

U.S. DEPARTMENT OF DEFENSE

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

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BUSINESS MEETING

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TUESDAY
APRIL 2, 2013

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The Task Force met in the Commonwealth Room of the DoubleTree by Hilton Hotel Washington DC-Crystal City, 300 Army Navy Drive, Arlington, Virginia, at 8:00 a.m., VADM Matthew L. Nathan, DoD Co-Chair, and Suzanne Crockett-Jones, Non-DoD Co-Chair, presiding.

PRESENT

VADM MATTHEW L. NATHAN, M.D., USN, DoD Co-Chair

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair

JUSTIN CONSTANTINE, J.D., Member

CSM STEVEN D. DEJONG, ARNG, Member

RONALD DRACH, Member

TSGT ALEX T. EUDY, USAF & SOCOM, Member

CAPT CONSTANCE J. EVANS, USN, Member

KAREN T. MALEBRANCHE, RN, MSN, CNS, Member

STEVEN J. PHILLIPS, M.D., Member

DAVID REHBEIN, M.S., Member

ALSO PRESENT

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DENISE F. DAILEY, PMP, Executive Director,
Designated Federal Officer

ANNE E. SOBOTA, Alternate Designated Federal
Officer

MARY CARSTENSEN, Senior Advisor to the
Secretary of the Department of
Veterans Affairs

COL ANDREA CRUNKHORN, Office of the
Assistant Secretary of Defense for
Health Affairs

KAREN GUICE, MD, MPP, Principal Deputy
Assistant Secretary of Defense for
Health Affairs

REGINA M. JULIAN, MHA, MBA, FAHCE, Director,
Military Health System Patient
Centered Medical Home Division

WARREN LOCKETTE, MD, Deputy Assistant
Secretary of Defense for Clinical and Program
Policy

TERRY RAUCH, MD, Office of the Assistant
Secretary of Defense for Health
Affairs

JOSE D. RIOJAS, Interim Chief of Staff,
Department of Veterans Affairs

MAJOR GENERAL DOUGLAS J. ROBB, Joint Staff
Surgeon

TIMOTHY J. WARD, Deputy Director, Program
Analysis and Evaluation Directorate,
Bureau of Medicine and Surgery

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

8:12 a.m.

MEMBER DEJONG: Good morning, everyone. Thank you for attending the April business meeting. This is the last information-gathering business meeting we will have before preparing our recommendations for the annual report.

During our next meeting in June we will spend time in breakout sessions creating our recommendations. In July for our final business meeting of the fiscal year we will gather to conduct our final votes on findings and recommendations going into the report.

Before we begin our site visit after-action review this morning I would like for us to go around the table and briefly introduce ourselves. Justin, can you start?

MEMBER CONSTANTINE: Sure. My name is Justin Constantine. Thank you.

MEMBER REHBEIN: Dave Rehbein, one of the seven non-DoD members.

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1 MEMBER EVANS: Captain Constance
2 Evans, Bureau of Medicine.

3 CO-CHAIR NATHAN: Matt Nathan,
4 Bureau of Medicine, military co-chair.

5 CO-CHAIR CROCKETT-JONES: Suzanne
6 Crockett-Jones, civilian co-chair.

7 MEMBER EUDY: Technical Sergeant
8 Alex Eudy representing the Air Force and Special
9 Operations Command.

10 MEMBER PHILLIPS: Steve Phillips,
11 Department of Health and Human Services.

12 MEMBER DEJONG: Command Sergeant
13 Major Steve DeJong representing National Guard
14 Bureau.

15 MEMBER DRACH: Ron Drach, non-DoD
16 member.

17 CO-CHAIR NATHAN: So, since our
18 last business meeting in February we've
19 conducted -- I'm using the royal "we" here --
20 have conducted visits at North Carolina Joint
21 Force Headquarters, Iowa Joint Force
22 Headquarters and Arkansas Joint Force

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1 Headquarters.

2 Members of the task force then
3 conducted visits along the west coast starting
4 with Camp Pendleton in California looking at the
5 wounded warrior facility there, San Diego Naval
6 Reserve known as the NOSC in California, Joint
7 Base Lewis-McChord which has a very large
8 population of recovering warriors in Washington
9 State, and Joint Base Elmendorf which has a very
10 small population of wounded warriors but has
11 very unique and specific issues based on their
12 geography.

13 The site visits to the joint force
14 headquarters provided an opportunity to speak
15 with both Army and Air National Guard
16 leadership. Also during this time was visits to
17 tour and speak with personnel at nearby Veterans
18 Affairs facilities.

19 During the west coast visits we had
20 an opportunity to conduct recovering warrior
21 focus groups at each location. We also
22 discussed topics such as caregiver support,

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1 non-medical case management, the IDES process,
2 and TBI and PTSD services within the recovering
3 warrior leadership.

4 A list of these site visits and those
5 members who were in attendance can be found under
6 Tab B of the briefing book.

7 We're going to begin our discussions
8 with the members who attended the North Carolina
9 Force Headquarters visit. If you could give us
10 some insights into what you saw.

11 MEMBER EUDY: Yes, sir. One of the
12 key things that we saw -- and this will relate
13 to all the Joint Forces Headquarters visits --
14 speaking first on part of the Air Force and the
15 Air Guard and underutilization of the RCC
16 program.

17 We found that whether they were
18 split up on areas geographically based by
19 TRICARE region and adapting nurse case
20 management, across TRICARE regions or sourcing
21 the closest RCC due to them coming out of active
22 duty bases.

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1 We found that there were Cat 2 and
2 Cat 3 servicemembers that require both medical
3 and non-medical case management but were getting
4 it piecemealed together conducted by their Guard
5 units themselves.

6 But one of the big things on the Air
7 Guard was they had a lot of electronic resources
8 that were being placed out. Several
9 installations were test sites for whether it was
10 different VTC capabilities or separate
11 processing systems. And those were not being
12 utilized.

13 MEMBER EVANS: Additionally we --
14 great visit, a wonderful facility and the Guard
15 definitely trying to reach out to the members.
16 But the lack of, again, the case management
17 oversight and RCC. And then collaboration
18 between the Guard, Air Guard and VA. That was
19 interesting how they just recently started that
20 collaboration process. And the VA,
21 when we had an end brief by the VA seemed to feel
22 as though DoD was very hesitant to get the

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1 patients to them. They mentioned one service
2 specifically but overall they were still trying
3 to bring that collaboration together between the
4 Guard and VA.

5 And I believe they have a national
6 contract for case management. I think we were
7 briefed on that. It seemed to be underutilized.
8 And that's seen by the staff as well as the
9 patients that were expressed in the focus group
10 as they didn't feel like they had the care
11 coordination aspect there.

12 But the staff definitely trying to
13 do the work of what should be done by case
14 management and the RCCs, the staff trying to take
15 on that workload.

16 MEMBER EUDY: One of the key best
17 practices I wanted to mention was the call center
18 that they had for behavioral health concerns.
19 Almost used as a crisis management where across
20 the entire state, active Guard Reserve component
21 anybody could call in and then be directed either
22 to receive some local care or find the closest

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1 mental health provider, behavioral health
2 provider. And everyone acknowledged that.
3 Even in the focus groups everyone said this
4 resource is great, being able to call in. It's
5 manned 24 hours a day. They said that was a
6 great resource. And it was acknowledged by
7 commanders also.

8 CO-CHAIR CROCKETT-JONES: I think
9 the most -- yes, and they had prioritized it with
10 monies that they were pulling from other places.
11 And it seemed to be working. They seemed to have
12 a real lack of collaboration, sort of no one had
13 sight of other things outside their lane and that
14 meant that they couldn't shift people
15 necessarily to the right thing.

16 And they were -- especially in their
17 voc rehab and transition sort of programs were
18 really, seemed a bit uncoordinated. It's a
19 little hard I guess when people are only getting
20 together so often. They also had a fair lack of
21 a view of family and family support issues.

22 MEMBER EVANS: A wonderful -- I

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1 think he was a physician assistant. He got off
2 of active duty, brought some of the processes
3 from active duty, what he learned from the WTB
4 to the Guard. And so definitely seeing some
5 changes there. Very proactive in trying to
6 bring the members together, track anyone that's
7 Category 2, 3. So I was very impressed with him
8 and think that he probably should spread some of
9 his best practices throughout the other Air
10 Guard and Reserve population. So definitely a
11 proactive physician assistant they and on staff
12 there.

13 CO-CHAIR NATHAN: That seems to be
14 a recurrent theme in a lot of these places where
15 you find one person who really is sort of a
16 champion and everybody sort of galvanizes around
17 that one individual.

18 So if I could just ask if you had to
19 -- and we'll cultivate all these as we progress
20 to the recommendations over the summer. But off
21 the cuff if you had to make one recommendation
22 about what you saw there that they need from a

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1 systems fix or they need an issue. You've
2 talked about some of the good things they've had,
3 and they had some good practices. But what's
4 the wolf closest to the sled then at that place?

5 MEMBER EVANS: I think my
6 recommendation would be the case management RCC
7 issue. I think we need to -- they have a
8 national contract. And I'm not sure why they
9 didn't utilize that contract. We were made
10 aware of one particular case and that was a
11 highly visible case. And the member did not
12 receive case management until later. So I
13 believe they really need to fix the case
14 management piece.

15 CO-CHAIR NATHAN: And that goes
16 with what you said, Alex, where they had some Cat
17 2's and 3's that sort of fell through the cracks
18 for a while.

19 MEMBER EUDY: Correct, sir. One of
20 the things that we continuously ask, especially
21 at the Guard sites, is awareness of both TSGLI
22 and SCAADL. When you have these Cat 3

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1 servicemembers that are on that weekend duty and
2 it ends up occurring.

3 And typically at these JFHQs there
4 is someone that has ended up kind of sifting
5 through the cracks, through the weeds.

6 CO-CHAIR CROCKETT-JONES: In
7 general it seems to me that one of the things that
8 when we go to the Guard and Air Guard sort of
9 sites there's -- I think that they -- they don't
10 have a view of how their various attempts to
11 handle their folks in transition, how the
12 different things mesh together, how they -- it's
13 a lot of separate streams.

14 And when they get someone who has
15 been active in the same programs, who sees the
16 alternative of things working together, he can
17 really -- that motivates a lot of change, you
18 know, different changes and a different view.

19 I think that that's almost like an
20 educational component for leadership that I'm
21 not sure how we, how that gets transmitted to
22 them. But I think that Guard leadership needs

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1 to get a concept, an educational concept of
2 transition plans.

3 CO-CHAIR NATHAN: Thank you.
4 Comments on Joint Forces Headquarters in Iowa?

5 MEMBER REHBEIN: I don't know why
6 everybody looks at the kid from Iowa.

7 (Laughter.)

8 MEMBER REHBEIN: I think the one
9 thing that really jumped out at me on that visit
10 out there was the inconsistencies in a number of
11 places. Communication between the Guard and
12 the VA seemed to be nearly non-existent. That
13 was a distinct problem.

14 But then the other thing that we
15 heard on the Army side, how difficult they were
16 finding it to be to find behavioral providers for
17 their people which was exactly the opposite of
18 what we heard on the Air side.

19 And if I may speculate for a moment,
20 the Army behavioral health folks were very
21 highly skilled, very qualified doctors to
22 include a psychiatrist, but they came to drill

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1 with the Iowa Guard from a long distance whereas
2 the Air Guard people were embedded in the
3 community. And I think that kind of personal
4 contact with the behavioral health community in
5 the state was what was driving that big
6 difference. Because the Army folks were not
7 embedded in that community. They didn't have
8 the kind of personal connections and I think we
9 all know just how much personal connections
10 drive those sorts of things.

11 But there was a very -- there was
12 considerable disconnect between the Army and the
13 Air there as to what they could -- whether or not
14 they could find behavioral health providers that
15 would help treat their soldiers. That was very
16 disturbing.

17 I want to make a couple of comments
18 to broaden some discussion here for a little bit
19 because not just in these three visits but in
20 some prior visits. Anecdotally we hear about
21 people coming into some of the CBWTUs that the
22 staff doesn't think are ready for that.

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1 We talked to -- I talked to one
2 soldier who said he was put in a CBWTU at his
3 urging and it turned out later he wasn't ready.
4 There is a group out there --

5 CO-CHAIR NATHAN: David, what do
6 you mean by he wasn't ready?

7 MEMBER REHBEIN: He needed health
8 treatment. He realized that he needed health
9 treatment that was more readily available in a
10 WTU. It was his push to get home. I think he
11 minimized his condition.

12 But there's also a group of people
13 out there in the National Guard that I'm worried
14 about. They're on Title 32. They're not
15 drilling. They're not yet back to work. Their
16 case management if they have case management is
17 remote and they're out there by themselves.

18 I just want to make a statement for
19 the record that I hope when it comes
20 recommendation time that we can devote some
21 focus to making sure that people are assigned
22 based on their medical needs, that where their

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1 location assignment is is being based on medical
2 needs and not based on financial pressures, not
3 based on a number of things.

4 But to return to Iowa, those two
5 disconnects were disturbing. It was exactly
6 the opposite in Arkansas as far as communication
7 between the Guard and the VA. That was very
8 good. When we went to the VA in Arkansas they
9 had a room full of people.

10 CO-CHAIR NATHAN: Now, at the
11 conclusion of your visit did you brief this out
12 to the folks?

13 MEMBER REHBEIN: Yes.

14 CO-CHAIR NATHAN: And what kind of
15 response did you get when you talked about the
16 disconnect between the VA and the Guard?

17 MEMBER REHBEIN: Not a -- we weren't
18 totally aware of the disconnect when we briefed
19 out because you do the out-brief before you do
20 the VA visit. And so we weren't totally sure if
21 this was a two-way.

22 Once we left Iowa and came home Ms.

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1 Dailey communicated that disconnect back to the
2 Guard and to the VA both through some email to
3 make, to urge them to close this disconnect.
4 But that was about all we could do at that point
5 because of the -- because of the separate
6 locations and the out-brief actually coming in
7 the middle before we had a complete picture.

8 MEMBER PHILLIPS: Just to expand on
9 that. Iowa may be somewhat unique because the
10 VA seems to be the target medical facility for
11 the Guard and Reserve as opposed to other
12 communities that they can go to other facilities
13 or into the civilian community.

14 So the VA in Des Moines is not geared
15 to return to duty concept. They're just geared
16 to process folks through.

17 When we met with the VA the
18 impression I had was that they thought they were
19 doing okay and that they weren't -- they didn't
20 feel that they were obligated to report back all
21 the details of the care and treatment that they
22 provided, that it was up to the servicemember to

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1 report back to their command. This was
2 especially glaring in behavioral health issues
3 where the VA felt that, well, I mean we cannot
4 report back or we don't report back some major
5 behavioral health issues to the command, that
6 it's up to the command to figure that out. So
7 there was this big disconnect, this big
8 disconnect.

9 A couple of other issues related to
10 the Guard behavioral health, Army Guard, is --
11 and I made some calls because I practiced in
12 Iowa. There are two psychiatrists who trained
13 in Iowa and then moved to I believe New York State
14 who fly back every month to provide behavioral
15 health care. And I don't know whether that's
16 good, bad, or indifferent, but that seems a
17 little -- a little obtuse basically to do
18 something like that. Whereas the Air Guard said
19 they had a list of 150 providers that they had
20 no trouble getting their folks in to see. So
21 that's something that needs to be looked at a
22 little further.

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1 The other areas that I noticed in
2 Iowa which we see everywhere is that the
3 families, especially the remote families and
4 caregivers, are just out of the loop again.
5 They're out of the information loop. They don't
6 really connect. They don't know what's going on
7 with their servicemember and that's an issue.
8 And they actually said we wish they could be more
9 proactive. The HIPAA rules again seem to be
10 interfering and so forth.

11 And a couple of technical things
12 which again I didn't realize but the line of duty
13 rules and processes seem to be different for the
14 active Guard and Reserve. And so that seems to
15 be somewhat of a block related to processing
16 folks through.

17 And the final thing that I wanted to
18 mention is that the medical packet
19 responsibilities and the preparation of those
20 seem to vary by the medical treatment facility.
21 And sometimes these packets sit for more than 90
22 days and then they have to -- a lot of the testing

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1 has to be redone because they've expired.

2 MEMBER REHBEIN: On the behavioral
3 health issue, and I don't know if this is -- I
4 don't know how to evaluate this number. I don't
5 know whether this is a high number or not, but
6 the Iowa National Guard had lost three of their
7 soldiers to suicide between December and when we
8 were there very early in March. And that seems
9 to me to be -- if that's a normal number then it's
10 excessive everywhere. But it's certainly
11 excessive. One member a month is very
12 disturbing.

13 MEMBER DEJONG: Now is Iowa doing
14 similar to other states where they're doing
15 their PDHRAs in conjunction with the VA or at the
16 VA facility?

17 MEMBER REHBEIN: In conjunction
18 with the VA but I doubt at -- I don't think at
19 the VA facility, no.

20 MEMBER DEJONG: Okay.

21 MEMBER REHBEIN: I believe there
22 are VA people there but I doubt very much that

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1 they're all at the VA facilities just simply
2 because of the numbers, because of that brigade
3 that deployed and came back. I don't think it's
4 at the VA facilities.

5 MEMBER DEJONG: Okay. Because a
6 lot of states have started to adapt actually
7 running them through the VA facility and doing
8 a PDHRA there at the VA hospital. And then that
9 kind of closes that gap so to speak and puts
10 people in touch with -- it shows you who the
11 OIF/OEF coordinators are. It shows you the
12 seamless transition. It shows you. So I know
13 we had mentioned that as a best practice many
14 places. Just trying to figure out which one of
15 these three if any are doing that.

16 MEMBER PHILLIPS: This wasn't -- my
17 impression was this wasn't the case in Iowa.
18 The reservist or the Guard would stand down but
19 they'd still be drilling periodically. But
20 they'd go to the VA for care, especially
21 behavioral health care. And they would express
22 some problems. The VA would not report these

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1 issues. And I think perhaps this was related to
2 the suicides that may or may not have been
3 prevented. They would not express the
4 behavioral health issues, report them back to
5 the command. So these folks were just being
6 sort of treated at the VA without anyone
7 following up. And yet they were still drilling.

8 CO-CHAIR NATHAN: So it sounds like
9 the recurrent theme from this visit is
10 stove-piping. The VA is in their corridor, the
11 National Guard care is in theirs. The Air
12 National Guard in theirs. Never the twain shall
13 really meet.

14 The National Guard is using sort of
15 rent-a-docs that are flying back in to sort of
16 see some of their folks whereas the Air Force --
17 Air National Guard has a cadre, organic cadre.

18 We're not getting the reports
19 crosswalked back from the VA system into the DoD
20 system.

21 It sounds like at the minimum we're
22 going to need some -- maybe a recommendation

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1 about creating a steering committee or
2 something, a matrix committee with
3 representatives from all those places to get
4 together and figure out how to better crosswalk
5 what they're doing.

6 I'm sure they're all passionate
7 about what piece of the puzzle they provide but
8 they're not integrating it together in a
9 functional matrix type organization. And
10 they're having people suffer as a result.

11 MEMBER REHBEIN: And I think that
12 was the intent of Ms. Dailey's email back to them
13 was not so much to create that matrix but to make
14 sure that all of those people were introduced to
15 each other and understood who each other were and
16 what role they played, and that they all had a
17 joint role to play. And that reading between
18 the lines we expected them to play a joint role.

19 CO-CHAIR NATHAN: Okay. Thank
20 you. Comments, insights on Arkansas?

21 MEMBER EUDY: I think most of our
22 concerns, and correct me if I'm wrong, Mr.

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1 Rehbein, were addressed in the previous visits.
2 I don't think there was anything outstanding
3 that we saw at Arkansas that wasn't occurring at
4 the other JFHQ facilities. MEMBER

5 REHBEIN: The one thing that comes to my mind,
6 and I don't know if this is indicative of the way
7 everything is done in Arkansas, but the
8 connection with the leadership during our visit
9 was much stronger, as strong as any place I've
10 ever been.

11 The adjutant general was there both
12 for the in-brief and the out-brief. And we had
13 everybody that we could think of that we wanted
14 to talk to was already in the room. So their
15 leadership team with the connection with us was
16 very strong.

17 And whether it's -- whether that's
18 an indicator of the way they do business every
19 day I don't know, but it's certainly better than
20 the indications that we saw in Iowa.

21 CO-CHAIR NATHAN: What sort of
22 footprint do they have in Arkansas size-wise?

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1 Did you get a feel for whether it's robust or a
2 small, discrete compared to your other visits,
3 compared to the other experiences?

4 MEMBER EUDY: I believe that the
5 population at least of the Air Force was maybe
6 a handful that they were providing care for.
7 But in regards to the Army somewhere between 30
8 and 50 servicemembers. Denise, does that sound
9 a little high or is that?

10 MS. DAILEY: All the Joint Forces
11 Headquarters have got at least on the Army side
12 they all run three to four hundred line of duties
13 that are open. I mean all of them do in the Army
14 side.

15 Now, the Air Force side generally
16 runs a little less in the number of line of duties
17 that they're actually managing. But the Guard
18 side, they're all running somewhere between
19 three and five hundred open line of duties. And
20 in fact that's lower than we saw last year which
21 had close to 900 that were still open. And 5,000
22 that had been opened and closed since their

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1 redeployment.

2 So they're managing a lot. They
3 have case managers on contract for the Army.
4 And then each case manager has three care
5 coordinators in these Joint Forces Headquarters
6 to manage those 300-350.

7 They gave us some recommended case
8 management loads. So for those care managers
9 it's a National Guard contract out of the
10 National Guard Bureau for the Army.

11 They all asked for more
12 psychological health resources. They've got
13 directors of psychological health. They're
14 contractors for the Army. They're contractors
15 for the Air Guard. They all asked for at least
16 one more in their Joint Forces Headquarters for
17 the Army side.

18 But they are managing large numbers
19 on the Guard side for line of duties. It's
20 extensive. And again, the Guard, National
21 Guard Bureau has put a contract in place to
22 manage those still open line of duties.

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1 All of them run, I think National
2 Guard at Carolina was the largest one running at
3 about 12,000, 10,000 Guardsmen, Army Guardsmen,
4 2,000 Air Guard. Iowa and Arkansas were running
5 about total 8,000 Guardsmen, 6,000 Army, 2,000
6 Guardsmen, Air Guard. So it was -- you saw a
7 pretty big, robust organization in North
8 Carolina and a little, and a smaller cohort of
9 Guardsmen in Iowa and Arkansas.

10 MEMBER REHBEIN: One of the
11 comments that was made down there though on
12 another subject in return to behavioral health.
13 Their state surgeon, their DPHs made the comment
14 that they had trouble finding providers,
15 civilian providers, that were well trained in
16 the evidence-based treatments. And so that was
17 a hurdle that they were seeing as they were
18 trying to get their people into treatment.

19 CO-CHAIR NATHAN: David, who was
20 saying that? That was coming from who?

21 MEMBER REHBEIN: Arkansas. The
22 state surgeon and the director of psychological

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1 health, both the Army and the Air side, that that
2 was their experience. And their civilian
3 providers had not received as much treatment in
4 the evidence-based -- as much training in the
5 evidence-based treatments as they needed, as
6 they felt they needed to have.

7 CO-CHAIR NATHAN: All right.

8 MS. DAILEY: And one real quick on
9 that. At North Carolina they said an
10 interesting comment which we might want to
11 follow up on. They said it's very expensive to
12 train civilian providers in the evidence-based
13 treatments. And that maybe DoD would like to
14 think about funding or some sort of initiative
15 to fund or supplement or subsidize that in the
16 civilian community.

17 MEMBER EUDY: Denise, correct me if
18 I'm wrong. Wasn't that where they were
19 expressing the fear on the part of civilian
20 providers to sign behavioral health diagnosis so
21 there was a -- amongst their provider force that
22 they were saying the servicemember to they said

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1 was afraid to put their name on the bottom line.

2 MEMBER REHBEIN: We heard that. We
3 heard that from the Army folks in Iowa that they
4 thought they had trouble obtaining civilian
5 providers' help because of the stigma that the
6 provider -- if the provider lost a patient to
7 suicide that that reflected on the provider and
8 so therefore they were reluctant to help. I
9 found that very difficult to swallow to tell you
10 the truth.

11 CO-CHAIR NATHAN: I think that's
12 going to be pivotal as time marches on, the
13 civilian-federal healthcare intersection.
14 We're going to be relying more and more on
15 civilian healthcare as we start downsizing, as
16 we start injecting more and more service
17 personnel into the civilian ranks from
18 downsized, from returning -- as we downsize in
19 the war, as we downsize in the service numbers.

20 I think we all at this table in this
21 room recognize the pivotal role that the
22 civilian, private sector, academic, DoD, VA

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1 partnership has to provide to care for these
2 folks. We're not going to be able to do it alone
3 in the MTFs. We're not going to be able to do
4 it alone in the VA system.

5 And I don't know that it's pragmatic
6 to fund, DoD to fund civilian training. I mean
7 I guess my bias is if you're a civilian in
8 practicing and you hang your shingle out you have
9 as much responsibility to maintain currency with
10 how to treat these episodes or these issues as
11 anybody in the federal healthcare sector.

12 I recognize some people just make a
13 practice of treating folks with mild anxiety or
14 obsessive-compulsive disease, but a community
15 can't tolerate that. A community is going to
16 have to have an ambient level of expertise in
17 treating post-traumatic stress, mild TBI and all
18 the anxieties associated with long deployments
19 and with long service. Otherwise these folks
20 are going to wash up on their shores in
21 homelessness and other things. So it really
22 behooves the community to get behind things.

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1 So I think this kind of
2 high-altitude views that you all provide are
3 very helpful in trying to shape and maybe
4 reinforce community integration among the
5 various sectors.

6 We have some pilot cities, you know,
7 in San Diego and others where they get this and
8 they recognize that this is a community
9 response. They can't rely simply on the
10 military or the VA or the universities to fix
11 this. They have to have a community response.
12 And so they formed a robust group of providers
13 and civic leaders who are meeting on this trying
14 to figure out how they can provide a community
15 response to these kinds of issues. But I think
16 we need to push that more and more where we visit.

17 MEMBER PHILLIPS: Kind of an
18 editorial comment, just my own personal
19 impression. I've spoken to a number of
20 psychiatrist and psychologist friends of mine,
21 civilians, and I hear repeatedly that they've
22 offered programs and packages to Guard and

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1 Reserve and DoD facilities. And they said that
2 there's a lot of -- not a lot, but there's
3 resistance to accepting the civilian plans and
4 programs. And I think it has to do perhaps with
5 education, with not following DoD principles and
6 so forth. I think both sides need to kind of
7 look at what's going on and harmonize their
8 efforts.

9 CO-CHAIR NATHAN: Steve, I think
10 you're right on so many fronts. Part of it is
11 that there's just a general inertial resistance
12 among the military to widen the aperture and
13 share the patients. And that's wrong.

14 Part of is that sometimes the
15 civilians say I'd like to offer you a Friday
16 afternoon every week to help see your patients.
17 Now there will be some weeks I can't and so.
18 I've personally witnessed that where good
19 intentioned civilian providers want to help us
20 but they can't commit to a regular schedule or
21 can't commit to a regular donation of time. And
22 so it's almost worse putting a patient into their

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1 care and then all of a sudden having the patient
2 left alone to where we have to pick it up again.
3 So that's some of the problem.

4 But there's no question that the
5 military has been, in my opinion has been less
6 than aggressive in pursuing some of these offers
7 from the civilian sector.

8 I think we're starting to see more
9 energy in that when you look at the Armed Forces
10 Foundation and the Fallen Heroes Foundation and
11 what they're offering and how they're offering
12 the partnerships. So I think we're getting
13 there, especially in TBI and in combining
14 talents to look at TBI in the various academic
15 and military centers of excellence. But I think
16 we still have a long way to go so your point's
17 very well taken.

18 MS. DAILEY: In one of the civilian
19 inroads, the point of contact that's been tasked
20 by the National Guard Bureau in their contract,
21 in their statement of work to develop that
22 network of civilian providers is the directors

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1 of psychological health in each state.

2 In their statement of work they have
3 to identify military-friendly,
4 military-experienced providers. And so that's
5 kind of the channel at least in the National
6 Guard and civilian state regions.

7 It's supposed to be one of the
8 conduits that is in their statement of work.
9 They're supposed to be providing that link to the
10 National Guard.

11 I would like to point out at North
12 Carolina first of all military-friendly, very
13 military-friendly, military-rich state. In
14 Iowa and Arkansas military-friendly but not
15 military-rich. Very few installations, very
16 few MTFs.

17 Joint Forces Headquarters North
18 Carolina has a very well-developed mental health
19 program. Alex mentioned it. They led their
20 discussions with us in mental health with we
21 spend \$2 million a year out of our operational
22 funds to support this mental health, this

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1 integrated mental health. It's the only place
2 we've seen it. And they led with the statement
3 we spend \$2 million a year. I'd rather give up
4 a tank or an aircraft engine and keep these
5 resources in my state.

6 Their provider of choice for mental
7 health is the University of North Carolina.
8 They have developed very strong MOUs and they
9 send most of their patients to the University of
10 North Carolina for treatment. They get back the
11 products they need in evidence-based
12 treatments. They get back the language they
13 need to process line of duties, to develop MED
14 packages if necessary, to provide profiles for
15 servicemembers.

16 That language and that channel has
17 developed with the universities. It's not as
18 well developed between the National Guard
19 Headquarters and any of the VAs to date. It's
20 a real specific set of requirements that they
21 need to do those things, line of duties, MEB
22 packages, evidence for ratings for the VA. And

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1 so they can set up that and control that with the
2 universities through their MOAs.

3 It's not as tight a relationship
4 with getting those type of products out of the
5 VA at this time.

6 MEMBER PHILLIPS: Just one quick
7 comment and I hope the committee will consider
8 this in our recommendations. We have three
9 excellent healthcare systems in the United
10 States. We have the civilian sector, we have
11 the VA and we have the Department of Defense.

12 And we work very hard to process and
13 transfer folks from one to the other
14 administratively. But again, this is my
15 opinion, we seem to have the attitude that once
16 they're out of one system they're in the other
17 system, the other system will take care of them.

18 And I think we need to set up
19 standards and practices that these systems can
20 work together and move back and forth and
21 harmonize. So that the sum will be greater than
22 the parts.

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1 CO-CHAIR NATHAN: I have a
2 four-letter word for you that's going to be
3 pivotal to that and it's IEHR, the integrated
4 electronic health record. And if we can get
5 that going and there's great push as you know
6 from the executive branch and there's some pull
7 by the military, the VA and the DoD. But if we
8 can crack that nut and get to the point that would
9 solve the problems where the VA sees a patient
10 and doesn't really have an incentive to try to
11 confer back the information on the patient. It
12 would be there for the command. Under privacy
13 rules based on what you can see and can't see
14 depending on who's looking at the mental health
15 record. But that's really the crux of it.

16 And that will solve so many issues
17 all the way from ownership of patients, feeling
18 ownership of patients to patient safety. And
19 economics too as a matter of fact. I mean it'll
20 just save so much money in removing redundant
21 tests and procedures and things like that when
22 people show up to emergency rooms and distant

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1 hospitals.

2 So again, I think if it were up to
3 me we'd all be wearing t-shirts in the federal
4 health sector that says "It's the IEHR, stupid."

5 And I think we're seeing great
6 interest there and effort and heat and light from
7 the VA and DoD, Karen. I think sometimes more
8 heat than light but there's some light coming
9 through on occasion now.

10 So anymore comments on Arkansas or
11 the Joint Forces Headquarters in total? Okay,
12 let's move out to where the sun sets instead of
13 rises, Camp Pendleton, California.

14 CO-CHAIR CROCKETT-JONES: I can
15 speak to some of the things that we saw. We saw
16 one thing that we enumerated as a best practice.
17 And I want to share it so that we don't overlook
18 it.

19 They had opted to have a program
20 where if one of their PTSD treatment programs,
21 if someone dropped out it initiated a contact
22 specifically from providers. And since we had

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1 heard in other places and sort of statistically
2 that the dropout was connected to poorer
3 outcomes a response -- this is the first place
4 we've seen a specific response that says if
5 someone drops out we find out why.

6 And I was really glad to see someone
7 starting that. I'd love to see if they can
8 codify improvements having -- and pulling folks
9 back in. But it was good to see someone coming
10 up with an innovation specifically to address
11 that problem.

12 But I'd love to give other folks who
13 were along on the trip. Yes, we did have -- we
14 did see an issue with nurse case management. I
15 can bring that up.

16 It's unclear. There are two
17 different philosophies of what a nurse case
18 manager does. One is that nurse case managers
19 make appointments and I was not super clear on
20 when the nurse case manager doesn't make
21 appointments what the other collateral duties
22 were.

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1 And I think that lacking the
2 appointment-making that the servicemembers
3 didn't really know what their nurse case manager
4 did either. They seemed sight unseen. They
5 were not the go-to person and they were this
6 nebulous, they were there but nobody knew what
7 they did or why they should contact them.

8 It was kind of a disconnection that may
9 also have been affected by the fact that they
10 weren't meeting their ratios either. So these
11 were people that had too many patients and it
12 wasn't clear what they did for the patients they
13 had.

14 MEMBER MALEBRANCHE: And Suzanne, I
15 would just add this was I thought surprising to
16 me because it's the first place we've heard that
17 they didn't even know about nurse case managers.
18 And I would venture that given -- not given the
19 appointment-making authority they were not
20 probably going to be going to them.

21 It was kind of surprising. That was
22 the first place we've ever heard that. But they

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1 were very I thought more engaged with their, what
2 did they call them there? Their squad, their
3 line person.

4 But the nurse piece was such a
5 surprise. I was so surprised. That's the
6 first time we've heard that.

7 CO-CHAIR CROCKETT-JONES: This is
8 Marine policy, that Marine policy is that the
9 nurse case managers do not make appointments and
10 that -- so although -- and we did see when we were
11 at Lejeune that RCCs were the primary go-to
12 person. But there was also -- at least they did
13 seem to also have some basic understanding that
14 they had a nurse case manager and that she did
15 stuff for them even if they weren't relying on
16 them.

17 But at Pendleton no one seemed to
18 understand exactly what they did. And they were
19 much more even cut out of the loop in my opinion
20 the way we heard from servicemembers.

21 CO-CHAIR NATHAN: A couple of
22 questions then. Because you're correct, almost

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1 everywhere the nurse case managers are
2 celebrated not only by the command but by the
3 recovering warriors themselves, and the
4 families. And the families.

5 Did you see a gap in care or a stutter
6 in the ability to maintain continuity of care
7 without it? And the second question is did you
8 brief this out to them? And if you did what kind
9 of response did you get from them when you talked
10 about we don't see your nurse case managers being
11 really pivotal in your mix?

12 MEMBER MALEBRANCHE: I'm trying to
13 remember because this western swing is kind of
14 all together for me. But I do recall that when
15 we did brief that out they were stunned. I mean
16 it seemed like they were surprised. But I don't
17 know that I ever saw a break in the continuity.
18 Suzanne, do you remember?

19 CO-CHAIR CROCKETT-JONES: Yes, we
20 did. We saw that there were sometimes big
21 delays in folks getting their own appointments.
22 That the only function that we saw the nurse case

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1 manager have was when someone had tried
2 repeatedly, and it had to be repeatedly. It
3 couldn't be just a one-time thing. They would
4 go back to the nurse case manager and say they
5 told me it will be 6 weeks. And then the nurse
6 case manager might step in, trouble-shoot and
7 get that appointment time down to something more
8 reasonable.

9 But it seemed to me that if you have
10 the combination of service providers and clinics
11 who do not prioritize folks in transition, and
12 you have nurse case managers who don't make
13 appointments these folks are getting -- their
14 care was taking -- their appointment scheduling
15 was a big hurdle.

16 And they also complained about how
17 long it was taking them to be seen in all these
18 various clinics. So there was a connection here
19 between that service not being provided and the
20 speed of their care and the consistency with
21 which they got appointments.

22 CO-CHAIR NATHAN: You all had been

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1 there? The first time? Okay. Again, just
2 this is sort of inside baseball. About a year
3 ago Pendleton really wrestled with primary care
4 for their wounded warriors. The warrior, the
5 Wounded Warrior Regiment believed it was up to
6 the MTF to be providing primary care or sending
7 primary care providers to the regiment for help.
8 And the MTF believed no, this is a Marine Corps
9 organic unit. You should be hiring your own,
10 paying for your own primary care thing.

11 This came to really a head and we all
12 had to intervene because it was going to become
13 a public debacle at a point. And so they fixed
14 that. They ironed that out and they threw
15 people into it. The MTFs threw people into it
16 and I think calmed those waters.

17 But I wonder if that's not a residual
18 of what we're seeing is sort of the lack of
19 organization of how to make appointments and get
20 them.

21 Now, I did hear one best practice
22 which was they've got a pilot study where they're

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1 measuring what they do in their behavioral
2 health patients. They're looking at the
3 results. They're sending out to everybody on
4 the net what works and what doesn't work. And
5 so they're one of the few places that I think is
6 trying to find out, try something, see if it
7 works, get the results and then share those
8 results with everybody on the net so that you
9 change the level of practice which is something
10 that's sorely needed. So I think that's
11 goodness.

12 Any other comments about Pendleton?

13 MEMBER EVANS: So let me chime in.
14 So at our last business meeting there was a brief
15 by the Marines. And the last -- and I made a
16 comment on this brief that do you really believe
17 the Marines own transition of care. And the
18 comment was yes. And so this is all the way at
19 way above my pay grade.

20 We've had problems with Pendleton
21 and the problem is that case managers are part
22 of the team but again the RCCs, they work for the

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1 Marine Corps, they work for the regiment. And
2 that's who they turn to as the primary go-to,
3 their RCCs. And so even my own Marine
4 counterpart on the team here, we've had that
5 conversation.

6 So it's a challenge to -- you know,
7 it's -- when you go to the Army commands and you
8 hear my case manager is the go-to person and then
9 when we come back to what you've seen at Camp
10 Pendleton.

11 So we're going out there to talk
12 about the relationship and where the case
13 manager -- and the role of the case manager on
14 the team. It's a quad team. It's the case
15 manager, it's the RCC, the section leader and the
16 primary care manager.

17 And the case managers have expressed
18 some concerns at Pendleton. The 26 to 1 ratio
19 we, if you look at BUMED's instruction they are
20 well within the ratio. If you look at Navy
21 Medicine West instruction they should be 20 to
22 1. And so we've been on the phone with them to

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1 say if you have an instruction that says 20 to
2 1 for your region then you have to be 20 to 1.
3 And so they've realized that after the visit.

4 So we're going to see how we can
5 better support Pendleton in getting them to work
6 as a team. The case manager -- the Marines are
7 not going to want us to make appointments for all
8 their Marines. They want their Marines to be
9 independent as soon as they get out of the
10 hospital. They want them to have that autonomy
11 to make their appointments. So the case
12 managers, they would probably get on us, you
13 know, have a weapon before they allow us to make
14 appointments for their Marines.

15 What the case manager should be
16 doing and what we've emphasized is that you have
17 to be engaged though. And so that member should
18 know that you're a part of that team, you're the
19 case manager. So I have to go out there to
20 figure out what's the disconnect on the
21 engagement.

22 And if they're not making

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1 appointments and they're not seen as the team
2 then what are they doing. That was the first
3 time when we got the phone call that maybe the
4 ratio is having an impact on continuity of care.

5 So we're going out next week. We're
6 going to look at what's going on as far as that
7 team cohesiveness with the regiment and case
8 management. But they were shocked. They said
9 they were shocked because they felt as though
10 they were being very supportive.

11 And they meet regularly with the
12 regiment to discuss care, any issues with the
13 Marines, the gaps. So we're going to bring that
14 one to closure.

15 CO-CHAIR NATHAN: You all did focus
16 groups out there?

17 CO-CHAIR CROCKETT-JONES: Yes.

18 CO-CHAIR NATHAN: What was the
19 tenor of the focus groups? I mean, happy, sad?
20 A happy face on the paper, a sad face on the
21 paper?

22 CO-CHAIR CROCKETT-JONES: One of

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1 the things I recall from the focus groups, from
2 the servicemember focus groups was that when
3 they got a section leader who was -- when they
4 could keep a section leader for a while that
5 section leader worked really well for them. You
6 know, when they're -- but that there was some
7 turnover issues so that they felt just when they
8 were starting to get into a groove of transition
9 and comfort, trust issues handled, then they'd
10 lose people. So continuity was definitely
11 something I recall from the servicemember group.

12 The -- actually before I talk about
13 the servicemember group I don't want to forget.
14 One thing that concerned us was that their
15 medical case management all said that they had
16 no anticipation of any surge headed their way
17 with the ending of the war in Afghanistan.

18 And that is the only place that we
19 have heard folks in leadership say no, we don't
20 think it's going to be a deal. We don't
21 anticipate a surge.

22 Everyone else is thinking and

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1 planning for a bit of a hit as things finalize
2 and folks say, okay, now I've got to get
3 treatment. I've been putting it off, I've been
4 putting it off. And everywhere else we go is
5 concerned about a potential surge and they're --
6 some are planning for it. They stated flat out
7 no, no, we don't think there's going to be one.

8 And so I was a little -- I have to
9 say I was a little surprised by that. I found
10 it to be -- it was an outlier. I don't think
11 we've ever heard anyone say flat out nope, no,
12 don't see one coming.

13 I am remembering correctly, aren't
14 I?

15 MEMBER EUDY: Yes, ma'am.
16 Regarding -- and this whole approach in all
17 services for section leader, squad leader, cadre
18 members and command members. I would ask the
19 task force to look at creating a recommendation
20 for those that are in those specific positions
21 whether that's a leadership position all the way
22 down to the line NCOs.

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1 For the Army it's having a combat
2 patch on your right shoulder, giving a
3 delineation amongst your brothers and sisters
4 that I've been there and I've deployed. I've
5 seen those things.

6 I'm not saying that those that have
7 not deployed cannot provide leadership at the
8 tactical level for our troopers of all services.
9 But when you're in those wounded warrior units,
10 regardless of service, the majority of those
11 that are there have previous deployment
12 experience. Regardless of whether they're
13 there for a combat or non-combat related injury
14 I think it just sets a tone for the establishment
15 of knowing what your brothers and sisters in arms
16 are going through and will go through.

17 CO-CHAIR NATHAN: Good point.
18 Anything else?

19 MS. DAILEY: Let me do a time hack
20 here, ladies and gentlemen. We can go into your
21 break at 9:15 if you'd like but we do have a hard
22 stop at 9:30 to bring in Dr. Lockette. So we are

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1 currently at time line about 5 after, 10 after,
2 7 after. So pace yourselves, please.

3 CO-CHAIR CROCKETT-JONES: Okay. I
4 just want to say that with the stand-out from the
5 family member focus group in Pendleton was that
6 they're untouched. They don't get enough
7 contact. And it was not -- it's not the
8 uncommon. It was standard.

9 CO-CHAIR NATHAN: All right. The
10 NOSC, San Diego Reserve.

11 MEMBER DEJONG: I know we had quite
12 a bit of discussion about this. The Navy has
13 some challenges in dealing with these. And I
14 think the way that we kind of rounded it up was
15 that they sort of did it on the cheap. But their
16 population is very low compared to the Army. So
17 there were some definitely struggles and some
18 definite challenges.

19 I've often wondered personally
20 about the east and the west model and how that
21 best works for reservists. We did get some
22 feedback from them that a lot of them just, they

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1 want to go home. They want to get care in their
2 home community, whether that's VA or whether
3 that's civilian side, they just, they want to go
4 home.

5 Other struggles that they have is
6 providing basic needs to the servicemembers that
7 are recovering. ADA-compliant housing.
8 Travel arrangements for them, getting back and
9 forth from their barracks to whether it's the
10 chow hall, the dining facility, whatever they
11 call it to their place of duty for the day and
12 appointments.

13 They provide transportation to
14 appointments but because of logistical, or
15 because of liabilities they do not provide
16 transportation from housing to anywhere else.
17 So they are required to -- and none of them really
18 have a car unless they bought it on their own.
19 They're required to get themselves from the
20 dining facility home and from home to their place
21 of duty to make it to their appointments on their
22 own.

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1 And whether that's on a crutch,
2 whether that's on wheelchairs, whether that's on
3 -- however they have to do it, a lot of times it's
4 a half mile or more on crutches.

5 That also is the case within the
6 non-ADA compliance of the housing. There's
7 people trying -- they don't have any facilities
8 for them to shower properly or a person can't get
9 wet. So there's some struggles there.

10 But there's also trying to provide
11 how much care -- not, I don't know how to put it
12 in words but their population is very small. So
13 they need to put more forward and more emphasis
14 on it, but they're also dealing with a very small
15 population versus the Army which through --
16 which jumped into it headlong.

17 MEMBER EUDY: Sergeant Major, to
18 follow up on your comment. We had discussed
19 this while we were there. One way I think it
20 could be recommendation-wise is as the Army has
21 done with those soldiers that are in the IDES
22 population, opening up SFAC services. If some

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1 of the same counter services of Safe Harbor were
2 available for those servicemembers at the med
3 hold east and west because the majority of them
4 will end up going through the IDES process. And
5 for some of them it is an extended period of time
6 so they're not finding these resources out on
7 their own and they're dependent on a yeoman or
8 a med NCO or a med chief to facilitate these
9 questions when that individual isn't trained to
10 the level that the folks at Safe Harbor are.

11 MEMBER MALEBRANCHE: I think one of
12 the things too, that these were all the Navy med
13 hold folks, but being closer to home for some of
14 them like Sergeant Major had mentioned, it might
15 not be in another Navy facility. Maybe they
16 could go to San Antonio and be closer to home and
17 get the care and what they needed in a larger
18 group as opposed to the small group.

19 And I think the ADA-compliance thing
20 was really concerning because there were stairs,
21 there are like three flights of stairs. And for
22 some people that's just not possible for them.

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1 I mean they obviously did it. And then I think
2 having one of them be a driver.

3 And they were I think cognizant
4 enough to know that they couldn't drive if they
5 were on medication so they would personally try
6 to help out their fellow sailors.

7 But they all really still want --
8 they wanted -- I think you run brought it up.
9 They really wanted to be sailors. They really
10 wanted to stay in and work hard and that was a
11 really heartening sort of thing. But they were
12 helping out each other and not getting help from
13 the outside in which is where you would think
14 that that would come from. So I thought that
15 made kind of an impact too.

16 And then in their choice of
17 providers they've got one of the largest Navy med
18 centers there but in their choice of providers
19 didn't seem to have a lot of will. Or they had
20 the will but they weren't able to change their
21 providers when they thought it was necessary.

22 MEMBER DRACH: The -- TRICARE came

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1 up as being very confusing to the reservist in
2 terms of when it kicks in and when it kicks out.

3 But also another issue that I
4 haven't heard before too much in site visits is
5 transportation was an issue both at Pendleton
6 and at the Navy.

7 For example, from Pendleton if they
8 needed to go to Balboa for medical care they had
9 to take the bus whenever the bus was available.
10 So they may have an 11 a.m. appointment, have to
11 take the bus at 7 a.m. and be there all day unless
12 they could bum a ride from somebody else.

13 And the same was true at the Reserve
14 unit. If they had to go over to Balboa there was
15 not a lot of flexibility in terms of
16 transportation unless they could get
17 transportation on their own.

18 And one of the concerns that the
19 senior reservist brought up was being so far away
20 from their families. There was only, I think
21 there was about 13 in the focus group and I think
22 only one had his family members with him in San

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1 Diego. And several of them had commented about
2 they'd like to be transferred back closer to
3 home. And that wasn't happening.

4 CO-CHAIR NATHAN: Yes, I think to
5 sum it up the two bright spots there were (a) it's
6 San Diego and (b) it's next to, or their care is
7 being at a world-class medical facility.

8 But other than that I saw a fairly
9 -- a group that probably arrived kind of unhappy
10 and got unhappier as they were there. They
11 either had good jobs and this was intersecting
12 with their family and their job, or they didn't
13 have a job and they were going there hoping to
14 maybe make something out of that. And they end
15 up in a barracks on a base with base
16 transportation. No personal transportation
17 provided. And feeling as though they're sort of
18 just in this Groundhog Day interrupted
19 occasionally by a visit at the hospital for their
20 care which they thought was good.

21 But again, I think it was -- I think
22 the Navy looks at this -- I'm not speaking on

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1 behalf of the Navy in my capacity now, but I think
2 they look at this as we have a very small group
3 of people.

4 We're trying to use the facilities
5 as they exist to try to house them. They're not
6 sick enough, or ill enough, or injured enough to
7 be in the med holding unit at the hospital so
8 we're going to partition them in an outpatient
9 basis at a Navy base. We're going to use
10 existing Navy resources and we're going to put
11 them sort of on the base economy system which is
12 substandard to some extent. For some of their
13 injuries and some of their issues.

14 And I think the one thing they can
15 do there that's been brought up before is they
16 can really look among the interagency and the
17 interservice and see who can be cared for closer
18 to home.

19 Because I think some of these folks
20 get excited about going to San Diego thinking
21 I'll be there a few months. How bad can it be.
22 I'll be in a beautiful garden spot of the

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1 country. And then after 6 to 9 months I've
2 peaked on the fun meter. I want to be back with
3 my family or whatever. So I really think the one
4 thing they can do there.

5 So I think the staff was engaged but
6 has been handed a difficult assignment. And we
7 saw a couple of bright spots in there, the chief
8 and some other people who they really thought
9 very highly of.

10 But overall they were pretty
11 disenchanted with the staff, the patients were.
12 The focus group said they don't care about us,
13 they're not interested in hearing our issues.

14 And I think the one thing they don't
15 do well there and I think this is a recurrent
16 theme for our other places is they don't bring
17 people in when they first get there and manage
18 their expectations. They don't bring them in
19 and say here's who you go to for this. Be
20 prepared for some frustrations in this. They
21 just assume that they're available to talk to.

22 CO-CHAIR CROCKETT-JONES: Can I ask

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1 a question? What was the average length of stay
2 for those folks?

3 CO-CHAIR NATHAN: I thought it was
4 about 6 months to a year.

5 CO-CHAIR CROCKETT-JONES: I just
6 think that if you ask the average person if you
7 became ill or injured and you were going to spend
8 6 months to a year recovering would you consider
9 that a serious injury they'd say 6 months to a
10 year? Yes, that's got to be bad.

11 And I think -- I think that there's
12 a disconnect to say they just aren't -- they
13 aren't that serious. And I know that they
14 aren't as critical as other folks.

15 But I'm thinking there is a serious
16 disconnect for people outside of medical
17 expertise and even anyone who -- I think there
18 is a serious disconnect to say we're going to
19 keep you here for 6 months to a year but you're
20 not that serious. You're not serious enough to
21 warrant extra resources. I think that that is
22 a serious conflict of purpose.

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1 CO-CHAIR NATHAN: But Suzanne, I
2 think that it's not just medically driven, it's
3 administratively driven. In other words unlike
4 somebody who works in a private sector and gets
5 hurt these folks are being evaluated for whether
6 they can return to duty or not. And so what
7 happens is they may have an orthopedic injury
8 that is borderline. Maybe they can get it to the
9 point of returning to duty, maybe they can't.

10 Part of our problem is -- and I agree
11 with you. I think it's a failed concept where
12 we say we're going to move you from your home
13 across the country and because of administrative
14 reasons we're going to house you as an outpatient
15 while we work through 6 to 9 months your leg
16 injury or perhaps your TBI or your PTS and decide
17 in 6 to 9 months whether you're able to return
18 to duty because you want to. Or we're going to
19 put you in the LOD system and we're going to get
20 you in the IDES system and we're going to give
21 you a medical disability and/or a medical
22 retirement.

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1 So I think a lot of the reasons for
2 the military people to spin their wheels for so
3 long is we're sitting there trying to decide if
4 we can get them back in or back out. The
5 byproduct of that is we leave these folks in a
6 sort of isolated environment without a lot of
7 creature comforts and accoutrements.

8 And I don't know that we can afford
9 them anyway. I don't know that the military or
10 the DoD can afford to give these people rental
11 cars. I don't know what they can afford to do.
12 So knowing all that, should we be moving them
13 this isolated in the first place? Or should we
14 find something else?

15 And so then if we say let's relegate
16 you to the private sector and let the private
17 sector look at your leg how do we then determine
18 if they are ready for duty or not if this is not
19 a military person. So we've got ourselves in
20 this sort of do-loop.

21 I think the biggest problem is we
22 just compartmentalize these folks away from

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1 their families and away from their support
2 systems. And then we tell them it's going to
3 take a while.

4 And then after 6 to 9 months we
5 decide you know what? You're not fit to return
6 to duty. We've tried everything we can. So now
7 we're going to put you in the IDES system. And
8 here goes another year in the IDES system.

9 Now at that point in my opinion there
10 should be no reason we don't have -- there's no
11 reason we can't send folks back to where they are
12 and work through the IDES system there. But the
13 IDES system was predicated on the fact that we're
14 going to keep you in one spot so we can do this
15 Integrated Disability Evaluation System using
16 the VA and one-stop shopping so it won't take so
17 long. So every corner we turn down it's
18 something else that sort of keeps the member away
19 from their family and under our auspices.

20 And again, we saw some people in all these
21 places which were just singing the praises of the
22 place and felt that it basically saved their life

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1 or gave them a new lease on life. But the
2 overarching sentiment was just not happy when I
3 got here and they haven't done anything to make
4 me any happier. And so I think that the
5 concept that's been mentioned that I really
6 believe is a good one is how do we get these
7 people back in the process closer to home.

8 Let's move on to Lewis-McChord
9 because that's a big place. We should talk
10 about that.

11 MEMBER MALEBRANCHE: I thought one
12 of the highlights of Lewis-McChord that stuck
13 out to me was how they had the behavioral health
14 social workers embedded in that WTB. And it
15 seemed like they were -- when we did the focus
16 groups they were well known, felt comfortable.
17 It seemed like family members and the
18 servicemembers felt like going to them. And I
19 thought that was a major thing.

20 I guess the one thing that this place
21 and others though, some places more than others
22 is the orientation. And I think you mentioned

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1 that of who does what. Like what is an RCC, what
2 is a nurse case manager. What is a behavioral
3 health -- is that the person to go to. It seemed
4 to be the person to go to because they were the
5 most involved. But I do think, I was surprised
6 at that model working so well and that they
7 seemed to be major engaged.

8 CO-CHAIR CROCKETT-JONES: I think
9 we should mention that in the -- they had an issue
10 with returns from CBWTUs. And just like Mr.
11 Rehbein had told us earlier that their feeling
12 was that folks, that it was very difficult for
13 everyone involved when they would send someone
14 to the CBWTU and get them back because it turned
15 out their medical or their family support
16 situation was not what it had seemed when they
17 left. They complained about a hiccup just in
18 that same way but from the other side saying that
19 getting those folks back in required a lot of
20 administrative work and it made for a very
21 unhappy transition. Everybody was
22 uncomfortable with that situation. So it noted

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1 also at Fort Lewis.

2 MEMBER EUDY: Two key things I
3 wanted to bring up. One being Guard members
4 becoming cadre members. It was expressed by
5 multiple briefs. The lack of time available on
6 station in the training process where they would
7 then report to duty as a now active Guardsman,
8 then be sent off to the cadre training course and
9 then return and their time left in order to be
10 a working cadre member was diminished. So they
11 talked about if they were to TDY them prior and
12 then be able to use them for the full duty time
13 allotted.

14 And then the second was for
15 servicemembers, again Guard and Reserve going
16 through the IDES process and falling off of
17 orders the comment was made by the battalion
18 surgeon regarding orders linked in the medical
19 readiness decision point. Establishing a set
20 duration of when you come off of the demob.

21 If you're going to need an extended
22 plan of care regardless of which physician is

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1 providing that, that you go on a minimum day's
2 worth of orders. And I think we need to look on
3 that as a task force to establish that so we don't
4 run into all the issues that come with falling
5 off of orders.

6 CO-CHAIR NATHAN: Now as I joined up
7 with you all just after that trip one of the
8 sentiments I also heard from you was you were
9 concerned about how one hand didn't know what the
10 other was doing, that various components there
11 -- it was a large group. So in fairness to the
12 staff there they've got a very large group to
13 handle.

14 But you were concerned about there
15 wasn't connectivity between the various
16 factions. Can you amplify that a little bit?

17 MEMBER MALEBRANCHE: Well, I think
18 part of this was they had just all moved into this
19 large, new facility. And they had not yet
20 coalesced in a lot of areas because it was still
21 new and there wasn't like a lot of signage even
22 where people were and they were still waiting for

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1 some physicians. I think that was part of it.
2 So they had not all worked together. The groups
3 that were in the past still did. So to even know
4 that oh yes, I think they're down there but we
5 just got here. So I think that was a huge part
6 of it. But then too it was such a
7 large group that you wonder now in the future
8 what that's going to mean. Is it going to stay
9 this way or will they start doing some of that.
10 So I think the same groups that worked well
11 together before are probably going to continue.
12 But you need to -- we don't know how the other
13 pieces might.

14 MEMBER DEJONG: They have a large
15 population of behavioral health there. I can't
16 remember the exact percentage but it was over --
17 well over 50 percent of their population's
18 behavioral health. So it seems to be almost
19 their focus of care there.

20 But there was some discussion
21 against the members of because their population
22 is so high, it's the largest WTB that's within

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1 the nation, and their population of behavioral
2 health is so high, you know, we're looking at the
3 resources and the availability of what they have
4 there and making sure that they can properly
5 commit to that large of a group of behavioral
6 health. So not exactly sure why it fell in like
7 that but that seems to be their population.

8 CO-CHAIR CROCKETT-JONES: Two
9 things that I want to remember from the trip.
10 The nurse case managers seemed to -- one of the
11 first things when their ratios got a little high.
12 The first thing that their participation in CTP
13 fell off, that this was time-consuming for them
14 and it sort of felt that other people had a handle
15 on it. That it would survive without them. So
16 that one, when they were pressed for time CTP
17 went to the wayside. So it didn't function for
18 the nurse case management as a very central
19 significant document.

20 And the other thing, I might sound
21 like a broken record, but family members felt
22 largely uninformed and leadership always

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1 convinced that they were reaching all the family
2 members. This is almost universal.
3 Everywhere we've gone leadership is pretty
4 certain that they have great contact with family
5 members and family members that we talk to feel
6 largely uncontacted.

7 MEMBER MALEBRANCHE: I did feel
8 when we briefed that at the out-brief that they
9 were going to take that on and start describing
10 the roles of each of the folks. Because the
11 families nor the servicemembers were exactly
12 sure who was responsible for what. And that
13 seemed to be something that they were very
14 interested in doing. So I think they're going
15 to take that on, I'm hoping.

16 CO-CHAIR NATHAN: That's a great
17 point. If you could predict almost one thing
18 you could do ahead of time at any of these visits
19 it would be to tell the command you don't have
20 the connectivity with the families that you
21 think you do. And because most of them are all
22 shocked at the end.

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1 When they hear the family focus
2 groups are saying nobody cares about me, or
3 nobody contacts me, or nobody lets me know what's
4 going on they're stunned. And a lot of times I
5 believe it's because they're relying too heavily
6 upon the active duty member, upon the warrior
7 themselves to be the conduit to the family. And
8 they underestimate, or overestimate actually
9 that the warrior is connecting with the family.
10 And the warrior is petitioning the family.

11 So the family is ticked off at the
12 command and they're ticked off at the warrior.
13 And they're expecting the command to come
14 around. So that's really an overarching theme
15 that I think is a lesson learned that has to be
16 given to anybody who gets in this business.

17 In the interest of time we'll table
18 Elmendorf for right now and maybe come back to
19 it later today or find some time in the morning.
20 Let's take 10 minutes and we'll make it up. I
21 guarantee you, Denise, we'll make it up as the
22 day goes on.

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1 (Whereupon, the foregoing matter
2 went off the record at 9:29 a.m. and went back
3 on the record at 9:38 a.m.)

4 CO-CHAIR CROCKETT-JONES: We now
5 welcome Dr. Warren Lockette, the Deputy
6 Assistant Secretary of Defense for Clinical and
7 Program Policy. Dr. Lockette also serves as the
8 chairman of the Centers of Excellence Oversight
9 Board. He will be briefing us on the board's
10 overall mission and its current perspective on
11 health-related centers of excellence. His
12 information can be found under Tab C of your
13 briefing books. Now I'm going to turn it over
14 to you.

15 DR. LOCKETTE: All right. Well,
16 first of all, I'd like to express my appreciation
17 to speak to you. I've not spoken to this
18 committee before so I'm not sure of the rules and
19 regulations. If there are questions you have
20 for me please let me know. I'm sure you will but
21 give some kind of signal.

22 So, I'm an academic so I'm used to

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1 talking and giving conferences as opposed to a
2 forum such as this. So please forgive me if I
3 have any faux pas here.

4 Well, it was interesting. One of
5 the first things that happened when I came to
6 Health Affairs was that the deputy assistant
7 secretary for force health protections sent out
8 a message saying that we have centers of
9 excellence that we really kind of need to get a
10 hand on.

11 And so what I'm not sure if the
12 committee recognizes is that I've been appointed
13 the chair of the Centers of Excellence Oversight
14 Board. But within the Military Health System
15 there are a number of centers of excellence, not
16 just those that have been mandated by Congress.

17 So the Centers of Excellence
18 Oversight Board has actually been reviewing a
19 number of programs and I think to have a
20 discussion about how the centers of excellence
21 or the CoEs function there also needs to be a
22 perspective of what these centers of excellence

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1 do.

2 So the questions from the task force
3 are listed here. You know these. And over the
4 course of my talk I will highlight the question
5 to make sure that I answer each specific question
6 that you have given.

7 I also want to give some additional
8 background information that might explain some
9 of the struggles and difficulties we've had in
10 laying a way ahead for the centers of excellence.

11 So, within the federal milieu if you
12 were to talk to people about centers of
13 excellence there is not a common understanding
14 as to what they are. So for example, if you go
15 to the National Institutes of Health they will
16 tell you as a federal agency they manage centers
17 of excellence. And they have very specific
18 centers of excellence that have been
19 congressionally mandated much in the way that
20 DoD has. But their primary purpose is research.

21 So these are the centers of
22 excellence that have been established by

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1 statutory mandate for the National Institutes of
2 Health. So when you come to DoD depending upon
3 to whom you are speaking a center of excellence,
4 a person may have a predisposed mind-set that the
5 program is primarily the management of a
6 research portfolio.

7 However, if you go to a non-profit
8 public service organization such as the Joint
9 Commission for the Accreditation of Hospitals
10 and all of our MTFs get this kind of
11 accreditation to operate, when they come into
12 our institutions, into our MTFs, they have a
13 different perspective as to what a center of
14 excellence is. They focus their centers of
15 excellence strictly on clinical care and give
16 these recommendations that the medical
17 treatment facilities or the hospitals establish
18 centers of excellence surrounding a particular
19 disease process.

20 So you already have two. You have
21 a research center of excellence focus, you have
22 a clinical disease center of excellence. And

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1 the reasons why these centers are engendered by
2 each of these parent organizations is given
3 here, either to improve the clinical quality of
4 care or to improve the research.

5 But then if you go to someone in the
6 private sector and ask them what is center of
7 excellence you get a varied response. And they
8 will tell you that, for example, this sample that
9 I cite says that there are two criteria in which
10 they judge a center of excellence. One is the
11 quality of care but the second center of
12 excellence criteria for this organization is the
13 cost effectiveness of the clinical care that's
14 provided. So it also becomes a marketing tool
15 because you can identify a particular hospital
16 or organization as having a center of excellence
17 and you can encourage your patients towards
18 those centers with the implicit understanding
19 that they will receive better care and more
20 cost-effective care.

21 So as an empirical scientist having
22 viewed these types of centers of excellence the

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1 first question that we had or we should ask is
2 when we're told to establish a center of
3 excellence or when someone requests the
4 designation of center of excellence is it
5 helpful to be a center of excellence.

6 Well, one of the oldest designations
7 for centers of excellence are those that come
8 from the National Cancer Institute. And
9 throughout the country there are a number of
10 National Cancer Institute-designated centers of
11 excellence for cancer research and care.

12 So I had a question. Okay, we have
13 all these centers of excellence. We're an
14 oversight board. We're going to be looking at
15 the effectiveness of our centers of excellence.
16 What do we find out about how other people do it.

17 Well, it's interesting. If you
18 look at -- this paper was published in Cancer in
19 2005. If you look at the care that you get when
20 you go to a cancer center of excellence you can
21 show better surgical morbidity for operative
22 procedures that you've had related to cancer.

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1 But what's interesting is if you
2 look at the same cohort of patients the outcome,
3 the overall cancer morbidity and mortality is
4 not improved. So do we say that these centers
5 of excellence have been effective?

6 Let me cite a more recent example.
7 The Centers for Medicare and Medicaid Services,
8 CMS, said in I think about 2006 that if you're
9 going to perform bariatric surgery for weight
10 loss you will only be reimbursed from the federal
11 government if that surgery is done at a center
12 of excellence that meet particular clinical
13 guidelines. And those clinical guidelines for
14 example would be volume of cases performed
15 because it's generally understood the more you
16 do a surgical procedure the more likely you are
17 to have a better outcome.

18 In this paper that was published in
19 the Journal of the American Medical Association
20 just a couple of weeks ago it turns out that your
21 outcome does not appear to be any better if you
22 have your surgery done at a hospital that has

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1 been designated as a center of excellence as
2 opposed to one that has not been.

3 So despite this longstanding
4 history of designating centers of excellence
5 it's often been overlooked that there's no
6 common agreement as to what constitutes a center
7 of excellence. And among all of these agencies
8 and organizations involved it's not always been
9 demonstrated that if you have a center of
10 excellence you have a better clinical outcome.

11 So, with this kind of understanding
12 the Center of Excellence Oversight Board went to
13 look at what we were doing within the Military
14 Health System because we had several centers of
15 excellence.

16 And rather than dictate to those
17 entities that considered themselves centers of
18 excellence we asked them what is it you think is
19 the advantage of being a center of excellence.

20 And I just want to spend some time
21 on this slide because this shows the difference
22 between centers of excellence within the

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1 Military Health System and that which is
2 happening in the rest of the country.

3 Unlike the civilian community where
4 centers of excellence tend to take a very focused
5 rationale or raison d'etre, within the Military
6 Health System depending upon the centers of
7 excellence that we queried the goals for those
8 centers of excellence were completely
9 widespread.

10 Some say the centers of excellence
11 should have a role at determining best practices
12 in clinical guidelines. Others say that the
13 centers of excellence really is just about
14 coordinating shared services and preventing
15 duplication of effort and reducing cost.

16 There's some individuals who
17 believe a center of excellence should be like the
18 NIH model where there's a focus on research or
19 translating relationship into the clinical
20 arena.

21 Sometimes we have a center of
22 excellence that was driven primarily by

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1 congressional interest. But it's not always
2 clear what the need or the specific need that was
3 driving the congressional interest that
4 resulted in statutory language.

5 So after finding out that we had
6 several centers of excellence in addition to
7 those which were congressionally mandated the
8 ASD for Health Affairs established a Centers of
9 Excellence Oversight Board with this mission
10 detailed.

11 And so we've been struggling with
12 this because one of our primary functions is to
13 establish and maintain the operational
14 definition of what a center of excellence is.
15 But we really don't have a
16 one-definition-fits-all as you'll see
17 subsequently.

18 But I think the most important role
19 that we have is to ensure that the centers of
20 excellence are a value proposition, that they're
21 meeting a definitive operational requirement,
22 that it is improving the healthcare of the

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1 servicemember, and that it's helping that these
2 services be done in a cost-effective manner.

3 So we asked the centers of
4 excellence to provide us with a CONOPS, with a
5 concept of operation. How is it by having your
6 organization chartered you will be able to
7 deliver on this mission?

8 One of the things that I've been
9 particularly concerned about is duplication of
10 services and overlap. I'm not just talking
11 about sequestration or continuing resolutions.

12 To me, I think we should always
13 operate as if we're in a cost-constrained
14 environment. And if there's an opportunity to
15 prevent duplication of services or to stop
16 services that don't really provide value to our
17 beneficiaries then we should not keep those
18 centers going.

19 We also asked the services to let us
20 know whether they think there is a particular
21 unmet need that would benefit from having a
22 critical mass that leads to a center of

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1 excellence.

2 Then I'll talk about some of the
3 other activities we have such as reviewing the
4 leadership of the centers of excellence through
5 the services' executive agents and the unknowns
6 that are coming in the future as we move to a new
7 health agency.

8 CO-CHAIR NATHAN: Warren, can I ask
9 a question?

10 DR. LOCKETTE: Sure.

11 CO-CHAIR NATHAN: Thank you for the
12 background on the diverse perspectives on CoEs.
13 If you had to imagine what do you think this
14 group, the Recovering Warrior Task Force, thinks
15 about when they think CoE?

16 DR. LOCKETTE: Well, I'm not sure.
17 I would think primarily it would be the
18 congressionally mandated centers of excellence
19 because those resulted from particular concerns
20 of the wounded warriors. So I will comment upon
21 that but I want to make sure that in terms of the
22 Centers of Excellence Oversight Board that we

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1 understand the full activity of what's been
2 occupying our time as you'll see in the next
3 couple of slides.

4 So, what is the process? So again,
5 for the congressionally mandated centers of
6 excellence they're established. The ASD for
7 Health Affairs identifies a service lead for
8 each of the congressionally mandated centers of
9 excellence who is then really responsible for
10 the oversight of that organization.

11 And I think one of the most
12 challenging things then for that executive agent
13 is to make sure that things it does is does with
14 service concordance. So a particular service
15 may be the lead agent for a center of oversight
16 but it really has to do it in concordance with
17 the other services.

18 And then once that charter has been
19 established through that center of excellence's
20 internal workings and has the approval of the
21 executive agent it comes to the Centers of
22 Excellence Oversight Board where we want to make

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1 sure that there was the appropriate service
2 buy-in from each of the services for the centers.

3 And then what we do is an annual
4 review of the centers of excellence which we have
5 not done as yet. We have reported on their
6 progress but we really haven't looked at their
7 cost effectiveness because none of the
8 congressionally mandated centers of excellence
9 are at full operating capacity yet. And they're
10 still struggling to tell us what those metrics
11 of effectiveness should be.

12 And again, this is the focus today
13 but I do want the Oversight Board to understand
14 that. And I think it's important for the public
15 to know that if there are other areas, and
16 particularly among wounded warrior care, that
17 are not receiving attention that can be brought
18 to the Center Oversight Board for discussion
19 with the services, for discussion of
20 establishing a center that has the critical mass
21 to take on the responsibilities for whatever
22 that particular question is.

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1 You know, it's kind of like
2 Clausewitz and friction of war. You really
3 don't know what your problems are going to be
4 until you're in the midst of them. So there is
5 the option there that if there are other
6 particular issues associated with the wounded
7 warrior that is addressed -- all those factors
8 that I mentioned previously that could be
9 addressed by a center of excellence, there's the
10 option for that to come forward.

11 The Oversight Board is
12 multicultural. These are the representations.
13 I serve as the ex officio -- or as the chair. And
14 the executive agent for our largest, the DCoE,
15 as the commander of MRMC who is ex officio for
16 the center of excellence.

17 So, we've been busy because we've
18 reviewed all of the CONOPS and the activities of
19 each of the centers. We haven't been able to
20 determine the cost effectiveness of these
21 centers.

22 I talked about all of these

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1 different centers of excellence. Again, the
2 CONOPS, the board has approved. They're off and
3 running. They tell us they'll be in full
4 operational capacity by 2013. But to let you
5 know as you can see that we've got the
6 congressionally mandated centers of excellence
7 and then we have others that came from within the
8 community.

9 So an example of one where the center
10 is pending approval is we found the United States
11 Air Force has a medical modeling and simulation.
12 They considered themselves a center of
13 excellence. There are members of this group
14 that also belong to what's known as a consortium
15 for medical modeling and simulation. There
16 appears to be some overlap, duplication of
17 effort. And we're trying to adjudicate that
18 process to make sure that we don't have multiple
19 centers of excellence all doing the same kind of
20 activity.

21 And then there are some centers that
22 say, you know, we really don't want to be

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1 MHS-wide, Military Health System-wide. Let us
2 rethink about our desire to be a center of
3excellence.

4 I think you're familiar with the
5 Defense Center of Excellence. It actually --
6 for psychological health and traumatic brain
7 injury. It actually incorporated a number of
8 centers of excellence that were already
9 standing.

10 So I think you've seen this
11 information at your previous session where each
12 of the centers of excellence talked about their
13 budgets, what their activities were, what their
14 operational capacity was and when the centers
15 themselves plan to be fully incorporated and at
16 work.

17 So what mechanisms exist to
18 systematically translate the results from
19 centers of excellence into policy? Well, there
20 is some duplication. One of the things that the
21 centers of excellence do is come up with clinical
22 practice guidelines, for example, in behavioral

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1 health.

2 However, there's also a Health
3 Executive Council between the DoD and the VA that
4 has a working group to establish clinical
5 practice guidelines. So we ask the centers of
6 excellence to ensure that these are not working
7 groups that have duplication of effort.

8 Now, it has never been intended that
9 the Centers of Excellence Oversight Board would
10 be making policy as a result of the output from
11 the centers of excellence. If there is a policy
12 since it must be coordinated among the services
13 what we ask is that these centers bring to the
14 Clinical Proponency Steering Committee which is
15 a meeting of all the deputy surgeon generals for
16 discussion as to whether there should be a
17 particular program or policy -- excuse me, a
18 particular policy that should be put forth for
19 the ASD of Health Affairs office to engender.

20 So this is the primary mechanism by
21 which --

22 CO-CHAIR NATHAN: Warren, have you

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1 seen any examples of that?

2 DR. LOCKETTE: Pardon me?

3 CO-CHAIR NATHAN: Have you seen any
4 examples of that?

5 DR. LOCKETTE: Yes, I have. So one
6 example would be a policy we had on the use of
7 atypical antipsychotics. There was concern
8 that atypical antipsychotics like Seroquel were
9 being used in the Central Command as a sleeper,
10 you know, as a sleeping medicine. And so this
11 clearly was not good clinical medicine. There
12 was an opportunity to improve.

13 So working with the personnel from
14 the Defense Center of Excellence the ASD for
15 Health Affairs came up with a policy for the use
16 of atypical antipsychotics in deployed
17 servicemembers in CENTCOM. Okay.

18 Another question was, again, Matt,
19 I apologize. I'm going to slightly deviate
20 because this is something very close to my heart.

21 It says how important does the
22 Oversight Board believe dedicated research

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1 funding is for centers of excellence? Well, the
2 question was too inexact for me to answer.

3 There's a difference between the center of
4 excellence conducting the research and the
5 center of excellence overseeing the funding of
6 research. And I'll give an example.

7 DCoE doesn't do research but it
8 oversees research in combination with those that
9 manage the research portfolio in Health Affairs
10 with Terry Rauch. So I think there's no
11 question that there should be -- there has to be
12 dedicated research funding for the topics that
13 are dealt with by the centers of excellence but
14 how those funds flow is a separate discussion.

15 And I just, you know, put this in
16 because the research is always fair game and
17 anytime there is significant concerns about DoD
18 budget. And this is a mystery. These are six
19 papers that were published in the scientific
20 literature.

21 And are you old enough to remember
22 Senator Proxmire from Wisconsin? He used to

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1 publish the Golden Fleece Award. And I can't
2 take credit for this but there was a wonderful
3 scientist, Julius Comroe, who wrote a mystery
4 and asked what did these six titles have in
5 common.

6 And the most common response was
7 that these were nominations for research funding
8 that received Senator Proxmire's Golden Fleece
9 Award as having no utility to the taxpayer. And
10 it turns out what these six papers had in common
11 was they were the first publications of a Nobel
12 laureate or member of the Institute of Medicine.

13 My point in telling this is I think
14 that the research that the centers of excellence
15 have not just immediate payoff but they will also
16 have payoffs that may not be immediately
17 apparent.

18 So the answer is yes, I would be
19 willing to debate that with anyone but I won't
20 dwell on it. I don't think I can be more
21 effective than just saying yes.

22 Finally, what have we seen at the

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1 Oversight Board's view in terms of impediments
2 to the effectiveness of the centers of
3 excellence? In other words, when we review the
4 annual reports from the congressionally
5 mandated centers of excellence things that will
6 come up will be limitations as to why they
7 reached a certain level of effectiveness but
8 could not go further. So these are things that
9 we're hoping the centers of excellence can work
10 through.

11 For example, a common institutional
12 review board. If you want to do a study on
13 behavioral health that is overseen by Defense
14 centers of excellence for behavioral health and
15 TBI each institution participating in that
16 research has to have an IRB empaneled to review
17 that research.

18 Now, we've seen the way ahead. The
19 infectious disease community has been able to
20 have a common IRB. But the role -- I mean if you
21 follow institutional review board for the use of
22 human subjects in research or animals in

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1 research, if you follow -- right now they're
2 trying to rewrite the common rule that guides
3 institutional review boards and there still is
4 not agreement as to what that new common rule
5 should look like. So I think that would
6 facilitate if the centers of excellence were
7 able to be empowered to designate common IRBs.

8 The next two items, they're so
9 obvious to me but I'll state them because they're
10 probably the greatest concerns. And that has to
11 do with resources. Because we work on an annual
12 appropriations with the exception of research
13 which allows a 2-year funding cycle it's very
14 difficult for the centers to do the kinds of
15 studies and develop the kinds of programs they
16 need to do because it has to be done in the year
17 in which -- the funds have to be executed in the
18 years in which they were appropriated. With
19 research you've got an extra year. But for the
20 most part that limits.

21 We have not seen that the centers of
22 excellence have uniformly been protected from

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1 sequestration or reductions in budget to
2 particular programs within the DHP, within the
3 Defense Health Programs. So I think human
4 resources is probably the greatest challenge.

5 Again, the centers of excellence for
6 -- congressionally centers of excellence that
7 you're most concerned about will tell you that
8 the primary reason that they have not reached
9 full operating capacity is because of human
10 resource issues.

11 The centers of excellence are meant
12 to be a shared service among the services. So
13 there needs to be agreement among the services
14 as to how these programs are approached.
15 Sometimes to be frank that's difficult.

16 I'll give an example. When again
17 the Air Force has had a longstanding modeling and
18 simulation but the other services have not
19 necessarily been in agreement with how the
20 center of excellence for modeling should be done
21 or what exactly the role for that centers of
22 excellence should be in terms of the acquisition

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1 of goods and services with the theory being that
2 if the services are able to pool their purchases
3 that there would be a reduction in cost. But yet
4 the individual services would like to maintain
5 some autonomy.

6 The other problem with the centers
7 of excellence that we have in the Military Health
8 System that is a little bit different than the
9 civilian world is that we have a dispersion of
10 our beneficiaries. So what you'll find is you
11 might have a center of excellence for vision or
12 eye but our patients are scattered throughout
13 the United States.

14 We find this particularly true, for
15 example, with the cancer center of excellence.
16 You can get great cancer care at Walter Reed.
17 They have established a center of excellence.
18 But does that mean that if we have a patient who
19 is a reservist on active duty who is in Missouri
20 or Oklahoma and has to have cancer care therapy
21 we could bring them to an MHS center of
22 excellence. But because of where they're

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1 geographically located we may lose that
2 individual. And so there's some difficulty in
3 trying to overcome the problem of dispersion of
4 the critical mass.

5 I think one of the most important
6 things that the four congressionally mandated
7 centers of excellence does or should be doing is
8 moving the basic science research into clinical
9 outcomes. And this process is known as
10 translational research.

11 That's a little bit more difficult
12 for an MHS center of excellence as opposed to say
13 a university center of excellence because there
14 is a relatively clear demarcation between the
15 basic scientist and the clinical scientist.

16 And this just isn't a separation
17 that has been done in terms of the people
18 involved in these programs but also between the
19 capacity of the services to accept at a more --
20 at the center of excellence level funding.

21 You know, we talk about DHP
22 programs, Defense Health Programs being Program

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1 6 dollars. Some of the basic science research
2 and clinical research that we do is covered with
3 what are known as Program 6 dollars, and some of
4 the centers of excellence have had difficulty in
5 accepting Program 6 dollars to support Program
6 6 kinds of activities that they do.

7 And a classic example of that is in
8 our clinical investigation programs. The
9 clinical investigation programs, we have the
10 unique ability at our MTFs because of our patient
11 cohort. So the clinical investigation programs
12 within the DoD exist as a requirement to support
13 graduate medical education.

14 So sometimes the argument we get is,
15 well, if graduate medical education training is
16 the reason we're conducting research at the MTFs
17 what business do you have accepting basic
18 science dollars.

19 Now, my response has been that if a
20 graduate medical trainee is also engaged in
21 basic science research that their ability to
22 think analytically and empirically is enhanced

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1 and actually makes them a better clinician.

2 The other things that hinder the
3 effectiveness of the output of the centers of
4 excellence is simply the commercial enterprise.
5 I mean, one of the strongest concerns I have is
6 in behavioral health. Some of the things that
7 I would like to see the behavioral health center
8 of excellence do is come to an agreement on a
9 measure of effectiveness for the beneficiaries
10 they see.

11 I'm an endocrinologist. I take
12 care of diabetes. I can look at my patients'
13 medical records and see whether their blood
14 sugars are in better control after having seen
15 me. I don't know if you can say the same thing
16 about a patient who is being seen by a behavioral
17 health provider.

18 Nowhere in the community, or
19 actually if you look at the measures of
20 effectiveness for behavioral health providers
21 the established and agreed metrics are how
22 quickly the patient is seen and whether their

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1 prescription is refilled in a timely fashion.
2 That doesn't really tell me whether the
3 patient's behavioral health.

4 Now, if it's a patient who has
5 depression is that depression ameliorated over
6 time? Well, I think our center of excellence
7 would like to do that but it has some difficulty
8 because there is pushback in the civilian world
9 that these measures aren't being done because
10 they're not appropriate.

11 So sometimes the centers of
12 excellence can take on very operationally
13 relevant questions but there's pushback from the
14 community.

15 Another example would be clinical
16 practice guidelines. I asked the center of
17 excellence for behavioral health to really come
18 up with a clinical practice guideline for
19 pharmacologic treatment of depression.

20 The literature reports -- there was
21 a wonderful paper published in the Journal of the
22 American Medical Association 3 years ago that in

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1 mild to moderate depression antidepressants are
2 no more effective than placebo in the treatment
3 of mild to moderate depression. So why do we
4 have so many patients on antidepressants in the
5 Military Health System?

6 So, the people that make up the
7 center of excellence practice within the
8 community -- the community writ large, for
9 example, in behavioral health. But one of the
10 things that the centers of excellence have to be
11 able to do is to be able to step back and say is
12 the community right in what they do with practice
13 guidelines.

14 Now, people think Lockette's biased
15 against pharmacologic treatment of behavioral
16 health. No, I then point to what the centers of
17 excellence for the National Health Service in
18 Great Britain say about the management of mild
19 to moderate depression.

20 So I think this, you know, what's
21 going on in the purchased care sector drives a
22 lot of our behavior in the Military Health

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1 System. And there's really no way to insulate
2 the thought processes for the kinds of output
3 that the centers of excellence have from those
4 kinds of biases.

5 So in summary, I think these are
6 kinds of things that the Oversight Board is
7 trying to struggle with to help make the centers
8 of excellence be more effective. Thank you.

9 MEMBER EVANS: I think one of the --
10 great presentation, but I probably will look at
11 the board members and say one of the things that
12 we struggle with is the cost effectiveness.
13 That was a little disappointing to hear that we
14 haven't really made progress with the
15 congressional mandate centers of excellence.
16 Are they cost-effective.

17 We -- probably 2 months ago we
18 received a presentation about just a variety of
19 CoEs. And again, some -- it seemed very
20 repetitive. And so we struggle with are we
21 meeting what the American public want with their
22 dollars, is it cost-effective and are we seeing

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1 with the research the clinical outcomes that we
2 want to see in our military system.

3 So I think going forward maybe over
4 the next year if we could look at even have an
5 answer, closer to an answer is this
6 cost-effective.

7 DR. LOCKETTE: Right. Look,
8 there's nobody who argues more, and my staff will
9 tell you about cost effectiveness than I do.
10 But this is why I prefaced my opening remarks.
11 Because I am so concerned about cost
12 effectiveness I wanted to know how all of the
13 other centers of excellence out there that were
14 federally or nationally mandated did in terms of
15 proving cost effectiveness. This is why I
16 presented the data on the bariatric surgery, the
17 data from the National Cancer Institute centers
18 of excellence.

19 They've been doing these centers of
20 excellence a lot longer than we have. And so at
21 first I was rather chagrined when I would say to
22 a center director is what you're doing

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1 cost-effective and I really couldn't get a
2 granular answer.

3 So the question is -- and then --
4 there are many questions that come up. For
5 example, what the centers of excellence do, is
6 it directly what they do or is it a program that
7 they oversee that is cost-effective.

8 So, you know, I'll give an example.
9 We are reviewing all of the behavioral health
10 programs within the Department of Defense
11 Military Health System this year. And we're
12 reviewing them for cost effectiveness. It's a
13 very difficult program because we can identify
14 the cost but what is the measure of effectiveness
15 of a behavioral health program?

16 Now, I think it's rather
17 disingenuous to say number of patients seen.
18 Because really what the bottom line to me as a
19 clinician and I think what your primary concern
20 is is that servicemember or beneficiary better
21 off. I mean that to me is the most important
22 question.

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1 MEMBER CONSTANTINE: So do you ask
2 them that?

3 DR. LOCKETTE: I've asked them.

4 MEMBER CONSTANTINE: At the
5 clinics?

6 DR. LOCKETTE: I've asked them
7 this, all right, because I have a very -- I'm not
8 a behavioral health practitioner. But I know
9 there's a Hamilton depression scale out there,
10 I know there's a Beck depression scale, I know
11 there's a PHQ-9 out there. There are all sorts
12 of things that we give to our servicemembers that
13 ask about how they feel. And I would like to
14 know.

15 And in fact one of the things, and
16 you can ask Gina Julian who's the next speaker
17 on the patient-centered medical home that's
18 speaking after me where we have behavioral
19 health practitioners that are going to be
20 embedded. And I'm saying what is the measure of
21 effectiveness. You really have to agree and
22 measure this.

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1 So, but for reasons that are unclear
2 to me there is tremendous pushback. Maybe Dr.
3 Lockette is uninformed and it's not as simple as
4 it appears to me. But frankly I think simply
5 doing something such as the PHQ-9 and seeing how
6 a clinic scores before and after a behavioral
7 health practitioner is embedded improves. I'm
8 going to hear from behavioral health
9 practitioners, I just know it.

10 CO-CHAIR CROCKETT-JONES: I just
11 want to say that one of the things that I know
12 several of us who have done a lot of the
13 installation visits. And we always ask how the
14 various centers of excellence impact the
15 functioning for the service providers that we're
16 interviewing.

17 And frankly we can't -- pamphlets is
18 about it for some. Some are more commonly
19 integrated into sort of the daily functioning
20 than others.

21 I can tell you that for good or ill
22 they are sight unseen to the end user. I mean

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1 except for those that provide some clinical
2 care. But it becomes very hard anecdotally at
3 least for me personally to give much value.

4 And I can honestly say that if the
5 Oversight Board still isn't clear on how to
6 measure effectiveness I just, I'm finding it a
7 bit overwhelming to consider the amount of money
8 that has been poured into some of these and
9 without yet establishing a measure of
10 effectiveness. I'm having trouble putting it
11 into words just how frustrating I'm finding this
12 reality to be.

13 And I would say anyone outside of
14 this tiny, of the small community of
15 policymakers in D.C. would probably be
16 explosively frustrated at hearing that we just
17 keep going forward and keep putting money in and
18 we have not even considered deciding if it's
19 effective.

20 And historically looking at centers
21 of excellence as a model I have to wonder what
22 ever made someone think that a centers of

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1 excellence model is -- I mean when I first heard
2 of the nurse case management model and case
3 management I wondered why we decided that was a
4 model and I actually got some research and data
5 that explained it. I felt much better about the
6 concept.

7 I have to say the more I hear about
8 centers of excellence the less I like even the
9 concept. And so I'm wondering if you can give
10 me -- do you feel you can give me any -- anything
11 to hang onto.

12 CO-CHAIR NATHAN: Suzanne, let me
13 see if I can frame it a little better so that
14 Warren can. So remember that if we were the
15 American Cancer Society or if we were the
16 American Heart Association how we might view
17 centers of excellence might be a little
18 different. It might be what is the cost of
19 keeping somebody with congestive heart failure
20 functional and what is -- but we're the
21 Recovering Warrior Task Force. And we are
22 focused on the care, the management and the

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1 transition of the recovering servicemember and
2 their families who have been wounded, ill and are
3 injured.

4 And so to us centers of excellence
5 are by design created to find the best practices
6 that are out there and afford our recovering
7 warriors and their family the best available
8 practice and care which I look at as a policy
9 issue.

10 In other words, what is our policy
11 on how we -- you've done a great job, Warren, of
12 talking and articulating about how it's so very
13 difficult. Because you have practices being
14 driven by the private sector, by the academic
15 sector, by the federal sector. They don't
16 always intersect. They're not easy to
17 cultivate sometimes. They're not easy to
18 change practice patterns.

19 But from our perspective of the
20 recovering warriors centers of excellence we
21 believe were stood up either rightly or wrongly,
22 many by Congress, by mandate of Congress, by

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1 somebody's pet project saying I'm very concerned
2 about the number of visual injuries that are
3 occurring in the wounded warrior. And I want to
4 make sure that people who are getting their
5 eyesight affected by these head injuries and by
6 this trauma is getting the best visual care.
7 Whether that be generated by the Mayo Clinic or
8 whether it be generated by Walter Reed Bethesda
9 how are we cultivating the best care to give
10 servicemembers who have impaired sight the best
11 care possible. So that not only are they
12 getting it at Walter Reed Bethesda but they're
13 getting it at Fort Hood, they're getting it at
14 Anchorage, they're getting it anywhere else.

15 And then what's happened is this
16 task force has heard from all the CoEs. And they
17 talk about startup problems many of which you've
18 elucidated, you know, hiring freeze, trying to
19 get our staff up, trying to do this, they all get
20 that.

21 When asked what is your raison
22 d'etre our raison d'etre is to do just what this

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1 guy Nathan said which is to find the best
2 practice either generate it among ourselves or
3 as you said go out and find it, the processes,
4 and cultivate what we believe should be the state
5 of the art for the recovering servicemember who
6 has a psychological health issue, a behavioral
7 health issue, a visual impairment, a hearing
8 impairment.

9 And admittedly, especially in
10 behavioral health it's an art still much more
11 than a science. And so it's very hard to find
12 what works well. So it's a tough call.

13 But here's the million dollar
14 question. When we have asked them when you
15 cultivate these best practices, when you find
16 something that you think is a winner how do you
17 get it into policy? How do you get that
18 translated, your term, translational research
19 or translational acquiring of process. How do
20 you get that so it becomes practice in the MHS,
21 in theory an organization, unlike the civilian
22 counterparts, that we have command and control

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1 over. And we can dictate how they practice.
2 You elucidated that with getting rid of Seroquel
3 as a sleeping agent.

4 When we ask them that question we get
5 blank stares. We get a shoulder shrug. We get
6 an I don't know.

7 I'll give you an example. The
8 visual center of excellence people came to talk
9 to us. Now, you know, I'm putting myself on
10 report here a little bit because that's -- the
11 Navy is the executive agent for that.
12 Interestingly it's run by Army and Air Force
13 personnel, mostly Army. In fairness the Army is
14 the executive agent of the DCoE but the director
15 of the DCoE is a Navy captain.

16 So I like this jointness but I'm not
17 sure it's getting us anywhere. Because when we
18 asked the visual center of excellence have you
19 got any examples of things where -- oh yes,
20 absolutely. We've learned through going back
21 and looking at records and cultivating data and
22 seeing best practices that the current way of

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1 treating an eye injury acutely is wrong, that we
2 need to be doing it with a non-compressive
3 bandage using a serrated aluminum eyepatch.

4 And we said great, that's exactly
5 what you're supposed to do. You found something
6 that's going to make a difference for hundreds
7 of servicemembers. Yes sir, we have, very proud
8 of that.

9 Is it being used? I don't think so.
10 Why not? Well, it's being used in the Navy and
11 the Air Force. How is it being used in the Navy
12 and the Air Force if the guys who discovered it,
13 who run the visual center of excellence are Army?
14 Well, we have some friends who work in purchasing
15 in the Navy and the Air Force and we told them
16 about it and so they started buying it.

17 Well, what about the Army? Well,
18 we're working it through Army channels. We
19 don't know anybody really in the Army. You're
20 Army colonels. Yes, but we'd have to do this
21 through channels and whatever.

22 So I said well, where is Health

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1 Affairs involved in this? Where is the policy
2 piece that Health Affairs will be the Tito that
3 sort of brings these Balkans together, the
4 services, and knock some heads and say here's
5 your new policy. We really haven't figured that
6 part out yet.

7 So my challenge to you is if you're
8 Health Affairs -- by the way, I'm part of the
9 problem. I am. I mean I'm a servicemember so
10 I'm part of the problem.

11 But you've said getting the services
12 to sort of coordinate this is a problem because
13 the services like their autonomy, guilty as
14 charged. The services don't like to be told how
15 to practice medicine, guilty as charged.

16 If you recognize all that where is
17 your, you know, your horsepower to come over the
18 top and say since you get to hear all the policy
19 things that centers of excellence do where is the
20 execution branch that tells people like me hey,
21 get over it, this is what we're going to be doing.

22 So do you feel you have the

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1 authority, do you feel you have the situational
2 awareness to take whatever goodness does come
3 out of our CoEs, however they cultivate it, and
4 make it happen for our servicemembers who are
5 recovering.

6 DR. LOCKETTE: Yes. I think we
7 have the authorities. So now what we need are
8 for the centers to come to us where those are not
9 -- where policy such as the eye shield is not
10 being deployed or where there is resistance or
11 there is a slowness to enact these policies.

12 Because as you know the last thing
13 the services want Health Affairs to do is to
14 dictate policy for things that they believe that
15 they can do. So we have to give them the
16 opportunity.

17 And so this is what we have said to
18 the centers of excellence. They have told us
19 their accomplishments. But we need to have them
20 identify where there are these stumbling blocks
21 in getting the kinds of policy.

22 I mean, I know the Seroquel because

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1 there were complaints from one of the services
2 and it came up to us as that there was not service
3 concordance for this policy. And we said fine,
4 we understand. Then this needs to be a Health
5 Affairs policy.

6 So we're willing to do that dictate
7 when needed. But we have to have the centers
8 identify to us where there is that resistance.
9 And that doesn't always happen or it certainly
10 hasn't happened in a timely manner. And I think
11 we can do a better job of asking the centers to
12 identify if exactly this is happening for
13 particular issues where they are ready to deploy
14 a policy that they think needs to be deployed
15 service-wide.

16 CO-CHAIR NATHAN: Okay, but let me
17 -- I'm creating problems for myself because what
18 we're going to do as the Recovering Warrior Task
19 Force is going to have me standing with my heels
20 clicked in front of my seniors. So I get it.

21 But what the Recovering Warrior Task
22 Force is hearing you say is because of service

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1 autonomy, because of service parochialism and
2 because of bureaucratic issues best practices
3 are not necessarily making it into policy.
4 That's what we're hearing you say. And you
5 know, what are you going to do about that?

6 DR. LOCKETTE: Again --

7 CO-CHAIR NATHAN: Your pay grade's
8 higher -- your boss's higher pay grade is higher
9 than mine. So the red dot's on you. You have
10 every right to knock me and the other SG's
11 around.

12 DR. LOCKETTE: So this just needs to
13 be identified to us. So I have identified some.
14 I talked about the use or potential
15 inappropriate use not just of the atypical
16 antipsychotics but antidepressants. And there
17 is not uniform opinion that there needs to be a
18 policy on this. So we will attempt to
19 adjudicate this.

20 Similarly for our measures of
21 effectiveness for behavioral health
22 practitioners is that we will ask and have asked

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1 the Defense Centers of Health -- for behavioral
2 health to tell us what should be the metric of
3 effectiveness for a beneficiary that's seeing a
4 behavioral health provider.

5 And if there is not -- sometimes
6 there's not service concordance because the
7 answer isn't known. So then it's very difficult
8 for us to act.

9 But for example that you painted
10 with the Fox Eye Shield where it's clear and the
11 evidence is there then yes, if we're told that
12 the Army has not done this we will act.

13 I mean it's not just in issues related to
14 Defense Centers of Health but it's like this with
15 all. I mean it, you know, I just went through
16 this medical treatment for patients that have
17 experienced sexual assault. We have not just
18 the policy function but the oversight function.
19 So if there is agreement within a particular
20 center for a clinical practice that should be
21 done and it's not being done and that is
22 identified to us at the Oversight Board then yes,

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1 policy will be written.

2 But we're not getting that kind of
3 feedback from the centers that there is not
4 agreement among the services for particular
5 issues that they're facing.

6 CO-CHAIR NATHAN: Okay, but I just,
7 I want to leave you with the reality that what
8 we have heard from the centers -- there's two
9 questions. Question number one is a center of
10 excellence worth its weight. Meaning is the
11 formation of it and the money that's spent, be
12 it \$20 million for the VCE or \$5 million for the
13 HCE, admin support, those kinds of things. Is
14 it generating best practice? Is it coming up
15 with something that more often than not can be
16 supported as being a great way to treat
17 something. There's always something better on
18 the horizon. There's some guy working in a lab
19 in New York who's got something better cooking,
20 but on the whole are they generating what they're
21 supposed to which is a way to create the best
22 practice that we currently have more often than

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1 not. Second question is is there a way to get
2 traction on it.

3 The first one I don't think really
4 belongs to you. It belongs to the services that
5 are the executive agents for those and watching
6 them and saying do you have what you need, are
7 you getting best practices, how are you figuring
8 out what works well.

9 The next one I believe is squarely
10 on your shoulders, is how is that getting
11 traction. When we ask the CoE directors how do
12 you get your ideas, how do you get your best
13 practices into practice we get a blank stare.
14 They don't have a good way of doing it.

15 Now I take partial responsibility
16 for that because if they work for the service we
17 should be asking them how to do it. But I
18 believe Health Affairs takes the other.

19 DR. LOCKETTE: I agree. So I would
20 like to get what those best practices that are
21 not being translated are. Cite me an example
22 where there's a best practice that has not been

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1 promulgated other than the eye which I will go
2 back and ask why the Army has been refractory to
3 do that. But tell me what those best practices
4 are that are not getting promulgated.

5 CO-CHAIR NATHAN: So you haven't
6 heard of any others?

7 DR. LOCKETTE: No. So then what I
8 did is I said okay, if we're going to look at cost
9 effectiveness, if you can't tell me cost
10 effectiveness, tell me how you're spending your
11 money. Okay, follow the money trail.

12 And what I get, for example, from the
13 eye folks is that the large percentage of the eye
14 money is being spent on development of their
15 registry.

16 Now, how do you do a cost
17 effectiveness analysis for a registry? Right?
18 I mean I'll show you. They have a -- I asked for
19 verification because I couldn't believe -- let
20 me show you this figure.

21 I asked for verification of this
22 from the eye. Fifty-four contractors to build

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1 the registry. Where do I think most of the money
2 for that center of excellence is going? Okay.
3 So how do I get a center of excellence to tell
4 me whether this is cost-effective if this is
5 their primary focus?

6 CO-CHAIR CROCKETT-JONES: Okay.
7 I'm trying to wrap my head around something. If
8 services have the power to resist policy why is
9 there a benefit to the model of a center of
10 excellence? Why aren't the services just doing
11 this? Because it's not like the center of
12 excellence seems to say you -- it is mandatory
13 for you to report best practices and it is
14 mandatory for those to be given to higher for
15 dissemination as policy. There seems to be no
16 part of -- there's no accountability.

17 I'm trying to get my head around this
18 but it seems to me that if the centers of
19 excellence aren't required to report up, aren't
20 required to give recommendation for best policy
21 on a specific timely basis, every quarter, twice
22 a year, something, if they aren't -- if that

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1 isn't something for which they are accountable
2 I don't see why it is of any benefit to give them
3 extra money separately than we could just give
4 services to do their own thing.

5 MEMBER EVANS: The Oversight Board.
6 So the Oversight Board. Oversight means that
7 you have the ability to say, you know, resources,
8 what's working, recommendations through that
9 service. So you have a representation from each
10 of the services on this Oversight Board.

11 And so to me, and granted I'm like
12 Suzanne, I'm struggling with this. To me the
13 Oversight Board should have the ability to go
14 back to the service to say I'm not getting the
15 feedback or I'm not closing that loop of what's
16 working, what the research is showing and how are
17 we getting that to the ground level.

18 Because what we are seeing is that
19 it's not making it from with the research down
20 to the folks at the ground, to our warriors.
21 That's what we're seeing. And we want to see --
22 if you're saying you're spending \$20 million on

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1 a registry, okay, fine. But what success are
2 you seeing with that registry? And that should
3 be going back to you.

4 CO-CHAIR NATHAN: Connie, let me
5 just add one thing in Warren's defense or
6 whoever's. Some of this is congressionally
7 unilaterally generated. In other words a
8 congressman somewhere decides that this is a
9 passion of theirs and they push money and they
10 push it to stand up. And then the services and
11 Health Affairs are now saddled with the
12 responsibility of trying to take this and create
13 traction out of it.

14 But we -- at the very least the
15 services and Health Affairs and the Oversight
16 Board owe Congress back what return on your
17 investment are you getting. Is your passion
18 well-placed or misplaced.

19 And so one of the discussions we're
20 having here, Warren, from our task force is how
21 do we metric this. How do we monitor this? We
22 recognize that there's some nebulousness on

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1 this. And for all we know this registry is going
2 to save eyesight 5 years or 10 years from now as
3 they collate the data. And it may be a long tail
4 before it gets something.

5 But we're not seeing, we're not
6 seeing where the engine is being hooked up to the
7 rear wheel drive by a transmission. We're not
8 seeing that. If the engine is the center of
9 excellence and the rear wheel drive is the
10 ability to move practice to a better level across
11 the recovering warrior population where's the
12 drive shaft that hooks that up? Because the
13 centers of excellence can't articulate it.

14 MEMBER REHBEIN: Sir, if I may let
15 me make a comment here. Having worked in the
16 National Science Foundation's centers of
17 excellence they were governed by the people who
18 had decided that we could do them some good and
19 they governed us by providing the money.

20 I don't think this model is ever
21 going to work well until the services take
22 ownership. Until the services step forward and

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1 say these are the things we need to do our job
2 better and you in the center of excellence can
3 help us by providing some of those things, like
4 they did the eye shield.

5 But until the services step forward
6 and take ownership and maybe the funding for
7 these centers of excellence should come through
8 the services. Because that's really what
9 everybody votes with is their checkbook.

10 You talk a lot about cost
11 effectiveness. I would maintain that the most
12 cost-effective outcome is prevention. And I
13 haven't heard much talk about what you see as the
14 role of the centers of excellence in prevention
15 of injuries and illness and wounds. Because we
16 can buy a whole lot of those eye shields and
17 prevent many thousands of eye injuries for the
18 cost of treating one. So I think there's a role
19 there for prevention that I'd like to hear you
20 address.

21 But I really think that in order to
22 make this system work well the services have to

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1 buy in. The services have to take ownership.
2 The services can't be out there as a reluctant
3 user, as feeling like something is being forced
4 on them. That's -- I don't think that's going
5 to work. I don't think human nature will allow
6 that to work.

7 MS. DAILEY: We are going to need to
8 wrap, ladies and gentlemen. Maybe one more
9 question. Mr. Rehbein, I can include your
10 questions about prevention in further briefings
11 so we'll hold that. I think it's important
12 enough that people have time to address it. And
13 then I know ma'am and Dr. Phillips have some
14 questions. And we'll need to wrap after that.

15 CO-CHAIR NATHAN: So let's just
16 finish up, Warren, if you would. Your response
17 then sort of to the generalized concern that
18 there may not be the connectivity between the
19 services and between Health Affairs to capture
20 whatever -- whether they're worth their cost or
21 not is an issue. But if they do generate things
22 do you feel the mechanism exists and do you feel

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1 it's robust enough and do you feel it's pulsing
2 the system enough to create practice change,
3 policy change.

4 DR. LOCKETTE: So the requirements
5 for the registry are congressionally mandated
6 for both the eye and the ear. So that is going
7 to get the attention of the centers because they
8 were congressionally directed to develop these
9 registries.

10 But they realize that you can't
11 immediately tell what the cost-benefit of having
12 that registry is. But the predominance of
13 effort is on the development of registry because
14 it was congressionally mandated.

15 I think speculating what's going on
16 here is that there are clinicians that are there
17 that are saying there are other things besides
18 the registry that we need to be looking at. And
19 so the things like the eye shield was
20 self-generated.

21 So don't misunderstand not having
22 the cost-effective data to say that there have

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1 not been accomplishments. Okay?

2 So each of the centers, I mean you
3 know, I asked for training and education. I
4 asked the director for psychological health for
5 behavioral health and TBI at DCoE to send me
6 documents that they were being effective with
7 their research portfolio and clinical efforts.

8 And he sent me a bibliography of
9 hundreds of papers that they have published and
10 disseminated in the academic peer review
11 literature just in the past 3 years. So there
12 is no question that the Defense Centers of
13 Excellence for Behavioral Health is making a
14 significant contribution.

15 So we have those accomplishments.
16 But to put a cost per beneficiary or traditional
17 measure of cost effectiveness, that's difficult
18 to do, and they're struggling with the best ways
19 to come up with that.

20 MEMBER PHILLIPS: Basic question
21 that might help me. Do the centers of
22 excellence understanding their diversity both

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1 scientifically and administratively is there
2 commonality related to standards of
3 terminology? Is there a common IT system or a
4 way that they communicate with each other
5 through a listserv or something that will
6 connect them more robustly? Standards of
7 medical terminology? I mean different services
8 have different terminology for the same things.

9 Do we have basic UMLS, Uniform
10 Medical Language Systems terminology and so
11 forth that everybody agrees upon? Or is that an
12 issue as well?

13 DR. LOCKETTE: I'm not sure I
14 understand.

15 CO-CHAIR NATHAN: Well, they belong
16 -- they're each in their own service because each
17 service is an executive agent for one of these
18 centers of excellence. So they're as common as
19 the services are common and they're as different
20 as the services are different. So they don't
21 have an overarching policy.

22 The genesis for these going to the

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1 services were the following. When the NICoE was
2 built and was to be staffed the Defense Center
3 of Excellence was the executive agent, the DCoE.

4 They weren't getting the staffing
5 hired because they weren't an execution agency.
6 They were a policy. DCoE as Warren has just
7 said, they provide policy. They don't have a
8 body that can hire and fire and put people in
9 charge.

10 So they said let's give the NICoE to
11 a service and let the service be the executive
12 agent because they know how to execute. But the
13 service shouldn't be on the hook for policy.
14 Health Affairs should be on the hook for policy.

15 The problem was when they built
16 these they didn't create a real good mechanism
17 for anything they executed at the service level
18 to become policy at the MHS level. And that's
19 where we're hearing the rub.

20 So Warren, we thank you. Again what
21 you've articulated as where we are now is where
22 the Cleveland Clinic was 30 years ago when they

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1 decided to produce outcomes. They were the
2 first major organization that said here, we're
3 going to publish how well we do when we fix
4 hearts. Up to then nobody had done that. And
5 the Cleveland Clinic and then everybody else
6 said uh oh, we better publish too because we're
7 not doing good.

8 And so you've given a good brief on
9 how we need to be outcome-centric. We need to
10 find out how outcomes are, how we're making a
11 difference in various things in behavioral
12 health and then figure out how to translate those
13 across the MHS.

14 This task force is just very
15 concerned with two things, the bang for the buck
16 for the center of excellence, that has to be
17 wrestled with. And then a second is if they give
18 good bang for the buck how is that bang being
19 translated across all the services.

20 And so you've educated us. Hopefully we
21 imparted some passion to you. And we thank you
22 very much for your time.

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1 DR. LOCKETTE: Thank you.

2 CO-CHAIR NATHAN: Now, we're a
3 little behind time so instead of a 15-minute
4 break we're going to take -- you okay with 5?

5 (Whereupon, the foregoing matter
6 went off the record at 10:51 a.m. and went back
7 on the record at 10:55 a.m.)

8 CO-CHAIR NATHAN: We welcome Ms.
9 Regina Julian who is the director of the
10 patient-centered medical home at the TRICARE
11 Management Activity.

12 Patient-centered medical home is --
13 I think you all have heard me talk about it before
14 and many of you are already familiar with the
15 basic concept. But it is a team-based
16 family-centric comprehensive healthcare model.

17 Ms. Julian is providing an overview
18 of the model and its implementation within the
19 Military Health System. And if you thought I
20 was passionate about centers of excellence you
21 ain't seen nothing yet.

22 But we really look forward to this.

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1 And I think all of us are fans. So please, take
2 it away.

3 MS. JULIAN: I had to hit my timer
4 on. I have to talk into a microphone. Usually
5 that's not something anyone ever asks me to do.

6 It's the first time I've been here
7 to brief you and I'm really glad. I'm very
8 passionate about this topic as well. I was born
9 a military beneficiary. Both my grandfathers
10 retired from the Army, my father retired from the
11 Army and I retired from the Air Force just 2 years
12 ago. So I am definitely a customer of our
13 system.

14 Today I tried to take into account
15 the questions I was given and tried to answer
16 them to the best of my ability. But if I don't
17 make sure you ask me questions and then if
18 there's something I need to follow up on I'm more
19 than happy to come back.

20 So basically we're just going to go
21 into a brief background about what it is, where
22 we are in our implementation in the Military

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1 Health System, some of our goals which we always
2 have to keep in mind because those are driven by
3 other people as well, and what does PCMH look
4 like in an MTF and how is it different than
5 before. And then we'll discuss a little bit
6 about how that impacts our recovering and our
7 wounded warriors.

8 So Dr. Lockette, by the way, is my
9 boss. And he always reminds me you guys didn't
10 develop this a few years ago. This has been
11 around for a long time. But the term was coined
12 relatively recently and now all the big groups,
13 the American College of Physicians, the American
14 Academy of Pediatrics and Family Medicine, and
15 large insurer groups are all very involved in
16 this concept.

17 It's a cornerstone of the
18 Accountable Care Act. And one of the -- but
19 regardless it's just good medicine. So what Dr.
20 Lockette always likes to remind me, he says I
21 don't know if you remember Dr. Marcus Welby, that
22 show. Of course I do.

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1 And so he was accountable for the
2 care. So we're trying to get away from this
3 episodic where you don't see the same provider
4 and you go there for strep throat and then you
5 go to someone else later on. So you want a
6 family physician or provider for your patients.

7 This link down here at the bottom is
8 the national collaborative. It's made up of
9 insurance groups, government, states, Medicare,
10 the military. And we try to get together and
11 share our results and our best practices and the
12 way ahead. It's a very collaborative group.

13 So just as an overview the
14 principles of a PCMH, you need to have a primary
15 care manager by name. Because we always say
16 that's from where lots of good things come.
17 When our provider knows you and you know your
18 provider that's where you can really start to
19 affect change in what we call the virtual space.

20 You know, if you see a physician or
21 provider four or five times a year that's not a
22 lot of time. So we want to be able to integrate

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1 with you and get at those underlying causes of
2 your disease and build a relationship that's
3 based on trust.

4 But part of that is the rest of the
5 team as Admiral Nathan said. So it isn't just
6 a provider alone in a room. There are nurses,
7 there are techs, there are Corpsmen. I was Air
8 Force, medical technicians. And we want them
9 all to work together so they know that patient
10 when they come in. And I'll show you what our
11 results have shown to date from our patients and
12 how they feel this is working.

13 So again I mentioned we don't want
14 to do episodic care. We want to look at the
15 patient holistically. What are their
16 underlying causes of disease. What are their
17 family situation, their behavioral situations.
18 Because all those things affect your health and
19 your ability to manage your own health.

20 We want to coordinate care -- I know
21 that's very important to this group -- across the
22 full spectrum of care. That's into specialty

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1 care, your admissions, other kind of behavioral
2 health and other specialties. We want to
3 coordinate that care.

4 And we want it to be safe and
5 high-quality. Clinical practice guidelines
6 are very important to us. Patient-centered
7 medical home is an evidence-based model of care
8 so it isn't we think this works, it's we want to
9 drive it with evidence.

10 And Dr. Lockette does keep us very
11 busy in trying to prove some of the effectiveness
12 with the numbers. So we had to do a lot of
13 standardization so we could look at the data and
14 compare apples to apples. And we're having some
15 success in that. And I'll show you that in a
16 little bit.

17 Enhanced access, very important.
18 What we always say is see today's patients today
19 and when you need to be seen because that's when
20 patients become dissatisfied.

21 And this is something we're having
22 to work on in the military and the private

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1 sector. Healthcare in the private sector is
2 reimbursed based on you come in, you get sick and
3 you get paid. So we want to try to change the
4 payment to keep the patient well, or to get the
5 patient well. That's a very important shift for
6 the whole country and for us as well.

7 So how did we start in the military?
8 Well, we had a couple of demonstrations. The
9 main one up in what used to be called the National
10 Naval Medical Center in Bethesda. And we have
11 a really bunch of visionary primary care leaders
12 in internal medicine up there led by one of our
13 members of our group. And they kind of started
14 PCMH in the military.

15 And the results were very good. And
16 based on that and because of the things that we
17 wanted to do which is to maintain great patient
18 satisfaction and we wanted to increase the
19 effectiveness of evidence-based medicine and
20 the use of it we decided, well, we will use the
21 model, the patient-centered medical home model
22 of care based on what our patients tell us they

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1 like, what we think that we need, where we think
2 we can affect change and health outcomes. This
3 is what we want to go with.

4 And so senior leadership which is
5 made up of our civilian leadership and our
6 surgeons general made the decision to implement
7 the patient-centered medical home model of care
8 throughout the Military Health System.

9 Today really I'm going -- we have
10 several demonstrations we're working on in the
11 private sector but today I'm going to talk
12 completely about the Military Health System, the
13 direct care, our Army, Navy, Air Force and
14 Marines.

15 So the first thing we did is they
16 came up with a policy in 2009 and it did several
17 things. But it assigned governance and that was
18 really important. Tri-service governance.
19 The service leads have the vote on this. We have
20 oversight and we help guide the collaboration.

21 But one of the things that was very
22 important is we meet often, we develop trust and

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1 develop a team ourselves. And part of that was
2 we haven't canceled -- they're twice a month.
3 We haven't canceled a meeting in 33 months now.
4 We know each other so well that when someone
5 breathes right before they speak we know exactly
6 who's going to talk. But that's the kind of
7 collaboration you need to get to where we are.

8 And we would like to speak with one
9 voice. It may take us a couple of months to make
10 a decision but we want it to be unanimous because
11 we want the standard in the model of care to be
12 the same if you go to San Diego or you go to Joint
13 Base Lewis-McChord at one of our clinics up
14 there.

15 A really important part of this
16 policy was to select an outside entity to
17 recognize or rate our patient-centered medical
18 homes. And we decided to use the one that's most
19 well known, the National Center for Quality
20 Assurance that has six standards and many
21 different elements. And they relate to care
22 coordination and access and all those principles

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1 I showed you on that first, on that page of the
2 seven principles of PCMH.

3 We wanted this because we wanted to
4 drive consistency again across the Military
5 Health System and so we picked the National
6 Center for Quality Assurance.

7 Now, they recognize
8 patient-centered medical homes nationwide, not
9 just military, from 1 to 3. Three is the
10 highest, 1 is the lowest. And we made the
11 decision in the Military Health System is that
12 we wanted all of our practices to be recognized
13 at least level 2 or 3 eventually at some point
14 in the future. And I'll show you where we are
15 with our implementation.

16 So one of the questions I know I must
17 have gotten right was what are the numbers and
18 names of the policies that guide
19 patient-centered medical home in each of your
20 services. So what you see here, and I won't read
21 them to you, but we have the policy memorandum
22 that established everything I referenced on the

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1 slide before, and then we have the Army op order,
2 the BUMED which is the Bureau of Navy Medicine
3 instruction and the Air Force instruction.

4 Now these will probably be reviewed
5 and revised in the near future but they were a
6 good starting point. They all dealt with kind
7 of standard business practice and rules. What
8 are your teams made up, what are your ratios.
9 There were slight differences because each of
10 our services are a little bit different and
11 they're the ones that have the authority to plan
12 equipped and resource. But they're pretty darn
13 similar and they're all available if you Google
14 this. And you can see them on the Web. Full
15 transparency.

16 So, remember one voice and we all
17 wanted to work together. And one of the first
18 ways we realized if we worked together we did
19 better was when we went forward to try to get
20 funding to clean up or fix primary care.

21 Primary care has always been under
22 the spotlight. And what we always were told is

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1 well, we need our teams to be healthy because of
2 deployments and PCS's and we need to have a
3 standardized team.

4 So we went through based on those
5 instructions you saw on the previous slide and
6 we said here's where you are now, here's what you
7 say you need. And we were able to justify to the
8 DoD comptroller for additional money that we got
9 starting in Fiscal Year `12 going to `16 to try
10 to get our teams healthy.

11 Now one of the things we did is to
12 try to make sure that our teams were balanced
13 between military and civilian, and those
14 civilians being GS and contractor to try to
15 mitigate some of the effects of deployment.
16 Because a lot of people when we started out said
17 how can you do this patient-centered medical
18 home with active duty. And we're able to do it
19 by kind of trying to balance those teams.

20 But we realized when we got
21 together, put our justification together, we
22 were able to justify the funding. However,

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1 funding isn't free. It came with requirements.
2 And those what you see here are -- we're held
3 accountable to these measures.

4 Now these aren't outcome measures
5 and the kind of things we want to get to but these
6 are those process measures we need to get to
7 first. We needed to build the substrate and the
8 foundation in order to get to better health for
9 our patients which is the next part of our
10 strategy.

11 So some of our near-term were to make
12 sure that you saw your same PCM, your same
13 provider as much as possible going in. And we
14 set a goal. And for the first time we've made
15 the goal for the last 3 months. And our
16 NCQA-recognized patient-centered medical homes
17 are about 15 to 16 percent higher than that.

18 And so that was -- what that is is
19 a change in culture. To get to those numbers
20 even in a military system with deployments and
21 everything required a huge change in our
22 practice patterns and in our expectations and

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1 everything that we did, it was a change in
2 culture.

3 That was something else we had to
4 make sure people knew that this wasn't going to
5 be a gimmick that we were going to do for a couple
6 of years but it was going to really be part of
7 our culture. I'm sure every single person here,
8 you're all senior. You know changing culture
9 takes a little while. But we're having some
10 success in that as well.

11 So then we wanted to improve the
12 access to care and improve patient satisfaction.
13 Now, patient satisfaction, even if we think
14 we've done all these things if the patient is not
15 satisfied as you talked about earlier in some of
16 your site visits did it really happen. If a tree
17 fell in a forest and nobody was there to hear it.
18 If the patient isn't satisfied, have we done a
19 good job?

20 So we look at that. Each service
21 has their own satisfaction survey. And then we
22 have a standard one at TMA. And what we just

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1 were able to pull out in the last few days is
2 compared to the national benchmark our patients
3 have felt satisfied with their ability to access
4 acute and routine care 18 to 23 percent
5 respectively better than the national
6 benchmark. Now, we still want to do better but
7 that tells us we're heading in the right
8 direction.

9 Now as far as your PCM by name,
10 remember we want to build the relationship
11 between the patient and the provider and the
12 team. And so we are scoring 29 percent better
13 than the national benchmark in the question do
14 you feel that your physician knows you and knows
15 your medical history. And that was good news
16 because that went along with our PCM continuity
17 going up. And this isn't team, this is
18 individual PCM continuity.

19 You mentioned integrated behavioral
20 health. That is part of our funding. That is
21 part of our model is that our patient-centered
22 medical homes have embedded behavioral health.

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1 We're in the process of hiring and training each
2 one of those people. It's very important.

3 And by embedded, what that means is
4 their office is actually there in the practice.
5 So, because you know there's a lot of stigma
6 involved. We found out people if they were
7 given an appointment in behavioral health they
8 didn't always make an -- well, they didn't make
9 an appointment, about half of them. And the
10 other half didn't even go.

11 And so what we wanted to normalize
12 this and have it so if something comes up in your
13 appointment that either you self-select or your
14 provider recommends and you agree we will just
15 walk you over across the hall to our embedded
16 behavioral health. And our patients and staff
17 really like that.

18 We're trying to manage demand. By
19 that we mean we're not trying to keep you out,
20 but we're trying to do it in the right way.

21 In the old days you'd have to go in,
22 make an appointment to get a prescription refill

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1 for an allergy medicine you've been on for 10
2 years. We don't want you to do that anymore.
3 We want to reduce the number of face-to-face
4 visits but still increase your relationship.
5 And we'll talk about secure messaging in a
6 second.

7 The overall goal is to optimize the
8 resources of our military treatment facilities.
9 We want to increase our capacity by changing our
10 practice patterns, meeting our patients' needs,
11 getting them healthy to bring more patients in
12 so that we can ultimately get more bang for the
13 buck that we spend on our military treatment
14 facilities to keep them viable.

15 CO-CHAIR NATHAN: And Regina, would
16 you agree that one of the tenets of all this is
17 the way we reward or acknowledge our providers?
18 And how they manage their populations.

19 It's going to require a sea change
20 -- Navy term -- to get away from the current
21 fee-for-service paradigm which is what we
22 employ. We measure how much care we do to people

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1 and that's how we reward our providers. And we
2 have to migrate to a system that rewards for
3 wellness and health.

4 And that is the long pole in the tent
5 for TMA, for Health Affairs, for the services to
6 figure out how to reward the provider for having
7 a healthy population as opposed to the current
8 reward which is how much care did you give a sick
9 patient.

10 MS. JULIAN: Absolutely. Remember
11 I said we had to fix our foundation and
12 substrate. And that was that we were ready.
13 Our old system was just fee-for-service. It was
14 patients coming in, and sick call, and how many
15 did we churn through in a day. And then they
16 could come back the next day with another health
17 problem.

18 We're holding our teams and our
19 providers accountable but we need to reward that
20 way. And that is a big change in the way we're
21 going to fund things.

22 So it requires us to be able to do

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1 better with our data to not only look at what
2 we're doing and who's doing it but how well we're
3 doing it. Are we being cost-effective and are
4 our patients getting healthier. And that is
5 really the big area that we're working on now in
6 the Military Health System.

7 MEMBER PHILLIPS: Do you have any
8 handle on whether or not it's really working? I
9 mean if you look back 10 years ago the DoD budget
10 for healthcare for the civilian sector was much
11 lower than it was, say, last year where roughly
12 50 percent of the DoD budget for military
13 healthcare went to the civilian sector. I mean
14 do you see a light at the end tunnel?

15 MS. JULIAN: We are, we're starting
16 to see that. You know, we -- you can see where
17 we started the implementation in Fiscal Year
18 2011 or calendar year 2011. There were a few
19 before that but that was the big year.

20 And we look at a lot of those
21 measures and you can't ever look at one. We've
22 developed kind of a composite which is a mix of

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1 continuity and access. But what you're getting
2 at is what am I sending downtown that I may have
3 capacity for. And that's one of those -- that's
4 why we have to improve the capacity of our MTFs
5 and maximize it. Requires the cultural
6 transformational change but keep the care
7 in-house that we can do.

8 Part of that though, sir, in
9 patient-centered medical home is we want our
10 internal medicine, family medicine and
11 pediatric patients -- providers to work at the
12 top of their license and their nurses and case
13 managers too, and their techs, all the way up.

14 The way that helps is you have your
15 clinical practice guidelines. You now have
16 more time. You're not -- I had one of our
17 physicians that used to be on our group and now
18 is out seeing patients at Randolph clinic. And
19 he said I haven't had to see a patient in 6 months
20 for a prescription refill. I handle that all in
21 another way.

22 And so he had open appointments.

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1 They're able to open up their enrollment at the
2 359th medical group. And they're not sending as
3 much downtown. So an important measure is what
4 care is going downtown now.

5 If you were at 72nd med group at
6 Tinker -- can you tell I was in the Air Force?
7 And Admiral Nathan, I love the water. So I say
8 I'm joint service -- is that they don't have
9 endocrinology that Dr. Lockette has. You have
10 that at your larger medical centers and tertiary
11 care places. So they're going to send that
12 downtown.

13 The measure though is am I sending
14 down endocrinology that can really be done in
15 family medicine because we freed up that
16 provider or internal medicine. And yes, we are
17 seeing that change. Good question, though.

18 CO-CHAIR NATHAN: Steve, I would
19 commend you to an editorial in the February issue
20 of the American Journal of Military Medicine
21 written by a brilliant -- the guest editorial on
22 patient-centered medical home written by a

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1 brilliant, brilliant individual.

2 (Laughter.)

3 CO-CHAIR NATHAN: Who clearly is
4 visionary. Clearly visionary.

5 MS. JULIAN: It was a great article.

6 CO-CHAIR NATHAN: And whoever the
7 commander was at Bethesda when they launched
8 that pilot project should also be given a pay
9 raise in my opinion. If we can find that person
10 who's probably too humble to acknowledge
11 themselves.

12 But to answer your question, yes.
13 So you know, we spent \$19 billion bucks on
14 defense healthcare in 2001. Last year we spent
15 \$53 billion on healthcare. Over 50 percent of
16 that has gone to the private sector.

17 So here we are paying for care twice.
18 What do I mean by that? We have funded these
19 MTFs and hospitals and staffs and everything yet
20 over 50 percent of the care is being paid for in
21 the private sector. So we're paying for it
22 twice.

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1 Part of that's because we've been at
2 war for over 10 years. We've been heavily
3 deployed. We've had to send patients out.
4 We've had to displace them. But most of that is,
5 as Regina is alluding to, is the fact that we've
6 lost our ability to become primary care
7 managers. We have allowed the specialty sector
8 to gain our patients. And the one thing the
9 military has going for it is primary care
10 management.

11 That's why American healthcare is
12 broken. The primary care model is gone. The
13 primary care doctor of America now is the
14 emergency room or the urgent care clinic. In
15 the military with patient-centered medical home
16 we're now managing the care again and we're doing
17 it in a way that the patients want to come see
18 us.

19 So in that article I alluded to what
20 we found at Bethesda which is significantly
21 decreased admissions to the hospital,
22 significantly decreased emergency room visits,

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1 increased patient satisfaction and decreased
2 purchased care costs. We can do it now.

3 And one thing you didn't really
4 mention, Regina, is one of the reasons we got in
5 this business, we heavily civilianized medical
6 homes because of the deployments of the
7 providers. So we hired civilian PAs, civilian
8 nurse practitioners and they stayed and held
9 down the fort so the patients always had a team
10 they could go to.

11 And the one lament as you know of
12 military medicine, of anybody in this room is
13 most of you would agree when I get in the care
14 is good but I'm frustrated by seeing a different
15 provider every time. Can I get an amen. Amen.

16 And I'm frustrated because
17 sometimes I can't get a hold of my provider or
18 anybody because the appointment lines are booked
19 up. And I'm told to call back the next day at
20 6 and by 6:15 they're booked up again. And
21 that's a big amen.

22 And medical home is designed to

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1 thwart all of that by giving our patients a phone
2 they can call anytime of the day or night and
3 connect with somebody on that team who can either
4 defuse the issue or send them to an emergency
5 room if necessary. So that's really access and
6 confidence that you can be seen is the big
7 game-changer in patient-centered medical home.
8 Sorry, didn't mean to steal your thunder.

9 MS. JULIAN: No, that's great. You
10 know, I said that we'd made our goal for 3 months.
11 That -- we were about 25 percentage points below
12 that with PCM continuity when we started. So to
13 have this huge system of 435 primary care
14 practices seeing 3.4 million people, 60 percent
15 of those patients seen in the last few months
16 have been seen by their own provider. And that
17 includes if you're enrolled to a resident. Our
18 top patient-centered medical homes are above 78
19 percent. The top last 4 months running has been
20 internal medicine at Naval Hospital Pensacola at
21 over 90 percent followed by Naval Hospital Oak
22 Harbor.

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1 And again, this required leadership
2 from the commanders to say when your patient
3 walks in, even if you are doing admin time you're
4 going to see your patient if they need to be seen
5 that day. And that's what it took.

6 So NCQA recognition, I'll just go
7 over this really quickly but because we'll talk
8 about it a little under care coordination. We
9 thought we would do 50 a year, 50 practices out
10 of 435. So you can see where -- how long it was
11 going to take to get there.

12 Well, the military always wants to
13 lean forward and everything is very competitive
14 so now here's where we are. We had -- so at the
15 end of December 2012 we had 92 percent or 157 of
16 all 171 practices recognized -- and again, we
17 were only supposed to have 100 -- were level 3
18 which is the highest. And that's much higher
19 than the civilian sector. We actually ranked as
20 the highest point scorer of all the cohorts
21 nationally that sought NCQA recognition.

22 This next year we're leaning forward

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1 more. And right now I have 157 undergoing
2 recognition.

3 How do we do this with no TDYs and
4 everything else? My office twice a week every
5 other week and we're going to every week on
6 Tuesday and Thursday to make sure all the
7 different time zones can be accommodated because
8 we're sea to shining sea we do best practice
9 webinars.

10 And so we start with access. We
11 work onto stakeholder communication. We do
12 care coordination, care planning. And it's
13 targeted to NCQA recognition but the stuff we
14 need to do for NCQA recognition are the things
15 that we need to do for patient-centered home
16 model of care.

17 And so everyone really dislikes me
18 when they start the process and I'm sure my name
19 is taken not too well. But at the end what we
20 hear from people is they say gosh, you know, that
21 was a lot of work but it was really worthwhile
22 because it helped improve our practices. And

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1 we're doing things now that we really didn't know
2 that we had the systems to do and things that
3 really help our patients and our patients really
4 like. So I'm happy to hear that, especially
5 since we have 157 going through this year.

6 We plan to be complete at the end of
7 2014. The Air Force and JTF CapMed will finish
8 up in 2014. The Navy and the Army will be fully
9 recognized.

10 Now one thing I want to say though,
11 NCQA recognition is just part of the journey.
12 This is a constant improvement, continuous
13 process improvement. So this is just one of the
14 things that we do. We are continuing to move
15 forward. So this is just kind of your starting
16 point.

17 So what does enrollee care look like
18 in a PCMH? Again, you have a team. The team
19 works with the same provider. And I say
20 provider because it's physicians, nurse
21 practitioners and PAs, whoever you're enrolled
22 to. And you have enhanced access to routine and

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1 wellness and acute care.

2 One of the things that we work on is
3 simplifying our templates so that we don't have
4 very complex templates that make it hard to
5 manage. Some of the best practices in the
6 private sector just have one type of appointment
7 and if you need to be seen 2 months from now or
8 today they'll work you in. You get one of those
9 appointments. So we're trying to get to that.

10 And what we've seen is the
11 percentage of time on the templates that are for
12 acute and routine -- and acute is I need to be
13 seen in 24 hours and routine is up to 7 days or
14 farther -- has gone from about 60 percent to 84
15 percent of our templates now. So that's good
16 news. That means that there are more
17 appointments available for our patients.

18 This is very important. So we have
19 secure messaging now. That is a secure way for
20 you to contact your provider. And this isn't
21 just your provider, it's the other members of the
22 team as well. So the case managers, the

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1 embedded behavioral health, but the main
2 relationship is between the provider and the
3 patient.

4 Right now we have about 20 percent
5 of our patients enrolled. We're adding about
6 25,000 a month. We plan to be 100 percent
7 deployed in all primary care clinics by the end
8 of the summer.

9 So any of you enrolled at Fort
10 Belvoir and you see some of the ads out there and
11 some people at TMA have told me wow, this is
12 really great. I never had a way to reach my
13 provider.

14 Now your provider is not going to
15 always answer you instantly but you can send
16 something 24 hours a day. And several of our
17 providers have said that when they were deployed
18 they had this. This was a really important
19 tool. Somebody was deployed on a forward
20 hilltop somewhere and they were able to contact
21 them through secure messaging. And they're
22 still able to follow those same patients because

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1 of continuing medical issues. So we think this
2 is a really important tool to increase that
3 relationship beyond the four walls of the MTF.

4 Sixty percent of the traffic is just
5 notes, communication back and forth to your
6 provider. And the second most is I think I need
7 an appointment, what do you think. So we also
8 do virtual appointments this way as well. And
9 then the provider uploads those back into the
10 system. So we have high patient and staff
11 satisfaction with this new secure messaging.

12 Individualized comprehensive care
13 plans if applicable are an important part of this
14 and an NCQA-recognized standard. And then
15 again the behavioral, the embedded behavioral
16 health.

17 What's really important is that
18 remember we're building the relationship. And
19 it's not just with the patient. If a patient has
20 a family that's an important part of their
21 healthcare.

22 So some of the other things that are

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1 rated by NCQA and that we're requiring people to
2 document in the medical records is to
3 collaborate if necessary with the entire family.

4 So let's say it's a wounded warrior
5 or a recovering warrior or it's a child who has
6 special needs. We need to develop a plan and
7 collaborate with the whole family.

8 We need to do medication
9 reconciliation which is also required. Care
10 coordination, care transitions management. So
11 for example, I'm enrolled here. Now I'm going
12 to be enrolled at San Diego. That's a
13 transition. It's a transition if I go to an
14 inpatient unit.

15 We're working now with trying to
16 work with the VA to increase that transition
17 between there. We belong to a group with Dr.
18 Stark and the rest of the primary care team in
19 leadership at the Veterans Health
20 Administration and we're meeting week after next
21 again to go over some of these issues, ma'am.

22 And we need you to have a clinical

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1 summary. We want to increase the health
2 literacy, we want your buy-in. So you need a
3 clinical summary of your visit when you leave.

4 So remember I talked about
5 standardizing workflow and making sure things
6 were consistent? And part of that is so that we
7 have data. Because you know we still have to
8 prove our worth eventually. We also want to
9 enhance evidence-based medicine.

10 So we came up with something called
11 the Tri-Service Workflow. It was started with
12 the Air Force. And what it is, we have an
13 electronic health system called AHLTA. It's
14 cumbersome but it's not that -- it's not
15 terrible. But this Tri-Service Workflow is
16 developed by providers for providers and the
17 team. And it's an overlay and it has embedded
18 clinical practice guidelines. It prompts the
19 provider.

20 You know, if any of you have read any
21 of Atul Gawande where he talks about we're really
22 smart but we have 15 minutes and we may not

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1 remember X, Y and Z. Now your whole team is
2 going to be involved with you to collect
3 information that -- some of these key things,
4 height, weight, exercise. We're looking at
5 some of the other guidelines, maybe sleep and a
6 general sense of health, alcohol use. And if
7 you test positive on any of these things such as
8 depression which Dr. Lockette mentioned earlier
9 then you move onto the next level and in
10 accordance with the clinical practice
11 guidelines you get the next type of care. So
12 it's not left up to I hope my provider remembered
13 the right thing to do but we're going to try to
14 prompt it.

15 So the most used forms in AHLTA, 90
16 percent of them are the Tri-Service Workflow.
17 In 13 weeks we have increased the use up to 11
18 and a half million total, about 500,000 a week.
19 So pretty much almost every appointment is
20 getting screened this way.

21 We have one service we're still
22 trying to finish off but by the end of the year

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1 everyone's going to be using Tri-Service
2 Workflow. This is a way if we're using the
3 standardized tool and doing it the same way on
4 every team now we're collecting information.
5 And now we can get at our outcomes and everything
6 else.

7 Which if you look, you know, Admiral
8 Nathan mentioned going from a system of
9 healthcare to health. Part of this is we need
10 to take care of these preventive issues. And a
11 lot of them based on what the U.S. Preventive
12 Task Force have said are related to these issues
13 here.

14 So we have currently 16 clinical
15 practice guidelines in your background slides.
16 You can see the ones that are embedded. And we
17 have 15 more. We're trying to build those
18 specialty aim forms now we call them.

19 We so we make sure that the right
20 referral goes to specialty care and it doesn't
21 get sent downtown. And if it can be done in
22 primary care it can. And if not it does need to

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1 go to specialty care. Let's make sure it's the
2 right care.

3 We're limited by funding. We're
4 putting in a request to build these. But the
5 specialists who usually are kind of hard to get
6 on board with some of this are asking now to be
7 part of this whole system. And we feel this is
8 a key component of building our integrated
9 delivery system.

10 So I called a couple of providers in
11 the field and said tell me what your case
12 managers do for you in your field. Because you
13 know those are part of your model. They said
14 well, they interface with me. Not every
15 patient. I don't have a case manager. I don't
16 need them. But of a patient that does they
17 interface with the PCM, the primary care
18 manager.

19 They help coordinate the specialty
20 appointments. They're reachable by the patient
21 and hopefully the family member. I heard some
22 discussion about maybe we need to work better in

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1 that area. And they arrange things like
2 handicap placards, home health, any kind of
3 additional services that the patient needs.

4 And again, care coordination is a
5 must-pass element in the NCQA. And we scored
6 higher than the national average in that area.

7 So the Warrior Transition Units,
8 each patient has a case manager obviously. They
9 already have issues. And then they have a
10 non-medical case manager.

11 So just a little bit about how does
12 this integrate with patient-centered medical
13 home. If you are not injured enough to be in an
14 Army formal wounded warrior unit or Warrior
15 Transition Unit your seen in your
16 patient-centered medical home or now your
17 soldier-centered medical home.

18 We used to call those TMCs, Troop
19 Medical Clinics and it was a lot of sick call and
20 cattle call you had heard it pejoratively
21 called. Now those are being recognized this
22 year. They're transforming really quickly into

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1 patient-centered medical homes.

2 Right now there's 62 of 144 total
3 Army practices of patient-centered medical
4 home. This is all the primary care practices.
5 And they're all level 2 or 3 and they will be
6 recognized 100 percent by December 2013.

7 And the Army gave me this map and it
8 showed their locations of their Warrior
9 Transition Units. And I do want to say that in
10 the Army their Warrior Transition Units are also
11 in the queue right now to be recognized as NCQA.
12 So they're undergoing transformation at this
13 time.

14 You mentioned earlier Madigan. So
15 Madigan was one of our first places. And they
16 have several level 3 patient-centered medical
17 homes up there and they're looking to finish the
18 rest of them this year.

19 Air Force wounded warrior care.
20 They're really mostly seen in the
21 patient-centered medical homes. The Air Force
22 has fewer proportionally recognized at this time

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1 but they're 100 percent level 3. And they will
2 finish up in 2014.

3 And then in the Navy they have --
4 their patient-centered medical home is called
5 Medical Home Port. Everybody can brand it in
6 their own way. The Air Force is Family Health
7 Operations.

8 And so 67 out of their 110 practices
9 are NCQA-recognized. And they're going to be
10 complete this year as well.

11 I do want to say a few words about
12 Marine-centered medical home because I heard the
13 transportation issues. So there are Warrior
14 Transition Units at Camp Pendleton and Camp
15 Lejeune. But we also got funding for the second
16 half of this year and then going forward for
17 Marine-centered medical home.

18 We're starting out with six of them,
19 two are in the Camp Pendleton area, Miramar, and
20 62 area. And I forget the one -- French Creek
21 by Camp Pendleton.

22 And so we have funding for that.

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1 And they have spent -- they have also bought in
2 addition to the regular primary care staff care
3 coordinators, LPNs on those teams to coordinate
4 care in the Marine-centered medical home.

5 And finally, one of the things
6 that's unique is based on what the line
7 leadership wanted is all their Marine-centered
8 medical homes have to be within a reasonable
9 walking distance of the units. And so that's
10 very different than many of our other
11 situations. But they required that because of
12 their footprint and their ops tempo.

13 So that's all I have for right now.
14 I'm sure that there's questions.

15 CO-CHAIR NATHAN: Questions?
16 Issues?

17 MEMBER REHBEIN: Just a quick
18 question. You referred to a comprehensive care
19 plan earlier in your presentation. Is that very
20 similar to what we know as the comprehensive
21 transition plan in the WTUs?

22 MS. JULIAN: I would have to look at

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1 that. But we have online comprehensive care
2 plan builders for different conditions. And
3 they -- this is what the patient has, this is what
4 they need. If you send me that or someone does
5 I can send you what our plan looks like and we
6 can compare. I am just not sure. Yes, ma'am?

7 MEMBER EVANS: It's different.

8 MS. JULIAN: Okay.

9 CO-CHAIR CROCKETT-JONES: I would
10 just like to say anecdotally I've seen this
11 change in the clinic where my family gets care
12 and it seems to be changing dramatically for
13 family care especially with the idea of a
14 holistic approach. I'm not sure we're seeing it
15 as clearly -- at least anecdotally I'm not seeing
16 it as clearly translated in the Warrior
17 Transition Units, especially this sort of
18 cultural change that your family matters to your
19 health. So I would love to -- if there's a way.
20 I'd love to know how you're going to measure that
21 or try to impact it, you know, increase the
22 collaborative sort of concept. I mean I think

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1 you would have to find some way to measure it in
2 order to increase it. So just, you may not have
3 that now, that may be something you're going to
4 go back and consider, but I would be interested
5 in knowing about that.

6 MS. JULIAN: I can tell you -- not
7 anecdotally. I can tell you what we're doing
8 right now. We're trying to improve our
9 satisfaction surveys to get at those new things.
10 So we're using the AHRQ, the Agency for
11 Healthcare Research and Quality recommended
12 verbiage to get at those same questions. And we
13 have until Thursday to get those in to our survey
14 people. That's the first thing. That's the
15 end side of it, right.

16 What are we doing at the front end?
17 So they answer that they're satisfied is that's
18 part of what we're trying to get to and we talk
19 about at my webinars for NCQA recognition. It
20 isn't just a pencil-whipping exercise, I always
21 say. This is what you have to do. This gives
22 us the guidepost. There are specific standards

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1 and elements that you have to meet for must-pass
2 elements in NCQA to increase the family
3 collaboration and communicate. And you have to
4 document it in the medical record.

5 And so those Warrior Transition
6 Units are going through that process right now.
7 So it is my hope and I certainly will emphasize
8 this when I go back to the office to make sure
9 that we absolutely pay attention to that for our
10 Warrior Transition Units.

11 MEMBER MALEBRANCHE: Ms. Julian, I
12 think one of the things that we found on our site
13 visits was that in some cases families didn't
14 feel welcome to their visits and/or the warrior
15 didn't choose to have them at their visits.

16 So, but one of the things that maybe
17 as you're looking, and especially where you have
18 displaced warriors when their families may not
19 be in the vicinity is part of the PCM education
20 of asking. And then maybe educating the warrior
21 as to what the benefit might be of having your
22 family. Because there seemed to be some

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1 disparity of how people were approached or
2 embraced or not.

3 And so that was something I think
4 that Ms. Crockett-Jones is getting to when we
5 asked about has your family gone to your
6 appointments. Well, no. And sometimes when
7 you ask them one didn't want them. So there were
8 some variation in there.

9 But I think just the fact that this
10 is essential to your healing and would be helpful
11 if they are in the area. If they're not what
12 would the approach be. You know, that sort of
13 question. How could we reach out to them in that
14 way.

15 So it obviously varies to
16 individual. But as we get better and better at
17 medical home and looking at a person as a total
18 person and well-being. And like are there
19 issues in your family we don't know about and
20 haven't even broached.

21 I think that that's going to be very
22 important because I think we didn't see a lot of

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1 that this time and perhaps -- of course we went
2 to one of the biggest WTBs where a lot of people
3 were displaced. But -- and in some cases we
4 heard from families that they were told not to
5 be present. So it's kind of interesting the --
6 you know, it's the full gamut. But I think it's
7 an education piece.

8 But also the primary care person.
9 Because you know, they're looking at a person for
10 20 minutes and if they need a longer appointment
11 they don't always have that. So those sorts of
12 issues maybe as you're looking.

13 MS. JULIAN: It looks like
14 something we need to look at adding to our
15 standardized process. We're not lazy but our
16 motto is make the right way the easy way. And
17 some of the ways we do that is to put that in the
18 Tri-Service Workflow to prompt. Because you
19 don't remember every single thing you need to ask
20 the patient.

21 In our more mature patients in our
22 medical homes we do have the family areas. And

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1 patients and families are welcomed. And we are
2 seeing changes like that. And I'm glad to hear
3 you say that you have noticed that.

4 We met with the architects because
5 we don't want them starting to build and retrofit
6 places for the future that don't fit our model
7 with big giant bays for surgery when we're not
8 doing surgery.

9 And one of the things we have added
10 is those patient education rooms and rooms for
11 families in the room. But I think that your
12 point is very well taken and it's very important.

13 We find that not everything that's
14 wrong with you is physiologically, or your
15 healing isn't just, you know, your cells and
16 everything mending, it's your support
17 structure. And your family may be some of the
18 people in the unit with you or it may be your
19 husband or wife or whomever. And we need to --
20 if we are really going to be holistic we need to
21 keep that in mind. I think that's a great
22 suggestion.

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1 CO-CHAIR NATHAN: One point. And
2 we need to start closing up because we're pushing
3 on the time envelope. But yes, the whole
4 country should be interested in this because
5 this is going to bring down the cost of care.
6 And the fact that it's not a fad because
7 Intermountain Health, Geisinger, a lot of the
8 multi-million dollar thousand-member HMOs have
9 gone to the medical home model.

10 Ironically, Karen, the warrior and
11 the reason we're interested in this as a task
12 force is the warriors are coming into this later
13 than the rest of the general population. We
14 still partition the warriors and WTUs, Wounded
15 Warrior regiments, while their families may
16 actually be enrolled to a patient-centered
17 medical home.

18 Now, as you heard Regina talk about,
19 the Army and the others are starting to roll out
20 this into their Warrior Transition Units as
21 well. But yes, the families have been
22 partitioned from this ahead of other families.

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1 And so we need to move into that.

2 This is basically an evolutionary,
3 somewhat revolutionary way of providing care.
4 And it all hinges on -- if you get nothing else
5 out of it, it all hinges on the ability to
6 electronically communicate with the patient
7 either through the rudiments of email, phone, or
8 ideally an asynchronous messaging system like
9 Relay Health or others that are web-based where
10 you can talk about. And this is how the families
11 will get engaged because we'll be pushing out
12 things on webs, educational things.

13 Quick sea story. When we started
14 this at Bethesda I gave them the money to build
15 a new medical home. Took half the medicine
16 clinic, put it in a medical home. Went down to
17 the -- I'm an internist so I go to medicine
18 clinic.

19 I went down to the old medicine
20 clinic. It's busy like a pizzeria on a Friday
21 night, people screaming, yelling, I got two
22 patients backed up here, I've got three.

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1 I went over to medical home. Nobody
2 there, quiet, mood music. And I said to the
3 staff, I said where are all the patients. And
4 they said oh, we're taking care of them
5 electronically. And I said well, it's not
6 medical home, it's home alone. And I said now
7 -- and people say where are the cost savings. I
8 said now you can enroll more patients. And they
9 go oh, we didn't really think about that part.

10 And so that's how we're saving
11 money. Because in medical home now instead of
12 1,500 patients per provider you can have 3,000
13 patients per provider because you have removed
14 the unnecessary office visits.

15 And the one thing you didn't mention
16 which is our younger patients love this model.
17 Our older patients do not. Our older patients
18 want to come in and see the doctor or drive in
19 and see the pharmacist, hand them their pills.
20 Where the 20-year-old soldier or sailor wants
21 everything done electronically, wants it mailed
22 to them and we're going to go to virtual care.

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1 So medical home is tapping into this virtual care
2 where the only reason you need to drive in to the
3 hospital is for your provider to either touch you
4 because you need to be touched, hear you because
5 they need to listen to something, or see you
6 because you have something they need to see with
7 their eyes. Otherwise we can eliminate at least
8 50 percent of the reasons any of us go see the
9 doctor if we have competent medical.

10 And that's what's going to bring the
11 families of the warriors engaged, when we
12 connect with them robustly electronically and
13 their person can then -- remember the biggest
14 problem we have now is they can't hear the
15 provider. In medical home they can text their
16 provider or send something by web-based
17 communication and the provider if it's working
18 right within 24 hours will get back to them and
19 say I'm so sorry you're not feeling well, or I'm
20 so sorry you're feeling disenfranchised, or I'm
21 so sorry you're feeling as though you're not part
22 of the care plan. Let's get you in here and talk

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1 about that. That's where I think the gravitas
2 of this all lies. So thank you.

3 MS. JULIAN: So just to go along
4 with this story. The person he's talking about,
5 we were traveling together to an offsite because
6 we like to get together with the services face
7 to face. There's nothing like that, right?

8 And he's typing away and I said
9 you're not listening to me, what are you doing.
10 And he goes I'm seeing my patients. And he
11 travels all the time but he has about 100 percent
12 continuity and his patients are extremely
13 satisfied. And this opens up more capacity and
14 allows us to optimize and save our system.

15 So we need to leverage all those
16 things that are -- we have now or that are
17 emerging technologies to reach our patients and
18 so wish us luck. If you have any other questions
19 I'm more than happy to come back. And it was an
20 honor to speak to you. Thank you.

21 CO-CHAIR CROCKETT-JONES: Thank
22 you, Ms. Julian. Are we ready for our next? Or

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1 do we need a minute?

2 DR. RAUCH: Okay, well I'm going to
3 start this off and then my colleague is going to
4 finish it up because we really have two separate
5 -- kind of two separate briefings on this topic.

6 CO-CHAIR CROCKETT-JONES: Let me
7 give the members just an idea of what we're about
8 to hear. That you are Dr. Terry Rauch and you
9 are the director of the Defense Medical Research
10 and Development Program in the Office of Force
11 Health Protection and Readiness Programs.

12 Your colleague is Colonel Andrea
13 Crunkhorn, chief of Rehabilitation and
14 Reintegration Division under the Office of the
15 Army Surgeon General. We have both of your
16 findings located under our Tab E. But please go
17 ahead and give us an idea of the separation and
18 take it over for us now.

19 DR. RAUCH: My focus will be
20 specifically on an overview of our medical
21 research and development program largely within
22 the Defense Health Program. And I'm going to

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1 start with the big picture and then narrow it
2 down to focus on polytrauma and GU injury.

3 COL. CRUNKHORN: Good afternoon, or
4 I guess it's still morning, sirs and ma'am. I'm
5 Colonel Crunkhorn and I'll be talking a little
6 bit more about the specifics of the five
7 questions that we were given to respond to
8 specifically about the pieces and the parts of
9 GU care, reconstruction, rehabilitation and
10 then reintegration back into active duty or back
11 into civil society.

12 DR. RAUCH: Okay. Within the MHS
13 our research and development focus is really on
14 force health protection and readiness of the
15 force. Now a lot of our research activities can
16 complement population health, quality
17 healthcare and some cost management but our
18 focus is largely on force health protection and
19 readiness of the force. And the R&D investment
20 is really the fundamental institutional means to
21 advanced practice of military medicine.

22 Within the MHS we deliver care on a

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1 coordinated continuum of care. And our
2 research strategy is also based on the continuum
3 of care construct where we will have research
4 investments on prevention, on screening and
5 diagnostics, on treatments and on
6 rehabilitation and reset back into the force or
7 back into civilian life.

8 Our objectives in research and
9 development. I will say a little bit more about
10 our transition and our translational activities
11 as we move from basic science into more advanced
12 development and then translating it into
13 clinical practice. I'll talk a little bit more
14 about that at really the last few slides in the
15 area of polytrauma and regenerative medicine.

16 I will say also that a lot of our
17 translational activities will end up in the
18 dissemination of new standards of care or it
19 could result in the development of a new drug,
20 for example, as a treatment, or as a prophylaxis.

21 CO-CHAIR NATHAN: Dr. Rauch in the
22 interest of time I think we are all very -- we

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1 understand what your goals are and where you're
2 trying to get. We probably need to public the
3 gravity of your presentation into what you're
4 doing and how you're doing it.

5 DR. RAUCH: Okay, fair enough. We
6 have a broad portfolio. Most of your interest
7 here I suspect is going to be in the combat
8 casualty care and the clinical and
9 rehabilitative medicine.

10 With respect to GU injury probably
11 the biggest advances in our investment in our
12 approach are going to be seen in rehabilitation
13 and regenerative medicine.

14 But the important thing is that
15 these portfolios all crosstalk in our research
16 approach because most injuries are not isolated
17 injuries. And you really have to take a
18 polytrauma approach in your research
19 activities.

20 It's important for everybody to
21 understand that we have a joint planning and
22 execution approach. And I use "joint" in the

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1 federal sense, not in the -- it's beyond the
2 tri-service sense.

3 We hold joint portfolio reviews.
4 In this particular case in last November we held
5 our joint portfolio review in regenerative
6 medicine and rehabilitation. And that's where
7 we will go over all of our research investments
8 in that area, you know, what's the state of
9 science, what's our research telling us, what
10 it's not telling us. And we do that with
11 participation of the VA, my colleague Tim
12 O'Leary sits the panel with me, and also with NIH
13 if NIH has anything invested in it. And that way
14 we fully leverage the federal dollar and avoid
15 duplication of effort and have a lot of crosstalk
16 there.

17 I said before that with respect to
18 GU injury probably the largest area that will
19 contribute to that will be clinical medicine and
20 rehabilitation and specifically regenerative
21 medicine and also probably some -- a little bit
22 of transplantation also.

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1 These are -- within regenerative
2 medicine these are our five focus areas. I will
3 say that GU is the newest in that p until now we
4 have really not had a significant research
5 investment in GU injury.

6 I will say a little bit about AFIRM
7 because that's really our strategy to get into
8 the GU injury research area. AFIRM I is just
9 concluding. It's been basically a 5-year
10 cooperative agreement cosponsored with Army,
11 Navy, Air Force, VA, NIH funding and also Health
12 Affairs. All three surgeons sit the board of
13 directors along with Health Affairs to kind of
14 guide the consortium activities.

15 I will say that going into this award
16 about a little over 4 years ago the goal of AFIRM
17 was to produce a product, one or two products for
18 clinical trials. It has produced at least 11.
19 It's been a very aggressive pre-clinical
20 program. And we've picked up a lot of those
21 clinical trials with DHP funding since then.

22 CO-CHAIR NATHAN: While you're

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1 still on AFIRM.

2 DR. RAUCH: Yes, sir.

3 CO-CHAIR NATHAN: Could you talk a
4 little bit about what you think are going to be
5 the main deliverables that have come from the
6 collaboration and the investment in the
7 regenerative studies?

8 DR. RAUCH: Yes. Well, right -- I
9 may have another slide on that. But like I said,
10 we have at least 11 products that have come out
11 of pre-clinical work and now are going into phase
12 I or phase II clinical trials.

13 AFIRM I largely focused on bone
14 regeneration, soft tissue regeneration and skin
15 regeneration. And so that's where the products
16 are really coming from and entering into
17 clinical trials.

18 For AFIRM II the solicitation went
19 out last year. And at that time we recognized
20 the need to add GU injury as a requirement as a
21 part of that solicitation.

22 Where we are now is we have selected

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1 a winner. It's undergoing cooperative
2 agreement negotiations. The final award should
3 be made later on this year. But I will say that
4 the winning proposal and the winner is just a --
5 he's a urologist, a remarkable pioneer in the
6 field, particularly in GU injury and
7 regenerative medicine. So it's really going to
8 be a sweet spot over the next 4 years of
9 scientific advancement I think coming out of
10 AFIRM II.

11 CO-CHAIR NATHAN: And I think
12 everybody recognizes just to put a little bit
13 more granularity into it that given the
14 dismantled mission in Afghanistan, the fact that
15 people are being blown up on foot as opposed to
16 in a vehicle or by bullets.

17 And Dr. Rauch, correct me if I'm
18 wrong, but about 20 percent of those people who
19 lose a limb through a dismantled IED suffer a
20 devastating GU injury with either total or
21 partial functional loss for both the typical
22 urinary requirements and then the concomitant

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1 loss of the genital function.

2 And so this has become something
3 that we didn't deal with in a significant issue
4 in previous conflicts. But here these young men
5 in their late teens, early twenties are being
6 incapacitated for life from a GU standpoint,
7 about one-fifth who come in with severe lower
8 limb injuries.

9 And that's why the deserved
10 attention, interest of AFIRM II ranging all the
11 way from rebuilding with skin flaps to
12 rebuilding with prosthetics to transplantation
13 is being considered. And you're right, the
14 urologists that we're looking at are ones who
15 have been basically just pioneers in this field.
16 Thank you.

17 DR. RAUCH: Yes, I think you're
18 right on point. And that is why 5 years ago we
19 really did not have a research program in this
20 area.

21 I will say a little bit, just a brief
22 piece on something complementary to the

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1 regenerative medicine approach to urogenital
2 injuries and that is transplantation.

3 Within the portfolio right now we've
4 focused largely on transplantation of hands and
5 face. At least eight hand transplants.
6 Probably most of you saw the last one done by Andy
7 Lee up at Hopkins at least probably now a couple
8 of months ago.

9 Four face -- well, actually five
10 face transplants now done by Bo Pomahac up at
11 Brigham and Women's. The last one he did was
12 about a month and a half ago.

13 And then we also are proceeding with
14 a major research consortium on transplantation
15 that we should be making the final award by the
16 end of this year.

17 I did say that I would wind up with
18 some translational activities and so this is how
19 you basically take a look at a portfolio and you
20 see how balanced your portfolio is from basic
21 research. We measure these by what we call
22 technology readiness levels or TRLs. And so

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1 what you will see, the lower the TRL the more
2 basic science approach it is. And then the
3 higher the TRL when you get into TRL 7 and 8 and
4 9, 9 you basically have a fielded product.

5 And so as you can see in extremity
6 regeneration and reconstruction and
7 transplantation of face, skin regeneration,
8 we've had a pretty balanced investment. And
9 then on GU and the peritoneum, and the peritoneal
10 cavity, that's basically a new approach that
11 we're going to pick up with AFIRM II.

12 CO-CHAIR NATHAN: Dr. Rauch, for
13 the task force's benefit and mine too if the
14 commandant or the assistant commandant of the
15 Marine Corps were here they would say this
16 because I know they say it to me all the time.

17 We worry very much that the military
18 is too myopic in trying to solve these issues on
19 their own and they don't widen the aperture
20 enough to try to include best practices and
21 incorporate research, send patients to places --
22 centers of excellence in the academic setting to

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1 look for best practices.

2 I tend to push back a little bit and
3 say if you look at what's being done at Hopkins,
4 if you look at the patients that we have in these
5 studies I think we're doing -- I think we're open
6 to anybody's best practice idea.

7 From your perspective, for a
8 recovering warrior who's suffered devastating
9 injuries do you feel there's enough robust
10 collaboration going on between the military
11 centers of excellence and the academic centers?

12 DR. RAUCH: Well, I think that
13 that's an area that we can enhance and improve
14 the relationships between our MHS clinical
15 research infrastructure and the infrastructure
16 out in the private sector with the Hopkins, the
17 Wake Forests, the Cleveland Clinics. And I
18 think that that's where we're trying to move to
19 with the next AFIRM mechanism.

20 And now it's becoming quite common
21 for on a given protocol like Peter Rubin up at
22 Pitt has a protocol to do facial reconstruction

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1 with autologous fat grafts. He now normally
2 includes a co-investigator out of the MHS. So
3 I mean, we're trying to move in that direction.

4 CO-CHAIR NATHAN: Thank you.

5 DR. RAUCH: Thank you.

6 MEMBER CONSTANTINE: Sir, a quick
7 question on that. I had my reconstructive
8 surgery at Johns Hopkins because at Bethesda
9 they could not do it. This was back starting in
10 2006 and it continues today.

11 My surgeon there, Dr. Rodriguez, is
12 a world-class surgeon and he's operated on other
13 military folks and wants to do more. And has
14 told me several times he receives a lot of
15 pushback when he's offered to come to Walter
16 Reed, other places.

17 And I heard what you just said, that
18 we're moving in that direction and you recognize
19 this as something that's important. But here we
20 are in 2013. What are the obstacles to that?
21 Who has a problem with widening the aperture?

22 DR. RAUCH: I'll give you my

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1 perspective. No one has a problem with it. I
2 think it's just more facilitating the networking
3 in the professional community. And exchanging
4 getting our principal investigators up at
5 Hopkins.

6 And that's happening now it's just
7 not happening enough. But it is -- over the
8 course of time it is happening more. Thank you.

9 CO-CHAIR NATHAN: Justin, I think
10 it's getting better. I'm encouraged but I'm not
11 yet satisfied as to how well we're integrating.

12 Some of it, the genesis of a little
13 bit of it is that we used to have private practice
14 physicians or plastic surgeons, whatever, would
15 say we want to come in and do our services and
16 help you out. And we'd look at their scope of
17 practice and we were better than they were
18 because we were doing so much more of it in
19 certain areas.

20 And then there were the niche people
21 who were very good at what they do. Maybe a
22 surgeon in Chicago does nothing but eye

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1 reconstruction that we don't do in the military.
2 It took us a while to understand that they could
3 help.

4 The only other impediment was the
5 family impediment which was I'm going to send you
6 to Chicago or to Palo Alto for a couple of weeks.
7 And the families would get there and say where's
8 our rental car, where's our Fisher House,
9 where's our ITO orders. And Stanford would say
10 we don't offer that kind of stuff. And the
11 families would come back to the military and say
12 you put me up at Walter Reed or you put me up at
13 San Antonio. How come you're not putting me up
14 here. Those should not ever stand in the way of
15 a wounded recovering warrior getting the
16 absolute best care this country has to offer.

17 So I think we're getting better at
18 it but it's mostly been because of the real push
19 from the chief of staff of the Army and the
20 commandant of the Marine Corps really pushing on
21 us and saying look, I know there's better
22 mousetraps out there. And so with people who

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1 are expert at the friction point like Dr. Rauch,
2 I think we're facilitating better lubrication of
3 getting folks out there.

4 DR. RAUCH: I mean we can certainly
5 write that into our -- and we do write that into
6 our solicitations where we require partnerships
7 between Wake Forest and MHS facilities. If
8 you're going to compete for it.

9 And that concludes my presentation.
10 I hope I did --

11 MEMBER EVANS: Excuse me, sir.
12 Right here.

13 DR. RAUCH: Yes, ma'am.

14 MEMBER EVANS: I'm trying to figure
15 out. From the ground level we've had the
16 regiment to kind of come back outside of the MTF
17 to say we want this patient to -- we identified
18 a patient that qualifies for surgery outside of
19 us knowing about. So how are we making that loop
20 so we get them into the MTF through the right
21 system to refer to one of the facilities?

22 We had a couple of patients that we

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1 had to go back and say okay, he needs to get into
2 the MTF system, make that referral. Or is that
3 the right process when the Wounded Warrior
4 Regiment identifies someone?

5 DR. RAUCH: Well, I'm not sure I can
6 answer that because that hasn't really played
7 into our R&D portfolio. But for the fact that
8 in the area of transplantation, for example,
9 it's my understanding that there's now a joint
10 board that can refer our beneficiaries out to
11 outside of the MHS. And I do believe that right
12 now, I've been told there's a Marine in the queue
13 for a face transplant up at Brigham and Women's.

14 So I mean I'm somewhat familiar with
15 that. I have talked with Bo Pomahac a little
16 bit. So he's kind of a little frustrated. I
17 wish things would move faster. So maybe you all
18 could provide a little insight as to how maybe
19 we could move a little faster. Or if we need to
20 move a little faster in getting some of those
21 patients out into that area. Is that fair?

22 MEMBER EVANS: Yes sir, that's

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1 fair.

2 DR. RAUCH: Any other questions?

3 COL. CRUNKHORN: So again, good
4 morning. And this is just a little bit more
5 detail in response to the specific questions
6 that were asked to try and help paint a little
7 bit more of a complete picture for you.

8 And I was still gathering this
9 information as the slides were due so anything
10 you have as follow-up questions we're more than
11 happy to take back. And there is a community of
12 very enthusiastic and passionate urologists out
13 there who are very interested in making sure that
14 this particular community gets the care that it
15 needs. So they are very much willing to answer
16 any questions you might have follow on.

17 As an aside I'm also the chair for
18 the Army for the Face and Hand Transplant
19 Advisory Boards. And so if you've got any more
20 particular questions about vascularized
21 composite allotransplantation we're more than
22 happy to fill in some of the gaps on that as well.

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1 So this is a follow-on really from
2 Dr. Rauch's slides, a little bit more detail with
3 a little bit more specifics on the broad area
4 announcement, what MRMC is doing for research.

5 It is well integrated. The joint
6 program committees are working well together.
7 It is beyond the MHS. It is trying to pull in
8 best practices from the civilian side as well as
9 VA.

10 And actually as a backup I brought
11 with me Colonel Marilyn Brew from JTAPIC which
12 is the Joint Trauma Analysis and Prevention of
13 Injury in Combat with me to help because it is
14 the non-medical piece that you had asked about
15 which is the POGs and the PUGs for protecting the
16 genital area and it is the soldier protections
17 that medical can't fix.

18 So if you look at the rate of injury
19 and death on the battlefield, at we're at about
20 90 percent. We've got 10 percent that we can't
21 save. And so our goal was to try and reduce that
22 to 5 percent that we can't save, that have such

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1 devastating injuries.

2 And when they went in and looked at
3 the data from ISR and JTTS, the Joint Theater
4 Trauma Registry, they really only could identify
5 about 2 percent where if we improved point of
6 injury or en route care that we could actually
7 save more lives. So 8 percent are such
8 devastating injuries at the time of injury that
9 medical cannot affect it. And that goes
10 to JTAPIC's role which is pulling in the
11 non-medical side of the house for soldier and
12 Marine and warrior protections. So that's down
13 here, PEO-Soldier and U.S. Marine Corps infantry
14 combat equipment.

15 So, who has the lead? It is really
16 a compendium of folks. It's both MRMC. It's
17 also Office of Naval Research very
18 collaboratively working together. As Dr. Rauch
19 already said JPC-6 and JPC-8 working together to
20 develop that broad spectrum for research and
21 then translating it into clinical practice with
22 AFIRM and with the face and head transplants in

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1 particular.

2 And they are now talking phallic
3 transplantation working with Johns Hopkins and
4 several other leads in the nation. Right now
5 it's still notional but they are looking for
6 potential transplant candidates. And the
7 JTAPIC down here that I already talked about.

8 And the PPE is the personal
9 protective equipment, your body armor. But
10 also goes to in fact the design of vehicles and
11 how you have vehicles that when you are mounted
12 as opposed to dismounted provide protection.

13 So just to kind of baseline. And I
14 apologize because I don't really know what your
15 all's level of knowledge is for JTAPIC. This is
16 their slide and this is all the groups that they
17 work with across the DoD. And over there
18 slightly off is the Marine Corps.

19 And these are the acronyms. This is
20 the number one thing. I know we live in acronym
21 soup so that might help.

22 So the committee asked about the

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1 targeted supports for who is doing the medical
2 and non-medical training. And there's pieces
3 of this answer over the course of the next couple
4 of slides.

5 So the bottom line is both Army and
6 Navy have worked very hard to get
7 specialty-trained, fellowship-trained
8 reconstruction specialists. There are now
9 residency fellowship-trained at Tripler in
10 Hawaii, at San Antonio, at Walter Reed and I'm
11 pulling a blank on one more. I believe
12 Portsmouth. I'll have to go back and look. But
13 they are out there. They're being forward
14 pushed and that training and development is
15 being institutionalized so it doesn't get lost
16 over the course of time.

17 Currently, specifically in regards
18 to hand transplantation Johns Hopkins now has
19 privileges at Walter Reed and some of the Walter
20 Reed surgeons are looking at privileges at Johns
21 Hopkins. And so getting that, and we're looking
22 at that being the course, the norm, especially

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1 as we start to withdraw from the area of
2 operations and we come back and the war wounded
3 come down, how we maintain those skill sets over
4 time.

5 And that was a question the board had
6 asked back in your October report about
7 sustainability of our war-related skills over
8 the course of time. And that's one methodology
9 of doing that.

10 CO-CHAIR CROCKETT-JONES: I just
11 want to interject here with these two slides, 3
12 and 4 both.

13 COL. CRUNKHORN: Sure.

14 CO-CHAIR CROCKETT-JONES: The
15 folks that I have talked to who are dealing with
16 these injuries don't really have much doubt that
17 they're getting pretty much the best medical
18 care that is available globally. Feel pretty
19 confident in that.

20 They feel completely unprepared,
21 uneducated and in an unbelievable fog when it
22 comes to the expectation management for moving

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1 forward with normal sexual relations or getting
2 as close to normal, what will be their normal.

3 Fertility, they don't understand.
4 They don't feel their necessarily getting the
5 most proactive fertility care and plans and
6 responses. They feel that no one's willing to
7 talk to them when they have questions. No one
8 knows who has the answers and nobody really wants
9 to talk to them.

10 About all of this, the sort of
11 real-life, you know, this is great that we are
12 looking at doing the best care that we can for
13 the physical injury. But this is -- the actual
14 maybe nexus of import for these folks isn't just
15 going to be how much can we restore, have we
16 restored it, now that we've restored it.

17 It's also what should I be prepared
18 for and the huge behavioral health element of now
19 these spouses have to talk to each other and
20 there is -- these are big, big issues with
21 serious separation of expectations. I know the
22 spouses are saying I want to move forward and

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1 normalize my life and I still want to have a
2 sexual life with my partner regardless of what
3 the physical limitations are. And I want
4 someone to tell me how to make that happen. And
5 I want someone to tell me what to expect. And
6 I want lots of education. And I want someone --
7 I want people to just talk to me about it.

8 And you've got lots of fear and
9 identity issues going on with the servicemember
10 who's injured who maybe doesn't want to talk
11 about it because there's so much fear and
12 unknowns.

13 And the one line that struck me is
14 actually on the next slide. I believe this is
15 coordinated with mental health participation.
16 This is -- that is -- that is pretty much, there
17 you go. That's where the experts stand is we
18 think somebody is doing this. That is the sense
19 that every family member I've talked to who has
20 any connection to this issue, that is exactly the
21 sense they have is that the people who they turn
22 to for expertise, the people who they are relying

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1 on for like their whole lives going forward maybe
2 think somebody is doing something. Do you see
3 what I'm saying?

4 CO-CHAIR NATHAN: Absolutely, but I
5 was under the impression they recently started
6 a program called intimacy counseling.

7 COL. CRUNKHORN: Yes sir, and
8 that's the next slides down. So this is a little
9 bit distributed across. And there is no named
10 behavioral health support or counseling
11 package.

12 And so when I went to behavioral
13 health and I asked them about this particular
14 aspect of care their response was that as part
15 of trauma, rehabilitation, behavioral health is
16 a standard of care.

17 So "believe" -- and I apologize,
18 that's my bad editing. As I was gathering the
19 information on this is that we can go back and
20 we can confirm that's happening. It is
21 everyone's expectation that it is happening.
22 And so that's very sloppy language on my part.

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1 CO-CHAIR NATHAN: But Suzanne, I
2 think your point's well made. But I think there
3 has been. And it's not universal. I think it's
4 mostly been borne at Walter Reed Bethesda --

5 COL. CRUNKHORN: Yes, sir.

6 CO-CHAIR NATHAN: -- for that need,
7 for the families saying. Because I just had a
8 case on my desk the other day of a Marine couple
9 who fell through the cracks. They didn't get
10 the intimacy counseling. And so the next person
11 they talked to was the commandant of the Marine
12 Corps. So the next person he talked to was me.

13 (Laughter.)

14 CO-CHAIR NATHAN: And so I
15 researched this and said what's going on and they
16 educated me about the intimacy counseling that
17 apparently covers most of these areas that
18 you're concerned about. What can you expect in
19 the future, how can we preserve your fertility,
20 how can we harvest your sexual tissue for
21 childbirth later or reproduction later, all
22 these things.

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1 They had missed this one couple and
2 so they went back and made sure they engaged
3 them, what are your options, what
4 transplantation for regeneration, for
5 prosthetic device, for plastic surgery.

6 So I do think -- I'm not trying to
7 steal your thunder but this is what I was told.

8 COL. CRUNKHORN: Sir, go ahead,
9 please.

10 CO-CHAIR NATHAN: Okay. But am I
11 being truthful here?

12 COL. CRUNKHORN: Yes sir, that's
13 exactly it. And I was going to try and find my
14 notes. I know there's urology who goes the
15 wounded warrior clinic. Urology is embedded
16 across the Walter Reed campus in every place
17 where these amputees and these traumatically
18 devastatingly injured young men, and mostly
19 young men, are located. And so they're there
20 and they're accessible.

21 I don't know that if we need a named,
22 stand-alone, stove-piped program specifically

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1 for this. But this is, they've already
2 identified this at Walter Reed as being a gap.
3 And I would have to go back and check and see
4 whether or not SAMC which -- and then San Diego
5 have parallel programs in place. But this
6 appears to be very comprehensive.

7 And then what's on the next slide is
8 what they're doing for provider education.
9 Because again, this is not just standing up a
10 special program for this particular cohort.
11 This is about making sure it's institutionalized
12 and it's sustainable and that as the uniforms in
13 particular retire or PCS or move on that the rest
14 of the staff at Walter Reed, this is so
15 indoctrinated and so embedded into the DNA of the
16 organization that we do this as a matter of
17 course. And I think that's what you're getting
18 at. People shouldn't fall through the cracks.

19 CO-CHAIR CROCKETT-JONES: Yes, I
20 frequently felt in talking to folks that it
21 wasn't necessarily that the resource wasn't
22 there, but that providers, whoever they wound up

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1 being comfortable with talking to were -- either
2 the provider was not comfortable as soon as they
3 hit the sexual intimacy discussion, and because
4 of that could not connect them well to the
5 resources that are out there.

6 And I'm not sure that having a
7 particular lead is helpful either because you
8 still, you're dependent on who winds up being the
9 person that they're comfortable talking to.

10 But it should -- I think that what
11 I was seeing was that there was so much
12 discomfort in talking about this subject from
13 the providers as well as some of the
14 servicemembers. And probably if they weren't
15 talking to me who is another spouse that might
16 be true of a good number of the spouses too that
17 this has so many sort of cultural flags and you
18 know, it feels like throwing a hand grenade into
19 a room for a lot of these folks if they're going
20 to bring up this subject.

21 CO-CHAIR NATHAN: This looks like
22 an effort here, this slide, to try to increase

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1 the comfort level and the ambient knowledge of
2 the staff that are going to be treating these
3 patients.

4 COL. CRUNKHORN: And break down
5 those barriers. And I will say one of the things
6 that the urologists asked me to make sure that
7 I brought up today is that it's not just the
8 trauma. The trauma patients are the most
9 compelling and certainly the most devastatingly
10 affected by the issues.

11 But there are a host of issues
12 related to TBI, PTSD and medication related to
13 dysfunction that are probably even less
14 recognized and addressed. And so this is an
15 area, unfortunately it's a little bit of a growth
16 industry, that we need to get folks comfortable
17 talking about these issues, and not just the
18 servicemembers but the spouse. So I think this
19 is a great initiative, again, brand spanking new
20 that needs to get replicated and propagated.

21 MEMBER CONSTANTINE: Ma'am, I want
22 to go back a slide that you have on there about

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1 a \$25,000 grant which I'm aware because I work
2 with the SemperMax Fund. And my understanding
3 was that that grant was from the Bob Woodruff
4 Foundation to Tim and Shannon Maxwell so they
5 could host one of their conferences with, and I
6 guess there's some providers also, but really
7 it's for the families who are going through what
8 Suzanne just described. Because this -- and
9 they had one as recently as late last year.

10 And so because these services aren't
11 addressed, and maybe it sounds like you're
12 rolling something out, but I guess here it says
13 that this grant from a private group to --
14 American donations to provide training to
15 clinical providers in the hospital. And that
16 seems backwards to me if that's accurate.

17 COL. CRUNKHORN: I can go back and
18 confirm that fact and double-check and make sure
19 that that's not a misprint and that it should be
20 in fact the patients.

21 MEMBER CONSTANTINE: I would just
22 say --

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1 COL. CRUNKHORN: Sure.

2 MEMBER CONSTANTINE: -- we're
3 relying on the generosity of the war effort,
4 people involved in the war effort to train our
5 providers.

6 But even so, the point is that it's
7 the private sector or the 501(c)(3) sector who's
8 having to stand up to provide this counseling and
9 train these families. And we've seen that
10 across the board with the Wounded Warrior
11 Company. I really hope that we can get ahead of
12 the power curve on this and start taking a
13 leadership role more than we already are.

14 And reaching back and finding people
15 who are injured in the last 10 years who have this
16 because a lot of times we don't do that. We say
17 okay, well from here going forward. But these
18 people will have these problems forever.

19 COL. CRUNKHORN: One of the
20 initiatives that the Army surgeon general is
21 working on is on this operating company model
22 where we're standardizing care across the Army

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1 footprint.

2 And one of the things that the
3 urology consultant is trying to push forward are
4 urology CPGs, clinical practice guidelines.
5 And so this would be one of those things you'd
6 want to embed.

7 And those clinical practice
8 guidelines are all DoD-VA because really they're
9 probably not DoD patients, they're probably VA.
10 So we would have to make sure we're handing warm
11 hands -- holding hands with the VA in order to
12 make sure we capture them.

13 CO-CHAIR NATHAN: I think it's an
14 evolutionary -- I'm not excusing the time line
15 but I think it's an evolutionary path.

16 We first encountered people with
17 bilateral above-the-knee amputations. And at
18 first those were -- "novelty" is the wrong word,
19 but they were unusual. And we figured out ways
20 to use multidisciplinary teams to get them back
21 walking again.

22 We encountered people who were

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1 triple amputees, people with severe head injury.
2 And the GU part was an afterthought because we
3 were so engaged in just trying to get people
4 walking and up and about again.

5 And now we've gotten to the point
6 where if somebody comes in with bilateral
7 above-the-knee amputations we recognize the
8 tremendous time it's going to take for
9 rehabilitative process but we have a system
10 down.

11 We can look them in the eye and say
12 we're going to get you up on legs again. We're
13 going to get you running again. And it may take
14 a year, year and a half, but we'll do that. So
15 that's almost -- second nature is too trivial but
16 it's become a codified process.

17 Now that we've sort of got that out
18 of the way and the process fixes for that out of
19 the way we now look and turn our attention to the
20 more spiritually and emotionally debilitating
21 injury which is that of genitourinary trauma and
22 dysfunction. And so now we're starting to throw

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1 our energies into that.

2 Probably should have done it at the
3 beginning and looked at it and said what other
4 injuries are going on but I think we were so
5 confounded by multiple amputations and having to
6 figure out how to put the teams together to deal
7 with those at one time.

8 So I'm not excusing the fact that
9 this is late coming to the game but I'm
10 explaining it a little bit. Because what we're
11 seeing now is an energy in GU injury both from
12 a process fix and a counseling fix that we
13 offered to amputees 15 years ago, 15 years ago.

14 Because 15 years ago if you came in
15 with an amputation we had 10 people come out of
16 the woodwork who had had amputations, we had
17 support groups. We talked to you, what you'd
18 expect. We told you what the latest therapy
19 was. We talked to you about the various
20 prosthetics that are available. We talked to
21 you about limb salvage or limb amputation and
22 whether you choose one or the other. And you

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1 knew everything about that 10 or 15 years ago.

2 We're now just getting to that point
3 in GU injuries because we're starting to
4 recognize the number of the population
5 unfortunately that's afflicted with this and the
6 numbers out there.

7 And as you say, Justin, I think the
8 real answer is we're going to go back to people
9 who sort of -- we didn't mention this 10 years
10 ago and now bring them back in and say look, we've
11 been ignoring this for 10 years. Do you have a
12 problem? We're very happy because you're on
13 your legs again and you're moving under your own
14 steam but we didn't take care of all your issues.

15 I'm sorry, go ahead.

16 COL. CRUNKHORN: No sir, that's
17 spot on. Our entire focus at the start of the
18 war was on saving lives and until we really
19 optimized the life-saving aspect of it this took
20 a backseat. And now it's more about quality of
21 life. And 2009 was the first year we had a quad
22 amputee who survived on the battlefield. And

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1 actually it happened to be Brandon Morocco who
2 just had the bilateral hand transplantation up
3 at GHU in December.

4 And so in the genitourinary in the
5 civilian sector as well this is all cutting edge,
6 it's all pushing the envelope for what we're
7 doing on both sides nationally.

8 So we owe it to our servicemembers.
9 We need to get there. It's recognized and we'll
10 move as fast as we can. I appreciate the
11 insight. That's good.

12 CO-CHAIR CROCKETT-JONES: I think
13 if we looked at it the same way we looked at how
14 for the physical loss sort of the industry of
15 adaptive sports has exploded. Well, urogenital
16 loss has a less comfortable and obvious parallel
17 reality. And medically getting someone to a
18 point where they feel comfortable and have --
19 aren't going to have traumatic constant problems
20 that's great that we've solved that. But we
21 need that same parallel path of functionality
22 and quality of life in the same way we sort of

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1 have jumped into that. And I'm glad to see that
2 this is beginning. I hope it moves fairly
3 quickly.

4 COL. CRUNKHORN: Fingers crossed.
5 For the counseling part I think that can. But
6 I think honestly, Dr. Rauch briefed about the
7 regenerative medicine and the transplantation.
8 And that unfortunately is going to take time.
9 And truly what I think a lot of our young men
10 would like, optimal recovery of function, it's
11 going to be what's in the research realm.

12 CO-CHAIR NATHAN: The frustration
13 is 100 years from now, everybody would agree in
14 100 years ago it'll be common practice to figure
15 out how to simply regenerate an organ,
16 regenerate a limb, regenerate a penis. Fifty
17 years from now it'll be -- transplantation won't
18 be just a chip shot and it'll be an ambulatory
19 procedure that's done somewhere.

20 The frustration for the young Marine
21 or soldier or sailor or airman now is boy, can't
22 we do it in 5 years instead of in 50 years. And

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1 that's all. So we know we're going to get there.
2 We know that face transplants, organ transplants
3 are all going to become basically common
4 procedures. We just don't know how long it's
5 going to take to get there. And that's where the
6 hurry is.

7 COL. CRUNKHORN: Yes, sir. And so
8 actually this was my concluding slide. We kind
9 of skipped, right. The only thing I really had
10 was behavioral health. And the evolving
11 director of psychological health for DoD and
12 each of the services will have a component or a
13 parallel director of psychological health
14 certainly will be one of those things we could
15 park within that forum and have that
16 standardization across the organization take
17 place.

18 CO-CHAIR NATHAN: And the only
19 other -- not the only other, one of the
20 significant other emotional issues to families
21 even before deployment is harvesting of
22 reproductive tissue. And TRICARE sort of got

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1 sideways with that a little bit and at first just
2 sort of retreated to the bureaucracy saying it's
3 not a TRICARE-covered benefit which is probably
4 the wrong thing to say.

5 So now I think they're looking at
6 their policy. Maybe you can -- do you know what
7 the policy is now? First of all, harvesting and
8 storing. A soldier has a devastating injury at
9 the battlefield. They lose their reproductive
10 organ. And then there's a question of
11 harvesting sperm right then and there and then
12 storing it at government expense, freezing, the
13 whole thing you would, and then doing in vitro
14 fertilization down the road. Do you know where
15 we are on that?

16 COL. CRUNKHORN: So I have bits and
17 pieces of it. And we could certainly get
18 something more comprehensive for you.

19 So the bottom line is right now in
20 theater there's nothing for harvesting right
21 away. But sperm can persist, it just may not be
22 as high of quality.

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1 And so I spent a fair amount of time
2 in the fall talking with the urologists at Walter
3 Reed and SAMC about this particular issue. And
4 at the end of the day we talked about actual sperm
5 donation before deployment at the SRP site. And
6 then talked about coning it down to just
7 potentially EOD, the explosive ordinance
8 disposal, military police, infantry, the guys
9 out on patrol who are most exposed if we really
10 are talking about a cost-benefit analysis. We
11 could do that and make a policy for that.

12 And then on reverse SRP as they come
13 back you choose either to continue to pay out of
14 your own pocket for that sperm to be stored ad
15 infinitum or the contractor is authorized to
16 destroy the sperm.

17 There were concerns about what are
18 we going to do for egg harvesting for women. And
19 when we went back and looked at what data we have,
20 and the data is not that easy to mine, there don't
21 appear to be any women who lost egg capability
22 who didn't also die because that would be a very

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1 devastating abdominal type of injury. So we
2 felt comfortable having it only be men.

3 And then that -- there appears to
4 have been a parallel effort actually up within
5 DoD. And so we hit a tactical pause after the
6 new year and we have not come back to revisit
7 that.

8 But we did talk about it. We
9 actually drafted up a policy for TMA to look at
10 doing that. It would require NDA language and
11 will require funding which of course is always
12 a hurdle. Not that it's not the right answer.

13 CO-CHAIR NATHAN: Maybe. Because
14 I'm not sure it'll be a problem or not. Congress
15 is very interested in this. Certain factions of
16 Congress are very interested in maintaining the
17 reproductive capability of our soldiers and
18 warriors who go into battle.

19 So I think the question will be --
20 I think the tough question will be it's where you
21 draw the line for who gets it pre-deployment.
22 In other words, should an MA who's patrolling in

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1 Djibouti be qualified for it, or should it just
2 be somebody going into kinetic battle. Those
3 will be sort of qualifications that will have to
4 be discerned along the way.

5 COL. CRUNKHORN: And right now I
6 think probably the biggest challenge for TMA is
7 the definition of who's entitled to any of that
8 reproductive persistent services. It's all in
9 only married servicemembers. And so if you
10 crosswalk that with who's actually having the
11 devastating dismounted injuries they're not
12 necessarily all married. They're very young.
13 And so that -- and again it goes with everything
14 else, the cost-risk benefit and the -- getting
15 the language and getting the legislation passed.

16 CO-CHAIR NATHAN: Well, when you
17 have a chance if you could send us back whatever
18 you think the latest and greatest comprehensive
19 policy is.

20 COL. CRUNKHORN: Yes, sir.

21 CO-CHAIR NATHAN: And Dr. Guice is
22 coming in a little later. We may corner her and

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1 just ask her, you know, drive-by, ambush on
2 what's going on there.

3 Any other questions for the gang?
4 Going once, going twice.

5 CO-CHAIR CROCKETT-JONES: Well,
6 then we get to break for lunch. Thank you both
7 very much.

8 MS. DAILEY: Thank you, Colonel
9 Crunkhorn and Dr. Rauch. We had to split this
10 requirement and one-half of it got down to
11 Colonel Crunkhorn a little late so I'm very
12 appreciative of the work you've done to prepare
13 for this. Thank you. And thank you, Dr. Rauch,
14 very much.

15 (Whereupon, the foregoing matter
16 went off the record at 12:34 p.m. and went back
17 on the record at 1:09 p.m.)

18 CO-CHAIR NATHAN: Welcome back from
19 lunch. We're now going to hear from Mr. Tim Ward
20 who is the deputy director of Program Analysis
21 and Evaluation for the Navy Bureau of Medicine
22 and Surgery.

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1 Tim will be presenting information
2 resulting from the Department of the Navy IDES
3 site evaluation. He'll also be updating the
4 task force on information regarding the
5 Comprehensive Combat and Complex Casualty Care
6 program also known as C5. This is a program the
7 task force was first briefed on during the
8 installation visit to San Diego in April of 2011.
9 You can turn to Tab F to view Mr. Ward's
10 information. Tim, go ahead. It's all yours.

11 MR. WARD: Good afternoon,
12 everyone. Can you hear me okay?

13 CO-CHAIR NATHAN: Yes.

14 MR. WARD: So my name's Tim Ward and
15 as Admiral Nathan said I work for BUMED M81,
16 that's Program Analysis and Evaluation. We
17 have a modest-sized effort dedicated to
18 performance improvement based on the leadership
19 that we've been provided by Admiral Nathan and
20 others to put this little group together. Upon
21 request we'll go out and look at certain
22 processes within Navy medicine and see if we can

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1 make them work a little bit better, can we make
2 it go a little bit faster, can we improve quality
3 or improve the cost structure, those kinds of
4 things. What I'll do today is just give you an
5 example of some of those. And of course the
6 three examples here are the ones that are all
7 focused on the IDES process.

8 Before I do that though I just have
9 to kind of tell you a little bit of background.
10 So I'm an industrial engineer and I have to start
11 out with an analogy so forgive me if I digress
12 for just a minute. I think you'll see the point
13 as we go through this.

14 This is a picture from 1908. This
15 is a Henry Ford factory. And at the time in 1908
16 this was called a job shop. Each one of these
17 tables, there was a team of people that would
18 build a car from bottom to top at that one
19 location. It was about six people all together
20 working as a team to build one car. As it says
21 on the slide here they performed tasks in a
22 variable order, no defined time expectations.

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1 If you didn't finish something today you'd just
2 come back and start it again tomorrow.

3 Extremely highly skilled craftsmen.
4 They carved the wheels, they stitched the
5 leather, they formed the transmission, they did
6 everything. They bent the metal. It was a
7 very, very high level of craftsmanship to build
8 one of these cars. And of course low volume, one
9 at a time.

10 So in 1908 this factory could
11 produce about 30 cars a year. If you equate it
12 to today's dollars it was about \$500,000 to buy
13 a car.

14 As you might imagine the quality of
15 the cars wasn't so great. There's a lot of
16 variability in the process. And if you wanted
17 to get your car fixed you had to go back to the
18 six people who built it because they were the
19 only ones who really knew how to build it.

20 And if you and I both walked into this
21 factory and bought a car on the same day when we
22 came back 6 months later to pick it up my car

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1 might be 2 inches longer or 2 inches shorter than
2 yours. It wasn't the same thing. So that's a
3 job shop.

4 You're going to hear me say job shop
5 a little bit later and I think you'll figure out
6 why if you don't already know. But let's fast
7 forward to 1920.

8 And so now we have the production
9 line. And so in a fairly short period of time
10 the entire process by which cars were made by
11 Henry Ford changed. We now have a well-defined
12 sequence of tasks, strict time performance
13 requirements.

14 The staff is still very, very
15 skilled but they have more limited skills.
16 They're focusing on a smaller range of tasks than
17 they did previously. And of course
18 repetitively and high volume.

19 So what happened when we changed the
20 process, when Henry Ford changed this process?
21 We went from a factory that could produce 30 cars
22 a year to a factory that could produce 250,000

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1 cars a year. We went from quality that was
2 abysmally poor to a much more standard approach
3 and the quality improved dramatically. And of
4 course the price dropped by orders of magnitude.

5 Okay, so I just needed to tell you
6 that because you need to understand that I am an
7 industrial engineer and this is kind of my
8 background. This is where I'm coming from.
9 And so the real point of the program that Admiral
10 Nathan has set up is for us to take these kinds
11 of methodologies and see how they can be applied
12 to medical practices and in this case of course
13 today the IDES process.

14 So here's kind of a description of
15 the overall IDES process. I'm sure you've all
16 seen this before. And so today I'm going to be
17 talking about the three on the left. First the
18 MEB, Medical Evaluation Board, then the PEB.
19 Then I'm going to go back and talk about the
20 treatment process and that's the C5 program in
21 San Diego. The three on the right are out of
22 scope for today's discussion.

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1 So a few more words on the process
2 that we use when we talk about performance
3 improvement in Navy medicine. It's a very
4 collaborative approach. So we have a team of
5 industrial engineers, a reasonable staff, about
6 six of us at BUMED and then we have contract staff
7 as well from the Johns Hopkins Applied Physics
8 Lab that we'll use as well.

9 It's hand in hand with the hospital
10 staff. It's data-driven and it's bottom-up.
11 So we collect electronic data from any
12 electronic system we get our hands on and if we
13 can't get it electronically then we're going to
14 go collect it ourselves. And so it's very, very
15 data-driven, very analytical in its approach.

16 And we're focusing on near-term
17 implementation. This is not about writing
18 reports about how you should be doing things.
19 This is about agreeing with the staff on what a
20 desired future state might be and then
21 implementing that future state over a short
22 period of months.

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1 So basically the approach is focused
2 on solid analytics and then change management.
3 As you can imagine from the Henry Ford slides
4 those first group of craftsmen, how do you think
5 they felt when Henry came up with the idea of
6 having them work on an industrial production
7 line? They weren't exactly enthusiastic about
8 it I'm sure. And so there are some change
9 management issues that we have to face all the
10 time.

11 In terms of timing these projects
12 typically are about 5 months in duration. The
13 first step is called a scoping step. That
14 usually lasts a few days, 3 or 4 days onsite where
15 we just try to get our arms around the scope of
16 the project.

17 And then there's a diagnostic phase
18 which is about 8 or 10 weeks long and that's
19 followed by actually implementing the things
20 that we've agreed to implement.

21 So I'm often asked, well, why does
22 the diagnostic phase take so long? Why 8 or 10

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1 weeks? Why can't you do that in 3 or 4? And the
2 answer is it's not just about the data
3 collection.

4 I guess the philosophy here is that
5 people will fight pretty hard for their own idea.
6 And so even if we have a good understanding of
7 what we think they need to move forward with,
8 what process they need to move towards, we're not
9 going to tell them that. We're going to tell
10 them that sort of Socratically. We're going to
11 ask a lot of questions, we're going to give them
12 comparative data, we're going to suggest things
13 that other people did and let them arrive at what
14 they think that best practice is.

15 Because if it's their idea then
16 they'll buy in and we'll get much better
17 implementation. The quote I kind of remember is
18 "A man convinced against his will is of the same
19 opinion still." We have to have them be
20 convinced and the best way for them to be
21 convinced is for them to have it as their idea.

22 So that's it for background slides.

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1 Now I'll talk a little bit about the Medical
2 Evaluation Board within the Navy.

3 Here are the questions that we
4 received from the committee. So how many sites?
5 Basically this was done at Camp Lejeune,
6 primarily at Camp Lejeune. It was about a
7 4-month project at Camp Lejeune. Followed by a
8 couple of weeks of consulting at Camp Pendleton
9 as well. Some of the ideas were immediately
10 applicable to Camp Pendleton. What did
11 we learn across the sites? Well, every place we
12 looked, what do you think we saw? We saw people
13 doing different processes. There was really
14 not a whole lot of similarity between locations.

15 All the rest of the questions here
16 I'm going to get to as we go through the slides.
17 But if I forget anything please feel free to
18 remind me.

19 So, this again, we're looking at the
20 MEB process. And if you break the MEB process
21 down into more detail that's really what's
22 described here. Someone has to refer the

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1 patient into the IDES process. Then there's a
2 PEBLO consult. That's followed by setting up a
3 VA appointment and then VA medical evaluation.
4 Then there's a narrative summary and a package
5 is put together for forwarding to the PEB.

6 The goal here is 100 days.
7 Fifty-five of those days are with the VA and
8 that's really out of the scope of what we can do
9 within Navy medicine. So we focused on the
10 10-day PEBLO counseling and then the narrative
11 summary process at the back end.

12 In addition to that narrative
13 summary what goes to the PEB is a non-medical
14 assessment as well, the VA's assessment and then
15 any related medical documentation.

16 So this is kind of a before shot.
17 This is one of the desks of a PEBLO when we got
18 started, you know, got paper.

19 So if you remember back to that first
20 Henry Ford slide this is a job shop. This
21 individual was being asked to do everything.
22 They had to coordinate with the VA, they had to

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1 work with the narrative summary and put together
2 the package for the PEB. They had to go around
3 and collect all the consults. They had to
4 interview the patient and counsel the patient.
5 They had to do everything. This is a craftsman
6 business. And so you come to work
7 every day and you see this on your desk. Where
8 did I leave off on the package on the top? The
9 rework, the amount of time it takes to get back
10 up to speed on where you left that package. So
11 at the end of the day you've worked all day long
12 but only three or four packages have moved off
13 your desk. And it's just as bad or maybe even
14 worse than it was when you started. So that's
15 where we started.

16 As you can understand I think things
17 are done in no particular order. We don't
18 follow something industrial engineers like to
19 call FIFO, first-in first-out. There's no time
20 expectations of when a package needs to move onto
21 the next location and there's very little
22 tracking and visibility.

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1 If we look at more in statistics the
2 top chart there shows the variation in
3 turnaround time for finishing the initial
4 consult with the PEBLO. A lot of variation but
5 not unusual for some patients to spend 70 days
6 before they finish that intake process, that
7 initial consult. The average was around 20-25
8 days but a lot of variation.

9 In the bottom, that's a narrative
10 summary, the chart. And that shows that we're
11 averaging about 45-50 days to get through the
12 back part of the process. And again, lots of
13 variation. So all typical things that you would
14 see in what we call a job shop. Not following
15 FIFO, no separation of tasks, unclear
16 expectations. And if someone goes on leave all
17 that paper on their desk sits there until they
18 come back. And limited management visibility.

19 So we studied these two processes.
20 And what conclusions did we come to? When I say
21 we, it's not the industrial engineers now, it's
22 the people involved with this process. So it's

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1 the PEBLOs, it's the folks onsite that are
2 defining what the future state is and what they
3 want to do.

4 And one of the conclusions that we
5 came to was that we could divide up these tasks
6 between counseling and administrative.
7 Administrative tasks are a little bit easier,
8 doesn't -- it's not quite as hard if you don't
9 have to interface with the patient so much.

10 So if we divide that up that should
11 make things a little bit easier. And then we can
12 lay out the space differently so that we have
13 first-in first-out processing, FIFO as I
14 mentioned. We can minimize the setup and
15 rework, improve visibility of the cases and have
16 clear time expectations so that we can manage to
17 those.

18 Here's the assembly line kind of
19 diagrammatically. The PEBLO or the person that
20 does the counseling at the beginning and at the
21 end is the same person. But in between there's
22 three different admin staff, one responsible for

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1 collecting and printing, obtaining all the
2 proper documents and assembling the record,
3 another one coordinating with the VA and the
4 third coordinating the narrative summary and
5 putting together the package for the PEB. So
6 here we've divided up the tasks in very clear
7 lines of authority and we can pass the packages
8 forward.

9 Physically in changing the space,
10 this is kind of what it looked like. And it may
11 sound sort of trivial but this process here, if
12 you go this way, this is all administrative. So
13 patients don't go back this way. We start here
14 at the first administrator and move on. So
15 packages here are getting ready to be shipped to
16 the PEB.

17 Over here, these are the PEBLOs that
18 are interviewing patients. So the patients go
19 this way but the patients don't come back here.
20 And so we basically tried to minimize
21 disruptions and allow the administrative staff
22 to do their tasks in order. And you know, few

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1 disruptions, FIFO processing, clear time
2 expectations.

3 Oh and by the way, nobody can put any
4 files in any file drawers. You have to keep all
5 the files you're working on on your desk. So the
6 lieutenant, Lieutenant Cook who is monitoring
7 this whole process, she could walk through in an
8 instant and see where the bottlenecks were.
9 They were on the desk. So if someone was slowing
10 down or something wasn't working quite right
11 it's visual management. You just walk past a
12 desk and you see what's going well and what's not
13 going so well.

14 And then here we are a few weeks
15 later. This is actually, this slide is sort of
16 the after slide on the top there. Initial
17 counseling, we got that down to 5 days. And the
18 narrative summary down to 2 days with very, very
19 minimal variation. So you could be assured that
20 when a package got to that point in the process
21 it moved forward quickly.

22 I mentioned again the same

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1 management techniques that were put in place to
2 allow this to happen. And that's really all I
3 wanted to say about the MEB process. Any
4 questions?

5 MEMBER CONSTANTINE: Sure. How
6 were you able to get the NARSUM reduced so
7 significantly?

8 MR. WARD: Well, basically it was a
9 matter of coordination. We had that, the person
10 who is responsible for that, when a package came
11 back from the VA and now it was time to do the
12 NARSUM they had a provider that they needed to
13 coordinate with. They knew who that was.

14 And the expectations for that
15 physician of how fast they would turn that
16 narrative summary around was well known,
17 managed. There's a lot of attention from the
18 CO, the XO and of course there's quarterly
19 reports of all the COs and XOs for the region,
20 so a lot of oversight to make sure that the
21 providers were completing those narrative
22 summaries in a timely way.

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1 They were dictating them. And so
2 the transcriptionist had a day to turn it around.
3 And by the way, putting most of the things that
4 needed to go together in the package to the PEB
5 were already done so we're just waiting for that
6 last piece and off it went.

7 And we had a very energetic
8 lieutenant who was keeping an eye on the whole
9 thing and managing it. That's really all it
10 took.

11 MEMBER CONSTANTINE: Thanks.

12 CO-CHAIR NATHAN: Tim, the QA of the
13 process. In other words, the good news is we
14 know that we used an assembly line approach and
15 basically using the same amount of people were
16 able to really increase the throughput. What
17 was your QA on those that came back with -- you
18 know, that were bad rounds?

19 MR. WARD: I am actually going to
20 cover that in the PEB.

21 CO-CHAIR NATHAN: Are you? Okay.

22 MR. WARD: But the answer is, the

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1 easy answer is it went up, it went up
2 dramatically. A lot of the reasons why it went
3 up was because of the process we put in place
4 here. But a good part of the reason was because
5 of better feedback with the PEB. The
6 coordination mechanism, the handoff between the
7 MEB and the PEB wasn't that great. We improved
8 that and that's really the part that
9 dramatically improved the quality of the
10 packages that the MEB was providing to the PEB.

11 CO-CHAIR NATHAN: Thank you. Like
12 any good attorney I would never have asked a
13 question I didn't know the answer to already.
14 So I appreciate the answer.

15 Justin, to your point, it highlights
16 the differences between the services a little
17 bit because in the Navy system, for the Navy and
18 Marine Corps the provider who takes care of the
19 patient dictates the NARSUM whereas in the Army
20 there's a central group of MEB providers who
21 don't see the patient who dictate the NARSUM.
22 And each service kind of likes its own way for

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1 various reasons.

2 But that has increased the accuracy
3 of ours because it doesn't get kicked back
4 because there's a disconnect between the person
5 who's advocating for the patient, their
6 provider, and the person who's counting on that
7 record, that electronic record to dictate the
8 NARSUM.

9 MEMBER REHBEIN: So as things leave
10 the MEB and go onto the PEB it's all electronic.

11 MR. WARD: I wish it were true. No.
12 It's three phone books and it's being mailed so
13 we're not quite there yet. There are some
14 portions of this at the PEB have been digitized
15 and so the coordination between the PEB and the
16 VA is electronic. But you'll see, I mean the
17 mountains of paper are still with us. That will
18 take a little bit longer.

19 Again, I think the focus here for all
20 these projects is near term. You know, we want
21 to implement change on the ground and be out of
22 there in 3 or 4 months. I think the entire time

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1 on the ground in the PEB from diagnostics through
2 implementation was 4 and a half months. So it's
3 near-term focused.

4 Okay, so onto the PEB. Of course
5 it's really the Navy and Marine Corps Physical
6 Evaluation Board so forgive me for not stating
7 that on the slide.

8 Based on the work that we did in the
9 MEB I often wondered looking at Camp Lejeune, I'm
10 watching the mail go out and we've got these huge
11 files going out every day. And I know there's
12 a lot of hospitals in Navy medicine and they're
13 all going to the same place. I envision that
14 warehouse scene at the end of the Raiders of the
15 Lost Ark. You know, where are they going and
16 what's that look like.

17 And I never thought I'd see but then
18 we were asked to go to the Navy Yard and take a
19 look. And the first thing I saw there reminded
20 me a lot of the Lost Ark movie.

21 So here it is, the PEB. This is the
22 focus where we'll talk about next. I think that

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1 it's kind of important for me to point out that
2 simply applying these standard industrial
3 engineering techniques have demonstrated that
4 we can speed the process, we can improve the
5 quality.

6 And the second half of this chart as
7 far as I know really hasn't been looked at very
8 much. I know from looking at the BBTS, the
9 transition phase, there's a lot of time there
10 now. It seems like there may be some
11 opportunity in other parts of the process beyond
12 the ones that I'll present to you today.

13 This slide is a -- we've
14 process-mapped a process for the PEB. We call
15 this the A to K chart. It starts at A there with
16 MEB package arriving at the PEB and it ends when
17 the whole file is packed up, put in a box and sent
18 off for long-term storage. So that's A and
19 that's K.

20 The purple parts are the parts that
21 are really done by the PEB folks. F and I are
22 done outside. F is done by the VA and then I is

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1 the member's decision to accept or not accept the
2 rating that they've been provided. So we got a
3 good understanding of what the process was and
4 that's kind of described here.

5 And here's a similar slide to what
6 you saw earlier for the MEB. This is one desk
7 in the PEB. And the dedication of these staff
8 and their ability to work is amazing to me. I
9 don't know how you come to work every day when
10 you know what your office looks like, when it
11 looks like this.

12 They're doing an amazing job.
13 They're really working very hard. But we have
14 a concept that we industrial engineers like to
15 segment things up into value-add and non-value
16 add. And when a file is sitting next to your
17 desk and it's not being worked on, well that's
18 just wait time. That's non-value add. The
19 value-add is when the person is doing something
20 with it.

21 And so if you look at all the
22 material here and how much time it takes for the

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1 person to actually process a record and how much
2 time it waits for that person to be able to
3 process the record, that's the non-value add
4 type. And the ratio between value-add and
5 non-value add here is very, very high. And so
6 that's something that we should be able to
7 influence.

8 You can also imagine that every once
9 in a while there will be an inquiry, you know,
10 where is someone's case file and it's a fire
11 drill to try to find that case.

12 So we looked at the three parts of
13 the process that were in the PEB's control. I
14 should mention that the person that divided it
15 up this way and basically the PM for this work
16 is in the back of the room, Tim Link, an
17 industrial engineer who works for BUMED.

18 What we found, what actually Tim's
19 team found was that at the beginning part of this
20 process from when the package arrives through
21 adjudication took 34 days. Once we received an
22 answer from the VA if the patient was deemed to

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1 be unfit until we were able to notify the PEBLO
2 back at the MEB was 21 days. And then it was 6
3 days -- if the member accepted the results it was
4 6 days to notify the service headquarters. Of
5 course if the member didn't accept the results
6 then we skipped back to D and we start the formal
7 board process.

8 Since most of the patients were
9 adjudicated in an informal way that's the
10 process we focused on. We have not looked at the
11 formal board process yet. So, but about 70
12 percent or so of the patients went through that
13 informal process and that's where the majority
14 of the wait time was so that's what we focused
15 on initially.

16 And here's some -- kind of the before
17 statistics. Again, until we get a package off
18 to the VA, 34 days, and then back from the VA to
19 the PEBLO back at the MEB, 21 days.

20 Same story from the MEB. Intake
21 process was variable. There was an informal
22 rework process between the PEBLOs and the MTF.

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1 What Admiral Nathan said earlier, if a package
2 went up to the PEB and it wasn't complete how do
3 we tell the people at the MEB what's missing and
4 how do we get that information back in the file.
5 It was informal. So rather than -- if someone
6 at the PEB knew who the PEBLO was at Camp Lejeune
7 they'd call them up and say hey, you forgot about
8 this signature, and maybe you got the person and
9 maybe the person wasn't there.

10 And so it was not tracked, very
11 informal, and things would wait. We didn't want
12 to report that a case came up that was not so good
13 so we'd leave that on our desk and wait for that
14 person to respond. And so incomplete and
15 missing items, those cases weren't being
16 tracked, they weren't visible to management and
17 a lot of time could be lost in that process.

18 Weren't following FIFO. I
19 mentioned all the other things. A lot of
20 interruptions. So, the PEBLOs from the MEB,
21 from the facilities would be calling. And I
22 actually was there at lunchtime one day and you

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1 know, no one else was around so the phone at one
2 desk rang and the person wasn't there. So then
3 the phone next to them rang and that person
4 wasn't there.

5 So clearly everybody at the MEB knew
6 who was where and what the phone numbers were but
7 how can you get any work done if your phone's
8 ringing all the time? So we had to kind of get
9 on top of some of those issues.

10 And to cut to the chase, here are the
11 things that we came up with. And again, this is
12 global "we." It was really the folks working in
13 the PEB who came up with these ideas.

14 So standardize the MEB package
15 content. We sent a checklist, developed a
16 checklist and sent that out to all the MEBs. So
17 now when they send a package up to the PEB there's
18 a checklist on top and all the boxes are checked
19 so we know that everything is in there. The
20 narrative sum is there, signatures are there,
21 all the dates are there and the package should
22 be good to go.

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1 MEMBER CONSTANTINE: I wanted to
2 ask you about that because I thought there was
3 a table of contents or maybe there is a checklist
4 on there. But these files are so huge, I assume
5 that whoever's sitting on the MEB or PEB relies
6 on the NARSUM to a great extent, right? But are
7 they going through all those folders?

8 MR. WARD: Yes sir, they have to go
9 through the folders. And in fact that's one of
10 the intake functions. There's a recorder
11 function. So after the package arrives and we
12 date/time-stamp it to say yes, this package is
13 here.

14 Then a recorder has to actually go
15 through all that material, put tabs on it to say
16 it -- was there a mental health consult? Okay,
17 well that's here, put a little tag there. And
18 they basically tag the whole package to make sure
19 that it's all there.

20 MEMBER CONSTANTINE: I wonder why
21 that wasn't -- I kind of thought this earlier
22 when I saw a little bit of the process, why that

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1 wasn't done on the front end. When the person
2 puts the file together to send in why don't they
3 go ahead and put those tabs in as they're putting
4 the file together?

5 MR. WARD: Well, I'm glad you asked
6 that. You know, what we've been talking about
7 of course was a standard package so that every
8 package looks the same. And there's a
9 three-ring binder with all the tabs in it.

10 And if it's got to be in paper then
11 every package submitted to the PEB should be the
12 same. If you needed a mental health consult
13 that's Tab G. If you needed an orthopedic
14 consult that's Tab H. It's all in the same
15 order, all in the same place and it should -- you
16 could probably cut out almost a day in the
17 recording function just to read through the
18 package and tab all that stuff to make sure
19 you've got it all.

20 MEMBER CONSTANTINE: I think right
21 now it's chronological, right? Which doesn't
22 really do much for you unless you know exactly

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1 what you're looking for. But unless you're that
2 guy's doctor you don't know where it was.

3 MR. WARD: It's all over the map,
4 you're right. There's some opportunity there.
5 And of course the staff in the PEBLO, just to go
6 a step further, you know, why stop with the tabs.
7 Why don't you have a template so that the docs
8 can actually, you know, we can give them a heads
9 up in performing the NARSUM and doing the input
10 that they need. How far down that road of
11 standardization can we go? Right now it's not
12 standard. So there's a bit more rework. But at
13 least the folks in the MEB can assess a package
14 and make sure that it's complete before they send
15 it to the PEB, and that alone dramatically cut
16 down the amount of rework and the phone calls and
17 all the rest that went back and forth between MEB
18 and PEB.

19 And then of course there are still
20 some and so we developed a little case tracker.
21 So it's a little database. When a package comes
22 and it is incomplete the recorder function has

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1 to put the information for that package in a
2 database. What's incomplete about it. That is
3 available to the management. That is sent back
4 to the people at the MEB and so we can really
5 facilitate that process of rework to make sure
6 we get a complete package and we're able to
7 process it relatively quickly.

8 If the PEBLOs have a question they
9 now call one number. It's a hotline. They
10 don't call all the desks and interrupt
11 everybody. And one person is responsible for
12 answering the hotline that day and everybody
13 else is working.

14 There is some electronic transfer of
15 information between the PEB and the VA. It's
16 not the complete package but the PEB decision
17 about fit and unfit, the non-medical assessment
18 of the CO and the NARSUM are scanned and that
19 scanned information is sent off to the VA for the
20 rating function.

21 And the rest here is pretty much the
22 same as you've seen previously. You know,

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1 establish time expectations, set rules and
2 responsibilities. And then one of the other
3 problems was that when you finish a case will
4 there be any follow-up and actions required. So
5 they didn't want to actually get rid of the
6 material and send it off to long-term storage.
7 They'd keep it at the PEB for a period of about
8 6 months or more.

9 So you can imagine the back of the
10 room was filling up with boxes. And so every
11 other week now they're packaged on a pallet and
12 off they go. And that just alleviates a lot of
13 square footage and a lot of excess handling of
14 materials so we can move on.

15 The bottom of the slide here on the
16 left, that shows you that checklist that I
17 mentioned that now goes on the top of every
18 package from the MEB submitted up to the PEB.
19 And again it's great, it's very simple but it
20 does eliminate a lot of rework.

21 And on the right this is a report
22 right out of the tracker. This is a slide from

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1 Quantico. And it shows you how many cases were
2 submitted from this location up to the PEB that
3 had problems, and if there were problems what
4 were they. You see that there was two
5 incomplete/missing signature. And another one
6 as well. So we can track the errors, we can give
7 feedback to the MEB and just basically speed the
8 process.

9 And this is the conclusion. So
10 within a relatively short period of time,
11 actually look at the X axis here, those are
12 weeks. So really within a modest number of
13 weeks we were able to cut the intake process from
14 34 to 11 days, cut the VA to PEBLO notification
15 from 21 to 9 days, and then cut a day off of the
16 response to the headquarters as well. Grand
17 total 36 days.

18 They process 8,205 cases a year.
19 That's 295,000 wait days that were cut out of
20 this process, or 809 man-years in about 4 and a
21 half months.

22 Questions?

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1 CO-CHAIR NATHAN: Tim, this is a
2 question that I actually don't know the answer
3 to. Where did we -- didn't we petition a PEBLO
4 in some of our bigger areas where we do a lot of
5 these to do nothing but be the consultant to the
6 PEB for cases to relieve the other PEBLOs from
7 getting calls about their cases?

8 MR. WARD: You mean at the MTF, sir?
9 Yes. So in the places where there's a lot of
10 workload like Pendleton and Lejeune, that's
11 exactly right.

12 CO-CHAIR NATHAN: Because your IEs
13 found that a PEBLO, even the assembly line PEBLO
14 who had done the counseling on an individual was
15 getting called by that individual saying hey, my
16 board's at the PEB, can you tell me how it's
17 doing. And that PEBLO would have to stop what
18 they're doing and call the PEB and try to do it
19 in the middle of interviewing other patients or
20 other warriors.

21 And so we took a PEBLO and said your
22 job today is to be the PEB guy. And when

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1 somebody comes in to ask a question about where
2 their board is even if you didn't do it, you get
3 their name, you call the PEB and you get an answer
4 back to them. That's all you do today. Let the
5 other PEBLOs who are preparing cases just
6 concentrate on that.

7 MR. WARD: Yes, sir. I couldn't
8 have said it better myself. The industrial
9 engineers I work with, I get a lot of grief
10 because I use the same analogy all the time. I
11 say the fire department and the bus line.
12 They're smiling at me back there already.
13 They've heard this so many times.

14 One of the things that tends to
15 really mess up processes are when you mix things
16 that should be done in a routine standard way,
17 in a scheduled way, with things that have to be
18 done emergently.

19 So imagine a bus line that's going
20 from stop A to stop B and in the middle of the
21 route somewhere it gets a call to go to a fire.
22 Well, nobody's going anywhere on time today, and

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1 by the way, you probably didn't respond to the
2 fire very well either.

3 We don't mix fire department
4 functions with bus line functions. The bus line
5 needs to go on time every day and the fire
6 department needs to be standing ready to take
7 care of that unexpected event.

8 And so that's part of what you were
9 talking about, sir. We have to figure out how
10 much of that random arrival of information
11 needs, of requests are going to come in. We
12 resource that and that stands alone from the
13 folks who are doing the day-to-day bus line job,
14 the standard job.

15 And that really does -- I can give
16 you lots of examples in healthcare about
17 operating rooms and emergency departments and
18 all kinds of areas where that philosophy kind of
19 holds true. And it certainly holds true here in
20 the PEB.

21 MEMBER PHILLIPS: Two quick
22 questions. Have you been able to or do you plan

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1 to follow up to make sure that this is
2 sustainable? And is the process scalable?

3 MR. WARD: So, yes, we do have a
4 sustainment function where we go back and look
5 and we have gone back to the PEB periodically,
6 about every 2 months or so.

7 The real trick to sustainment is an
8 IT system that gives you the metrics. Now, for
9 -- in our MTFs we have more control over that than
10 we do at the PEB. So the Pentagon IT department
11 has developed a management tool to track and keep
12 visible all these things in the PEB but it has
13 not been implemented yet. They're still going
14 through the authority-to-operate loops to put
15 the thing on a Navy system. So that's going a
16 little bit more slowly than we would like but
17 it's coming.

18 In the MTFs we have gone to Pendleton
19 and Lejeune only. I think there's been a lot of
20 discussion and it's a small world in Navy
21 medicine so a lot of this has just kind of morphed
22 everywhere else. But I think maybe there is

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1 some opportunity there to do it in a more
2 standard way and make sure things are keeping
3 track.

4 Looking at the systems, the data, it
5 looks good. We're able to respond in the MEB
6 process. We're able to respond in under 100
7 days. So I think the process is under control.

8 MEMBER PHILLIPS: And is it
9 scalable? I assume it is but I mean if the
10 volume triples or quadruples it'll still work do
11 you think?

12 MR. WARD: Yes, sir. I think -- if
13 I go back to that slide that had the stick
14 figures, you know, the five stick figures. It's
15 important to put the correct process in place but
16 then you need to resource it. How many can they
17 do in a day. We've got those statistics. So
18 when do you need to add a second production line
19 if you will. How many do you need, how many
20 people on that do you need. That's part of the
21 analytics. And so it's really not rocket
22 science at all. It's totally scalable.

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1 CO-CHAIR CROCKETT-JONES: Denise,
2 which of the locations that we have been to --
3 I can't quite bring it to memory -- were the
4 pilots for the digital -- turning the entire
5 caseload into a digital product. Where were we?

6 MS. DAILEY: San Antonio.

7 CO-CHAIR CROCKETT-JONES: Never
8 mind. If it was San Antonio then --

9 MS. DAILEY: The Air Force PEB and
10 MEB process at San Antonio were the electronic,
11 the e-file, one of the e-file pilot sites for a
12 case management system that they want to use
13 through the whole system.

14 CO-CHAIR CROCKETT-JONES: So are
15 there any Navy sites that are on that same pilot
16 or is that an Air Force-only?

17 MS. DAILEY: Well, the PEB at the
18 Navy Yard was on that pilot but asked to be taken
19 off if I remember correctly. It was not working
20 for them. And I don't know the other locations.
21 It might be -- I won't speculate on what the other
22 locations were.

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1 CO-CHAIR NATHAN: Again, I always
2 preface this because sometimes it sounds
3 parochial because we like -- are proud of the
4 fact the Navy was the first one to hit their
5 numbers and get within spec first. We attribute
6 a lot of that to yourself, Lieutenant Cook who
7 was just, you know, looked like the guy in
8 Ben-Hur holding the whip over the Greeks who were
9 rowing the boat.

10 But the analog was, and this is where
11 we sometimes get a little different from the
12 Army. And the Army -- I always preface this.
13 The Army, to answer your question, when it comes
14 to economies of scale we pale in comparison to
15 the number of Army records out there. In other
16 words, the Army wounded warrior population and
17 the IDES population compared to the Navy is much,
18 much bigger. So they really have a huge
19 monolith to get their arms around.

20 That said, the initial criticism of
21 the Army was that when they were getting behind,
22 like doing shop work, jobs work, they just simply

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1 asked for more people to do more of what they were
2 already doing.

3 And we kept saying, you know, rather
4 than ask for 1,000 more people to throw at this
5 why don't you look at significant process
6 change. And again, what we talked about was who
7 dictates the NARSUM.

8 And there is -- once you get an MEB
9 group going that really knows what they're doing
10 and can get good electronic fidelity from the
11 AHLTA record you can dictate a NARSUM although
12 it did cost them some problems where they got
13 kickback from the PEB.

14 And the other was the Army, when they
15 would do the MEB looked at all conditions, all
16 ratable conditions, not just those that are
17 unfitting, whereas the Navy dictated a NARSUM
18 with just unfitting conditions for service
19 continuation knowing that the VA would
20 eventually process the remaining conditions.

21 So those were some of the
22 differences in process. But as a result of this

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1 the Navy and the Marine Corps got down within
2 spec at their 100-day mark for the MEB and the
3 295 for the PEB rating.

4 MR. WARD: Yes, sir. With no
5 additional resources.

6 CO-CHAIR NATHAN: With no
7 additional resources. Because when you're out
8 at sea all you have is the crew itself.

9 MR. WARD: Any other questions on
10 the PEB? Okay, then I'll move along to the C5,
11 Comprehensive Combat and Complex Casualty Care.

12 This is from San Diego. So, here
13 are the questions that you asked about the
14 program. Have there been any changes that have
15 occurred after your visit? I think you'll see
16 some.

17 The point of this project was not
18 actually to -- it was to implement change but it
19 was basically to develop a better understanding
20 of what are all the component parts within C5 and
21 how do they function together. So I think these
22 questions, other than question 4, we'll answer

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1 along the way. But I want to come back to this
2 what are the major challenges question at the
3 very end.

4 Admiral Faison, this is a quote from
5 Admiral Faison before we started the project in
6 the scoping. Identify the benefits and
7 resource requirements of C5 program to enable --
8 to ensure continued world-class rehabilitation
9 care for wounded warriors and family members and
10 other C5 patients in light of probable volume and
11 funding fluctuations. So that's the problem
12 and it was very clearly and succinctly stated by
13 Admiral Faison.

14 This project was about 10 months
15 long so it was longer than a typical project. It
16 just has a lot more moving parts to it. And we
17 had to develop some interesting tools to help
18 manage this process as part of the project.

19 So there's three tools that were
20 developed. One is called the FACET, the
21 Forecast and Capacity Evaluation Tool. This is
22 a resource-planning tool. Then there's

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1 something called the PMA, Program Management
2 Aid. This is a tool that is basically used for
3 case management. All the notes and everything
4 are kept in here and the handoff between case
5 managers is facilitated.

6 I'm not going to go over the Program
7 Management Aid today. Basically that's about
8 an hour discussion to walk you through all that
9 but I'd be happy to do that at another time or
10 give you a demo of it or whatever if anybody is
11 interested.

12 I'm going to focus on the FACET
13 because that's sort of a higher-level tool. And
14 then I'm going to show you just a little bit of
15 this guide for patients with lower limb
16 amputations. So I'm going to focus on 1, a
17 little bit on 3. I'm skipping 2 but I'll be
18 happy to talk about that at another time or give
19 you whatever background information you might
20 need.

21 So, what is the FACET? Well, we
22 have to anticipate appointment demand. We have

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1 to understand what the provider capacity is. We
2 need to know about the patient population. How
3 many people are arriving, how many patients are
4 arriving, what's the timing, what's the case
5 mix. Those are all the variables that we deal
6 with on the input side.

7 And what we want to know when it's
8 all over is we want to know how many providers
9 do I need, how many rooms do I need, how much
10 money do I need. What are the resources that I
11 need to run the C5 program.

12 And that's -- we didn't know all
13 that. The C5 program was sort of built a piece
14 at a time over the course of 6 or 7 years. And
15 so now we've got a great program that's up and
16 running, but how do we sustain it and how do we
17 resource it sufficiently but not excessively
18 moving forward.

19 So, to design this FACET tool for
20 resource planning the first thing we had to do
21 was categorize patients into meaningful groups.
22 And to give you -- just every one of these steps

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1 here, there's a lot of work behind each one of
2 these things, a lot of statistical analysis.

3 Identifying and defining patient
4 categories, that's like developing the
5 diagnostic-related groups, the DRGs. I mean we
6 had to look at all the patients that had passed
7 through the C5 program, divide them up into
8 categories that were clinically meaningful
9 because if they are clinically meaningful we're
10 not going to have any great discussions with any
11 of the providers. But they also had to have a
12 resource component to them as well. They had to
13 have similar resource utilization. So just
14 coming up with those categories was no small
15 task.

16 And then we had to summarize the
17 patient episodes of care. Well, some of those
18 episodes, some of the parts of the episode are
19 on the inpatient and so you use Essentris. A lot
20 of is on the outpatient, that's AHLTA.

21 But there's also -- there's also lab
22 results, X-rays, all kinds of ancillary services

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1 that have to be taken care of. There's this data
2 from the surgical scheduling system. There's
3 probably 17 or 18 different IT systems that need
4 to be put together to allow us to summarize the
5 episode of care. And I'll show you a little bit
6 about that in a minute.

7 Understanding provider capacity is
8 also not a small task. Studying arrival
9 patterns. Studying patient case mix. And then
10 combining all those things into a tool that is
11 easy for anybody to pick up and use, that was the
12 goal and that's what we built.

13 So patient categories. I've
14 eliminated a lot of description about how we
15 arrived at these 10 categories, all of course
16 with clinical involvement. But here are the big
17 10. These are the 10 patient types that are
18 treated in the C5 program. Bilateral
19 amputations, unilateral amputations, other
20 amputations, TBI, gunshot wounds, multiple
21 fractures, you can see the list.

22 And then what do we need to know for

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1 each one of these. Well, we need to know what
2 services each one of these patient types consume
3 and in what order. What's the timing of it and
4 how long does it take them to recover and those
5 kinds of issues.

6 So here is an example of a bilateral
7 amputation episode of care. We kind of call
8 this the DNA chart. But what you see is for this
9 patient type there were 56 bilateral amputations
10 that were processed through the C5 program.
11 Fourteen clinical areas on the lefthand side.
12 And what you see here color-coded across time,
13 so this chart goes out to about 3 years but most
14 of the care for these patients really is within
15 the first 2 years. And actually the vast
16 majority is within about 18-20 months.

17 But the red means that they're
18 getting more than three appointments per week,
19 orange is two appointments per week, yellow one
20 appointment per week. And so you see physical
21 therapy on the top there, huge amount of physical
22 therapy for the first 30 weeks or so of a

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1 bilateral amputation patient. And you get the
2 idea.

3 So we have now been able to
4 categorize and really define the care pattern
5 for bilateral amputation patients across 14
6 different clinical areas across time that were
7 treated through the C5 program.

8 And so this is not the average.
9 This is the 70th percentile. For resource
10 planning purposes if we designed everything for
11 the average then half the patients would arrive
12 to not have enough resources. So we err on the
13 side of being a little high. So we want to set
14 it at the 70th percentile.

15 And given this now you can use these
16 charts, this description of the care that's been
17 provided to anticipate the future. When the
18 next patient arrives that's a bilateral
19 amputation patient how many resources are they
20 going to consume. Well, we now have a really
21 good idea of that number. And we can put that
22 into a little model and we can use that to predict

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1 resource requirements in the future.

2 Questions on this? Here's another
3 one. This is multiple limb fractures. Same
4 idea but totally different resource
5 utilization.

6 And then the last one is gunshot
7 wounds. Again, a lot less physical therapy.
8 But what's interesting to me anyway I thought was
9 if you look at the mental health they're okay in
10 the beginning but right about 30 weeks or so is
11 when the majority of gunshot patients need more
12 mental health services, more care in that arena.
13 So patient care patterns differ and we've been
14 able to characterize all those. So
15 we've got this type of description provided for
16 each one of the 10 patient types and we can now
17 have a really good idea when a new patient
18 arrives. Or if we want to talk about the future,
19 what if something happens in North Korea and we
20 get patients that are going to be of different
21 categories. We can understand what the
22 resource consumption of those patients will be.

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1 MEMBER REHBEIN: I would expect
2 that some of these patients would have fit into
3 more than one category. How do you characterize
4 care in those cases? Because TBI and bilateral
5 amputation seem to me a number of the providers
6 would be the same.

7 MR. WARD: Yes sir, you're right.
8 And so we try to use the method that the DRG,
9 Fetter and Thompson used in the eighties to
10 develop DRGs. It's the one that's going to have
11 the highest resource consumption. That's the
12 one that dictates the patient category that that
13 patient is put in.

14 And so, and of course this is a
15 statistical game. So the larger a sample we
16 have the more confident we are. And we don't
17 need to be that precise. We want to be a little
18 bit -- we want to estimate -- overestimate just
19 a little bit but not too much. And that's why
20 we set it at the 70th percentile.

21 So for resource planning this is a
22 great tool. What is an individual patient going

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1 to do? That's hard to predict. That's pretty
2 much impossible to predict. But for resource
3 planning this is pretty good.

4 Okay, the next slide talks about
5 provider capacity. How many -- when you have a
6 case manager how many patients in the C5 program
7 do they visit in a week. What about EMT,
8 internal medicine, mental health. So we had to
9 do a lot of statistics on provider utilization
10 and build that into the model.

11 With the war in Afghanistan in
12 particular the summer months are the most
13 active. And most of the patients, I mean almost
14 all the patients don't arrive at San Diego first,
15 they're processed through Walter Reed and then
16 to San Diego. So there's a lag and you see that
17 bump there around August-September. That's
18 when the majority of the patients were moving to
19 San Diego. They'd finished some care and now
20 they're basically moving forward in
21 rehabilitation. And so that's when they get to
22 San Diego.

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1 That changed from year to year. We
2 had 5 year's worth of data to look at these care
3 patterns. And so this is actually a 5-year
4 moving average.

5 But you can actually look at any
6 individual year and there is variation in there
7 by year. The amount of change and variation in
8 the arrival pattern has a great deal to do with
9 resource consumption. So it's important to
10 understand how it changes.

11 And then here's just a few slides to
12 kind of walk you through how this tool is used.
13 It's something you put on your laptop. It's a
14 spreadsheet type tool.

15 And so this is the first screen.
16 You get to choose whether or not you want to
17 restrict the population to just those that --
18 just those patients that use physical medicine
19 and rehabilitation services or the total
20 population. In the C5 program there were a lot
21 of patients that were screened and then not
22 admitted to C5. So should this patient go

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1 through the C5 program. That screening would
2 happen in C5 and then many times, no, they would
3 not be placed in the C5 program. And so if you
4 want to include that work you'd use a total
5 population number or choose total population or
6 you could on the top here as we've done this
7 example restrict the population to those
8 patients that required a great deal of physical
9 medicine and rehabilitation.

10 Next screen then. When you're done
11 with that the next thing that pops up is you get
12 to decide what the annual arrival rate will be
13 of new patients. That's in the top box there and
14 we've placed 200 here.

15 And then you get to decide that
16 arrival pattern, that seasonal pattern. And
17 there's several things for you to choose from or
18 you can actually build one yourself if you don't
19 like these options. But in this case we're
20 going to use the 2011 arrival pattern.

21 And then thirdly you get to decide, the
22 user gets to decide on the case mix. So you can

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1 use the historical information on that mix of the
2 10 different patient types, how many of each, or
3 you can go on the bottom here and you can adjust
4 it any way you wish.

5 So if a planner, someone who's
6 talking about resources thinks that in the next
7 war we're going to get more bilateral amputees
8 or more TBI or more this or that or the other
9 thing you can adjust the tabs in the bottom here
10 and run them out and see what happens to resource
11 consumption.

12 And this is just a summary tab. So
13 this summarizes all the parameters that the user
14 has put into the model and then off we go.

15 So this is the output. What it
16 shows you is the number of providers in FTEs for
17 each 1 of the 14 clinical areas. And the graph
18 here shows the utilization of that provider type
19 across time over the year. So a physical
20 therapist, we expect a jump in physical therapy
21 between August and September. We can actually
22 see how the need for physical therapists given

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1 all the parameters we put in fluctuates and
2 varies across the year. And of course that's an
3 artifact of the seasonality that we talked about
4 earlier.

5 So now, previous to this tool there
6 was really no way for a planner to look forward
7 and say hey, this is what's happening, this is
8 what I think I'm going to get downstream. How
9 many physical therapists am I going to need?
10 How many case managers am I going to need? What
11 do I need to plan for? And now we have a tool
12 that allows us to do this.

13 And what's really, to me what's
14 really important about this of course is that
15 getting back to Admiral Faison's question, what
16 are the resource requirements to maintain the
17 viability of the C5 program moving forward. We
18 now can estimate those numbers very accurately.

19 MEMBER EVANS: So, and I may get in
20 trouble, but the question that I have is that do
21 -- this started, we started C5 probably, what,
22 5-6 years ago. And it was because of the war,

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1 because we needed to move the Marines closer to
2 the west coast to the base and provide that care
3 in San Diego. So I would think we would do a look
4 5 to 10 years from now.

5 Are we, DoD, Navy medicine, is this
6 the business we want to be in. Because we
7 started this because of the war. Is it
8 cost-effective? My favorite term.

9 And again, I don't know, but it's
10 just a question. I understand Admiral Faison's
11 wanting to sustain this but is this the business
12 we want to sustain or is this something that we
13 want to shift. VA really is our rehab.

14 So it's a good question that I think
15 5 to 10 years do we stay in the rehabilitative
16 medicine. Is it sustainable or is that
17 something that civilian or VA should be looking
18 for moving.

19 CO-CHAIR NATHAN: I think it's a
20 great question. We've been wrestling with
21 that. You know, before the war we used to get
22 criticism for having physiatrists on the staff

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1 to take care of chronic stroke patients because
2 those should be transferred to a rehabilitative
3 facility, not -- MTFs shouldn't be in that
4 business.

5 An interesting dilemma which
6 specifically, Tim, is you may or may not know
7 about the C5 in San Diego is they went through
8 a period of time there where they were really
9 taking heat because they were not hitting their
10 marks at all getting wounded warriors into
11 prosthetics.

12 And they couldn't get the
13 prosthetist to come in and do the fittings.
14 They were way behind. It was taking weeks and
15 months. There were letters coming left and
16 right to the CNO, the commandant of the Marine
17 Corps. They were coming to me. They were
18 yelling at me. So I'm a good leader, so I yelled
19 at Forrest.

20 And come to find out here was the
21 problem. So a lot of these people, Connie, were
22 being discharged from the C5 and they were going

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1 to go to the VA for care.

2 Now, if you were the VA and you were
3 going to get in the prosthetics business which
4 most VAs do because vets that had amputations
5 since time began but mostly elderly vets who have
6 ischemic peripheral vascular disease, diabetes
7 who lose a foot or a leg or something, you know,
8 that kind of thing.

9 Where would you put the center of
10 gravity in southern California if you were the
11 VA of your prosthetic rehabilitation? L.A.
12 That's where the population is. It's huge VA.
13 So you'd put your prosthetics thing in L.A.
14 because you have a few in San Diego but you have
15 this huge population of vets in L.A. who are
16 coming to get their amputations taken care of.

17 So they didn't have anybody in San
18 Diego. So they kept coming back to the C5
19 because they'd go to the small VA in San Diego,
20 relatively small, who said we've never seen
21 prosthetics like this. These things are, you
22 know, we can't do that.

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1 And so they'd tell the soldier you
2 need to get in the car and drive to L.A. And the
3 soldier said I'm not driving to the VA in L.A.
4 I'm coming back to the C5. I dare you not to take
5 care of me. And we did of course and it backed
6 everything up.

7 So then the VA got very, very
8 energized about this. And to their credit the
9 VA said look, let us help you hire on the VA
10 payroll some prosthetic experts to put at the C5
11 and working with VA patients which is I think
12 that sort of joint partnership makes sense. The
13 numbers came down and Forrest hired some more
14 physical therapists.

15 But it begs the question. At some
16 point when all this stops being acute injury, God
17 willing, and we end up with just chronic
18 rehabilitative and restorative care which
19 amputees need a tremendous amount of, the
20 readjustment and refittings and new prosthetics
21 and those kinds of things, whose business is
22 that.

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1 Right now it's been all our business
2 because aside from the VA polytrauma centers
3 which are amazing the average VA is not equipped
4 to handle a high load of these kind of new type
5 things coming along. So we've sort of figured
6 it out on our own and kept them in our system
7 equilibrating with the VA.

8 As the pressure comes, and it will.
9 I think our next speaker will allude to some of
10 that when he comes in to talk about the Defense
11 Health Agency. As the pressure comes for the
12 military treatment facilities to downsize, to
13 get smaller, to stop -- to not being as robust
14 as they are and figure out how to be more
15 concentrated and supporting just war-fighting
16 we have to wrestle with who's going to take care
17 of these.

18 I don't know if, Karen, you have any
19 philosophical thoughts about it from the VA
20 standpoint.

21 MEMBER MALEBRANCHE: Well, I guess
22 one of the things that has come up before in the

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1 VA and continues to is the military has a lot of
2 experimental prosthetic devices that are --
3 companies are going to the military I think in
4 hopes of promulgating that. And the VA doesn't
5 necessarily have that. And like you said, not
6 everywhere.

7 So sometimes then when veterans
8 start out in a place like the Walter Reed and then
9 they go to a little tiny place in Oklahoma there
10 is not the people there at that VA to take care
11 of that device without having to send it back.
12 I mean, there's a lot of those sorts of issues.

13 The VA though has always prided
14 itself on being the rehab piece of doing all
15 this. But like you said, the centers where we
16 have and the population that we have has been
17 different.

18 But what's interesting I think is
19 that some of these younger vets now are
20 incentivizing our older vets who say you know,
21 I don't think I want this wheelchair. I think
22 I want the running leg, the swimming leg, the

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1 this. I mean there are some interesting things
2 that are coming from this.

3 But I think it's also a matter of the
4 economics and the research and what we can and
5 cannot do. And we don't give five different
6 legs that they might get here in the D.C. area
7 at a place where we don't have someone to work
8 it.

9 And there is I think even some new
10 devices, I'm thinking in Texas somewhere too
11 that we have people that are getting fitted for
12 these. But then when they go back to their home
13 who's going to help maintain? They can't be
14 mailing this back. So there are some of those
15 issues I think that are a big concern.

16 CO-CHAIR NATHAN: No, it's a great
17 philosophical question. And I've teased
18 Forrest Faison, the commander out at San Diego,
19 about being the colonel in Bridge Over the River
20 Kwai.

21 If you remember that movie the whole
22 point in building this massive architectural

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1 wonder was to tear it down at the precise moment
2 the enemy were going to cross it. And at the end
3 he couldn't bring himself to do it because he'd
4 built it and he was so proud of his prisoners who
5 had built this bridge he could not destroy it
6 even though it was going to help the enemy if he
7 didn't destroy the bridge.

8 There may become a time when we have
9 to sort of relegate the C5 to, you know, mothball
10 status. I hope that day comes because it means
11 we no longer need that kind of acute -- yet it
12 does an amazing rehabilitative service for all
13 kinds of things. So I think it'll always be
14 present, the question is how much it drops to a
15 surge status. And I think it'll be an
16 equilibrium of that.

17 Amputations at the end of the day as
18 I tell most civic groups, there have been less
19 than 1,500. If you're one of those 1,500 who
20 have suffered a single or a multiple amputation
21 then the numbers are immaterial to you. To you
22 that's your whole life and I get it. That's

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1 1,500 too many.

2 But we have that many TBI and PTSD
3 patients being produced every month. And so I
4 think what we're going to be doing is training
5 our guns more on the behavioral health and the
6 TBI over the long run as the amputations
7 equilibrate and go back into a more normal loss
8 from a motor vehicle accident, motorcycle
9 accident, that kind of thing.

10 Tim, keep going.

11 MR. WARD: Well, so on that point,
12 sir, so we have actually done some of the math.
13 And if you want to maintain the C5 program of
14 course the real bottleneck is the prosthetist.
15 And how do you -- how many prosthetists do you
16 need and how do you ensure their currency.

17 And the answer is well, you can't
18 have one, that's a single point of failure, so
19 you've got to have at least two. And two is kind
20 of on the edge, but if it's two supported by
21 enough prosthetic techs that's good. And so you
22 can actually use the tool I just showed you to

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1 back into the number of patients that you need
2 to maintain the skill set in San Diego.

3 And it looks like, you know, we're
4 still running some of the numbers but it looks
5 like the answer is about 40 new patients a year
6 that would be amputees that would be sufficient
7 to keep everybody busy in the gait lab and the
8 PT.

9 And so if the decision is made that
10 this is a viable program that we want to maintain
11 we need about 40 patients a year, new patients
12 a year coming through the program of a similar
13 character in terms of the injuries that they
14 sustained to the historical C5 patients.

15 CO-CHAIR NATHAN: And that works
16 for me but you have the CFI in San Antonio which
17 is going to need a throughput. You have the MATC
18 at Walter Reed which is going to need a
19 throughput. And so again where is the center of
20 gravity for amputation, traumatic limb salvage
21 going to occur.

22 MR. WARD: Right. And actually

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1 that's my last slide, on this subject, anyway.

2 MEMBER EVANS: We're actually
3 utilizing this too at San Diego. So we're using
4 this currently.

5 MR. WARD: So we have briefed this
6 to the folks at Walter Reed and San Diego and to
7 the VA here in D.C. as well. This tool is based
8 on the care patterns that were provided in San
9 Diego. We have not done the statistical
10 homework on what care was provided at Walter Reed
11 or at Brooke Army.

12 So there is some, you know, are the
13 care patterns the same? Are they different?
14 How different are they? This tool right now is
15 not easily ported to another location. With
16 some statistical homework it could be but right
17 now that hasn't been done yet.

18 CO-CHAIR NATHAN: I was just
19 talking to my co-chairwoman here but one of the
20 things we may do for this to maintain currency,
21 the same way we're looking at trying to maintain
22 currency in level 1 trauma support is what

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1 they're doing in San Antonio where they have an
2 MOU with the city where they're a level 1 trauma
3 center and take care of people who are non-DoD
4 beneficiaries for trauma that are brought to
5 them.

6 We may end up doing the same thing
7 with some of these places where we will then make
8 a deal with the state or the city and say that
9 19-year-old who's not in the military who loses
10 his leg or her leg on a motorcycle or to a gunshot
11 wound or to something else, we'll take care of
12 to try to maintain some currency. So
13 there's all kinds of things we can look at in the
14 future. Necessity is the mother of invention.

15 MR. WARD: And so the question of
16 what should the overall MHS capacity be for
17 treating amputation patients in the future,
18 that's a key question.

19 We have three locations right now,
20 mainly three locations. What do we want that
21 future state volume to be.

22 It turns out we did the math on

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1 purchased care workload and other things that
2 happened outside of the war wounded. There's
3 about 180 MHS beneficiaries every year that are
4 below the age of 65 that have a traumatic
5 amputation for other than a vascular problem.
6 So it's not diabetes, it's not age-related. And
7 so about 180. But that's probably not enough to
8 run all three programs.

9 And by the way, earlier this morning
10 you were talking about patients who wanted to get
11 closer to home. If you want to be in the C5
12 program you've got to be in San Diego. And so
13 to somebody who has a traumatic event like that
14 happen somewhere else do they really want to move
15 to San Diego for a year and a half, 2 years? So
16 there are issues like that to resolve.

17 But anyway, we have the math, we know
18 the numbers. The decision about how to maintain
19 this capability throughout the MHS, that's on
20 the table.

21 Okay, I wanted to go over one more
22 small thing and then I'm done. I've got about

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1 three or four slides to go.

2 So this is a slide that just shows
3 you the -- it's a guide for patients with lower
4 limb amputations. I think one of the things
5 that always intrigues me is do the patients
6 understand their process.

7 Do they understand where they are
8 and where they're going and how long it's going
9 to take and what can they expect. And what we
10 found was that there's a lot of very
11 well-intended folks but the information is very
12 diffuse and it's very hard for patients to figure
13 it all out. So can we put it all in one place.

14 And so the list on the left there are
15 the different sources. And there's more than
16 that, but there are a whole lot of sources of
17 information that patients who had had a
18 traumatic amputation can access. And what we
19 did really was put it all in an iPad tool so they
20 can page through it and access it at will.

21 So here it is. This is the iPad
22 screenshot. And then there's the table of

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1 contents. And you click on a button and it moves
2 you to the page.

3 And all the web -- so if there's
4 another site like the VA/DoD CPGs for lower limb
5 amputation that's on a website, click on the
6 button. If it's web-enabled you go off to that
7 website. So all those links are in it.

8 But here's kind of the slide I think
9 sort of summarizes it. It takes patients
10 through the process what they can expect in terms
11 of protective healing, pre-prosthetic training,
12 prosthetic training, and then return to a higher
13 level of functionality and activity. And click
14 on the button and it takes you to more definitive
15 information about each one of those phases.

16 MEMBER REHBEIN: Sometimes iPad
17 means iPad and sometimes iPad means mobile
18 device. Can you tell me which one you're
19 referring to?

20 MR. WARD: Well, this is actually
21 for an iPad. It could be for any mobile device
22 though because it's just PDF files with the links

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1 in there. So it could be on any -- I don't think
2 you could make it work on a phone. The screen's
3 not big enough. You wouldn't be able to read it.
4 But yes, it's any mobile device. And that's all
5 I have.

6 GENERAL ROBB: Admiral Nathan along
7 the lines of what you were just talking about of
8 maintaining currency in the end of war years as
9 far as who's going to be the keeper of the
10 scrolls, keep the power line burning.

11 There is a discussion on a request
12 for the Defense Health Board to look at that
13 issue of maintaining again a core competency if
14 in fact we decide that's what that is for
15 polytrauma rehab, primarily for amputees coming
16 out of primarily from actually Retired General
17 Franks. And so we're in the process now of
18 teeing that up in that request to go through P&R
19 to actually have that up.

20 And then again, precisely what you
21 said. You know, what are the branches and
22 sequels for maintaining currency competency.

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1 Where should the standard of gravity be? You
2 know, can we afford to have three currently or
3 do we collapse to one and then all three services
4 rotate through and then have the ability
5 ultimately to expand in case we get into a
6 conflict like this.

7 So all these questions are being
8 asked right now. And again we're going to have
9 the folks look at that to kind of maybe give us
10 some research and some homework to figure out
11 where we need to go with that.

12 So again I appreciate that question
13 because I think it's going to tee us up what we
14 need to do as we lay down currency competency not
15 only for trauma care but for polytrauma rehab and
16 several other things as we call it in the end of
17 war years.

18 CO-CHAIR NATHAN: Thank you,
19 General Robb. Appreciate that. Any other
20 questions for Mr. Ward?

21 CO-CHAIR CROCKETT-JONES: Thank
22 you, Mr. Ward. I think the task force now has

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1 a 15-minute break.

2 CO-CHAIR NATHAN: Why don't we try
3 to, if it's okay with you, make up a little bit
4 of time, take 10 minutes.

5 (Whereupon, the foregoing matter
6 went off the record at 2:24 p.m. and went back
7 on the record at 2:36 p.m.)

8 CO-CHAIR CROCKETT-JONES: At this
9 time we welcome Major General Douglas Robb, the
10 Joint Staff Surgeon under the Offices of the
11 Chairman of the Joint Chiefs of Staff. Major
12 General Robb is providing us an overview of the
13 Defense Health Agency and its impact on
14 recovering warrior care. The information can
15 be found under our Tab G. I'm going to turn it
16 over to you now.

17 GENERAL ROBB: Well, thank you all
18 very much for the opportunity again to give you
19 all an update on where we are on Military Health
20 System governance reorganization and reform.

21 Now, the good news is that if I get
22 out of bounds Admiral Nathan who's been a part

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1 of this can get me back on track. And so he
2 probably knows as much about this as I do
3 primarily because again of the three services he
4 is a leader and they're prime players in where
5 we're going.

6 And so this is a good news story. I
7 know there's a lot of angst out there because any
8 time you reorganize and you have a status quo
9 you're comfortable with it even if you're not
10 happy with it, but you're comfortable with it.
11 And so we're going to talk about where we think
12 we need to go.

13 I'm going to do something that's
14 non-standard for me is I'm going to pretty much
15 read off the script here only because again this
16 is new. It's somewhat complicated at times, can
17 be if you don't understand it. And I want to
18 make sure I cover everything. And number 3, and
19 Admiral Nathan knows me better than anybody. I
20 can get off piece pretty quick. And so that'll
21 allow us to stay on the trail.

22 So I am currently the Joint Staff

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1 Surgeon, primary medical advisor to the Chairman
2 of the Joint Chiefs of Staff. And I was asked
3 to co-chair along with Dr. Guice -- again, as you
4 know, she's the Principal Deputy Assistant
5 Secretary of Defense for Health Affairs who will
6 be speaking to you next about the IC3. We were
7 asked again to come up with a transition plan for
8 MHS governance. So next slide, please.

9 So my purpose today is to update you
10 on these several topics. It won't be as long as
11 you think but these are all the primary issues
12 that we need to talk about. I'll give you a
13 high-level overview of the current healthcare
14 system. It's always good to know where you
15 start, and then keeping the end state in mind.
16 And then what it means for the Defense Health
17 Program. And then I'll give you a brief
18 background history of the governance and how it
19 has transformed from 2 years ago to today through
20 a series of memorandums from the Dep Sec Def.
21 And then lastly I'm going to describe how the new
22 transformation impacts the recovering warriors

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1 which I think is key for you all to understand.
2 And then from there I'll hand it over to Dr. Guice
3 who then will talk about the Integrated Care
4 Committee, or the IC3. So next slide.

5 Here's the bottom line. We know
6 healthcare costs are increasing, both in
7 complexity and cost. And as you know that
8 complexity drives cost. So at the heart of the
9 issue is the fact that the Department, the
10 Department of Defense, must be able to sustain
11 an effective, an efficient, but just as
12 important relevant healthcare system which
13 improves cost containment and unity of effort,
14 all leading to better health, better care,
15 better readiness at a reduced cost. Where have
16 you heard that before? Quadruple aim.

17 Now, additionally and as we're
18 living that dream every single day in the last
19 really 12 to 24 months the future fiscal
20 considerations and the broader crisis is of
21 course a fiscal crisis that are facing our
22 nation, the Military Health System must do their

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1 part, must do their part.

2 So this slide gives you the main four
3 big reasons for the growing care and healthcare,
4 but primarily TRICARE costs for the Department
5 of Defense. These include an increase in new
6 eligible beneficiaries. So the population is
7 going up so therefore you multiply that by head
8 count per cost, our costs are going to go up.

9 You've got expanded benefits. So
10 the benefits, the amount of benefits, the type
11 of benefits and who we cover have increased
12 primarily over the last decade. You've got
13 TRICARE for Life now, TRICARE Young Adult,
14 TRICARE Retired Reserve, TRICARE Reserved
15 Select and also increased prescription
16 benefits. And all those again have evolved over
17 -- again, Admiral Nathan was chair primarily
18 over the last 10 years so it's a different
19 environment than when we first started
20 practicing medicine.

21 Additionally you've got not only an
22 increased number of folks covered and increased

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1 benefit but you've got increased utilization
2 across both our military treatment facilities,
3 what we call the direct care system, and also the
4 TRICARE network or the purchased care system.
5 And we're seeing that specifically in emergency
6 room visits, orthopedics and mental health
7 visits.

8 And finally, healthcare inflation
9 is what it is and it is higher than the general
10 inflation rate. Any questions on that slide?
11 Next slide, please.

12 So many of you all have seen this
13 slide at least that have been part of the MHS
14 governance reform initiatives for the last 2
15 years.

16 We refer to this as the planet or the
17 solar system slide. It represents the Defense
18 Health Program, or the DHP, budget by O&M
19 activity groups. The blue circle over there on
20 your right reflects the pure management activity
21 dollars as a small percentage as you can see of
22 the overall Defense Health Program budget.

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1 So when everybody talks about well
2 just eliminate some management, see how many
3 people you can save, that's small dollars
4 compared to where the dollars are being spent and
5 that's in the direct care system and on the
6 network. So what you really want to do is create
7 a system that affects those circles downstream,
8 either curb the cost or decrease the cost.

9 So reducing the cost in the military
10 healthcare system requires a focus on the cost
11 in that big red circle. Particularly in that
12 direct care system our MTFs and the private
13 sector care or the network TRICARE system.

14 To affect those costs at the core of
15 the new governance model that I'm going to
16 describe to you is a shared services approach and
17 the implementation of what we're going to call
18 enhanced multi-service markets. And you go
19 what's that. Well, we'll talk about it.

20 So now a shared services approach
21 will increase the effectiveness and the
22 potential efficiencies in all areas of cost in

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1 the red circle. MHS shared services approach
2 provides an extremely attractive potential
3 would turn on relatively small investments.

4 As an example, right now you've got
5 Army, Navy and Air Force all separate
6 contracting systems save for, well pick
7 something, linen, you know, or hazardous waste
8 disposal. In fact you may have even within a
9 particular service, you know, you may have
10 multiple contracts doing the same thing. So it
11 makes intuitive sense if you do the business case
12 analysis, remember, we're going to do that for
13 each one of these product lines that a
14 centralized contracting potentially,
15 potentially may be the way to go. And so this
16 Defense Health Agency with the shared service
17 portfolios that you see will give us an avenue
18 to do that, one, give us the authority to, and
19 number two, give us the ability to.

20 Then also let's talk a little bit
21 about the multi-service markets and how they're
22 affecting direct care and the purchased care

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1 systems in the red area. And again, I'll talk
2 about where those locations are.

3 But there's six what we're going to
4 call enhanced multi-service markets and they
5 include the National Capitol Region. A lot of
6 folks know that as JTF CapMed today. And they
7 represent our largest medical centers as you can
8 imagine. And they also are the bulk of our
9 graduate medical education which makes sense
10 because they're at our largest medical centers.
11 And that's where our specialty care is.

12 And these multi-service markets
13 execute about 35 percent of our direct care
14 costs. And they serve our largest and more
15 concentrated beneficiary populations.

16 So where are those locations?
17 National Capitol Region, San Antonio, Colorado
18 Springs, Hawaii, Fort Lewis, Puget Sound, and
19 I'm missing one. Bobby, what's the sixth one?
20 No, San Diego is a single market which is going
21 to behave like a multi-service market.
22 Tidewater. I'm sorry, Portsmouth. Spoken

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1 like a true Navy man. So big house on the east
2 coast, yes.

3 So, how are we going to do that?
4 Well, primarily we're going to do it by how we're
5 going to manage the budget to support what we're
6 going to call 5-year performance business plans.
7 So what we're going to do is again it will be
8 policy and then through execution that these
9 markets.

10 Right now if you're in San Antonio
11 the Air Force has a budget and the Army has a
12 budget and they collaborate on how they want to
13 deliver care. But then the money then flows
14 back down through the services. So the plan is
15 that they will create a single business plan.
16 Doesn't mean they're not going to take care of
17 the Air Force product lines and the Army product
18 lines, but then the lines that cross, okay, the
19 money's going to flow that way and earmarked that
20 way. So you can see it's going to force a better
21 integrated delivery care system for those
22 markets. Next slide, please.

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1 So you say hey, Doc Robb, you talked
2 about this before. And the answer is yes, we
3 have. Yes, we have. There have been 18 studies
4 since 1946 I think into '48 on MHS governance.

5 Now about one-half of them
6 recommended a more unified organizational
7 construct such as a unified medical command.
8 And just under one-half of those recommended a
9 more centralized authority for delivering
10 shared services or a Defense Health Agency-like
11 entity. And there were a couple of them that
12 said keep as it is.

13 But it wasn't until our most recent
14 MHS task force in 2011 where the previous 17
15 studies, they were not able to gain the consensus
16 nor the effort required to implement the large
17 governance transformation that we are currently
18 experiencing.

19 Those 2011 task force
20 recommendations and now the most recent MHS
21 governance implementation planning team -- I'll
22 talk about that -- the leadership from both the

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1 Department and the services have agreed upon and
2 are now implementing the vast reforms to MHS
3 governance that will have a positive outcome on
4 cost effectiveness, collaboration and we hope
5 overall efficiency.

6 What is key is that we intend to
7 maintain this momentum and work towards full
8 implementation with a proposed full operating
9 capability date of October 2015. Next slide,
10 please.

11 So here's how we got to where we are
12 today. So the current MHS governance reform
13 initiative began in June of 2011 with a Dep Sec
14 Def memo directive to stand up the task force on
15 MHS governance which delivered its final report
16 to the Dep Sec Def in September of 2011.

17 The task force recommendation to the
18 Defense -- actually, the task force recommended
19 a Defense Health Agency model for overall
20 governance and recommended the enhanced
21 multi-service market model for providing
22 budgetary management authority for the six

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1 identified multi-service markets to include the
2 National Capitol Region.

3 Subsequent to that, March 2012, the
4 Dep Sec Def memo planning for the reform of the
5 governance of MHS which was based on the task
6 force on MHS governance recommendations
7 directed the establishment of the Defense Health
8 Agency, the six enhanced multi-service markets,
9 and the transition of JTF CapMed to the NCR
10 Medical Directorate which will be a subordinate
11 organization, by the way, of the Defense Health
12 Agency.

13 And then further directed the
14 standup of the MHS Governance Implementation
15 Planning part two. Next slide. Part three.

16 So in January of 2013 the MHS
17 Governance Implementation Planning Effort
18 presented their implementation planning
19 recommendations to the Dep Sec Def. So after
20 compliance with the FY 2012 NDA language the Dep
21 Sec Def signed the 11 March 2013 memo,
22 implementation of Military Health System

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1 governance reform, and he directed the
2 implementation. Now, directed the
3 implementation of the MHS governance reform in
4 accordance with the FY `13 NDA language. So
5 there we are. That's how we got to where we are
6 today.

7 So we are now in the implementation
8 mode and from the March 2013 memo and we have
9 begun the transition implementing those
10 recommendations. Next slide.

11 So here's our way forward. So the
12 Department as you can see is committed to MHS
13 governance reform as depicted on this slide.
14 The MHS governance reform began -- it will begin,
15 actually it has begun with pre-IOC in the spring
16 of 2013. So that's where we are today.

17 And as you can see from this the
18 pre-IOC includes selection of DHA director, the
19 standup of the MHS governance transition team,
20 which has already been done, and a completed
21 assessment of the 10 shared services which we are
22 in the process of doing now. And we'll talk

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1 about what those 10 shared services are here in
2 a moment.

3 Initial operating capability will
4 occur in October of 2012 with the standup of the
5 DHA as a combat support agency which will be
6 responsible for the designated shared services.

7 Now, ASD Health Affairs
8 reorganization will also be implemented by this
9 time. And we'll talk about what's going to
10 entail. And then the six eMSM's or enhanced
11 multi-service markets will stand up to include
12 the transition of JTF CapMed to the NCR Medical
13 Directorate under the DHA.

14 In October of 2014 the enhanced
15 multi-service markets will be executing,
16 monitoring and evaluating their 5-year business
17 performance plans and the NCR Medical
18 Directorate will be fully operational under the
19 DHA again as an enhanced multi-service market.
20 By October of 2015 the DHA, Defense Health
21 Agency, will be fully operation-capable, FOC.

22 So let's reminisce just a little

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1 bit. Much like the Defense Logistics Agency of
2 25 years ago the Defense Health Agency will face
3 similar challenges. There will be an
4 evolutionary process from a far-reaching
5 Department strategic initiative to a more
6 relevant world-class medical support
7 organization whose ultimate goal is to provide
8 second-to-none medical readiness support to the
9 war fight while delivering better care, better
10 health at a reduced cost to our 9.7 million
11 beneficiaries worldwide.

12 And as you are acutely aware, and as
13 I mentioned before, in this era of fiscal
14 realities the MHS has the responsibility to the
15 Department and the medical organizational
16 reform is a must-do. So let's get into the
17 details of what it's going to look like. Next
18 slide.

19 So here's the notional
20 reorganization for OSD Health Affairs. And you
21 say it looks like it does today. Not really, all
22 right? Not really.

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1 What you're doing is you're removing
2 the dual hatting of the ASD Health Affairs,
3 Assistant Secretary of Defense Health Affairs,
4 and the director, the TRICARE Management Agency.
5 So most ASDs are policy only. And again over
6 time our organization has morphed into a
7 combination of policy and execution. And I
8 mean, for reasons that were there.

9 And so here's an opportunity while
10 we created this thing called the Defense Health
11 Agency, an opportunity to set that right. So as
12 part of the MHS governance planning team's
13 efforts the Health Affairs work group evaluated
14 the current functions of Health Affairs and the
15 TRICARE Management Agency and they recommended
16 how policy and execution should and will align
17 in the future. So they recommended
18 through the current dual hatting policy of
19 policy and execution in Health Affairs with TMA
20 being the execution arm in Health Affairs be
21 separated with the standup of the DHA.

22 The intent is for Health Affairs'

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1 focus to be on policy development but they will
2 work with the Defense Health Agency to ensure
3 proper execution of Health Affairs' policies and
4 the TRICARE health plan.

5 Health Affairs is going to be still
6 responsible for advising DoD leadership on all
7 departmental health matters and be responsible
8 for policy development, approval and oversight.
9 Policy development, approval and oversight,
10 while executing the ASD Health Affairs fiduciary
11 responsibility as a Defense Health Program
12 appropriation holder.

13 Note that the warrior care policy
14 and oversight will remain as the Deputy
15 Assistant Secretary of Defense, the DASD. I
16 know a lot of folks have been asking that
17 question.

18 Now the following slide is going to
19 depict the transition of the current TRICARE
20 Management Agency and the healthcare plan and
21 the other TMA execution responsibilities to the
22 Defense Health Agency. Next slide.

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1 So here's the Defense Health Agency
2 organizational structure. So, the Defense
3 Health Agency will deliver the TRICARE health
4 plan. It exercises the direction and the
5 control of the NCR Medical Directorate. So
6 you're going to see here, here's Warrior Care
7 Programs. And down here you see here's the
8 TRICARE health plan and here's the NCR Medical
9 Directorate. So I'll step you through these.

10 And it provides the shared services
11 listed on the slide for the services medical
12 departments. So one of the groups was what are
13 the shared services, what is the core of what all
14 three services do that might be better served
15 with a more centralized approach. And that's
16 what these are. TRICARE health plan, pharmacy
17 programs, medical education and training,
18 medical research and development, health
19 information and technology, facility planning,
20 public health, medical acquisition with a small
21 A by the way, and budget and resource management.
22 So that's the initial start.

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1 So right now each one of the services
2 either does those in parallel or does those in
3 silos. And it makes sense that this core here
4 can provide standardization, decreased
5 variance, hopefully increased efficiency which
6 it should and we really hope decreased cost which
7 again it should. That's why we're doing
8 business case analysis on each one of these
9 product streams. And they will deliver that to
10 the services.

11 So this is not the Defense Health
12 Agency shared services, this is the services'
13 Defense Health Agency. That's the way I look at
14 it. That's the way I look at it. This is not
15 the Defense Health Agency or Health Affairs
16 Defense Health Agency. This is the services'
17 Defense Health Agency.

18 Now, the Warrior Care Program,
19 something I think folks are going to be
20 interested in this room here, their execution
21 now will fall under the Healthcare Operations
22 Directorate. Remembering that from the

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1 previous slide the Deputy Assistant Secretary of
2 Defense for Warrior Care and Policy will
3 continue policy development, approval and
4 oversight and execute again the fiduciary
5 responsibility for those programs.

6 Now the Defense Health Agency will
7 be led by a 3-star. And again it's going to be
8 designated a combat support agency.

9 Now, what does that mean? The 2011
10 MHS Governance Task Force recommended the
11 designation of the DHA as a CSA, combat support
12 agency, to ensure that the chairman, okay, the
13 combatant commanders and the services were
14 properly supported by this new agency.

15 And you say how is that so. Well
16 mainly because the way it's going to be set up
17 is you don't see this but here's the chairman's
18 organization. There's a dotted line that goes
19 right to this guy's -- he can put his finger in
20 his chest as we say and say hey, you're not
21 supporting my services. Or DHA goes back to the
22 chairman and says hey, the services aren't

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1 playing.

2 So it's a good relationship. It's
3 the same relationship DLA has, DIA and all the
4 other groups. And they are required every 2
5 years to submit again a status of support and for
6 the chairman to comment on you are or are not
7 supporting again our enterprise.

8 Now, the DHA is organized to manage
9 those shared services that will transition from
10 the three service medical departments and TMA.
11 The ongoing shared service assessment process
12 applies objective analysis and ensures proper
13 consolidation of services that will either
14 reduce the cost on the direct healthcare system
15 -- remember we were talking about those two big
16 blue balls over here, those two big planets --
17 and into a minimized variance across the MHS.

18 Now we're going to specifically talk
19 about the NCR Medical Directorate. That will
20 provide -- the NCR Medical Directorate will
21 provide the authority, direction and control
22 over the Walter Reed National Military Medical

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1 Center and Fort Belvoir Community Hospital and
2 their satellite clinics. And then the director
3 will receive specified support services from the
4 Defense Health Agency. Next slide, please.

5 Now, what are these multi-service
6 markets? And I talk about this because for the
7 folks that aren't military in the room C2 is
8 command and control, command and control. This
9 is a relationship to ensure strategic alignment,
10 not command and control as you have many times
11 in military organizations.

12 And you say well, where's the
13 authority? The authority is around the money
14 flow because money sometimes trumps -- no, I'm
15 just joking. But money does drive behavior,
16 money does drive behavior.

17 So the Multi-Service Market Work
18 Group recommended that out of the MHS Governance
19 Task Force we identified 14 potential
20 multi-service markets. And I apologize.
21 Multi-service markets means where two or more
22 services within a catchment area which is

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1 usually a 40-mile catchment area, TRICARE
2 catchment area, reside.

3 So San Antonio -- Air Force, Army.
4 Tidewater -- Air Force, Navy is the big man on
5 campus. Air Force is there with Langley and
6 then you've got Army presence also. You look
7 out at Hawaii, of course you've got a large Army
8 footprint, you've got a large Navy footprint and
9 you've got a medium-sized Air Force footprint.
10 You go out to Colorado Springs, you've got a
11 large single Army base but you've got four Air
12 Force bases out there. So you can see where the
13 opportunity for more direct collaboration and
14 integrated delivery is there.

15 Then you go to San Diego which is
16 actually in an extremely large market as far as
17 volume and also Fort Bragg, another extremely
18 large market as far as volume, but those are
19 considered single-service markets. However,
20 their expectation is that they will play by the
21 same business rules as far as performance,
22 business performance rules as the multi-service

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1 markets. So if you add those to the six
2 multi-service markets you're going to get
3 upwards, up to 45 percent of our direct care
4 costs.

5 Now, the enhanced multi-service
6 market manager and their staff is going to
7 oversee the respective markets as an integrated
8 delivery system as we said before and they're
9 going to direct the collaboration, input into
10 5-year business performance plans. So working
11 from the bottom up let's talk about how this is
12 going to work.

13 The enhanced multi-service market
14 manager, so let's just pick San Antonio for
15 example. Okay, you've got 2 -- either a 1- or
16 a 2-star down there. They're going to
17 alternate, the Air Force and the Army will
18 alternate being the lead down there. The staff
19 will remain the same but they'll put together
20 this 5-year business plan and then that market
21 is expected to live by that 5-year business plan.

22 So they're going to be accountable

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1 to this Multi-Service Market Governance Council
2 as we call it. So they're going to build these
3 plans and then we're going to have this thing
4 called the Medical Deputies Action Group which
5 are going to bless those plans. And then if
6 there's any issues they work up through --
7 everybody knows what the SMMAC is today, Senior
8 Medical Advisory Council, right here.

9 Now this organization out here is
10 new. That's new. And that is called the
11 Military Health System Executive Review. And
12 we've added that because we wanted more line
13 involvement in senior Military Health System
14 strategic decisions and initiatives. And that
15 is going to be the service vice chief's forum for
16 the DoD leadership input into the strategic
17 transitional and the emerging issues facing the
18 multi-health system, the Defense Health Program
19 and the DoD.

20 So we're hoping that that MHSER as
21 we call it is going to provide a forum for
22 improved line medical partnerships and inform

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1 MHS corporate decisions through the enhanced
2 line understanding of the MHS financial
3 realities as we talked about on that second slide
4 and the challenges.

5 But more importantly it's a
6 mechanism for senior line input into the
7 transformational MHS governance decisions. So
8 we've already had that first meeting and they've
9 already blessed off on this MHS governance way
10 ahead. So we have buy-in on where we're going.
11 Next slide.

12 So here's the impact of the MHS
13 governance reform and the DHA to the recovering
14 warrior. So what you'll see is these governance
15 reforms may impact the recovering warriors
16 primarily through the establishment of the
17 Defense Health Agency and the standardization
18 and the consolidation of common clinical and
19 business process into a cost-effective and
20 efficient shared services. These
21 transformations will improve the experience of
22 care as well as access to care across the MHS

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1 enterprise through more efficient and
2 cost-effective practices.

3 Now, the next briefing that you're
4 going to get which is the VA/DoD warrior care
5 coordination or the IC3, that's primarily where
6 the rubber meets the road. And I'm going to tee
7 up Dr. Guice. She's not here yet. So this is
8 the big enterprise that we're doing to again
9 deliver more cost-effective, efficient and more
10 relevant healthcare.

11 But the IC3 which I think is
12 primarily what you all are as interested in as
13 anything, and I was also a co-chair of that task
14 force also, is where the rubber meets the road.
15 And that's where we're going to connect the DoD
16 and the VA together. One mission, one policy,
17 one plan. One mission, one policy, one plan.

18 And what we had going on before was
19 -- okay, she's not here. I'll steal her
20 thunder. So what was going on before was we had
21 a lot of good people doing a lot of good work but
22 in an asynchronous manner, in an asynchronous

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1 manner.

2 So you had two departments, the
3 Veterans Affairs and you had Department of
4 Defense doing some good work. I mean not
5 perfect work, but pockets of good work. But
6 they weren't synchronous.

7 And then you had within the DoD Army,
8 Navy, Air Force and Marines not necessarily, at
9 times, at places they were, but not across the
10 board in asynchronous manner. You even add in
11 the Department of Veterans Affairs doing care
12 services and benefits, individually maybe doing
13 some good work but in an asynchronous manner.

14 And so what we're going to build, and
15 she's going to talk about that, and kind of all
16 this was all coming together was when you think
17 about common doctrine or common strategy. And
18 I share this with you because you can think about
19 it before Dr. Guice gives the briefing.

20 So let's use the military as an
21 example. The President says here's our
22 national security strategy. There's the end

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1 state. There's the overall guidance.

2 Then the chairman takes that
3 overarching guidance and then he adds the joint
4 support to that plan. And then the Army, the
5 Navy, the Air Force and the Marines all synch
6 their plans up to the chairman's plan which is
7 then synched to the President's plan. One
8 mission, one policy, essentially one plan.

9 So what you saw was there was no
10 overarching guidance for the DoD and the VA. I
11 mean we kind of thought we knew where the end
12 state as but there was no overarching guidance.
13 So we're going to create the first interagency
14 departmental guidance. So you can talk about
15 that.

16 And then the DoD's plan needs to
17 synch up with that. The VA's plan of course has
18 to synch up with that. And then you're going to
19 have a common operating picture, common
20 operating plan. You're going to get this whole
21 brief across the board which we don't have before
22 that cuts across all four services, two agencies

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1 and again the three what I would call portfolios
2 of the VA.

3 And so that's going to be, again, a
4 fascinating piece of where the rubber meets the
5 road and then integrated again with the Defense
6 Health Agency and better delivery of care,
7 integrated care, through the enhanced
8 multi-service markets. All of that going
9 together, again.

10 And in your interim report that you
11 had about a year and a half ago or so, a year ago
12 or so, we took those line items through the IC3
13 and some of it from this and matched them up on
14 where are the gaps, where are the seams, you
15 know, where are the redundancies and where do we
16 need to go. So, next slide.

17 I believe that's it. So that's a
18 high-speed pass through the MHS governance
19 reform, organizational change, specifically
20 focusing on a couple of areas again for this
21 group. Where does the wounded warrior and what
22 is the recovering warrior current policy and

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1 execution. Where are they going to be
2 transitioned to in this new organization. And
3 with that I'm opened up for questions.

4 MEMBER MALEBRANCHE: General Robb,
5 on the mission and structure you have the
6 National Capitol Region Medical Directorate.
7 And then you have in the enhanced service market,
8 that's a separate one. What's the
9 differentiation and what's that -- there's
10 nothing under the box. I mean what's behind the
11 box? What's that mean?

12 GENERAL ROBB: Okay, so let's go
13 back.

14 MEMBER MALEBRANCHE: Okay, that far
15 right, the National Capitol Region Medical
16 Directorate. That's separate in and of itself,
17 but it's also part of the multi-service market,
18 National Capitol Region. What's the
19 differentiation of that?

20 GENERAL ROBB: Okay, so that's a
21 good question. I could be evil and ask Admiral
22 Nathan to answer that question but I won't do

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1 that.

2 CO-CHAIR NATHAN: He just wouldn't
3 like the answer he gets.

4 GENERAL ROBB: Yes, that's right.

5 CO-CHAIR NATHAN: But I do want to
6 thank you because even though you consider this
7 a high-speed pass everybody needs to know he was
8 speaking about twice as slowly as he normally
9 does.

10 GENERAL ROBB: Yes, yes.

11 CO-CHAIR NATHAN: And so we're
12 grateful for that.

13 GENERAL ROBB: That's because I had
14 to read. But that's a good question.

15 Now, so we mentioned that there's
16 six multi-service markets. And again they're
17 defined by assets in a geographical location.
18 So you've got, again, we've got Puget Sound,
19 Hawaii, Colorado Springs, San Antonio,
20 Portsmouth.

21 Now they're all what we would call
22 traditional multi-service markets in the sense

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1 that there's two or more services sharing that
2 area and then they're going to have a
3 multi-service market staff. The money's going
4 to flow initially one way then over time we will
5 create a flow of money that's earmarked towards
6 what we call the 5-year business plan.

7 Some of them are going to be individuals.
8 Like Hawaii will be led by the Army. Puget Sound
9 will be led by the Army. Portsmouth will be led
10 by the Navy. San Antonio will rotate leadership
11 between the Air Force and the Army because they
12 have -- both have very large equal mission
13 population footprints. So for equity.

14 And Colorado Springs, that
15 multi-service market lead director will rotate
16 between the Air Force and the Army. Again, Army
17 has a very large facility but a large base, but
18 the Air Force population and the mission set
19 there is almost equal there. So that again they
20 will rotate.

21 Now, let's get -- what about the
22 National Capitol Region? Okay, now, Walter

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1 Reed National Military Medical Center and Fort
2 Belvoir Community Hospital through a series of
3 decisions that begin with BRAC, transition
4 through JTF CapMed organization to execute the
5 BRAC.

6 A decision during that time was to
7 make those hospitals joint hospitals and not
8 service-led hospitals. Hang with me here. So
9 now Bethesda is not a Naval hospital and Fort
10 Belvoir is not an Army hospital because if they
11 were it would be exactly like the other
12 multi-service markets as far as organizational.

13 But since they're joint hospitals
14 and we have chosen to keep them joint hospitals
15 they have to belong to somebody. That was the
16 question. Who do you hang those two
17 organizations onto?

18 So we created the thing called the
19 NRC Medical Directorate, transitioned JTF
20 CapMed to the NCR Medical Directorate.
21 Right-sizing the overhead staff because BRAC is
22 done. Now we have to put it somewhere. Because

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1 it's a joint organization it's got to be hung on
2 a joint organization. So you can hang it on a
3 COCOM which by law you could, like NORTHCOM, but
4 that doesn't make a lot of practical sense. So
5 we chose to hang it because it made geographical
6 location and the product lines were more
7 congruent with what it is. We hung it on the
8 Defense Health Agency. So that will
9 be -- but the market, okay, just like that could
10 have been a Navy hospital, could have been an
11 Army hospital. Then you have all these smaller
12 forces Army hospitals. Even though it's still
13 going to behave like a multi-service market.
14 But it's just going to have a different
15 organizational construct. But it will be
16 executing a 5-year business plan just like San
17 Antonio, Tidewater or Pacific Northwest and
18 Hawaii.

19 CO-CHAIR NATHAN: Along with the
20 regional facilities.

21 GENERAL ROBB: Yes, yes.

22 MEMBER MALEBRANCHE: Okay, I have

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1 another question, one more to tag onto this.
2 What happened to North Chicago in all of this?
3 Which is a federal facility. Where do they fit
4 in the structure? They're still under
5 healthcare operations in there somewhere?

6 GENERAL ROBB: Who do they belong to
7 now? They belong to -- it's still a Navy
8 hospital.

9 CO-CHAIR NATHAN: Still Navy.

10 GENERAL ROBB: Still Navy, yes.

11 MEMBER MALEBRANCHE: So it's still
12 Navy. It's not one of the markets.

13 GENERAL ROBB: In this construct,
14 in this large organizational reorganization
15 they're not at that level per se, no. But what
16 we learn from them --

17 CO-CHAIR NATHAN: You've got a VA
18 hospital.

19 GENERAL ROBB: Right.

20 CO-CHAIR NATHAN: You've got a Navy
21 hospital. They happen to co-locate at the same
22 building. They share services. They have MOUs

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1 and MOAs that allow them to do all kinds of things
2 together. They jointly man the wards, they
3 jointly man the ICU. Like England and America
4 separated by a common language they are
5 separated by separate EHR which is the bane of
6 their existence, VistA and AHLTA, and that's
7 where we're working very hard to figure out how
8 to use Janus and other things to try to put them
9 together. But they are both separate
10 facilities that answer to their separate bosses.

11 So at Bethesda the soldier or the
12 sailor or the airman working there answers to a
13 boss who runs that facility. But the sailor
14 working at FACC answers to the Navy boss whereas
15 the VA staffer answers to the VA boss.

16 GENERAL ROBB: It's another -- it's
17 another continued trial run of is there merit.
18 And we continue to -- that's a whole other
19 briefing, you know, the merits of does that make
20 sense to continue to look at are there
21 efficiencies to be gained, et cetera, et cetera,
22 from that quote unquote "marriage" up there at

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1 Chicago, yes.

2 CO-CHAIR CROCKETT-JONES: Okay. I
3 have a couple of questions. One's totally
4 nitpicking. Isn't Anchorage also a
5 multi-service?

6 GENERAL ROBB: Right. So it was 1
7 of the 14, yes. Yes, it was.

8 So what I didn't have up there was
9 the criteria that they used to choose the 6 out
10 of the 14. So there's a lot of different ways
11 we could have done this but we did it with
12 population, volume, primarily at the inpatient
13 centers and there were a couple of other things.
14 So there's three or four or five criteria and I
15 apologize for not having them in the top of my
16 head that kind of made a cut line where you saw.
17 So the larger markets kind of rose to the top.

18 Now, and as we roll this out and try
19 to get it right we figured let's go after the 35
20 percent or 45 if you count Fort Bragg and Balboa,
21 let's go after that first. Instead of
22 transitioning the entire MHS multi-service

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1 markets at once, let's get it right. Let's go
2 for the biggest bang for our buck initially and
3 then -- but you're right. As soon as we learn
4 the lessons learned the sooner we get this going
5 right and in the right direction we will expand
6 the same ROE or business case analysis to and
7 then the business performance plans to the --
8 again there's another -- 8 and 6 is 14. There's
9 another eight of them out there. Yes, ma'am.

10 CO-CHAIR CROCKETT-JONES: Just one
11 of the reasons, we were just there and that made
12 me think of it. And also because their
13 remoteness drives so many special concerns that
14 I'm wondering if this multi-service market, the
15 model you're suggesting might not -- might not
16 actually help them out.

17 The other question I had is is there
18 a plan on the lead for that Defense Health Agency
19 lead, that 3-star you indicated, is that going
20 to be a rotating through the services or is that
21 just going to be an appointed position or what
22 is their plan for that?

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1 GENERAL ROBB: Okay, so what that
2 will be. In fact there's going to be -- several
3 of these are going to be joint positions. One,
4 probably this one, probably this one and then
5 this one. Military as opposed to SES.

6 So the answer is there's a joint --
7 for joint billets there's a joint process. And
8 it is a nominative process. So just like DLA,
9 DIA and all these other, the COCOMs, combatant
10 commands, there is a nominative process. And so
11 the services can choose to submit a name and just
12 like we do today we have two actually rotating
13 nominative positions. One of them is TMA,
14 TRICARE Management Agency deputy director.
15 That's a nominative. My position is a
16 nominative position. It historically rotates,
17 historically. But there are times when
18 services have other needs and they may choose to
19 skip a cycle or some will say who they want. It
20 just depends.

21 But it's a nominative process.
22 Just like most of the joint staff physicians,

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1 they don't always rotate. They can rotate.
2 Sometimes a service takes through deals over
3 time. We'll see how it matures. But the answer
4 is yes, it will rotate.

5 CO-CHAIR NATHAN: And Doug, if I
6 could just add a little bit to the first
7 question, just clarify it. Remember, the
8 reason the multi-service markets enhancement is
9 being put into place is that in theory they're
10 not operating in that catchment area at peak
11 business efficiency. One service is doing its
12 thing that may not make sense for the whole area
13 while the other service seeing care may not make
14 sense.

15 A hypothetical example. One
16 hospital has an -- a Navy hospital has an extra
17 dermatologist and is using that extra
18 dermatologist to be the QA coordinator, in
19 charge of valet parking and other things.

20 GENERAL ROBB: That's not how it is.

21 (Laughter.)

22 CO-CHAIR NATHAN: The Army hospital

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1 next door is desperately short of a
2 dermatologist. And so they're sending all
3 their dermatology out to the private sector.
4 Whereas if the two had an overarching business
5 plan and could look at dermatology in toto for
6 the area they would then make business
7 decisions.

8 That in reality may not go down easy
9 with some of the services. Some of the services
10 may say you're kind of impinging on my autonomy
11 and the way I like to operate my business.

12 That's where the E for enhanced
13 comes in. Enhanced is a euphemism for I've got
14 a big stick and I'm going to make you do it,
15 services. And all the services are going to
16 have to capitulate to some extent because all
17 three services at different areas are working
18 together.

19 In Anchorage it's a little less
20 service parochial because they're all in it
21 together, meaning that the Army and the Air Force
22 are really, there's a small contingent of

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1 personnel at Elmendorf. But they're mostly
2 driven there by the market economy of what's
3 available completely in the military and what's
4 not. And so the footprint there, it doesn't
5 mean you couldn't do it. It just means it
6 doesn't have the amount to be gained
7 percentage-wise by making better overall
8 business decisions in that market with its small
9 inpatient production than you do in San Antonio,
10 Portsmouth.

11 GENERAL ROBB: But over time the
12 same business performance plan process will
13 migrate out to the other -- so that the entire
14 system is as efficient as we can.

15 And again, to try to piggyback on
16 Admiral Nathan's example. There will be -- we
17 can see in the future that remember, our MTFs
18 exist, military treatment facilities, primarily
19 they're inpatient facilities. They exist for
20 -- the primary reason is so that we can create
21 platforms, readiness platforms for our
22 healthcare providers to become as current and as

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1 competent as possible to execute the contingency
2 mission.

3 So, what I call, it's a currency and
4 competency model which is why our graduate
5 medical education is there to large facilities.
6 Just like in the civilian sector, you know, the
7 larger the volume, the larger the acute care, the
8 better the experience for graduate medical
9 education.

10 They also serve, again, to take care
11 of the garrison-based populations and the
12 beneficiaries that we've been asked to take care
13 of, again, soldiers, sailors, airmen, Marines,
14 their families.

15 So when you look at it that way, and
16 the Air Force has kind of evolved. Not because
17 I'm Air Force, I'm joint now, but I've watched
18 the Air Force. Because of the way their bases
19 are set up they don't have the large populations
20 to support the large medical centers like they
21 used to because medicine has changed. There's
22 no 10-bed community hospitals left anywhere in

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1 America unless you live in western Wyoming.

2 So what happens is the Air Force now
3 gets their currency and competency in other
4 people's houses. So that's why you see with
5 BRAC down in San Antonio it's a different model
6 than up here. But they have the exact same
7 footprint, inpatient footprint to drive a
8 currency and competency model. But they
9 actually have employment inside Brooke Army Med
10 Center. Twenty years ago that would have been
11 unheard of.

12 We have a large footprint, about
13 one-third of Landstuhl Regional Medical
14 Center's delivery of inpatient care are Air
15 Force providers because all our large hospitals
16 over there, like Weisbaden and the other places,
17 are gone now.

18 So we get our currency and
19 competency, when I say "we" the Air Force gets
20 their currency and competency to support the
21 contingency response for Europe inside an Army
22 hospital called Landstuhl Regional Medical

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1 Center. And then they share staff. They
2 actually share the senior staff but it's
3 commanded by an Army person.

4 So I see that maybe to be the future.
5 So that Balboa may say hey, if I had an extra
6 surgical or EMT team I could generate this much
7 recapture and the Navy may have -- and the Army
8 may have an EMT team that is not as productive
9 as some other place and they wish they could --
10 higher currency and competency rates. They may
11 choose to put them inside. They may advertise
12 a vacancy.

13 I could see in the future where we
14 start plugging holes in other people's houses
15 for currency and competency. I don't know,
16 Admiral Nathan, does that? That's kind of the
17 thought process of where do I get currency and
18 competency to fulfill the readiness
19 requirement. At the same time if I'm doing
20 that, the way I do that is I recapture from the
21 direct care -- on the network into the direct
22 care system. So where can I balance my assets

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1 to get the most recapture.

2 But what that really drives, it
3 drives our costs down, but it drives our
4 readiness and our currency and competency up.
5 Admiral Nathan, comments on that?

6 CO-CHAIR NATHAN: I think you're
7 spot on, Doug. We are -- our system is skewed
8 currently. We have MTFs that are understaffed
9 and under capacity and overrun with patients and
10 patients are spilling into the private sector.

11 And we have other MTFs of all three
12 services that are really the Maytag repairman
13 and are sitting there just waiting for the phone
14 to ring because there aren't enough patients in
15 the market, or the penetration in competition
16 with the private sector is too great. And we can
17 throw more staff, we can build prettier
18 buildings, but we're not going to entice
19 anymore. So we're looking very hard at how we
20 can right-size our facilities.

21 Expanding what Doug was saying,
22 medicine has changed now. It's more ambulatory

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1 than it ever has been before. So many of our
2 MTFs across the services are small ones.
3 They're only in one inpatient business
4 primarily. What is that inpatient business?
5 Any guesses? Babies. They're delivering
6 babies. So it's not uncommon to go to one of our
7 small hospitals and say what's your census and
8 they'll say it's three and a half. You'll say
9 a half. Yes, a newborn.

10 And so we have to decide if we want
11 to maintain the overhead. We have some
12 hospitals where the ICU census is one or two per
13 day, patients per day. So you can't make a
14 business case for that. But like General Robb
15 was saying, you can't make a readiness case for
16 that. You're not maintaining your current
17 competency as an ICU team if you're taking care
18 of just one patient a day. You're not seeing
19 enough of illness and acuity to do that.

20 Yet we have other ICUs in other
21 facilities that if we could double the staff
22 would double the load. And so we're going to try

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1 to redistribute.

2 Now, there's a couple of things that
3 stop that, that could stop that. One is
4 political pressure. Go to a particular
5 representative of a particular state and when
6 you try to close the missile base whether it
7 makes sense or not you're going to get some heat.
8 If you try to close an air base, an Army base,
9 you're going to get some heat. If you try to
10 close a hospital you're going to get some heat.

11 And then the second is the line
12 themselves. The line officers, line leaders as
13 much as they want to save money and medical, some
14 of them like having their own sort of dedicated
15 inpatient facility right there on the base
16 because they can control that. They can control
17 the quality, they can put their finger in
18 somebody's chest who wears a uniform, who works
19 for them.

20 And so on the one hand they're saying
21 medicine, you've got to get cheaper. But don't
22 take my inefficient hospital away from me

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1 because I really like it. And so some hard
2 questions are going to have to be generated.

3 But what's happened is these
4 questions which have always been around for the
5 last 20 years have finally become realistic and
6 on the front burner because the cost of medical
7 care now in the DoD I think is legitimate. I
8 think people are getting value for what we spend.
9 But it's inefficient and it is going way too
10 high. And it's going to eradicate the
11 discretionary spending of DoD if we don't get a
12 handle on this.

13 And so we talked about medical
14 centered home today which is a big change in the
15 way we're going to manage our patients. General
16 Robb has talked to you about the multi-service
17 markets which we're going to build in a much more
18 business-centric way rather than
19 service-centric way.

20 All these represent change to people
21 who if you're long in the tooth like I am, you
22 know, it's hard. But on the other hand you

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1 cannot fly in the face of what we think is
2 progressive change.

3 And whenever you turn on the radio
4 and you listen to an ad by Kaiser that talks about
5 on my mobile phone I changed my appointment, I
6 made a new appointment, I got my lab results, I
7 sent a note to my doctor and I scheduled my
8 mammogram, that's what we're in competition
9 with. And if we don't meet and exceed that
10 expectation we can't expect our patients to want
11 to enroll to us. So we're busy doing that.

12 And the shared services.
13 Everything Doug said is absolutely true.
14 There's no reason we should have three separate
15 service IT programs, three separate pharmacy
16 programs, three separate facility planning
17 programs.

18 The hard part is how do you decide
19 how much the DHA serves as policy and how much
20 do you decide it gets execution and ownership
21 rights. Because the very same line leaders who
22 say I am all for standardization but nobody

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1 better tell my Air Force commander how to run his
2 pharmacy or her pharmacy. And so again they're
3 going to have to reconcile themselves to what the
4 CONOPS is going to be.

5 MEMBER EVANS: I'm just looking at
6 where we look at the structure and depiction of
7 warrior care programs. And working with the IC3
8 I find this warrior care programs. When we talk
9 about politics and line involvement and who has
10 oversight of processes when it comes to our
11 warrior care this little area right here is very
12 concerning only because we have problems we're
13 trying to -- when we talk about change, you know,
14 everyone says go to warrior care programs. But
15 I'm not sure if they truly have the authority or
16 where they -- and I see we've kind of moved them
17 further down on the --

18 GENERAL ROBB: Further down from
19 what?

20 MEMBER EVANS: I believe they used
21 to be directly under -- and I'm not sure. It may
22 not be.

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1 GENERAL ROBB: Remember it was
2 policy and execution were combined in the old
3 model. So there's still a DASD. So back here,
4 go back here. So they're still here. Policy is
5 still at the same level. It's still a special
6 interest item so it's still at DASD. Okay?

7 Now the execution, remember, the
8 execution was to blend it inside of TMA. So
9 we're going to consolidate a little bit more and
10 it's going to be dropped into the healthcare ops
11 there. I mean there's work to be done on that.
12 We don't have all those line by line yet.

13 But the answer is the execution is
14 going to be separated from the policy. But my
15 vision, having been part of the IC3 task force
16 creation and seeing where they're going to go I'm
17 going to tell you where money is to be made we
18 execute that one mission, one policy, one plan.
19 We get that, what I call that competency
20 checklist right. This group here -- well, let's
21 go forward one. Okay, right here. Okay, what
22 you're going to see, that community of interest.

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1 And again you're going to hear from Dr. Guice.
2 That community of interest is what's going to
3 draw the integration together. Okay?

4 And I'm not so sure who's going to
5 be leading who to be honest with you. My
6 thoughts, and Karen was part of that group. I'm
7 not so sure they're not going to be leading the
8 thing and we're going to be following. We'll
9 see. We'll see. But I understand your
10 concerns and that's the part we're going to work
11 with.

12 I see these guys, how do I advance
13 position these folks right here, whoever -- the
14 whom, number one, and then how to best support
15 the vision of the IC3. Comprehensive plan
16 really is what it's going to be. Community of
17 interest of which there will be an integral part
18 of one.

19 MEMBER REHBEIN: Sir, coming at
20 this totally from the outside I just need to
21 clarify a couple of things. One, the -- okay.
22 The WTUs will still belong to the Army. Wounded

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1 Warrior Regiment will still belong to the
2 Marines.

3 GENERAL ROBB: Yes.

4 MEMBER REHBEIN: But if they fall
5 inside of one of these eMSM's their healthcare
6 will be delivered by the Defense Health Agency.
7 That doesn't --

8 GENERAL ROBB: No, no, no.

9 CO-CHAIR NATHAN: Only at Walter
10 Reed and Belvoir. Because Walter Reed and
11 Belvoir are the only two MTFs in the whole
12 Military Health System which will be carved out
13 of their services and put under a joint oversight
14 of the Defense Health Agency. Every other MTF
15 in the world will still belong to its parent
16 service.

17 GENERAL ROBB: Yes.

18 CO-CHAIR NATHAN: So the commander
19 or the director at Walter Reed Bethesda who used
20 to report -- at Walter Reed used to report to the
21 Army Surgeon General, Bethesda the Navy, and so
22 forth. Now the combined commander/director of

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1 Walter Reed Bethesda will report ultimately to
2 the DHA, to the 3-star who is the Defense Health
3 Agency director.

4 Bremerton Hospital, Brooke Army
5 Hospital, SAMC medical center, San Diego, David
6 Grant out in Fairfield, Travis, will report to
7 their services and be on the hook to their
8 services.

9 GENERAL ROBB: So and I think that's
10 a good question. It's confusing. Because
11 really what we're talking about is the business
12 plan.

13 But right now each of the three
14 services, four with the Navy doing it for the
15 Marines, are historically now creating their
16 current 3-year business plans.

17 So again I'm going to use a for
18 example. In Tidewater. So Portsmouth is -- I
19 don't know where they are in the cycle but
20 hypothetically speaking the Navy is creating
21 what historically is a 3-year business plan that
22 really is for Portsmouth Hospital only. Going

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1 up through the Navy channels.

2 Then they aggregate that at
3 regional, de-conflict, push it up to BUMED.
4 Then they take that, give it to Health Affairs,
5 say here's how much I want to execute military
6 medicine, Navy medicine.

7 In the Tidewater at the same time
8 Langley Air Force Base First Fighter Wing
9 Hospital, is creating their 3-year business plan
10 for the Air Force hospital which will then be
11 aggregated in Air Combat Command which then will
12 go up to AFMOA which will then go up to the Air
13 staff. And then Eustis I guess would be there
14 in the Tidewater area would have theirs going up
15 through the Army channel.

16 Now, what we just agreed upon, sir,
17 what your deputy agreed upon whether he informed
18 you yet or not is that --

19 (Laughter.)

20 CO-CHAIR NATHAN: Maybe he's not my
21 deputy anymore.

22 GENERAL ROBB: He's leaving anyway,

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1 right. So the middlemen made a good call that
2 day, sir, was the fact that all three of them
3 agreed that the next step we need to do, because
4 now we're saying you need to create as a market
5 a 5-year business plan. So as you can imagine
6 you just can't turn that one off and start the
7 new one. What they're going to do now is
8 collectively bring, say, Eustis', Langley's and
9 Portsmouth's individual plans which they're in
10 the process of creating, we're going to bring
11 them together, de-conflict them and then
12 notionally apply them to what would now be the
13 futuristic 5-year business plan. So that's,
14 we're working our way through that.

15 So that's -- but the care will be
16 delivered --

17 MEMBER REHBEIN: By the service.

18 GENERAL ROBB: Correct, but it's in
19 an integrated system now as opposed to stovepipe
20 system. Now, that's not to say that those
21 multi-service markets -- and Tidewater was
22 probably as good as anybody. They weren't

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1 already doing notional or volunteer
2 collaboration anyway. But when the rubber met
3 the road there were times when they wanted to do
4 initiatives that may have been better, not only
5 good for the Tidewater area but better for the
6 enterprise. But as service chose to use those
7 assets somewhere else that better served the
8 service and not the enterprise. And so this
9 organization here combined with the
10 multi-service markets is going to force us to do
11 something we've never done before and that's in
12 an open forum de-conflict and ask the services
13 to make the case on what about me is better than
14 what's better from the enterprise. And then
15 ultimately Health Affairs will funnel or channel
16 the dollars where they think is best for it.
17 There may be times when the service does win but
18 we never had an opportunity where you debated
19 that in an open forum about what's best for the
20 enterprise and these multi-service markets.
21 Now all the services realize it's
22 going to be give and take at times. There's only

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1 winners and losers. But I would argue unless as
2 an enterprise we have to get stronger, more
3 effective, more efficient, more cost-effective,
4 more relevant, and we have to preserve and
5 enhance our readiness projection platforms. Or
6 it doesn't matter what the service thinks
7 because that's ultimately what we need to do is
8 provide -- I mean we have an incredible track
9 record in this last conflict of providing,
10 again, highest quality care. But that's
11 becoming very expensive. Remember there's a
12 tale to the lowest mortality rate in the history
13 of warfare, and there's a tale to the lowest
14 diseases non-battle injury in the history of
15 recorded warfare.

16 And so in order for us to continue
17 to be viable we've got to get better at
18 preserving those platforms. And the only way
19 we're going to do that is in a collaborative
20 manner. And I will again defer to one of the
21 surgeon generals who's got a large stock in where
22 we're going.

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1 CO-CHAIR NATHAN: I mean at the end
2 of the day, you know, some people treat this like
3 the parable of the pig and the chicken that are
4 walking down the road and they're both hungry and
5 they're talking about breakfast. And the
6 chicken looks over at the pig and says how about
7 ham and eggs. One of them contributes, the
8 other one is all in.

9 And I think that we all recognize,
10 my counterparts as well, that we have to look
11 beyond our service parochialisms within our
12 catchment areas and make some compromises which
13 some could be painful. An example. Maybe
14 we'll have somebody who goes to a service
15 hospital who's been put there to be the director
16 of something to groom them for executive
17 medicine so they're in a leadership position.
18 Yet they hold a valuable skill that nobody else
19 has in that catchment area. And the market
20 manager looks at them and says I'm sorry, I know
21 you're training to be an executive officer, but
22 I really need you to practice your trade of

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1 rheumatology or cardiology because that's what
2 I'm short of. Unless your service can send
3 another one of you out here to do that I need that
4 because it doesn't make business sense.

5 Where does this get sideways with
6 the services? The readiness option. For
7 instance, if Jack Welsh were here he would look
8 at the spreadsheet of military hospitals and he
9 would say what's your inpatient census, what's
10 your outpatient load, okay, got it. Close this
11 one, close this one, close this one, close this
12 one.

13 Let's take a hypothetical example,
14 29 Palms. Twenty-Nine Palms does not have a
15 very robust inpatient service. You can't make
16 a business case to keep 29 Palms alive. But yet
17 it's the closest thing around. So do you turn
18 to the military commander who runs that base, the
19 Marine Corps general, and you say are you okay
20 with then if your Marines get hurt on the
21 battlefield we're going to have to put them in
22 an ambulance to send them an hour and 10 minutes

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1 down the road to the nearest hospital that can
2 take care of them. He's going to say hell no.
3 I'm willing to pay for that contingency. I'm
4 willing to pay for that.

5 And so that's where we have to
6 wrestle at the DHA level, at the SG level, at
7 every level with how much readiness are we
8 willing to pay for. Because there's a cost.
9 And I believe that most people are willing to pay
10 for it as long as they believe the readiness
11 gives them return on investment. So that's
12 where we are.

13 MEMBER REHBEIN: If I may, looking
14 for cost savings. Do you envision then that in
15 these enhanced multi-service markets you may
16 have one service hospital taking care of all the
17 baby deliveries and another service hospital
18 having another specialty?

19 GENERAL ROBB: We do it now, San
20 Antonio. We -- before they did the BRAC
21 movement they had a division of labor between
22 Wilford Hall Medical Center and then Brooke Army

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1 Med Center. They did. They divided up OB, they
2 divided up peds. There was a Venn diagram where
3 you had these services were here, these services
4 were here and these were shared services.
5 Because depending on your population you figured
6 out what was the best use of resources and then
7 one was the size of the population service. So
8 they did that. There is precedence exactly for
9 what you just said. Yes. Yes. Yes.

10 CO-CHAIR NATHAN: Anything else?

11 GENERAL ROBB: Give us a tough one.
12 One mission, one policy, one plan. I'm setting
13 you up, Dr. Guice. One mission, one policy, one
14 plan.

15 CO-CHAIR NATHAN: All right. Well
16 Doug, as always, thank you for an informative
17 discussion on a difficult subject. And I think
18 I heard Dr. Guice is here. Great. Okay, so we
19 can take a few minutes break here. Let's see,
20 what have I got, 3:44. Okay, so let's take a
21 15-minute break and we'll be back at 1600.

22 (Whereupon, the foregoing matter

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1 went off the record at 3:44 p.m. and went back
2 on the record at 4:00 p.m.)

3 CO-CHAIR NATHAN: Okay, well we'll
4 go ahead and get started. It's a real pleasure
5 to welcome and introduce Dr. Karen Guice who is
6 the Principal Deputy Assistant Secretary of
7 Defense for Health Affairs and Mr. Joe Riojas who
8 is the interim chief of the staff for the
9 Department of Veterans Affairs today.

10 Clearly the positions and the
11 authority levels that they represent send a
12 great signal to the task force of how seriously
13 we take this DoD-VA interagency care
14 coordination as they talk about -- as they are
15 the co-chairs of the Interagency Care and
16 Coordination Committee, otherwise known as IC3.

17 They'll provide the task force with
18 an overview of that and discuss the IC3 efforts
19 that are relevant to recovering warrior care.
20 And also joining them today I believe will be Ms.
21 Mary Carstensen who is the senior advisor to the
22 Secretary of the Department of Veterans Affairs.

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1 And you can find their information under Tab H.
2 So Dr. Guice, welcome and thank you.

3 DR. GUICE: Well, thank you very
4 much. So it's a pleasure to be here. It's good
5 to see so many familiar faces and some new faces
6 too. As I was a member of the task force for a
7 little while and then when I switched over to DoD
8 I had to leave you guys and come do the job that
9 I'm doing now. But I'm really delighted to tell
10 you what we've been up to with regards to VA-DoD
11 warrior care coordination.

12 As you all know this has been a topic
13 of some concern in a variety of GAO reports and
14 even in some of your own reports about some of
15 the confusion, some of the roles and
16 responsibility conundrums and the many calls to
17 kind of sort this out, figure it out and do
18 something better in the future. So that's what
19 we're really trying to do.

20 We tried to make this effort a very
21 high-level effort. So we'll go through some of
22 the governance structures in a little bit. But

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1 we really wanted to focus on getting people who
2 could represent their equities, make decisions
3 and move things forward at a very high level. So
4 I'll talk to you about that as we go forward.

5 Mr. Riojas has joined me here. He
6 is -- my co-chair used to be Mr. Gingrich. Mr.
7 Gingrich retired last Friday and this is the
8 newbie. So we welcome him and I'm glad that he
9 was able to join us today.

10 So we're going to talk a little bit
11 more about kind of where this started.
12 Secretary Shinseki and Secretary Panetta
13 established a joint task force in May 2012 to
14 kind of say would you just kind of get to ground
15 truth on warrior care and coordination and what
16 are we doing, what do we need to do better.
17 Actually General Robb was part of the leadership
18 of that task force and was of great help and value
19 to the committee in trying to figure this out.

20 First they reviewed a lot of the
21 recommendations that had been made and a lot of
22 the problems that had been identified by a

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1 variety of reports. And then this common and
2 recurring theme which you all have heard over and
3 over again that because we have multiple case
4 managers, multiple care coordinators, no clear
5 lines of roles and responsibilities it leads to
6 enormous confusion for families and for
7 servicemembers who are just really trying to
8 concentrate on getting better.

9 You all have heard stories. You
10 know, I have so many case managers I don't know
11 what to do with them. I don't know what they all
12 do therefore I can't use them in a smart way. Or
13 they all come in and give me a business card and
14 I've got a 3-foot stack of business cards. I'm
15 your case manager for X. I'm your case manager
16 for Y. And I can't remember and I can't figure
17 it out. And I just put the cards over here and
18 I can't deal with it.

19 So this was part of our task was to
20 figure out ways to do this better, to make sure
21 that the handoffs between the two departments
22 are indeed those warm handoffs that we talk

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1 about.

2 And as you all know the entire
3 process is a little bit more complicated because
4 wounded warriors frequently while they're still
5 wounded warriors on the DoD rolls move between
6 the two departments' health systems for their
7 care depending on what their needs are. So we
8 move them back and forth and back and forth based
9 on their requirements and their needs for their
10 healthcare which is a really good thing because
11 both departments have excelled in certain areas.
12 And that's a good thing, making sure that we
13 provide that coverage.

14 But when we do that we do lots and
15 lots of these handoffs, and sometimes they're
16 warm and sometimes they're skipped. So how do
17 we do that better?

18 A lot of the confusion came talking
19 about the Federal Recovery Coordination Program
20 and the Recovery Coordination Program. A lot of
21 people said fix those problems, fix that, fix
22 that, thinking that that was actually the entire

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1 problem.

2 We thought maybe it is and maybe it
3 isn't, and that was some of the things that the
4 task force actually helped us to define, how much
5 of a problem as opposed to how much of a problem
6 was -- or whether that was just a symptom of a
7 larger problem.

8 So, we talked a little bit about
9 leadership. Full interagency participation,
10 representatives from health, personnel and
11 benefits. So this is really both clinical and
12 non-clinical case management care coordination.
13 It doesn't matter if you're the clinical care
14 coordinator or the non-clinical care
15 coordinator, this was a way to actually pull all
16 of those communities together because they all
17 share elements of these handoffs and
18 information-sharing about how to get someone
19 what they need in a timely way.

20 We had four approaches to the tasks.
21 You can see them there, the community of
22 practice, the comprehensive plan, policy and

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1 oversight, and then sustainment.

2 So first of all, the community of
3 practice. This was the recognized need that we
4 really just needed to form a community of
5 practice, both clinical and non-clinical.
6 Share best practices, learn from one another,
7 move things forward.

8 This is hard enough when you're
9 dealing with one department but now we're
10 talking about two departments. So how do we do
11 that and make sure that there's a viable
12 community of practice between the two
13 departments that helps achieve the aims that we
14 really want to get to.

15 Comprehensive plan. Well, as many
16 care coordinators as there are, there are
17 probably as many comprehensive plans. Every
18 case manager -- care coordinator will construct
19 a recovery plan or a comprehensive plan. So
20 pretty soon you've 12 case managers and 12 plans.
21 How does the recovering warrior know which one
22 is relevant, which one they should pay attention

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1 to, which one should they scrap?

2 So if we're going to make these
3 really viable tools to help individuals achieve
4 what they need to achieve then we've got to do
5 that better. So how do we have a focus on a
6 single comprehensive plan between the two
7 departments that actually gets somebody where
8 they need to go? And how do we as two
9 departments deal with that and figure out ways
10 in which to make that a reality?

11 Policy and oversight. Well, this
12 was a really interesting one. I think the team
13 defined about 127 different policies between the
14 two departments. So how do we actually take
15 those policies, rationalize them, balance the
16 needs of what we need to do and make one policy.

17 Now we probably won't actually be
18 able to pull that off because we've got policy
19 police on either side in each department that
20 like formats in a certain way and we've got
21 lawyers who want things done in a certain way.
22 But as long as the DoDI which governs the DoD and

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1 provides instructions for the field on how to do
2 things, and the VA Directive say the same thing,
3 define things the same way and allocate
4 accountability and responsibility the same way
5 we achieve the same end. So that's probably
6 what we're going to have to do from a very
7 functional, practical way. We're going to have
8 to do it differently in format for the two
9 departments. But it can read the same and mean
10 the same, and that's a key thing.

11 And then how do we sustain things for
12 the long term? How do we continue to fund
13 programs? How do we continue to make sure that
14 we're doing the right thing over the long haul
15 to make sure we're still doing the right thing.

16 All right, so the task force, their
17 initial findings are kind of listed on here.
18 It's not because we don't have dedicated people.
19 We do. We have people who go to work every day
20 and work their hardest to get the maximum outcome
21 of their day. They work hard, they take good
22 care of people, so that wasn't an issue. It

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1 wasn't that we had bad people out there not doing
2 anything. We've got good people and they're
3 doing great stuff.

4 But we sort of let a system grow up
5 that was asynchronous and discoordinated. So
6 how do we bring some coordination and
7 synchronicity to that?

8 The collective efforts by both
9 departments were well-intentioned. A lot of it
10 grew out of necessity, fix this now kind of
11 thing, and we did. We threw programs together
12 and put people in those programs and told them
13 to go do this. And we did that over and over and
14 over and over again to where we have now about
15 47 different programs who all say they do things
16 very similar or at least components of the same
17 thing. And that's something that we need to
18 take a look at.

19 We have diffuse governance and
20 oversight lacking fixed responsibility,
21 accountability and a common voice. Well, we
22 first start out by just looking at the structure

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1 of the JEC, the Joint Executive Committee as you
2 all are well familiar with. And you know we have
3 a Health Executive Council and we have a Benefits
4 Executive Council. Health deals with health,
5 Benefits deals with everything that's benefit
6 but health. Clinical care coordination,
7 non-clinical care coordination. They didn't
8 talk. So part of this was
9 because of the way we were structured. And once
10 you kind of understand how that happens and then
11 how those little silos grow up then you can kind
12 of figure out, okay, now how do we actually break
13 those down and create a structure that pulls this
14 community of practice together that I talked
15 about a little bit earlier and puts them in a way
16 that it can pull from those two supporting
17 organizations, be responsible to the JEC and
18 deliver what we know we need to deliver.

19 There was no common integrated
20 comprehensive plan. VA didn't have a way to see
21 the DoD plans, DoD didn't have a way to see the
22 VA plans. It's all about information, all about

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1 getting people information so they can do their
2 job better and the wounded warrior can get the
3 things that they need in the order in which they
4 need them to maximally recover. So it's -- the
5 premise is quite simple but we sort of executed
6 it in a very asynchronous and kind of complicated
7 way if you think about it.

8 And then we knew we had suboptimal
9 transitions in the coordination of care, we knew
10 that. And no single point of contact for
11 patient and families at any given time, and
12 that's something that you guys heard over and
13 over and over again.

14 All right, so what did we do after
15 we got the report from the task force? Well, we
16 decided that what we really needed, we really
17 needed the Secretaries to articulate what their
18 vision was for this particular activity.

19 And the Secretaries said that they
20 expect one mission, one policy and one plan.
21 Common interagency guidance driven by an
22 overall, overarching formal interagency

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1 governance structure -- and I'll talk about that
2 in a minute -- interagency community of
3 practice, single comprehensive plan,
4 sustainable model, and then using a lead
5 coordinator concept which we'll talk about. I
6 think the entire memorandum was provided to you
7 all so you can actually read the entire content
8 of the paper.

9 All right, now how does this square
10 with what you all have recommended? Because you
11 all have thought about this a lot too. It wasn't
12 just that the task force stumbled to this. I
13 mean we had some guidance and some concerns
14 raised by you and GAO. So how does what you all
15 have put forth as your recommendations match
16 with what the task force identified and where
17 we're going to go?

18 So the first thing you recommended
19 was publish timely guidance to standardize the
20 care. Ensure there's sufficient numbers of
21 case managers available in a variety of places.
22 So that's sort of in our way of matricing this,

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1 that's where the one policy will help, help guide
2 that, help define it, help standardize it and
3 help enforce it. We will have that one single
4 policy that will govern what we do.

5 Your other series of
6 recommendations, standards, oversight and
7 guidance for the CRP and the CTP. Services
8 adopt a common comprehensive plan. The
9 services ensure that families can access that
10 plan. That's the one plan concept. Between
11 two departments one plan for one person. Not
12 12, not 15, 1 that we both share, that we both
13 see, that the patient sees, the family sees, they
14 use it, they understand it and they can access
15 it anytime they need to.

16 Your other two recommendations that
17 are relevant were to develop meaningful
18 qualifications, skills and training, and then to
19 standardize and define the roles and
20 responsibilities. That's kind of driven
21 through the one community. We have one
22 community, they agree on how they're going to do

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1 things. We put that into policy and drive it
2 that way. So that's kind of how what you've
3 recommended fits with what we see and what we're
4 recommending.

5 One of the things obviously is you
6 need to have a governance structure that works
7 and that addresses the problems and pays
8 attention to the solutions until the problems
9 are solved.

10 So we proposed an Interagency Care
11 Coordination Committee, the IC3, under the JEC.
12 It's not in the HEC, it's not in the BEC, it's
13 its own freestanding thing, immediately
14 responsible to the JEC. That was the way we
15 could actually bring the non-clinical and the
16 clinical together in a way that made sense with
17 a governance structure to get action at the
18 highest level quickly.

19 Okay, now that we've got a
20 governance structure what are we doing with it?
21 The community of practice, what they're doing is
22 their goal is to introduce a model of care

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1 coordination that increases clarity and reduces
2 confusion. That would be a really good thing as
3 we've all recognized.

4 What they're focusing on right now
5 is implementing something we call the lead
6 coordinator feasibility assessment. This was
7 the idea that out of all the case managers you
8 have and all the care coordinators you have one
9 of them would be designated lead at any one point
10 in time.

11 That lead would change depending on
12 where you were physically and in the point of
13 your recovery. So if you're in a hospital your
14 lead coordinator would be most likely one of your
15 clinical case managers and that makes sense.
16 Having someone who understands that clinical
17 location, knows the clinical providers, can help
18 pull all of that together. Doesn't mean that
19 all of those other case managers and care
20 coordinators go away, it just means that now they
21 are organized under a lead case manager or care
22 coordinator who will help de-conflict what they

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1 do for the patient. So again, one point of
2 contact for the patient and the family who can
3 then organize the baseball team to bring their
4 best to bear for the member.

5 Now when they leave that hospital
6 and they're out in the community and they're at
7 home and recovering you may have a designated
8 non-clinical case manager as the lead
9 coordinator who will do the same thing. But in
10 sort of the organizing, making sure the
11 non-clinical stuff as well as the clinical
12 stuff, making sure the appointments get made,
13 making sure that the clinical case managers stay
14 involved as they need to, make sure that those
15 other people who are trying to get you things to
16 make your life easier, to make your recovery
17 better are pooled and harmonized. So that we
18 sort of get away from 12 case managers, don't
19 know who they are, they change every time I
20 change my location, they change every time I --
21 so we're trying to actually de-conflict that.

22 Not get rid of a bunch of programs.

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1 This is about harmonizing them and getting the
2 information more streamlined for the patient.

3 We began the assessment at Walter
4 Reed and the VA Medical Center in D.C., in
5 Richmond in January and we're collecting a lot
6 of information about how it's working. We've
7 got a lot of -- obviously when you do a
8 feasibility study you're looking for those
9 things that are, you know, how do we figure out
10 who the lead coordinator is? Who gets to
11 designate the lead coordinator? How does that
12 work? How does that lead coordinator actually
13 really, really, seriously communicate with all
14 those other case managers? How does that work?
15 Who fills in that single comprehensive plan?
16 Who uses the checklist?

17 So it helps us kind of refine all of
18 those little details that are deadly if you don't
19 do a feasibility study. We want to make sure it
20 works. We've tried a lot of things over the past
21 few years and some worked and some didn't. But
22 what we don't want to do is add more confusion.

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1 We want to add clarity and organization to what's
2 currently being provided.

3 Interestingly enough a lot of the
4 case managers have said we've sort of been doing
5 this anyway, kind of informally we've been doing
6 it, but it's really nice to have a structure. So
7 we're trying to make sure we give them the right
8 tools that they need, that they are coordinating
9 the care, that we figure things out.

10 And we've made some fairly
11 interesting discoveries along the way. And I
12 think it's been a really good thing. So we're
13 rounding up the information from that and then
14 we will figure out what we need to put into place
15 to make it better and work better. And then
16 eventually if our hypothesis is correct we will
17 be promulgating the program throughout the
18 country.

19 Okay, the comprehensive plan. All
20 right, we said one plan. Okay, well that's easy
21 to say. The art is how do you actually pull that
22 off.

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1 So what we're doing is creating a
2 single tool where we will have the comprehensive
3 plan that will be accessed by all of those who
4 need to access it because they have a need for
5 the information that's in it.

6 It will be role-based access. You
7 can see what you need to see in order to get your
8 work done. So clinical, non-clinical, they'll
9 all be able to see this. The lead coordinator
10 will probably be the one who's authorized to
11 actually implement and put things in there.

12 We came up with this wonderful idea
13 that really what we needed was a checklist.
14 Kind of like when you clear base you have to go
15 through a checklist and get people to sign off
16 that yes, you turned this in, and you're not
17 delinquent at the library and all of those kind
18 of things that you all have to do when you clear
19 -- post your station.

20 So we took that concept and came up
21 with an interim solution which is a smaller,
22 truncated checklist for us to kind of again

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1 validate that it works and then a much longer,
2 more complicated checklist that will eventually
3 form the foundation of what we're talking about
4 in sort of our generation 2 of the comprehensive
5 plan.

6 So what we're doing now is we applied
7 for JIF funding and were given some money for the
8 next 2 years to actually make this a reality. So
9 working with our IT partners about how we
10 actually then create that visibility of the
11 single plan for all the programs that need to see
12 it and how that's actually going to work. So
13 we're very excited about that capability and the
14 generosity of the departments to give us some
15 money to do it. But we think that's really key,
16 have one plan.

17 Okay, policy and oversight. These
18 guys had to read all those policies and kind of
19 understand where there's duplication, where
20 there are gaps, where there are things that we
21 can smooth and make a little bit better. So
22 they've been doing this really deep dive in all

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1 of the departments' -- both departments'
2 policies on care coordination and case
3 management to really understand what we need to
4 be doing.

5 And they are working on an
6 overarching interagency guidance. As I said
7 it's probably going to be two but they'll say the
8 same thing and that's how we'll fix the need to
9 have different formats for both departments in
10 terms of how policy is actually promulgated and
11 written.

12 So as soon as the policy gets
13 finalized then they will move into kind of
14 oversight of the policy and make sure that the
15 execution of policy is working like we expect it
16 to, making sure that the outcome that we believe
17 will happen actually happens. And if there are
18 things that need to be changed or refreshed or
19 redone in a certain way that we do that in a very
20 timely way.

21 We don't just put, okay, policy on
22 the shelf, check, done, walk away. We're not

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1 going to do that. We're going to make sure that
2 it gets implemented and if it doesn't get
3 implemented the way that we think it should be
4 implemented figure out why. And we're going to
5 try to make sure that we get the outcome that we
6 believe will be the result of having this policy
7 in place.

8 Okay, so this kind of gives you our
9 time line at the top. You can see our to-do list
10 over there on your left, my right. And you can
11 kind of see where we have kind of scoped out what
12 we need to do over the next couple of years and
13 out into the future to kind of make this vision
14 a reality.

15 And that's it. So I am happy to
16 answer questions. Mary Carstensen is here. I
17 guess Mr. Riojas had to go back. Since he's new
18 he's got probably a whole lot of work to do. But
19 we're happy to answer questions. Several of the
20 members of the team are sort of coming and going.
21 Doc Robb just walked out. Maybe he'll be back.

22 But we're happy to talk to you more

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1 about this. What we'd like to do is actually
2 come back in the fall when we know a little more
3 and we've been able to finish our feasibility,
4 understand what we need to fix and kind of put
5 that next generation of how we're going to do the
6 lead coordinator out there.

7 CO-CHAIR NATHAN: Well, Dr. Guice,
8 it's certainly all goodness. Pretty hard to
9 argue with the concept. The pragmatic
10 implementation is going to be the long pole in
11 the tent, herding all the various cats across the
12 agencies. There may be questions on that in
13 particular.

14 But I'm curious as to one of the
15 things we hear a lot about in the military is also
16 our -- in the Department is how much are we
17 engaging with the private sector, the academic
18 sector. How much are we sharing back and forth
19 between the VA and/or the DoD and places like the
20 RIC in Chicago or UCLA. And we do intersect in
21 those places at Operation Mend and other
22 organizations that sort of formed benevolently

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1 de novo where we now trade patients and whatever.

2 Is there any thought given to
3 widening the aperture in a way that also creates
4 something that not only encompasses the DoD-VA
5 transition point but oversight into case
6 management into the private sector?

7 And the reason I ask is our line
8 leaders, our warrior leaders at times will come
9 to us and say you're not utilizing some of these
10 niche specialists enough. You're trying to let
11 the VA or the DoD system fix things and it's not
12 that your heart is in the wrong place but you
13 don't have some of the expertise that some of
14 these places have carved out.

15 We talk about the TRICARE benefit,
16 and what we can and can't afford, and what we can
17 and can't do, and what we should or should not
18 do. Any thought to that as we have you here to
19 talk about sort of this overarching look at how
20 we manage the care of our warriors?

21 DR. GUICE: Sure. To me knowing
22 what is out there in the private sector is part

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1 of the toolbox of the case managers and care
2 coordinators. So part of it is making sure that
3 they know what's out there to remind people on
4 the recovery team that there is availability of
5 this or there's availability of that. So part
6 of it is just the education of the care
7 coordinators. But that's that one community,
8 and working on that and making sure people have
9 visibility about what's available for
10 individuals as they go through their recovery.

11 For us to take on the private sector
12 case management would be a daunting task and we
13 just -- it's a bridge way, way too far. However,
14 I think that as we kind of define this space for
15 us we might be showing the private sector a way
16 of doing business that then they can adopt as we
17 move forward in the Affordable Care Act and how
18 do we actually really do case management care
19 coordination in the private sector.

20 So we have an opportunity here which
21 is kind of unique. In the private sector no one
22 pays you to do case management and care

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1 coordination. It is done as a part of kind of
2 more of a global fee.

3 And then that's part of the dilemma
4 in the private sector. It also changes. You
5 know, if you're hospitalized your care
6 coordinator case manager waves goodbye at the
7 door. So we might be actually modeling some
8 tools and some ways of doing business between two
9 departments that would be helpful for the
10 private sector.

11 But I think that knowing of those
12 programs that your line leadership has
13 identified and certainly has become aware of
14 over time, that's really making sure that our
15 case managers and care coordinators understand
16 that those resources are there and how they can
17 leverage those to the benefit of the individual
18 that they're trying to care for.

19 MS. CARSTENSEN: Just to add onto
20 that. We did include TRICARE in our first
21 community of practice as we were developing this
22 whole process because we knew that we had -- that

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1 we were outsourcing some of our services. So
2 that is something that we've been considering as
3 we work through this.

4 And I think just to reiterate this
5 is really somewhat of a paradigm shift. I mean
6 it's not facility-based case management, it's
7 not episodic case management or discharge case
8 management. We are really talking about
9 coordinating care and services over a very long
10 period of time for some of these clients.

11 And that is a different look and a
12 different approach than what we see with our
13 civilian counterparts. So I do agree, I think
14 we're going to see some difference, some
15 learning here that's going to be very informing
16 for ACA and for other efforts.

17 MEMBER PHILLIPS: To follow up on
18 the admiral's question, and I may not have the
19 numbers exactly right but I've read that roughly
20 20 percent of veterans use the VA. And then the
21 other 80 percent either mix or go elsewhere.

22 And related to future plans, again,

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1 is there anything in the works that is addressing
2 that to try and keep the veterans in the VA, to
3 do more to become more efficient and
4 cost-effective?

5 DR. GUICE: I think we'll ask VA to
6 comment on that. But I think that the issue is
7 that we have done a tremendous amount through the
8 TAP program. I think there are more of this
9 generation of veterans who've signed up for
10 healthcare in the VA than there have been in
11 previous -- after previous conflicts.

12 We do know that those who leave the
13 military service and are retired either because
14 they are 20 years and retired or because they
15 leave for medical retirement, we do give them
16 TRICARE. And frequently they will get care in
17 VA when it's useful and helpful or come back to
18 the Military Health System depending.

19 It's kind of based on their
20 preferences as to where they think they're going
21 to get the best care for whatever is their
22 particular problem. We know that a lot of the

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1 guys with amputations come back to the DoD just
2 because that's the relationship they've had.
3 You know, they know their prosthetist and they
4 know their rehab med. So they will kind of
5 gravitate there. So it's going to be a balance
6 and it will sort itself out over a period of
7 years.

8 But we're also doing a couple of
9 things. Both departments have engaged in
10 something called a modernization study. So the
11 Department of Defense is doing one, the
12 Department of VA is doing one. And at the end
13 of that we're actually going to sit down and say,
14 okay, show me your card hand and we'll show you
15 our card hand and we'll kind of match up where
16 we've got capabilities and capacity
17 differences.

18 The VA has not made a big investment
19 in OB care. We have. So are there ways that we
20 can actually share patients that way? And I
21 know that's already going on in San Diego where
22 the VA is sending women veterans to Balboa for

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1 care and delivery. That makes sense from a
2 total government perspective. So are there
3 more places where we can do that.

4 So this DoD-VA comparison about
5 what's the capability and capacity here for VA,
6 what's the capability and capacity there for DoD
7 and are there ways that we can do smarter
8 partnering that will actually leverage the best
9 that the government has to offer for our
10 servicemembers and veterans.

11 MEMBER PHILLIPS: What I was
12 driving at, and it will come as no surprise to
13 anybody in the room, is that if we could figure
14 out a way, and perhaps this committee can
15 continue to push it, is to harmonize the health
16 information transfer between the three sectors,
17 the DoD, the VA and the private sector, which
18 would make that process I think a lot easier.

19 DR. GUICE: You're absolutely
20 right. And so I'm sure you all have read all the
21 press about the electronic health record and how
22 the departments are either doing that well or not

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1 doing that well. It kind of depends on the day
2 of the week and who you're reading.

3 But the interoperability of data is
4 the most fundamental thing that we can do. It
5 is the thing that will actually make the
6 interoperability of health information between
7 the two departments and the private sector work.

8 It is not necessarily about the
9 computer that sits on your desk or even the
10 software that delivers the information. You
11 know, you think about we all go home and we turn
12 on the TV and we all see the same program. But
13 we all don't have the same TV. That's because
14 the data standards drive the way that you are
15 presented with the picture.

16 So the more we can standardize that
17 the better off we'll be, particularly in that
18 private sector care where we really need that.
19 And we need that information. DoD relies on the
20 private sector to a much greater extent than the
21 Department of Veterans Affairs, and that's for
22 a reason. Sometimes it's because we don't have

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1 a military treatment facility in an area or we
2 don't have the right capability or capacity in
3 an area, so we really do need to rely on that.
4 And then we have a huge retiree population who
5 live all sorts of different places and they need
6 access to care. So it's how we actually do that
7 data interoperability.

8 And we're working very hard through
9 the IEHR project to actually make the data --
10 using data standards make it standardized and
11 interoperable. And the more we push the ONC and
12 HHS to come up with the standards that's a good
13 thing for all of us.

14 MEMBER PHILLIPS: Thank you. I
15 just wanted to get that on the record, that we're
16 all on the same page.

17 MS. CARSTENSEN: Just also, just to
18 comment on the utilization of the VA. About 30
19 percent of veterans use VA healthcare. Thirty
20 percent are eligible but have -- are using some
21 other source for healthcare, like Dr. Guice
22 said, many multiple eligibilities and maybe an

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1 employer-based insurance plan. And then about
2 30 percent of veterans may not be eligible for
3 care based on the legislative rules associated
4 with that. So those are the numbers.

5 I think that part of what we're also
6 experiencing within the task force and what
7 we're working towards is those handoffs. And
8 Secretary Shinseki would often say, you know,
9 what our work generates in DoD.

10 And so somehow we need to know who
11 they are because it doesn't just happen that we
12 know. And so they have to be transferred over
13 to us. And that's really what we see as this
14 community of practice, the value that it's going
15 to bring to us is the relationships for those
16 warm handoffs.

17 Some of our initial work showed that
18 about half the time we weren't doing that. And
19 so this is an opportunity for us to again create
20 the tools and the mechanisms, the policies, the
21 processes to assure that happens.

22 And that our folks can make informed

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1 choices so that perhaps that isn't their right
2 choice or isn't the best choice for them and
3 their family. But we need to make sure that it's
4 an informed choice.

5 MEMBER MALEBRANCHE: I think one
6 other piece that we're trying to do in trying to
7 get them, Dr. Phillips, is what -- the PDAs and
8 the PDHRAs. You know, when they're still active
9 duty they can't enroll but they can register.
10 So there is a huge outreach effort on behalf of
11 the VA. And I think in a couple of site visits
12 we've noted where they were done at the military
13 facility.

14 So we try to register the
15 servicemembers so that we know who's coming and
16 we can do a little outreach to them so when it's
17 time they can enroll. So we're trying a lot of
18 different venues in terms of outreach. But you
19 know, you always have to know who your population
20 is and that's something we don't. You're right,
21 there's a lot of that electronic piece that will
22 be helpful if they don't choose to go elsewhere.

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1 So that's another venue.

2 CO-CHAIR CROCKETT-JONES: How will
3 case managers -- with this idea of a lead
4 coordinator and transitioning and knowing who
5 the next one's going to be. I want to, in like
6 a particular instance, for instance when there's
7 an institutional sort of philosophy that's
8 different.

9 Like for instance, we see a lot of
10 folks when they are in treatment for PTSD or
11 other behavioral health they -- certain
12 medications are used, multiple medications are
13 sometimes used. And then they get to the VA
14 eventually and part of that transition involves
15 a lot of anxiety itself because they really don't
16 know what to expect.

17 But when they get there there is a
18 different set of medications. They have to
19 switch over. There's a different philosophy
20 about polypharmacy. We heard both
21 servicemembers and family members and even
22 OIF/OEF program directors all with concerns

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1 about this sort of differing institutional
2 philosophies about what's the best practice.
3 And I sort of wonder if this is going to be a bump
4 in the road for this continuum of a lead
5 coordinator or similar thing.

6 DR. GUICE: So I think part of that
7 is being worked on the clinical practice
8 guidelines. We have a DoD-VA clinical practice
9 guideline working group and I know that they've
10 addressed some of these issues and are coming up
11 with that shared joint approach. So there will
12 be the consistency of the clinical practice
13 guidelines.

14 Then there needs to be the oversight
15 to make sure the clinical practice guidelines
16 are implemented and adhered to, and that we get
17 the outcome that we want. So we're working
18 through kind of some of those particular issues.

19 And hopefully what you picked up
20 from General Robb's presentation is Health
21 Affairs as it de-hats the dual hatting and
22 becomes policy and oversight, that the function

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1 of following up and making sure that things are
2 implemented so that we get the outcome that we
3 wanted when we developed the policy, to make sure
4 that that actually works. So that's how
5 at DoD anyway we're going to make sure that we
6 build that oversight piece in just to make sure
7 that we're getting things right. Because I
8 think that probably has been missing from some
9 of our -- the policy oversight tandem that really
10 needs to exist. So I think moving to the new
11 structure will actually afford us that
12 opportunity to make sure we don't miss that
13 important role of OSD.

14 GENERAL ROBB: I'd actually follow
15 onto your answer on that on the CPGs. It's that
16 much like in the trauma community where we change
17 behavior in the trauma community with clinical
18 practice guidelines.

19 So we have this thing called the
20 Joint Trauma System and across all three
21 services now we have a joint organization down
22 in San Antonio that through data-driven we now

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1 have clinical practice guidelines that now are
2 the standard of care for the delivery of trauma
3 care which we didn't have before. So that's a
4 mature organization that's done there.

5 We have a cyclic process where you
6 collect data, analyze the data, drive
7 performance improvement, i.e., clinical
8 practice guidelines, collect the data, analyze
9 the data, drive performance improvement. And
10 so what you're seeing right now through the
11 Defense Center of Excellence for -- the DCoE,
12 Defense Center of Excellence for Traumatic Brain
13 Injury and Psychological Health is they're
14 setting up a very similar paradigm to live in.

15 And again they're not as mature as
16 the trauma community was before the war and of
17 course actually grew up during this current
18 conflict. And so they're going to have the same
19 concept where they're driving data collection
20 through a registry, they're going to analyze it,
21 drive performance improvement, clinical
22 practice guidelines, and continue to do that

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1 cycle.

2 And that -- and because of the way
3 the organization is set up is that, remember,
4 you've got the Department of Defense and the VA
5 both that are sub-portfolios of that
6 organization. So they're much like you see in
7 their continuum, like you see in the trauma care
8 continuum down in San Antonio you're seeing that
9 relationship develop as now the DCoE matures.

10 And so Dr. Guice is talking about how
11 do you drive that. Because remember we weren't
12 practicing -- when you trained at Yale and you
13 were taught to do trauma this way, and you were
14 trained at L.A. County you were trained in shock
15 trauma. But now we've got a consortium in the
16 Department of Defense where these, the clinical
17 practice guidelines, they drive the way we treat
18 in theater trauma care and our outcomes again are
19 incredible because of that.

20 And I see that same transfer of
21 process to occur in the psychological health,
22 PTSD. And it's not going to happen overnight

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1 but we are well on our way of going in that
2 direction. Dr. Guice, does that kind of help
3 back that up?

4 DR. GUICE: Absolutely. Now, you
5 know, what you're articulating is a level of
6 frustration about how the practice of medicine
7 is different depending on where you are. And
8 that's not any better out in the private sector.
9 It just is.

10 The other thing that we want to make
11 sure that we do is once clinical practice
12 guidelines are actually promulgated or you know,
13 you've got a chance, or a recommended change and
14 a better way of doing something it takes about
15 10 years for that actually to get implemented.

16 We hope that we will not wait 10
17 years, that we can actually use some of the tools
18 that we've developed to actually make sure that
19 we get those in place and that we start
20 reinforcing that this is what the community of
21 practice in this case for psychological health
22 has agreed that this is the way to do business.

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1 So we're hopeful that we can get all of these
2 things in place.

3 But it always seems a day late, a
4 dollar short to patients and families when you
5 recognize that we've needed to do this for a
6 while. But it does take a while to work through
7 this what's the best science, what's the best
8 practice, what's the best way of doing it. And
9 getting everybody to agree to a similar way of
10 doing business. And then implementing it and
11 redoing your business processes to accommodate
12 doing the business in a new way.

13 CO-CHAIR NATHAN: Other questions?
14 Issues? Concerns? Well, thank you both.
15 Clearly the clinical practice guidelines are
16 sort of invisible to the patients and to the
17 beneficiaries and yet they make a tremendous
18 difference in both patient safety, efficacy and
19 the latest and greatest.

20 One of the recurrent themes that we
21 hear from people who come before us in site
22 visits is trying to get as close to one-stop

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1 shopping as possible from families and from
2 warriors who are looking for some sort of
3 continuity and connectivity where they're not
4 handed off to person to person, to agency to
5 agency.

6 So this is -- we're clearly on the
7 right path here trying to find a person who
8 starts with them at the beginning of their
9 travels and stays with them through their
10 travels, who doesn't say, "Oh, you're case
11 48-TAC-B, I've heard about you," but says "How
12 are you doing, Joe? I'm your lead coordinator.
13 I'm going to stay with you while you transit the
14 DoD, the VA system."

15 And especially those people out
16 there in the hinterlands who are really
17 dependent on either their small local
18 facilities, federal facilities, or the private
19 sector for care.

20 DR. GUICE: So I just want to make
21 sure that you don't leave here thinking that
22 there's going to be a single lead coordinator

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1 who's going to stay with the patient forever.

2 The lead coordinator will change
3 depending on where the individual is and their
4 needs at the time. What we have put into place
5 now is a system of accountability for making sure
6 things get done.

7 So rather than 12 case managers and
8 12 -- and you never know who did what, now we've
9 got a lead coordinator. It's their job to make
10 sure that the handoffs are smooth, that the
11 information gets -- it's a single point of
12 accountability.

13 CO-CHAIR NATHAN: The point is the
14 warm handoff.

15 DR. GUICE: Yes, absolutely.

16 CO-CHAIR NATHAN: And we've heard
17 success stories in some of the pilot programs
18 where an individual has left Walter Reed and has
19 gone somewhere else and a new lead coordinator
20 has called them up without having to be called
21 and said I know you're here, I know you've
22 arrived, I know your case, I talked to so-and-so,

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1 welcome to this area.

2 That's success. That's success, as
3 opposed to the patient having to -- or the family
4 having to show up at the doorstep and say who do
5 I see. I used to be followed at Walter Reed and
6 now I need to be seen at this VA. So I think --
7 that's a small pilot but boy, is that, you know,
8 a phone call, \$1.95. Care manager, \$85,000 a
9 year. A warm handoff, priceless. So I think
10 we're getting there.

11 Anything else? Well, thank you
12 very much, Dr. Guice, Dr. Carstensen. It's a
13 pleasure having you here today.

14 I think that's our agenda for today.
15 For those of you who are worried about coming
16 tomorrow I won't be here so that may sweeten the
17 pot a little bit and you may decide to show up.
18 But hopefully in my stead will be General Stone
19 and General Mustion. And I think you have a
20 robust activity planned.

21 Suzanne, any comments before we
22 close today? Steve?

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1 MEMBER PHILLIPS: Just are we going
2 to do Elmendorf or do we want to hold that till
3 tomorrow?

4 CO-CHAIR NATHAN: Why don't we hold
5 that till tomorrow and we'll talk when
6 everybody's fresh. Because that's probably
7 about an hour, 2-hour conversation. I'm just
8 kidding. Yes, I'm just kidding. All right,
9 thank you everybody.

10 (Whereupon, the foregoing matter
11 went off the record at 4:46 p.m.)

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