UNITED STATES OF AMERICA

DEPARTMENT OF DEFENSE

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DEPARTMENT OF DEFENSE
RECOVERING WARRIOR TASK FORCE

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DECEMBER BUSINESS MEETING

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MONDAY,
DECEMBER 9, 2013

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The DoD Recovering Warrior Task Force met in the Romeo & Julieta Ballroom, 110 Lexington Avenue, 3rd Floor, San Antonio, Texas, 78205, at 8:30 a.m., Suzanne Crockett-Jones, Co-Chair, Presiding.

MEMBERS PRESENT:

SUZANNE CROCKETT-JONES, Co-Chair
CSM STEVEN DeJONG, ARNG
RONALD DRACH
COL KAREN T. MALEBRANCH (Ret.), RN, MSN
DAVID K. REHBEIN, MS
COL RUSSELL A. TURNER, (Ret.) MD*

ALSO PRESENT:

COL DENISE DAILEY (Ret.), Executive Director, Designated Federal Officer
JOHN L. BOOTON, Director of Operations, RWTF
LAKIA BROCKENBERRY, RWTF Staff
STEPHEN LU, RWTF Staff
DAVID McKELVIN, RWTF Staff
JOSEPH NAGORKA, RWTF Staff

* Participating by telephone

C-O-N-T-E-N-T-S

C-O-N-T-E-N-T-S (Continued)

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

8:30 a.m.

EXECUTIVE DIRECTOR DAILEY: Good morning, ladies and gentlemen. I'm the executive director of the Task Force. If I have the members seated, I will turn it over to Ms. Crockett-Jones, the Civilian Cochair for the Task Force.

Good morning, ma'am.

CO-CHAIR CROCKETT-JONES: Thank you, Denise. I'd like to welcome everybody to our second Task Force meeting this fiscal year. This is also our second meeting outside of the Washington, D.C. area, and we are very excited to hold this event again in San Antonio, Texas.

Before we begin, I ask that we go around the table to conduct introductions. Why don't we start with you, Mr. Rehbein?

MR. REHBEIN: I'm David Rehbein. I'm one of the seven civilian members of the task force.

DR. PHILLIPS: I'm Steven Phillips, one of the civilian members of the Task Force, and

I work in Health & Human Services, specifically the National Institutes of Health.

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

MR. DRACH: Ron Drach, non-DOD, formerly from the Department of Labor.

COL MALEBRANCHE: Karen Malebranche from the VA.

CO-CHAIR CROCKETT-JONES: I'm Suzanne Crockett-Jones, Civilian Cochair.

I would like to note that Vice Admiral Matthew Nathan, Major General Richard Mustion, and Technical Sergeant Alex Eudy are scheduled to be absent both days of this business meeting, but we have -- do we have Dr. Turner on?

DR. TURNER: You do have me here.

CO-CHAIR CROCKETT-JONES: Would you like to introduce yourself, Dr. Turner?

DR. TURNER: I'm Russell Turner, and I'm a physician, and I'm over the Internet.

CO-CHAIR CROCKETT-JONES: Very good. Thank you very much for joining us. I know that

this is tricky.

Since our business meeting in October, we have conducted installation visits to the Marine Corps Wounded Warrior Regiment Headquarters, the Community Based Warrior Transition Unit and Joint Forces Headquarters in Utah, and the Warrior Transition Battalion at Fort Hood. The site visit to the Wounded Warrior Regiment provided us an opportunity to hear from several programs and sections, although no focus groups were conducted.

We were also able to have a detailed look at the Sergeant Merlin German Wounded Warrior Call Center. Our site visits in Utah to the Community Based Warrior Transition Unit and Joint Forces Headquarters in Utah allowed us to discuss medical and non-medical case management with both Army and Air National Guard leadership. We also allotted time to tour and speak with personnel at the Veterans Affairs Medical Center in Salt Lake City.

The Fort Hood Warrior Transition

Battalion site visit conducted last week focused on medical care case management, the IDES process, and TBI/PTSD services. Focus groups were conducted in Utah and at Fort Hood. A list of the site visits and those members who were in attendance can be found under Tab B of our briefing books.

We need to begin a discussion with the members who attended the Wounded Warrior Regiment headquarters visit in Quantico, Virginia, and then we'll move on to the other sites.

So, Ms. Malebranche and Mr. Drach, you were at the Wounded Warrior Regiment, and so would either of you like to comment?

COL MALEBRANCHE: Mr. Drach took some notes. I don't have those in front of me. I thought that the -- it was interesting from the Wounded Warrior piece that it seemed like the Marines, as we always have known, take care of the Marines. I had a little concern about the transition piece. We were trying to clear that up because it doesn't sound like they ever

transitioned -- for me, of course, I'm looking at the VA. I know that they do because we have a Marine there. However, there was some particular pieces of that, and I will go back to my notes and look for that, for the transition piece. It did seem that their RCCs are extremely well trained, and I think also because the smallness of the Wounded Warrior Regiment, they do things really well. I don't know that we see that just because of volume alone, and the site was very nice.

It would be nice if we could learn some lessons, and I believe they were going to share some training with us from the RCC program and the like, but I think overall it was very interesting. I was surprised how far they've come in the long journey that we've all had since they've stood up. So I thought that part was pretty enlightening.

Mr. Drach?

MR. DRACH: A few things. The RCC workload ratio of 1 to 22 and the ratio for the Section Leader was 1 to 11. There were 143

wounded Marines in receipt of the SCAADL, the Special Compensation for Assistance with Activities of Daily Living, as of October 1 of this year, 2013.

What I found -- apparently, what's been very useful to them is the Wounded Warrior Regiment Handbook, keeping it all together. That, apparently, is also on their Wounded Warrior Regiment App, so it's very handy for the wounded Marines to have access to that; by having the app loaded on their Smartphone or iPad, or whatever.

There was one comment, I'm not sure who made it -- or maybe it was just in my own notes -- that perhaps more Section Leads should have some combat experience. But I think we've heard some of that in the past at some of the site visits were it was indicated that their -- their main point of contact had not had any combat experience, and they thought it would be helpful for the individuals to have, if nothing else, the empathy for them to have served in a combat area.

Also the Wounded Warrior Regiment

has a very robust Facebook page. Major Brian Bilski gave us a very good briefing on their internship program and what they're doing in the area of employment. That's about it.

CO-CHAIR CROCKETT-JONES: Thank you. I think I want to also mention that they were probably the most -- one of those proactive programs as far as they were prepared and trained and open to the concept of getting resources to family members.

Is there anything else that anyone can remember? Denise, was there anything that we missed in covering this?

MR. REHBEIN: Just one. Just one note here that I made that came from the DES Council about the need for an electronic record and how that would increase access and greater efficiencies and greater effectiveness. So that's just one more place that electronic records could be used.

CO-CHAIR CROCKETT-JONES: Yes. The services seem to be going forward individually

every -- you know, this is not something we're seeing consistently. As far as on the matter of IT, we haven't seen a push for a single cross-service method for getting records into a digital form or for using digital recordkeeping.

EXECUTIVE DIRECTOR DAILEY: I think one of the other features that we saw at Quantico, because they are small, they have jointly located at their headquarters obviously, the care for their wounded, ill, and injured. They've also located their reserve component element for care of the reserve wounded, ill, and injured. They also have oversight and report and monitor the Marine IDES.

So, in essence, at that one headquarters, the Wounded Warrior Regiment has a finger on the whole population of wounded, ill, and injured in the rainbow. The active duty, the reserve component, and everyone in IDES in the Marine Corps are monitored out of the Wounded Warrior Regiment headquarters, and it's a unique setup among the services.

DR. PHILLIPS: Just a quick question related to your mention of the family caregivers. Are they doing anything different to recruit or inform the family caregivers that support them?

CO-CHAIR CROCKETT-JONES: I would say that their decision -- that the one thing that is specifically unique is their decision to have a -- you know, an assigned Cadre, you know, unit person who basically becomes accountable. It seems to lead to a little more proactive attitude. Also, there was -- they still experience lower turnout than like at family events, lower response in contact. I mean, this is a persistent issue across the services. However, they have not seemed to accept that as a standard. So they don't back off from trying, having had less than stellar results, which is -- it's a frustration that every service is feeling and it can lead to the unit basically saying we've tried, and backing off from the proactive attempts.

So if we want to talk now about the Utah visit, if we're all done with Quantico. Do

you want to start with this?

CSM DeJONG: Yeah. Utah was interesting, to say the least. What we've learned there is that remote care is changing. The way we were briefed is that remote care was going to be handled by the -- by big Army. It's going to be handled by the medical facilities within the certain areas for CBWTU right now for Utah. Their future is unknown because it looks like they're going to be falling under -- I can't remember the exact date. I don't have my notes with me -- under Fort Riley, Kansas, and they will be running remote care from there.

With that, their future was kind of unknown. They do have a passion for what they do. They feel they relate to the service members -- that their Reserve National Guard and Reserve Service members were -- they feel that they can provide a better continuum of care for them, yet their future is unknown. And it's going to be interesting to see in the next couple of visits to -- you know, as we delve further into the

National Guard realm of this if the rest of them have been briefed the same way as far as what remote care is going to -- what's going to happen with remote care and who's going to manage it.

Is there anything more about CBWTU?

MR. REHBEIN: I want to piggyback on that just a little bit. In that change -- and this doesn't apply to everywhere, this just applies to Utah. When that change occurs and must be moved to Fort Riley, those soldiers are going to lose a unique access tool. The national and the -- I believe that's where the musters are held for the CBWTU Utah, and that is a place that is -- is a national -- it's a national asset. They get to use it because they're there close. Once they move to Fort Riley, they lose the use of that facility.

While we were there, there were at least two other groups there that were the ones going through -- I don't know if you call the inpatient counseling, but certainly intensive outpatient support, but that's the kind of thing

they do. That's the kind of thing they're very good at, as well as with some physical aspects of developing abilities rather than evaluating disabilities. I'm sorry to see that the Utah folks won't have that.

COL MALEBRANCHE: I wanted to mention that I thought when we visited with the VA there, it seems like the CBWTU, as well as the behavioral health folks and the folks from the Guard there seemed to have a good relationship. They were doing some unique things that we thought might proliferate.

They had that job day. They said that it was actually -- I don't remember what they called it, who all they invited. It did seem that they were using their resources in the community more so than other places, maybe because of the remoteness of Utah, and what is there and what is not there, but it did seem that they had some very good relationships. They knew each other by name.

I thought there was a little bit of a disconnect in some of the roles that people

played there and I'm trying to separate it, because I know that you asked about CBWTU and I know that the TAA there thought the initiative was an entrance person. They all seemed to know each other. The CBWTU or the VA, the National Abilities Center, there was a real good community effort there that was going on that we don't see at all the other places.

MR. REHBEIN: One of the CBWTU sergeants made a comment. He's been assigned both as a Platoon Sergeant at a WTU and at a CBWTU, and in his estimation, the jobs are not the same. He specifically said there needs to be some specific training -- additional training to be a Platoon Sergeant in the CBWTU because of the remoteness -- because of the remote care aspect, because he's dealing with people on the telephone all the time. And I thought that was just an experience that should be taken into account, since he's had both jobs.

CO-CHAIR CROCKETT-JONES: I'd also say that my impression was that they were -- they

were -- they felt stretched as far as their resources went and -- and that was reflected in their -- they were less trained -- you know, less aware of resources available to them. Which is, again, something we see at CBWTUs. They are more focused on local and it makes them less, I think, aware of some of the national-level resources that are available for them and for their service members in care.

I will say they were more aware of even more so than some places we have been of headquarters assets and aware of VA resources. They had more -- they were more coordinated than other places we've been. So they are succeeding at some better level of communication.

And I want to say that -- I know we're jumping ahead, but in contrast, there has been a different shuffle at Fort Hood where the Arkansas CBWTU is now administered by the battalion at Hood. Instead of, you know, shifting the activity which seems to be what is anticipated at in Utah, they have just shifted the hand. Fort

Hood felt comfortable with that and thought it was a better outcome. So I think that we need to look quantitatively at that -- at the two sort of plans as they -- you know, as we understand them better, perhaps we would be able to recommend one method of consolidating resources over the other. Depending on how -- how effective it is at actually consolidating resources one or the other, so ...

CSM DeJONG: No. I definitely agree. I'd like to look a little bit in our last year here at remoteness as becoming in the forefront of things, how it's going to be managed, what's working and what's not working, who's managing what, looking at a way forward and making a recommendation to remote care as we move forward throughout this year.

Moving on to the Joint Forces Headquarters. A few interesting things were brought to light there as far as one of the big ones is how the State of Utah is not using Pinellas Park for their disability evaluations.

They are a test site. I don't remember what they call it, but they're a test site for their own state, and it would be interesting to get some follow-up on that to see how that's working, to see what's working with Pinellas Park. And I know we're set out to go to Pinellas Park, and if this is the model we're going to, I hope it's not a wash going out there as everybody's going away from using it. But I think it's going to be good to get a look at Pinellas Park and how -- it was kind of disheartening that this is changing within the last year of our existence because it would be something worth following to see what's working and what's not. But I don't see that in the future.

Another interesting thing as far as the National Guard side of it. We've always looked at family programs as basically an adjunct to general call and how they want to use it. Some states have a J9 and some states, as far as Utah is concerned, it falls under their J1, which brought up some -- they're still doing a great job

in the programs and some of the feedback I got, but it also brings up some issues of budgeting and other things that they brought up to where it's not a specifically funded program throughout the state where some of the states that do use -- the J9 model is specifically funded for family programs to where as it falls under their J1, they're basically taking the moneys of that from a J1 budget to support their family programs. I think we're going to see this still across the United States based off of the sheer numbers of how many soldiers each state has.

Looking at the state of Utah, they were looking at, you know, just over 6000 for soldiers and airmen within that state, and then you go to a couple of other states that are sometimes three or four times that. It's going to be kind of interesting. I don't know if there's anything -- if we have enough information to actually use as a best practice. In the past, I don't think it got much traction, but whether there's a right -- right, wrong -- right or wrong

answer as to how to best field the family programs at the state level.

CO-CHAIR CROCKETT-JONES: I also have in my notes that the folks that Utah brought us a concern about the Medical Readiness Centers, about the appropriate training for those folks and the MOS from which they might be drawn, and that -- that there should be a matching of experience and skills to the job since it was demanding and some folks stepped up to it more easily than others.

And I wanted to bring that up since at that point I didn't know if there was a particular policy or if it was just a practice or if there was if basically -- that slot gets filled by just basically who's available, which is what I suspect is the case; that there is no -- that that is assigned based on whoever -- at every headquarters based on who has -- who has the time. And that might not be the best method. This might need to be a matter of policy because that person's job winds up touching so many people who

are wounded, ill, and injured.

MR. REHBEIN: One of the other questions that was raised in my mind -- and this goes back to that subject of remote care and how to deliver things remotely. The ideas -- people raised the question of whether or not telephone briefings are equivalent to the face-to-face briefing that the active component gets. And the thing that's -- that's a valuable question to ask, particularly as I think maybe we have more people in remote care. It's not just briefings across the board or the way it ties to delivery, and ties the telephone to our ear, and I'm listening to what you have to say and asking questions as they occur to me. Are there better ways to deliver those briefings to make these briefings be what they really need to be just to -- the point I think the Task Force needs to keep in mind and look for in other places and see if there are other -- other sites that have addressed that one way or another.

DR. PHILLIPS: If I may comment.

The civilian sector is moving more and more toward programs of remote care using the existing technology. I mean, for long times -- for long periods of time going back in time, we would respond to, say, major disasters internationally through Telemedicine and telecommunications and sort of the -- and advising the boots on the ground, who are subject matter experts related to some type of trauma, what to do. At HHS, we're doing that a lot. And the reason I mention this is, it might be good to think about getting all the folks that are doing this -- DoD, non-DOD -- perhaps into a room at some point and look and see what's -- what is happening, lessons learned, and so forth, that sort of thing.

CSM DeJONG: One note, and I note that Ms. Malebranche brought it up. Every state that we've visited so far seems to really rely on that TAA, the Transition Assistance --

COL MALEBRANCHE: Transition Assistant Advocate.

CSM DeJONG: And it seems to be on

the command side and on the service member side, their go-to person for all the answers. Now, one of the things that we talked to them about is that that's a contract position, so that contract can go away at any time. We know the budget crisis that we're in, so we may want to look at ensuring that that position across the state somehow is retained, because they are a wealth of knowledge and they are the go-to person on all sides for the connection between benefits, VA, end of service. And everybody knows that contracts dry up, so that might be something that we want to look at, trying to make sure it stays in place. More than just the best practice-wise, but maybe look at informing some sort of recommendation out of that.

COL MALEBRANCHE: One thing the VA does help training of the TAA, and I noticed at that particular place when we were talking about -- the Vet Centers aren't as widely known as I thought, and that's one area that perhaps we need to do a little bit of training and marketing to the TAAs and the people that are on site,

because, you know, there's like 300 bricks and mortar and 150 mobile Vet Centers. They didn't distinguish the difference of the Vet Center from the VA and I think that's a pretty important decision.

Fort Hood probably knows more than others because of the history there. I mean, I think that would be helpful. I think that would be somewhat helpful. I was really encouraged in that the state has really touched on even the nurse case managers of the CBWTU, and Utah seems very engaged more so than other places.

CO-CHAIR CROCKETT-JONES: Are we ready to move on to Fort Hood?

EXECUTIVE DIRECTOR DAILEY: One last comment on CBWTU. They are leaving Pinellas Park. They are no longer sending their patients to Pinellas Park when they go through. I guess they physically go to Fort Riley, and they're there for four to six weeks until all their appointments are done, until they've had all their briefings, and then they're heading back. Previously they had

been taking and getting their IDES taken care of at the VA or through a nearby hospital and then sending it down to Pinellas Park for consolidation and movement to an MTF. At least a package to MTF. So the CBWTU, which is consolidating everything at Riley for their IDES, and then you had the headquarters which was doing it the way the CBWTU had been doing it, people were going out to the VA to get their various appointments and they were then sending their packages down to Pinellas Park. They haven't sorted out the IDES piece yet for how to do it consistently across the board.

CO-CHAIR CROCKETT-JONES: Are we ready to move on to Fort Hood? If you would like to speak about our trip, Mr. Rehbein.

MR. REHBEIN: Let me touch on a number of things at Fort Hood, because it was a very interesting visit. Since it was three days ago, it's very fresh in my mind.

They have very good -- they have a very good set of family support programs, but they

are very underutilized. One was called a Spouse Empowerment. I don't remember the other one, but it's an empowerment program for spouses. There's another one called Operation Sound-Off, which is a PTSD support group. I got the impression -- and we addressed this with the leadership and the committee. I got the impression that as things changed at Fort Hood that there is not a mechanism to inform the families of the changes, and so a family that's been in the program nine months, a year, still believe that the program exists as it did when they came in because that seems to be when most of the information is given to them is on entry. So there needs to be a way, in my opinion, at Fort Hood to circle back to those families to tell them about the changes periodically. We know what we see for changes in the programs over the last four years, and if there's no way to tell the families about those kinds of changes, then they don't know, because it's a large installation.

To change to another subject a

little bit, their IDES people were doing an electronic record. They had set it up on a shared drive. Those folks that needed access had access to the electronic record and they found that to be a very effective way of dealing with it. Their one problem was, of course, that the VA still requires the paper record. So that was something of a drawback there again, but that shared drive with the electronic record in a central repository where they could access seemed to be something that they really -- that they really appreciate.

They will be in NICoE satellites. That is coming. They were a little bit unclear at this point, but then that as NICoE -- as NICoE attempts to replicate itself in nine satellite sites around the country, the challenge there is for NICoE to replicate the quality that they have in the current site in Washington. So that's a -- I think that's -- so that's just something to -- that's just something for us to keep our eyes on as long as we can.

But then there was serious talk

about TRICARE delivery of PTSD treatment. Because a fair number -- significant number of their people were receiving PTSD treatment on the network through TRICARE and while all of those providers were trained in evidence-based techniques -- they had to be -- there was no way to verify that those providers were using those evidence-based techniques. And that was -- that was a real concern. They were afraid that -- they were afraid that a number of their PTSD folks that were going out on the network were simply receiving support counseling, talk therapy, but they had no way -- they really had no way to know unless they brought the soldier back in and specifically started to ask questions about it.

And I was not totally aware of this, but evidently once that soldier walks into a provider's office and sits down and begins the session, there's no way to really control what that provider uses.

CO-CHAIR CROCKETT-JONES: And the -- there was a feeling that there is a specific

guideline -- a specific TRICARE policy -- which we need to hammer out the conflicts in these policies, because the -- while the nurse case managers and the social workers wanted to channel folks specifically to providers who they trusted to use the evidence-based therapies, TRICARE policy did not allow them to filter the list in that way. That if someone was in the pool, that the unit could not filter them out of the pool based on, you know, maybe their concerns or the history of straying from evidence-based therapies. And because of that, they felt that conflict, they felt disempowered to follow up on this.

Whether that conflict is embedded in the dynamic wording of the policies or whether that is an interpretation. Either way, we need to get it clarified and make sure that this isn't replicated in other places since, you know, traction on improvement and outcomes in this area is just -- it's been a source of frustration.

Do you mind if I jump in or do you have some more?

MR. REHBEIN: No, go ahead. I have one more thing, but I want to end with it.

CO-CHAIR CROCKETT-JONES: I want to reiterate that it wasn't just in reaching family members when it comes to basically new Cadre doing sort of a -- new folks coming into the unit. There seemed to be generally a -- the current leadership seemed to be very proactive in getting their Cadre trained and sort of spreading the concept of a protective Cadre. They were -- they got mostly high scores from our focus groups, as nurse case management did, which we don't see in many places. They were trusted enormously, and that's -- that's significant, but also in that area, those who had been in longer and -- perhaps some of the Cadre who had been in longer, there was a definite difference in that sense of trust. And so leadership had obviously been succeeding in creating this, but they weren't -- you know, there was not a back-reach to hit folks who had been in the unit for longer periods of time. Perhaps turnover will resolve that, but in the meantime,

they need to look not just at family members who had been once resourced and backed off, but they -- you know, this was a -- this idea when things happened is something we need to promulgate that -- that you have to look back at the folks who have missed out so far. You know, you can't just rely on the new sweeping -- hitting the new folks sweeping in, and that was sort of highlighted there, because they're doing such a good job.

MR. REHBEIN: A couple other points; one dealing with the Comprehensive Recovery Plan. They all have heard of it, they all participated in it. And maybe this is a little bit colored by the fact that the focus group was primarily -- senior NCOs primarily, but when we asked if they found it to play a role in their recovery or was it just a check-the-box to a soldier, they said it's a check-the-box. They really didn't see the value.

Now, maybe that's because these were primarily E-6s and E-7s, and so they know about

goal setting and planning careers and being responsible for themselves. Unfortunately, the ice storm canceled our junior soldier focus group, and so we weren't able to ask that same -- that same question to them.

The one thing that concerns me the most -- and I don't know that this is unique to Fort Hood -- when they prepare people -- they prepare soldiers to leave the military to do something, they told us that of their people, 45 percent have no plan to either obtain more education or employment. I think it has to do with the severity of the injuries, the wounds, and so they feel financially they'll be okay. But somehow -- they don't know that somehow they're being left with the opinion that there isn't more to life than just a paycheck. And that's the people I think we need to have some real concern with, because if they don't feel like life's productive six, 12 months down the road, there's a real risk there. There's a lot of risk there for those folks. 45 is a big number. I would --

maybe 10 percent I would have thought, maybe. That's kind of the numbers we've heard before, but 45 percent is a big number when you're dealing with what used to be a Brigade that's about to become a Battalion.

MR. DRACH: 45 percent?

MR. REHBEIN: 45 percent of the people that are leaving the WTU have no plans to either obtain further education or employment. They're simply going home because they feel like they have enough money to support themselves through compensation programs, Social Security, whatever it might be. And so they're looking primarily at the money.

COL MALEBRANCHE: Were those folks from all over that were going -- I mean, they were going all over, not just pretty much local? They're being spread throughout?

MR. REHBEIN: They didn't break it down any further. They surveyed the people as they were leaving the program, who had plans after leaving the program.

CO-CHAIR CROCKETT-JONES: Briefed them?

MR. REHBEIN: Yes.

CO-CHAIR CROCKETT-JONES: I have to say, there were two things that occurred to me when we were looking at that number. One is that I'm worried this may be closer to the real number. It might be high still, but I'm afraid that this might be closer to the real number that other places are getting. I think that sometimes when we're getting that 10, 15 percent, that that might be a masking number to the reality. That was one thing that occurred to me.

The other thing that occurred to me is that one of the things I think is lacking, and we've seen this in other places, is that in the process as they are -- as they get close to the end of their IDES process, they -- they feel they go into a holding pattern as they wait, but I think that also the programs back off and know that they're getting ready to go. And I think at some point in that ending the IDES process, one of

the differences we see in who's making plans, who's allowing the holding pattern to put them in a sort of passive state is if someone goes through and works the numbers with them. I think that we've heard from IDES legal and other places that nobody's -- nobody's calculated the offsets with them. Nobody's -- you know, that we've heard in some places that -- that folks were not prepared for the length of time for benefits to kick in, that people were unaware of caps on compensation in some places and what was going to be taxed, and what was not going to be taxed, and also what their -- what their real health care costs were going to be. What they -- you know, what they were going to have to -- what was going to have to start coming out of pocket. And sort of this raw numbers issue with respect -- and that in a way we -- they sort of skated by getting hard numbers because if you're waiting for the rating, you don't know what the hard numbers are going to be. And so I think it's easy to say "I'm just going to" -- "I don't need plans," if you really have no

sense of what -- what your monthly income and outlay are -- is going to be.

MR. REHBEIN: I think it's a broader issue than that, even if you've been through all those considerations. I personally have a couple of friends that retired for financial reasons. Not because they were ready to retire, not because they had any kind of a plan after they retired, but because if they didn't retire, then their financial situation was going to be downgraded because of changes in the pension plan. They are both struggling very badly, because their only consideration was financial.

As we -- as we look at people that are injured in the service, we learned a long time ago with spinal cord injuries, we bring in somebody that's been through it a couple of years ago to talk about -- to talk to the new person about what this is -- what life is like. As we look at brain injuries, we do the same sort of thing, and I'm wondering if there shouldn't be some kind of a program, somebody that left the

service with no plan, to come back a year later, year and a half later, and talk to the soldiers about what life is like when you do that.

We hear in focus groups, from spouses particularly, about how valuable it is when their soldier finds something that they can do to be productive, how much it helps their mental attitude. It doesn't have to be a job, it just has to be something that makes them feel productive. And I'm concerned if people leave -- that if 45 percent leave the military without any sense of what it means for -- what they're going to do to feel productive, I got to tell you, I think that's where the suicide comes from. A fair component of it. People just go home and sit down and say "I've got enough money to support myself, I'm not going to do anything. I don't have anything to do but think about my life and how it" -- "sometimes it's not very nice."

Maybe I'm pessimistic. I don't know.

CO-CHAIR CROCKETT-JONES: I think

everyone here shares the concern that people, in reality, turn an unmotivated transition to something positive.

MR. REHBEIN: I'll put that soapbox away from the time being.

DR. PHILLIPS: We do know that about folks that win the lottery. People that win $40 or $50 million, you talk to those people a year later, they're not happy. They'd like to give it back.

CO-CHAIR CROCKETT-JONES: I think that's one of the reasons that this sort of financial counseling might be a key. I think that they have an unreasonable expectation of what their compensation is going to provide them, and I think if someone -- yeah. If someone were pointing out that this -- you know, that sustaining you is not -- maintenance is not the same as thriving and not just for more financial compensation, but that a productive life isn't just, you know, about this -- this minimum maintenance, that you're going to have to be

proactive. Even if they want to do nothing, they're going to have to be proactive about how they structure that. So I think we're all -- I think we all share this concern.

MR. REHBEIN: Maybe this is simply a question that we need to ask as we do the remainder of our facility visits this year to get a feeling is this unique to Fort Hood or is this more across the services just what the number is.

CO-CHAIR CROCKETT-JONES: Programs or focus groups for service members should include a -- a poll of do you have an intention to work or education or -- I think part of the reason why we might -- we need to find what the right wording is because some folks intend to go on to not -- nonprofit basically activities. And so we need to find a way to ask that question that doesn't limit it to employment and education, since we've seen folks go -- become mentors, active and adaptive sports, you know, have an otherwise productive and proactive life, a thriving life, but without strictly being under those two headings.

DR. PHILLIPS: I just wanted to mention further about the pathway to possible depression. I think we need to the address and identify that because if you're -- I'll agree if you have a plan to do the mentorship, that's fine, but no plan at all, like Mr. Rehbein says, is planting the seeds for depression based on that, and I think we do need to address that.

COL MALEBRANCHE: The other piece to keep in mind when we talk about transition, a lot of times we go through the transition from DoD to VA. That's not the only transition, and one of the subjects here at the Agency Care Coordination Council is the different points of transition during the lifeline of an individual. And one of the transitions is the transition to community or transitions to other things, which is why the VR&E piece has taken such a strong role and why there's been such a push out there, because it's rehab, it's also for family members who have the same sorts of issues of transition because they're transitioning with a person.

So I think when we talk about transitions, that's going to be a very key piece and that is to be an ongoing piece and a number of people in that role, but we're also looking at the Lead Coordinator. And I know we're getting a briefing on that later on in the upcoming time frame, but that is a huge piece to look at, that transition point to community, back to home, back to something. And hopefully we're hitting on that mark and not just transition to VA.

DR. PHILLIPS: I was going to say, this is such an important issue for our industry and for our future. If there are any ways we can look back -- and there may be studies out there -- five years, ago, ten years ago, and perhaps the VA has some numbers as to what has happened to these folks, even though people say "I'm not going to get a job, I'm not going to go to school," or if they do say they are going to get a job and they are going to go to school, I think it would be more effective when we make our recommendations if it's possible to have -- at least have some

numbers and some statistics, and I'm not sure how to do that.

MR. DRACH: I think that's a good idea, but I tend to think that it doesn't exist. I know VR&E is either finished or in the midst of doing a longitudinal study on VR&E clients, but that doesn't break down, you know, the Wounded Warrior necessarily from this generation, I don't think. I don't know what categories were looked at, but the last time -- and this was quite a while ago. And when I asked VR&E, how many of their clients were OIF/OEF, they didn't know. They may have changed, but they weren't tracking that at that time.

Again, that was a couple of years ago. But actually, as I was going through the agenda, something I want to ask later on, what, if any -- what's the word I'm looking for -- you know, when you put something and you track them over time. Not a longitudinal study. Focus group -- not focus group. Registry. Like a registry.

DR. PHILLIPS: Get a sampling of a registry.

MR. DRACH: I'm an amputee. I lost my leg in 1967. I have never had the VA in those 47 years come to me and say, "Hey, here's something new on the market." Now, I qualify that by saying when Dr. Gianinni was the head of the program over there, she used to call me because she knew me. But the VA, there's no registry. Is there a registry from TBI? What if something comes up 10 years from now, how do we reach these individuals? Somebody with PTSD, there ought to be registries for all these various conditions.

COL MALEBRANCHE: They have started those up, Mr. Drach, but -- TBI registries, PTSD, and that was one of the previous efforts at the VA for Agent Orange. They reached out to folks that they knew. So that registry has become quite the thing, but you'll hear probably different things from -- from some of our experts when they get these registries. What they were trying to do with this was again attach it to a register

because a lot of these are co-morbid, and if you're in one register, you would think that you should be in another, but that's not an automatic pull. And so if you're not going for one -- so there's a lot of -- but there is effort, yes, for the registry. So what kind of information is kept there is a little different.

MR. DRACH: Excuse me. You also go back to when Admiral Mullen was chairman of the Joint Chiefs, he put together the Sea of Goodwill, which was all about community reintegration. The University of Pittsburgh is putting together right now a handbook -- and I forget who is the director to it, but it's all about community reintegration. I'm not sure when that's going to be out and how valuable it's going to be is another question. But as you were talking -- and the 45 percent is very alarming. What is the motivator, you know? Your recommendation that perhaps somebody went through this a year, year and a half ago, but, you know, again talking about longitudinal studies, what happened to those ones that left three, four,

five years ago with no plan. Have they subsequently changed their mind? Are they sitting in the corner?

I don't know how many of you saw the special on HBO, but, you know, they did a really, really good job depicting the problem. They did a terrible job in talking about the solution and about the resources. There was a tagline at the end that scrolled down real fast about all the resources that were out there.

But the two things that I remember about that -- I think they profiled five veterans living with PTSD. The two that I remember was the one being carted off to jail and the other one sitting in front of his computer all day looking at all his pictures from Iraq and Afghanistan. Family, three kids, I think.

And HBO did a good service in depicting the problem, they did a terrible service in not talking about the resources and success stories. So I'm an employer, I walk into my HR office tomorrow morning and this guy that was

flipping up the pictures, I'm going to tell my HR people, uh-uh, this guy is a problem.

CO-CHAIR CROCKETT-JONES: Is there anything else we need to cover from these sites, Denise, that we may have missed, or are we good?

EXECUTIVE DIRECTOR DAILEY: I think we're good. Y'all have done a good job this morning covering these areas.

Our follow-on briefers are here.

CSM DeJONG: If I could make one quick point before we -- I asked earlier, I don't really know where it fit in. But following recent budget crunches and how we're trying to balance the budget through our DoD, I don't know how many members of the Task Force have noticed that one of the things that we advocated for in the past -- in the beginning of this Task Force were the special compensation paid to Cadre is due to come off due to budget constraints across the DoD. So it may be something that we want to look at throughout this last year, how that's going to affect the Cadre thinking that they want to continue to

have -- support these WTUs without that special compensation pay, we may want to look at how and we may want to field that question to the current Cadre, if that's going to affect their decision to remain or possibly would have affected their decision to come into that position. Just see what that may do. That's all.

CO-CHAIR CROCKETT-JONES: Thank you. We definitely need to look at that.

Let's see. I have us being a little ahead of schedule, so if we are back at the table at 9:45 and start with the next -- if they're ready, start with their briefing.

(Whereupon, the foregoing matter went off the record at 9:28 a.m. and back on the record at 9:46 a.m.)

CO-CHAIR CROCKETT-JONES: Welcome. From the San Antonio Military Health System, we welcome Army Major General Jimmie Keenan, the Military Health System Director; and Major General Byron Hepburn, the Deputy Director; Air Force Colonel Michael Higgins, the Chief Operations

Officer.

I know there's somebody I'm missing up on that panel from my list. I'll let you introduce.

The San Antonio Military Health System will be briefing us on the impact on access to care and the impact regarding collaboration with the Department of Veterans Affairs as a result of the Enhanced Multiservice Market Reorganization. Turn to Tab C in your binders to review the information.

I'm going to turn it over to you, and you can complete the introductions.

MG KEENAN: Thank you so much. Our one member that's also here with us is Lieutenant Colonel Paul Connors. He's the chief of our business operations for the Enhanced Multiservice Market. And I also brought my senior enlisted advisor, Command Sergeant Major Jamie Johnson. He's sitting in the audience as well.

Again, we want to thank you for having us here today to talk about the enhanced

multiservice market. I know we are the first enhanced multiservice market to brief you. And I'm going to give you an overview from really the Defense Health Agency level, so you can see where we fit and you can see the other enhanced multiservice markets, because they do cover areas where we do provide wounded, ill, and injured service members' care.

So we'll go to the next slide. This has been an evolution is probably the best way. We have looked at government studies from as far back as 1949, all the way through to the DoD Task Force on MHS governance in September of 2011. This was an 18th study over 62 years. It recommended adding central authority and then also recommended the Defense Health Agency model for the military health system governance.

In March of 2012, it was directed by the Secretary of Defense that there would be a reforming of the military health system, and from that we came into the Defense Health Agency, which is headed by the director, Lieutenant General

Robb.

And then we have our shared services, which there are several shared services that have stood up in the Defense Health Agency to include things like logistics, facilities planning. Also all of our TRICARE referral office is now centralized under one director that oversees all three TRO north, TRO south, as well as TRO west and the overseas markets; that's under Mr. Bill Thresher. He's the acting director.

And then JTF CapMed, which you're familiar with in the National Capital Region. It is now a directorate under the Defense Health Agency.

And then lastly, you see here the Enhanced Multiservice Markets. And I'm going to show you a map in a minute that shows you where those enhanced multiservice markets are located.

So then in March of 2013, it was directed that we start the implementation, and on 1 October 2013, the Enhanced Multiservice Markets stood up formally.

Now, I'll give you some background here on the San Antonio Military Health System. It's actually been in place over two years because it's part of BRAC. We had some closures here in San Antonio and some consolidations, and so we'll talk about that as we go along.

So these are the locations of the Enhanced Service Multiservice Markets. And as you'll see, the National Capital Region is one, and it falls directly under the Defense Health Agency, so it is not under a particular service as a Lead. So it is the only one that is under -- directly under the Defense Health Agency and reports to Rear Admiral Bono, reports directly to Lieutenant General Robb.

The other one you'll see is Colorado Springs, and that rotates between the Air Force and the Army. Right now, the Air Force has the Lead for that market, and that's Colonel Tim Ballard from the Air Force Academy.

Tidewater is led by the Navy, and that will always be a Navy Lead.

San Antonio rotates between the Air Force and the Army, and I rotated with Major General Byron Hepburn in September. He had been the Lead for two years of the market, and now I'm the Lead for the next two years.

Puget Sound, which is out at Joint Base Lewis-McChord, is an Army Lead, and that one now is led by Brigadier General John Cho.

Then Hawaii Tripler. That is the State Army Lead, and that is led right now by Brigadier General Dennis Doyle.

I forgot to mention the lead at Tidewater, Virginia is Rear Admiral Wagner.

One of the interesting facts is that when you look at these six eMSMs, over 40 percent of all of the Military Health System direct care is delivered in these six markets.

Now, this shows you how we are configured specifically. As you look at the San Antonio Military Health System, I'm the director and General Hepburn is the Deputy Director. That rotates every two years. We also

partner with the San Antonio Uniformed Service Health Education Consortium. This is with the university, the Uniformed University, as far as to provide graduate medical education here in San Antonio.

And then you'll see underneath we have several commands. We have Brook Army Medical Center, which commands SAMMC, San Antonio Military Medical Center, as well as other Assigned Army Clinics, and I will show you that slide in a minute.

We have the 59th Medical Wing, which is commanded by Major General Hepburn. And under that we have the Wilford Hall Ambulatory Surgical Center, as well as assigned Air Force clinics that fall under the 59th Medical Wing.

And then we have our San Antonio Military Health System Executive Committee, and that's composed of leadership for both the BAMC as well as the 59th Medical Wing Command and our staff. Our chief operating officer rotates; just as I rotated in to take the directorship, our

chief operating officer rotates. And that is always the opposite service of the director. So Colonel Mike Higgins came in this summer, and he is a physician and he leads our group over at the Lincoln Center to coordinate the Enhanced Multiservice Market here in San Antonio. And then you'll see some of the other positions.

And this just gives you an idea of what is composed in the Multiservice Market, the type of operations that we have. As you'll see, we have a Chief Medical Officer, and they look at the clinical operations across our system. We look at referrals from our civilian partners that are out there. There is, you know, care that they provide that we might not. Also, coordination with the VA, which we do quite a bit of collaboration. I'll talk more about that in a minute.

Referral management. We want to bring as much of the care here in San Antonio in our market back into our direct care facility because we know that's important to ensure that

our physicians, our nurses, our techs are prepared to deliver care on the battlefield as well as to provide that care to our returning warriors when we come back here to San Antonio.

We also look at our resource management. One of the key things that is interesting with this Enhanced Multiservice Market is there's a ability now as the market lead, and that's where the enhanced piece comes in, is as the director and the deputy director we're able to move resources between our facilities without having to go back to the services to do that, to put them in the right place where they can best deliver care throughout the market.

The other thing that will happen on 1 October of 2014 is the budget. We will be able to consolidate the budget between the Army and the Air Force facilities and use that money where it's best to support care within our footprint.

Now, just so you have a visual, and I'll show you on a map here in a minute, but under the 59th Medical Wing we have, of course, Wilford

Hall Ambulatory Surgical Center. We're actually building a new facility down there -- a state-of-the-art ambulatory surgical center down there that's going to better meet our needs and our beneficiaries' needs.

We also have the North Central Federal Clinic, which is a partnership with the VA which is directly north up 281. If you're familiar with San Antonio, I'll show you a map in a minute. And we provide care there for enrolled beneficiaries, and we partner with the VA. We have some shared services there which include our ancillary services, lab, x-ray, and pharmacy. So that has been a great partnership.

We also have our Randolph clinic. And at that clinic we're actually working on a partnership right now with the VA where they would actually put providers over at that clinic.

And then we have the Reid Clinic which is down at Lackland. We have a large trainee population. All brand new airmen. This is where they are trained here in San Antonio. So

a huge training mission down there.

And then going over to the Brook Army Medical Center side. They command San Antonio Military Medical Center, which is an integrated facility. Key word there is "integrated." Not joint, but integrated.

So we have almost probably 1300 airmen there right now that that's their place of duty every day where they come to work, and provide care across the gamut within our eight ICUs, the only Level I Trauma Center in DoD here in CONUS, and bone marrow transplants, Center for the Intrepid. Of course, a brief you'll get later is from our Warrior Transition Battalion there at BAMC.

We also have the Fort Sam Houston Primary Care Clinic which is located across the street from our Liberty Barracks, our Warrior Transition barracks. We have the McWethy Medical Clinic. We do integrated medical training for all the services here in San Antonio at Joint Base San Antonio, Fort Sam Houston.

So we have airmen. We have Marines, we have Coast Guardmen. Every service does medical training at Fort Sam now under the METC, which is the Medical Education Training Command. And that's headed by Rear Admiral Bill Roberts.

We also have the Schertz Clinic, which is one of our community-based medical homes, as well as the Taylor Burk Clinic which is located out at Camp Bullis, which is where we do a lot of our field training. But we have a lot of our population that lives up that I-10 corridor that get their care there.

So this gives you a visual. San Antonio, you may not realize it, it's the seventh largest city in the United States. It doesn't seem like it to us because it's sort of spread out, but population-wise, it is the seventh largest city in the United States. As you can see, we are almost in a complete circle around San Antonio.

One of the key things that I'll point out is that we do coordinate services with

the Audie Murphy VA, with Ms. Weldon, who heads that system here in San Antonio, and we actually partner with them. We have several MOUs and MOAs with them. We do quite a bit of their cardiac/thoracic surgery. The capability is through us. Many of our soldiers rehab over there at Audie Murphy.

Then we also are partnering with them, as we mentioned before, on primary care and also on our operating rooms. So we are going to be providing four operating rooms to them from our 28 that we have in our system so that we can provide care not only for our service members but also to our veterans. So we're excited about that.

But we are meeting with them monthly. And quarterly, we have a consortium when we meet with the VA and we discuss partnering opportunities and how we can not have so many duplicative services but actually how we can do the most care, whether it's over at the VA or it's over at San Antonio Military Health System or over

at Wilford Hall Ambulatory Surgical Center, or one of our primary care clinics.

And, in fact, if you look at this, you probably notice that we have a little bit of a gap right here. We have a large number of our veterans and our retirees moving to that Leon Springs/Helotes area. We had talked to the VA, and we're going to be partnering with them in the future. We'll probably put a DoD facility out there first. But as we plan that facility, we're going to plan growth to be able to expand to have a VA presence there with us out in Helotes. Because when we look at the growth that we have here in San Antonio of our veterans and our retirees, that's where we see the growth, and we want to be able to partner with them on that.

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

MG KEENAN: Yes.

CO-CHAIR CROCKETT-JONES: As you're increasing your partnership with VA, how are you overcoming like the formulary issues with the

pharmacy services and these seemingly minor but serious obstacles?

MG KEENAN: What we've actually done is we're sitting down with the VA -- just like what we had to do as an Army and Air Force, and standardize our formularies here in our system, we're sitting down with the VA to standardize our formulary with them.

The other issue that we see is, we have TMOP for our mail order pharmacy. The VA has a different system, and theirs is actually easier to use.

And so one of the things that -- we went back to the Defense Health Agency, because pharmacy is a shared service. It's part of the Defense Health Agency. We're supposed to be getting to a common operating company model on pharmacy in the Department of Defense, is that we've said we need to have a system as easy as the VA's system is.

Because when you go in for your appointment in the VA and you get your first fill

of prescriptions, they automatically enroll you into the mail order. You don't have to come back to the facility.

And, as we know, one of the biggest costs that we have right now in the Department of Defense that has really added to the budget is the pharmacy -- the retail pharmacy. So we're trying to recapture that retail pharmacy business back into our direct care system, but also through TMOP. We believe there's some real opportunities with the VA if we could get to one system like they have.

So those are some of the things as part of the Enhanced Multiservice Market lead group. I'm the Lead for that group. Those are some of the issues that we're pushing up to Lieutenant General Robb and the Defense Health Agency, that we believe that that would be a great initiative if we could make it an easier system like the VA's. Where when I visited the North Federal Clinic, I go into the pharmacy. And they have two different systems. They have to do two

different systems. And I didn't see many VA patients there. They were only getting it if they had a new refill.

But there were a lot of DoD patients there getting refills. And they said, yeah, that's our business is refill, because, you know, we automatically just send them to the mail order. We do it for them. We enroll them, and it's pain free for them.

We've got to get to that in the Department of Defense. I think that that's probably one of our biggest challenges right there. But we are working here in the San Antonio Military Health System with the VA to standardize our formularies. But I think the bigger issue is we've got to make it easier for our patients to enroll in TMOP or a similar system or the system of the VA.

COL MALEBRANCHE: That system is a CMOP. I hope, General Keenan, that you're briefing this in Washington because, boy, would they love to hear this.

MG KEENAN: When you go and you're talking to the people in the clinic and you actually see the operation of the North Federal Clinic, you say this is a no-brainer.

Tidewater, I will tell you, has the best practice of how they're working to enroll their beneficiaries into TMOP. They've gotten more enrolled than any of our eMSMs, but it's really labor intensive because you really have to put people out there. My mother is almost 79 years old, and if I told my mother, hey, you need to go online and you need to enter all these prescriptions and you have to -- it's not going to happen. So we've got to make it seamless for our beneficiaries, and I think that that would be a big win, and it would also save money. It would save a lot of money that we could spend on other areas in health care where we need it.

Okay. Just so you understand, you know, this is really the home of military medicine. And I know they try to say that up in the National Capital Region, but I have to tell

you we're producing more care here with fewer people than the National Capital Region. We believe we're the flagship of military medicine here in San Antonio.

And when you look at it, it's about $3 billion direct, about 1 billion indirect economic impact. We have nine military treatment facilities, all those clinics that you saw. Over 12,000 staff members and over 240,000 eligible beneficiaries. Not all those are enrolled.

Now, we're working to enroll more of our beneficiaries because we realize as the number -- you know, thank goodness, that are not -- that are being brought in to our system via Medevac from Afghanistan and places, that number has gone down somewhat. We need to bring our beneficiaries back in so that we can keep current so that we have those skill sets so we're ready for the next -- the next place we deploy. Because it's not if we deploy, it's where we deploy to next.

Across the services, we have to

maintain that currency and ensure that our ICU nurses are taking care of those complex cases, that our OR teams are taking care of those complex cases, so that they're ready for the next conflict.

And that's where we really are focused right now is making sure that our military staff are taking care of those complex case mixes, because that's going to be important because we know the American people are not going to accept anything less than what -- the day we pull out of Afghanistan, we know we've got a 20, 30, 50-year tale of care that we are still going to be required to give to the casualties and the veterans of this war, let alone where we're going to go to next. And so we've got to maintain those skill sets.

We do that well here in San Antonio. We have 37 graduate medical education programs here with almost 600 residents. And those residents pass their boards, have a high percentage of pass of 92 percent the first time.

We also have four CCATT teams. These are our critical care teams that fly that are available on call 24/7 here out of San Antonio with General Hepburn in the 59th. We're the largest DoD inpatient facility. And as I mentioned, we're the only Level I Trauma Center.

Now, what's significant about that? If you say, well, do you generate enough trauma military-wise? That's where a lot of people don't realize we've been in partnership now for probably 30 years with the City of San Antonio and Bexar County and across the southern part of the United States where we have an MOU and we provide trauma care to the civilian population here in San Antonio. That helps us maintain our currency for our beneficiaries.

So if you were watching TV last night here in San Antonio, you might have heard a report about a police officer who was shot in the head. That police officer is in our intensive care unit over at SAMMC right now getting his care.

So there are two Level I Trauma Centers. We used to have three when Wilford Hall was an inpatient facility, and when they downsized, we had to increase under BRAC the size of SAMMC. So now we provide 50 percent of the trauma care, and University Hospital provides 50 percent of the trauma care.

This is significant in our partnership so that we're able to maintain those currency skills with our trauma surgeons, our neurosurgeons who operated on this police officer. The care -- because of the critical injuries, you know, you think about the care he's having to get in the ICU. That would be the same kind of patient that we would be taking care of in Afghanistan in our hospital over there. So we value that skill and being able to provide that service here in San Antonio because that helps us keep our skilled and complexity case mix where we need it.

Also, we have the only bone marrow transplant unit, and we're actually working with

the VA to partner to bring their patients over to SAMMC. We have the only burn unit. And if you go visit the burn unit -- a lot of people don't realize this. We get burn referrals from not only across the United States but also from -- from other countries. So we provide burn services not only to our DoD beneficiaries, but we're also a referral center.

In fact, I was talking with the chief of our burn unit, the Institute of Surgical Research, which falls under the Medical Research and Materiel Command, and they had gotten five members from a house fire. So we will take those patients and provide that care. And, again, that keeps us current so when our service members come in, not only are we doing cutting edge research there and developing new types of skin grafts, but we're also able to keep our skills sharp so that we're ready for that next DoD casualty that might come.

Center for the Intrepid: One of the things that we were talking about --

Mrs. Crockett-Jones and I were talking about, is how do we maintain those skill sets as our deployment winds down? So at the Center for the Intrepid, there's several things we're doing.

We're maintaining our expertise with amputee care, but we've moved beyond that. There is a device that was developed here at the Center for the Intrepid called the IDEO. It is a brace prosthetic system which is -- now we've moved into limb salvage. So instead of having to amputate a limb or somebody that has had to have an ankle fusion that would have to leave active duty, this brace system enables a service member to stay on active duty. A condition before that would have had them leave active duty, they can actually elect to stay on active duty.

Also, they're trying it with stroke victims or people who have like neurological damage. And what we found with this, what it does is, it actually provides support so that you can run. It's a four-week program that they go through. It's a brace prosthetic, but it's a

system. And they train you, and within the first week, soldiers -- and, I mean, it brings tears to your eyes, because there are Soldiers and sailors and airmen and Marines who could not run, could not even walk well, who now once you put this brace on and they train with a team there at the Center for the Intrepid, are able to run.

So now we're at the point where we're partnering with the VA to train their prosthetic folks to be able to make the brace -- because it's made to each individual; it's not an off-the-shelf thing. And then we're also training Walter Reed, Bethesda, to be able to make the brace. We're bringing their prosthetists down here to San Antonio and training them and then training their physical therapy and occupational therapy teams to be able to replicate this service across the United States. So we're very excited about that.

The next step the Center of the Intrepid is focused on is how we rehab our soldiers after injuries -- training injuries,

because we never really focused on that. We'd say go to PT for eight visits or whatever. Now we're going back and looking at how we can work quickly, bring our Soldiers, our airmen, our sailors, our Marines, back to duty faster, similar to what we do with our world-class athletes. You think about the NFL and how they are able to bring back like RG3, you know, the Redskins. He's not playing that well, but it's not necessarily because of his knee. We won't go there.

But similar to a program that they pay, you know, tens of thousands or more to rehab in civilian organizations, we're now focusing on how can we prevent injuries and then how can we bring our service members back to duty sooner and strengthen them and then prevent those injuries later.

We see a lot of ACL tears, a lot of knee replacements and things like that. Those constant wear injuries, those are the kind of things that they're looking at too at the Center for the Intrepid is to actually look beyond --

while maintaining those critical skills for amputees, but to look beyond. So we're constantly looking forward and pushing the envelope at the Center for the Intrepid.

Wilford Hall Ambulatory Surgery Center: Largest outpatient facility, a brand new facility, which will open, we believe, initially in the spring of 2015, and also the largest blood donor center. There's a reason for that. Remember all those trainees I talked to you about? So that's a huge mission there.

We also have the largest centralized appointing and referral management. We have centralized appointing and referral management so that if someone calls in and they have a referral, let's say to an orthopedist, we can ensure that we keep that in our system. And if they live closer to Wilford Hall, to send them down there, or if they live closer to SAMMC, to send them there, but to get them to the best place the first time for their care. And we're aggressively working to improve that every day.

I talked to you about some of the cutting edge innovation and research, and it really, truly is a partnership for us. It's a partnership with the METC, with the AMEDD Center & School, with how we train our young airmen and our medics. They come over to SAMMC and to Wilford Hall to get their training so that they're actually taking care of patients.

And then we partner with these other agencies, with NIH, the VA, the CDC, as well as with academia. We have a very focused group here in San Antonio that's focused on the biosciences and biomed, and they've invested a lot in it. So we partner with them too to ensure that we're offering the latest innovations in care here in San Antonio.

Now, what are our short-term focus? Well, as I said, we're in initial operating capability on 1 October, and then we have been tasked by the Defense Health Agency that we have to recapture $237 million in health care over the next five years. That's a very robust goal we

have, but we believe we can do it. We believe we can have cost savings, and at the same time, more importantly, that we are putting our patients first throughout this and ensuring that they get the quality of care that they deserve.

We also are looking at metrics. You know, we're trying to get away from metrics that say, you know, how many visits did you have, how many times did you see your PCM, and get more to outcome-based metrics. And that's what's key for us. Did the patient get better, did their health improve, how are they able -- you know, for our wounded, ill, and injured service members, how were they able to transition and how do we measure that in outcomes, not just the number of visits, which really doesn't do that.

And then as part of this is continuing how we're building our relationships with the VA. I can truly tell you, and I think Byron will tell you the same thing, what we've been able to do as the San Antonio Military Health System -- not separate commands of the 59th and

BAMC, but what we've been able to do as a system with the VA and the collaboration has made a true difference for our veterans and for our service members here in San Antonio because we're now talking on a weekly, monthly, sometimes daily basis in how we collaborate with their care. And that I believe is key.

And then long-term is full operating capability. We're supposed to be at full operating capability in the VHA by 1 October 2015. As I said, we get these enhanced authorities officially on 1 October 2014, but we're moving out as quickly as possible to start those coordinations, especially when you talk about the budget.

And then the other thing that we are really seeing as an eMSM is being able to look at not necessarily best practices, but Dr. Goss will tell you the proven practices, to look at proven practices about what works. And, for instance, here in San Antonio, we had a number of our beneficiaries that would go visit an ER out in the

community. Well, then they would just get admitted there. So what we've done is we've set up a transfer cell so we can make sure we bring those beneficiaries back to our facilities if it's prudent with those providers. And so that was a best practice we learned from Balboa.

So we're bringing those beneficiaries back into our system to get their care so we can ensure continuity of care, and it's going quite well. We started this in late September, early October, and we've had probably close to 70 folks that we've been able, through a soft introduction to our civilian partners, to bring back and transfer in. And we go out 300 miles, and we will go pick them up.

So what we found is that by educating those Methodist, Baptist, Christus Santa Rosa, even the University of Texas Health Science Center in Houston, they've actually sent our beneficiaries back to us so we can provide that continuity of care. And that's really good for our beneficiaries.

And then, you know, we talk about this in the Department of Defense, transitioning from a health care system to a system of health. That is critical to us, is that we start to educate our beneficiaries about the -- you know, the consequences of nutrition, activity, and sleep and how we balance that and what our responsibility is as a beneficiary to look at those things and what we can prevent, and build resiliency, not only in our service members, but in our families too.

So we have the Ready Resiliency Campaign in the Army. We have the Healthy Base Initiative as part of the Department of Defense where we've got some pilot sites. We're actually going out and looking at how we provide, you know, nutrition. You know, going into our commissaries, I was in the commissary yesterday. So I'm in the commissary at Fort Sam, and it's like walking a gauntlet on either side. As you're pushing your buggy to get to the queue to -- it's just candy. Piles of candy and everything like that. And so I

look around, and here's a gentleman with a six-year-old pushing in the buggy. And what's the kid doing? "Hey, Dad, can I have that? Can I have this?" So it's really making us aware of how we think about our health and healthy choices.

And we think that that's very important as we move from a health care system to a system of health is to really start to focus on the prevention side and still provide those critical things that we have to do as far as combat casualty care, but to get our population focused on what we can do to be resilient and to be focused on prevention.

So a big order that we have here in our Enhanced Multiservice Markets across the six Enhanced Multiservice Markets. The one here in San Antonio, as you can see, is a true partnership. If you notice at the bottom, our motto here at the San Antonio Military Health System is, "Patients First, Partners Always." I don't make a decision without Byron, he doesn't make one without me, because we realize the

importance of what we have to do in coordinating, and our patients are always first. That's what's key for us here in San Antonio.

And I think that's my last slide. And so what we do is we'll put it up for questions. So any questions that you have, please let us know.

Yes?

MR. REHBEIN: If I may, ma'am. We're moving into a period of many more females moving into the physically intensive parts of military service. Are you seeing differences, or is your work able to feed back into designing training programs to prevent injuries? Do you see differences in what's needed in rehab programs to recover from injuries based on male and female body differences?

MG KEENAN: Well, I can tell you that the Medical Research and Materiel Command is part of AFRIMS, which is their lab that specifically looks at that. In the Army, they're working with TRADOC to actually look at what kind

of exercises that we need to be training, specifically our females on, but also our males on, and I'll tell you one that is critical is core.

And one of our number one conditions that we see among all of our service members as far as the DoD is lower back injuries, and how do we prevent lower back injuries. And one of the things we found is that when you look at our physical fitness -- and we'll be doing physical fitness -- we haven't always been good about really building that core strength.

And so that is a focus area that we're working on that -- MRMC and U.S. Army Public Health Command is partnering with TRADOC on to build those exercises in, and then they're pushing them out to the units through our master fitness trainers as well as our physical therapists are trained on those as well.

MAJ GEN HEPBURN: If I could add on to that. What we are doing with our basic trainees here in nutritional medicine, a very

clear focus on prevention, with the nutrition and vitamins we're giving them to treat stress fractures. A lot of focus on female health and wellness.

As a segue, as far as talking about partnering, you know there are a lot of female veterans that are still in the obstetrical years, and we're delivering them over at SAMMC in a partnership. So it's a nice synergy here in San Antonio.

DR. PHILLIPS: Thank you. Obviously, I mean, it's very commendable you've integrated into the whole community. That's just wonderful beyond words.

Along these lines related to budget, I'm sure you have a number of civilian contractors that you use, and how will our budget system -- I mean, do you have any predictions of impact on that?

MG KEENAN: Yes. One of the things that we've seen as we're looking at our staffing, particularly at SAMMC where we have a large number

of our contractors, what we're actually doing is we're working with the Air Force and the Army because we've identified that at some of our smaller places our nurses, our doctors, our OR techs are not getting the complexity of cases they need to deploy. And that concerns us.

So what we've been directed to do is to look particularly at our contractors and who's doing the work. What we found at San Antonio Military Medical Center in our ICUs -- our eight ICUs, the majority of the ICU nursing care was not being done by somebody in a blue or green uniform, it was being done by a contract or a civilian.

So we're targeting first those contracts. We have to have some civilians for continuity of care because when General Hepburn has his CCATT teams, and they have to be available 24/7, and, you know, when they're not flying a CCATT mission, they're working in an ICU or in the emergency department, we have to be able to have our civilians there to provide continuity.

But what we're doing right now is,

we're doing our capital distribution plan for the services. And, in fact, the plan is in June we're going to do a joint one, which we've never done before, in the services. We're going to be able then to distribute to make sure that we have our military people working in those high-volume areas like San Antonio, like Joint Base Lewis-McChord, like the NCR, put more of our military personnel there so that they're going to have the skill sets they need. That will help also bring down those contract costs.

But that will ensure that our medics, our nurses, our airmen, they're ready to deploy, because that's critical. Right now I can tell you, because I have the southern region of the U.S., so I have Fort Polk, I have Fort Sill; my surgical teams in the OR at Fort Sill and Fort Polk are not getting the same quality of case complexity that you get every day over here at San Antonio Military Medical Center.

And so that's one of the things as -- across the services, across the Defense

Health Agency and our three Surgeon Generals have recognized that, and we are working to move those teams, because it's really a team. You know, you can train your surgeon, but if your nurse anesthetist or your OR tech aren't trained at that same level, it can cause a clink when you deploy.

So we want to make sure that they are ready, that they have the case complexity and mix, so we're actually looking at that. And that's going to actually help us get to the reduction of those contract personnel.

CSM DeJONG: Furthermore, I had a note on that also. Maybe this was what Dr. Phillips was getting at -- maybe it's not -- with bringing the civilian patient load into these facilities, how does that affect the budget?

MG KEENAN: We actually do get reimbursed. So if they have third-party insurance, we go after that reimbursement. And we do quite well with that. And you notice I said when they have third-party insurance. There was actually legislation several years ago by the

Senate Appropriations which actually gives us a reimbursement for those indigent patients.

Because that was a bit of a bill for us here in San Antonio, and that included when Wilford Hall was a Level I Trauma Center, that we were taking in a huge bill. That was taken back by the consortium in San Antonio, that there was a value here because of the training, we needed to take care of our military members. And so we do get reimbursement for that.

Is it as much for when we have a third-party; no, as an indigent patient. And unfortunately, we do have a very robust knife and gun club here in San Antonio, which generates quite a bit of our patients. And a lot of them do not have insurance, but we do get some reimbursement for that.

And so we balance that with the understanding that for our Graduate Medical Education programs, that they're getting a case complexity and the type of cases that they need to be proficient, and that's key for us. So it's a

balance, but we do get reimbursement.

MAJ GEN HEPBURN: Another key is that part of that is done with federal moneys, but there are state moneys that go to both University and to SAMMC.

Along the same lines, there's two trauma centers -- Level I Trauma Centers here in San Antonio. One is SAMMC, the other is University. And we leverage them in a big way. We have Air Force nurses over there training -- some day there will be Army nurses too -- both in the emergency department and in the ICU for the trauma patients. So it's a win-win here in San Antonio.

COL MALEBRANCHE: A couple of questions. One with regards to the IDEO brace. You mentioned the VA prosthetists are being trained on that. Is that just local or across the country? Because I know there was an issue of us bringing veterans always back to San Antonio, and so is that now more widespread?

MG KEENAN: Yes. They're actually

bringing them from Washington, D.C. down to train. The VA is actually sending their prosthetists from Washington, D.C. down to train.

Because that was the whole issue because the key to the success of the IDEO brace is getting that four-week training program. You can't just like hand it to somebody and say, hey, go out and run. There are specific, you know, physical exercises. And in talking to them about it, in some cases, these are people that haven't been able to run for several years or walk without a cane or some kind of a brace to even walk. So it's as much the mental preparation of it and being in a group of others.

And it's very interesting when you see the group come in, because everybody comes in at different times, but just from a command sergeant major that was in the program that I met to a PFC and, you know, the tears in their parents' eyes saying, "Wow, you know, I never thought they'd be able to do that again." And for them not to have to make that choice -- because

many of them were at the point they were saying, "You know what, I would rather you amputate that limb so that I can have a prosthetic device so that I can run again," because for many of them, being able to get up and exercise.

And one of the things we've seen too -- one of the issues we see a lot with some of our amputees, or if you haven't had your limb amputated yet, is because they can't do the physical exercise because of the instability of that limb, they tend to gain weight, their muscles atrophy.

And what we've found with that brace is now they can safely get back into shape. They lose the weight, which reduces the stress on the joints. It is just truly amazing.

COL MALEBRANCHE: But there will be opportunities for other prosthetists around the country, not just the National Capital Region.

MG KEENAN: Right. Well, actually, what's interesting, the gentleman who actually developed the brace was a prosthetist here at the

Center for the Intrepid. And he actually gave the patent rights to the military, and he has since moved back to Upstate Washington because his family's from there. He moved back home, and he's working with an orthopedic company. And so, yes, it's going to be promulgated across the civilian sector too, which is exciting.

From what we've been able to see with the use even in our stroke patients, to see someone with a stroke who could not move one side of their body who can now use this brace and is running, is so liberating for them. It's just amazing, and it changes their whole mental, you know, outlook and gives them hope.

And so that's one of the things, to be able to spread that, but he actually did give the patent to the military, and you're going to start to see it being produced across the United States.

But the key point that we keep stressing is, you've got to have the training piece. It's just not like an off-the-shelf brace.

They do a mold specifically to you, and then you come back and they fit you for it and then they train you with it.

COL MALEBRANCHE: I went to Bethesda and I saw where they were doing a different kind of a hot carbon mold for the other leg to make them kind of equal, so that's kind of interesting.

The other piece is here at the METC, where you're doing training with UTHSCSA folks and also including the Navy, are you also making sure -- I was just thinking equity across the services would be one thing, but with the civilian sector as far as licenses, credentials, that sort of thing? Because when we look at the intermediate care technician from North Chicago, one of the things is to get people jobs as they transition out. The VA does require that you have licensure if that's what the professional organization requires.

And one of the things -- looking at SAMMC, what a perfect place where you're getting all this education, how those prerequisites as

part of your training so that when you are ready you have a skill that is also marketable. Is that occurring or is there some different -- I know there's so many different programs. I don't know where they're all at.

MG KEENAN: Well, let me put on my Chief of the Army Nurse Corps hat. Okay? One of my other hats.

One of the things the three Corps Chiefs from the Army, Navy, and the Air Force, that we were tasked to look at is -- exactly look at that for our medics. And particularly they can be LVNs or LPNs. Right now in the Army, we have an LVN program -- LPN program in the Army, and so we license our 68 Charlies. We're going away from Whiskeys with a Mike 6 to now we're going to be a 68 Charlies again. So we're going back to that, but ours are licensed. In the Air Force, the 4 & Os have the same training, but they're not licensed.

So this became an issue for us that was brought to us, particularly here in

San Antonio, but also at Landstuhl, in the National Capital Region, Tripler. We said, okay, we'll get to a level of competency.

So we've been in discussions with the Air Force with Major General Ediger, who is the Deputy Surgeon General for the Air Force, also with Rear Admiral Gil Roberts, who's in charge of the METC, about how we could get to a licensure for our 4 & Os.

And that's something the three services are working on, because we realize right now when a 68 Charlie leaves active duty, they have an LVN license. They can go out and they can get a job. We also realize that in our patient center medical homes, the requirement of the standard is you have LVNs.

And so one of the things we're working with the Air Force on right now -- and we're going to get a brief in January from the Task Force. We have a Task Force of the three services with senior enlisted advisors that are going to come back to us and talk to us about

competencies and recommendations.

But one of the things we've been talking to the Air Force and the Navy on, the Navy's interested in partnering in the LVN program that we have here for the Army for their corpsmen. The Air Force is considering it. And so that's one of the things that we're trying to get to where we can actually offer them a license.

There's another program that the Air Force is working on right now with St. Philips College to also bridge to get them the educational credentials that they would need to be able to challenge their licensure exam. But that is something that we are working on. Because right now, you know, if I don't have that license, it's very difficult when I transition to the civilian sector without that license. But that is a challenge that we've identified as part of the Enhanced Multiservice Market. And we've actually elevated up to the Defense Health Agency and been tasked to the Service Nurse Corps Chiefs to work on.

Do you want to add anything?

MAJ GEN HEPBURN: That was a good summary. Again, I would just say that we are doing everything we can to mitigate the differences in policies between the services so that our technicians are ready to go into the world. But this will go along when we come to some standard. I know Admiral Roberts at METC is doing everything he can with his Army and Navy colleagues to make sure -- and Air Force colleagues to standardize the tech training across all the disciplines. The more we're standardized, the better off it's going to be.

There will be some service uniqueness, for an IDM TU, or whatever, on a submarine, but overall, we should able to standardize more. Thank you.

CO-CHAIR CROCKETT-JONES: I have a question for you. Actually, I have two. When we were at Walter Reed, the intention among the leadership was for joint services, but there was perception among both folks who were service

providers and users, both family members and wounded, ill, and injured that we spoke to, that there was a bit of territorialism that existed persistently.

And I'm wondering how you're sensing your region. I have another question, but I'll wait after you talk to me a little bit about that.

MG KEENAN: Okay. One of the things, I think -- and Byron, as he said, he went through the Kubler-Ross stages of grief with the BAMC command and then with the 59th because it is -- I mean, it is hard. You know, I showed up in June, and I'm like, okay, let's go. Let's all work together. But Byron and his team and Ted Wong, who was here before me, and Joe Caravalho, they have really worked to brand San Antonio Military Health System. And you'll see things with the 59th on them, you'll see things with Brooke Army Medical Center on them.

But what we really try to stress with our staffs is that we're all in this together, and we are there to take care of the

patients. We're taking care of America's sons and daughters, and at the end of the day, that's what it's about. And, you know, we're adjusting every day on how we integrate and work together.

And I think now that the eMSM, which superseded the BRAC requirement that we consolidate and we integrate, we had all of our senior leaders in strategic planning last Monday and Tuesday. And we started off the training. We did four hours of Arbinger training, and it's leadership and self-deception, getting out of the box. And it's making you aware of how you see yourself and how you see others. And are you about what you can get from somebody or what you can give to somebody?

And it was amazing. After we did even the four hours training, we're going to continue the training because there are actually military assets located here in San Antonio that provide that training. I had people that came up and said, wow, it made it so much better when we went into the Strategic Planning because now we

are using a common language.

And General Hepburn and I were talking about this. We've had people coming up to us and they're saying, "You know, I was so in the box about this or how they were doing this, and now I understand that it's I'm in the box. It's not them, it's me, and I've got to think about how I'm cooperating."

So we did that, which I think is going to help us. But a lot of it -- I have to give credit to General Hepburn and the staff that stood up two years ago. It's just hard work because we do have different cultures. But if you don't get to the cultural piece, the culture will eat strategy. You can have all the strategic planning in the world, but if you don't get at the culture piece and say why are we really here and what are we here to do.

You know, we understand. We're in Bagram. I was in Bagram last December, and you've got Army and Air Force, and everybody's working together, you know, could care less. But what is

the difference then when I'm in Bagram and when I'm back over here at SAMMC or at Wilford Hall? What is the difference?

And that's what we have to -- where I think the issue becomes is more at the senior level and in that senior management level, not really the people that are providing care every day. It's really us. We have to model that for our young airmen, for our young Soldiers, and our civilians to say, we're all in here taking care of patients together. And it doesn't matter what color uniform you're wearing. We realize, you know, we've got to learn the ranks. We have to understand each other and the rank process. And the officer's side, it's easy, it's the same. But we have to understand our enlisted members' ranks and what those positions mean and understand culturally what that means.

But it has -- it's been an effort, but I give total credit to General Hepburn and to General Wong for working it. Is it perfect every day in our facilities? No. You know, you can say

I was out in Colorado and I've got some of that medical stuff or whatever, but I will tell you that it gets better every day because we model it. We're truly partners. And that's how we introduce each other, that we're partners, we're in this together because we know the survival of the Military Health System is dependent on us. And we want to make sure that it's going to be there for the future for our sons and daughters that are going to serve in subsequent conflicts and wars. We want to make sure it's there for them too.

Do you want to add anything, Byron?

MAJ GEN HEPBURN: Great summary. I would just say, you know, in two minutes. What we talked a lot about two and a half years ago was, you know, you repeat Kotter from Harvard, leading change it's two to seven years running high-performing health system or industry with partners that are really engaged.

Now, we've made big headway over the last several years. I'm glad that the Sergeant Major is here because our NCO leadership is a key

part of this. It's a really key part of this.

And what we're doing now, the Army has the honor of commanding an integrated medical facility and they are doing a great job of that, but what we're in -- this is where we're going with this. The sense up in Washington is, like General Keenan said, down at the midlevel and lower levels, nothing through the leadership positions, so we have developmental opportunities, is probably where some of that tension can come in behind closed doors. If you walk through the halls of SAMMC, just like General Keenan said, patients are number one. We'd never compromise that. Behind closed doors, we'll work out who is going to be the OIC and who is going to be the NCOIC. And that's where we're maturing the structure over there so that everybody, both Army and Air Force, and maybe some day Navy, will have developmental opportunities.

CO-CHAIR CROCKETT-JONES: Thank you. And I can say, by the way, you're right. It was about opportunities. But it was also space

acquisition with another place where folks sensed a territorialism; who was getting what space for what offices and programs. So just as a ...

MAJ GEN HEPBURN: I tell you what, I'm glad General Keenan said it. A lot of it is the leadership, NCO and officers, and the tone. And I'm going to brag on one my USU classmates, Jim Ficke, an Army Colonel, just retired. He's now Head of Orthopedics at Hopkins. He set a tone of teamwork from day one. He's a West Point grad, I think he's got a Ranger tab on. But it was all about the team. And that permeated that whole ortho department.

So there were some spots where we need to move forward even better, but I would say overall it's pretty darn well hard-wired right now and it's getting better.

CO-CHAIR CROCKETT-JONES: Good. I have another question for you.

As you were talking about an increase in pulling in beneficiaries and the fiscal opportunities in getting civilians into the

system, what's going to emerge as a way to maintain preference for wounded, ill, and injured to get front line status and stuff like that in medical opportunities?

And it's just a concern for me. I understand the need. When I hear about more people being drawn in, my concern is that we still shuffle those folks who are in transition either back to duty or transition out, you know, to be getting front-of-the-line care.

MG KEENAN: They will always be at the front of the line, and that's our policy is always be at the front of line. And they are our prime beneficiaries, they will always be first. Our active duty is our priority; wounded, ill, and injured service members are our priority. They will always be at the top. And we only bring those other beneficiaries in as we have space to take care of them.

But we would send -- so a TPlus, someone that's over 65, downtown for care, let's say for a surgical procedure. They would not have

the same priority as our wounded, ill, or injured service members or active duty service members and their families.

CO-CHAIR CROCKETT-JONES: Is it policy?

MG KEENAN: Yeah. And that's how TRICARE works.

But what we do want to do as we see fewer amputations and things like that. We do need to be pulling in more joints. So one of the things we've done is, we've started to market to our over-65 population who needs joint replacement, because we need to have that skill set. We don't want to lose that skill set. We have marketed them to bring them back in to have right of first refusal for their care.

So we get to look and say, can we do that surgery, do we have space to do that surgery? If we have space to do their surgery, we're going to bring their surgery back in. And we partner with the VA on cases like that too about what cases can we bring back in either to our system or

to their system, because it's federal dollars; and what can we do to best utilize our federal dollars and our providers to make sure that we're providing that care within our system. Because it does provide that continuity of care.

COL MALEBRANCHE: One thing that I was wondering about as far as your capacity and your abilities here -- because Texas has a lot of rural areas, people traveling, I don't know if you're allowing in mental health or how are you doing in the mental health arena in support to that population of Wounded Warriors?

MG KEENAN: Okay. We do have Telemental Health here in San Antonio that we provide. We have a cell here at Southern Regional Medical Command of 18 providers that provide Telemental health. And then we partner with -- the VA, also has a robust capability for Telemental health.

Where we see our biggest challenge right now, honestly, here in San Antonio, we have an inpatient acute behavioral mental health unit

at SAMMC. The VA also has a unit at Audie Murphy. And when we become full at SAMMC, we actually send our beneficiaries -- our active duty beneficiaries will go over to the VA until we get space to move them back over to SAMMC.

One of the growth areas where we see a large leakage out to the network is in residential treatment facilities, so when we think about drug and alcohol, and a lot of our Warriors, it's a combination program, a dual-track program that they need, PTSD as well as substance abuse.

So right now we refer here locally. One of the large facilities that we use is Laurel Ridge. We also use those for adolescents. We have quite a bit. And we know adolescents, behavioral health is a huge issue across the United States.

One of the proposals what we are building as a health care system right now is to actually build a residential treatment facility within SAMMC. We actually have the bed space to do that. So we're looking to do that so we could

bring those beneficiaries back in, as well as using an intensive outpatient program to bridge, because we know that that's important. When we look at a system of health for behavioral is to be able to have those entities for our beneficiaries.

But we work closely with the VA on behavioral health to ensure that if there's a capability we can't provide, especially inpatients where we've had issues, that we can reach over to the VA and they'll take our patients. Because we believe it's important to keep them in our system, especially for our wounded, ill, and injured service members.

COL MALEBRANCHE: Thank you.

CO-CHAIR CROCKETT-JONES: Everyone good?

Okay. I want to thank you very much. Lots of good information, lots of ideas that will be generating discussion here among the Task Force. Good to see you again.

MG KEENAN: It's good to see you again too.

CO-CHAIR CROCKETT-JONES: And I think we have time for a brief five-minute break before our next presenters. Thank you again.

(Whereupon, the foregoing matter went off the record at 10:55 a.m. and back on the record at 11:07 a.m.)

EXECUTIVE DIRECTOR DAILEY: So, ladies and gentlemen, may I have the Task Force members return to their seats, please.

CO-CHAIR CROCKETT-JONES: Mr. Alex Barberena, Deputy Director of VA/DoD Medical Sharing, and Mr. Mark Goldstein, the VA Liaison at TRICARE Regional Office-South, who are discussing DoD and VA Formal and Informal Agreements. They will be presenting information on the types of formal and informal agreements between VA and DoD. We have information under Tab B in our binders.

I'm going to turn it over to you.

DEPUTY DIRECTOR BARBERENA: Okay. Thank you very much. And thank you very much for the invitation to San Antonio. To be quite

honest, I was excited when I heard this. I thought there was going to be warm whether while I was was down here. That, obviously, has not been the case but I will tell you it's worse in D.C., so I'm still glad to be here. And I appreciate the opportunity to be able to talk about what I think is one of the exciting programs and smart programs that we have between VA and DoD.

So to get started -- I mean, by the way, with me is one of my team members, Mark Goldstein, who is stationed here in San Antonio. He is part of our VA staff, part of the VA/DoD sharing team. He is located at the TRICARE Regional Office South and liaisons with DoD whenever we have any issues. And we have three team members, one in each TRICARE regional office and in the system.

Okay. Let's get started. So looking a little bit at what we're going to talk about today, I'd like to provide you with a general overview of our sharing program. The VA/DoD Share Program. I would like to discuss a

little bit about the laws that provide us the authority to share with DoD. We'll touch a little bit on the TRICARE agreements and models of sharing that we have. And most importantly, I'd like to be able to address your questions that are there at the bottom. And as we go through the presentation, I think we'll be able to do that.

So we all have our vision and mission, and our program is all about collaboration between VA and DoD. So through this, we hope to enhance the overall health care experience of all our federal beneficiaries. And we propose to do this by promoting the sharing of medical resources between the two agencies.

The laws that allow us to share, that provide us that authority, are based in Public Law 971-74. It directs both the Veterans Health Administration and DoD to oversee the opportunities for sharing of medical resources between the two agencies. This is then codified in Codes 38 8111 and 10 1104 of the U.S. Code. And what this does is basically provide for the VA

and DoD to be able to work together sharing of health care resources between the two agencies.

We focus our efforts primarily on two types of sharing agreements, both local and national. I'll talk about the national ones in just a little bit.

So let's take a look at the local ones. So local, or direct sharing as we like to call it, is a sharing activity between two local organizations, a VA and a DoD facility. The heads of the two facilities agree to what services they're willing to share. Reimbursement is direct. That's where we get the direct sharing from. It's paid from one local site to the other, or it can be a barter -- a bartering system, in which case there is no exchange of funds.

The image that I've attached there is the sharing agreement that's used. Both VA and DoD use the same form. And it simplifies that effort. It's a fairly quick form to pull together. It draws out the information that is needed to document the services that are going to

be shared, and I think it facilitates the effort for the folks who are involved in that.

Throughout the U.S. we have -- yes, sir?

DR. PHILLIPS: Just one real quick question. Does this include credentialing of personnel? Can you move personnel back and forth?

DEPUTY DIRECTOR BARBERENA: We do. Yes. I'll show you a little bit. I'll give you an example of that in just a little bit.

DR. PHILLIPS: Thank you.

DEPUTY DIRECTOR BARBERENA: Right. So throughout the United States, we've got about 200 active sharing agreements. And there's an approximate there because these are actually live. Every day we're having some services that are no longer needed, or we've gotten to a point where there's no more capacity, so we fluctuate in that number.

But generally, the sharing activities are taking place between 59 VA medical centers and 38 military treatment facilities which

are providing health care services for veterans.

Something that I do want to tell you with respect to this. There have been as many as 400 sharing agreements in the past. There's a downward trend in this, simply because we're moving from individual sharing agreements for every specific service that we had to a Master Sharing Agreement. Again, we're looking at how can we facilitate this effort so that it makes sharing easier. So we have a Master Sharing Agreement, and underneath that we can have addendums for the specific services that are being shared.

And this becomes especially important. As you see the last bullet there, these agreements -- within a 30-day notice, they can be terminated. So we don't want to complicate this too much. And this Master Sharing Agreement, serving as an umbrella in an area, really serves a good purpose for that. But this is actually a good move for us, these master sharing agreements.

So in FY13, you can see VA has

purchased $119 million for services that have been rendered to veterans by DoD, and DoD has reimbursed VA about $89 million for services to DoD beneficiaries.

We also have 11 joint venture sites, and one of those is the Federal Health Center in North Chicago. These sites are locations where sharing has been really finessed. These folks have a local executive committee. They share both ancillary and specialty services. They share training and education. They point to improved access and continuity of care --

(Interruption.)

DEPUTY DIRECTOR BARBERENA: The range of services that they share are listed there for you. As you can see, it's everything from graduate medical education to laundry to cardiology, very specialized services. So it really is what these sites have capacity to share --

(Interruption.)

DEPUTY DIRECTOR BARBERENA: I like

this graphic. While it looks a little busy, I think it helps you to visualize the sharing that takes place. Basically, I love the fact that we have a pointer. This is the way it operates when the two facilities -- the two local facilities are operating separately. So you can see we have VA on one side, DoD on the other, and operating separately.

As sharing begins here in the second column, we see that beneficiaries of VA are able to refer to DoD or vice versa --

(Interruption.)

DEPUTY DIRECTOR BARBERENA: All right. So we have sharing beginning to take place here in column 2.

Column 3 then takes it a little bit further where they're collocated and we are actually sharing ancillary services.

Column 4 takes it a step farther yet, and here we are sharing -- in addition to ancillary, we have collocated or co-occupancy, but they're also sharing specialty services.

And finally, at the end here, column 5, we have the fully integrated facility. And I gave you an example of that at North Chicago. Down at the bottom you can see some of the facilities that are some examples of the kinds of sharing that are taking place here.

So, like I said, a little bit busy, but really a good graphic to explain some of the sharing activities that are taking place.

I mentioned that we also have national sharing activities taking place. I've provided some examples for you here. The reimbursement in these cases all vary by the terms of the individual agreements.

The top two here are reimbursed through TRICARE. This is the polytrauma care for active duty with spinal cord injuries, traumatic brain injuries, and blind rehabilitation, and the IDES which is also reimbursed through TRICARE.

The next two are examples of where the agreements are reimbursed, in this case through the pharmacy contractor -- the TRICARE

pharmacy contractor, or the TRICARE dental contractor. Then we have an instance here where VA is directly reimbursing DoD for the services that are provided under the Allergen Program. Here we have VA medical facilities all sending their extracts to Walter Reed in Bethesda. They're providing the results of those tests, and VA is reimbursing DoD directly for that.

We do have other collaborative activities. An example would be the purchase of prosthetics where we see some economies of scale there.

A little bit of a different kind of national agreement is one where VA actually negotiates with the TRICARE managed contractors. Here we have VA participating as a TRICARE network provider. Every VA in the United States is a TRICARE network provider. As capacity exists, we can accept TRICARE beneficiaries for care.

So here we have some of the benefits that those agreements provide. Continuity of care, the provision of services that may not

otherwise be available at a military treatment facility. These are usually specialty-type services. And we also have a streamlined process for referrals and authorizations as an example.

The reimbursement in this case is negotiated directly with the managed care contractor. In the south area, we have Humana. That's who we've negotiated with here. In the west, we just finished negotiating contracts earlier this year with United Health Care as they transition into the role of managed care contractor for the TRICARE west region.

So you can see FY13, TRICARE reimbursed about $62 million to VA for care provided to DoD beneficiaries.

Here I just wanted to show you a little bit of how the TRICARE map overlays over the VISN, the VA regions, if you will. Veteran Integrated Service Networks.

So the blue area is TRICARE north. The yellow area is TRICARE south, Humana, so Health Net in the north, Humana in the south. And

as I mentioned just a little while ago, United in the western region. And the numbers you see there are the VA VISNs. They don't line up, so it's kind of difficult to do a direct overlay, but that gives you an idea.

So some of the benefits here that we see of sharing. We've recaptured care. You heard General Keenan talk a little while ago about how important that is to recapture some of that care that is leaking out into the communities.

We look at economies of scale. We realized some of those by combining other services with our partners. We realize enhanced clinical currency through increased patient mix and complexity, which becomes very important. Combining of services for Graduate Medical Education, also very important, and increased training opportunities while reducing costs. So a quick glance at what we see as some of the benefits.

Hopefully through this we've answered your questions. The answer to both of

those is yes and yes. And in the case of the latter question is yes. Throughout the United States, we have national sharing agreements, and as I mentioned specifically, we have local sharing agreements as well. So that's a quick glimpse through the sharing program.

I'm open to your questions.

COL MALEBRANCHE: I think it's important to note on the one slide where you talk about North Chicago and joint ventures, that North Chicago is the only integrated -- completely integrated facility, and that is a legislative piece. And I think the Task Force did visit North Chicago, and that has a unique budgetary situation in that it was legislated and there's a treasury fund, so that's very unique. This office happens to fall under my purview, so I thought it was important that you note that piece, because North Chicago is an unusual one.

And to show all the other various levels of collaboration and all the other joint ventures, they're not all the same, they're all

labeled joint ventures, but they're significantly different from one to another. And they're usually instigated at the local areas, and they bring them forth. And the Health Executive Committee has been overseeing that. But North Chicago, again, is very significantly different and the only integrated.

DEPUTY DIRECTOR BARBERENA: That's a great point. I actually had that question a little bit earlier because I saw the Federal Clinic here in San Antonio, and I asked Mark if that was the same type, and it really isn't. While they are collocated, they operate differently and DoD sees DoD patients and VA sees VA patients. But it's not fully integrated like North Chicago is, so that's a great point.

COL MALEBRANCHE: We use the term "federal," but I think we don't always definitize what "federal" means.

DEPUTY DIRECTOR BARBERENA: You're absolutely right. Thank you.

DR. PHILLIPS: I'll just make a

comment for the record. The previous presentation and your presentation are really part of my bucket list. I mean, I would just love to see -- forget what's in a name, as Shakespeare said. This harmonization of integration, I think, is absolutely the way we have to. And, again, on my wish list is to have all the facilities, VA, DoD, be called a federal health care facility.

And I would even take it one step further. If you have civilian facilities that want to be part of this, they can apply and be certified as a federal health care facility. I mean, it puts the Military Health Care System, the VA Health Care System in the driver's seat, and it also allows integration of all three systems which are being used, as we know statistically, by veterans and so forth.

So that's just my comment for the record.

DEPUTY DIRECTOR BARBERENA: Right. And I appreciate that, because that's why I say this. This is one of the smart programs that we

do have between our agencies and makes it really exciting to be able to work with these things. And also because they're so different.

Just as Karen mentioned, each one of them is just a different opportunity. They're great people, really innovative thinkers. You would think, well, these are just regular services that are being traded here in some way, but really how, you know? We, in some cases, are sharing staff; in some cases, just sharing a building. But it's really providing for that collaboration, which I think is important, and certainly those are important first steps.

And when it gets to be really humming, if you will, is where we have some of these joint venture sites, and they really have it very well finessed at that point.

DR. PHILLIPS: I've worked in all three systems in my practice, and it really works very well. It works well at every level; patient level, staff level.

DEPUTY DIRECTOR BARBERENA: I saw

another hand back there. Yes, sir?

MR. GONZALES: To address your comments, my name is Edmundo Gonzales. I'm with the Assistant Secretary of the Air Force for Manpower and Reserve Affairs, and we are responsible for the Wounded Warrior programs.

At Travis Air Force Base, I saw probably the most unique collaboration that I've seen, which was for an acute mental health facility. Very specialized people who were in real trouble. And the relationship is between the VA and the DoD through the Air Force and the five-county region. So we were not only sharing the facility, which is very specialized and very expensive, but the subsidization of sharing the cost made it possible. But we are also staffing it, which was unique, from the three organizations.

And my sense was that we could be doing that throughout the country with these specialized kind of groups.

DR. PHILLIPS: I appreciate that.

There are models everywhere that make tribute to that activity.

CO-CHAIR CROCKETT-JONES: I have a question for you. In looking at your slide briefly, the local sharing agreements. Local agreements have the potential for suspension, being a 30-day time frame. What exempts the national agreements from that kind of suspension? If they are under it -- what is the move to raise agreement to policy level positions that would eliminate rapid suspension/disruption of sharing?

DEPUTY DIRECTOR BARBERENA: At the national level, it works a little bit different, so there's a little bit longer lead time there on those national agreements. Usually a 60 to 90-day period. So not a whole lot longer.

But yeah, it is one that troubles us a little bit too, but -- it has gotten in the way occasionally, but not tremendously, I would tell you.

And it is good in another sense, because when we want to start up sharing

activities, we can also do it very quickly. So we can ramp up or ramp down rather quickly.

And what we see is that these facilities, because they have priorities -- DoD has priority over the DoD beneficiary and VA has priority over the VA beneficiary, we can, you know, prioritize those as we need to so that we're not displacing those beneficiaries.

I believe it goes along with the question that you were asking a little bit earlier with regard to the civilians, but in this case, they are both federal beneficiaries.

It's a two-way street, of course, but it really hasn't gotten in the way tremendously, I would say.

Have you seen anything different? I turn to Mark. Mark, by the way, before coming to work with us, he was involved with the sharing activities at the VA here -- the VA Medical Center here. So he might have a little bit greater insight into that.

MR. GOLDSTEIN: Actually, I had two

examples of a situation where we did a sharing agreement thinking it was going to be a long-term, but really, on the blind side, it really wasn't going to be. One of the reasons was our cardiac cath lab -- we had two of them at the VA, and we're going to renovate both of those, not at the same time. But we took one offline to do, and while we did that, we sent patients over to Wilford Hall in that four- or six-month time frame. So that was one time where we did just an agreement -- a three-year agreement with them, and we ended up suspending that right after we knew we had both rooms renovated.

The second time is when we had one of our general surgeons at the VA that was also a reservist and was deploying. In that time frame he was going to be gone, we also lost another contract surgeon. And so we went to Wilford Hall and asked them to provide general surgeons if they had the capability to do so, and they did. They provided two general surgeons for about a year while those individuals were deployed, and then

while we rehired behind the other surgeon.

So those are shorter-term agreements, but we had to do the three-year agreement because that's kind of what the process is.

CO-CHAIR CROCKETT-JONES: I see the advantages, especially in local agreements, for there to be an ability to suspend when circumstances change. I guess my concern is that under future -- you get to the national level, there are sort of political will issues, and I would hate to see sort of an investment in the sharing that gets lost because it failed to be at a policy level that would survive changes in leadership.

So that's really the nature of my question is sort of, to create the longevity, this Task Force -- the members have frequently been concerned about maintaining the improvements that we see beyond the current conflicts and not having to have the wheel reinvented down the line. So that's really the source of my concern about this.

I get that local agreements, you know, are much more variable, but I'm worried about the policy level.

COL MALEBRANCHE: Ms. Crockett-Jones is so very astute, because we worry about that too at the VA. And I'm going to take this one, Alex, only because I sit on some of those different groups.

We have had some long-standing partnerships, years and years, that have gone away in 30 days that had significant impact. That's why it's so important to have very good partners and partnerships and relationships and leaders.

And one of the big concerns that I was so happy to hear General Keenan speak to this in this multiservice market, because I was trying to figure out, and I actually asked, I think when General Robb was here too, about how does the VA fit into that market and where are the partnerships? Because those do make a huge difference, and over time, it has a big impact.

So those larger things are also

being looked at, I know, at the health executive level from Dr. Woodson and Dr. Petzel, the Undersecretary for Health.

But also one of the things in the last presentation and also the one that we previously had as a Task Force from the DHA. If you notice, the National Capital Region Multiservice Market fits under the DHA Health Affairs. The other multiservice markets fit under the services of the Surgeon General. So this is one of those things, I think, over time we're going to -- we don't be here as a Task Force, but one of the things to really be careful and look at so you don't lose exactly what you're saying at this time: Lose some of that connectivity and long-term good partnership; things that are coming out of this. That's huge.

CO-CHAIR CROCKETT-JONES: And I'd like to reiterate that as a Task Force when we go on installation visits, the concept of transition to the VA and this permanence in joint policy or joint sharing and programs filters down to a

significant issue for the service member who is in transition, especially one who is facing medical retirement that they did not plan.

A lot of the tough changes that they're facing are stressful and made more stressful by their lack of confidence about transitioning to the VA because of lack of familiarity, especially when you're talking about very young service members who have no practical experience in that future.

So I see only benefit to sort of a leadership that gets more comfortably long-term integrated because I think that filters down to an ability for the people that we are talking to in our focus groups to have comfort and make their choices and plans for their transition to the VA out of the Military Health System more smooth and eliminate some of the issues that we see routinely. So it's significant.

COL MALEBRANCHE: And, Alex, I don't know if you can speak to this in any of the current sharing agreements or joint ventures, but

the Health Executive Committee is looking at credentialing and privileging being local throughout VA and DoD and eventually to even beyond that. But that's work that's got kind of short-term feasibility.

Where we have those agreements now, has that been worked individually or has that been a local fix or how is that?

DEPUTY DIRECTOR BARBERENA: I think it has been.

Mark, are you aware of any specifics on that?

MR. GOLDSTEIN: Well, if you recall, the VA/DoD demonstration projects that came out of the NDA A03 when the JIF was born, the Joint Incentive Fund. San Antonio was actually a pilot site, or a site attached to the administration project to do CC clause and Vet Pro that have some transfer of the credentialing files from one to the other, just like a transfer brief would be from one NTF to another. So those providers that were going between VA and DoD facilities, it would

be just like a transfer brief.

But they found that they went through the process, and I think they only were able to really move one or two files over that two- or three-year period, and so they just found that it wasn't going to be advantageous to use those programs and that bridge between the two. So I never saw that it kicked up or kept going.

Now, of course, under the sharing agreements, there may not be necessarily one for credentialing, but, obviously, if there's providers going from one facility to the other, they're doing straight primary verification on one facility to the other. Unfortunately, but that's what they're doing.

DEPUTY DIRECTOR BARBERENA: And that's what I'm familiar with. Yeah.

MR. REHBEIN: If I may for just a moment. Do you track how much sharing actually goes on? The reason I ask that question, we just finished a visit to the CBWTU and Joint Forces Headquarters in Utah. One of the VAs in their

area, they have stopped referring anyone to because they never get anyone in. So that's a TRICARE situation; and for whatever reason, that particular VA Medical Center was not treating any of their folks.

So while we have sharing agreements, do you track how much sharing goes on between the participants in those sharing agreements?

DEPUTY DIRECTOR BARBERENA: I would tell you that financially we track it, so we have some sense of where there's been an exchange of dollars. We can track that.

I think what you're referring to, and we do experience that occasionally, is an issue of capacity. So when these facilities reach capacity -- just like any other local provider might, when they reach capacity for whatever panel they have allotted for a specific insurer, if you will, we have a similar issue. If there's just no capacity to be able to do that, then, of course, they could stop, in that particular case, the TRICARE referrals accepting any referrals.

We've seen that with the polytrauma center at Richmond as well. They'll reach capacity at some point, but then when they have it again, they open up. So it just depends. So you still have an open sharing agreement, if you will, and some rejections may occur, but at some point they'll open up.

And actually, of the things that we're looking at in our own strategic plan is how to develop a tool, if you will, that would allow us to see where there's capacity for what. And so that would become a reporting activity. I'm not sure, you know, how far we'll get with that, but it's certainly something that we're interested in addressing.

MR. REHBEIN: Ms. Malenbranche and I talked about that particular situation a little bit. Because there was some perception on the part of the CBWTU that the reason they were having trouble getting folks into that VA was the lack of a DD-214. So exactly what the situation was out there, I don't know. I'm just wondering -- it

just makes me wonder about the necessity to do some more detailed tracking of how much sharing actually goes on.

DEPUTY DIRECTOR BARBERENA: To me, that sounds like a little bit more like a lack of education, to be quite honest.

MR. REHBEIN: And actually, we don't know because that VA was far enough away that we didn't get a chance to make a visit up there.

DEPUTY DIRECTOR BARBERENA: This is actually one of Mark's efforts as well. He holds a monthly educational session on different topics, but he calls it TRICARE 101, TRICARE 102. And he's educating our VA facilities about how to administer the TRICARE benefits program at a VA. So that's really curious about the need of a DD-214. It doesn't make sense, and that's why I go to the educational piece.

MR. REHBEIN: I don't know if that was actuality or perception. I can't address which box to check on that one.

DEPUTY DIRECTOR BARBERENA: Okay.

Thank you.

CO-CHAIR CROCKETT-JONES: Okay. I think that we've grilled you enough.

(Laughter)

CO-CHAIR CROCKETT-JONES: Thank you, Mr. Barbarena.

We are running a little bit early. We are now going to break for lunch, and we will be back here at one. Thank you again.

(Whereupon, the foregoing matter went off the record at 11:43 a.m. and back on the record at 12:59 p.m.)

CO-CHAIR CROCKET-JONES: Welcome back. This afternoon we welcome Mr. John Shero, Executive Director from the Extremity Trauma and Amputation Center of Excellence, who will be providing an update from the July 2013 briefing about the future of DoD amputee care.

Turn to Tab E in our briefing binders for the information found there. I'm going to turn it over to you.

MR. SHERO: Thank you and good afternoon, ladies and gentlemen. I understand that you had a wonderful lunch. And just as a point of reference, I was going to be joined by Dr. Billie Randolph, the Deputy Director from Extremity Trauma and Amputation Center of Excellence. Unfortunately, she couldn't get out of D.C. although many of you did. She is with us virtually on the telephone.

So today I'm going to give you basically what is the exact same briefing that was presented to Dr. Woodson and the Service Surgeons General on 18 September when I presented this at the Senior Military Medical Action Counsel or SMMAC. And there will be a good bit of history and background in this.

So on this slide you'll see the quote from General Fred Franks. And, again, just as a point of reference, many of you probably recognize General Franks' name as during Desert Storm in the first Gulf War when he led the 7th Corps through the Left Hook, which is considered

by many to be the most brilliant mechanized armored tactical movement of modern times coming through the Iraqi Desert and cutting off a large, large portion of the Iraqi Armed Forces.

And I was briefing a group of physicians this Saturday, two days ago, and mentioned General Franks, and not one of them knew who he was, so how quickly we forget. But the reason that General Franks is so critical to this discussion of amputee care is, General Franks was a young officer, a lieutenant in Vietnam, was very badly injured and was a limb salvage patient that then elected to undergo a delayed amputation. He, along with General Shinseki, now Secretary of the VA Shinseki, both elected to remain on active duty following their injury and subsequent amputation. But, ladies and gentlemen, during that time it was the exception, and those are two very unique individuals.

Today we have a very different environment thanks to the effort of many folks and lots of congressional assistants and leadership as

well. But the reason I want to speak to this is, General Franks included that as part of a letter that he sent to the Chairman of the Joint Chiefs of Staff, General Dempsey, and I'll speak more about that in just a couple of slides. But it does frame the discussion of what is the future of amputee care in the Department of Defense going to be. And this really is our challenge during the interwar years: What are we going to provide for amputee care through our Department of Defense and what are we not; and how the EACE is associated with this is the National Defense Authorization Act of 2009.

These are the key tenets that are -- that formed the Extremity Trauma and Amputation Center of Excellence. And the first I would point to you is a comprehensive plan and strategy for DoD and the VA in the mitigation, treatment, and rehabilitation of extremity trauma and amputations. And that is central to this discussion. Also, to conduct research of the four congressionally mandated centers of excellence, we

are unique in that we have a congressional mandate to conduct research. And the other is, again, to just improve extremity trauma and amputation care.

I call this slide the cliff chart, and literally you can see why I refer to it as that. Starting in 2001-2002 when hostilities kicked off, then Lieutenant General Jim Peake, Surgeon General of the Army, based on historical context said through the Soviet experience in Afghanistan, I think we're going to see many similar injuries. Very prescient on his part, and that's when he chartered what was at that time the Walter Reed Army Medical Center to reinitiate traumatic amputee care as part of the services that they provide.

So as you can see, we had a very low number of amputees early on in the conflict, yet that grew fairly significantly. And here in 2005 to 2007, it grew very rapidly especially during the surge in Iraq during OIF. I happen to have experienced this firsthand as the Deputy Commander at Brooke Army Medical Center when we were

receiving CASEVAC aircraft every 18 hours and literally filled every bed in the hospital. I'll also talk about that experience in a couple of slides when we discuss the Burn Center model of care.

So when things in Iraq calmed down, the number of amputees went down significantly. Yet again, in Iraq -- or correction -- in Afghanistan, during OEF during the surge, we saw a tremendous spike in that; and right here was about when I came on board as the directer of the EACE. And one of the first things that we did following my appointment as director was, in January of 2012, we had the first meeting of the Federal Amputation System of Care Leadership; that was both the DoD Advanced Rehabilitation Leadership, as well as the VA Amputation System of Care Regional Amputation Center Leadership. And at that meeting, I discussed the fact that we need to start looking over the horizon, because right now we're very, very busy, but at some point in the not too distant future, the numbers are going to

fall from theater. And as we process our Wounded Warriors through and they are returned to -- from acute care through rehabilitation to a sustainment mission, we need to assess what other potential categories of beneficiaries, what other potential patients, could be added to our continuum of care that could assist us in sustaining our training and education mission as well as our research and ongoing care mission. So you see there the numbers drop very, very rapidly as the Afghani forces took over the ground combat role and the U.S. played less of a role in ground combat.

So, again, General Franks -- this is another part of the message that he sent both to General Dempsey as well as to General Campbell, the Vice Chief of Staff of the Army. Basically, General Franks reiterating that we need to do a good assessment of what we can do for our future war fighters, that they should enjoy the same level of care as our current war fighters are. So that touched off a series of events. And I'm not going to go into all of this. Suffice it to say

that -- that then Major General Robb, who was the Joint Staff Surgeon, was asked to come brief the Defense Health Board. General Dempsey chartered the Defense Health Board to conduct a thorough review and study of -- not just our current amputee care, but more specifically our future amputee care, and to make recommendations based upon their study.

So I can tell you that at this time we are very, very -- the EACE is very, very involved with the Defense Health Board and the Health Care Delivery Subcommittee of the Defense Health Board in that review. I also -- again, I had mentioned a briefing of this that I did on 18 September. And, again, the slides that you're seeing here reflect that information.

So these are facts and assumptions that I used in detailing where we're at and where we've come from to the SMMAC. So I really feel it's important to note that while we are leading this effort and we have achieved a formidable level of competency in the provision of amputee

care, it wasn't that long ago following the Vietnam era that what was then a world-class system of care for amputees was completely dismantled.

And I'll make reference here to a quote from then Lieutenant Colonel Alcide Lanoue, later Lieutenant General Lanoue, the Surgeon General of the Army, when he was an orthopedic surgeon at Valley Forge. And General Lanoue -- Lieutenant Colonel Lanoue at that time -- said that having a distributed system of collective patients to centers of excellence was the best model of care because that was how you built the highest level of staff competency in dealing with these very, very complex patient care needs. And I think that's especially true even today.

So one other note there is, as an all-volunteer force -- in previous conflicts, in World War II, Korea, Vietnam, we could draft our way into making sure that we had a sufficient fighting force. In the all-volunteer Army, that's no longer correct. And what we do for our Wounded

Warriors today and our future Wounded Warriors in future conflicts will resonate in their communities and through their families and, ladies and gentlemen, one of the key things that we need to be cognizant of is when we fail to provide that world-class care, there will be a -- there could be a significant negative impact to that in terms of recruiting and retention.

The next to the last bullet here that I'll speak to under "Facts" is, there are existing models of care for a similar type of patient capture, and I'll speak to that specifically. The Institute of Surgical Research Burn Center at Brooke Army Medical Center is tied to the South Texas Trauma Care Consortium. And if you are a burn patient in South Texas you are referred to Brooke Army Medical Center to the Burn Care Center there, irrespective of your status, irrespective of whether you're a DoD beneficiary or not. What that has allowed them to do is -- during the interwar years, to sustain that very high level of competence necessary for caring for

their very, very complex patients. So burn patients, again, enormously complex, very, very high demands for inpatient; and then following inpatient, output rehabilitation and therapy. And, ladies and gentlemen, I think that is a model that we could look to in the DoD for future opportunities to sustain our skills in the Advance Rehabilitation Centers.

On the assumptions, I would just mention a couple of things. That we are assuming that DoD is committed to sustaining that capability, and further that there is a collaborative role for both VA and DoD in amputee care. The DoD amputee care model is centered around the three Advanced Rehabilitation Centers. The VA is obviously much, much more widely distributed across the U.S. They also have tremendous competence in dealing with the more elderly dysvascular patients, and that population that they have oriented on over the past years. DoD has attained their competence in extremity trauma and traumatic amputation through the past

conflict for the past 12 years of the war.

Yes, sir.

MR. DRACH: On your average medical retiree at age 25, that's all medical retirees, that's not just amputees. Is that correct?

MR. SHERO: No, sir. That is a great question. And I would say to any of the members, I'll take questions at any point during this.

Those are the statistics for our amputee population, specifically from OIF/OEF. So if at any point you have questions, please do ask.

Since we're back on this slide -- I'm sorry. I was remiss in not mentioning that as I had alluded to earlier, Secretary Shinseki and General Franks were the exception during Vietnam. We have had 463 of the 1640 amputee Wounded Warriors from OIF/OEF that have elected to remain on active duty and continued to serve. And, ladies and gentlemen, something that is very unique, that 68 of those have returned to theater in a fully qualified role having -- after their

amputation; after having sustained an amputation. All the way from Rangers, Special Operations, both Seals and Green Berets, down to Combat Infantrymen. And I think that is something that we as a nation, specifically we as an organization, and DoD and VA, should be very, very proud of.

CO-CHAIR CROCKET-JONES: Can I ask a question?

MR. SHERO: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: How do you see the apportionment of new patients between VA and DoD. How is that --

MR. SHERO: I'm sorry. Can you speak up?

CO-CHAIR CROCKETT-JONES: How do you see apportionment of patients between VA and DoD? As it goes forward, how will that mix go? And I'm asking this question for one of our Task Force members who is on the phone, but isn't sure he'd be heard.

MR. SHERO: I think that's a very

pertinent question, and I believe that's a question that the Defense Health Board and -- the Health Care Subcommittee and the Defense Health Board will address in their recommendations.

Again, previous -- and I'm just -- this is where -- and I'm talking previous, not future. But previously, the DoD has been oriented more on the traumatic amputation patient; the VA has oriented more on the dysvascular patient. That's not necessarily the way that it will play out in the future.

Again, our thought is that there is a collaborative role for each of these as we go forward. You know, one more time, the DoD has a tremendous amputation system of care network across the U.S., the DoD is more locally centered, regionally centered, and I'll show you another graphic on that in just a moment.

Any other questions at this time?

Okay. So this slide I really think is a great summary of what the EACE is all about and why we exist and what we do through our

efforts. And first is, we have three primary programs through the Extremity Trauma and Amputation Center of Excellence. That's clinical care, research, and global outreach. And all of those have a unity of effort and a synergy toward one thing; and that is ensuring that our Wounded Warriors receive the very best care possible; and if they choose to remain on active duty that they're fully allowed to realize their dreams to achieve their goals going forward. So you don't do that without having a tremendous team of other cohorts, constituents, and collaborators that you deal with.

So over here on this side you'll see that we have a multidisciplinary care team at the Advanced Rehabilitation Centers, are VA collaborators. Family-centric rehabilitation is a key aspect of the care that's delivered in the Advanced Rehabilitation Centers, but we're also tremendously involved with academia and industry and research consortiums to ensure that we bring to bear all the tools that we have in our arsenal

so that we can provide that very, very best care possible.

And then across the bottom, I would just say that these are a number of the things that we also do, all oriented on providing outstanding outcomes to our Wounded Warrior population.

COL MALENBRANCHE: Is your registry that you note that, is that integrating with other like the TBI or other registries?

MR. SHERO: Right. I'll actually speak specifically to that. That's a great question.

So currently, we really do not have a register, we have a database. So we have the amputee database that is maintained by us. We do have VA personnel who have access to that amputee database. Again, unique to us is we were the only ones of the congressionally-mandated centers of excellence who did not get a congressional mandate to implement a registry. However, we think that that is a very important part of our role and our

mission, so we are moving forward with that initiative to establish an amputee registry in collaboration with the VA, but more specifically as part of the Integrated Health Federated Registry, the IHFR, under the USD P&R.

MR. REHBEIN: If I may for just a moment. The fourth goal "Expand Patient Base," does that imply that you're going to go back to some of the folks that sustained amputations before the center was created? How do you go about --

MR. SHERO: Sure. That's a great question. And I would tell you if you go back to the cliff chart and look at where we were in late 2010-2011 and well into 2012, because it takes such a long time for these very critically injured traumatic amputees to fully rehabilitate, all three of the ARCs were full to the brim, and they had, by and large, disengaged a number of their nonactive duty beneficiaries that otherwise would have been eligible to get care. So if you were a family member who had been in a car accident,

chances were during that time when they really did not have any excess capacity at all to see other than the active duty cohort, then those were disengaged to the TRICARE Network. So that's specifically what I was referencing in that is, as the war has drawn down, as the number of new casualties from theater has drawn down, we need to look very hard at implementing the right of first refusal, or ROFR, for our TRICARE beneficiaries within the catchment areas. And, in fact, the ARCs, the Advanced Rehabilitation Centers, are doing that at this time.

Any other questions?

Okay. This is the chart that I was speaking of earlier. And basically, this shows how the three Advanced Rehabilitation Centers are very well positioned in terms of their support to the three TRICARE Networks, as well as strategically aligned to our unified commands and combatant commands and how those are arrayed across the globe.

So first you see the Military

Advanced Training Center at Walter Reed and how they are oriented both against the TRO North, the TRICARE Region North, as well as EUCOM, CENTCOM, and AFRICOM in the unified and combatant commands. And TRO South area is the Center for the Intrepid at Brooke Army Medical Center here in San Antonio and how they are aligned to South COM. And last is the C5 at Naval Medical Center Balboa -- or Naval Medical Center San Diego, I'm sorry -- and how they are aligned to PACOM and TRO West.

So, again, I just wanted to show that alignment is both geographically in support of our TRICARE regions, but more specifically geopolitically in support of our combatant commands. Those are well aligned.

Okay. My first disclaimer here is this information was pre-decisional. It was just information that I presented to the SMMAC to frame the discussion and to give some sort of rough look at different courses of action that could be explored by the Defense Health Board and by the SMMAC as we go forward in assessing what the

future of DoD amputee care could potentially look like.

So going from top to bottom, the most robust care model would adopt something like the Burn Center model of care that I had referenced earlier. And, ladies and gentlemen, now is when I'll give you my personal frame of reference for that. I was the Deputy Commander at Brooke Army Medical Center during the surge in Iraq during OIF, and I saw the capability of the Burn Center to expand and to take in these tremendous numbers of acute casualties that we were getting from theater. If we had not had that capability in place and then built so it could expand, we would not have been able to care for our Wounded Warriors. So that's specifically what I'm talking about in this case of adopting the Burn Center model and allowing -- and, again, probably this would take some Congressional language or Title X relief but allow the DoD Advanced Rehabilitation Centers to take in patients who are non-DoD beneficiaries.

Second course of action would be to keep all three ARCs with a reduced operational capability. That means they would draw down -- again, if they could not -- if they were not capable of drawing other categories of patients, not just DoD beneficiaries, but non-beneficiaries as well, there would be some potential decrement to their current capabilities and capacities. Another would be to potentially remission one or more of the Advanced Rehabilitation Centers to serve as a sports medicine or wellness center. And then the last -- and potentially the most Draconian model would be to divest ourselves of amputee care, potentially partner with the VA and/or state institutions and seek a training model for them, somewhat similar to what they do with the trauma surgeons and -- the trauma surgeons that train with civilian institutions.

One potential issue with that -- and this has been discussed in fairly great detail within Army Medical Command is for amputee care, and specifically for complex rehabilitation of

amputees, it's not like a trauma surgeon; because you train and provide care as an interdisciplinary integrated care team of physicians, orthopedic surgeons, physical medicine and rehabilitation physicians, PT, OT, all of the skills that go into the provision of care for these very, very complex patients. I feel -- and this is just a personal opinion. I feel that we would be doing a potential disservice to our patients if we just tried to emulate that model of care and just -- you know, just send the orthopedic surgeons to orthopedic training, send PM&R for PM&R training. Again, if you don't train as an integrated team and do what is done on a routine basis in our Advanced Rehabilitation Centers, then you lose that interdisciplinary care team.

EXECUTIVE DIRECTOR DAILEY: And, Mr. Shero, can I just make sure that I have it for the record. Your Burn Center model centers around the collaboration at the Central Texas University and the SAMC Hospital.

MR. SHERO: Right. Let me try to

reframe that. What I was referring to as the Burn Center model was a potential for all three of the Advanced Rehabilitation Centers to be allowed to enter into collaborative agreements as Brooke Army Medical Center has done for trauma care, but these were --

EXECUTIVE DIRECTOR DAILEY: With who?

MR. SHERO: Well, each of them would be a different region. So currently in San Antonio, it's with South Texas Regional Trauma Consortium. I'm not sure what it would be in San Diego and Washington, D.C.

EXECUTIVE DIRECTOR DAILEY: Just a better description of what it is here real quick, so I've got it for the record.

MR. SHERO: Sure. Absolutely. Is that sufficiently detailed?

EXECUTIVE DIRECTOR DAILEY: Anybody else have any questions about the model that he's talking about that's here, and that he's talking about as a model for these other centers? Does

anyone have more questions about them?

COL MALENBRANCHE: Well, one of the things I was going to ask is, I thought that you already did at one of the centers take like international patients in for training, but you also do at Brooke. I don't know if that's Secretarial Designee or something special with other countries, but I thought -- I was aware that something was going on which was very similar at the Burn Center.

MR. SHERO: Oh, okay. Right. Colonel Malenbranche, let me answer your question directly.

All three of the Advanced Rehabilitation Centers have cared for non-U.S. casualties of the war under the Secretarial Designee Process. So that was nothing new, that is just a continuation of the patient administration process.

COL MALENBRANCHE: Similar to what the Burn Center did. Correct?

MR. SHERO: No. Not at all similar

to what the Burn Center does.

The Burn Center is actually very unique, in that they have a delegated authority to establish Secretarial Designee status for their patients delegated all the way down to, I think, the deputy commander level at Brooke Army Medical Center. For all of our Foreign National patients that sought through the Sec Des process, that goes to OSD level; it takes weeks to months to get those executed, and those are very deliberate processes that they go through.

DR. PHILLIPS: May I suggest the message that I'm hearing related to the strategy of the model is that it's scalable and sustainable, and so they're using these mechanisms to create that model.

MR. SHERO: Correct. Absolutely correct. And that's a very insightful comment on your part, sir.

One other thing that I would speak to under -- it could be either the model -- Model No. 1 or Model No. 2, the Burn Center model, or a

slightly reduced operational capability is, again, I think that we have the potential to recognize and leverage our Advanced Rehabilitation Centers for local, regional, and national significance and truly let other folks benefit from what they do.

And what I'm speaking to there specifically is, we have FBI, CIA, Homeland Security, as well as, you know, Texas Highway Patrol, that sort of thing. All of those folks are very similar to our patient population. They're young, they're in pretty good shape, they generally want to return to high levels of activity. And specifically, when speaking of on a local level; firefighters, policemen, those folks on a local level, I think that's absolutely correct. They are very similar to our current patient cohort, and they have much the same expectations for recovery, rehabilitation, and return to a high level of activity. So all of those could be potential areas where we could capture patients who are not DoD beneficiaries, but who have those same similar goals.

And I will tell you that after the tragedy at the Boston Marathon, our physicians were in very tight communication and collaboration with the folks in Boston, and sharing of expertise and that sort of thing. But we also sent a patient cohort to Boston to speak with them. And, again, what you'll find is, in the Advanced Rehabilitation Centers, the impetus gained from seeing other amputees, other casualties, other patients, who are well down the road in their recovery and rehabilitation is tremendous. Very motivating to someone who's still in bed, still very acute in their care needs and that sort of thing, so that's tremendously powerful in the recovery process, and in giving people goals to look forward to. And, again, ladies and gentlemen, I saw that in action in the Burn Center. That was part of their standard procedure is, if you were a new burn patient, within the first week, you had a peer visitation from someone who was well down the line in their burn care recovery; and they could describe to you what that

recovery looked like, what the rehabilitation entailed, what your future goals could be. So very, very powerful model for that.

Any other questions?

Okay. So this was -- this was kind of the summary slide from the briefing to the SMMAC, and since I was briefing on 18 September, and just prior to that Dr. Woodson, the Assistant Secretary of Defense for Health Affairs had sent a 9/11 message out. I thought it was especially poignant particularly when we talk about we now have a lifetime responsibility to a generation of our service members, veterans, and families. And as we have increased the likelihood of survival, we've accepted the responsibility for ensuring that we provide a lifetime of quality care, and I really like this one, our responsibility is to be ready for anything. So, again, particularly poignant to me and striking as was preparing these slides for the SMMAC.

And below is basically just a summary of the things that I talked about. The

one thing that I didn't speak to specifically is to pioneer a national extremity trauma and amputation system of care modeled after the Joint Trauma System. These were some of our traumatologists within the DoD that said, you know, we've done this and we've done it in the civilian sector, and the military ought to look at doing that for amputee care in the same similar vein that we have done it for trauma care. And then as I have spoken to, to have the ARCs viewed as national level resources, and I would just expand upon that to say national, regional, local-level resources and to truly be viewed as the treasures that they have come to be. And then the keep faith with our current Wounded Warriors providing that world-class care, not just now but into the future.

One other aspect of this is we know that there will be a significant number of delayed amputations from the current conflict. We just recently performed a delayed amputation at Walter Reed that was ten years post-injury; so the

estimate of that is still undetermined. We're not exactly sure what that tale is going to be. We do know that the tale is going to be there for some significant period of time. We have 18,000 extremity trauma patients from the current conflict. Again, 18,000 extremity trauma patients from the current conflict, and of those, some percentage will proceed to a delayed amputation.

Yes, sir.

MR. DRACH: On your delayed amputations, how are they being included in your 1600, if you have somebody who is now 10 years post injury.

MR. SHERO: Right, sir. That's a great question.

As those delayed amputations occur, we enter them into the database, so -- and actually I produce a monthly report of amputees, new amputees, as well as historical data. And even though when the monthly report from one month to the next we may have only gotten a handful of new patients, you'll see the total number of

amputees increase, and that's because the delayed amputees are then carried into the database and recorded there.

MR. DRACH: So let's say five years out, after we're all out of Afghanistan, et cetera, and the delayed amputee has his or her surgery at the VA, I'm assuming that you'll be able to track him or her at that end of database later?

MR. SHERO: I will tell you that I currently do not have the capability to track that in the VA. You know, there's a number of things that could -- that could potentially be done to improve that, but that's -- that a great point.

MR. DRACH: But how would you -- I think I heard you earlier say that you're developing a registry. How will that person get into the registry?

MR. SHERO: Right, sir. That's I was trying to address.

If the amputee is seen at one of the three Advanced Rehabilitation Centers, I'm

absolutely certain that we will capture them and ensure that they're entered into the database. If they've been discharged from the Service and they elect to use a civilian insurance or their VA benefit, then we have very little capability at this time to track them and enter them in. As we go forward, and we -- and we actually realize the Integrated Health Federated Registry for all of the centers of excellence and we get a true VA/DoD Integrated Health Federated Registry, then we could.

MR. DRACH: So going forward, it's on your radar to try to figure out a system to track them or include them.

MR. SHERO: Right. Absolutely. And thank you. That's a great question and great point.

So I'll just wrap this slide up by saying that as defining the optimal patient base, that is one of the tasks that the Defense Health Board Subcommittee on the Delivery of Health Care has taken on. They are doing a very, very

deep-dive assessment of the three Advanced Rehabilitation Centers, and what they are currently doing and historically have done, but more specifically what they are going to do in the future and how that should be shaped and what it should look like. So they are still working on that; and, again, we are very much in collaboration with them.

MR. REHBEIN: I saw your definition of "Amputation." What's the definition of "Extremity Trauma"?

MR. SHERO: The orthopedic community has defined "Extremity Trauma" for us. I'm sorry, sir. I can't give you the textbook definition of that off the top of my head. I can get that and send it to the board.

MR. REHBEIN: If it's out there, I can find it too.

MR. SHERO: I would tell you even a more slippery definition is "Limb Salvage," because we do not have a peer-reviewed, scientifically noteworthy definition of "Limb

Salvage." Although, in February the Extremity War Injury Conference is having a limb salvage track or limb salvage breakout where we hope to get to that, because, you know, the -- it really varies from provider to provider even on how they define "limb salvage." And one of our orthopedic surgeons here would say, "Well, if I've ever discussed an elective amputation with a patient, that's the definition of limb salvage." Other folks would say, if you have an ankle fusion or calcaneus fracture, you're a limb salvage patient, because at some point in time, you may elect for a delayed amputation just based on the fact that you no longer have range of motion or you have constant pain and every time you walk -- and, again, General Franks is an example of that. He told me that when he was trying to go through his rehabilitation and get through recovery, he said, "I couldn't squash an ant without excruciating pain, and that's why I elected to have an amputation, so I could continue to serve."

CO-CHAIR CROCKETT-JONES: What would

be the -- what kind of time frames are delayed amputations? You know, I know that's a broad question, but what's the range?

MR. SHERO: Three months to ten years. That's where we're at right now. So basically, we say if you're within -- well, especially if you're still an inpatient, then that's really not a delayed amputation, that's just an amputation as a consequence of your injury. But if you're three months out and you've gone through an output rehabilitation course of care and elected for a delayed -- or elected for an amputation at that point, by definition, then you become a delayed amputation. And, again, the best -- or correction -- the longest was that I have seen to date was ten years. So anywhere within that range at this point in time, but as we go farther out, you know, they may -- and the population ages and that sort of stuff, they may even be longer.

CO-CHAIR CROCKETT-JONES: Okay. So now I'm understanding the real complexity of the

database expansion and why it would be really important, because we don't know at this point really the number of delayed amputations. We don't have a good fidelity on that because some of those might be sight unseen?

MR. SHERO: Right. And we certainly don't have the fidelity and situational awareness of those that we would like. I would hope -- and, again, this is a hope. But I would hope that someone who has been through a course of care at one of the ARCs before they elected for an amputation they would go back there to see if there are any new technologies or new initiatives available that might change their mind.

And I understand that General Keenan talked about the IDEO. So that's a new -- relatively new technology that is a real game changer in terms of limb salvage patients who otherwise might have elected for a delayed limb compensation.

MR. DRACH: Just to follow up on that. A friend of mine who lost a leg in Vietnam

in the late '60s just had his second leg amputated about a year ago after a successful limb salvage. So 40 years later, he's a secondary amputee. But post-Vietnam, we saw quite a few people who developed osteomyelitis five to ten years after discharge, and then had to have the limb -- usually, it was a leg -- well, as far as I know, it was always a leg had to be amputated. And so I think we still -- even though I think the medical model has changed such that there may be a mitigation of osteomyelitis, I think it will still be there. We'll see it.

MR. SHERO: That's -- I had wondered and I had hypothesized that even today some of the folks who were extremity injured patients from the Vietnam conflict were getting delayed amputations, so you've just confirmed my hypothesis. But I had suspected the same thing.

MR. PHILLIPS: And, Ron, to your point, a traumatized limb is more susceptible down the road, as you say, not only the osteo, but if you have co-morbid conditions like diabetes or

vascular or atherosclerosis, that limb is more susceptible because it's been injured.

MR. DRACH: Well, the friend of mine just had who the second leg amputated, it was a result of his injury, it wasn't from diabetes.

MR. SHERO: And the physical therapists in the audience will tell you that it makes the contralateral limb much more susceptible to, you know, arthritic changes, and -- because of the gait imperfections, that sort of stuff. Now they're having much more significant co-morbidities, low-back pain, and so there's a whole sequelae of other bad things that come along with not necessarily an amputation, because we know that for the amputees, but certainly for the extremity trauma and limb salvage population as well.

COL MALENBRANCHE: So knowing this, and -- about the history and having this in patients' records and being able to look at this over time or farther down the line would be something -- and we've talked about this, but I

just -- for the record, I think this would be something very significant in terms of the registry and even if they're not on the registry with these types of conditions, these are things that we could look back and see years and years later.

But the other thing I was wondering, and I think we asked it somewhere along the line, where -- is there a concern right now about the center as far as funding in the future? Is there -- I saw there was a look to put it under the Advanced Health Agency. Was there a concern about funding or something going away where this might not continue where it is today?

MR. SHERO: Are you talking specifically to the EACE or the ARCs?

COL MALENBRANCHE: Yes. The EACE.

MR. SHERO: Okay. Our funding is in the POM -- in the Program Objective Memorandum from DoD through Army Medical Command targeted for the EACE. We have -- last year, we submitted a POM on financial requirement which was not

accepted because the Army could only fund three POM issues forward to Health Affairs, and ours didn't make the cut. We are going to resubmit that POM on financial requirement in this coming POM cycle, so -- so the short answer is, we know that we have a base level of funding, but to do all the things that we believe are within our mission template, we do need a POM increase and we will submit that as a POM.

COL MALENBRANCHE: So -- that's under the Army, so should that come under DHA then that's different. That changes things.

MR. SHERO: That's one of the questions we've wrestled with along with other COEs, because, you know, for Vision Center of Excellence, they have to submit their POM first through the Navy for a hearing -- it's through the Air Force. For the EASE and DCoE, it's through the Army. So while each of those centers has a joint DoD and VA mission template, we align for resourcing under a service.

COL MALENBRANCHE: So this is the

only one that's legislated to be both DoD and VA.

MR. SHERO: Both DoD and VA. Right.

COL MALENBRANCHE: So are you not getting funding from VA?

MR. SHERO: The VA has funding for their staff that they are bringing on board, but I don't receive any direct funding from the VA -- correction -- we. Not I, we. We don't receive any direct funding from the VA. We are fully funded for their staff which are integrated with us.

MR. DRACH: So are you and Dr. Randolph both DoD employees?

MR. SHERO: No. That's the beauty of this is, I'm a DoD employee, she's a VA employee, and that's how we are able to collaborate. And that's -- sincerely, that's why we wanted her here today, so we could demonstrate that DoD/VA interaction and collaboration.

So just a couple of key points about what has changed since the 18 September briefing to the SMMAC. That's where the Undersecretary of

Defense for Personnel & Readiness chartered the Defense Health Board to conduct their review. The DHB Subcommittee has already visited the Military Advanced Training Center at Walter Reed. They are going to visit the Center for the Intrepid next week, and they are projected to visit C5 in San Diego the second week in February, if, in fact, that one -- that time frame is approved. And then the DHB is going to prepare a report as a disinterested party that will go forward to the USD(P&R), and I would imagine from USD(P&R) to the joint chiefs. And one more time, just to reiterate, we are in very, very close collaboration with them to ensure that if there are issues or questions, we can assist them in addressing that we've taken care of that.

So, ladies and gentlemen, if there are no questions.

EXECUTIVE DIRECTOR DAILEY: So the Defense Health Board, which is a Federal Advisory Committee just like this one, has been given a task of the deep dive on what is going to be the

future for care for this population. So they're going to pick one of the courses of actions on page 9 or come up with their own --

MR. SHERO: Or something else. They're not bound by any constraints on their -- either assessment or their recommendation.

EXECUTIVE DIRECTOR DAILEY: Correct. They're informed by what these statements on page 9 are, and they'll do their own research and they're going to make a recommendation to P&R, and then he will -- he agrees or wants to modify it, he forwards that on to the Joint Staff.

MR. SHERO: Other questions?

EXECUTIVE DIRECTOR DAILEY: This is it, ladies and gentlemen. You've got ten minutes left. You don't get another chance, so chat with him.

CO-CHAIR CROCKET-JONES: So that is for the rehabilitation centers, you know, the actual -- or is that also for -- does that affect a larger plan? That's what I'm -- you've now made me -- is that just for the ARC ...

MR. SHERO: Let me see if I can reframe the question. So within DoD, the three primary Amputee Care Centers are located within the -- within what I showed on the map there. Walter Reed, BAMC, and San Diego. Not that there's -- that other military treatment facilities don't do amputee care, but those are the big three. So much as -- you know, to sort of put this in a completely different framework. If you're going to do heart transplants, you don't want to do those in every community hospital across the U.S. You want to concentrate that expertise into a specific area where you really have enough number to ensure that your staff retains their proficiency, but also to have a small enough number that they're not disseminated all across and you don't get a large enough number to actually attain excellence in your care. Does that make sense?

CO-CHAIR CROCKETT-JONES: Yes.

COL MALENBRANCHE: So one of the things we looked at were looking at centers of

excellence like the Vision that came up with the eye shield, and I think that was one of your background questions. What do you consider as the director the most significant accomplishment of this center of excellence in the course of particularly this last year and/or overall?

MR. SHERO: I would tell you, this is not something we did, this was done at the Center for the Intrepid, but the Intrepid Dynamic Exoskeletal Orthosis, the IDEO. Ladies and gentlemen, that is a game changer for extremity trauma patients who would have elected for delayed amputation and then had to wear a prosthetic for the rest of their life. And the IDEO is a tremendous opportunity for us to change that from a delayed amputation to a limb salvage patient that has to wear a brace. And very, very different outcomes. If we had an hour to talk about the IDEO, I could show you video clips that would just -- they're jaw droppers. It's just amazing how this thing can change a life and return someone not from -- you know, walking with

a limp, using a cane, but doing sprints and cuts and jumping.

There's a guy who had an ankle fusion -- and in an ankle fusion, you have basically very, very little range of motion in your ankle. And not only do you walk with a limp, he couldn't jump over, you know, a matchbox. And he's jumping onto a 36-inch platform. I can't do that. But that's the kind of game-changer that the IDEO is. And getting that out into -- not just at the Center for the Intrepid, but getting that out into the other ARCs and very soon to the VA, I think will have a tremendous impact on a lot of lives. So right now they're manufacturing the IDEO at the CFI. They've just begun manufacturing it at -- at MATC, at Walter Reed. The C5 in San Diego has folks here this week that are getting their training on the IDEO process and how to manufacture it and how to screen the patients and make sure they're appropriately screened and appropriate patients for that technology. So in the very, very near future, we'll have all three

of the ARCs -- and we're also beginning the training of VA personnel in the very near future. So I think that's a very important role that we have played in trying to spread that out.

The other is, not just a specific research project, but I think in the embedding of EACE employees, so we have service employees, paid for by EACE and they are embedded in the Advanced Rehabilitation Centers working side by side with the clinicians who deliver this care on a day-to-day basis. I think one of the most important aspects of what we do is ensuring that those embedded researchers identify clinical gaps. In other words, what is it that we need to do that we're not able to do right now. Address that through relevant research, ensure that the research is funded, executed, and published, and then fed back into the clinical practice so that we literally change clinical practice growing forward based upon the identification of clinical care gaps by our embedded researchers. So I think that's very important, and we've got a number of

examples of that.

CO-CHAIR CROCKETT-JONES: So do you anticipate that the rehab for those that are going to be new users of the IDEO brace, will that -- will that four-week therapy process that gets them to full functional use of that brace, is that going to happen at the rehabilitation centers in or at large -- I mean, is that where you're going to start the focus, or is there another venue that is anticipated for that? Is it going to be more dispersed? Do you know?

MR. SHERO: I can answer for what's going to happen at the three DoD centers, and that is, you can't just manufacture the IDEO without the Return to Run Program, because we actually have published research that shows that one without the other is not effective. So the Return to Run, plus the IDEO is the -- that's -- the product plus the process equals the outcome. Hanger, which is the largest manufacturer of prosthetic devices in the U.S., I think they've got like 600 different locations across the U.S.

Hanger has hired a prosthetic specialist who is going to guide them in starting something, if not IDEO, similar to IDEO. They are -- as I understand it, they are seeking licensure, because this is a patented -- DoD patent-held product, that they are starting the licensure agreement process, and they're beginning that as well, so it will be available across the U.S. So if I -- if I said this is just for DoD, absolutely not correct.

CO-CHAIR CROCKETT-JONES: No. I'm just wondering if this is going to be initially that -- will those who have potential to gain this, will they be returning to those centers basically for the -- initially, you know, will the first wave of this involve people going back to the rehab centers, and -- even though it's for a short period of time? I mean, I'm not saying it's negative, I'm just wondering if this is going to be an anticipated shift around of some people.

MR. SHERO: Let me see if I -- what you're asking is, and let me try to give an example. If you're a soldier assigned to Fort

Polk and you have an ankle fusion and you're considering a delayed amputation, would you have an IDEO built for you by the guys at Fort Polk or would you be sent back to the CFI at San Antonio?

CO-CHAIR CROCKETT-JONES: More specifically.

EXECUTIVE DIRECTOR DAILEY: Follow-on.

CO-CHAIR CROCKETT-JONES: Instead, assuming you would have to have it built at a center that does prosthetic work, my question is, is would the follow-on -- would the follow-up -- what is it? -- Return to Run? Is that what you called it?

MR. SHERO: Return to Run, yes.

CO-CHAIR CROCKETT-JONES: If the Return to Run was also going to be done at a rehab center or at the place where -- at a more central location, at least in the near future, you know, is that a reasonable expectation?

MR. SHERO: Right. Okay. Let me try to see if I got your question this time.

So the folks who came from Walter Reed and the folks that are here now from the C5 in San Diego came as a team. They came as a prosthetist and a PT. I don't know if they sent -- and a tech. So a prosthetist, PT, and prosthetic tech came as a team to be trained on this. And the reason why is, it is an integrated multidisciplinary team that provides this product and this care to achieve an outcome.

So it's not just the device and it's not just the Return to Run Program, it's the device coupled with the Return to Run Program that gives you the outcome. So does that answer the question? They come as a team --

CO-CHAIR CROCKETT-JONES: I'm just trying to figure out where initially they would be doing -- is that all done together or basically, if you go and get your IDEO brace, are you going to be able to complete your Return to Run Program back at home? I'm -- I wonder this, because as we go around looking at installations, sometimes one of the barriers to some of the more innovative

care for various things is done -- it's units getting their people to a location and being comfortable with them staying there for, you know, TDY basically for a number of weeks. I realize this is a small population, but, you know, we go from installation to installation and, for instance, NICoE is -- you know, getting into NICoE, they have a limitation; for some people, it's all the way across the country. One of the barriers is as these innovations come out, just -- is a person going to pretty much have to be able to get their unit to give them up for that full chunk or are they going to go get a brace and be able to do a Return to Run Program more close to home? I realize eventually, it will be everywhere, but initially. That's what I'm trying to figure out.

MR. SHERO: I think at this time, we are only training folks on Return to Run in places that have the IDEO manufacturing process in place. Could that change in the future? It could. Although as with any other protocol, if you don't

do a certain number of them, then you don't gain the expertise that you need to do it well. So whether that's heart transplant or Return to Run for a complex patient with an extremity trauma, I think you need to have a certain number that you do on a recurring basis in order to achieve proficiency and hopefully mastery. Does that make sense?

COL MALENBRANCHE: Mr. Shero, I think this kind of attaches since you and I had a conversation before too. It's not only active duty, then you have the veteran. And understanding just how this was with heart transplants, there was a center of excellence, people went there. But I think it's expectation management too. Because now you have a veteran, and the people that we're seeing, active duty as well, go to rural areas that are kind of like, you know, Utah and I know in parts of Texas there's rural areas, yet they go to those places. And then for them to stop their families, stop, have to get the travel and all those sorts of things,

that's the concern. So I guess the thought is, understanding it's new, and that it's not all out there, hopefully it will be some day, and that's going to be the contribution of this particular or maybe some other agencies, but that more than one place could do that. And the expectation management of the these individuals and their families will be helpful because there's a lot of cost initially, but there's more than just cost. There's whole -- the whole impact on the family and community. And I think that's where I see Ms. Crockett-Jones, because I was thinking about that in terms of the Veterans, because it's like, well, I need to stay on active duty or I'm never going to get everything I need. And that is a lot of that thought process as well.

MR. REHBEIN: If I may change the subject for just a moment. If you think about what amputation capabilities DoD needs to keep, that's driven in some -- and probably fairly heavily by the numbers of people on amputations. Do you have a projection of what a steady state

level is? Assuming that we don't go into a heavily deployment schedule, and assuming that families are also included along with serving members.

MR. SHERO: Right. With regard to active duty who are injured through MBAs, training accidents, that kind of stuff, believe it or not, it's a fairly broad -- there's a lot of variance in that from year to year. So anywhere from 50 to 120, based on the year -- the fiscal year that you're looking at. And, you know, the other thing is -- and Dr. Chuck Scoville is a mentor and friend of mine. He is the grand old man of amputee care both for the Army and DoD. But Dr. Scoville is famous for saying an amputee is not an amputee. So a simple below-knee unilateral amputee is fairly easy to deal with. That's just one limb. But what about a hip disarticulation patient? Well, it's just one limb, but it's four times more complex and resource intensive to deal with that. So a four-quarter amputation is not the same as a wrist disartic, or something like

that -- a wrist disarticulation patient. It's very, very different based on the level of amputation and other concomitant injuries that go along with that that impact the course of care and the rehabilitation requirements. So I think to assign a number without much more data to back that up would be a bit of a misnomer.

DR. PHILLIPS: May I suggest that's where the registry, I think, would be very important because you have a history or registry of 20 or 30 years of amputees who need progressive help in new technology. And as they age, they have to deal with the different type of process of these.

MR. SHERO: Right. And I can tell you that Dr. Wilson is very, very interested in how we are assessing the longitudinal care needs of our amputee population, not just our OIF/OEF population, but of our amputee population.

EXECUTIVE DIRECTOR DAILEY: Maybe Dr. Randolph might also address this, and I'm back on page 9. Although these were nonbinding, and

the Defense Health Staff will be able to come up with different courses of action, where is the VA? Was there any discussion about collocating ARCs with VA amputation locations that were very involved in their own piece of amputation? I see -- we see these three, they've been dominant in the Department of Defense. Even at these three locations, there isn't a lot of VA overlap in these locations.

MR. SHERO: I'm not sure that I would agree with that as a statement.

EXECUTIVE DIRECTOR DAILEY: Okay. Good.

MR. SHERO: And here's why. I'll give you a quick for instance. I'll give you two quick for instances: At MATC, Military Advanced Training Center at Walter Reed, they have VA staff that come over and work in their prosthetics lab on a routine basis. One or two days a week, they come over, they work there, and they take their products back to fit on VA patients. At the C5 in San Diego, they actually just got approval for a

joint incentive fund, or JIF proposal, to collaborate and work much more closely with the VA. Their former medical director, which is a PM&R doctor, physical medicine and rehabilitation doctor, just left active duty and now is the medical director for the rehabilitation care at the local VA. So they're working very, very closely in a much more collaborative relationship than previously.

Here in San Antonio between the South Texas VA and the Center for the Intrepid, they recently got a resigned memorandum of understanding or memorandum of agreement to have nine -- to sustain having nine VA staff physically working in the CFI, working alongside the DoD providers. So that's seven VHA and two VBA staff who are working here in San Antonio.

So I would challenge that statement just out of hand based on that evidence.

EXECUTIVE DIRECTOR DAILEY: Good. Good. We've been at these locations. The collaboration at C5 when we were there in San

Diego was not what you're talking about today, so that's good to hear.

But do I hear, then, that the state of the art is -- for amputation is shifting from the VA into the DoD?

MR. SHERO: One more time. I'm not sure that I agree with your premise that one place has state of the art and the other doesn't.

EXECUTIVE DIRECTOR DAILEY: Okay.

MR. SHERO: I really think that -- the statement that it's shifting from the VA or shifting from DoD is not correct. Because, you know, the VA provides wonderful amputee care to our Wounded Warriors who have transitioned, and they're now no longer on active duty and they are getting their care through the VA. So the premise that one has supremacy over the other, I think, I would challenge.

EXECUTIVE DIRECTOR DAILEY: Okay.

COL MALENBRANCHE: I think that the IDEO brace at least is probably one piece of technology we're looking at as far as state of the

art. But the other part, I think, for -- that's significant here is, the Department of Defense has a number of companies that come and give -- I'm trying to think of the right word. Give or contribute to DoD with a lot of research dollars and do things that VA -- that they don't necessarily do with VA, because they are getting a lot more visibility in the general public with these types of grants and things. So, I mean, there's a piece of that in there too, I believe, Mr. Shero, that probably leads, because one of the things we've had with VA is, yes, we have certain things, but we don't do necessarily experimental and sometimes there are, you know, in the research piece of this would be under those folks. So we do and we don't.

And then at the VA in DC, those particular folks getting trained right now, that's fairly new and that's the DC VA only at this point. Right? There's no other prosthetists from other places just yet.

MR. SHERO: Right. It's the CFI

prosthetist that's starting his program of training. So the VA prosthetist embedded at the CFI that is starting this program of training.

COL MALENBRANCHE: All right. So this is very much in its infancy, which is why we haven't seen it in the past few years going around. So within this last year, that would be something that's within this per annum, and then hopefully will proliferate further. So it is accurate how Ms. Daily is saying how we haven't seen this before because it wasn't there last time, and now it's something that's occurring. So I think that's significant.

MR. SHERO: One other aspect that I did want to maybe talk just for a moment is, you said a lot of folks -- a lot of industry and academic research is going to the DoD that's not going to the VA. I would tell you that we also believe that the collaborative effort between DoD and VA must be expanded. And we have some great examples of projects that work. The DEKA arm, the Dean Kaman arm, that is a joint DoD/VA project,

it's a really, really exciting proposal being examined in two VA locations and one DoD location here at the CFI. Another is the osseointegration effort at Salt Lake City between Utah School of Medicine, Salt Lake City VA, and that should be kicking off the second quarter of 2014. So about April-May they'll start the first of the 10 patients for osseointegration that they're going to do there. And when they expand to the next ten, they are actively working with us to see if they can do some of those in the DoD centers, so --

COL MALENBRANCHE: Is that under the auspices of the Center of Excellence or the auspices of research?

MR. SHERO: Those are research activities that we are collaborating with. So it's their research, but we're closely collaborating with them. So Dr. Joe Webster is the VA lead for that, and he's the medical director for the Amputation System of Care for the VA. And, again, we are very closely collaborating

with those efforts.

COL MALENBRANCHE: So a slow start, but we're getting there. It's been years.

MR. SHERO: Right. That's an accurate statement. You know, the EACE is still building from nothing. I was the first employee hired, and that was two years and two weeks ago, and we just crossed our 50 percent threshold in October of this year for having 50 percent of our staff on board. So we're still working hard to gain the staff, the research or the -- the staff and assets that we need to execute what was envisioned by Congress as our mission.

COL MALENBRANCHE: Thank you.

MR. SHERO: And I'm sorry I've run over time. Dr. Packer, I owe you one.

CO-CHAIR CROCKET-JONES: That's okay. Thank you very much. We are going to take a 15-minute break, and -- actually not quite 15 minutes. We've run over. 2:15 back here at the table for the Hearing Center of Excellence. Thank you again, Mr. Shero.

(Whereupon, the foregoing matter went off the record at 2:10 p.m. and back on the record at 2:26 p.m.)

CO-CHAIR CROCKETT-JONES: We now welcome Air Force Colonel Mark Packer, the Executive Director for the Hearing Center of Excellence. He will be updating us on information provided to the Task Force in his January 2013 briefing.

I would like to recognize the last time he briefed the Task Force he was an O-5, but has now been promoted to the grade of O-6. Congratulations on your promotion.

Please turn to Tab F for the information for this briefing, and I'm going to turn it over to you.

COL PACKER: Thank you, ma'am. I appreciate that. And just proof that even a blind squirrel finds a nut once in a while. Happy to brief you again today and update you on our progress. Go ahead and flip to the next slide -- or I guess I have control. Right? There we go.

So we set up the overview according to the questions asked for the brief, and will proceed through the questions as they were asked of us, according to this overview. Prior to that, I just wanted to update you or refresh your memory about what the Hearing Center of Excellence is all about. And as you realize and understand, combat is chaotic and there are many competing noises that are competing for signal detection, but also sounds and noises that override sensory reception of hearing. So the ability to hear and communicate is essential to safety and mission accomplishment and command and control, force management on a more broad scale. But it's also the -- the noises that are experienced through combat are also a population health risk or an occupational health risk. We know besides that that some of the noise exposures -- the routine occupational noise exposures and some of the off-duty noise exposures can be prevented by hearing protection. And so we'll talk about some of the Hearing Center's plans to try to prevent

the preventable hearing loss and address the deal of the signal and noise dichotomy.

The scope of the injury is massive. There's 1.88 million -- these are FY 12 numbers from the Annual Veterans Benefits Report. 1.88 million vets that have an auditory system injury disability. That's over 970,000 for tinnitus or 774 for hearing loss. So by this point in follow-on fiscal year, we should have -- according to current rates and trend, we should have over a million cases of tinnitus and 800,000 cases of hearing loss. So it's picking up at a rapid and alarming rate.

1.4 million claims have been filed with the VA since 2001, and 450 of those are directly related to the war efforts. It turns out to be nearly $2 billion annual compensation event. So with that, hearing loss is insidious, cumulative, progressive, and invisible and oftentimes escapes attention or gets pushed off due to other priorities, so -- so the Hearing Center of Excellence's task is to raise awareness,

provide better education, training, and protection and combat these injuries.

As you can see, the readiness issue is the military relies on the human factor, the hearing -- critical sense of hearing to be able to provide the safety and the awareness and the team unity and communication that drives all missions. The population health risk is evidenced in that industrial nations are showing alarming rates of increased prevalences of hearing loss aside from military. Teens and 20s are showing increases in their rates of hearing loss due to whatever we put in our ears, and what we use at home in the garage or out in the yard.

So we have both of those exposures to combat, and the signal to key in on. But the Hearing Center has a unique mission, as well -- or unique injury pattern in that most all other war-related injuries are largely attributed to the war effort and the war exposures. With the hearing, due to the population health exposures and risk, hearing loss and tinnitus are the number

one and two most prevalent disabilities still in all areas of peacetime as recorded by the Veterans Administration, so a unique caveat.

MR. DRACH: Excuse me. Can you go back?

COL PACKER: Yes, sir.

MR. DRACH: The 450,000 injuries from OEF/OIF and OND. About a year or so ago, CBS News reported 60 percent are returning with some sort of hearing problem. Does that fit with your 450K thing?

COL PACKER: That's a ballpark estimate. I think that does fit. The other thing, referring up here to this where hearing loss is insidious, cumulative, and progressive. Noise exposure can also potentiate further and align with other metabolic or aging processes that cause hearing loss. So the audiogram is a rough estimate of diagnostic capability. You can have molecular and cellular damage in the hearing organ and still have a pretty normal audiogram. So our measures in that line -- or the disabilities that

are being accounted for in the VA are lag indicators of earlier damage. And many of these 1.4 million that have made claims since 2001 are due to other war efforts and are becoming more manifest due to the aging process, et cetera.

MR. DRACH: Thank you.

COL PACKER: So this is just the lead component model. We run down through the Air Force, we have service liaisons, and our directorates are lined up to really key in on the two primary measures of effectiveness that we want to make a difference in prevention and clinical care.

So addressing the FOC question, the Hearing Center of Excellence has established a hearing health improvement network that is a collaborative network of researchers and clinicians and hearing conservationists that align to focus on those issues that we just mentioned. The registry effort, this JHLASIR, the Joint Hearing Loss and Auditory System Injury Registry is still in the works, and many parallel efforts

have completed that will help to develop the actual build of the registry. So right now we have the data management infrastructure in place through agreements, the Defense Occupational and Environmental Health Readiness System is the surveillance system and occupational system that captures the prevention data has been upgraded and has capability for sharing with the VA as -- as required by law.

AUDBASE is a method to capture the clinical audiograms from the military treatment facilities to be added to the registry. This has been DIACAP'd and is certified to be used on military systems. The reporting concept -- or the infrastructure and the architecture have been approved and are pending build just based on our funding is operational and maintenance, and there's a question related to whether or not it needs to be research and development dollars, so we're waiting for that answer. But the reporting metrics have been established according to the NDAA, and so aside from the actual registry we

have the ability to pull the information from current systems to answer the demands of Congress.

This next line, the DoD Hearing Center of Excellence has been the go-to person for the DoD and the VA as far as hearing-related issues. So aside from the service lane representation, we communicate with the consultants on a frequent basis, and many of the requests come in to the Hearing Center to answer those questions. The DoD/VA transition partnership for auditory care has been defined. We're working with the VA to smooth out that transition to create the resource sharing opportunities as possible. And the DoD Hearing Center of Excellence prevention plan and education strategies continue and will continue to be executed in that way.

Staffing update. We have -- the VA has gotten through the processes and we have a new deputy as of the 30th of December. So Lynn Henselman, a Ph.D. audiologist, will be joining us here shortly. The Air Force liaison position has

been filled. The Army and Navy have been working those issues, but due to staffing and freeze issues, have not been able to contribute to that to this point.

So the input on the goals and objectives. As you can see, we have the stoplight, red, amber, and green indicators to update the progress on these issues since last time around. This is the prevention and surveillance strategy. I'm just going to go over, unless you care to discuss things further, on the ones that have changed color. So the development of downloadable educational tools for HCE Website. There has been a push this year to develop educational tools and we'll see some of those later on in the presentation for the prevention teams and for the clinical teams. They are downloaded and available on the Website.

Determine the scope for the Fitness For Duty standards for appropriate military occupational specialty codes. So an analysis to look at hearing critical tasks in the effort and

to develop this -- this standard metric that links the hearing ability to hearing performance in the field has been accomplished.

Integrated development of ear protection and qualified products list is in the iterative process looking at all the emerging technologies for hearing protection, and identifying the standards necessary to protect at a minimal safe level. Ongoing project with the Army.

Comprehensive hearing health program strategy is developed. We'll get into that a little further into the presentation as well.

Standardized surveillance and strategy is outlined for prevention, and we'll show some slides that talk to that as well.

Next is the clinical care and rehab lane. So the first bullet, the change was establish DoD Information Assurance Certificate. We alluded to that earlier on. This is -- the DIACAP process to bring in the clinical audiograms into the registry has been accomplished, and is

being executed. The software packages are being pushed out to the services at this time.

Develop acquisition policy for hearing prosthetics leveraging VA purchasing power. We have another slide detailing that a little further on, but currently that policy has been established and executed to require all hearing aid purchasing throughout the Department of Defense to be -- to run through the VA Logistics Center in Denver for the purchasing and for group pricing on these hearing rehab devices.

Establish plan for transition for care sharing with the VA. This, I think, will be an ongoing agile system where we identify and execute relationships on an as-needed basis to provide closer care to members and veterans according to resources in their area.

Global Outreach: The hearing prosthesis acquisition standardization. The -- it required some work to output, so we'll the view the global outreach as kind of data out. That's our strategic communication, the web-based

platform, and the work with the relationships with the service consultants and liaisons to get the word out. And so to kind of operationalize the purchasing agreement policy. We've been able to push that out and see that successfully executed.

Partner with hearing health advocacy groups. That's an ongoing relationship that will also be an iterative process, but several of the advocacy groups have strong relationships with our teams.

Activate the Hearing Health Caucus: There were three Congressional Hearing Health Caucus meetings over the last two years.

Promote Fitness for Duty; clinical practice guidelines, clinical tools, et cetera. So an ongoing effort to push knowledge and product analyses out to the field for improved care and improved standardization of understandings.

Lead NATO effort. There are several international efforts that are ongoing. This NATO effort ended up pushed back, so we're still yellow here actually. The final meeting got pushed back

to this June based on some travel arrangements. So the iterative process, again develop rehabilitation and restoration technologies with international partners. And these are ongoing and will continue on a relevant basis.

Establish advisory boards: With the establishment of the collaborative networks within the Hearing Center. We'll detail with those again with some future slides. We are able to stand up relatively responsive, as-needed ad hoc advisory boards to provide the subject matter expertise for many situations.

Informatics: This is basically an overview that was addressed in an earlier slide, and so I'm going to see if there's much different here. Other than we're still yellow on the actual registry, the infrastructure needs to be built in. We've identified the Health System Data Warehouse as the parent source. It has yet to be determined whether we can use our current funding or whether we need to change to a different color of money to accomplish that task. But other than that, we are

green in all lanes.

As far as research goes, partner with a grant sponsoring agencies to provide Gap analysis, prioritization of the planning stages of research. We have worked with all of the services and with the various joint programs to develop that front-end planning strategy.

Coordinate auditory research portfolios between sponsoring agencies. Again, that's going to be a maintenance task. And we have a research portfolio coordinator who is invested with the different services and their programs to identify all of the ongoing hearing balance related projects and catalog those.

Consolidate auditory-vestibular scientific interest resources opportunities on an interactive web-based platform. We are -- we have a contract in place using a system called Seidel that the VA also uses to help profile members within a research network showcasing ongoing projects, fields of interest, availabilities and so on and so forth, that will be used to draw in

the collaboration and identify capacity within the system for ongoing projects.

Formal approval for MOUs for the Hearing Center of Excellence centralized IRB is accomplished.

COL MALENBRANCHE: Is that centralized IRB, is that inclusive of the VA or is that the services only?

COL PACKER: No, ma'am. Good question.

We approached the VA and the VA was involved in early planning for that. However, due to idiosyncrasies within the two agencies that was not able to pull through. So although that has not occurred, we are able to stand next to the VA as an associate member so that -- so we just have two processes to follow and follow along for IRB approval. They have their centralized system and we have a centralized option or DoD. So rather than, you know, setting out a multistage project at five, ten, fifteen separate sites through both agencies, we can now just enter into portals.

COL MALENBRANCHE: So the DoD's part is centralized and the VA is?

COL PACKER: Correct.

Integrate with strategic planning for translational research, as well as -- I have a slide that kind of speaks to this graphically, but as well as being at the front end of the strategic planning phases for research funders and grant agencies, we also have the teams in place through this collaborative network to take on emerging technologies and get that back into the field in the hospitals.

So update on the Joint Strategic bullet that was asked to develop a comprehensive plan for the registry utilization to encourage/facilitate research, develop best practices and clinical education. So this is, again, showing where we are with the registry development. I think that we're functional with data management and at an execution point for the build of the actual registry, but that is one of our dependency issues that we're waiting for the

owner of that process to decide on the funding mechanism.

The reporting features are established, and to utilize the information within the registry, we have also built in an auditory data mart -- or excuse me. This is ongoing. We have an auditory injured model within the joint theater trauma system, so we have the theater data pull as well, but with the registry system in place, and by launching Audbase to capture the clinical data, then the hearing health improvement network and its strategic communication plan and strategic partnerships are ready to take on that information and use it to provide the analysis and the information dissemination to the relevant parties. There is active collaboration to utilize registry information currently in place within these systems, and these -- these collaborative groups and partners have helped in the strategic planning and advisory for many of our current efforts.

So this looks like it's kind of

washed out, but basically, this shows full operating capability with the -- with registry use shared through a collaborative network across the DoD and the VA. Right now we do have the centralized IRB green, so we're just waiting for the registry to build out, and we should be at our definition of full operating capability.

Along with that, one of the central pieces for the information needed for the registries is the surveillance standardization. And across the services, we've been working to kind of standardize that process. This shows for the criteria that we consider as crucial to management of the system, baseline audiometry at accession to the military is happening across three of the four services. Annual assessment is happening, to a large extent, in three of the four services. And then we have an outlier with the annual assessment being done on a risk basis.

Updating the research productivity. So this speaks to some of the productivity across that collaborative network that has been

discussed. A number of projects in development. Grant applications are currently standing at 26.

CO-CHAIR CROCKET-JONES: Can we go back just one second to the slide -- the last slide?

COL PACKER: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: Does the Hearing Center of Excellence take a stand on what the optimal, you know, three services are doing pretty much one way and one service is doing it a different way? Does the Hearing Center of Excellence have a -- consider one of these two choices a best practice?

COL PACKER: Yes, ma'am, we do. And this is -- this surveillance strategy has also been recommended by an Institute of Medicine study in 2006, as well as the government audit that concluded in 2011. And the Hearing Center of Excellence and all of the DoD hearing conservation teams for the services have agreed that those recommendations should be implemented. The baseline testing, I think, is crucial to get an

accurate front-end gauge of hearing status, and something to base any further surveillance data metric against.

This annual assessment is another condition that we feel is highly important to our surveillance strategy with an invisible injury. The more times we have contact with members, the more education and training and the better visibility that we have with those troops to develop some kind of personal behavior change and accountability to taking care of ears and to looking after wingmen with these kind of issues. So our stand at the Hearing Center of Excellence is that we should all be green across right here.

CO-CHAIR CROCKET-JONES: Okay. Is there any plan for the Air Force to increase and start doing baseline assessments, or is that an area where the Task Force, you know, should be recommending a change in policy? Or I'm just ...

COL PACKER: Thank you for your -- this is a good discussion, and it's conversation we had for two or three years with the Air Force.

I think Air Force medical lines stand in concurrence with this recommendation, and we've been gathering data to bolster the case and to showcase the case. Basic trainees are owned by the Education and Training Command, and so we have analyses showing how we would like them to do their business, but we have no authority to push it into their service lane.

So while we continue to have these discussions at a corporate level, it still has not -- in fact, we did a POM for a maintenance package to make this happen. Within the Air Force, we have a single side of accession here in San Antonio, and there are good working models across the other services to manage large troop flow through accession centers where we could gain that data easily and readily. So we've been having those discussions and will continue to have those discussions to try to push it into the education training realm.

DR. PHILLIPS: Without you saying it, I think it would be helpful for us as a Task

Force to ask to say that. And, you know, you obviously have to be commended on this work. It's moved along very quickly. And I look at your -- your registry perhaps as a standard that could be used as a template that could be used for other registries. So I don't know what we will finally do, but I think the word about being green across the entire line would be helpful.

CSM DeJONG: We've often put in a conversation as to -- obviously millions and millions of dollars are spent on these centers of excellence, and trying to figure out how to best utilize the centers of excellence. And this is the kind of a case in point to me that that center of excellence on a very critical and expensive long-term injury is making a recommendation that the services really have an option on whether they want to accept it or -- and utilize it or not. And that, to me, starts to bring up the question again as, you know, what -- why haven't the centers of excellence, if we're putting our best and brightest committees to come up with the

greatest ideas on prevention, care, and future care if no one's going to follow them.

COL PACKER: Agreed. Thank you for those comments. I think that's a common roadblock or challenge.

COL MALENBRANCHE: This is huge when you look at the compensation from when they become veterans. And we're looking for baseline entry level, this would be one of those things did you have it when you came in. And I'm not trying to be facetious, but the Air Force has pilots, and aren't they one of the groups that has the highest incidence -- or historically, they did. I'm sure hearing conservation and prevention is much better, but since that is such a huge compensation benefit for later, it would seem that should be -- I think to reiterate what Ms. Crockett-Jones and the Sergeant Major said, should be absolutely.

DR. PHILLIPS: And especially on the recruitment side for when our young people are constantly at 120 decibels, you know, coming in injured before. I mean, it's a very important

element.

COL PACKER: It is important. And I mean you go to a Seahawks or Chiefs game and you're exposed to 140 decibels. Right? To the Air Force's credit, I think that they have a risk-based system which naturally provide a very good benefit; however, what we've found is that for members who discharged the Air Force and receive disability within a year of transition, 60 to 80 percent of those new claims are coming from groups outside of conservation. So it showcases the population health risk. We're just -- we're missing it from, you know, the flanks and the other ends. Thanks for the discussion. I appreciate that.

MR. REHBEIN: One question, sir. Because we're spending a lot of this -- we, you, the program, is spending a lot of time evaluating where we are now and quantifying health effects, but I'm not seeing much discussion of prevention. This is a -- we would all agree this is a readiness issue. And if people's hearing is being

degraded, then our readiness level goes down. Is there going to be significant effort put into prevention evaluating devices, doing those kind of things?

COL PACKER: Yes, sir. We have a capability-based assessment of the prevention programs and how the Comprehensive Hearing Health package of programs that we'll showcase in just a little bit. Along with an attempt to work with the acquisitions lanes to bring the best products and make that a standardized central process.

MR. REHBEIN: Okay.

COL PACKER: So research update. Again, this is collaborative productivity across the networks. And I'll detail some of the network functions. The Auditory Research Working Group is, again, that practice-based research network involving principal investigators that are clinicians and scientists across the services. And we have specific lanes of research, pharmaceutical intervention for hearing loss, looking at prevention and rescue medical

treatments, auditory Fitness for Duty standards that runs that prevention -- runs in that prevention lane trying to identify the level of hearing necessary to accomplish mission tasks and give us a better idea of how to recommend to line commanders how well our troops can participate in the mission, as well as point out that as an early intervention system, going back to the surveillance strategy. Once we identify folks with this system in place, we'll be able to practice more personalized medicine and offer those individuals who have been identified with better hearing protection as necessary. So there are stratified levels of prevention. And according to the organization within which they work, they have prevention available to them. Once their hearing has been damaged, rather than lose their expertise and experience, it would make sense to enhance that as well as protect it to keep them on the job as necessary or as capable.

The DoD and the VA are working several epidemiological projects. The COEs are

working together to try to identify a more holistic best practices working with extremities, chronic pain, psych health TBI, and vision to identify the crossover injuries and multisensory problems and solutions.

And then international efforts through the -- through NATO Human Factors of Medicine, the Coalition Warfare Programs and Air and Space Interoperability Councils to look at best practices between nations.

So here we just see the lifespan of a service member and veterans. There's multiple stovepipes that have been created around research, and -- which have different levels of effort and different areas of interest within the different services. In the Centers of Excellence -- and here you see hearing in the middle, crosscuts all of those service needs and stovepipes of the scope of injury. So we're working from -- to get a comprehensive picture at a subject matter level of what is going on, who's doing the work, and develop the teams that are in association with the

field-based and hospital-based teams to transfer those products back into play.

So research leading change. The millennium cohort has a huge ongoing project that you're likely aware of where they have now nearly 200,000 members being followed with a questionnaire-based epidemiological analysis. And their recent efforts have been to look at the occupational environmental health readiness systems, the surveillance systems, and look at the effect on hearing loss. And the first effort will be published over the next few months.

Research driving policy. So one of the other potential strategies that we're looking at is to take a look at otoacoustic emission as a means of surveillance, which -- the otoacoustic emission is used for universal newborn hearing screening to take a look at every baby that's born and key in on those infants that have no hearing and recognize them for further, more diagnostic effort. It's a quick, easy portable tech driven -- or available metric that could be identified

through other current readiness lanes to develop a metric. It's been shown through studies to serve as a potential marker for future hearing loss an early indicator. It shows potential cochlear damage prior to any threshold change in the audiogram, and maybe a marker that can, again, provide an early indication prior to the acceleration of age-related hearing loss from noise exposure. So we're very interested in possibly outlaying this into the services as an early metric for hearing.

The Public Health Services -- or excuse me -- the Noise Hearing Injury Category Watch List has been developed to work within the registry system to mark key indicators, diagnostic indicators, that will trigger tracking so that we can develop best outcomes metrics and look at prevention and care strategies that may highlight as best practices.

We're developing research that predicts performance standards. So as you see here, this is an early line of research thought

showing that if you take someone with good hearing and pit them with someone with poor hearing at an operational task -- and in this case it was tank operations -- the time to identify targets is lengthened, the incorrect command heard is erred, the correct targets identified declined, enemy targets killed, declined wrong, target shot increases, and tank crew killed by enemy goes up by a factor of four. So as you can see, even though this tank operator may look and perform otherwise physically very well, his hearing is extremely important to his operations. So the Fitness for Duty line of research is, we feel, very important to being able to showcase to line commanders the ability necessary by their troops for hearing.

This just follows along with that line of Fitness for Duty Standards are in progress and we're hoping to have those complete by 2015. That's identifying hearing critical tasks, that analysis that was alluded to earlier, identifying the acoustic environments where grouped exposures

occur, and develop a signal and noise or speech and noise test within those environments and then pit that against a clinical assessment.

The Allied NeuroSensory Warrior Related Research effort was a method to look at the multisensory losses across the COEs. 1300 projects were looked at. Fortunately, there was very little duplication, but also there was very little collaboration across this group. We're in Phase 2 of this analysis and it's showed that a lot of the effort was clumped into early technical readiness level, so nothing that is boots on the ground ready. So we feel that at centers of excellence, we have the duty and responsibility to identify ongoing projects that have the translation potential to help field the actual best practices and opportunities.

Hearing Center of Excellence Influence: So this is the capabilities-based assessment for the prevention packages. Comprehensive hearing health programs are necessary to change the behavior within the

military. There are too many nuanced premises that lead individual members to not take care of their ears. So this was developed through a doctor in our organization, looking at the logistics and capabilities within the system, and how we can adjust to anchor changes through institutional policy changes that will improve accountability and change, as well as define the initiative and task-level missions that will help to develop the behavior change necessary to protect hearing. It's being taken on by a retired colonel who has large experience within the Army Hearing Program that has been shown to make quite a bit of difference so far, and I think that the Army Hearing Programs are a great model to look to for this development.

So clinical education and training. We've been involved in many different venues. We have ongoing coursework and symposia, we have many seminars at several different meetings, and we have developed and put out information that is relevant and helpful for clinicians in various

fields of auditory and vestibular injury.

This is just that translational slide that kind of shows how we align with some of the research funding programs. We work with a tactical team of clinicians and researchers again, and field-based members with access to populations of interest. These weigh into the front end to develop the gaps and the priorities within our field. Many of our initiatives align with some of the stovepiped efforts through the researched funding lanes, and we have multiple communications through that system to develop awareness, to showcase the magnitude of this injury, and then to work through their strategic-level planning for those programs and bring back the items that will, again, be translated into the field.

This is the end result of what we hope to find with this Fitness for Duty effort. If -- what we are working to achieve is this score on clinical speech test in noise, pair it up with an audiogram result and then delivering a two-by-two matrix that showcases how well your

ears hear in isolation to how well your level of hearing performs in the field. Match that together and give a better indicator and an early indicator for how well you can do in the field.

As some of the accomplishments for the last year, we just recently deployed to the theater the first in-theater diagnostic capability for hearing loss. This unit called the Otogram is a hardened, full compatibility device that has been outlaid to the Concussion Care Centers to help identify and -- and diagnose blast-exposed troops. Currently, if a persistent deficit is identified within the theater of care and diagnostic capability is needed, it air vacs to Germany for diagnosis. So this a highly relevant application in theater for working with groups to develop a portable balanced diagnostic as well. And we held an IPT with subject matter experts that looked at four of the currently available products. And so I hope to align that with this in theater.

We are working currently to look at

a Telehealth analysis for how Telehealth can augment the Department of Defense. The Department of Defense has just over 200 audiologists across its services. Many of which in the Army-Navy and hence Marine Corps are occupational and not participating in the surgical care or management of patients. Within the DoD -- or excuse me. Within the VA, there has been massive need to bring on audiologists, because we are feeding them a lot of hearing injury. So over the past four years, they've upgraded their audiology team support by 300. We feel that a hundred of those may have been highly relevant in the Department of Defense to develop some of these prevention strategies and hopefully decrease their need later on in the VA.

CSM DeJONG: Sir, so what we're hearing is -- I just want to clarify what I heard was. A hearing injury is now a case for medical evac to Germany. Correct? Is that what you're saying? So there's no longer -- I mean, is it falling in the same category now as eyesight? Is

it -- are we getting close? I guess if you could clarify that a little bit.

COL PACKER: Yeah. Sure. So the theater care -- first of all, a hearing injury doesn't bleed, doesn't hurt, and likely young, healthy, athletic men and women in the services go out, get their bell rung, and if they aren't bleeding, they shake it off and they go back to work. And so a lot of injury is not diagnosed up front, and even when it comes down to evaluation management of more severely injured troops, we know that hearing loss factors into their ability to diagnose TBI. The Glasgow Coma Scale is a three-metric parameter that identifies your ability for -- to have brain function through motor responses, appropriate responses, and eye movement. If you can't hear the questions, then you can degrade that GCS by a couple of points just because you can't hear.

With those -- and more severely injured troops that are evacuated, I think that hearing loss again is a low priority for that

troop movement. So if -- most of what we see in the auditory injury module in JTTR is the objective damage. The perforations, the spinal fluid leaks, and that kind of thing, coming from the ear. And it's all kind of inpatient based through the air vac system. So hearing is deferred to an output evaluation that gets picked up in a clinic later on. So a lot of times that progressive, insidious, cumulative loss is not picked up and can be missed for various reasons until later on when you're back stateside.

CSM DeJONG: Well, I understand that, but with this new device you were saying that it -- it's an early detection, and that does qualify them for possible medical evacuation. Correct?

COL PACKER: What we're hoping to do is put it in place so that we can prevent that medical evacuation, so that we can -- as troops come in, they're -- with the proper exposure or with an indicating exposure, they're evaluated for TBI on site and they're allowed to rest in place

depending on, you know, how severe. Similarly, with that exposure, if we're talking about the signature wound of war as a blast, and these guys are coming through -- guys and gals are coming through, then that same blast could obviously damage the hearing. A lot of them have tinnitus, a lot of them have hearing loss that will manifest and then recede. So as they come into this center, we can document their initial event exposure, we can look at it again after a period of silence to see if it responds and they return to normal. We can educate them about prevention and care in the field and keep them on site rather than have them -- there is an amount that are outsourced through the air vac system to Germany just for diagnostics. I was there for three months, and it wasn't routine, but it was not infrequent either that we would get folks in and -- just for a hearing test.

CSM DeJONG: Now I further understand that. Thank you.

COL PACKER: VA/DoD Hearing

Prothesis Purchase Standardization is what we alluded to earlier. VA sees and treats and provides hearing aids, cochlear implants, and rehab devices at a much discounted rate just based on the bulk of their services. The Department of Defense has a policy in place now to purchase all of those materials through the VA processes through an online accountable system that will allow us to not only develop a -- maximize our purchasing power and develop that line through cheaper prices, but also gives us the accountability that through their system -- their online system we can see what the utilization patterns are across the system which may indicate and point to best practices. So we're excited about that. We're working with them this upcoming year to look at other potential patterns that could use that same process of prevention devices, looking at the bone conduction devices, and there are three new middle ear implants that they will be looking at. So we're excited about that relationship.

Speaking of the middle ear implant devices. So hearing aids are the workhorse for hearing loss, and they do a great job rehabilitating mild to moderately severe losses. Cochlear implants have proven themselves to overcome some of the profound losses that we see. And there are bone-anchored systems that provide bone conduction strategies to overcome conductive and mixed hearing losses. We have a gap, and especially with the noise-induced hearing losses; that when there's a steep-sloping hearing loss with fairly well preserved low frequency hearing, but very moderate-severe to severe loss in higher frequencies, we're not at the cochlear implant category yet, and yet hearing aids don't provide a great strategy for those individuals. There are three new middle ear implant systems available on market and FDA approved that are available, and we have trained our DoD otology surgeons to implant those. They're certified and capable of implanting those in the system now.

IRB Background: We've talked about

this, and I think we'll skip over it in the interest of time. It's functional and we're using it.

The leveraging capability of network is what we rely on. We are facing an enormous problem in hearing loss and auditory injury, and yet our Hearing Center of Excellence organization has 28 folks on managing documents. We have execution lines available through current standing programs within the services in hearing conservation through clinical care and within research, but these have been working in isolation to this point. So it's exciting to be able to coordinate those efforts to focus the priorities. And this is -- the web site is an outreach tool but also this SciVal Experts is another way to showcase the availabilities and capacities within the system to leverage that care.

Here are a couple of the products that are put out online that help in the realm of prevention and education.

And then this is a device that is a

simulated surgical trainer that helps -- many of the blast injuries are very difficult surgical cases. And training for residents and to certify and to achieve success within those cases requires cadaver training. We have instituted across the DoD these hearing loss simulators, which is a fantastic little device where you can actually upload scans of a patient that you will be operating on and do that case beforehand. So it's great for resident training, it's great for military surgeons who don't see a high volume of cases, and it's great for the difficult cases that we see that require a little forethought and some surgical planning.

So policy changes. Updating DoDI 6055.12 we alluded to before with the capability-based assessment of the Hearing Conservation Programs. The Comprehensive Hearing Health Programs would like to include hearing conservation as part of the overall comprehensive package, but alter the wording in this DoD Instruction to develop the behavior changes and

the educational opportunities and training strategies that will change behavior and institute the changes that we'd like to bring that accountability into the system through.

We talked about hearing acuity is a readiness issue, and we talked about the surveillance strategy. So a high priority for us is to continue to recommend that standard that we feel is necessary to gain a baseline -- a good, adequate early baseline, and the ongoing surveillance through the -- through possibly the OAE strategy, but through the current DOEHRS audiograms that are available.

COL MALENBRANCHE: That last one on the share data between VA and DoD. You are doing a registry you mentioned.

COL PACKER: I'm sorry?

COL MALENBRANCHE: A registry. Are you doing a registry?

COL PACKER: Yes.

COL MALENBRANCHE: And where does that data come from? How is that -- is that being

pulled from places into it or is it being entered? Are you able to do some sort of sharing about clinical data that way?

COL PACKER: Yes, ma'am. The beauty about hearing loss is the metrics are digitized and easily forwarded to our registry system. And we'll obtain that data from the Occupational/Environmental Health System, we'll obtain that data from the clinical audiograms, and we'll gain that data from trauma theater through systems that have been identified. Data share agreements have been updated and the DIACAP has been achieved, and so on and so forth. So the registry is a landing spot for all of those metrics we'll be pulling from. The Health Services Data Warehouse that will house that information has a great clinically relevant front end through CarePoint. So clinicians seeing a patient can utilize registry information on a daily basis with their patients. At the same time, researchers can use the aggregated data to look at population health and overall epidemiology

interests.

So hearing loss is a population health issue. I think that we need to continue to beat that drum. There is significant risk in the military, and the military has been shown to elevate the risk over occupational cohorts. But we also know that people are picking up -- are exposed to risk at home and off-duty.

The rapid process to share data. I mentioned that through the registry effort too is that it is difficult through the DoD to access and pull VA data, and they have been helpful and responsive to us, but it takes -- puts us back in the queue for these pulls. So if there was a strategy that could help to speed up that process, then that would be helpful.

I think that's it for the bulk of the -- of the brief. Are there any questions that I could answer?

CSM DeJONG: Sir, with the last statement of sharing data between the VA and DoD. I know last time that we spoke with you, we had

some questions about the continuity of testing between DoD and VA. Is that still -- is that still very different or similar? Are there -- is there anything in the works to try to standardize that? And one of the examples that we had used was DoD, at least in the Army style -- I'll speak for myself -- uses a little sound booth, and you push the button and you count to three and push the button again; and you know pretty much every three seconds they're going to make a noise. And then you go to the VA when there's a possible claim, and they have a much more complicated, much more what I believe is the sophisticated test to then give you your rating.

Are we -- is there any work with DoD and VA to try to standardize the testing for hearing loss and testing for -- with the annual-type testing?

COL PACKER: Yes, sir, there is. So with the -- the click-it button in the booth method that you talked about, that's the standard surveillance test for folks with normal hearing.

They test their air conduction thresholds. And once someone has been identified to have a shift in the baseline -- so the baseline is extremely important. Again, once their hearing has changed, that triggers an appointment for a more formal audiogram. If you survive your career in the services without a hearing deficit, then at exit from the Air Force -- or services, if there has been significant exposure of subjective loss, then that same clinical audiogram will be obtained for VA purposes.

It's currently being discussed in separations -- the DoD-level Separations Health Assessment, and will be standardized; the clinical audiograms run off of various equipment but are fairly standard. And this deployment of AUDBASE will standardize that across the services, and it will be information that is -- that can be matched with the VA audiograms.

CSM DeJONG: Okay.

CO-CHAIR CROCKETT-JONES: Okay. Thank you, Colonel Parker.

COL PACKER: Thank you very much.

CO-CHAIR CROCKETT-JONES: Is it "Packer,"

COL PACKER: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: I'm sorry.

COL PACKER: That's okay.

CO-CHAIR CROCKETT-JONES: We have until 3:30. Do you want to take 5 minutes and then we'll be back at the table?

(Whereupon, the foregoing matter went off the record at 3:24 p.m. and back on the record at 3:37 p.m.)

CO-CHAIR CROCKETT-JONES: From Humana's Military Warrior Navigation and Assistance Program, we welcome Ms. Carmen DeLeon-Dingman, Case Manager with TRICARE Regional Office-South.

MS. DeLEON-DINGMAN: I am not with Humana, I am at TRICARE Regional Office. I am speaking on behalf of the Warrior Navigation & Assistance Program.

CO-CHAIR CROCKET-JONES: We have

information on the Tab G of the binders. And I'm going to turn it over to you to introduce your co-speaker, or are you together or different?

MS. DeLEON-DINGMAN: I do want to introduce Margaret Wilson. She is the Supervisor for the Warrior Navigation & Assistance Program, and she has been kind enough to join me here in the event that there's questions that maybe I cannot answer.

Good afternoon. As was mentioned, this is about the Warrior Navigation & Assistance Program. Hopefully I can answer all the questions that are presented by the Task Force. This program is a division of Humana Government Business, and it is Humana Military's program.

The agenda is basically an overview and missions and goals, and within all those little subtitles are the questions that were asked.

So the program was created by Humana Military to guide the warriors and their families through this tremendous maze of health care

systems. And it was -- its goal was to connect them with available resources, either throughout the government or through communities, and to hopefully return them to productive lives and overcome the hurdles that they were encountering.

It was established in December 2007 by Mr. Larry Burchfield, the former Executive Officer for -- I'm sorry -- Senior Executive Regional Director for Humana Military. It was an Above & Beyond by Humana Military. During 2007, we were in the TNEX contract, which is TRICARE Next Generation, and they saw it as a way to help the service members and their families. So it was an Above & Beyond.

And the next contract, the T3 contract, when the contractors put in their bids, they included this program as an enhancement to the contract, and it was accepted and they are our South Region contractor.

As I mentioned, it was dedicated solely to Wounded Warriors and their families. Since inception in December of 2007, they've

approximately helped 21,128 members. To this year, calendar year 2013, there's about 3554 members that have been assisted, and currently they have 98 cases open. And those -- all those cases are followed to resolution, or they may refer them to a resource that can assist in resolution for whatever issues are being brought forth.

MR. REHBEIN: Just so I understand your population, are you referring to combat wounded or wounded, ill and injured?

MS. DeLEON-DINGMAN: Wounded, ill, and injured.

EXECUTIVE DIRECTOR DAILEY: And real quickly. These are individuals who have the enhanced access code, or is it anyone being case managed or --

MS. DeLEON-DINGMAN: "Enhanced access code," meaning the 415 and 416?

EXECUTIVE DIRECTOR DAILEY: Correct.

MS. DeLEON-DINGMAN: The ones that are utilizing that the most is the Army. They are

flagged, and that's later on in my presentation.

Once the wounded, ill, and injured is identified as a Wounded Warrior, they will get flagged by Humana's Military system to identify them as a VIP, so to speak, and then they will get some additional, you know, assistance for that. Okay?

Any other questions?

The mission, as mentioned, was to guide the recovering warriors and their families through this maze of health care that we all have encountered, and then to connect them with available resources and to also provide guidance and clinical support to military and civilian health care professionals. Their goals were to assist with treatment options, rehab, reintegration of the recovering member, advocate for the recovering warrior, and also their goal was that no concern or issue go unresolved.

Their approach: They do assist in the navigation piece. They educate on health care benefits, especially TRICARE and the correlation

between TRICARE and Medicare and some of the other agencies, like the VA Social Security, possibly other community resources that may have some other possible resources available to them. And they do assist with clinical coordination.

The types of support: As I mentioned, is they get flagged as a wounded, ill, and injured. They help with medical billing and claims. They not only navigate the government agencies, which is TRICARE, the VA, Medicare, and Social Security, they also assist with localized medical equipment, especially for some of these wounded, ill, and injured that it is so specialized equipment that our regular durable medical equipment companies may not have, it. So they integrate with the VA or other companies that may have something, especially if they're crossing regions.

They do link with Behavioral Health Resources; they will give information, if they're in our South Region for Value Options, which is the payable health subcontractor for -- for the

South Region through Humana Military. They also assist with transitional care when they're relocating.

MR. REHBEIN: When you say the veterans navigating the various agencies of Veterans Administration, you're referring to only the health care side of the VA, or are you also referring to the benefits side?

MS. DeLEON-DINGMAN: They will refer them to the VA benefits side, but they are --

MR. REHBEIN: They don't necessarily assist with the claim.

MS. DeLEON-DINGMAN: No. But they will point them in the right direction to ensure they get the right person to help them.

Satisfaction: Satisfaction surveys are not done. There is a -- they are prohibited by DHA. There's a certain way that it needs to be done. There needs to be higher approval, so at this time, that has not been something that is done by this program. They do provide high levels of customer service. They have been recognized by

various forms, whether it be by phone calls of gratitude or letters of appreciation. They've also received awards like Outstanding Customer Service by the Florida CBWTU in 2008; the Outstanding Medical Vendor Award, presented by the Institute for Defense and Government Advancement. They've also received internal Humana Outstanding Team Awards for Extraordinary Customer Service for Wounded Warriors. They also received an award at the Humana Summit, which was presented to the WNAP Nurse Navigators for providing excellent service to Wounded Warriors and their families.

They get referred by various ways. They can self-refer, the services -- the branch of services can refer, providers, FRCs, case managers, civilian, or military. There are times when I hear about a case as my role as nurse consultant for the TRO. I may get called by a headquarters person or somebody at an MTF that has somebody that needs assistance, whether it be -- you know, they're getting ready to retire or are retired and I will refer them also.

CO-CHAIR CROCKETT-JONES: Can you please tell me -- I'm interested, first of all, what is the most common point of referral in that list, if you know? And the second thing is, is there -- are there definitions to cutoff for end of service. Does any wounded, ill, and injured who gets referred to you get this help, or is there a level of serious or very serious injury or anything like that?

MS. DeLEON-DINGMAN: Everybody gets assistance. Even though it was created for the wounded, ill, and injured, their goal is to connect the service member or the family member with someone who can help them. I think the point of entry -- I think a lot of referrals -- and, Margaret, correct me if I'm wrong. It appears as the interaction with the MTFs and the WTU/CBWTU case managers is a large avenue of entry. Like I said, there are self-referrals. I make some, but they're minimal compared to some of the other ones that they get, which is usually at the WTU/CBWTU levels.

Here's a little bit of the demographics, and this is for 2013. These are the -- by branch of service how many have been assisted so far. They do not keep or collect information on pay grade or condition or rank, any of those things. That is not something that's kept as a report. If you were to call me or call them, they could probably give you, you know, sergeant whoever called about whatever. Of course, we have to worry about HIPAA and PII, but there's ways we could at least get that information if we needed it. But we don't normally -- Humana doesn't keep it, and neither do I.

And then you mentioned something -- one of the questions was, if they're no longer active duty. It's all branches of service. National Guard and Reserve Component members. They could be mobilized, they could be demobilized, they could be retirees, they could be TRICARE For Life because they're retirees, but they have the dual eligibility because of

Medicare. So they help everyone.

CO-CHAIR CROCKETT-JONES: So when you say you're not keeping -- what I'm wondering is, are the 21,000 that you've helped discrete members, or is that 20,000 times of assistance. That's what I'm wondering. Are we maining records --

MS. DeLEON-DINGMAN: Those are members. There's another breakdown of what types of assistance is provided that I keep and they keep, but I didn't include that because it depends -- it could be a variety of calls, as far as they called because they didn't know how to get ahold of Social Security, or they called because they needed -- a couple of years ago they got a piece of equipment and now they need new equipment; they haven't needed anything for years. And so now they moved, so they want to find how to fix something. So they will help research it and point them in the right direction. So there's a variety of things that get their calls, and so they work through that, so -- but yeah. 21,000 is

the members to date, or whoever called to date. Because not all of them are the wounded, ill, and injured, it may be a family member, it may be a spouse, it may be a parent that called because they have a question.

CO-CHAIR CROCKETT-JONES: Okay.

COL MALENBRANCHE: How is it that you interact with all the other case managers? Do you go into the record and like if they got a nurse case manager from the MTF or from another area, how do you interact together, or like an RCC or an FRC? How is that communicated?

MS. DeLEON-DINGMAN: Usually teleconferences are the ones. We don't have all the records at -- Humana nor I. We just see -- you know, we get to see the referral and authorization process, some of the clinical notes with the interactions that occurred. This is a nonclinical -- and I should have probably put that earlier on.

This is a nonclinical program with clinical folks helping supervise a program.

Margaret is an R.N. We have -- there's another R.N. in the program. But even though its focus is nonclinical, it's very clinical involved because of all the injuries and things that are needed.

In addition to that, if the need arises that they need to push it back to a case manager, they communicate with whoever the caller is to connect with whatever case manager it is: FRC, WTU case manager, MTF case manager, VA case manager, all of those folks. And if it gets brought to my level at the TRO, I, without -- they already know me. It's like if we're going to start talking about these cases, we need to bring all the players to the table so that we can all communicate and collaborate together to ensure that we're getting the right resolution. A lot of times, they can do everything they need to do without my involvement, but yes. There is that communication back and forth.

COL MALENBRANCHE: So is there a warm handoff? If they're coming to you on that line, do you do a warm handoff to the -- what you

consider the appropriate or the person --

MS. DeLEON-DINGMAN: Well, it's not always necessarily a warm handoff, it's -- it's resolution of issues, because nobody knew how -- nobody knew what to do next. They did everything that's in their toolbox and there's still issues. So we bring everybody together, we try to communicate. You know, most of the wounded, ill, and injured have their military case managers. Humana Military has a case management program, which is separate from this. Very clinical case management. If we need to get them involved to help the MTF case manager, that is something that also occurs. If it's moving from the South Region to the North Region, we do try to do that warm handoff to the next region. And it also depends -- usually the VA, the FRCs, those are the folks that are going to stay with them forever.

And so getting them on board early when we're encountering issues, then yes. There will be a warm handoff, because I will get my counterparts at the other regions involved to say

I have a very complex, challenging case the WNAP has alerted me to. I've been in communication with X, Y, and Z, and these are the folks that are moving to your area, so yes.

COL MALENBRANCHE: Okay. And were you involved or aware of the Lead Coordinator Pilot? Have you been engaged with those folks at all?

MS. DeLEON-DINGMAN: Through the VA?

COL MALENBRANCHE: Well, the VA and the DoD.

MS. DeLEON-DINGMAN: With running of the DoDI?

COL MALENBRANCHE: The Lead Coordinator Pilot, which is part of Interagency Coordination piece.

MS. DeLEON-DINGMAN: Yes. At TRO level, yes, we are.

COL MALENBRANCHE: I know that pilot was out here in San Antonio. I didn't know how you interfaced with that.

MS. DeLEON-DINGMAN: And we have our

separate little workgroups at the DHA TRO level so that we can coordinate with the service leads and some of the other case managers in the services, and with the VA so that we can collaborate and put best foot forward to see how we can improve, make changes, or keep things the same so that we can standardize and hopefully have more consistency across the board.

COL MALENBRANCHE: So you mentioned DODI. There's a draft DODI that you have inputted and are working with folks on?

MS. DeLEON-DINGMAN: As I mentioned, connecting the warrior and their families, the multidisciplinary team is something that I mentioned. The Health Care Navigators are essentially customer service health care finders. The nurse navigators -- as I mentioned, Margaret is a supervisor, and then there's another nurse on board. And all the clinical stuff that the customer service health care finders get will funnel it through. The health care finders, pretty much the whole warrior team, has all

branches of services represented, so that also helps their program, I feel, because it gives insight onto how some of the branches work.

As I mentioned, they assist with transition from active duty. They do assist with relocation, they do have a separate 1-800 line, and there's also an after-hours voice messaging system that someone, the very next day during duty hours, they will call back and see how they can assist.

As far as the care coordination is involved, they do -- they interact, coordinate, and act as a liaison, not only with TRICARE and TRICARE Benefit, VA, Medicare, Social Security, the branches of service, the military case managers, the FRCs, the MTFs.

I think there was a question about some of the other programs within the other services and how is it different. And the other programs have a tendency to be branch specific, Air Force, Army. Even though we're joint based at a lot of these installations, there's still Army,

Air Force, Navy, Marines; and they have their own program to kind of help with the coordination or with MEBs or PEBs or things of that nature. So they cross all gamuts. It doesn't matter what uniform the service member is wearing, they are going to assist or find somebody who can assist them with whatever issue is on the table.

They also communicate with military and civilian providers if there's things that are needed. You know, it may or may not be a TRICARE benefit, it may be something that the VA covers but TRICARE does not, so they also not only get us at the TRO level involved, but work through some of that to see how they can help with whatever is being asked. And then they work closely with the Military Medical Support Office, which is the MMSO.

And MMSO right now is the one that governs -- or not governs, but the MOU with the VA regarding TBI, spinal cord, and blind injury rehab, so MMSO is the one that helps with the referral and authorizations. They are also the

ones that are the prime remote located -- more remote service members that may need something, so they're like the pseudo-MTF, so to speak. They don't belong to an MTF in particular, but MMSO helps with that aspect of it.

COL MALENBRANCHE: And how many people are you talking about in terms of your office and that -- the contract office, this case manager group that's managing all these cases? How many people is that?

MS. DeLEON-DINGMAN: There's one of me, six of them maybe. Right?

MS. WILSON: Five.

MS. DeLEON-DINGMAN: Five of them.

COL MALENBRANCHE: And this is an additional resource that's not part of the contract you mentioned that is provided.

MS. DeLEON-DINGMAN: Yes. Well, it is part of the contract now. The T3 contract. It was not -- originally, in its inception, it was something that they put together because they saw the need. And if you're not familiar with Humana

Military's staff, most of them are retired O-6s, O-5s, so they come with a lot of military background. So even though we're care coordinating, they are not case managers. I am a case management consultant, so I am not their case manager. Although we see the cases through to ensure that they've connected with someone.

COL MALENBRANCHE: So they're care coordinators, but they're registered nurses, for the most part?

MS. DeLEON-DINGMAN: Two of the five are. The supervisor and one of the VA liaisons is a nurse. And then the other three are health care finders. So the program essentially is a nonclinical program, but in our world, how can you not be clinical.

COL MALENBRANCHE: Thank you.

MS. DeLEON-DINGMAN: Okay. Any other questions?

EXECUTIVE DIRECTOR DAILEY: Can you give us some examples to help us understand how you're assisting them with a real-life example,

please?

MS. DeLEON-DINGMAN: Margaret, do you want to do that?

MS. WILSON: I do come equipped with two or three success stories as we'll call them.

In -- I have one service member who's in the Army. He retired after serving in Desert Storm; however, he had been in the military for a period of time. When he retired, he did not include and did not accept Medicare B. Nowadays, we know that we have to have Medicare B in order to have TRICARE, but he was not advised of that, although that is not uncommon. We get so much information on our out-briefings, that a lot of times we forget. And I'm sure he received notices and he received letters, however, he did not understand what he was reading as well. He continued to get his care, but over the course of years, he was also -- he started in on dialysis.

And over the course of that period of time, he accumulated a bill amounting to like $600,000. Of course, claims started building up

and they are asking when are you going to pay this. His spouse called us because -- we were fairly new, and they wanted to know what could be done; could we provide them with assistance. Actually, they were looking for funds. But with one of the health care navigators collaborating with the providers, collaborating with Medicare and TRICARE and everyone else involved, this $600,000 bill was taken care of without any cost to the service member himself.

Another success story, and we have -- we hear this quite often. Service members are billed for services that they receive while they're still on active duty. And one service member, of course, totaled about $11,000. And, of course, he called us, contacted us, collaborated again with the providers for the services that were involved. And, of course, his bill was taken care of with no cost to him.

MS. DeLEON-DINGMAN: I have a story. I'm sorry. Excuse me. One of the stories that just keeps coming up is the transition across

regions. They're getting ready to retire, they're waiting for their VA rating. The military case manager may have contacted somebody from the Warrior Navigation & Assistance Program wanting to know, well, what places can we move this service member to because maybe they need custodial care or some kind of subacute care. So with that, they will contact me, we will get all the entities involved that need to be involved to find a place that will be covered so that they don't have, after retirement, an exorbitant amount of money due to whoever or whatever facility they go to. So that's one of the outreaches where a military case manager will call Warrior Navigation, and they'll reach out to me so that we can collaborate and try to figure out what the best place for this service member is; and if it's in another region, I'll get the other region consultants involved also.

I'm sorry, Margaret.

MS. WILSON: Another one of our real success stories was a service member -- a young

service member during the Christmas holidays, he had been diagnosed with cancer, and wanted to be -- his one wish was to be close to home in Florida for Christmas because that's where his family was at that time. He had no -- no idea how get there. One of the case managers from the facility called WNAP and, of course, we started looking for facilities that would donate time, that would offer some form of transport. And this was air transport as well. But we did find a transport carrier that would transport as a Christmas gift. And so we were able to get the service member home December 24th so he could be home with this family.

MR. PHILLIPS: I've got a two-part question. The first part may not be answerable, and that's fine. Objectively, do you have any objective criteria that you use to determine successful outcomes or not? I mean, I've heard very subjective -- I mean, those are wonderful stories and that's very helpful, but I don't know if you can develop objective metrics.

MS. WILSON: It might be rather hard. We do a follow-up on the cases that we assist with. And, of course, we call them just to make sure that things have been -- hopefully turned out the way we planned. And the information that we get from the service members and from the family members.

DR. PHILLIPS: It sounds like you're filling a very important role. I mean, you're learning things and you're doing things that the system perhaps is not quite doing. And you're on contract, aren't you? You're a contractor?

MS. DeLEON-DINGMAN: No. I'm a government employee. I work for DHA. I oversee the contractor.

DR. PHILLIPS: Okay. But the program is sort of a contract program.

MS. DeLEON-DINGMAN: It's an enhancement. Correct. And so to answer the -- like you mentioned, it may not be able to be answered. I think that's correct.

In -- we went round and round with

how are we going to measure -- what metrics would we use to actually measure success. And there is from A to Z a variety of issues that come forth. A lot of them may be medical, but then again, a lot of them aren't. So as Margaret mentioned, the follow-up calls was one of the things that we measured. You know, if they get a call today and they're talking to -- maybe let's say it was you, and we're going back and forth and we resolve -- they resolve the issue on that call, then that was how we started measuring the outcome. Because some of them took follow-on calls; maybe it didn't get resolved at this first call, but I'll call you back tomorrow or things of that nature.

So in that regard, that's how it started out just measuring. And then they went a little step further -- or not a little, a lot -- to say now we haven't heard from them, we're hoping that everything's fine. So they initialed a follow-up call to ensure, "Remember when we spoke, how are thing going."

There's some cases that I am even

involved with for many, many months just to make sure, because the severity of the injury may take a more lengthy amount of time to resolve. And it's very, very complex, very, very clinical in nature.

So yes. That's a hard-to-answer kind of question and that's kind of where we are as far as measuring metrics and making sure and keeping tally of those things that don't get resolved and how long it took, but successfully, they seem to be resolving pretty quickly.

DR. PHILLIPS: And that's what I was asking. I mean, I certainly understand you all are doing very good things and helping a lot of folks that sort of fall between the cracks and so forth. What I was driving at, you're learning a lot about how to do things. You are doing a lot of things. But as a contract-type of program, if that contract goes away due to budget cuts, are you preserving that information? Are you transferring that to the full-time people? Is it sustainable?

MS. DeLEON-DINGMAN: Yes. Being -- as a government representative, I can tell you that -- I've been doing this for many years. And because of the many years, I was one of the case managers before case managers existed for the wounded, ill, and injured at Fort Sam, so I brought that knowledge with me. Because we, by the seat of our pants, had to figure out how are we going to help these service members. So with that, the collaboration between the TROs, DHA, the VA, we are bringing some of these stories forward because this isn't over. You know, we may be told we're at the end of a war, and hopefully it's over, but we still have members to care for. That is what we do.

So we have separate workgroups. We bring all that information -- I'm very vocal. You don't know me very well, but I'm very vocal. I speak very close with leadership. Mr. Thresher is our regional director for all of the three regions. So all of that information, my goal is to take it forward to improve at all levels, and

to collaborate and communicate, especially with our partners not only through the contractors -- the three contractors through the regions. Because even though they're separate contractors, we still have a mission.

And then we have our VA partners and what we're going to do, because they're transitioning to veterans, so yes. I would like to believe that all the things that we're doing and all the things that they're doing, the things that aren't working I will verbalize, the things that are working, which seems to be the majority of the time, those are the things that we're also verbalizing. And I know that we've spoken to the other TROs, and you all will be hearing from the other regions. I can't speak for their program.

DR. PHILLIPS: Thank you.

MR. REHBEIN: Some of the most difficult cases that we've -- that I've been exposed to are folks that are not in a CBWTU, but are simply assigned to a Joint Forces Headquarters and are recovering. Can you -- and I don't see

them listed here. Can you assist folks like that too? And how do you -- how do you get in touch with them?

MS. DeLEON-DINGMAN: We don't get in touch with them. They need to get in touch with Warrior Navigation, and as I --

MR. REHBEIN: I understand that, but how do they find out about Warrior Navigation?

MS. DeLEON-DINGMAN: There is an outreach brief to all the MTFs, to some of the Musters, to some of the -- all of the WTUs, CBWTUs. It's a marketing that Humana Military does. And you know, the TRICARE Service Centers, which are located at all the MTFs -- or now have brochures of anything government-wide or other conference that has wounded, injured, or wounded -- not wounded. Service members in general. Some of the military conferences, Humana will be out there with their brochures. So there is a huge marketing outreach program, in addition to the briefs that may be to the MTF commanders or within the TRICARE Regional Offices.

We will speak of Humana Military and what Humana Military has to offer, which includes this program. I am often asked to speak at various conferences. I will bring that information with me. It is not uncommon for me to get calls from all the services at the headquarter level. So I think through all of that communication it does get put out there.

DR. PHILLIPS: Do you have any response, percentage numbers, just like you're talking to the Joint Forces folks -- and obviously they have to reach out to you. Do you have any record or knowledge of how many people actually contact you or --

MS. DeLEON-DINGMAN: We do have those numbers. I don't have them off the top of my head. We do.

MR. PHILLIPS: No, no. I'm just wondering. You put a tremendous effort out, and is it just one out of a hundred, or is it a good number?

COL MALENBRANCHE: Do you know how

many?

MS. DeLEON-DINGMAN: I don't know off the top of my head.

DR. PHILLIPS: What I would like --

MS. DeLEON-DINGMAN: We do have tally, because that's part of the information that I gather. I don't have it off the top of my head. Percentage-wise or number -- you know, call volume-type things, so no. I know we have about ...

DR. PHILLIPS: Well, what I was driving at is, you're doing good work on one side and yet for some reason you're not proactively contacting the folks on the other side, but you're providing information. Whether or not that's something we could address to enhance your coactivity on -- you know, on that group. If a lot is responding, that's great. If only a few are responding and yet you find out down the road that there's a greater need, that's something you could address.

MS. DeLEON-DINGMAN: As a Task

Force, I think visibility and that information being included is valuable. I'm not quite sure I'm clear on what you mean by "folks on the other side." This is South Region, we're very Army centric ...

DR. PHILLIPS: I meant those that are in the WTUs. I mean --

MS. DeLEON-DINGMAN: Oh, I see. Yes. Well, by reaching out to the other services also, you know, the Air Force doesn't have what we -- you know, everybody talks WTU, WTB, CBWTU. We know that's very Army, even though sometimes we want to say the generic.

So interaction with the Air Force and the Navy and the Marines, they are -- they have a different -- little bit different programs. And they are trying to increase their reachout, but they get notified and informed of what is available in our region.

So we try to be protective when we can. Definitely I will speak the program because it's like, "Have you ever heard of ..." and more

and more word is coming out. And I've had people from -- and I think Margaret has gotten calls also where they're from other regions and they have other contractors but they wanted information from WNAP. And they will provide them information, but then they have to go back to their region and get whatever it is they needed. If we need to connect the dots, we will do that also.

Did that help?

CO-CHAIR CROCKETT-JONES: Do you have a protocol for referral to clinical case management? Is there a checklist that would trigger a referral to a more comprehensive case manager? And, if so, do you do that in-house to nurse case managers within the Humana system or, you know, do you routinely look at referrals to like FRCs or something like that?

MS. DeLEON-DINGMAN: It depends on the case. I don't know that there's an a official protocol.

Do you have an official protocol?

MS. WILSON: We do we have protocol

that comes up in our system that will say "Case Management," and we will refer usually to our in-house case managers. If this is a case that would be one for communication or out of region, then we have contacts also that we will communicate with the out-of-region case manager.

Now, for the other case managers or the cases that are maybe just care management, we will discuss with the case manager or with the FRCs, and many of the FRCs will contact WNAP with the case. Sometimes they have case meetings or family meetings, or what have you, and they will ask us to sit in with them on quarterly conferences.

MS. DeLEON-DINGMAN: And for the clinical case management, if there isn't a military case manager involved that we're aware of -- and this is aside from the Warrior Navigation & Assistance Program, then absolutely there is a protocol. And it is within the contractor's program to add that case management TRO. So yes, there's also flags, whether it be

active duty or nonactive duty, where they will be flagged as needing some intervention for whatever it is. And then the criteria goes forth to see if they're eligible for case management, if the member is willing to accept case management. So there's -- but yes. There is that. And then including all the entities that we've already spoken of.

COL MALENBRANCHE: How do you engage with the VA? So if you have a member that's -- I assume that they're out in the network being cared for, and you must be helping them with that, and they're in a transition to the VA. Do you have a direct access to the VA for transition?

MS. DeLEON-DINGMAN: I do. I'm very -- I worked very closely with the FRCs and, you know, Mark Goldstein is in our offices also, so he's got connections that I may not have sometimes. But usually -- like I mentioned, I've been doing this for a while. So within the military case manager, there's usually a VA case manager that has been identified and a Federal

Recovery Coordinator that's been identified, and then we'll interact with them to see how we can help.

COL MALENBRANCHE: I guess when you've been talking about Federal Recovery Coordinators, those are for people who are severely ill and injured. I'm hoping that they do have a case manager generally by the time they're going out. The referral would be more of a care coordination with the VA, and I'm just wondering, do you have routine meetings together and as a region with the VA, with the Army, and the Air Force, I guess is quite heavy down here. Do you have some sort of routine case management --

MS. DeLEON-DINGMAN: At the DH level we do with the service leads, and I believe there is a VA representative. The complexity of the case is going to determine how often we meet and with whom. So routinely, just it's Tuesday and it's the second Tuesday of the month, no. We do not.

COL MALENBRANCHE: But you should --

do you receive complex cases that have not been getting care or something otherwise? I mean, do you get them -- you wouldn't get them normally as the first stop. Right?

MS. DeLEON-DINGMAN: It's rare. It is rare to get a case that nobody has been involved with. And you're right. And at my level, at the TRO level, it's usually cases that are so complex and there's so many pieces to the puzzle that need to be put together because all the other things have been tried or we need to move them across regions. But in general, it might be -- in that instance, it might be somebody who's already transitioned out and then years later something came up, and who do I call. You know, and they have one card left and maybe that's somebody from OWF or somebody from a MTF, and that's when they'll call. Or somebody from headquarters will call me and say this is a member who was at SAMC, but we're not sure where the disconnect was, they've already retired years ago. And so we try to connect that. That really is

rare for the most part.

COL MALENBRANCHE: How many years has WNAP been in existence now?

MS. DeLEON-DINGMAN: Since December '07.

COL MALENBRANCHE: And the TRICARE Service Centers are going away, are they not?

MS. DeLEON-DINGMAN: They haven't gone away yet.

COL MALENBRANCHE: But you do outreach individually. I mean --

MS. DeLEON-DINGMAN: Yes, they do.

COL MALENBRANCHE: To whom?

MS. DeLEON-DINGMAN: To the MTF, to the MTF commander, to the Military Case Managers. Yes.

COL MALENBRANCHE: And then so the other contract folks as well when people are crossing, they know of you -- I mean, so United and HealthNet know of you and have some sort of counterpart --

MS. DeLEON-DINGMAN: Yes. And that

is the something that I've pushed. One of the things that you-all mentioned is crossing regions and collaboration amongst the three. When I came into this job, it was -- one of my goals is to bring the three regions, continuity, standardization. We're not always going to be like that, but we're trying. So we brought the three TROs together, we brought the three contractors together to do that case management point of contacts, and how we can transition. In general, those that we know of do well. It's the ones that we don't know about. And I can't tell you numbers of those, but in general, we've brought everybody together. Just brought United into the fold to let them be aware, just like we're going to be more aware of what they have to offer.

COL MALENBRANCHE: So this is a combination of case management and care coordination.

MS. DeLEON-DINGMAN: For me, yes.

COL MALENBRANCHE: From a --

MS. DeLEON-DINGMAN: For Warrior Navigation & Assistance, it's care coordination --

COL MALENBRANCHE: It is a separate case management division --

MS. DeLEON-DINGMAN: Within Humana Military's contact they have a separate case management program. And if they have a military case manager, that military case manager with the Humana Military case manager will need to communicate and collaborate. Because, in general, military case managers, if that's who their case manager is, whether it's remote or in an MTF, that's who's going to be managing them. And the secondary person or a resource person may be a contractor or case manager or Warrior Navigation & Assistance depending on what the need is.

COL MALENBRANCHE: And I'm sorry I'm asking so many questions, but I wasn't aware of you.

And so now, you had a number up there too, a 1-800 number. Are you affiliated, connected to, or do you have any interaction with

the Military OneSource and/or other 800 numbers?

MS. DeLEON-DINGMAN: We are not affiliated with Military OneSource. That's a separate entity, DoD. They're aware of Military OneSource, and that's a separate and marketing campaign. That, upon occasion, does come up, you know, as one of the resources; Military OneSource is a nonclinical resource, and there's a wonderful Website that goes along with that, but we are not affiliated with Military OneSource.

COL MALENBRANCHE: And then your number, you said they take a message because that's like a nonurgent number, and you must have a message on there and they get back with them.

MS. DeLEON-DINGMAN: Yes. For after duty hours.

COL MALENBRANCHE: Thank you.

EXECUTIVE DIRECTOR DAILEY: Carmen, do you ever think that you're getting a caseload that could be handled by all these other resources? I mean, there's a lot of medical case managers, nonmedical case managers, RCC, squad

leaders, liaisons, DoD/VA liaisons, OIF/OEF Program Management Offices. Who's not doing their job that they end up coming to you?

MS. DeLEON-DINGMAN: I don't know if it's they're not doing their job or the complexity of the cases is going to -- is going to -- they are going to need more -- it takes a village. How's that?

Sometimes these cases are so complex that although our military case managers are well versed in the military aspect, it gets quite challenging when you have to understand and know how to navigate or provide resources to what are you going to do when you get that letter that says you are eligible for Medicare Part B? Well, why am I eligible for Medicare Part B when I'm 22 years old, but I've been severely injured. Or there's a spouse who's also 21 years old and doesn't understand those things. Or connecting them with Social Security, because they may be eligible for some of the Social Security benefits.

Unfortunately, I think in general,

the acute situation at the MTF level and getting them through MEB and PEB is one aspect of the job. And hoping to put them where they need to be so that they can move forward in their future chapter of their lives because of the changes that occurred. Knowing all the outside resources -- we've been doing this for 20, 30 years. Some of these case managers haven't been, so I'm a little hesitant to say they're not doing their job. Some of our programs, like the Army's program, is a lot more robust than some of the Air Force or the Navy or -- but it's a different -- you know, the services are all a little bit different. In the South Region we're very heavy Army. So with that came very heavy WTUs and WTBs and CBWTUs, and things like that.

So I think, in general, if all the services had the same type of program that encompassed all the things that are needed, that would be ideal. And I don't -- you know, when you bring someone who has been a nurse and they're working out in medical/surgical units and now,

guess what, you need to put on that case manager hat because now you're at a CBWTU because you've been activated as a Guard and Reserve Component member. And so it's -- it's a new life, you know, and has access to care standards that the Army hopes for, versus what's really available at an Air Force MTF.

So it's -- I don't know that they're not doing their job. I think they're doing the best they can with the information and all the things that are thrown at them in various arenas.

COL MALENBRANCHE: Okay. My last question. Knowing all the programs that are out there from all the different services out there, what do you think that you bring unique to the table, and/or -- I guess, you know, we've had such -- there's been such chaos around all the case managers that are out there. What do you bring to the table that others don't, or what is needed, or can you give me some of your thoughts on what you think is missing?

MS. DeLEON-DINGMAN: It's going to

be very biased thoughts, because I don't have information about the other regions. As far as at the service level, I think what Warrior Navigation & Assistance Program brings to the table is that they ensure that all the people that need to be involved get involved. That doesn't mean it's not happening somewhere else. It's happening with us. We work very close together. They know that if they can't answer the question, I'm going to -- they're going to bring it to me and I'm going to continue to dig and get those people involved. And if I need to call headquarters, I'll call headquarters. That's not their role, that's my role as a government person.

So the complexity. You know, in making sure how all of those people come together and trying to resolve issues that -- you know, you go to a military case manager, and there might be the Army Relief Fund or some other fund through the Air Force or through the Navy, but some of it's entrepreneurs that have donated funds, some of it is I'm going to get a loan. Humana has

found some entrepreneurs that are -- we're a very patriotic world and city, per se, so they bring some of these entrepreneurs and they reach out to some of these folks to get some assistance. I don't know that that's happening in other regions. But when there's a service member saying, "My bills are overwhelming, and they're getting ready to foreclosure on my house," and the WNAP people figure out a way to get them some help, that's above and beyond in my mind. It's not an "I can't help you, call our main relief fund." It's "Let me see what we can do, let's work through the claims, let's work through the bills and see what we're doing," because it might be somebody who's about to get their house foreclosed or they need shelter or they need food, or it's getting ready to be Christmas and they're chronically ill, terminally ill, and they need to be there with family and because that's one of their wishes.

So that's kind of the things that they do on a regular basis, in addition to helping the navigation of the health care system. And

also ensuring that the folks that are involved at the case management level, whether it be VA, MTF, or wherever, that they're all involved with that.

I don't know too much about these other programs. They're not as robust as they would like to be. I have gotten calls to say give us examples, help us, who do we talk to, things like that. And I can only hope that it's going to get better with all of the services.

Any other questions?

CO-CHAIR CROCKET-JONES: No. I think we're all good. Thank you very much for presenting this to us.

MS. DeLEON-DINGMAN: Thank you for having us.

CO-CHAIR CROCKETT-JONES: I think this is the conclusion of our day. What time are we here in the morning?

EXECUTIVE DIRECTOR DAILEY: 8:30.

CO-CHAIR CROCKETT-JONES: Do we have anything else before we go?

EXECUTIVE DIRECTOR DAILEY: We did

give you the January and February agendas, so I think we'll have some time tomorrow afternoon to look at the January and February agendas, and you can tell me if you want to pull the plug. That will -- that will work just fine.

And then tomorrow afternoon, the weather is getting iffier and iffier. I think that for the evening boat ride we're looking at a max temperature of 39 and descending tomorrow. So I would leave the date, the time, open if you want to go, but there's a good chance it's going to get canceled. So tomorrow evening may be a boat ride or it may be an evening on your own, or we'll go out someplace and have dinner in groups or small groups and get ready for the next day. So tomorrow evening is still very fluid depending on weather.

CO-CHAIR CROCKETT-JONES: Okay. And I'm going to ask the Task Force members to look at those January and February agendas with an eye to creating a sense of your -- what you view as a priority, so that when we discuss them tomorrow,

we can see if we have a consensus for keeping an agenda that is fully on Task Force. Okay?

All right, then. See you tomorrow morning at 8:30.

(Whereupon, the foregoing matter was adjourned at 4:30 p.m. to reconvene the following day, December 10, 2013, at 8:30 a.m.)