, "No, no, no, this is going to be a journey, no destination," and this could take weeks to months to sometimes years, to sort of coach you along through this, they're not interested in it and they drop out.

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: They believe that is the highest thing.

So, I really think that the onus is on us and the Military health system, to set expectations up.

We've worked so hard in trying to reduce stigma and telling everybody, "Raise your hand when you need help," that they do it, but we don't do a good job of telling them, "This is not going to be a quick fix. This is going to be something that may take a while to work through."

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: And so, I'd be interested in your comments on that.

CAPT. HAMMER: I agree with that, totally. I had a conversation, some time ago, with Dave Mather, who is the psychology training director in San Diego, and I said, "You know, when we look at," -- what we're looking at with PTSD is very different than any other medical entity.

If I have pneumonia, it's a relatively passive thing, all I got to do is take my penicillin four times a day for the next 10 days and I'm probably going to get cured, if I don't do something really stupid.

So, I stay home, I rest, I take my pills and then in 10 days or two weeks, I'm probably fine.

It's not like that with PTSD, and it's not even like a surgical intervention, you know, where you have to do a lot of rehab and that sort of thing. You still have people coaching you through and getting you

through that.

He described it as more like, okay, you're going to do a self-appendectomy, and I'm going to hand you the tools and I'm going to talk you through it, as you do it, and that is a lot of what psycho-therapy is like sometimes, when people have significant issues. It's difficult and it's hard.

I look at and try to compare. You know, my ultimate goal with stigma, for example, would be, you know, to have two Marines walking down the street and they run into each other and one says, "Where are you going," and the other one says, "My therapy appointment," and it doesn't matter whether it's his physical therapy or his psycho-therapy.

You know, you would never see somebody, you know, either -- maybe you will, but you probably would not see somebody say, "Hey, you know, I don't know, I'm kind of busy this week, and I got a lot going on. I

know I've got Leukemia, but I don't think I'll go to my chemotherapy this week." Just unthinkable.

You've got to do that. You have to do it, because of your Leukemia.

We don't think that way about PTSD or about depression, and yet, it's probably just as important, and when you look at a lot of what is going on in terms of the mental health of the force, you know, that is critical.

So, yes, I agree, and I agree, we have made strides, but we still have a long way to go, and on our side, we've got to engage with the patients. We've got to make them feel welcome, and help them engage in the therapeutic process, and again, that is very difficult.

So, it's a long conversation, because it's a very complex thing that doesn't translate directly sometimes, with other medical entities.

MS. DAILEY: And this was one of our recommendations, which was that, you know, we struggled last year and we crafted recommendations around getting continuity of care for service members, but that continuity of care was about them coming to their sessions on a regular basis, and at one time in our recommendation discussions we said, "We needed to engage commanders about getting people back into care, who may have dropped out."

We crossed over into that lane of HIPAA, which said, "Well, would you tell your commander that you're in PTSD training, and would he leverage his command authority to get you back into it, and if you did, you would be crossing over and violating HIPAA requirements."

CAPT. HAMMER: Right.

MS. DAILEY: And so, we struggled with that question, when we developed the recommendation last year, of monitoring

compliance, which is a strong word, following up creatively to bring people back into treatment, and then going back through your programs, through your data and looking at your providers to ensure that they are doing evidence-based treatment.

So, that was one of our recommendations in our 2011 recommendation, which you touched on briefly, was more about care at the primary care setting, and at the primary care setting, identifying PTSD symptomology early, before it crises.

CAPT. HAMMER: Right.

MS. DAILEY: And that is where we think resources at that time need to be invested also, so that they aren't at suicide or acting out or UCMJ behaviors, before they are engaged in the psychological health system.

CAPT. HAMMER: Right, and I -- to add to what Admiral Nathan was talking about, yes, we've gotten our commanders to say, the

line commanders to say, "Yes, raise your hand and get help," and sort of encourage people.

There is a corollary on our side, which is that the system is able to accept them. Like you were talking about, that the primary care folks are attuned to this, that this back pain may be psychological, or this odd complaint of this headache, might be more, you know, TBI/PTSD related.

CO-CHAIR NATHAN: One of the tenets of medical home is to embed mental health expertise --

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: -- in the primary care clinic, and as a primary care specialist myself, what a world of difference it makes to see a patient who is obviously emotionally distressed, who has somatic complaints and rather than to have to write out a consult or type one in, and then depending on the patient to go to either the clinic to get an appointment or the health

benefits advisor to make one outside, I can walk them down the hallway, to the individual there, who will see the person at that time, and incorporate the care.

So, I'm very encouraged by that. I do think when it comes to stigma, that there is the letter of it and the spirit of it. The letter of it is, you will not find anybody in the chain of command of the Army, the Navy, the Air Force, the Marine Corps, who will tell you -- who would tell you, "I will not support one of my people," if asked, "I will not support one of my people who needs help, if they're failing emotionally." That is the letter of it.

When you talk to the Warriors, when you talk to the soldiers, when you talk to the Marines, and you ask them, "How is the spirit of that conveyed to you," they're going to say, "The officer is not too bad." The officers are pretty much saying, "If you need the help, go get it."

The gunny, not so much. The gunny is stressed. The staff sergeant is stressed. They've got a mission to do. They're in a high-op tempo. They need every hand to the pump, and so, there is a subliminal message there, that says, "I can't stop you, if you got to go see the doc, but boy, it ain't helping me, if you do," and we've got to crack that nut. We've got to somehow, continue to pressure from the top and from the bottom, to make a difference, because I believe that we've done a great job in educating people with embedding both resiliency training with comprehensive soldier fitness, and with the embedded cost training and the Marine Corp, the OSCAR teams, but we have yet to really change the culture.

CAPT. HAMMER: Yes, sir. One other thing that I think is important as part of this, is mental health case management, and I know that the previous speaker was

talking about case management, I won't belabor it.

But case management is good, in the medical/surgical realm. It is not -- I think we need to develop this capability because I think people fall through the cracks easily, and staying on top of folks, this case management piece is part of that, to sort of, you know, "Hey, you know, you didn't make it to your appointment the last two times. We called to check on you. How are you doing? You know, what is going on?" So, I think that is a key thing.

Continuing on to the answer to that question, you know, improving care for those already engaged. So, implementation science and looking at strategies to improve any treatment, new treatment modalities that come out. Provider adherence to CPG's, developing the tools to be able to do that, measurement based care strategies.

Again, we need to get mental

health care providers using measurements and clinical tools, just like any other provider does.

Monitoring and bench-marking clinical performance, and enabling the system, so that improvements and feedback can be implemented whenever appropriate.

MS. DAILEY: Then my last wrap-up to that is, what piece of those bullets do you have a part of, that you at the DCoE can influence?

CAPT. HAMMER: I think we have a part of all of that, maybe not so much the case management, but you know, educating about case management.

But in terms of systems of care, strategies to improve and recognize PTSD, when you look at the RESPECT-mil program, what they've been doing with behavioral health and primary care, it's huge.

I mean, the number of screening that they're doing in the Army, I think

probably is something that needs to be done all -- through all the services and that is getting into the Navy and Air Force is only in its infancy at this point.

Looking at training providers and that is -- I think, you know, we talked about some of the disadvantages, or potential problems with being under MRMC, that actually is one of the advantages of being with MRMC, is being able to be a part of the research community to say, "There it is, there is that new research thing that is coming out. Let's start figuring how we're going to implement this," and practically, within the real-time clinical care.

That is one of things I also that -- with our collaboration with the VA, the VA already has a pretty robust implementation science process or program in place, that we can leverage and learn off of.

So, we don't have to reinvent the wheel. We just sort of, "Let's do what

they're doing," and sort of match it and implement how we do it within the military healthcare system.

MEMBER PHILLIPS: Case management, I had asked the previous speaker about specialization in case management, and I know there isn't really, unless there it's very local, personal.

But considering the long term issues related to mental health issues, is that something the VA could consider? I mean, I don't assume the VA has case management mental health specialists, but is that something to think about?

CAPT. HAMMER: Do you have an answer to that, Alison?

DR. CERNICH: I don't think at present, sir, there is a plan to do specialization or special credentialing or classes of providers, not that I am aware of. I would have to check with our care management and social work service.

But as of right now, we have programs that are specialized, that obviously get training for various aspects of care.

So, for example, medical surgical, geriatrics, returning Veterans and the specific challenges or benefits programs or other things that they need to be familiar with, but it's not by credential and it's not by education, necessarily.

MEMBER PHILLIPS: The other examples are good examples of something that works, and at the higher level, I mean, at your level and the provider level, they're specialize, and maybe at the introductory level.

I mean, that is just something to think about, and if there is anything that we can consider.

CAPT. HAMMER: Well, it's an excellent point, because mental health case management is very different than med/surge case management. Med/surge case management

is, let's get you into the right, you know, follow on rehab sort of thing, let's do that sort of thing, and a lot of it is, getting appointments made and that sort of thing, as it would be with mental health.

With mental health, you've got a huge compliance and other valiance to it, that you need to address, and I think that is where it's difficult. It's not just sort of check all the blocks, and okay, made all the check blocks and they're good to go. It is a little more involved.

DR. CERNICH: And sir, the only other thing is, I will say, in mental -- in mental health services in VA, there are specific case management programs that tie to clinical programs.

For example, there is mental health intensive case management program. There are case managers that are tied generally to the substance abuse services and PTSD programs, and if there are specialized

care programs within the VA, there are generally care managers that are assigned to those programs and understand the patient population, and the specific needs.

I don't know, however though, if there are -- and this is something I would have to follow up and get back to you on, I am unclear as to whether there are specialized education and/or credentialing for that, is more what I was reflecting.

There are care management programs within VA that are specific to mental health conditions or mental health services, similar to med/surge or another program or discipline.

I think more what I was getting at is in terms of specialization of care management for mental health. I was looking at it more from the credentialing and education piece. So, I was coming at it from a different perspective.

MEMBER PHILLIPS: No, but both,

and you know, just connecting the dots, I would -- it's not my specialty, but mental health does require a lot of hands-on and TLC and that type of thing.

CAPT. HAMMER: Right.

MEMBER PHILLIPS: And you connect the dots between the benefits of a service animal, and I don't want to equate things, but you know, they are very helpful for these folks, and so, maybe you can translate that experience into some sort of specialty like that, to help.

CAPT. HAMMER: Okay, question number --

MEMBER CONSTANTINE: Captain Hammer, on the last question, sir, I didn't -- I may have missed it, but did you say anything about the Reservists and what is being done for Reservists with PTSD?

CAPT. HAMMER: Well, the biggest thing for Reservists is, you know, the Reservists with PTSD is, in terms of just the

pure PTSD, isn't any different than what is going on with the active duty member.

The problem with the Reservist is that they are separated from what is going on in the active duty population, where they're -- or the active duty environment, where there may be more resources or more easily accessible resources.

So, case management is going to be critical for the Reservists, engaging them in care.

In terms of educating the providers out in the larger system, that is going to be another important aspect of that, as well.

So, but it's improving the system of care in such a way, and I don't think -- the clinical outreach, I think is going to be an important part of that, as well, and ensuring that -- it is like anybody else, ensuring that access to care, ensuring that everybody has access to care, and enabling,

once they get care, that they're able to get into it.

MEMBER CONSTANTINE: But what is being done out there?

CO-CHAIR NATHAN: Let me just -- if I could hone down your question, I think by way of example, because I'm not facile with the benefit access.

Pretty easy, Reservist is on -- is activated and on active duty and displaying issues with PTSD, got it on active duty, siphoned off to care and then that care is documented and they're allowed to continue with that care.

After they've left active duty, they're now in the Reserve inactive, and they start manifesting issues, and they need medical care.

What is their access to the DoD system vice the VA system, or is there one?

CAPT. HAMMER: You have to help me out with the VA benefit on that, because

it's three years post?

DR. CERNICH: For anyone post-active duty, it's --

CAPT. HAMMER: Post-discharge, it's three years.

DR. CERNICH: -- to post-discharge it's three years and then for anyone who served active duty and combat, it's five years. I can verify that, with the VBA site, but that is codified. There is a specific website for VBA that lists, and it's also on the TAP site.

There is a specific list for what the healthcare system benefits are for Reservists and Guard.

CO-CHAIR NATHAN: For VA access?

DR. CERNICH: Yes, sir.

CO-CHAIR NATHAN: Right.

CAPT. HAMMER: But in terms of solving the problem of getting -- engaging with Reserve component members, who are living far from a base, don't have access

either close to a VA or a -- and I'm not -- again, and I can probably check back with you and get an answer to what happens if they're still on Reserve status, but not activated, how do they get help, if they're drilling or whatever.

I can -- I believe when they're drilling, they're able to get -- they can get care like anybody else.

MEMBER CONSTANTINE: I just wonder, I'm a Reservist and I go to the drill and it's not something we talk about. I am in kind of a weird unit, but I imagine other units have similar worries, not something you discuss. We're there for one weekend, to get our stuff done.

But during the week, I may have all sorts of things going on, and I just wonder, do the Reservists out there have -- besides on their own, combing through websites, do they know about these things?

CAPT. HAMMER: What we do have in

the Reserve components, and this has been set up -- and let me -- I don't have complete knowledge of it.

I know that what we have is, within the Reserve world, you have both the Reserves and the National Guard. There are directors of psychological health in both Reserve and National Guard overarching units.

One of the things that we did was, we looked at various aspects recently, with National Guard units, both Army and International Guard units, in how effective some of these programs were.

Some of the directors of psychological health were very hands-on, where they actually provided clinical services. Others were more of a consultant to the leadership and would direct people for services.

Those are available to help the leadership direct, you know, what needs to be done, but there was varying -- the results of

the study was pretty wide, you know, wide variance across the board, and with the International Guard it was even wider in some cases, and a lot of it was personality dependent.

So, it is more complex with Reservists, but if you want -- we can look into that and get it -- a better answer for you later on.

MEMBER CONSTANTINE: Thank you, sir.

MS. DAILEY: I mean, it does vary by service. For example, the Navy has laid out a very, what they have described, quick process where if they've got a NOSC, they've got an individual who is -- who PTSD and he -- in the NOSC, identifies that they are off the rails. They can call the N95 cell, and that N95 cell will put them on orders immediately and they can elect, they can elect to go to MedHold East or West, and this same type of cell is supposedly set up in the

Marine Corps Wounded Warrior Regiment.

There is a Navy Marine -- there is a Marine cell in the Wounded Warrior Regiment for identified Marines who need to be brought back on active duty, or identified Marine Reserves who need to be continued on active duty.

But your concern about the average forces identification of their cases as well, is well identified, not well identified, but that is the issue, right? The NOSC, the Marine Reserve unit has to identify that PTSD, and the real issue is, they can't leave them out in their communities for healthcare because that takes away from their work, and one time -- if they are not going to work because of PTSD, then they aren't going to be able to get to appointments, and so, it begins that downward spiral. They're unemployed. PTSD is kicking up, and if their unit hasn't identified it to get them back on Title 10, then this spiral

to hell deepens.

CO-CHAIR NATHAN: There is also the returning Warrior workshops for Reservists.

CAPT. HAMMER: Right.

CO-CHAIR NATHAN: Which is a great mechanism to acquaint the Reservist and the family with what services are available and not only to talk about stress and talk about family dynamics for the short run, but in the long run, to talk about if you do have problems or encounter emotional health issues, here are your outlets, via the NOSC and other things.

One of my concerns is that, and I don't know what the latest is, but these returns -- and somebody in the audience may, but the returning Warrior workshops where they're funding was at jeopardy, and I think it may be incumbent on us to, you know, come over the top on that, and recommend that those things be fully funded.

CAPT. HAMMER: We'll get back to you on that, and I'll get you a better answer on that.

I think -- I was looking at this, in terms of answering a question more about the clinical aspects of treatment, rather than the systematic aspects. You know, even if somebody is paying attention and they do well during the workshops and get demobed and everything, it's four weeks later and now, they're starting to have issues. How do they get back and help, and how do we improve that process?

That is a tough one, particularly for Reservists in rural areas, where it's going to be difficult for them to access care.

MEMBER EVANS: So, Denise, are we able to have someone come in and brief us on the returning Warrior workshops, because I think going forward, we probably should make a recommendation, because I think funding,

it's a great opportunity for the Reservists and --

MS. DAILEY: Is this a -- I have not heard of the Wounded Warrior Workshops before. Is this Navy unique, or are we talking about Yellow Ribbon?

CAPT. HAMMER: It's under the auspices of Yellow Ribbon. The Navy is Returning Warrior Workshop, is the Navy's Yellow Ribbon Program.

The Army does a slightly different program.

MS. DAILEY: So, which one do you want me to bring in? I mean, the Yellow Ribbon Program?

MEMBER EVANS: The Yellow Ribbon Program, because I think they are the one, I think that is the way the funding, overall funding --

CO-CHAIR NATHAN: And these are the ones that are best designed for those people who are not near a medical center or

an MTF, because they are held in various localities throughout the country. It's a weekend of funded per diem, for active member or Reserve member and spouse. It allows them to sort of have a little mini-offsite, where they can learn about short-run issues, and then learn what is available for the long-run issues.

But again, I think it would behoove us, since this is so -- I think this is critical to a segment of recovering Warriors, that we worry about.

We have enough bureaucratic issues with the ones in our MTF, but the good news is, we at least know about those. There is somebody to complain to.

Once you get out into the interstitial space of the country, that is where I worry where people are falling through the cracks.

CAPT. HAMMER: Okay, question number four, how will the anticipated changes

in DSM-5, including expansion to four PTSD symptom clusters and the addition of new diagnoses, trauma and stress or related disorder impact the availability of PTSD services?

The long and short of it is that a lot of PTSD care is delivered in the primary care setting. We're concerned that adding the complexity without any real evidence of improved diagnostic accuracy or efficiency is going to cause some problems in primary care, and may cause folks to punt more to specialty care.

So, we're concerned that we may see an increase in demand in behavioral health specialty care resulting from increased referrals, and that may affect access to care.

We're anticipating that what we're going to need is widespread provider education and training, regarding the modified diagnostic criteria, and we're going

to have to monitor how well we're doing, in terms of service utilization and diagnostic rates, so that we can monitor what the effectiveness is.

But the short answer is, we're worried it's going to cause some confusion and result in people just saying, "Well, we'll just send them to specialists."

Question number five, what are new PTSD best practices in training providers, assessing treatment provided and using clinical records to assess treatment provided and addressing non-completion?

So, provider training and consultation on empirically validated treatments, one of the best practices that we have, I think is the Center of Deployment Psychology, as well as there are a number of VA and DoD entities, or a number of VA entities that do treatment, as well, in both CPT, that is cognitive processing therapy and prolonged exposure therapy.

So, there is a lot of good provider training and consultation models out there that are either free or extremely low cost for providers, that are helpful.

We think investments in IT systems that not only document care, but provide helpful clinical decision support may assist providers and again, this isn't what we're doing in DoD, but there are a lot of clinical decision support tools that are being developed out there in the IT world, that can be helpful.

One of the things that we're doing is developing this process called First Steps, which takes what has been learned in RESPECT-mil and improving that.

Establishing systems that follow up with provider training with monitoring and feedback, again, that is a best practice. You can't just train providers and then say, "Okay, you did your prolonged exposure training, off you go."

In order to get really good at it, in order to be very effective at it, what you need to have the provider do is have some ongoing supervision from a master therapist, to really help them do that.

So, getting some performance bench-marking and help them do what they need to do, to correct any problems is important.

Non-completion of therapy is often due to complexity of matching the right therapy with the right patient, at the right time, and I think addressing continuity has to take into account, okay, what are we doing with this patient and how well do we make decisions about what that patient gets, you know, what method are we going to do? How long are we going to do it, and how much do we put them through?

So, there is still a lot to be learned on that, but I think we've come a long way in the last several years, in terms of what we're doing, in terms of psycho-

therapy.

Number six, what is DCoE's assessment of availability of evidence-based treatment for TBI?

So, evidence-based treatments for TBI are available through a lot of the clinical practice guidelines and clinical recommendations that we have.

We have a comprehensive dissemination plan, developed with all of the service TBI program managers. We have a number of different hard and soft copy forms of information that are available through DVBIC. The service -- each of the services has specific websites, where they put that information out. They provide a lot of training, up until we had a lot of conference restrictions, we were doing pretty well in providing those opportunities for education at conferences.

We have web-based and webinars available. So, evidence-based treatments for

mild TBI, the clinical practice guidelines and recommendations are getting out there, and I think people -- I think it's very much available throughout the system.

Treatments for severe and penetrating injuries are much more evolved and much more robust than mild TBI, and I think we need to do a lot more in terms of developing evidence-based therapies for mild TBI, and I think DoD and VA are leading the way in advancing the science for TBI management.

We're doing a lot, in terms of looking at, what are we doing for clinical practice guidelines, and I think if you look at the examples, some of the things that we've produced in coordination with the -- with our service partners have been good, return to duty guidelines.

There is a lot going on that I think is available, and all of the services programs, I think, reflect that pretty

robustly.

CO-CHAIR NATHAN: Paul, let me just drop anchor on that for a second.

Since thousands and thousands of people enter the rolls every year --

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: -- in the service, with mild TBI, 80 percent are not combat related.

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: They are falling off of ladders or in a motor vehicle --

CAPT. HAMMER: Sports injuries.

CO-CHAIR NATHAN: -- accident, sports injuries.

CAPT. HAMMER: Mixed martial arts, yes.

CO-CHAIR NATHAN: Backwards gain or off a balcony.

But Jim Kelly, Dr. Kelly, would you like to comment on that at all, from your

perspective on the NICoE of evidence-based and TBI, since it's such a prevalent problem, and will create a tail in the service and the VA, for years to come.

I know you heard Dr. Kelly yesterday on NICOE, but if you didn't catch it in his talk yesterday, and I wasn't able to hear it, as you know, he's been working with the NFL and other contact sport agencies that are heavily invested now in how to deal with what is perceived as mild TBI on a recurrent chronic basis, and some of the drama that relates to it.

DR. KELLY: Sir, I'm over here. The only really strong evidence-based scientific treatment for mild TBI thus far, universally accepted, seems to be specific educational modules and reassurance in teaching the patient about what it is that they have, and how this is going to play out and what to worry about and what not to worry about.

So, even in the emergency department, those studies that have looked at specifically giving people information about what to expect, how this is likely to play out, and what to worry about, what not to worry about, those people with the information, get better, more predictably and quicker than those never given that information, that then wonder, are they losing their minds? Are these symptoms something that cause further deterioration and they actually do create problems for the patients.

All of the other kinds of things that are symptomatic, treatments are still less strong, in terms of the scientific evidence in -- if you really look at double-blind placebo controlled trials and so forth.

All of the different kinds of things, and you didn't hear all of it, that the TATRIC/MRMC people have been behind as well, but their science lists, I don't how

many different trials of medications and other interventions for TBI that have simply failed, when brought down the path of true scientific scrutiny.

So, what we're doing at NICOE with that very intensive program that I described yesterday, and the treatment that is very individualized, that kind of thing will lead, no doubt, to additional information and lessons learned, as we already have in the first two years.

Getting that through the kind of scrutiny that I was engaged in, in developing the sports concussions guidelines, for instance, that level of evidence-based scrutiny for evidence-based medicine thinking is a fair way down the road still. We're just not very close to that, especially with such a complex comorbid population, as we're seeing in the Military.

So, it is not a very satisfying answer, I am sure, but that is really where

we stand for the mild TBI piece of this.

The diagnostic part and what is or is not a mild TBI, is as much of a dilemma that we have to solve, what is the threshold, if you will, of what is a TBI and what isn't a TBI, at that really mild, under the spectrum.

That is something that we really need to nail down first, then the other parts that you heard about before, which is a uniform understanding and definition of what it is we mean by mild TBI, otherwise, the science can't even proceed.

CO-CHAIR NATHAN: Thank you. What I hear you saying is that the biggest hurdle right now, at least evidence-based, is diagnosis and then once diagnosis, education and awareness of signs and symptoms, and that seems to itself, maybe via the Hawthorne effect, to change the course of somebody's prognosis with mild TBI, and the good or bad unintended consequence of all of this is as

more and more of this has reached the newspapers and the lay-media and the general awareness, we're seeing more and more in the medical -- in the service lanes of people who are now coming in, complaining about TBI that they felt they underwent at some point, mild TBI, that is responsible for disciplinary issues, responsible for employment issues, making claims against the Government, hiring attorneys to do disability ratings.

And so, we're looking for that magic blood test, scan, something, that helps us, akin to what we do in concussion testing and the AOR, at Leatherneck and other places, where we use the reaction time and other things to determine if somebody truly has had a cognitive impairment, from concussion, and as Dr. Kelly says, this is not just your sports groups. These are the people who have also been wounded, physically.

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: And also

present with perhaps, TBI in the face of also, an extremity catastrophe or a visceral injury or whatever.

CAPT. HAMMER: I think in terms of answering the specific question though, we have come such a long way, from when we were in the middle of the War, and we were still struggling with, what do we do, to Jim's point.

The big thing is education, and not only education of, you know, what it is and some general clinical sort of thing, but also, to ensure that people get adequate rest, and that is one of the advantages of what happened with the concussion care centers.

When you say to people, "You need to get rest," you know, "Yes, yes, right, I'll rest," and so, I'll just sit here and play video games and read, or you know, whatever.

No, you need to sleep and sleep

and sleep until you cannot sleep anymore, and then sleep some more, and really get actual brain rest, and I think a lot of that is what we're able to do now, based on a lot of the work that everybody has been doing.

So, to your point, yes, it's education that's the big thing, and of course, the research continues to look at biomarkers and genetic issues and all the other things that we look at.

Number seven, what can DoD and the services do to better meet the needs of recovering Warriors with TBI and Reserve component recovering Warriors with TBI?

Like we've discussed before, severe and penetrating TBI's have a relatively mature process. They're available across the MHS and VA systems of care. Leverage a lot of different points of support. They're easy to see, and much easier to understand.

Recovering Warriors with

unresolved mild TBI symptoms after four to six weeks of treatment require more case management interventions, to include development and implementation of a comprehensive recovery care plan, getting a lead coordinator and usually, that is where DVBIC comes in, is looking at having a TBI care coordination program that can help provide follow up services to ensure that they get the symptomatic relief that they need.

One of the things that -- again, speaking to Reserve component recovering Warriors, is ensuring that they do get good screening on -- you know, as they're coming back from deployment and returning home.

Completing the post-deployment health assessment accurately, if they screen positive, getting a complete evaluation to ensure that we are adequately characterizing the right diagnosis. They get a diagnosis, make sure that they have a comprehensive

recovery plan, again, that also involves a process of education on what they should and shouldn't do.

Then assign a care coordinator so that they can get some help, and again, getting them the care coordination and getting plugged into the system, so they can get what they need, I think is going to be an important component, more for the Reserve component than it would be for active duty, where you can have much more accessibility to care.

Number eight, what are new best practices and evidence-based treatment for TBI?

I think Jim already covered some of that, regarding education, but in terms of evaluation, the MACE, we have the latest version, the fourth version. We've developed some concussion management algorithms for the deployed setting.

The important thing about this is

not so much in terms of treatment, but in identifying, so that we can get people to get them what they need, in terms of adequate evaluation and rest, before they do something to further injury themselves.

I mean, that is the key with concussion, is that you can completely recover from a concussion, before you get put at risk to getting another one.

So, having a combat medic or core algorithm that helps them manage that, having an initial provider algorithm, a comprehensive algorithm and a number of different algorithms step wise that providers can go through, in order to determine what they need to do for care.

We're looking at managing and putting out a clinical recommendation regarding the assessment and management of a number of different things.

So, some of the more recent things are management of dizziness associated

after mild TBI, and then neuro-endocrine dysfunction, as well, looking at some of the things that primary care providers or other providers might need to look at, if people have persistent symptoms following concussions.

Question number nine, regarding the DoD instruction 6490.11, that was originally the DTM, the directive type memorandum regarding management of mild TBI or concussion in a deployed setting. Please provide the key differences between the DTM and the DoDI and provide any information related to issuance of this policy.

So, some of the key -- again, we created a table there in your slides, to go through some of the key differences.

One of the things was the removal of the FOUO designation, enabled us to, you know, get it out. It isn't just in theater. We were able to disseminate it widely.

So, for official use only is no

longer part of the designation, so we can publish it widely, and make it much more widely known.

Then revising the MACE and the clinical management algorithms. Those were released in this past May. Those were represented to the state of the science at the current time, and then they -- we have those on a two year revision cycle, to re-look at those every two years.

So, getting the -- getting that information out there in the field is important.

The highlights in red are the difference in the DoDI, in other words, providing more documentation requirements, medical evaluations. Looking at further responsibilities and outlining them in a much more clear way.

We have mandatory rest periods, not just evaluation periods, but mandatory rest periods are noted.

One of the issues here, we had the command directed requirement was originally eliminated in the field, feels that they wanted -- they lost a certain level of flexibility with commanders.

So, we have more -- a more directive guidance on what should be done.

We changed the term from 'mandatory event' to 'potentially concussion event' here, and then you know, data collection and reporting procedures, as well.

The last slide, this one should be in red, the four hour recommendation was taken out. So, and in terms of procedures and medical guidance, no one neuro-psychological assessment tool is recommended over another. It's just that you do one -- you use a neuro-psychological assessment tool, and those are the key differences in that table.

Question number 10, what are best practices in the treatment of moderate and

severe TBI, and whether it be CBG's or other guidance for the field.

So, this much under the purview of the joint theater trauma system. They have provided a lot of clinical practice guidelines in the management of patients with severe head trauma, because it is -- falls more within the surgical realm than the primary care medical realm.

They have updated their recommendations annually from experts in both the neuro-trauma and neuro-surgery field, as well as contribution from those of us in DCoE.

Their guidelines are utilized by all services in the management of moderate and severe TBI, and they provide very specific treatment protocols.

So, there is a lot of folks involved in this, both from the Brain Trauma Foundation and the American Association of Neuro-Surgeons, and there is a lot of money

also deployed in support of research programs for improving intra-cranial pressure and hydrocephalus, treatment for intra-cranial pressure and hydrocephalus.

So, those were the specific questions that you all had for me, and pending your questions, that concludes my brief.

MEMBER EVANS: Captain Hammer, this year or last year, we recommended the PTSD tracking and the training for providers, and yesterday when I presented that to NICOE, I am not sure which Center of Excellence should be monitoring that, but we don't really have a system to say, okay, you know, primary care providers at this command, so many have been trained on PTSD, on best practice or clinical guideline.

We don't have -- I don't believe we've started a tracking, a record review system, where we can look at -- we may have, that should be part of the best practice

record review system.

So, I just -- I think we need to have some type of system in place, where we can show that we're at least training, and that we are looking at records and that we have feedback on what is working, what is not working, and I'm not sure if we have that in place. If we do, we haven't been briefed on it.

CAPT. HAMMER: No, I don't believe that is in place. You're speaking much to the -- this may be sort of a credentialing issue, and you know, a scope of practice kind of issue, as well.

In the mental health field, generally, you have various types of -- you're sort of assuming that you're competent to do psychotherapy, you know, of various types in general.

What I don't think we've really done well at, and maybe need to look at, like you're suggesting, is do we need to look at,

do we credential providers specifically for different types of psychotherapy, so that they are credentialed for those or have those in their scope of practice, or maybe being supplemental privileges, or look at the privileging aspects of that, as well.

That may be probably the most easy way to do that, but it may be difficult, because I am not sure what -- there may be other nuances to changing privileging and credentialing that I'm not aware of.

But it sounds like that is the kind of thing you're looking at, rather than just an informal database of, you know, who has been trained, much like, you know, who got -- I mean, even things as simple as CPR, you know, ACLS kind of training, is tracked and -- in training folders and training files and that sort of thing.

MEMBER EVANS: Right, I don't think we're looking for credentialing aspect of it. I think we're more interested in what

is working. Have you looked at what is working for the service member, and is that -- whatever is discovered to be working, have we educated the providers across the MHS, and is this what we see working at one facility.

So, I don't think we're looking at it, at credentialing. It's a lot -- you know, I get a lot of emails about PTSD, you know, military missing the diagnosis, and a lot of service members complaining.

So, I think what we're wanting to see is that we have taken the initiative to look at records, to do a comparison of what is working.

DR. CERNICH: Sir, I think one of the things that may get to that is one of the initiatives that Captain Hammer spoke to in the 2013 way forward, and one of the things that DCoE is leading is the psych-health dashboard and the clinical pathways.

CAPT. HAMMER: Yes, outcome measures.

DR. CERNICH: And so, I think from that perspective, one is to create a dashboard of psychological health metrics that can be tracked across the enterprise, and this is in the MHS strategic plan, with Captain Hammer's lead. That is number one.

Number two is the clinical pathways. So, how does an individual service member, be it Guard or Reserve or active duty, how do they start in the clinical process? Are they detected at the primary care level or are they coming, presenting themselves to mental health services, or are they referred?

How do they enter, then what is done with respect to diagnosis? Is diagnosis noted? Where is diagnosis made? Is diagnosis made at the primary care level? Is it then confirmed at the mental health level, et cetera, and then it moves through a diagnostic pathway, all the way to outcome.

There are two aspects of that, in

the psychological health strategic initiative. The first is whether or not that model, if it's implemented, in various -- they're doing a pilot. So, we're partnering with an academic partner, that has already briefed this, as part of the strategic initiative, to do a micro-implementation to see how this is working with specific metrics.

DCoE then follows on with a couple extra metrics or more specified metrics, that they think may be useful in addition to that micro-implementation, and looks at the MHS at large, after modeling that pathway in a small group of MTF's.

So, I think what we're trying to do is essentially pilot what you're talking about. Where does the person enter the system and how do they interact with the system? Where do they potentially drop out, and where do we need to improve our processes, and how do we get them to a

positive outcome?

But also tracking that back to, what is their outcome -- what are their outcomes and how are we measuring that, and both through process measurements and through active outcome measurement.

CAPT. HAMMER: So, what I thought you were talking about, training of providers in specific types of therapy.

MEMBER EVANS: Not so much training, but educating, just exact -- she answered perfectly. I think that is what we're looking for, that we have some type of system in place, looking at CPG, getting that across the -- educating the providers across the MHS, on what is working and what is not working, recommendations.

CAPT. HAMMER: Well, we know what works, in terms of what therapies are appropriate for what types of diagnoses.

What we don't know is how well are we doing those, and again, that speaks to

can we look at a registry of people that have PTSD? Do we know what kinds of therapies they are getting? Do we have feedback on outcome measures and scores, such as PCL scores, or you know, PTSD checklist scores, that tell us how well they're doing.

We're starting to develop that, that whole system, and that is what Dr. Cernich was talking about, the dashboard of measures and outcomes and pathways.

MS. DAILEY: And was that the project you were having trouble gathering a working group on?

CAPT. HAMMER: Yes.

CO-CHAIR CROCKETT-JONES: I have a question about just one note on the slide.

The Reserve component was the CRP for TBI, should be assigned at DVBIC/TBI care coordinator.

How many DVBIC/TBI care coordinators are there, and is this only for those who are not tracked in like, CBWTU's or

-- I'm trying to get a better handle on what that means.

CAPT. HAMMER: How many -- yes, you just went over the whole personnel. How many do we have?

DR. CERNICH: So, at present, there are 17 DVBIC/RCC's that are located in various catchment areas, primarily around major medical -- Military treatment facilities, but they're also four located at VA medical centers, four of the poly-trauma rehabilitation centers, and there are actually two also located at the DVBIC civilian rehabilitation sites, one in Johnstown, Pennsylvania and one in Charlottesville, Virginia.

So, they are regionally distributed and they try to give them a catchment area that is relatively large, and really, they are suppose to be support to, rather, you know, sub-plant, the MTF resources, and they're also suppose to be

more community outreach based, than they are to be in competition with other resources.

So, if it is a Reserve or a National Guard member who has lost touch with medical command, they're there to be a resource. They attend all the Yellow Ribbons in the area. They are there to do outreach to local medical facilities, they reach out to regional VA's, as well, to try to connect people to care.

So, I think they are really meant in mission, to be an adjunct to and a support for folks that are not already being served by a care coordinator, and they are also involved, just in terms of coordination, because I know this is a major issue, DVBIC and VA poly-trauma and others have been involved in the IC3 initiative.

So, they are part of that care coordination package. So, they are trying to ensure that their efforts are not in any way, interfering with the larger care coordination

initiative.

CO-CHAIR CROCKETT-JONES: Do they have a case load limit?

DR. CERNICH: They do have case load limits. I don't know specifically what their case load limits are. They also are developing a care coordination tracking application that should, if not part of the IC3, you know, if for whatever reason, they are not part of that tracking application, they will also have an independent tracking application for DVBIC internally.

But they are also tracking the care coordination tracking application that is part of the IC3 initiative.

CO-CHAIR CROCKETT-JONES: Okay, thank you.

DR. CERNICH: You're welcome.

CO-CHAIR NATHAN: Questions? Issues for Dr. Hammer or associates?

Paul, thank you very much. This has been a very robust discussion. It's a

vexing problem, one that is often invisible, and one that -- and I'm not trivializing any dramatic injury of War, visible or not, but this one, when moderate to severe, takes the family with it.

It's one thing to have a physical injury, which I'm not trivializing, but you can get back and engage in your normal sort of psychological health with your family. It's another to have an injury or an effect that is created, that sort of removes you from the light and the brightness of the family.

And so, and it's one that we have yet, to probably maybe even see the crest of the weight in our society.

CAPT. HAMMER: Yes, sir.

CO-CHAIR NATHAN: As we deal with it, and so, we're very interested in what you and Jim Kelly and all of the people are doing.

Our job is to look and see that

we're just providing the best care and the best opportunity for recovery, and ultimately, re-integration of a Warrior and their family, whether they be wounded, severely injured or ill.

So, we're vitally interested in what is new, what works, how we find out what is new, how we find out what works, and then the application of it, into practice and into changing lives and the traction of it.

So, we appreciate your passion, in what you do. We recognize some of the logistical stove-pipes that exist, and our mandate is to try to find out how we can throw our weight into helping you do your mission to make a change for that individual.

So, barring any questions for Dr. Hammer, thank you, Paul.

CAPT. HAMMER: Thank you, sir.

CO-CHAIR NATHAN: I think that being the last thing on the agenda, I would -- I'll ask Suzanne to make any comments that

she wishes.

I'll state by saying that I still consider myself sort of a neophyte here, but again, I am impressed by the agenda. I'm impressed by the caliber of speakers, by the caliber of the members of the Task Force. It always makes me feel somewhat intimidated, to be among this collective intellect.

I'd like to thank Ms. Dailey and your staff for the tremendous logistical support. You herd some pretty impressive -- you herd some pretty impressive cats here, that tend to want to go their own directions, and you do a very good job of it, and so, I'm always impressed by that, and I would just ask the members of the Task Force, this is a journey, not a destination.

If you have concerns, if you have ways that you think we could be doing business better, that we could cultivate better use of the time, or better use of the expertise, please don't be shy about letting

us know, how we can build a better mouse trap.

There are lives that hang in the balance, and I'd like to think that we're going to change some of them with our efforts, and with that, I'll ask Ms. Crockett-Jones if you have anything you'd like to say.

CO-CHAIR CROCKETT-JONES: No.

CO-CHAIR NATHAN: Ms. Dailey, any administrative comments?

MS. DAILEY: No, sir, we're off to Chicago tomorrow, for those of us that are heading out, so, I will see some of you tomorrow, and next meeting is end of February. It is the services briefings to us on their programs.

I will circulate the agenda again. Again, a list of questions, the things we're asking them to brief us on. I'll give you one more look at items you would like to insert in there, or what you

want them to talk to us about, and then I have to go to the Federal Register. I'll have to publish it in the Federal Register.

So, I'll circulate it one more time for input and then we'll lock down that agenda for February, end of February, six weeks from now.

CO-CHAIR NATHAN: Great. Okay, class is dismissed.

(Whereupon, the above-entitled matter concluded at 4:15 p.m.)

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