UNITED STATES DEPARTMENT OF DEFENSE

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

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JANUARY BUSINESS MEETING

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MONDAY
JANUARY 27, 2014

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The Task Force met in the Washington Ball Room of the DoubleTree Hotel Washington D.C.-Crystal City located at 300 Army Navy Drive, Arlington, Virginia, at 8:30 a.m., Suzanne Crockett-Jones and Matthew L. Nathan, Co-Chairs, presiding.

PRESENT

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
VADM MATTHEW L. NATHAN, DoD Co-Chair
CSM STEVEN D. DeJONG
RONALD DRACH
TSGT ALEX J. EUDY
LT COL SEAN KEANE
KAREN MALEBRANCHE
RICHARD P. MUSTION
STEVEN PHILLIPS, M.D.
DAVID K. REHBEIN

ALSO PRESENT

DENISE DAILEY, Task Force Executive Director

CAPTAIN ANTHONY ARITA

COLONEL RICHARD CAMPISE

DR. ALISON CERNICH

DR. TOM DeGRABA

COLONEL GEOFFREY GRAMMAR

CYNTHIA GILMAN

KATHY HELMICK

KATY HUSSEY-SLONIKER

CAPTAIN SARA KASS

DR. JAMES KELLY

DR. MARY LAWRENCE

PATTY MORRIS

DR. DONALD SPARROW

CAPTAIN RICHARD STOLTZ

DR. HELEN WHITE

T-A-B-L-E O-F C-O-N-T-E-N-T-S

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

(8:33 a.m.)

CHAIR NATHAN: Okay, I think we're ready to get going.

Technical Sergeant Eudy, it's great to see you. We were going to put your picture on a milk carton. Didn't know where you were.

Well, it's great to have a quorum. I think we've got everybody here. And it's nice to have a full house. So we'll go ahead and get started. Ms. Dailey, do you have any administrative comments before we start?

DIRECTOR DAILEY: No, sir, I do not.

CHAIR NATHAN: Okay. So, folks, good morning. And welcome to the January 2014 Business Meeting. Over the next two days we're going to cover some topics, which will include updates from various centers of excellence: the office of the Assistant Secretary of Defense for Health Affairs, the

Interagency Program Office, and Implementation Guidance for Job Training and Employment Skills Training Authority.

We'll also receive information from the Veterans Metrics Initiative and the Wounded Warrior Project Technical Training Academy, as well as three nonprofit organizations devoted to supporting the Recovering Warriors.

Again, for those folks who may be new in the audience, if we could go around and ask the Task Force members to identify themselves. And if we start with Dr. Phillips.

MEMBER PHILLIPS: Well, thank you. Good morning. Steve Phillips. I work at the National Institutes of Health. And I have 25 years as Active and Reserve.

MEMBER EUDY: Technical Sergeant Alex Eudy, representing both the Air Force and Special Operations Command.

MEMBER KEANE: Lieutenant Colonel

Keane, representing the Marine Corps Reserve.

MEMBER MUSTION: Rick Mustion, Commanding General of the Army's Human Resource Command. I represent U.S. Army.

CHAIR CROCKETT-JONES: I'm Suzanne Crockett-Jones. I'm the civilian Co-Chair, and the spouse of a Recovering Warrior who has retired and is now in Veteran status.

CHAIR NATHAN: Matt Nathan, the DoD Co-Chair, and the Navy Surgeon General.

MEMBER MALEBRANCHE: Karen Malebranche, representative, Department of Veterans Affairs.

MEMBER REHBEIN: Dave Rehbein, Army Vet, research scientist at Iowa State, and past National Commander of the American Legion.

MEMBER DEJONG: Command Sergeant Major Steve DeJong, representing National Guard Bureau.

MEMBER DRACH: Ron Drach, civilian member of the Task Force, retired from the

Department of Labor and Disabled American Veterans, and Vietnam Vet.

CHAIR NATHAN: Thank you, Ron. And thank you to everybody. Since our last business meeting there have been multiple installation visits immediately following the December meeting, business meeting, which occurred in San Antonio, Texas.

Members remained to visit the San Antonio Military Medical Center, SAMMC. That visit provided opportunity to hold focus groups with the Air Force, Marine Corps and Navy Servicemembers and family members, as well as spend time with the Marine Corps Wounded Warrior Regiment, and the Navy Wounded, Ill and Injured Annex leadership.

There was also a discussion with the chief of the Warrior Care Clinic at Brooke Army Medical Center. And as well as meeting with the staff at the San Antonio Polytrauma Rehabilitation Center.

The first installation visit in

January was to Tampa, Florida, where we conducted site visits at the James A. Haley Veterans Hospital and Tampa Polytrauma Rehabilitation Center. Probably their most robust. There are a few of them that are pretty big. But probably their most robust Polytrauma Center.

The Reserve Component Soldier Medical Support Center, the Special Operations Command Care Coalition Headquarters at McDill, and the University of South Florida's Office of Military Partnerships.

That visit allowed us to get additional insight on the VA Hospital and Polytrauma Rehab Centers' functions, as well as witness the inner workings of the Reserve Component Medical Support Center, and the Special Ops Command Care Coalition.

Before leaving we also met with the Director of the Office of Military Partnerships at the University of South Florida, who discussed several initiatives

that impact the wounded, ill and injured population.

The Task Force then conducted a site visit to the Community Based Warrior Transition Unit in Illinois, Rock Island. They were able to meet with unit leadership and staff to discuss the medical and the non-medical case management, as well as vocational services. They also conducted servicemember and family focus groups.

Due to weather they cancelled the scheduled installation visit to Hunter Holmes McGuire VA Medical Center, and the Polytrauma Rehab Center in Richmond, Virginia, the Portsmouth Naval Hospital in Portsmouth, Virginia, and the MEDHOLD East in Virginia. That visit will be rescheduled for 4 through 5 March.

A list of the site visits and respective attendees can be found at Tab B of our briefing books.

And let's begin, if we could, with

a discussion from the Members who attended the SAMMC site visit in Texas. So, that would be Ms. Crockett-Jones, Ron Drach, Ms. Malebranche, Dr. Phillips and Dave Rehbein.

MEMBER REHBEIN: Well, I'll kick it off a little bit here. As I went back through my notes, we talked with so many groups that it was, in my mind, a little bit difficult to really draw something that I would consider to be strong enough to even get into a recommendation. Except for possibly one thing.

And maybe this isn't even a recommendation. Maybe this is just kind of a best practice. But as we talked to the family focus groups, they felt left out of many of the activities, particularly the Marines. Because there were so many of the activities that were aimed at the Marine. And the spouse and the kids were still at home.

So they were asking for more family, couple-oriented activities, where they

could -- they and their Marine could be together, helping to heal together. Rather than the Marine being off someplace hunting, or whatever, and the spouse and the family being at home.

That's really the only thing that I picked up there that I -- because they were such small groups. It's hard to draw large conclusions from small groups.

MEMBER PHILLIPS: Let me add a few things. Broadly speaking, I was very impressed. And you probably know that the San Antonio community is fairly integrated, military and civilian. So as far as caring for the citizens, they all pitch in and work together.

If there's a civilian that needs Polytrauma care, and vice versa, if there's a military member that needs something that the civilian sector can provide, there seems to be full integration. And I don't know if this is military policy, but they all work together.

And I think that's to a great benefit of the citizens in that area. And that's a wonderful model. And I don't know what we could do related to recommending it be reproduced or considered in other areas. But, of course, San Antonio is fairly unique, related to the military and civilian population.

The one thing that stood out to me was that at the Joint Base there are lots of different activities provided by the different Services, but they're not integrated. And I think that's something that we could consider.

For example, the Marines were next to Army, that had activities, but could not support the Marine activities, such as the PEBLO type of function. The Marines had to use the remote access to their PEBLOs, I think in Florida. Even though they were just next door. So I'd appreciate any other comments that the visitors had.

CHAIR CROCKETT-JONES: Yeah, I'd

agree that there was some -- as we see more and more joint operation types, as the medical care starts being shared across Services, we're not seeing at the same time an integration of Warrior care. And that goes for even some of the more mundane daily services or opportunities.

And we saw that there. I think SAMMC was a good place where we saw how compartmentalized a lot of this still is. But that because everyone's co-located, families see how other Services get benefits or access. So it's going to cause -- eventually that leads to a lot of tension and problems.

Also, Mr. Rehbein, on your point, I think that this is sort of an issue everywhere, in that when people transfer from inpatient care, and the crisis is sort of -- the biggest part of the crisis is over, and now they're in a recovery mode and sustained outpatient care.

Families suddenly have this moment

to breathe. But they're also now becoming way more responsible for different portions of that care. And it's a different -- they now have to rework this new normal with their servicemember. And it's a tough balance.

Keeping a recovering servicemember busy and productive and positive in their recovery, versus having enough time to -- you know, having too much time can lead to -- you know, we've seen those problems in other places. But there needs to be a balance where a family has time to heal and get used to their new normal with that servicemember.

And I think that we weren't quite seeing that at SAMMC. So I'd agree with what both members have said. The other thing was, I believe SAMMC -- there was confusion. SAMMC was yet another example of where we saw some confusion about polypharmacy. Wasn't that the case? Didn't we see that there too?

And also, considering their population, of how seriously injured those

folks are, we did not see much SCAADL. And so I'm really wondering how effectively SCAADL is getting out to families.

And I will say, though, that SAMMC was -- it was a community that had a lot of civilian participation. I'd love to see that everywhere we go.

MEMBER DRACH: Just following up a little bit on what Mr. Rehbein said, too, about the activities. As I recall it, a lot of the activities that the spouses were making reference to were being provided by outside organizations and nonprofits and other benevolent organizations.

And a lot of them were designed specifically for the Warrior, by him or herself, and did not include the spouse or family. And there was some level of frustration about that.

They may have traveled to see their spouse. Or they may be staying there. And they're disconnected for the weekend, or

whatever, because the spouse, the Wounded Warrior is off on some event, hunting, fishing, or whatever.

The other thing that, and if I heard it correctly, I'm not sure I did. That they were being told that they can't be involved in the internship program through Operation Warfighter. And I may have disconnected on that conversation. But that was a little disturbing.

And I also, my note says that there was a lot of confusion about who does what in the recovery process. And I heard this since day one. They're being overwhelmed by offers of assistance. Some of them -- I know it's somewhat anecdotally, but back in the early years they would wake up at Walter Reed and they would have a drawer full, or their nightstand would be full of pamphlets and business cards, and all this information about what could be done for them. And it's pretty overwhelming. That's about it.

MEMBER MALEBRANCHE: I think the other thing, in addition to the things that were said here, to re-emphasize again the disparity between the Services on how things were delivered. And one would think that after all this time there would be some similarities. And there weren't.

And also the case management from Service to Service, and group to group was significantly different. And, again, one would hope after this amount of time.

And the Lead Coordinator concept is being piloted down there. Some knew about it, some did not. And the groups that we spoke to, all of them should have known about it. So I thought that was significant as well.

CHAIR CROCKETT-JONES: I think the other two notes that I have are the difference in PEBLO access from Service to Service was startling. And catching on to what Dr. Phillips said, some of the PEBLOs had very low

case loads but seemed relatively uninformed about them, which was a little disturbing.

And this was a place where we also saw a lack of understanding of what a CRP was. And this is something that was repeated at more than one of these visits.

CHAIR NATHAN: So, I wasn't a member of that team visiting. But, you know, from a global perspective, there's really -- I mean, you can sort of count San Diego and Fort Lewis-McChord in as large repositories of Wounded Warriors. But, generally, San Diego much less so now. Their numbers are dropping as far as acute care. And they've never, ever had the footprint of a Walter Reed-Bethesda or a SAMMC.

I think that you've observed that there's still some immaturity in the development of integration and there's no parallel lines along the Services. The Navy still provides its admin support for the wounded warriors there out of Corpus Christi.

And the Marine Corps, only until the last couple of years, was really integrated well into the Brooke facility. They were sort of operating on their own. And it became an us, and a have and a have not, and us versus them. And I hear tell that's gotten better. But it's not matured yet.

So I think this is indicative of this large area, where, again, this Task Force has said over and over again we need to have much more one-size-fits-all across the Services for congruency and policy.

Easy to say, difficult to do. Because each Service has sort of grown their own that works for their culture and the way they organize themselves in the Active and Reserve components.

But, again, everything you're saying resonates with what I have seen and heard from that area, which is an amazing acute care facility, when you combine the prowess of Brooke Army Medical Center with the

Center for the Intrepid rehabilitation facility and the VA down there.

Yet now we're really starting to deal with, from a strategic standpoint, we're really starting to deal now with the essence of this Task Force, which is the Recovering Warrior.

We were for so long, in the military medical and the VA medical system, just set back on our heels with the numbers, the relentless numbers of acutely, catastrophically injured people coming in, either with emotional and/or physical injuries.

And now, if you go down to SAMMC, or you talk to Walter Reed, or you talk to San Diego, it is more often rare than common for them to get a catastrophically injured warrior into their hospitals. That's the great news. The great news is that what used to be lots of people, three times a week rolling up to their doors -- I was talking to the Commander at

Walter Reed-Bethesda last week. And I said, "can you tell me about how many patients you've had who've presented from the battle with amputations?" Now, when I was there, it was not uncommon to get ten, 12, 15 people in a week, at the zenith of all this. He's had two in the last two months. I think that's wonderful.

I think that that is indicative of the fact that the op tempo is slowing down and we are starting to evolve into a new thing. But now the concentration comes into how do we manage these folks? And as Suzanne says, how do we make sure that two spouses riding down the elevator together, from different Services, as they talk about what each one, their loved one is getting, or their family is getting, doesn't feel there's the have and the have nots.

So, again, I think this just reinforces what we've been saying for a long time, which is we have to find congruency in

these programs. Easier said than done. Any other comments on the SAMMC?

(No response.)

CHAIR NATHAN: Okay. Let's talk about the next visit, which was down to the Tampa area. Would any of the members who were on that trip care to articulate their observations?

I can start by simply saying, I think most people are impressed with, who don't -- you don't normally think, if you're not in this business, you don't normally think of the Tampa Bay area being sort of a mecca of warrior care and/or interest. But when you realize they have this tripod. One is the Haley VA Hospital, which is clearly, clearly been capitalized and staffed, and resourced to be, if not the flagship trauma center, close to it, for the VA.

And then you have SOCOM down there, the Special Operations Command, which is the epicenter for their Care Coalition,

headed by some very impressive former special operators themselves, who take charge of that Care Coalition the same way they took charge of missions when they were up.

And as I commented to the group, when you're down there, when you see somebody walking around that campus with a beard and a ski cap on, you don't know if they're there to fix the plumbing or if they just came out of deep cover.

And then between them, situated between them, is the University of South Florida, which has taken upon itself almost a crusade-type mentality to increase its portfolio in research and in contributions to the Veteran/Wounded Warrior mission.

The good news is that I think they're trying to do some amazing integrated care between those three areas. They may be getting a little redundant. Because I was left thinking, okay, University of South Florida, you're also sort of trying to do the

VA mission at the same time.

But they truly want to build, they're looking for the funding to build that amazing new pavilion they'd like to build that's dedicated to the rehabilitation of veterans and the research and education. So I was impressed by the community.

And Florida, by and large, has always been a very Veteran-friendly state. The Legislature there is very Veteran-friendly. And they recognize they have a very large Veteran population there that if they don't get their arms around, not unlike Southern California, if they don't get their arms around they're going be dealing with a lot of issues, in the way of homelessness. Because of their zip code and their climate, they're going to be dealing with a lot of issues in homelessness and people adrift. And so I think they're trying to meet that head on.

The other thing that I found that

was interesting was our visit out to the Chairman Young Army National Guard Center, where they're undergoing their transition. And they're going to be handing off their case management mission. That was interesting and concerning at the same time. And I'll let others who have more understanding of that comment on that.

But that brought to light again what Ms. Crockett-Jones and I were talking about before, is as we're gaining some traction on the Active component recovering warfare in the more Active component areas, are we seeing the same amount of resourcing and maturity of processes and policies in the Reserve components?

And the answer is probably not. All good intentions. But, again, that visit highlighted to me where I worry that we're not creating a system that's equal to the Active component. And Reserve component people can still fall through the cracks pretty easily.

MEMBER REHBEIN: If I may, sir, I want to follow up what you just said a little bit. Because I felt the same thing. Pinellas Park was created to deal with that huge backlog of Reserve component. And they've done that very well.

But in talking to them, it does not appear that anything has been done to alleviate the problems that created the backlog. Specifically, they said that they see as many incomplete packets coming in now as they did when they first started that operation.

And that's complicated by the LOD process in the Reserve component. I'd like to see the Task Force look at making a recommendation, not of how to fix that problem, but somehow, whether it's DoD or the Service -- because the problem is primarily Army; that's where most of the National Guard is -- somehow create a group that can address that problem, and figure out a way to make

those packets right when they come in the door. Because every time they have to go back the unit it just adds more time, and drags things out more for the people out there that are really struggling with some problems out there.

And there are folks in the National Guard and Reserves that are really struggling. So I'd like to see us, at the end of this process, when we have our report, that we have something recommending that a study group or a task force be put together to look at that problem.

Because I think, as the op tempo goes down, the emphasis is going to go away. But everything, the potential is there to create that problem all over again the next time we have to go into a high deployment rate.

CHAIR NATHAN: Suzanne, I think you said it well when we were speaking earlier. If this nation is going to -- and,

again, this was a little bit an aberration, the length of this war, and the degree of people that had to be called up to source it.

But if we're going to continue to put the burden on such a large proportion and population of our Reservists, we have to figure out a more robust infrastructure for supporting them in a recovering capacity. Recognizing that I don't think anyone foresaw, in the '90s, that we would have this many folks scattered from around the country, in the interstitial spaces, fighting, and as many wounded as there are.

But now we're trying to catch up in how do deal with these folks, and maintain continuity of care, and maintain awareness of how they're doing.

CHAIR CROCKETT-JONES: And when you combine that with the special sort of processes that are unique to the Reserve component, I think it's -- especially as we see this transition to absorbing CBWTUs, and

turning them -- going to a CCU structure, I'm very concerned that just the understanding of the differences in process is going to be lost. We need to somehow get the subject matter expertise preserved in the new structure of the care units.

And I also want to bring up a side point. And, Denise, maybe you can tell me if I'm wrong to think it was Tampa. It might have been SAMMC. Where we heard a little concern on behavioral health providers that were contractors, whether they were actually providing evidence-based treatment. Where did we -- was that Tampa? Or was it --

DIRECTOR DAILEY: Yeah. Fort Hood, the --

CHAIR CROCKETT-JONES: And that was the --

DIRECTOR DAILEY: And that was the network providers. Difficult to assess whether they were providing evidence-based treatments, in accordance with the DoD

clinical guidelines, and documentation back. That was Fort Hood.

CHAIR CROCKETT-JONES: And we've been asking a little about it ever since. And I think that every -- there is a lack of ability for us to know. I mean, I think that's what we sort of confirmed since then, is that there's only so much contractor oversight you can do.

You can't be there at the point of use. So I still want to keep that in our attention span, and to puzzle over a fix for that.

So, anyone else from our trip? Ms. Malebranche, anything you wanted to contribute about Tampa?

MEMBER MALEBRANCHE: Well, I thought the Tampa Polytrauma group did a really very good presentation, that showed that there's a lot of work going on. And similar to what the Admiral said, there's a lot of community involvement there, which is

very good.

I was happy to see that the Federal Recovery Coordinator, who had been off campus, was relocated with the liaisons. It surprised me that the person was off campus to begin with. So that was kind of a pleasant thing to happen.

The other thing about Pinellas Park that still is concerning, and I think we've all said it, maybe in different ways. But the sustainment factor, it's a tiger team to do this. But the long term of being able to grow and, you know, swell and come back over time. I don't know that those best practices are captured. Because when those people that are there leave, how is this going to be sustained over time with others?

I mean, what's left behind? Like, how would you do this in the future? It sounded like there's some very significant system changes. They had some, a few suggestions. But, still, like in the

paperwork process, and that sort of thing.

But, again, that's kind of concerning. Because then there's always going to be this bulk coming in that's slow, and then going out again. So the process still needs to be looked at.

And then at SOCOM I thought it was interesting. We heard some really good innovative things that they're doing. And one of them, I'm trying to remember the name of that one that they said could be proliferated beyond just the SOCOM group. I can't remember the name of that.

CHAIR NATHAN: Soft Crossroads.

MEMBER MALEBRANCHE: Yes. That was really interesting to me. I've never seen that. I thought that was a really, really best practice sort of thing that we could put out in the Task Force.

CHAIR NATHAN: They were also pushing a -- it's anecdotal, it's not really scientifically proven yet, but the ART

therapy, which was -- they swore by it at SOCOM, which was the quick sort of fix, the quick interventional for post-traumatic stress.

One hour to three hour total of meeting with somebody with PTS, to get them to sort of extinguish the PTS through finding ways to image it.

And they swore that they could take people with moderate to severe PTS, and basically have them kind of back on gyro after a few meetings. So, we'll see. You could tell there was a little bit of cynicism at the Polytrauma Center about it.

MEMBER MALEBRANCHE: Because it's not a proven therapy. But it was written up in AMSIS, the journal, this month, by that group.

CHAIR NATHAN: Yeah.

MEMBER MALEBRANCHE: So I think that's going to have some --

CHAIR NATHAN: And we've invited

them to come up to the NICoE. So, we'll see. We'll let the people at the NICoE look it over, and see if it's something that can be adopted for general DoD, DVA use.

MEMBER DRACH: Yeah, on the Polytrauma Center, they indicated that their referrals of patients come from a lot of different sources, and that some families have been actually staying at the Fisher House there for over two years.

Going to the Pinellas Park, one of the concerns that they expressed that apparently is contributing to the backlog, is determining line of duty for diseases.

And at least my note says that they mentioned a brain tumor. You know, did the brain tumor develop while that individual was on active duty? Or did it develop, you know, some other time, some other period of time? So that was one of the problems they brought out.

At SOCOM, I was very impressed

with their employment initiative. And they're working very, very, I think, diligently, to make sure that the recovering special ops warriors that are getting ready to transition out have this new, pretty sophisticated, employment linkage program. And they have a -- that's it.

MEMBER DRACH: Yeah, to follow on to that. Every time I hear about the SOCOM Recovering Warrior efforts, in this case the Care Coalition, I'm both extremely impressed, and at the same time frustrated. Because it represents, again, sort of this parallel universe.

And some of the things they're doing -- and this is the nature of the culture. And I completely understand it. It's the way special ops fights. It's the way they heal, sort of among themselves, taking care of themselves. Not really widening the aperture beyond -- willing to help anybody who comes to them for help. Because they created

some programs which were, a surprise to them, were redundant.

In other words, they brought up a couple of programs they had. And some of you who were on the trip said, well, do you know we're already doing that in the VA? Do you know we're already doing that somewhere else?

And they had no idea. Again, it points out the need for a clearinghouse to do this. And, boy, I think if we can get other benevolent organizations to -- and, again, many are not funded to the level that SOCOM is. They really take care of their own.

But, once again, it points out the fact that we've stovepiped so many of the programs that are Service-dependent. In this case, at least it's joint. It's SOCOM. So they're taking care of soldiers and sailors, and Marines, and everybody who's in the special ops forces -- Air Force -- that are in the special ops forces.

But again, it highlights how, if

we had a time machine, and again, easier said than done, that could go back, I think most of us would agree that we would have set up some sort of tribunal in the beginning of this conflict to have people get a common operating picture of best practices for Recovering Warriors. Because I think many of the Services are trying to catch up to the SOCOM way of doing business.

That said, SOCOM has a smaller number, a more elite number, and a higher ratio of support personnel to actual warriors than the other Services do. But, nonetheless, they have some great ideas that can be templated across the nation.

Other comments about the Tampa area?

MEMBER REHBEIN: Just one last thing. And I made a note here. I really don't have a lot of specific data to back it up. But I made the note. And this follows along with your point about the stovepipes.

That the interaction between DCoE and DVBIC and NICoE did not seem to be particularly formal. It depended upon personal relationships. And I think that's -- again, that's a struggle.

How do we share the kind of information that's being developed in one spot, everywhere? It's not just a problem in the healthcare field, in the Recovering Warrior field, it's a major problem among people everywhere. But this is an area that I think we really need to see what we can do to alleviate some of that.

CHAIR NATHAN: All right. Well, thank you. And we'll finish up now with the observations from the folks who were at Rock Island, Illinois, at the CBWTU there.

MEMBER DEJONG: It was a great visit. Not unlike CBWTU Utah. It had a very professional staff, with a very genuine concern for their Warriors. Doing an excellent job of managing remote care, and

finding resources out in the community for the needs that arise.

One of the biggest concerns I took away was the transition to CCU. There's a huge concern, both on the Recovering Warrior side, family side, and on the cadre side of it, to ensure that the same level of care, and the same relationships that they have built, can possibly continue.

On the Recovering Warriors' side, they have care that has been coordinated for them within their areas. They have relationships built with some of their providers. And they're worried that as the CCU comes into play, they're going to use those relationships that have been helping them through that.

Not unlike remote care anywhere else in the nation, there's a little disconnect between families and their Recovering Warrior, and information available and resources available.

One of the things that we have seen with remote care, and that concern was also with the families, as far as families seem more concerned with, not so much -- being out of the loop was a concern. But also, as they transition this, the ones that understood the transition, that their Warrior was going to receive the same level and continuation of care that they have now.

MEMBER EUDY: Coordinating that consolidation back to the CCUs, something that we see prevalent within the CBWTUs is the education to the Active component on taking care of Reserve component issues. Especially in this consolidation of the CCUs now that I believe that they're going to Knox, if I'm not mistaken, from that CBWTU.

The pattern has been, don't worry, it will get taken care of by the CBWTU. We heard amongst the focus groups that, as those Reserve component soldiers moved back, you know, and come through, they feel like they

were in a holding pattern at the WTU, to then get to the CBWTU to get home. And that's who knew how to take care of their issues.

So a lot of anxiety on the part of, not just the nurse case managers and the platoon sergeants specifically, making sure that training encompassed the Reserve component.

But the servicemembers themselves, making sure that, when you send me back to a CCU, or that my services are done in an active duty place, that they know how to take care of my specific Reserve component issues.

So I think education, again, amongst Guard and Reserve issues will be big amongst the Services.

CHAIR CROCKETT-JONES: The notes I have from the trip say that, everything you've highlighted. Plus, this is a site where folks did not understand what a CTP was, or what its purpose was. Or some couldn't identify it even.

This was another site where we saw confusion on the definition of polypharmacy. And both of which are just, to my mind, a lack of -- you know, these are policies that have had attention. So we would expect folks to be a little more consistent in their understandings.

But there was also an issue with the IDES Legal Services there, access to IDES Legal Services, and understanding of what was available, and what the policy was as well.

And this is sort of a Reserve -- this is just a repeat, that the Reserve component gets less information and needs better resourcing to get access to all the services that have been, you know, funded and generated for regular servicemembers, you know, for the component one. So, just agreeing with everything you've said as well.

MEMBER EUDY: One thing to ask the Services during the next business meeting would be, excuse me, to the Army specifically,

how are you going to keep those connections, and the knowledge base that you've developed by having the CBWTUs, now that you're going to the CCU model?

That was expressed by all the staff, you know, with the years in place, once we move back. And some of those billets will have to be re-competed for within the Reserve component to fill back in CCUs.

How do we keep that knowledge, and pass that information on to that active duty location that will service those regions?

CHAIR NATHAN: Any alibis, save grounds for any of the visits? Going once, going twice. Okay. Thank you for your all's observations and suggestions. Denise, how are we doing on time?

DIRECTOR DAILEY: We are ahead of schedule. How about we take a 15 minute break? Come back at 9:30 a.m. I think I have our Center of Excellence for Vision here already. Raise your hand. Could you all

start 15 minutes early? Let me see what I've got, sir. But I need everyone back at 9:30, please.

CHAIR NATHAN: Okay, 9:30, aye. Thank you.

(Whereupon, the meeting in the above-entitled matter went off the record at 9:16 a.m. and back on the record at 9:34 a.m.)

CHAIR NATHAN: We'd like to welcome back Dr. Lawrence, and the folks from the Vision Center of Excellence. And, Mary, I'll let you introduce who you have here today with you. But for our first, this is our first briefing today. And Dr. Lawrence is the Deputy Executive Director for the VCE.

And she will provide the Task Force with an update from the last briefing, which occurred a year ago, as well as additional information regarding important accomplishments in recent initiatives. You can find Dr. Lawrence's information in Tab C. Thank you.

DR. LAWRENCE: Thank you very much, Admiral Nathan. And I'd like to, before I start, say thank you very much to Denise Dailey and David McKelvin for all their help and support as they, as we got prepared for this briefing.

Mrs. Crockett-Jones, and Admiral Nathan, and esteemed members of the Task Force, I'm very pleased to be able to be here this morning, to provide you with an update on the Vision Center of Excellence.

The agenda I won't read for you. But it addresses the questions that we were provided from the Task Force. And I'll just quote Sara Wade, who is the wife of a vision injured warrior. "We've accomplished a lot over the past three years. But there's still a lot to be done toward giving back people, toward giving people their lives back."

A little background for the new members of the Task Force, and the other people here in the audience who may not be

familiar with the Vision Center of Excellence.

We were established by the National Defense Authorization Act in 2008, to improve the prevention, diagnosis, mitigation, treatment, research and rehabilitation of military eye injuries and diseases, including visual dysfunction related to traumatic brain injury.

The NDAA that established us required the establishment of a vision registry, to collect longitudinal data. And information from that registry could and would be used to guide research to promote best clinical practices, to guide clinical education for the treatment of vision related injuries for our Servicemembers and Veterans.

The NDAA mandated that the Secretary of Defense would collaborate to the maximum extent practicable with the Secretary of Veterans Affairs, institutions of higher learning and other appropriate public and private entities, to carry out the

responsibilities of this center.

In October of 2009, the VA and DoD MOU was signed. And that outlined the responsibilities for the Department of Defense, and Department of Veterans Affairs, in our center. This is a slide, this is Slide 4. This is lifted from the Department of Defense Report to Congress in April 2011. And gives a initial definition of Centers of Excellence.

And I know there's been a lot of discussion on what a Center of Excellence is, and should be. The Centers of Excellence focus on the associated group of clinical conditions. And create value by achieving improvement in system wide outcomes, through clinical, educational and research activities.

The COEs are to develop pathways of care covering the clinical spectrum, from prevention through reintegration and/or transition. And the products of pathway of care include guidance regarding structure,

documentation and the Electronic Health Record, clinical practice guidelines, process and outcome measures, educational materials, innovation, identification of research priorities, and strategies for improving access to care.

In terms of this last bullet, we have been spending a lot of our efforts doing coordination of care. When the VCE was established there were quite a few problems with inefficient and uncoordinated care between medical treatment facilities in the Department of Defense. And between departments, the Department of Defense and VA.

And so we have been working hard to make sure that care is more coordinated, and our patients aren't "falling through the cracks". Our mission is improve vision health, optimize readiness, and enhance quality of life for Veterans and Servicemembers.

We provide leadership and advocacy

for programs and initiatives, focused on improving the full spectrum of ocular care, from prevention through rehabilitation and reintegration. We contribute to the continuous improvement in the DoD and VA system wide vision care, through clinical, educational and research activities.

This is a diagram showing that the data that we can glean from our own vision registry, which I'll tell you about in a few minutes, where we are in that development, and other data sources to support evidence based clinical care, best practices, research, education. And to advise policy across VA and DoD.

We have different mission areas, including our clinical care integration, education and training, rehab and reintegration, research and surveillance. And all those are aimed at improving vision health by optimizing readiness, and enhancing quality of life.

Our stakeholders are varied and many. And many of them have different priorities that we try to balance. At the Center, however, always our Servicemembers, Veterans and their families, everything we do is focused on what can improve their lives.

We work closely with our providers, researchers, and educators, in both the Department of Defense, and Department of Veterans Affairs. And we have many other stakeholders, including those in academia and private sector, in the vision care space.

We work closely with the other Congressionally mandated Centers of Excellence, the Defense Center of Excellence for Psychological Health and TBI, the Hearing Center of Excellence, and the Extremity and Amputation Center of Excellence.

We have been working collaboratively on several projects, including a clinical recommendation that we work together with the Defense Center of Excellence

for Psychological Health and TBI. And we are actually leading the registry efforts for all of the Congressionally mandated Centers of Excellence, as they develop their registries.

CHAIR NATHAN: So, Dr. Lawrence, can you describe a little bit more, the mechanics of how you work together with the other COEs?

DR. LAWRENCE: We have several meetings, where we meet with other Directors and Deputy Directors, throughout the year. We also have a registry governance committee, that meets approximately once a month.

And we, when we've decided on a project, we usually have assigned leads for that project, that work together with the other Center of Excellence counterparts.

So, for example, for the clinical recommendation that we did with DCoE, we had leads from our organization, and leads from their organization to work together at putting together a group of subject matter experts to

develop the clinical recommendation.

CHAIR NATHAN: Do you have any kind of memorialization of those kinds of integrated activities? Do you keep a matrix log of where you're cross-pollinating ideas?

Do you have something on your normal drum beat of staff meetings, or of your colleagues at the VCE, that codifies some of the things you're working on? And speaks to the connectivity with the other Centers of Excellence, COEs?

DR. LAWRENCE: I don't think we have a matrix of all of the collaborative efforts. Most of the efforts we do are collaborative. But each single project, or effort, we do keep notes. And if not official minutes, we keep usually meeting notes of our collaborative efforts to move things forward.

CHAIR NATHAN: The reason I'm going down this rabbit hole is simply because we've come to learn of the amazing prowess of the various COEs in their own lane.

But we have been concerned about the integrated synergy, or lack thereof, between the COE, and how that can be translational into practice changes, policy changes, procedure changes, guideline changes, DODIs, that can take the considerable efforts that you put in. And you're an amazing cadre of experts and passionate people.

How do we translate that into something, not only in your own lane, but as you just mentioned, into collaborative power that can make a difference across the entire spectrum of Recovering Warrior care, from the psychological, to the physical, to the visual, to the auditory?

DR. LAWRENCE: Right.

CHAIR NATHAN: Many times, which these are interconnected.

DR. LAWRENCE: Right.

CHAIR NATHAN: So we're very interested when you say, we work together with the other COEs. I'm interested in knowing if

that's kind of informal, you know, we meet with them once a month.

And we kind of tell them what we're doing. They kind of tell us what we're doing. As opposed to, we demarcate those efforts with something. So that we have to come back to it each month, or each quarter, and look and see what progress has been made together.

DR. LAWRENCE: Right. In the research arena, we have a once a month call with the other Centers of Excellence to discuss the research priorities. And I'll get to that a little bit later in the presentation.

But we work together, especially with the Hearing Center of Excellence, and the Pain Center Excellence, on the CENC, which is the Chronic Effects of Neurotrauma Consortium, which is a very large grant to establish a consortium for research activities.

And the neurosensory aspects,

which would be, of traumatic brain injury, is hearing, auditory, vestibular and pain, are all working very closely and collaboratively together.

So there's certain, in the research arena we have it absolutely established once a month. And the registry arena, we have it absolutely established once a month. And so those two are very regularly established, codified, regular meetings.

And I must say that I agree wholeheartedly that collaborative efforts are important. We cannot stay in our silos. And it was, last week I was up at Fort Detrick, and with the CENC, Chronic Effects of Neurotrauma Consortium, and meeting with some of the neurologists.

And they said that they really didn't know a lot about the auditory, the ENT, neuro-otology, and the neuro-ophthalmology. And they were very interested to have this collaborative effort, so that we can really

address the whole spectrum of traumatic brain injury in our Wounded Warriors. Because it's not just one single thing. So absolutely agree wholeheartedly with your comments.

CHAIR NATHAN: Tunnel vision, as it were.

DR. LAWRENCE: Exactly. Karen.

MEMBER MALEBRANCHE: A couple of things, I guess. So just to kind of clarify. So for the Center of Excellence, this is really a advisor for policy, not implementers, right? I mean, that's for clarification, the Centers of Excellence in general?

But how do you relate, what's the Oversight Board do? When you were talking about some of the different things, how does that relate to you, and what you're, you know, the different things that you're doing, like the registry? Do they make sure that you're connected to the other two, the other centers?

DR. LAWRENCE: The COE Oversight Board is a Department of Defense Board. It

has many very senior medical leaders from the Department of Defense, and a VA representative.

And they do have meetings approximately every two months. Although the last meeting I believe was in, maybe September or October. And there has not been another meeting since then.

There's, as many of you know, there's been a lot of talk about where the Centers of Excellence should be within the military health system. Currently we're each under one of the Services. And the COE Oversight Board was really, I think, to bring everybody together.

So that even though we report to the Navy, to have Army, Air Force and VA leadership know what we're doing, I think that to ask Dr. Lockette, who is the Chairman of the COE Oversight Board. He might better answer that than I have.

But we have, it's been an open,

he's had a very open committee. And we have always been able to attend. We sit on the side, and we're not actually members of the Oversight Board. But we like to hear what they have to say. And we have always been invited to attend that meeting.

MEMBER MALEBRANCHE: I guess, for the registry, because everybody's so interested it seems about registries. Does the Oversight Board pull all that together, like the registry from the eye, the auditory? Or is that not part of that?

DR. LAWRENCE: The registry effort is really under DHA. And I might let, and I really apologize. I forgot to introduce three people from the Vision Center of Excellence that are here with me, sitting at the panel table.

And that's Mr. Don Sparrow, who is the Strategic Planning Officer, Ms. Helen White, who is the Director of Information Management and Informatics, and Patty Morris,

Ms. Patty Morris on the right, is the Director of Technology.

And she has been heading the development of the architecture, building the architecture for the registry. And, Patty, I might let you answer this question.

MS. MORRIS: So when it comes to registries, we actually follow the DHA, formerly TMA's guidance and governance. So you have two sets of governance when it comes to the registry capability. And that governance ensures that we stay aligned and collaborate with each other.

One side of that governance is on the functional side. And they have a functional sponsor and a committee that they work through that establishes all of the actual functional requirements. Then we're going to tell the IT side what it is that we need to build, so that the business community can do their business.

And then from there we collaborate

closely, and work on the IT side, through the IT governance, to ensure that we are architecturally designed properly to integrate into the enterprise, as well as, we leverage each other's capability.

For example, the registry DVEIVR has many capabilities inside of it that will be leveraged, because we've already built them to build the DCoE's registry. Because the concept was, there isn't a reason to rebuild something that we could leverage, and already meets a significant portion of their functional requirements to help move them along.

So for sake of simplicity, yes, we do go through a significant amount of different governance to make sure that we stay aligned. And that we do try to reuse, as much as possible, functionality and capabilities that already exist.

CHAIR NATHAN: Okay. Thank you.

MEMBER PHILLIPS: A question.

Just going back to Slide 4, you emphasized the strategies for improving access to care, which we know how critical that is in a broad fashion.

Have you reached a point where you've discovered best practices, or created a template that might be a recommendation across the board? Could you comment on that a little bit?

DR. LAWRENCE: Yes. That's further down in the slide deck. There's one that we have, we're trying to promulgate, which is the use of the Fox eye shield.

And we also have developed a clinical recommendation, again, I'll talk to that later, for primary care providers to address visual dysfunction related to TBI. So yes, there's a lot of things that we would like to focus on. Those are two major issues that we have focused on in that arena. So thank you very much.

Okay. So we divide eye injury or

vision injury into sort of two buckets. The ocular trauma, which is injury to the globe or eyeball itself, the orbit and the eyelid. So for those people familiar with neuroanatomy, I say anterior to the chiasm.

And then the brain or TBI associated visual dysfunction, which is the optic nerve, the diffuse brain injury that is not well understood, affecting visual processing, the cranial nerves, which affect the eye movement, visual field losses, photosensitivity, and other visual dysfunctions related to TBI.

The continuum of care for eye and vision injury are depicted at the top, with the Department of Defense being at the top. And you'll notice that there is no rehabilitation, vision rehabilitation in the Department of Defense.

So all of our vision injured patients that need vision rehabilitation actually get moved over to the Department of

Veterans Affairs for their vision rehabilitation. And then that -- So we take care of active duty Servicemembers in the Veterans Affairs for vision rehabilitation.

And this has been the case since just after World War II, when the Department of Defense decided that the VA would do this. So there's a lot of movement, which I alluded to earlier, in terms of coordination of care for these patients.

The other thing I'd like to point out is the treatment canisters here are, it's not from acute to recovery really easily and really quickly with one facility. Many of our Servicemembers have ten to 15 points of care, as they go from the point of injury into rehabilitation. That means ten to 15 transfers between facilities.

And previous to us being in existence there were a lot of surprise arrival, surprise surgeries. And if we know somebody's coming, we know there's an eye

injury, we can help coordinate that care so that people are ready.

And it's seamless, and we get them to the right place. If they have a retinal problem, we get them to a facility that actually has a retina doctor, for example.

CHAIR CROCKETT-JONES: Can I ask you a question? Is there a standard for screening? I know on the list of the TBI associated vision dysfunction some of that list is pretty obvious upon any TBI screening, or an introduction to an MTF.

But your diffuse brain energy visual processing, and the visual field losses seem like they're a different kettle of fish than the others. And I'm wondering, is there a standard across the Services for triggering screening for those two items?

DR. LAWRENCE: That's a very good question. And it's something we are trying to address. And we've put a clinical recommendation. Again, that's a little

1 further down in the slide deck. But
2 absolutely you're right on.
3 The clinical recommendation was
4 published, well, I'll get to that in a couple
5 of slides. But something that needs to be
6 addressed. And the VA system, all patients
7 that are admitted to a VA Polytrauma Center
8 must have, by VA directive, a complete eye
9 exam.
10 And that's been quite good, with
11 very, very high, like 98, 99 percent patients
12 who have. Some people can't go through the
13 eye exam. But a very high percentage of
14 patients in VA Polytrauma Centers do have a
15 complete eye exam. Sorry?
16 (Off microphone comments)
17 DR. LAWRENCE: Yes, good point.
18 So right now, you know, we take visual acuity,
19 that's looking at the black and white, big
20 letter E at the top, reading through. It's
21 the high contrast. It's in a dark room. It
22 is not reality.

There's not a lot of visual confusion, like it is driving, like you'd see driving a car, with lights and different things that need to be paid attention to, with different contrast sensitivities, different colors. So visual acuity is really what we take in the doctor's office. And that's not reality.

The other thing that is important in people with traumatic brain injury, is checking the visual field, and checking their eye muscle movements, and their tracking, their saccades. And so many of the tests that we do in an eye doctor's office are probably not representative of real vision.

And actually, many years ago when I was younger at Massachusetts Eye and Ear Infirmary in Harvard, I helped develop an activities of daily vision scale, which was the first look at qualitative vision. And then that went on.

And my colleague I was working

with on that went on to help the National Eye Institute develop what's called the NEI, National Eye Institute Visual Functioning Questionnaire. And that looks at questionnaires of how people are functioning.

Now, it's subjective. It's from patients. But that gets it closer to what, how a patient is really functioning visually. That is really designed for, and been validated for four types of visual loss. Mostly in an elderly population, civilian population. So cataract, macular degeneration, glaucoma and neuropathy.

So it's mostly an older population, civilian population. There are questions on it that, you know, can you read the newspaper? Well, our injured Warriors don't read newspapers. I mean, my kids, my teenage and college age kids say, you're a dinosaur if you read a newspaper. They all get their news from on line sources.

And so, that's the age group of

our Wounded Warriors. The average age is 24 when they get wounded. So we need to have a visual functioning questionnaire that really gets at what are the visual dysfunctions of our Wounded Warriors.

And that's one of the things we've planned for. That's going to be a multi year project to get it validated. But it's so important. Thank you so much for asking that really important question. Because the tests we do in an eye doctor's office are not really getting at some of these issues.

CHAIR CROCKETT-JONES: Thank you. Because I know that many people are surprised when they take a visual fields test, at their visual field loss.

DR. LAWRENCE: Right.

CHAIR CROCKETT-JONES: Because, you know, the systems are so, our systems are redundant. And because people adapt. So I'm especially interested to know what triggers a visual field test for folks with TBI. But,

we'll get to that.

DR. LAWRENCE: Okay. One of the questions you asked us to answer was full operation capability. We had put forward in the joint strategic plan of the joint, the VA, DoD Joint Executive Council, that we should FOC by the end of FY 13, which occurred in September.

However, we briefed last year that we only are at about 30 percent of the staffing levels that we anticipated. And we've also briefed that to Representative Young, on the Subcommittee on Defense Appropriations.

I'll just say that our current staffing levels are unchanged from FY12. We are really working hard to fulfill our mission, do the things we think are important. We are filling the staffing shortfalls with contract support right now.

And we, it probably isn't long term best sustainable solution for getting to

full operational capability. But that's what we're doing at this point. And we've had a lot of successes. And we're doing great things.

CHAIR NATHAN: What's the sticking point for migrating from contract to GS personnel?

DR. LAWRENCE: Well, there's a hiring freeze. And, you know, I mean, right now the DoD is contracting, and probably not increasing staff.

CHAIR NATHAN: So, it's simply the mechanics of hiring? It's not a lack of qualified applicants?

DR. LAWRENCE: No. We haven't been approved to hire these positions.

CHAIR NATHAN: No. That's a common malady that's all over the place.

DR. LAWRENCE: Yes.

CHAIR NATHAN: But I didn't know if it was that, or if you were just having trouble.

DR. LAWRENCE: Yes. Not all --

CHAIR NATHAN: Salaries are competitive?

DR. LAWRENCE: Salaries are competitive. And there are people who love to help, love to jump on board.

CHAIR NATHAN: Okay.

DR. LAWRENCE: It's really that we just don't have the positions.

CHAIR NATHAN: Right.

MEMBER PHILLIPS: I don't want to be too redundant, and deviate. But I think that's a critical point. Staffing levels are a critical issue. And perhaps we could make a recommendation related to that.

An example I just saw recently, over at Walter Reed Bethesda, at the Ophthalmology Clinic. They see roughly 25,000 patients a year. And they have four administrative staffers. No support for their physicians, and so forth. And that really prevents good access to care, and quality

care.

DR. LAWRENCE: Yes. You're absolutely right. When the docs are doing administrative work that you can get a GS-7 to do, you're not really giving --

MEMBER PHILLIPS: And they're leaving. You're losing quality people.

CHAIR NATHAN: This is, I mean, we're from the Government. We're here to help. And it is a challenge right now. The hiring freeze has caused a tremendous imbalance of support personnel across military treatment facilities.

And so, this is the challenge of sequestration, and of budget changes, and of roll-backs, and of ALT POMs. I'm not saying we have to accept it. But that was my question, is that you are now under that bus. But the good news is you have qualified applicants if this thicket opens up.

DR. LAWRENCE: Correct.

CHAIR NATHAN: Okay.

DR. LAWRENCE: Thank you very much. I have another 20 slides to go through. I will take direction from you. I'm happy to have this be conversation, and not run through it. You can read it. I'm happy to run through it quickly, and do questions at the end. I will, I just want to make sure that I do what you want me to do.

CHAIR NATHAN: Well, we want you to get to your main points that you think are most critical. So we'll try to lessen our interruptions. And we'll let you move gingerly through those areas where you think it's either redundant or intuitive.

And since you're funded by, you're sponsored by the Navy, we'll drop anchor on those areas that you think really warrant the Task Force's attention.

DR. LAWRENCE: Okay.

DIRECTOR DAILEY: And we're good on time. We have half an hour to 45 minutes left of your time.

DR. LAWRENCE: Okay.

DIRECTOR DAILEY: So we're good on time.

DR. LAWRENCE: Okay, great. Leadership changes and pending decisions, I've been functioning as the Interim Director since the first of April. And I had a call from Admiral Stocks, who is in charge of wounded, ill and injured M-9 at BUMED, that a new Executive Director has been selected.

CHAIR NATHAN: There's one on Dr. Woodson's desk.

DR. LAWRENCE: Yes.

CHAIR NATHAN: And it's up to him to sign it.

DR. LAWRENCE: Okay. I had heard that he had approved.

CHAIR NATHAN: This is --

DR. LAWRENCE: But I have not seen an official announcement.

CHAIR NATHAN: Right. And so we're still waiting for his official approval.

DR. LAWRENCE: Okay.

CHAIR NATHAN: And I think it's going to happen. But this could be deja vu all over again. But I think we're going to see his signature.

DR. LAWRENCE: Okay. In that case, I will not mention any name. And we have some additional VA positions that we're hiring for. And we should have those filled within the next couple of months.

A big success story, our registry. And I'll let you read those bullet points. It's really just sort of a nice picture. The time line for what we're doing on the registry is across the bottom here. I'll just highlight a couple of things.

We really, our functional requirements were approved in August of 2009. We were approved by the Defense Business Certification Board in September of 2010. We've developed, sorry, development of the pilot in October 2010. So just after we got

the approval. And we've been working hard to develop the registry.

We're actually putting data into the pilot project now. And have been working forward through acquisition category, reaching classification of Acquisition Category IV program. And we've had a successful testing that VA data can go into the DoD system, which is really great.

And we completed operational acceptance testing just a couple of months ago. And we expect to go to full operational capability with this in the beginning of Q3, in this fiscal year. Most acquisition, IT acquisition -- Am I saying this wrong, Patty?

MS. MORRIS: We're expecting to go into IOC. FOC isn't actually --

DR. LAWRENCE: Sorry.

MS. MORRIS: -- anticipated in until the beginning of FY15, ma'am.

DR. LAWRENCE: Right. Sorry. IOC, I apologize, in the beginning of Q3. And

the -- Usually this process takes five years for a DoD IT new program. And we're going to be doing it in three years. So we're way ahead of schedule. We've been able to come under budget. And so we're doing great things in this arena.

This is a little schematic of how we get data from DoD medical systems. VA Injury Data Store, which is authoritative source from VISTA, or CPRS in the VA system.

We use other data sources, like registries like the Joint Theater Trauma Registry, and the Combat Trauma Registry. And all of those data sources dump into the Defense and Veterans Eye Injury and Vision Registry. As of January 8th we had almost 23,000 unique patients enrolled into the vision registry.

I'll just tell you two wonderful things that we have heard just recently, two awards. The DVEIVR was selected as one of the top 30 innovative solutions for igniting

innovation 2013 showcase. That showcase and award ceremony will be February 6th in the Ronald Regan Building.

And also, we learned Friday, that Ms. Patty Morris was selected as one of FY13's Federal 100, which are leaders from Government, industry and academia, that have the greatest impact on Government IT, or Federal IT program. And so she will be honored at a black tie event on March 20th, at the Washington Hilton.

CHAIR NATHAN: So, Dr. Lawrence, two things. One is, congratulations.

DR. LAWRENCE: Thank you.

CHAIR NATHAN: Number two, why the big deal? In other words, what's your sound bite for why DVEIVR is going to change somebody's life.

DR. LAWRENCE: Patty, would you like to take that one?

MS. MORRIS: I think for me, the way I see DVEIVR being able to change

someone's life, it's for the first time the vision community will be able to actually look at quantifiable data that is collected from both medical systems.

Currently, today, the data itself is, the only portion of it that's actually computable, that you could do research and longitudinal analysis and studies against, that portion of it, it only makes up 20 percent of the data.

Actually, that's what we thought. It turns out it's more in the 15, ten percent range. Most of that data actually has this computable.

So we've come up with a method that is going to allow the business community to be able to look at key data elements that the vision community agreed upon, across the spectrum of care, that is going to allow them to do those longitudinal analysis. And actually use that information to guide research, guide changes in clinical practices.

They can use that information to help guide policies. Maybe their -- And they can use that information also to guide gaps in what's being documented by the physicians or care.

So if I had to identify where do I think this system, and what this system's going to bring to our user in the next 15 years, you look at all of the amazing capabilities of prosthetics today. But if we have the data to be able to guide some of that research in the vision world, I think that we possibly could see a prosthetic that could provide vision back.

I mean, we have a capability to allow someone to feel and sense hot and cold. But they have a lot of research and a lot of data that they can use by looking at the longitudinal spectrum. And the vision community's never had that before. And this system is going to allow them to have that.

CHAIR NATHAN: So, you're going to

go from ten to 15 percent to approximately what, do you think?

MS. MORRIS: Well, currently, today, they're going to make it to where all of the data elements that have been identified will be able to compute, will be computable in DVEIVR.

The next step, to take it one step further, and actually help work with the Electronic Health Care Record Team to try to get a computable eye note. So that at some point in time the manual extraction of the non computable data can meet the computable data. And you'll have that continuing space.

DR. LAWRENCE: So all of the vision care encounters, in both DoD and VA, are non computable. We don't even have visual acuity or interocular pressure, which are just pretty simple numbers, as computable data.

Everything has to be hand extracted, and then put into this computable database, which is the vision registry, that

then can be followed longitudinally every time.

MS. MORRIS: And the key to that, to really point out the biggest key to the data piece, is the vision community identified their data elements. And so when we're extracting that information, they standardized that data. They said, this is what that data means across our community.

So when they're going to do their longitudinal analysis, and their studies, and use that data, they all are using it with the same relationship and value across the board. That also provides value to our other registries.

So that when we're able to share the data with other registries, and other individuals looking at it, they're going to be looking at that information utilizing standardized data standards, their national standards, to say, oh, we understand what this data element means, and what that value means.

And so, they'll be able to have the same understanding, based upon what the vision community has determined that data to mean.

DR. LAWRENCE: And we've been able to get VA providers and DoD providers that have been working together on this since, what --

FEMALE PARTICIPANT: 2008.

DR. LAWRENCE: -- 2008. And many of the people that were on the original committee have since gone on to other things, and are still dedicated to this project. And we've been able to get Optometry, Ophthalmology, blind rehab providers, who often in other arenas don't talk very well.

CHAIR NATHAN: Right. No, no, we get it.

DR. LAWRENCE: We've been able to bring together a lot of --

CHAIR NATHAN: You had me at, hello, okay. But I was just trying to

articulate it.

DR. LAWRENCE: Yes.

CHAIR NATHAN: And basically what you're doing is, you are harnessing very large population demographics, and standardized patient encounter metrics, be it certain diagnostic or examinable criteria, that you can then act on, because you have very large and standard to draw from, and make changes in research.

DR. LAWRENCE: Right.

CHAIR NATHAN: Okay. Next.

MEMBER PHILLIPS: Even greater, this big data effort will allow, with national standards, a civilian input as well.

DR. LAWRENCE: Absolutely. Absolutely.

MEMBER PHILLIPS: Terrific.

DR. LAWRENCE: Other significant accomplishments, I've already spoken to this, is this assessment and management of visual dysfunctions associated with mild TBI. This

is a clinical recommendation that we worked with DCoE.

You can the DCoE logo at the top, and ours at the bottom. To come up with clinical recommendations for primary care providers across the systems to ask patients about visual dysfunction, so that they can get appropriate referrals to eye care providers. We're also working on other clinical recommendations for eye care providers.

So that first one was for primary care providers. This is for eye care providers. And looking at ocular motor dysfunction. So looking at eye movement disorders, which is huge. And visual field loss associated with visual dysfunction.

We have been working on many aspects of the Fox shield, or the rigid eye shield. We've developed an E-learning course on proper application of the Fox shields for ocular trauma cases.

We've been working on initial

inclusion of the Fox shield in joint first aid kits, and coordinating with the Services to make sure they're in individual first aid kits. We have spearheaded an effort to include the use of the Fox shield in the 2013 edition of the Tactical Combat Casualty Care card. And that's been recently approved.

In December, so last month, a United States Forces Afghanistan memorandum went out, instructing the USFRA Afghanistan personnel to reinforce the distribution of the Fox eye shields into their armamentarium for eye injuries.

The Fox shield is something that is done for any presumed, should be put over for any presumed eye injury. It protects the eye. Any other portion of the body, if there's any kind of an open wound, any kind of injury, you put a pressure patch on.

That's true for every part of the body except the eye. You cannot put a pressure patch on the eye. Important contents

like retina and iris, and other important neural tissue gets extruded. And once it's extruded it can never be used again. It's gone forever.

So we want to put a protective eye shield so no pressure gets put on it. There should not be any kind of a dressing put between the eye shield and the eye. Because the gauze of the dressing gets attached to the little pedicle of eyelid skin that may be the only bit of eyelid that's left, or to bits of interior of the eye that can --

CHAIR NATHAN: No, we understand.

DR. LAWRENCE: Okay.

CHAIR NATHAN: The eye shield is designed to keep all pressure, extreme pressure off the orbit.

DR. LAWRENCE: Right.

CHAIR NATHAN: And it wasn't being used very much at all.

DR. LAWRENCE: Correct.

CHAIR NATHAN: Your Center of

Excellence did a wonderful job of documenting the benefits of it, and the lack of use of it. It's now being put to the Services, to the Joint Staff.

And it will either be in the Service's individual kits. Or it will at least be in joint kits that will be available on the battlefield. So that people, hopefully that standard of care will change.

DR. LAWRENCE: Yes.

CHAIR NATHAN: Got it.

DR. LAWRENCE: Yes.

CHAIR NATHAN: Thank you very much.

DR. LAWRENCE: One of the issues is that currently only about four percent of eye injuries have the proper use of the eye shield. That's current today. So it really says, we need to work harder on this.

We designed an electronic pamphlet dedicated to the inpatient care team for blind and visually impaired Veterans. And I'll just

pass this around. This has been distributed to all the VA hospitals. And we're working with the DoD to get this distributed.

Many inpatient eye care, inpatient providers, nursing staff, really don't know how to help a patient who has visual impairment, how to put their food in front of them and tell them, well at 6 o'clock is your meat, and at 10 o'clock are your potatoes, and at 2 o'clock are your peas, how to get them to the bathroom. So this is something we've been working on.

We're also working on a similar type of product for outpatient, the outpatient setting. We've gone through and documented all the policies, guidance and recommendations relating to eye care on both systems, the VA and DoD. And we've inventoried and catalogued about 100 policies.

And we'll then go through and do a gap analysis, or any differences between the two, or any inconsistencies across the system.

So it would be nice if the VA and DoD had similar complementary policies for eye care.

We've looked also at patient and provider education tools. We've collected about 150 tools for patients, family members, and about 80 for providers. And again, we can use them to find what's the best, and promulgate them or modify them for the military or Veteran Service care systems.

We've also developed policies and guidance for our -- Where am I here? We've also hosted a knowledge based workshop. We did this in August, in Spokane, Washington, entitled "Managing Vision Disorders Following Traumatic Brain Injury".

We had a VA and DoD Ophthalmologist and Optometrist to teach them about current practice for managing visual dysfunction related to TBI.

We are conducting a systematic review of all the literature to do a meta-analysis to be published, looking at visual

field loss and ocular motor dysfunction, or eye movement dysfunction associated with TBI.

We've convened an expert working group in collaboration with the Combat Critical Care Research Program, up at MRMC. We've compiled a glossary of terms to accompany the eye care provider clinical recommendations.

We've done an educational awareness campaign. I'll talk about that in a few minutes. To encourage appropriate use of eye protection and the Fox shield. And we've developed and updated, and validated a visual function questionnaire, plan to develop that, which I discussed just a few minutes ago.

So these are some of our accomplishments that we're proud of. The strategic communications plan, our goals are to create an external Vision Center of Excellence visibility and organizational awareness, to establish, build and strengthen

VCE partnerships and collaborative relationships, and to increase the quality, quantity and consistency of VCE communications.

Our major products are Shields Save Sight campaign that I'll talk to in just a moment, and the Annual Report, which should be coming out in about three months.

The Shields Save Sight campaign that we have developed is to raise awareness, leading to increased use of APEL, or Authorized Protective Eyewear Lists, protective wear, and also the use of the Fox shields.

And we have been trying to communicate important safety information to promote these practices. And could I ask you to play these two spots for me now? These are two spots that were developed and put on the Armed Forces Network.

(Videos played)

DR. LAWRENCE: So these were two

relatively low cost spots that we put together. They were aired nearly 700 times on TV and radio, through the Armed Forces Network.

They were shown during NFL games across the globe to our Armed Forces, including aboard U.S. Navy ships. That was a seven week program. It ran from October 1st to November 17th. We've also secured three ad spots on Infonet system, which is in the National Capital Region, 44 installations in the National Capital Region.

And we are thinking that that message exposure will be to 160,000 personnel weekly for about three months. We also established Facebook and Twitter pages. And we, by the campaign's end, which was mid-November, we had secured 106 Facebook and 37 Twitter followers, which actually exceeded our goals.

We've had a 44 percent increase in our web traffic to our web site. And I guess

I should go to the next slide here. And had quite a number of downloads for the APEL, or the Authorized Protector Eyewear List, Eye Pro, and injury response.

And we have had a Navy blog, resulting in 241 page views. And it's been shared 19 times. And we are securing placement of the Eye Pro feature on the national, the Army National Guard blog. So that's our campaign, our strategic communications campaign.

For a strategic plan, our current strategic plan under which we're operating was approved by the Center of Excellence Oversight Board in January of 2012. And that's one of the functions of the Oversight Board, with the help, approve our direction and our strategic plan. We're in the process of updating that now. And the time line for doing that is across the bottom here.

We're in our strategic framing segment of that strategic planning pathway.

And we are in the process of completing interviews of our stakeholders. And just a note that we, depending on when the new Executive Director comes on board, we would like to obviously have that person's leadership as we set the direction for the next few years.

Okay, vision research. Just an overview of the VA and DoD vision research program. VA funds research only intramurally, so only to VA investigators. There are currently 19 funded project in the vision space. And that includes pre-clinical, translational and clinical.

They're also funding two Vision Research Centers of Excellence, one in Atlanta. And that's affiliated with Emory. And one in Iowa City with the University of Iowa. These are the VA hospitals there. The DoD funded research program is both intramural and extramural.

There are 67 funded research

projects covering prevention, genetics treatment, all the way through rehab. And we, the VCE provides a lot of vision research coordination. We track the vision related research outcomes, in terms of publications, patents and product development.

We have established and chair an interagency research scientific steering committee. We have chaired the Clinical and Rehabilitative Medicine Research Program, CRMRP, the JPC, Joint Programmatic Committee-8, which is auditory, vestibular and vision committee.

We help with the programmatic chair, and help with the programmatic review of that. And we review the proposals submitted for the, we've reviewed for assistive technologies for the JPC-8 program. So we work very closely with MRMC at Fort Detrick for these activities.

Other research productivity. We've developed a simulation in eye care. And

two reports are forthcoming. And that is in collaboration with TATRC, Telemedicine and Advanced Technology Research Center.

We completed a study jointly with the Joint Trauma System Institute of Surgical Research, eye shield compliance. And that's the date that I showed you on the earlier slide. We are also helping with a Natick sponsored blast study on eye protection. And we've had several poster presentation at the Blinded Veterans Association.

We had 16 speakers at ARVO, which is largest eye research meeting in the world. People come in from everywhere in the world. And we co-hosted a symposium on traumatic brain injury at that research. It was standing room only at that symposium. The military health system research symposium, we had the eye shield compliance poster presentation.

The American Academy of Ophthalmology in 2012, so that was Fiscal Year

'13, we had a symposium on telemedicine in the DoD and VA. And American Academy of Ophthalmology, that's the largest Ophthalmology meeting in the world.

In 2013, so just in November, we had two big symposiums, one on blast eye injuries, lessons learned from Boston, West, Texas, Iraq and Afghanistan, and one on VA, DoD leading the way on simulation. I'll just take a minute to talk about the blast injuries.

When the Boston Marathon bombing occurred, we knew that there would probably be eye injuries. And yes indeed, there were. We were on the phone to the providers at several of the medical centers where the victims were taken. We had weekly conference calls, putting together our oculoplastics and retina doctors in the military with the Harvard affiliated doctors, and BU affiliated doctors.

Tufts actually did not, Tufts Medical Center did not get any of the eye

injuries. And I won't go into why. But we had a weekly conference call.

And it was amazing to hear that a young retina surgeon, Major from Walter Reed, could be telling these senior Harvard retina professors that no, you don't have to worry about this. We see this all the time in blast injury. No, you don't have to operate, just watch and wait.

And it was a wonderful collaboration. And it really helped the care of our civilian injuries in the Boston Marathon bombing. Likewise, several weeks later, we had the West, Texas fertilizer plant, which is another blast. And there were a lot of, actually more eye injuries out of that tragedy.

And again, we had the West, Texas, and we were all, all three, the military, the Boston Marathon, and the West, Texas eye doctors were all on calls together every week, for many months.

And we then put together a big symposium with all contributors from all three, at the American Academy of Ophthalmology, very well received. We're going to be publishing some of that.

We also have two current ongoing Army Small Business Innovation Research, SBIR projects. One to develop a slitlamp, a smartphone slitlamp. So a slitlamp is when you go into the eye doctor, and they have a little microscope they sit behind.

And there's a little, narrow beam of light that gets shined into your eye. That's a slit beam. And it's a slitlamp. And that's the tool we use to do most of the eye exam.

And we're trying to develop a smartphone application for that, which would then be able to, in austere, if we had an application on smartphones in austere conditions, we could actually get, hopefully, maybe telemedicine could get the images back

to an eye doctor. So it could really help with the care of these injuries.

And also, another SBIR for biocompatible material for corneal wound healing. So in terms of research suggested, changes in practice, which, Dr. Phillips, is your question. We would like to see the use of, and compliance with eye shields for trauma.

And the study that I showed you the results of go into the third bullet. Overall, four percent of eye injuries are adequately treated initially. That's pretty bad statistics. So we have identified that there needs to be continued education, logistics and policy to address the Fox eye shields.

CHAIR NATHAN: I think this one is a team effort.

DR. LAWRENCE: Yes.

CHAIR NATHAN: Because you made us aware of this, we then, me in particular, sent

salvos to the Services, saying, what are you doing about it? I sent a salvo to the Joint Staff Surgeon. And the Joint Staff Surgeon just briefed me a week ago on where they are on the JFAK --

DR. LAWRENCE: Oh, okay.

CHAIR NATHAN: -- system. And how they're going to all the Services to get them to be compliant with the IFAK dissemination of this. So this is exactly -- It didn't happen like we wanted it to.

It should have been traction from you to DoD, Health Affairs, make this happen. But it eventually got to the Joint Staff Surgeon. And now we're going to see a change in practice. Four percent is abysmal. It's unsatisfactory. It translates into loss of preservable vision.

And so I'd like to think that over the course of the next weeks, to months, to years, we're going to see that ramp up tremendously.

DR. LAWRENCE: That's good. And I think that points to a, to one of the things, I think, not just the Vision Center of Excellence, but other Centers of Excellence, is that we don't really --

You know, we're new. And the MHS and the Veterans Health Administration don't really -- Because we're new. And so we're sort of, haven't really worked out all the processes.

But we need a way to formally move through the system. And we're getting this through. But we're sort of, by hook and by crook getting it through. And it's a great thing. But to formalize a way to advise on policy, and to, would be great.

MEMBER REHBEIN: Dr. Lawrence, if you would for just a moment, and this is really outside Task Force purview. But do mechanisms exist to translate something like the Fox eye shield out into the civilian first responder community?

Because it seems to me like there would be a, not only a large need for it out there. But a way that, a way frankly that you could demonstrate that the Vision Center of Excellence is not strictly DoD.

DR. LAWRENCE: Absolutely. And actually, neither the Boston Marathon bombing -- I called the residents who were on call at Longwood, and Mass Eye and Ear, and Mass General.

And I said, would you please start tracking whether they're coming in with the Fox shield? Because that's something that, you know, we want. There were no Fox shields at the tent, at the end of the marathon. Luckily, the bombs went off right there, where there was medical help.

But they had no eye shields in the tent, the medical tent there. And that's something that the providers, eye care leaders in the Boston area -- Of course, these are the eye care leaders in the world too, because of

their academic standing.

We're going to publish some of this stuff. And that's going to be one of the things we're going to try to push. So our job at the VCE is to collaborate.

At the very beginning I said, Congress's mandate from the NDAA is to collaborate with academia, with the civilian sector. And yes, absolutely, you know, we're very small. We're a small staff. We have, this is really important.

We're sort of trying to get it through the military first. But we're concurrently working on getting this practice change out into the civilian --

DR. LAWRENCE: Yes.

CHAIR CROCKETT-JONES: Can I ask you what, comparably, is there any way for you to track how long it takes when you change, when you come out with a clinical practice guideline, how long it takes to change the actual practice? How effectively guidelines

are received?

And then, does practice really change? And what are those time lines? Is there any way for you all to have sight on that?

DR. LAWRENCE: Well, I think that's something we could possibly do some tracking on if we're collecting some of that information in the vision registry. You know, for a lot of practice guidelines that are put out by, say the American Academy of Ophthalmology or the American Optometric Association.

Some of the published reports are in civilian sectors. It takes a really long time to get that changed. And you need to have doctors who are very influential get up at big meetings and speak. And so, it takes a lot longer than we would like in the civilian sector.

I don't know that there are any published studies. To my knowledge there are

not in the vision space, looking at moving that forward. There may be in the other spaces in the military. In the military, and in VA, you would think it might be a little easier.

Because there are things like directives and DODIs, and other things that might make that process go more quickly in a military system. And probably Admiral Nathan and others could speak to that better than I could.

CHAIR NATHAN: Well, Dr. Cortese, who is the former CEO of the Mayo Medical Center, gives a brief on this. He talks about, from the time that an innovative idea, be it a pharmaceutical, a drug, a procedure is discerned at the bench by a researcher, by somebody doing innovative practice. From the time that actually makes itself into general practice across the United States is 17 years.

That's on average. Some are shorter, some are longer. These kinds of

things, this is not going to take 17 years for this. We'll have DODIs on this.

A great example of that would be concussive care in the battlefield, which took a few years. But it didn't take 17 to all of a sudden change the game on how we treat concussions and blast effects on the battlefield.

So I'm optimistic. I'm sad that it's taken this long. But I'm optimistic that we'll turn the corner on acute eye trauma in the next year.

DIRECTOR DAILEY: Five minutes. Ladies and gentlemen, we'll need to wrap here.

DR. LAWRENCE: Okay. So I have three more slides. In terms of disseminating vision research information, we worked hard to get a pretty complete list of all the Department Chairs of the Departments of Ophthalmology at every United States medical school. And also the Optometry schools across the country.

And when the vision trauma research program Request for Proposals went out, we got it out to that whole list. And we increased the number of submitted proposals from 151 to 280 this year. That's an 80 percent increase in research proposals.

The good news is, we got great research proposals, and lots of them. And the bad news is, we had to review them all. So it was a huge amount of work right before the Christmas and New Years holiday.

But we got through them all. And we have invited many back to do full proposals. That was just a pre-proposal.

We've participated in a lot of collaborative consortiums, the Allied Neurosensory Warrior Related Research Consortium, ANSW2R, and also the, I've already mentioned earlier, the Chronic Effects of Neurotrauma Consortium.

And we're working together to provide neurosensory, specifically vision

input into those neurosensory issues. Oh, geez, I'm --

DIRECTOR DAILEY: And two minutes, Dr. Lawrence.

DR. LAWRENCE: Okay. We have newsletters and the trauma system weekly videoconference that we always have somebody on. But we have some limited pathways for dissemination of our products and our knowledge.

We also have the VCE Advisory Council, which represents specialty care leaders from across the DoD and VA. We use our website and social media. But developing a good, viable program to disseminate our products remains a challenge for us.

And we have already talked about filling some of the key roles. We have several of our directorates who yet to have a director. But we all work across. And we're working hard to fill these needs.

I've already talked about

establishment of a procedure to influence policy across MHS. And our next big need is, as the war efforts are coming to a close, and our troops are coming home -- A year from now we should be out of Afghanistan, if I read the papers right.

We need to look at readiness during peace time. And looking at simulation to keep our eye trauma skills up, and at the peak of what they need to be at the beginning of the next conflict. Or for manmade or natural disasters.

We are doing a return on investment analysis of all of our initiatives and projects. We're looking, the ideal would be a monetized return on investment. But looking at other tangible and intangible if we can't monetize it.

To collaborate with VA and DoD planning committees. And to develop a communication network plan. I'll just end by saying that the wars may be ending. But the

consequences of the injuries to our Warriors will be with us for decades and decades.

And we can't abandon our work for these Servicemembers and Veterans, as they go through the system. We must capture and codify the lessons learned from this last 12 years of wars. And move them, continue to work to institutionalize best practices. And make sure we're prepared for the next conflict or --

DIRECTOR DAILEY: And we do have a question. Tech Sergeant Eudy, please.

MEMBER EUDY: Ma'am, very quickly, on Slide 30, the second bullet down, the establishment of the procedures to influence policy. As you mentioned earlier, I believe you said you were not a member of the Oversight Board of the DCoE Oversight Board.

So do you have a, are you a stakeholder? Do you have a vested interest to see where the organization is going as a whole? And how to make sure these

advancements and everything is circulatory?

That the ideas are coming around? That administratively things are working through? Or is it, the brain doesn't know what the hands are doing? So would that be a benefit to be a sitting member of that?

DR. LAWRENCE: I guess that's -- We are invited, and we speak. And we're freely allowed to speak. And I've raised my hand and been able to speak. So whether the Directors of the COE should be voting members when, I don't know. Whether an oversight board, the people that are being overseen, should be voting members.

So I guess that's not for me to decide. But I will say that they've been very open in the past. There's also talk, and you may have heard that the COEs may be moving out from under the individual Services. I think that the MHS is thinking about where the best place for these COEs to be, whether they should be under DHA or not.

And as I said, the COE Oversight Board has not met for many months now. So my guess is there's a lot of change going on. And we don't know exactly for sure where we will be. And that's one, where we are in the organizational structure is one thing.

But also how we effect policy change, how we advise that is sort of a separate issue. No matter where we are, whether we're under the Navy or under DHA, there should be a codified way that we can take our expertise and our best practices that we're suggesting, to advise on policy.

CHAIR NATHAN: Thank you. One quick question. And I may ask this of the NICoE folks. So there's a lot of hubbub about being able to recognize dementia and changes, based on exudative changes in the retina fundoscopic examination.

Maybe that's the early warning system we have for recognizing Alzheimers. I don't know. Are you engaged at all in the

research of that with people with TBI and/or PTS?

DR. LAWRENCE: Well, the Center of Excellence actually doesn't do research. We don't have a lab --

CHAIR NATHAN: No, but do you have visibility over --

DR. LAWRENCE: Absolutely. And looking at, there's a push to look for end points for TBI. And there may be some visual endpoints, or some endpoints that we can see on the battlefield, on the football field, right at the time of a motor vehicle accident, that might help prevent --

CHAIR NATHAN: I guess my question is, is your interest piqued at all --

DR. LAWRENCE: Absolutely.

CHAIR NATHAN: -- in the retinal exam --

DR. LAWRENCE: Absolutely.

CHAIR NATHAN: -- as being maybe the first physical finding of TBI?

DR. LAWRENCE: We don't know what it could be.

CHAIR NATHAN: Okay.

DR. LAWRENCE: And there, you know, biomarker, blood marker, retinal marker, whatever. But I think, you know, I mean, when you look at a cartoon, when a cartoon is, depicts a TBI, how do they draw it? They draw it usually crossed eyes and stars above their heads.

CHAIR NATHAN: Yes.

DR. LAWRENCE: Visual, right? So it's ocular motor, and it's the visual phenomenon. So probably most TBIs have some visual phenomenon. And I personally think that probably 100 percent of TBIs have a visual phenomenon initially. And sometimes it lasts seconds. And sometimes it lasts forever.

But it would be great if we could have a marker that's in the retina, or in the iris, or pupillary function. That's something

that we really need to test empirically to get the answers to.

CHAIR NATHAN: Very good.

DIRECTOR DAILEY: Any of those proposals that came in, or that you're looking at, are any of them focusing on that?

DR. LAWRENCE: I didn't read all of those. I read a segment of them.

DIRECTOR DAILEY: Okay.

DR. LAWRENCE: I did not read one that's focusing on that.

DIRECTOR DAILEY: Okay.

DR. LAWRENCE: But there's another big push looking at endpoints, that I'm working with actually Dr. Glenn Cockeram, looking at endpoints for TBI.

CHAIR NATHAN: Well, Dr. Lawrence, thank you very much. This is a very thorough brief on where you've been, where you are and where you're going. On behalf of the Task Force, thank you and your panel for coming. Reading your bio, I only have one remaining

question. Who do you root for when Harvard plays Yale?

DR. LAWRENCE: I have a son at Yale.

CHAIR NATHAN: Okay. All right.

DR. LAWRENCE: So I'll root for Yale.

CHAIR NATHAN: All right. Thank you again.

DR. LAWRENCE: Thank you so much.

DIRECTOR DAILEY: Ten minutes, ladies and gentlemen. And then we'll have NICoE, 11 o'clock, please.

(Whereupon, the meeting in the above-entitled matter went off the record at 10:51 a.m. and back on the record at 11:03 a.m.)

CHAIR NATHAN: Okay. Now we're going to hear from the distinguished folks from the NICoE. And who's going to be the lead? Sara, are you going to do that?

CAPTAIN KASS: Yes, sir.

CHAIR NATHAN: Okay. So, Sara, after I'm finished, if you'll just introduce your panel to those who haven't met them before. But this is Navy Captain Sara Kass, who is the Deputy Commander there.

And she will be discussing updated information on Post Traumatic Stress Disorder and TBI evidence based treatments, NICoE metrics and assessments, and perhaps the status of the NICoE satellites. You can find their information in Tab D. Sara.

CAPTAIN KASS: Good morning. Thank you for allowing us to come again this year, to speak with you about what we're doing at the NICoE, and to share our thoughts on the questions that you provided to us.

An agenda for what we'll speak about today really is just specifically addressing the questions that you presented to us. But first, what we'd like to do is just set the framework for that with our mission statement and our value proposition. In 2011

we --

CHAIR NATHAN: Who's here with you, Sara?

CAPTAIN KASS: Oh, I'm sorry. Let me start by doing that. So again, Sara Kass. I have with me Dr. James Kelly. He's the Director here at the NICoE. Dr. Tom DeGraba, who's the Deputy Director and the Chief Medical Officer. And Colonel Geoff Grammer, who is our Department Chief for Research.

And they all have expertise in different areas. And I'll be having them join me in talking about the slides that we have for you today. So again, our goal is to set the framework of our talk this morning by talking a little bit about our mission statement and our value proposition.

And in 2011 we did a scan of our stakeholders and customers. And went out and asked them to provide us feedback on where they felt NICoE could provide value to the organization.

We used that information. And those stakeholders were a broad swath of people from, patients, families, clinicians, line and medical leadership. And used that information to create our five year strategic plan. And that plan was created in, as I said, finally codified around June of 2012.

And from that we developed our mission statement up front, that again, talks of us as a Military Health Institute, striving to understand the complex comorbid traumatic brain injury and psychological health conditions. Specifically the population of patients that we're focusing on are those people who have both traumatic brain injury and some sort of psychological health condition with it.

Typically, for the patients who come to the NICoE, they have been in the traditional health care system, and have not improved to the level that they, their family, their line leadership or their providers have

felt that they should achieve.

And so they come to the NICoE, where we deliver comprehensive and holistic care. We conduct focused research. And we strive to export that knowledge to inform the system.

This year, in January, December and January, we worked on taking our five year strategic plan, and our mission statement, and our experience in crafting a value proposition. We want to make sure that as we proceed with doing the work that we're doing, we believe that we're adding value to the system, obviously.

As NICoE has matured there was an initial interest in NICoE's clinical productivity. How many patients are you seeing? And of course, that continues to be on people's mind.

But it is firmly my opinion, and I think that of those of us here today, that while we believe that the value of the care

that we provide for the patients who come to the NICoE, there is value in how we care for those patients. We believe that a comprehensive, intensive evaluation up front decreases long term costs to the health care system, as well as improving the lives of the patients and families who come to the NICoE.

That, in and of itself, is part of our value proposition. But I truly believe that if we end right there, it will not necessarily justify the existence of the NICoE. It has to go beyond that. And that's where the role that we play in research and education is so critical.

If we don't learn from the patients who come to the NICoE, and take those lessons learned, and export them into the entire MHS and beyond, we will be shortchanging what could be accomplished.

And so we wanted to craft a value proposition to focus not just on clinically what we do, but really highlights the role

that we play in research, as a clinical research institute.

There has been much discussion of late about NICoE and its mission, and the way forward. And we're engaging in those conversations. And I don't have a final answer for you of, this is what has been decided the mission of the NICoE is.

I think that there is absolutely an interest in making sure that the Military Health System is getting every ounce of the value it can out of the NICoE. And that's truly justified. There's a push for increased clinical productivity.

And I think it's our responsibility at the NICoE to explore where we can be more efficient, and where we can push for increased utilization of the clinical staff that we have.

But I would be remiss if I didn't state that I am concerned that if we push too hard for clinical productivity, we run the

risk of diluting something that I think has the opportunity to teach us an awful lot about how we care for this patient population.

So I think that it is as important that we pay attention to our clinical productivity as it is pay attention to the research productivity that we deliver. Because I think, really, to separate one from the other will shortchange what we're able to do. So that is the foundation on where we're moving forward in.

We know these are times when we must be efficient, we must be measuring that efficiency. And we'll continue to strive to do that as we move forward in our five year strategic plan.

The first question we were asked to address was about new best promising practices in evidence based treatment. For that I'm going to turn it over to Dr. Kelly. And, Admiral Nathan, I think Dr. Kelly will address your question regarding the eyes as

the window to dementia.

DR. KELLY: Thanks, Captain. Good morning, Task Force members. Again, we can find our answers primarily to the questions that were asked. But I know that you'll have additional questions. And we'll do our best to answer them as we go.

Admiral, with regard to the question, which we don't have answered on this page, with regard to the opportunity to pick up on dementia features in the retina. That research is not something we're directly engaged in presently.

But we're engaged in long term outcome measures with other organizations that will be looking at those very things such as the DVBIC 15 year study, and so forth. Our neuro-imaging is a piece of that.

And the neuro-imaging opportunity for us with radioisotope tags in both brain and other body tissues, such as retina, could lead to an opportunity for us to see that.

It's not something that's seen acutely. It is a long delayed, if you will, Alzheimers type change, as you alluded to, with the tangles and plaques, and so forth, that actually are in brain tissue.

As perhaps members of the panel are not aware, the optic nerve itself that you see, that the doctor sees through your pupil with the light, is actually not a nerve. It's not a nerve at all. It's actually brain. It's brain tissue.

And so an opportunity to look at that brain, that one interface at least, is the only place in the human body that the physician has direct access to looking at brain, without fancy imaging techniques or surgery. And so, we are very intrigued by that.

And perhaps the group is also unaware that the hyperbaric oxygen research project out at Fort Carson has a retinal evaluation piece of that. And I don't

remember exactly the numbers of subjects. But it's well more than 100 people will be in that project.

And so we could very well be gaining additional information through that evaluation, as a part of what had been previously hyperbaric treatment directed research for people with mild TBI. So there may be a better answer for you, Admiral, in the not too distant future.

So the first question, what are the new or best promising practices in evidence based treatment of individuals with both PTSD and TBI? And again, I should point out that the individuals who come to us, that are our patients, and serve as our subjects, have both traumatic brain injury, and some comorbid psychiatric condition.

So what we're seeing actually, as listed here, I'd like to point out that the intensive outpatient program that utilizes a very patient centered interdisciplinary model

of care is the thing that we know, that we're utilizing, which is working. And we'll have evidence that we can share with you.

So that certainly is an opportunity for taking people who have struggled in the more conventional system. And we, with this intensive outpatient project, are showing benefit sequencing of the evaluation.

And then the interventions with early assessment of sleep, and pain and headache, at the very beginning of the month long span that they're with us is absolutely critical.

The point that we're making is that it makes no sense to launch into treatments for things that aren't going to help the individual with the most basic of life problems, such as getting through a night's sleep with restorative and deep sleep.

And pain management. Because again, with just those two problems, if you're

not sleeping and you're in pain, your neuro-psychological testing, and every other aspect of your evaluation is going to look bad, because of those problems.

So we address those early on, so that we can actually intervene more quickly, and target that individual's problems. Combining integrative medicine, such as ART therapy, acupuncture, animal assisted therapy, as examples, with traditional therapies, then enhances insights into the symptoms and the causes of suffering for that individual.

And then we provide skills based training to enhance self regulation of the autonomic balance for emotional stability, such as the measuring and intervention and individual can learn for heart rate variability, with heart math, yoga, expressive writing, and so forth.

These are some of the things that we're learning as best practices, that are part of the patient centered,

interdisciplinary intensive care model that we see are working. Recent proven practices that are being promulgated to a broader TBI population.

You've already heard about a little bit of this, with the second one being the Vision Center of Excellence, from Dr. Lawrence. And we participated in that mild TBI visual evaluation and intervention project.

The assessment of auditory processing and vestibular functions, as a part of, or earlier on before neurocognitive evaluation, was a part of what we'd been working on with the Hearing Center of Excellence.

And then our neuro-imaging team has been very involved in the development of the DVBIC and DCoE neuro-imaging guidelines that have been disseminated across the DoD. Next slide. Sara.

CAPTAIN KASS: So the second

question we were asked to address is an overview of the size and composition of our clinical staff. Again, I think it's important.

We try not to specifically say, this is only clinical staff, and this is only research staff. Because the clinical staff is a component of our research staff. Because they're collecting the clinical data on these patients that is being used as the foundation for the research that we're doing.

So we've given you our composite staff here. But in that you can see a breakdown of that which is aligned to clinical operations. And that group is, fortunately, our most robustly staffed at this point in time.

Our overall staffing plan is for 117 total FTEs. We're currently at about 72 percent staffing. The civilian staffing is only at 64 percent. And the area where we're taking the most significant, I guess reduction

in forces, is in education and training, and research, which again, I think is a significant impact in our broader sense of delivery of value to the organization.

So, as you see, I would say that there are two significant challenges that we face with this. And we'll get back to this on slide, the fifth question. But one is being able to fill our civilian staffing requests.

And like many in DoD we faced a significant challenge this year with sequestration and budget cuts. But on top of that is just civilian hiring freezes. And those have significantly hampered our ability to bring on board the staff that we need.

And the second is, we still operate without an authorized manning document. Every time I lose a uniformed personnel, it's beg, borrow, and stealing from Admiral Nathan, and others, to try to fill those positions. And we've been fortunate to get support up to this point. But I think as

we're able to move to an authorized manning document, that will help as well.

CHAIR NATHAN: Where have you settled out now? And have you noticed much of a difference as you've been put under the Defense Health Agency?

CAPTAIN KASS: As we've been placed under the Defense Health Agency, and significantly contributing to that as being placed within Walter Reed National Military Medical Center, we've probably faced even more significant hiring freeze challenges.

And part of that has to do with the overall manning of Walter Reed National Military Medical Center being, I believe, overmanned with the alignment of Walter Reed Georgia Avenue and NNMC coming together.

Their total manning document is higher than they need for their operations at this point in time. And so appropriately, the Defense Health Agency is working with them to address their staffing model. But that has

meant no hires of any kind, or very limited hires.

And the problem is, if you have two times too many nursing assistants, and I need a biostatistician, it doesn't solve my problem. And we're working. It's just significant challenges to try to get hiring actions through that system. And I think it's slowing us down. And I think that's unfortunate.

CHAIR NATHAN: That's correct. They have a distribution problem out there.

CAPTAIN KASS: Yes, sir.

CHAIR NATHAN: They're over their numbers, but they're poorly distributed. Not through their fault, just through accumulation of who they can and can't hire.

And so some clinics have people standing around with nothing to do. And others are extremely short handed. And it's affecting their productivity.

CAPTAIN KASS: Yes, sir.

CHAIR NATHAN: Okay.

CAPTAIN KASS: Dr. Kelly.

DR. KELLY: Next slide. So your third question was, what is NICoE's assessment of the availability of evidence based treatment for TBI across the DoD?

In our view, the guidance and training regarding those opportunities, for both PTSD and TBI, has good penetration across the DoD, through the Military Services. And we will defer to the next group that you'll hear from DCoE, regarding effective utilization across the DoD of those evidence based treatments.

The challenges, in our view, remain in the area especially of standardized collection of robust assessment and outcome metrics. Especially with regard to comparative effectiveness research, which is a very important part of what it is we're engaged with. And other organizations are as well.

We recommend continued work with DCoE and DVBIC around concussion outcome measures, through the working group. In fact, there's another meeting that was planned for this week on that very topic.

And recommend that continued coordination with the FITBIR, the Federal Interagency TBI Research database and common data elements, from our standpoint, which Dr. DeGraba, and Dr. Reedy, in neuro-imaging have participated in all along.

While there is a compendium of options for caring for patients with comorbid conditions, such as TBI and psychological health, there isn't really a guideline, per se, that looks at how to manage people who have both conditions. It's more a matter of a menu of options and opportunities that are out there right now.

And what we're looking at is how NICoE's experience with comorbid patients may actually add to the practice guidelines as we

go forward.

CHAIR NATHAN: Jim, where does NICoE stand with the fairly, I don't know how controversial it is. But it's certainly been in the media lately. The removal of the MRI machines from Afghanistan.

DR. KELLY: Sir, I haven't heard anything about that. Maybe there's a specific news item, or whatever, that you've seen.

CHAIR NATHAN: Well, they're coming out. And so, you know, they're standing down the MRIs there.

DR. KELLY: Okay.

CHAIR NATHAN: And many people support that. Because they believe they, the lay person believes they haven't been that much value added in the acute management of TBI. They certainly have been helpful in somebody who has a head wound, or whatever. But they medevac those folks anyway.

So most people are arguing that the MRI was not founded in clinical relevancy.

Now that they're coming out there's heat and light being generated as a result of that.

DR. KELLY: Sir, they were actually decommissioned many months ago. And I was in Afghanistan in May, this past May. And they had already been shut down for a couple of months, or three months at that point. And I heard various interpretations of their usefulness from people on the ground at the time.

If we go back to why they were there in the first place, it was to use what is the elite athlete protocol for return to duty. So they had to have a normal MRI scan after a significant blow to the head, with symptoms and so forth clearing as well, before they would be returned to duty.

That was the original plan that Admiral Mullen and the team had, when he asked Navy to buy them and install them, and so forth.

Even at that time our

neuroradiologists went to Europe to make sure each of the three machines had the same stuff on it, so to speak, so that they could, at three locations, do the same things.

And yet, it became clear after they were all operational that they weren't all doing the same thing. So I think what happened is, on the ground people had their own ideas about what was the machine for, and whether it was going to be useful, before it actually played a role in the protocol, as it had been intended by Admiral Mullen.

So, it was a bit of a self fulfilling prophecy. This is me talking. I think that it was a missed opportunity. I think that some additional research could have been done with outcomes from its use, in a different way than had been used.

And they've all heard this from me before. This is not me saying something new. But I'm on the minority side of that. And have no control of what happened under the

circumstances.

So we, you know, NICoE was expected to take those images into our system. And then make sure that we were comparing apples to apples. That opportunity never happened. So NICoE really had been taking a backseat in this whole thing, right from the very beginning, after we were involved.

CHAIR NATHAN: Well, thank you for your comments. It jives with what I've heard, which is, their clinical relevance was fairly minimal. And that's why they were dismissed.

What you're saying is, the research, you know, data they might have provided from a longevity standpoint may have provided more value than they took advantage of.

DR. KELLY: I think that's certainly part of it. But also, it was not used, to my knowledge, in the way it was intended, even clinically, in the decision making process that was intended from the

original plan.

CHAIR NATHAN: Okay.

DR. KELLY: And next question I'll hand off to Dr. DeGraba.

DR. DEGRABA: So, the question comes up, what metrics do you use to really identify whether or not an interdisciplinary approach can actually change the course of trajectory of recovery for Servicemembers who have had comorbid TBI and psychological health condition, and who are not responding to conventional therapy?

So what we're going to show on this slide are some of the key metrics that we have utilized to demonstrate that a four week intensive outpatient model does have benefit for patients who, in a number of cases, for years have not been improving.

In fact, many who are deteriorating over the course of time. Demonstrating that this model actually can reverse that course, and get patients back on

a course of recovery. That they are not irreversibly injured, that they cannot be productive.

And a number of cases go back to their active duty settings. First of all we took a look at, and the bottom line up front is, we took a look at surveys at the end of their stay. And identified that 99 percent of the patients described that we addressed issues of suffering, and put them back on a course of recovery that they did not believe possible.

The metrics that we used as our key indicators, you'll see here, are six indicators. We convened working groups prior to opening the NICoE, of national and international experts. And looked at those features that we knew were going to be signs and symptoms of persistent deficits that our patients would have coming to us.

And so we looked at headache pain. We looked at satisfaction of life survey. We

looked at a neuro-symptom behavior inventory, which is 22 elements of neurological deficits. We looked at sleep scales. And looked at dizziness indicators.

And then finally, of course, post traumatic stress, the PCLM, to take a look at post traumatic stress in our patient population. We took those measures at the time they entered the NICoE, and at the time they finished their course.

And what we identified was a significant reduction of suffering and symptoms in all indicators of the scales utilized, for the patients moving through the NICoE in their four week model.

What this provides us is actually just the tip of the iceberg of what we collect. We utilize a systematic approach, and a database collection that currently collects over 1500 data elements on our patients, only able to be captured when you utilize an interdisciplinary approach in a

four week intensive model.

That helps us understand more than just the scale, but what the patients are subjected to when they are subjected to TBI and psychological stressors.

In addition to that, we also are beginning to take a look at the utilization of data from the data centers within the DoD, to look at utilization of the health care system. In other words, does the utilization of this interdisciplinary approach allow patients to start getting better, so they're not using the health care system.

And what we've identified in a cohort of patients coming through, who have completed at least a year of post NICoE stay, that there's a 13 percent reduction in patient provider encounters, when you look at the encounters, the year prior to NICoE, versus the year after they leave the NICoE.

In addition to that we have also taken a look at retention within the military

system. And so we looked at 147 patients who were discharged by 2012, who have at least a year follow-up in metrics. And what we have found, that 78 percent of the personnel coming through our center were retained at one year.

Now, this is interesting because if we ask the primary providers who are referring patients to us what they believe the likelihood, whether likely or very likely, whether patients would be able to stay in because of their medical condition.

And only 50 percent of the patients coming through have that belief by their own provider that they will be able to be retained. And so these one year retention levels for us are very significant.

And more information needs to be gleaned as we go through this data, to understand the retention reasons. But these are the preliminary data that we're starting to get back at the one year follow-up.

And finally, the other important

issue is, how do our providers refer to us, see us as of value to them? And we worked with the DCoE and their RAND study to develop a questionnaire in which providers at the MTFs were asked, how was the NICoE's value to them. And those data are yet to be released.

But we're very interested in knowing how our providers see the information that they get from the NICoE as a value for them, going on in the treatment of our patient population.

I'd like to stop here. There are many other individual research protocols that address everything from neuro-imaging to neuroendocrine, to new techniques, like magnetoencepahalography, where we look at damage to the electro-physiologic system of the brain.

There are a number of different studies that we are starting to publish and submit as abstracts. But I'll stop here and see if there are any questions with regard to

our outcome metrics.

COLONEL GRAMMER: I have one caveat to Dr. DeGraba's comments there. What was interesting about some of the outcome metrics is, if you take patients who presented to us with traumatic brain injury, but do not meet criteria for PTSD, those patients also had a statistically significant improvement across the board of their symptoms, or within the NSI questionnaire.

So this isn't just improving PTSD and having, you know, collateral improvement in TBI. Both conditions, when isolated, appeared to improve from this model of care.

CHAIR NATHAN: So we cut the ribbon on the NICoE --

DR. KELLY: June 24th, 2010.

CHAIR NATHAN: Yes. A day that will live in history, or infamy, depending on whether you ask Mr. Fisher. What do you all know now that you didn't know then?

DR. KELLY: We've seen

CHAIR NATHAN: About TBI.

DR. KELLY: We've seen about 550 patients over that span of time. We now have a dataset, as a result of what is the opportunity to look at significant numbers of individuals now, that Dr. DeGraba's referring to.

A variety of things have become very clear to us. That getting the diagnoses right, the constellation of diagnoses that are attended to TBI, such as eye movement abnormalities, which you heard a little bit about earlier. And vision processing, which we're also seeing a part of on magnetoencephalography.

Hearing and hearing processing. So auditory comprehension, and the brain's management, if you will, of that information. And the actual substrate, the organ injury itself, are now things that we're able to see because of the advanced imaging and the advanced subject matter expertise analyses

that we're doing, that have been missed previously in that same patient population that has come to us.

Those opportunities have not existed throughout the MHS largely. And so this is not intended to be a ding on them, if you will. This is an advanced scientific clinical research institute that's finding thins in these very same people that had not been appreciated before, which gives us an opportunity to help them with those very problems, with vision, with hearing, with autonomic nervous system features that they can actually control themselves, with sleep regulation, and so forth.

So there are many things that we're learning about traumatic brain injury in this population. And it starts with getting the diagnosis right, as to what the concomitant problems are in that population.

CAPTAIN KASS: I think one thing I'd add that I think we've learned is that

while the intensive interdisciplinary approach to care that we employ at the NICoE is not indicated for all patients who experience TBI or psychological health.

That there is a subset of the population who suffer from that who do not get better in the traditional system. And that there is a role for a referral center, such as the NICoE, to explore the ways that we can refine that diagnosis.

That we can deliver care in a very comprehensive manner that allows us to understand patients in a way that the traditional system just does not allow us to understand them. And they can get better.

Oftentimes, what I've heard is, this is the patient's new normal. And now it's time to just help them at that new normal. I think we have to be open to the idea that there's still room for improvement. And we have to have a system where we're able to get people to that opportunity.

CHAIR CROCKETT-JONES: Are you getting any sense of what the factor or factors are for why some folks don't respond to the traditional treatment?

CAPTAIN KASS: Great question. I'm going to pass it down. Because I think the research folks are starting to get a bit of information on that.

DR. DEGRABA: So, let me just answer. And I'll also have Colonel Grammar also talk about this. The paradigm shift that we are approaching is that we're taking this kind of rubric of mild, moderate and sever TBI kind of out of the picture. And really start describing how the brain is injured.

What are the neural networks? What are the parts of the brain that are actually injured when patients are exposed to TBI and psych health issues?

Previously to this, all the studies that have been done would lump everybody with an MTBI in one group. And try

to either give them therapy or look at their natural history. And we know that a patient who has MTBI by criteria and definition is very different than the person standing next to them who also may have been exposed to the same blast injury.

And so our approach to this is to look at all the pieces of the puzzle, from neurological, psychiatric, neuropsychological evaluation. And combine those with neuroimaging, electrophysiology.

And what we're finding is that there are different sub populations within this group, and this rubric of MTBI, that are really responding to therapies in a different fashion. And it's one of the advantages of the program that we have.

So let me just put a face to that descriptor. We had an officer come in who actually took himself off line, because he was having difficulty with executive function. Wasn't able to make decisions rapidly. Having

difficulty remembering things that he needed to remember on a day to day basis.

And most people would look at that and say, ah, this is classic TBI, where the frontal lobes and the temporal lobes are involved. Because executive function in the frontal lobes were affected. And the temporal lobes where memory is laid down was affected. And that's what he was kind of tagged as.

When he came to us we were able to do more detailed neuropsychological testing, neuroimaging, and finally, electrophysiology studies where we actually demonstrated that the injury in his brain was actually taking information that he was seeing, and bringing it to the area of the brain that identifies words and concepts.

So he was actually having a visual processing problem, and an auditory processing problem, as opposed to being able to lay down memory, or make executive decisions. And it completely changed how we understood his

neural deficit, and the rehab that is now being engaged to help him with processing. As opposed to him doing memory testing and memory exercises.

So those are the types of things that we believe we're finding at the NICoE, by being able to look at the whole picture of the patient's care.

COLONEL GRAMMAR: I guess he'll let me use this mic. So, I don't have a whole lot to add from what Dr. DeGraba just said. I think the important points are, there's a fair amount of debate within the literature on what this population actually suffers from.

And there are some authors who actually feel that perhaps there's a psychiatric component that is predominant. I think probably one of the most important things that we're beginning to discover now is that in some patients that is not appearing to be the case, as illustrated by the case report Dr. DeGraba just gave.

And this is very important. Because these patients may present with symptoms similar to psychological health conditions. But the treatments are going to be different, because the underlying lesion is different.

So, for example, if someone has autonomic dysregulation, their ability to maintain basal motor tone, their ability to maintain adrenergic tone is impaired. And if you don't address that as an underlying cause, then you may be sort of cutting them short on what treatment options are available.

For some populations it, at least it appears that if you have PTSD and TBI, and this is not a big surprise, those patients do worse. It's hard enough to contend with PTSD. You add cognitive deficits on top of that from neurologic injury, and it just makes sense that those folks aren't going to do as well.

But the good news is, again, with this data it does appear that most, many of

these patients are responding to the treatment program that we do have.

CHAIR CROCKETT-JONES: I guess my question a little further is that there seems to be a lot of movement to get a discrete re-defining of TBI, to match the integrity of the actual injury.

Is there a similar move in behavior health that you are aware of, to get a sort of get a more discrete and defined psychological profile? Or is all PTS the same kind of a thing? I mean, I still seem to hear that PTS is PTS. So TBI --

CAPTAIN KASS: So as we're talking about sub populations for TBI, are they doing the same thing as sub populations for PTS?

CHAIR CROCKETT-JONES: Yes.

COLONEL GRAMMAR: So, certainly the distinction has been made in the scientific community, differentiating between combat related Post Traumatic Stress, and civilian related Post Traumatic Stress.

And they probably have different trajectories in and of themselves. We are, that is part of what we're doing right now, is looking at this. You know, with --

Chronic psychological health conditions obviously can set up patterns of neurotoxicity, and actually cause biologic correlates associated with it. So, you know, there are going to be some folks with existential crises.

There are going to be some folks with integrative issues that, you know, with reintegrating back within families. And there are going to be some folks that have comorbid psychiatric conditions of substance use, and so forth.

And each of those populations is going to present differently, respond differently to treatment, and have a different trajectory. That is exactly the data that we have been collecting on our patients right now. And what we hope to further define in

the year to come.

CAPTAIN KASS: Okay. The next question is about what changes are needed outside of NICoE to enable NICoE to better fulfill its mission? The first three bullets that we have there really are kind of administrative in nature.

What we need to do, and again I mentioned up front there's discussion of what the mission of the NICoE is. Those discussions are ongoing. But what we need to get to is, no doubt about it, this is the mission of the NICoE.

We have a very firm opinion that the mission of the NICoE should be a balanced clinical research institute mission, not purely clinical throughput. But those discussions are ongoing. Once the mission is solidified, and everybody's agreed to that, defined performance measures that tell us what the target for success is need to be codified across the system, so that we're all aiming at

the same target, and we know when we're making progress to getting there.

At times we hear, you're too expensive for what you achieve. And when I ask, what equation are we using to make that determination? Have we considered return to duty and cost savings from training?

I think we just need to be open and transparent about what success looks like, and how are we measuring success. Because I'm confident that the folks at NICoE will march swiftly towards the direction of success.

I think we are, based on our definition. We just need to make sure it aligns with what everybody else believes success looks like. Along --

CHAIR NATHAN: So, Sara --

CAPTAIN KASS: Yes, sir.

CHAIR NATHAN: Questions 7 through 10, really the spirit of them. If you could frame your answers in this spirit. The Task Force is aware that numbers of people with

mild to moderate TBI are stifling. Thousands and thousands and thousands.

Only about 20 percent coming from the combat kinetic arena. The others are coming from garrison type accidents, motor vehicle accidents, falling off a balcony, whatever. So, and the NICoE was brought in to be -- And different people would say different things. But brought in to be a test kitchen, to sort of look at new and innovative ways to diagnose.

As Dr. Kelly has said, you found new and innovative ways to diagnose. New and innovative ways to treat. And you would admit that you can only treat a select small few. But the ones you do, priceless if you can make a change in someone's life.

CAPTAIN KASS: Yes, sir.

CHAIR NATHAN: But the Task Force is interested in how do we then --

CAPTAIN KASS: Export that.

CHAIR NATHAN: -- export that in

the largesse to whatever? Be it a NICoE satellite, be it the Mental Health Clinic at Fort Lewis-McChord, be it whatever. And so we're really looking to see, you know, what you think is happening.

And some of these things are within your control. And many of them are not. But remember, we started off in the beginning, as the Task Force formed, with the Services, each Service saying, don't bother me. I've got my own recipe for taking care of Wounded Warriors with mental and emotional health disorders.

And we said, no you don't. There's one best way to do it. And we need to use the DCoE. And we need to use places like the NICoE, where we're putting a lot of money, a lot of high priced personnel and equipment in, to finding better ways of doing business.

You're distributing, you're discussing with us now, you are finding bigger and better ways of doing business. And so the

satellites were created in the spirit of trying to take your recipes you created in the test kitchen, and try to implement those as much as possible, recognizing they'll never duplicate the amount of equipment and personnel, and expertise you have.

But processes and algorithms for care can be exported. So that's, as you answer these questions, that's what we're really looking for. We recognize that over the last 12 to ten years, there have been about 1500 or so people with amputations. But there are that many people who are developing PTS and mild to moderate TBI every few months

CAPTAIN KASS: Yes, sir.

CHAIR NATHAN: And so, you know, what are we doing about it?

CAPTAIN KASS: Yes, sir. And I think, just quickly, and then I'll, as Jim addresses some of these other slides we'll keep that in mind as we talk about it.

But in the discussions about

NICoE, and NICoE alignment that we've had, one of the things that has come up, and this was again with stakeholders, key stakeholders from across the system of care. From the Services to DVBIC and DCoE, and others, MRMC and the University, about the system of care.

And I think that really was where it comes back to is for the satellite specifically. And where most care is delivered in our health care system is at the MTFs, under the command and control of the commanding officers and the Services.

And so, as we look to figure out, okay, the test kitchen has found this, let's try to put it into the system. The process by which we move those things through our health care system needs to be more clearly defined.

And we need to have a process by which that can be done, when you're asking somebody from a different Service to do something different than they've been doing it before.

And so the next steps with the NICoE alignment effort that we've been engaged in in the last couple of weeks, has been refocused to a, let's further define the system of care, who the roles and responsibility belong to for vetting of, for identifying innovative best practices, and trying to be the test kitchen.

To, who is that unbiased organization that vets those best practices, and prioritizes testing and implementation of those? What is the system by which we test an implementation and evaluate it? And then, as we've determined that this can work outside of a place like NICoE --

Because just because it works at NICoE doesn't mean it works in the system. Once we've determined it works in a little broader population, how do we export that out to the entire MHS?

And I think that's ideally, and I think that's what I heard Dr. Lawrence talk

about too, where we need to get to in order to be able to implement change. And I think the NICoE satellites form a good opportunity for how we work on that implementation.

As we move forward in those discussions we'll try to focus in that way as well. If we don't move things out of the test kitchen, then again, it will be less effective than where we are intended to be. And the satellites, I think, play a key role in that.

I already talked about manning document. I'm not going to reiterate that again. I think that the other, the last three that I have, have more to do, again, with the system. I think where we're able to get to the standardized both assessment and outcome metrics, we get into that comparative effectiveness research, to see what's working and what doesn't.

Continuing the research funding that we have. We know that we don't know all that we need to know. And we need to make

sure that those efforts continue, so we continue to care for this population, as well as unfortunately, those that may experience TBI in future conflicts.

And then finally is an IT system that is standardized, with standardized access. And we collect a lot of data. There's so much data. And there are not enough people within the walls of the NICoE to evaluate all of that data. And I think that's probably true across the system.

So, how do we create that data repository, and make sure that everybody's putting data into it in a standardized way? And then, whether it's working with FITBIR, as a federal interagency TBI database, or some other organization, that we're making that data available to the civilian academicians as well, so that they can be similarly evaluating this information.

The next, the remaining questions that we had all have to do with the NICoE

satellites. As we said, we don't have command and control of the satellites. But we are the link to them at this point in time.

And Dr. Kelly is the one who oftentimes briefs on that. I'm going to turn it over to Jim to talk to those. And, Jim, just please keep it in mind what the Admiral talked about.

DR. KELLY: So, is this Slide 8? Yes. So the status of the satellites at the present time is that the first two of what could be nine are up and running. So at Fort Belvoir, just south of us here, since last September.

And as you see, the numbers there that are reported, as to the patients that they're seeing, and the encounters, and so forth. I should point out that Mr. Arnold Fisher, who was with me just last week, down lower you see that Fort Bragg had a groundbreaking ceremony last week.

Mr. Fisher, unannounced I am told,

showed up at Fort Belvoir, which he's occasionally known to do, just about a week ago. And was delighted to see what he saw going on, and how it is that it's working there.

And I think that it does represent one model of how it is that rolling out much of what it is we've been learning at NICoE can work and influence the care locally.

Camp Lejeune similarly had a ribbon cutting ceremony on October 2nd. Had already been seeing patients just weeks before that actually. And as you can see, has enrolled more than 1,000 patients since it began. And yet, they are still are not fully operational. And still on some occasions need to refer into the civilian network, outside the Camp Lejeune health care system.

So again, the Fort Bragg groundbreaking just happened. That's the fourth satellite to be built. The third in line is Fort Campbell, which will open, we're

told, toward the end of this coming summer, 2014.

The Five Intrepid Spirits, they're all being called now, are yet to be determined in the order. I heard from Mr. Fisher last week that he thought that joint base Lewis-McChord was perhaps the next one on the list. But I don't think that, as far as I know nothing firm has been established about that.

Next slide. The target population for the satellites in the referral process. So the intended target for each of the NICoE satellites are active duty Servicemembers with TBI, with or without the comorbid psychological health conditions, such as those that we see at NICoE.

And so for the Intrepid Spirit at Fort Belvoir, it's a broad range of TBI patients. I should point out that all of their TBI care right now is being provided at the NICoE satellite at that location.

And for Intrepid Spirit Camp

Lejeune, the mechanism of injury may be combat related, or non combat related. So they've opened the aperture, if you will, to who it is they're seeing in that setting as well.

And then the referral process at Fort Belvoir, the referral can be made by anybody, any health care provider with access to the CHCS system. And at Camp Lejeune, it's actually referred by the Medical Officer or PCM, following 90 days of initial treatment. So the implementation of an existing TBI protocol in the hands of the primary care providers first.

And if, in fact, that doesn't work, then they're referred over to the TBI center now at NICoE. Patients there also may be, may self refer, and present themselves to the center.

Next slide. What services? Now again, this is the list of the services that were thought to be available at each of the satellites. It's a bit of a menu, if you

will. Although, they're, on one level or another, expecting to be able to provide these services that you see listed in both columns.

What they will typically not have in the building are things like neuroimaging. So they don't have big scanners. And then sleep medicine. Right now, none of them have had overnight sleep labs in the facilities. And then they would still consult with nutritionists or pharmacists, or so forth. So they don't have the full robust subject matter expertise that we have in house at NICoE.

But they may have access to it elsewhere on Post. And then future services planned at Camp Lejeune include a return to duty program, which they anticipate starting in April of this year.

Next Slide. Will the satellites provide consultation and education services, as well as treatment? And again, leveraging what it is that we're doing at NICoE, called the Project ECHO, which is an acronym for

Extension for Community Healthcare Outcomes, based on the model at the University of New Mexico, which we have visited.

They actually participate in this project on a quarterly TBI psych health education forum, that emanates from NICoE, but actually is engaging the satellites as well.

The Fort Belvoir location has the following educational offerings, which I won't read to you, right there. And then you see the additional ones, the educational offerings in the third bullet, at Camp Lejeune, which I should point out, are partnering with the existing systems, such as DVBIC, under DCoE. So Defense and Veterans Brain Injury Center has educational modules, and personnel in these locations to participate as well.

Next slide. And I believe it's the last of our slides. And Question 10. How will the satellites monitor post discharge outcomes? You'll see there that the menu again, the list of outcome measures that

they're using is longer actually than some of the ones that we had started with at NICoE.

It incorporates much of what it is we're doing. But again, without there being a command/control relationship between NICoE and those organizations, they select what they think are the most appropriate for their populations.

And then what we're looking at is opportunities to do comparative effectiveness research, in collaboration with them, as a NICoE network. And then the last bullet, the first two. And NICoE will be having a research meeting later this week.

Actually the three of us on this end of the table will be traveling down to Camp Lejeune on Wednesday, for an all day meeting on Thursday to address these very issues, as to what their early experiences with those outcome measures, and what the way forward is, as a network.

And as more of these satellites

come on line, how that could actually guide the path for us. And that's the end of our brief at this point. And we're certainly open for questions.

CHAIR CROCKETT-JONES: I have a question for you. The outcome assessments, are they conducted, how often? Is there a single outcome assessment? Is it redone at intervals? Can you describe that to me?

DR. KELLY: Sure. So at NICoE, the six measures that we use are done on day one. So when somebody comes in to us. And then on the day before discharge, four weeks later. And then --

CHAIR CROCKETT-JONES: Is there any follow-up?

DR. KELLY: What we're looking now is at six month and one year follow-ups. We actually have additional personnel that we're trying to build into an outcome research project that has separate funding, for more of that to happen as time goes on.

But right now, without there being a robust data management system that's network wide, as you can appreciate, we actually, literally have to do telephone conversations with people, and track under those circumstances.

COLONEL GRAMMAR: Ma'am, I'll just add, we also have funding to utilize a tool called the Wounded Ill and Injured Registry, which is a web based rating scale tool that imports directly into our system. That should roll out some time this spring. And, you know, contracts are done, and so forth.

So again, trying to automate some of this process as well, to collect more of that longitudinal data. But that has some challenges that we're trying to overcome.

MEMBER REHBEIN: Sir, if I may? If we can go back to Slide Number 10 for just a moment? As you talked about the services that are going to be, that are provided at the Intrepid Spirits, you used the word, "may"

have access to, a couple of times.

Should I read this list as a, on Slide 10, as a list of mandatory? And then there are others that provide value, but are not critical? Is that the correct reading of this list? How do I interpret that, what you were saying?

DR. KELLY: That's a great question, a great question. So what we've been learning -- And this is, again, been a bit of a fluid process for us as we built NICoE itself. Was to try to figure out what really was going to help.

And the proof of concept, if you will, of that co-location of the experts in the same building. So that the patient just went one place. And everybody was built around the patient, as opposed to having individuals find the care in a system that is often in multiple locations on a given military base. That's the beauty of the physical plant.

I've never been able to do that in the private sector, not ever, at some pretty darned good places I've worked. This is a unique model. And it's showing benefit. Because the patient, whose brain is not working right, is not being asked to figure out the system. The system surrounds the patient.

So we started with that concept of care two years ago. And the Services then said, yes, these are the people that we think, we agree, add a satellite location with less, much less of a research mission, and much more of a clinical mission, should have in it. And so that was the agreed upon list.

The availability of those personnel at any given location, and/or the people that do some of the similar work at a similar location, changes the entire picture for a given site.

So to try to get some of these personnel at Jacksonville, North Carolina, for

instance, might be a challenge. Although it's been less of a challenge than we thought it might be. And having people come to Fort Belvoir has had certain challenges, as well as any hiring in the current atmosphere, as you can imagine.

The other part of it is, at each location, what they already have at the MTF was not going to be found, it would be silly to have a redundant system. So you wouldn't add something that already existed inside the NICoE.

If, in fact, they had robust overnight sleep evaluations, and that sort of thing, that would be unnecessary to put inside the satellite. So each satellite, architecturally, and in the leadership of their chain of command, got do decide what goes in the building.

So we had agreed upon what should go in the building. But it's not, in each case, turning out to be that. And it's for

all those reasons, the hiring, what they already have on Post, what the needs are for that particular operational tempo of that location, and on and on.

MEMBER REHBEIN: If I may, one last follow-up then. So in those situations where there is already a robust sleep program on base that they have access to, how do you ensure that the results for that particular Warrior are integrated back into NICoE? That that's not just something else that they go do as part of this?

CAPTAIN KASS: Yes. So at the satellite locations -- And again, this list, we got this list of services from the satellite locations. So right now, at Belvoir and at Lejeune, these are services that are available.

Just to follow up on your earlier question. Not necessarily every patient will get everything that's there. But it's available should they need it.

As for, how do you get the information back? I think it gets at that comprehensive case management part of what's here. Is making sure that if a patient gets sent over for a sleep study, that that information is tracked as quickly and as agilely back into the system.

So your care is still being coordinated for TBI and psychological health. Your care is being coordinated through the NICoE satellite, through the Intrepid Spirit. And so just like, so my background, I'm a primary care doctor. So they become sort of the primary care management of that person for those conditions. They're bringing them back in.

And, in fact, it is a primary care doctor at each of these locations that is sort of the team leader for the individual when they're there.

MEMBER MALEBRANCHE: I'm from the VA. And I'm thinking our Polytrauma Centers

and our Rehab Centers were basically TBI Centers to begin with. What's your connection to the VA for that? Or is that connection --

Assuming, of course, that, I mean, these folks are going to be Veterans. What are you -- Because I know they have a polytrauma system up here, where they start out. What's the connection there? Is that, or has that discussion been ongoing?

CAPTAIN KASS: Yes. So I'll talk a little bit about, kind of at the administrative level. And then at the deck plate level I'll pass off.

But in coordinating with the satellites, and trying to create how things will work between NICoE and the satellites, we created something called the Clinical Coalition, which is a monthly telecon with the directors from each of the satellite locations, as well as NICoE.

And with that we've invited others, including DCoE and DVBIC, and a

representative of the VA. Because we want to have VA advice, guidance and integration, as we're able to.

As well as, DCoE oftentimes brings together that perspective as well. So at the kind of planning with the satellites' perspective, that's where there's some integration.

For the individual patient, when they're being cared for at the satellite, again, I think a lot of it has to do with coordination at the site, sometimes with that DVBIC representative, and the regional care coordinators that are in the regions, who help to track the patients, and help them as they transition from the DoD system of care to the VA system of care.

But again, I'd probably be overstepping my knowledge of exactly how they're executing it at each of these satellite locations. But that's the intended way that some of those connections are being

made. Does anybody have anything else to add?

DR. DEGRABA: Just one thing that I would like to add. So, the National Research Action Plan, which is the, kind of the culmination of the Executive Order back in August of 2012, directed NIH, DoD, VA, and the Department of Education to come together and take a look at research in the behavioral health world, in Post Traumatic Stress, TBI, et cetera.

And one of the things that we are able to do, because of that action plan being put into place, is to take a look at research that's being done in the different agencies. And look at the correlation of data elements that are being collected.

And so again, as we stood up our data system, we utilized the common data elements that are put together, again, by national and international group that's housed at the NIH. It's online, and capable of being used by anyone and everyone. As well as

working with FITBIR, which is the Federal Interagency Traumatic Brain Injury Research working group, that is creating a national database.

And so one of the important things is, as Captain Kass was saying, how do you correlate, and how do you make sure that the data that's being collected in one place fits with data that's being collected elsewhere?

And so we're utilizing this federal interagency initiative to be able to, as best we can, align the data that we're collecting, with data that's being collected nationally, so that those data can be merged ultimately, hopefully in the FITBIR database.

DR. KELLY: Sorry. And just lastly, even just this morning, Dr. Cernich, who you'll hear after lunch, from DCoE, sent an email to Captain Kass and myself with names of personnel at the central VA office, to collaborate with this very issue that you're raising.

So again, another partnering organization helping with making those sorts of connections for us. And, in fact, I started out, even before the building was being built, at the central office explaining to the TBI leadership at the VA what NICoE was, what we're planning to do. And what the opportunities could be for collaboration, right from the very beginning,.

MEMBER REHBEIN: So, if I may? One more question. And I'm going to use the MRI systems we talked about in Afghanistan as an example. Because they were funded, put in place. But they were never used as was originally intended.

If you don't have command and control of the Intrepid Spirits, how do you ensure that someone on site doesn't begin to implement their own vision of what it should be? How do you maintain that it stays operating according to the principles and the knowledge that you've developed?

DR. KELLY: Again, that's a very good question. And we struggle with the very same concern. We've never assumed that we would have command and control over what happens locally. Ours is a coordinating and collaborating role.

And so a lot of this has to do with the willingness and opportunities for us all to work together, for those Servicemembers and their families, in moving the ball forward down the field. And I think for the most part, that's exactly what motivates people to work together, and to do things very similarly.

There are challenges, as I mentioned earlier, in terms of even staffing these places. But we do share your concern that without there being command and control over all of the system that way, there will be different ideas, and different movements, and different uses even of the facilities, than what had been initially intended.

CHAIR NATHAN: So, since I've been ground up in the gears of this, in my position, the NICoE has a point, in that if you're really going to get congruency, and create a template of care, that they should have the ability to do cause and effect throughout the satellites.

The Services would contend that their patient populations that are designed to be cared for in the satellites are dramatically different than those that are sent to the NICoE, which is, the NICoE is really a tertiary care TBI center for those who just can't do better. So the truth lies somewhere in the middle.

I would also add, on the VA, and this my impression, Karen. I'm speaking just for myself. That the good news is that the VA, in my opinion, having seen so many of their facilities, it really is an amazing reservoir of expertise in Post Traumatic Stress, Post Traumatic Stress Disorder.

Really tremendous experience and longevity. And an innate working knowledge of how to treat many of these patients. The bad news is that the VA is more discoordinated in centralization of these things than we are in DoD.

And they're working hard themselves to try to figure out how to share best practices. And they've created over the recent times some committees and oversight committees to try to tap into that. But they are a very decentralized organization.

But we would encourage you to work with them as much as possible. And I know you know that. To extrapolate on Mr. Rehbein's question, not only --

The NICoE satellites are designed to be sort of high target, high value organizations. Put them in places where they're a reservoir and congregations of large recovering warriors with TBI and with PTS, Lejeune, Hood, Campbell, Pendleton.

That said, when the NICoE first started you had trouble, we had trouble getting the services. And it wasn't the services, per se. It was various places in the services, to refer patients to you.

Because at the first, they just didn't see the sense in it. They felt like each place, bit it a Lejeune, a Hood, whatever, felt, you know, we're pretty good at this stuff. We know what we're doing. You've since shown that many of the patients who were first sent to you, sort of grudgingly, you were able to re-diagnose, and use more refined techniques to not only diagnose, but to treat these patients, and make a difference.

Has that paid off? Are you now seeing more of a willingness on the general military centers of care, not the satellites, but the ones out there where satellites are being built, or even the smaller ones, to refer to you, or to call you, or to utilize your resources?

Are you still seeing recalcitrant attitude of, we've built our own place out here. We're doing well at it. We don't really need Washington or DC, or Bethesda to tell us how to treat these patients?

CAPTAIN KASS: My answer would be, yes, we still see recalcitrants. We see places where not feeling that they're going to get anything better than what they got, the can give at home.

And I think part of our approach to that is, we've got to look at, while the patient is a critical customer of what we do, if NICoE's job is to be that referral center, and learn from that referral center, then our primary customer we need to be surveying how we're serving them is the referring providers. And we haven't done that to that point.

That's one of the new initiatives that we move forward on as to those places who send us a patient, but then that's it. Did we not meet their needs? Did the patient do

great while they were at NICoE?

But when they went back the provider had no better information as to how to take care of that patient, than they had when they sent them? And so we didn't meet that referring provider's needs. So we need to make sure we're serving that customer, and making them satisfied.

So we have areas of some pushback. We also have areas of incredible loyalty. And we can get enough of your services. The Special Forces are one of those populations where, if they could just perhaps send all their patients, save all of our spots for our patients. We'll be glad to fill them up for you, Captain Kass.

We think we need to serve a broad population. We're very honored to serve all the people who come through the NICoE, including the Special Forces. But we can't just be a Special Forces facility. But they have been very loyal. And they send a ton of

patients.

So we see it from both ends of the spectrum. But we do still see some resistance, there's no doubt. We've got to figure out how to meet those customer's needs.

CHAIR NATHAN: Well, and this is where we come in, in trying to create recommendations and awareness in DoD that there's still good intentions and great passion out there in the aegis. But they call it a best practice, because it's a best practice.

And we need to help you take pragmatic things you've learned. Not some of the nuance things that may or may not be proven to bear fruit in the future. But some of the pragmatic things you've learned and discovered that can be templated across the enterprise, and help you get that message out.

Any other questions for the panel? With that I thank you, on behalf of my Co-Chairman, and the rest of the Task Force, for

updating us, for what you do. And we'll look forward to hearing more new and innovative things that come out of the NICoE. Thank you.

DIRECTOR DAILEY: Ladies and gentleman, lunch is arranged in the Madison Room for the members, which is around the corner. My staff will get you down there. And we'll be back here at 1 o'clock. 1 o'clock has the Defense Center of Excellence for Psychological Health and TBI.

(Whereupon, the meeting in the above-entitled matter went off the record at 12:12 p.m. and back on the record at 1:01 p.m.)

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

(1:01 p.m.)

CHAIR NATHAN: Okay, I think we've got a quorum, so go ahead and take our seats and get started. So welcome back from lunch this afternoon. We welcome Captain Richard Stoltz, who is the Director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

Captain Stoltz and his associates will provide the Task Force with an update from the DCoE's last briefing in January a year ago, as well as adding additional information regarding important accomplishments in recent initiatives.

You can find their information in Tab E. And Rich, if you would introduce your colleagues, please.

CAPTAIN STOLTZ: Sure. Thank you so much, Admiral Nathan. And it's a real pleasure for me to have my first time sitting before this board.

It's a pleasure for me to introduce some of the staff members of DCoE, starting with Dr. Alison Cernich, which is the Deputy Director for the Defense Centers of Excellence for Psychological Health and TBI.

She's been at DCoE for about four years and has been in the deputy role for just about a year and a half or so. She is a VA employee, which I view as a tremendous asset since so many of the people we treat will in fact be transferring services into the VA after they leave active duty.

Sitting next to her is Captain Tony Arita who is a neuropsychologist, and is the Director of the Defense Health Clinic Center, basically our psychological health arm of DCoE.

Sitting next to him is Kathy Helmick who is the Deputy Director of DVBIC, Defense and Veteran's Brain Injury Center. She was acting director at one point. She's been at DCoE for quite a few years and is an

ICU nurse.

And then sitting next to Kathy is Colonel Rick Campise who is in charge of our T2 East or T2 National Capital Area, T2 standing for telehealth and technology.

Most of our staff that do that are out on the west coast at Fort Lewis-McChord. But we have a small group here, and he's in charge of them as a lot. Able to pursue that angle here with a lot of meetings in the National Capital region.

If we can go to the next slide, so I really only have two slides after the agenda before I get into the questions that the group asked.

Just a little story before getting to the first of those slides. So I came to DCoE in the director role in May of this year. I had been out of the Beltway for five years, including two overseas tours.

And when I got to DCoE, I understood that its mission was to advance

psychological health and TBI prevention and care. But I really was unclear exactly what that meant.

What were the major things it was supposed to do? So I spent a good six weeks asking an awful lot of people. I was fortunate to have inbriefs with quite a few senior people in our military heath system.

And I came up with this next slide, which is my Director's Intent that tries to crystallize so what does DCoE do? This is what we do. This is our focus.

First of all, we very much take a collaborative approach to everything we do. We are not a think tank that sits and comes up with what we think are the best ideas, and then try to tell other people please do these.

We are very much recognizing that there's a tremendous amount of resources out at our MTF's and our operational forces and other organizations.

And we need to gather that

information, academic settings, other organizations in the civilian sector that we need to take in consideration as we're trying to figure out the best ways to move psychological health and TBI care forward, and to analyze it, evaluate it and standardize it.

And also that we very much need to target our providers, because that's where patients, you know, that's where the rubber meets the road.

And so if what we do is simply put together a clinical practice guideline and say hey we've done this, good let's move onto the next thing, but we don't spend time interacting with the providers, if we don't see that it's being utilized, if we don't get feedback on the quality of it, then it's possible we put a lot of work into something that its value and its utilization is quite small.

So that's the first piece there. Certainly, in my opinion what a center of

excellence ought to do across the board is to really know what's going on in their areas that they're responsible for.

So in psychological health and TBI, what research is really needing to be done? And we should then inform those that are in doing that research, these are our ideas about what you ought to be up to.

And while we might do some research ourselves, we also really want to make sure that we're paying attention to the research that's coming out and what it says.

And is there anything in there in what it says that should affect the practices of what providers are doing as they're treating patients with psychological health or TBI conditions.

So we are working on that. We partner with organizations to identify the gaps, hopefully eliminate redundancies or maybe some areas where there's an awful lot of research and it's not really yielding too much

new information while important areas aren't being covered much at all.

So that's another thing we're about. We're certainly about evidence based care. And certainly when you look at psychological health and TBI, you'll see that there's all kind of claims being made out there about hey, let's do this when there's not too much evidence that it really works.

So we should be about pushing evidence based practices. And then as we know what they are, making everything again to sort of translate that knowledge into practice.

And then within my first week in my brief turnover with my predecessor, Captain Paul Hammer was my one time I went to the SMMAC, and he provided the overview of DCoE's program evaluation that they had done on roughly 140 -- you have a question, sir?

MEMBER DRACH: Yes, Captain, before you move on.

CAPTAIN STOLTZ: Please.

MEMBER DRACH: I know that you all have had a relationship with SAMHSA, probably since very much the beginning. Do you have any relationship with the National Institute on Disability and Rehabilitation and Research?

They just put out, I guess in mid December, early December a notice in the Federal Register that they're setting up an advisory, I think it's called an advisory council, a research advisory council, RRAC.

I forget what the RR stands for. One of them is research advisory council. Rehabilitation Research Advisory Council.

And one of their goals, or one of the roles they see is counsel taking on is giving advice on the counsel for research, what kind of research should be done on disability.

And when I read the Federal Register notice, I was thinking is there some way that you all, or DoD in general, would be willing to or able to collaborate with this

new RRAC?

Now the caveat is that the RRAC will be stood up, depending on the availability of money. So it may or may not come to fruition. So just something to get on your radar.

CAPTAIN STOLTZ: Well we appreciate that comment. And we definitely are involved with the rehab component. I personally have not had interface with them myself. I don't know if we can --

DR. CERNICH: Yes, sir. So we do meet with NIDRR, both in my capacity with VA, we collaborate firmly with NIDRR for the TBI model systems.

But we also, Ms. Helmick and I both sit on some research advisory committees at MRMC related to some of the consortia awards for TBI.

And so we're also in conversations with them there. We've also looked at with MRMC in looking at how we help them with the

gap analysis piece, whether we should stand up an advisory council.

And what we're doing right now as part of the work that we're doing with them on knowledge translation is determining what counsels we would have to set up and what the mechanisms would have to be for that.

And as you know, there's a lot of regulations around setting up federal advisory councils. And so you have to do that very carefully within a research process, especially when there's acquisitions involved.

CAPTAIN STOLTZ: Okay, so I appreciate your question, sir. Anyway, when I was here in my first week and the SMMAC was briefed on where we were with the program evaluation of roughly 140 or so psychological health programs, there was obviously tremendous interest in that.

And for good reason. Many of you remember the time not too long ago where there was a whole bunch of money that was thrown in

to starting programs relating to psychological health and TBI care.

And so a lot of programs started up, and there was a desire now that we knew that the money was going to be shrinking, how do we know which programs worked, which ones didn't, what components were more effective.

And so DCoE undertook that. And there remains a tremendous amount of interest in that. So that is one of the core functions that we were doing last year, and if anything, we're stepping up services on it this year.

And then the last thing that's very, very important to me because I came into DCoE and I learned pretty quickly, boy, they've put out a lot of good products.

But before I came to DCoE I didn't know what they were. And so how many providers are there out there that are not aware of all these wonderful things that DCoE has produced? And so how do we get these things out to more of our providers.

And so we are stepping up our emphasis on penetrating through on that level so that all the work that we did, we can start to experience it, having a positive impact on patient outcomes.

So this is the last slide I have before going into answering all of your questions that you had for us. These are just some things that we do that impact the system of care.

How do you know if something's effective or not if you don't have a way of measuring it? And if you have a lot of different programs that, first of all they may not even be measuring anything.

But then if they are measuring something, what they're measuring is very different from program to program and then you can't compare.

So one of the things we're doing to impact the system of care is coming up with tools that standardize outcome measures and

system performance, and even ways to measure cost across the board so that we can begin to better understand the effectiveness of various programs.

We already talked about the program and evaluation. We've already talked about the importance of sort of the book ends piece of research, having good input, as well as the importance of translating the completed research to the field.

And then there are three joint incentive funds projects that DCoE is currently doing that I think will impact the system of care.

There's an awful lot of chaplains in the DoD and the VA. And there's a lot of people that like to go to them as opposed to formalized behavioral health providers.

Chaplains have confidentiality. And how well do we work together, and how well trained are those chaplains to deal with some of the common issues that walk in the door of

behavioral health providers?

So we have a pretty extensive training going on now with chaplains that we think will make the link between behavioral health providers and chaplains better, as well as chaplains more effective in what they're doing as they're dealing with our servicemembers.

The problem solving training and primary care settings. That's pretty much connected to medical home.

That's pretty much taking advantage of people that might, again, be reluctant to see and go through a formal evaluation with a behavioral health professional, but will come in and see their doctor, have easy access to learning a process that can help them deal with the issues they're facing in their life that can help them get better and hopefully prevent them from developing more severe psychological symptoms.

And then the last thing of the practice-based implementation network in mental health, this is a project aimed at identifying 10 to 15 or so different sites where we will work with them, help them better track, in particular, their PTSD cases.

What are the barriers, what are the obstacles, what can we do to have that be more effective? And by working very closely with these sites and having them do things we're suggesting and working with them, we hope to make some significant progress there that can then be expanded to other sites throughout the MHS.

So now we are to your responses to questions. And of course, the first question has to do with those 11 PH and TBI programs that were studied by RAND in 2011. And what's the outcome of the eight remaining evaluations? And next slide please. And so think you can see that those are all pretty close to being completed.

You know, data analysis, one's still writing a report, waiting security evaluations. And we're giving you what we think will be when they'll all be completed.

And then sort of the main outcome of that was this, we found in that first program evaluation where we looked at roughly 140 programs that many of those programs did not have any good evaluation internally.

And what the RAND study has produced is four different manuals that go about telling people that have a program internally how they can build in their own self monitoring of that program, how they can build in process improvement, how they can build in evaluating themselves because then you have a stronger program.

Then you're engaging on better understanding how effective you are and if you try certain things to change it, whether or not it improves it.

So those four manuals were just

released by RAND, and we're hopeful that many people will utilize those. It's not real complicated program evaluation.

The stuff that we do at DCoE is far more sophisticated and involved. But it's much better than just starting a program and coming up, well this is what we're going to try to do and not have sort of a structured approach to your own type of evaluation.

So the next question has to do with developing standardized measures for TBI care. So you can see that we do in fact now have two that are approved.

We worked with the services to come up with those two. Initially there was some debate about other measures. Many of these are already in use.

But we reached a consensus in collaboration with Health Affairs and all the Services about what these should be. They were then briefed.

I briefed them and then Colonel

Hinds, the Director of DVBIC, together we briefed them to the Policy Advisory Council. And they agreed with them. And supposedly now they're being written into policy.

In addition to that, in September, Dr. Woodson wrote policy on three psychological health measures that are now mandated through the MHS, one for anxiety, one for PTSD and one for depression.

And all of these instruments are very easy to use. They're short, only take a few minutes.

I think many of you might be familiar that the mechanism is through the Behavioral Health Data Portal, which is an Army product that is currently throughout the Army medical system that's also in the process of spreading throughout Navy and Air Force.

And that will hopefully be completed sometime this year to at least get many of them on. So it's a very convenient way to implement what has been signed into

policy.

So the next question was 1C and talking about the relationship between DoD and VA. And this is really a tremendous success story. If we can go to the next slide.

So if we see that first bullet where we have 300 vet centers now that can treat active duty servicemembers. And I've got some numbers here I can quote for you that 450,162 have received services at these vet centers.

I mean, that's 40 percent of the people. This is vet centers that frequently are staffed by peers, peers that are doing well, that served overseas.

It's been cited as a success story by the U.S. Medicine Institute for Health Studies. And I'll quote one of the things that they said, that the VA Vet Centers have proven to be a best practice model in fostering peer to peer relationships for those with combat stress disorders.

The best way to overcome concerns about stigmatization is through person to person contact with someone who has recovered. So tremendous success here with this.

But that's not the only way that we are cooperating with the Veteran's Administration. And we have other things on the next slide.

So you know, the Senior Oversight Counsel came up with a DoD/VA integrated mental health strategy. They divided it up into 28 different parts. DCoE had the lead on 16 of those parts.

And as you can see that those parts are put into those four categories, everything from the integration of mental health into primary care, which is very much one of the best ways to reduce stigma because if you can get somebody into primary care and you have behavioral health nearby, right there, then maybe it's much easier to get them into that as opposed to getting a more formal

consult, and then going somewhere where they're getting a full eval, vice just responding to the question of the primary care provider that they saw.

Lots of working together to ensure quality and continuity of care and evidence based approaches to PTSD.

You know, with the stigma, if you have a person that has a problem and finally breaks through that, and then goes sees a provider that doesn't help them very much, well that just is not very helpful at all.

So a lot of effort has gone into people working very hard to establish what are the most effective treatments in getting that word out so we don't have people that are struggling finally break through that barrier and then not get help.

And I will tell you, I think this is very important, many of these cases are not easy cases. I'm somebody that's treated an awful lot of people with PTSD.

But I will tell you those returning from Iraq and Afghanistan frequently had the most complex and difficult to treat PTSD that I have ever encountered.

And there's numerous reasons for that. One is that there's multiple traumas as opposed to one trauma. Two, that that is of course a war where you had to stay hyper-vigilant a great deal of the time because your enemy was not in uniform. You didn't know, there could be a civilian walking around.

Three, you knew when you left you were going to have to come back again, which then made it more difficult for people to say ah, it's over. I can then relax, now I can explode. Sort of keeping on that sort of hyper-vigilance.

You know, the psychological strategy to use when you're in combat is not the psychological strategy to use when you're trying to heal from the trauma of combat.

And many servicemembers can't make

that adjustment when they know they're going to go back and forth between deployments.

So this is very difficult, and it makes it all the more important that we do everything we can to train our providers to handle those kind of very difficult cases.

DIRECTOR DAILEY: Captain Stoltz?

CAPTAIN STOLTZ: Yes.

DIRECTOR DAILEY: Can I just also interject here very quickly. I didn't see in here, and I know this is not an exhaustive list, but I would like to bring to your attention that military community and family policy has two non-clinical sources for family members.

One is their Military Life Health Consultants that they've got an expensive contract out on. And they also are providing Military One Source counseling.

And I just want to put that on your radar. And in maybe your future slides, if you're doing any work with them, those are

also gateways as you noted for people kind of breaking through those barriers.

And so some time spent with them or collaborating with them on, again, our expensive contracts at Military Life Community Policy, MCFP and PNR has let out might be worth your time also.

CAPTAIN STOLTZ: Oh, absolutely. And we've certainly been in touch with them. And again, as I mentioned at the beginning, we see it as very, very important that we do this outreach and make those connections and work together.

So perhaps we should move on to the next slide. This again is more stuff that we're doing to DoD and VA partnering. We do have the In-Transition Program. And I actually have some numbers here.

So that in 2013, we had 1,671 people call. Now these are folks that may be leaving military service, may be transitioning to VA for the first time, maybe even just

changing duty station.

But they're in a bit of a quandary. They have this number, they call it. We've had tremendous success with this. And this of course is very important for those that are familiar with the whole concern about suicide.

We know that all too often they can occur when people are in a state of transition. This is a very important service that we offer, and people have been extraordinarily pleased with it. We are very well networked with how to help these people that may be in a bit of a limbo.

I mentioned the JIF Projects before. Moving Forward is a website that is specifically geared to help people that again that are in transition, literally moving from one place to another.

We do a lot of things for families as well. We have a parenting site that's very helpful. And then we have, and you'll hear me

talk several other places about these things called mobile apps that are downloaded onto smartphones.

And DCoE has done a tremendous amount of this. That's a major thing that our T2 branch of DCoE does. And I can't tell you just how important this is.

I see it very much as the wave of the future. So many people are downloading large numbers of these and utilizing these, and finding it to be a very helpful tool for them.

Everything from a mood tracker that's sort of a self evaluation to sort of having your own mobile coach with you and many others, and then there'll be others listed as we move along.

MEMBER REHBEIN: Captain, may I interrupt for just a moment?

CAPTAIN STOLTZ: Please do.

MEMBER REHBEIN: The previous slide, the In-Transition Program up there, one

of the things the task force has continually been concerned about is getting the right information into warriors hands at the right time.

How do they find out about that In-Transition Program? Does their current mental health provider give them that information before they leave?

Someone that's going to potentially utilize that program, how do they know it's there?

CAPTAIN STOLTZ: Well, it's in many different places. And on the web, for one. But yes, go ahead.

DR. CERNICH: So one is if they call, let's say our outreach center, that's one of the ways that they could get networked. The other is that we have extensive contacts with care managers within the system through our outreach office.

And so we do regular contacts with them to let them know about the In-Transition

service and to have them avail themselves of that.

The highest utilization is really between duty stations. So if somebody is moving from one duty station to the other, there's care management coordination.

And then the other piece of it is even when you get that person to the duty station with a warm hand off, part of it is coaching them into care because they've got to get a new provider, they've got to reestablish trust.

And even if you've already told the story for that person and reviewed the chart, it's still making sure that they make that first appointment. So it's the coaching into care part that's been the real success.

The other thing is with DoD and VA as part of this, this actually grew out of the integrated mental health strategy, one of the other pieces of it is that we have really good connections with VA care management,

particularly in the OEF/OIF/OND Care Management Office.

And so the lead for In-Transition actually was an OEF/OIF Care Manager in the VA. So he's very well networked with that. And he lets folks know about that.

And mental health also has highlighted on their national calls, and we have it highlighted on the OEF/OIF/OND Care Management calls on a regular and routine basis.

So within all of those communities, what we've really tried to do is highlight that this is a program that is available to help folks move between.

We're not trying to replace another care management system. We're also very well aware of the Lead Coordinator Program and the other care management programs ongoing between DoD and VA.

So this is a service to help coach somebody through that transition rather than

being the specific care management, if that makes sense.

MEMBER DRACH: Ma'am, when you say the care managers, does that include the recovery care coordinators and the federal recovery care coordinators?

DR. CERNICH: Yes, sir. So all this is doing is helping, and specifically usually if they have an FRC or an RCC, if we get involved, we then coordinate with them to the best extent possible.

We're not going to take over that FRC or RCC lead in any way, shape, or form. That's not our role. Our role here is if we get a reach out from a care manager who says I have a patient with PTSD. They're moving from Fort Carson to Fort somewhere else. I need to hook them up with care. Can you help me identify? We have identified sources of transition, we get them hooked up with a provider.

And then we work, we have

behavioral health coaches that essentially work with that servicemember to keep them connected and to get them to go to that first appointment.

MEMBER DRACH: So is this incorporated into the RCC training?

DR. CERNICH: I believe it is, sir. I would have to verify that for you. I know our outreach program has worked with the FRCs, the RCCs, the RCCs that are in DVBIC also to help with TBI where they can.

And they're also working with OEF/OIF/OND Care Management. So they're very well networked into how those systems work.

MEMBER EUDY: Mr. Drach, I was just at the auditing, the annual audit of their curriculum course, and yes it is heavily involved.

Both TBI and PTSD are spoken by subject matter experts, along with the various resources, and then what the role is for the non-medical care manager, or RCC to then get

their servicemember to those services. It's very heavily involved.

CAPTAIN STOLTZ: Next slide. So this is about our engagement with the SMMAC. Next slide. So this may not look like it's answering the question.

So since my first week here and being part of that program evaluation brief, I have not been asked to brief to the SMMAC, and I haven't felt a great need to do so but would be happy to do so if asked.

But I do feel a lot of support from MHS leadership. I have no concerns or complaints. This is our organizational chart that chose how our three centers are part of the Defense Center of Excellence and how we are an executive agency under MRMC up in Fort Detrick.

We have regular contact with General Caravalho. He gets a sitrep from us on a weekly basis. And certainly in my early phases, I had opportunities easily available

for me to work with the leadership in health affairs and get guidance from them.

So I don't feel a need to have more engagement with the SMMAC, but would be happy to do so if called upon.

I will tell you that in the beginning, as I was struggling, trying to figure out DCoE's role and I did have a chance to talk to Dr. Woodson and told him I was trying to come up with clear language about that.

And he looked at me and he said you are the single point of accountability for psychological health and TBI. And I found that to be very helpful. I have embraced that. The staff knows that. We have put it on various things.

And so when the White House calls Health Affairs, when the press calls, when Congress calls, all of those things, we are the ones that then get the call from there.

And we feel good about that. We

are energized by it. And we understand that when it comes to these issues across the MHS, we are it. And we're glad to be it. And we feel like we have support from the many leaders we have above us.

CHAIR NATHAN: Rich, going back to that slide, I wonder if it shouldn't be more of the reverse, a dotted line up through the executive agent, and a solid line up through the Centers of Excellence.

I realize that the AdCon all comes from the executive agent. But what is your interpretation of the oversight board and its ability to facilitate what you believe is the way ahead, your policy recommendations, your guidances, your removing of redundancies, your collaboration with the other Centers of Excellence?

Well, I think that's a great question, and we could spend an awful lot of time talking about it because there's certainly been a lot of things going on.

So I'm aware that all kinds of things are being explored. Whether the CoE oversight board is still going to exist or not is, I think, sort of a question that's up in the air.

I have been personally asked to chair a task force to bring together reps from nine different Centers of Excellence and talk about alignment issues with them, talk about standardizing a definition of what a Center of Excellence is, what's the best way to set it up.

There has certainly talk about DCoE and some other Centers of Excellence moving over to be under DHA. And if it moves under DHA, would it fall under the research directorate or would it fall under healthcare operations?

So there are all different kinds of ongoing discussions there. I do think personally it would be extraordinarily helpful to clarify at least what the core competencies

are, the core functions are of a COE because I can tell you again, when I came here again, not paying much attention to what DCoE and NICoE and the other Centers of Excellence were and then trying to figure that out.

There is just an awful lot of confusion and I think not a clear understanding. I also think there's a tremendous amount of merit into having basically a hub of people that would serve quite a few of the CoEs on all sorts of things.

So like, if we're looking at cost, if we had a health economist that could do that for a bunch of CoEs as opposed to have each one have to do one.

So my impression is that how much longer we're going to stay with MRMC is very much up in the air. And how much other CoEs are going to stay where they are is up in the air.

My hope is we find an efficient

way to join a lot of them together so that we can get better utilization, more effective utilization of the resources we have, because I'm certainly aware that we're under financial constraints in the future.

I don't know if that answered your question.

CHAIR NATHAN: Well, I think the State of New Jersey would have welcomed your answer a couple of weeks ago because it was very eloquent and ginger, sort of stepping around the issues because I'm going to push on you a little bit.

You're doing back flips because you're watching all this cooperative stuff between the VA and DoD. You're doing back flips because you know what your job is. Your job is to be all things psychological health and TBI for the DoD, or at least represent that.

And then when I ask you, and then you tell us that you haven't briefed the SMMAC

and you're not really engaged with the SMMAC. That's not your responsibility, that's the SMMAC's responsibility.

And so I look at the next rung and I think okay, well if you're not talking to the SMMAC, you must be getting rudder orders or you must have a robust interchange to do translational action of what you think is the best way forward with the oversight board.

And you say yes, you know, I don't know if the oversight board's going to be around. We don't know. It's kind of good. I mean, you gingerly park the bus on top of it and then kind of rolled over it.

And then you say, but you know, and I don't know what's going to happen to MRMC and if that's. so I'm trying to find out who do you work for?

I mean, you go to Dr. Woodson and he tells you you've got it. You're all things psychological health. But are you going to him and saying to him, are you going to the

Army?

Army's your Executive Agent. Are you going to the Army SG and saying listen, there's real problems with this policy or this policy or we're not doing enough in this or we're not investing enough in this, or we noticed that there's two redundant streams of research going on here and here and we need to coalesce those? Who's your action person?

CAPTAIN STOLTZ: Well, it's primarily General Caravalho. He's the one that gets the detailed reports every week. He very much is aware of what's going on. And then --

CHAIR NATHAN: He's not coming to the SMMAC and changing policy at the SMMAC level. I mean, I know Joe and he does a lot of good work.

But he's not a frequently present entity representing your interest at the SMMAC. And you've just told me he's not really representing them at the Oversight

Board.

CAPTAIN STOLTZ: He's not a member of the Oversight Board.

CHAIR NATHAN: Right.

DR. CERNICH: Well actually, sir, he is a member of the Oversight Board. I think the challenge, though, is the Oversight Board has not had a meeting since September of this year.

They meet quarterly, and we were supposed to have a meeting. We haven't had a meeting. So the CoE Oversight Board hasn't met to give us guidance from that perspective.

And I say that because I transitioned that to Captain Stoltz just for one meeting. So his ability to say the rudder check from that, even over the past year, even in those quarterly meetings, it was just trying to establish who were the CoEs and what their potential functions were.

And we had just gotten to potentially how we would measure our return on

investment, and we haven't had a meeting since then.

The other mechanism that we've used to inform policy in recent days, and I say recent in the past month, is with the new DHA governance.

What we've really tried to do, and I think is in our slides, is look at the medical operations group, the Policy Advisory Council and some of the other lower level guidance bodies and working our recommendations to policy through them to go through the established governance structure in DHA.

And we've made General Caravahlo aware of that, and he has been very supportive of it. So that's the way we've pivoted. Some of the governance issues were very unclear to us, I think as they were unclear to a lot of people, for four to five months.

So now what we've tried to do is really engage with the bodies that are saying

we're the Policy Advisory Council, we're the ones that oversee operations.

We're still trying to figure out who does exactly what. But I think we're learning that process in the same bruising way that other people are learning it.

CHAIR NATHAN: Okay. Not a bad answer because what you're saying is don't pay attention to the guy behind the screen. The new way ahead is we're really going to work with the DHA, which is this consolidated agency that focuses on policy.

And they will, as a member of the SMMAC, and they are. The DHA is represented by both Dr. Woodson who is the guy in charge of the DHA over Doug Robb who makes things --

So that's fine, that's fine. You understand my question that DHA ain't showing up on your slide there. And you just told me it's really the DHA who's going to sort of, you know, get me through this.

Dr. Woodson shows up as the

Assistant Secretary of Defense. But not the DHA.

DR. CERNICH: Yes, sir. And this is the alignment that we had previous to the change in governance. So we need to modify the slide, obviously.

The only other thing that I will say, too, is that in the past, the other piece that we don't have on the slide is the coordination with the services. And that we do more informally and then bring it to the governance bodies.

CHAIR NATHAN: Well, that's supposed to be the SMMAC.

DR. CERNICH: Well, right. But I'm saying before you get to the SMMAC, you've got to work with the behavioral health line, you got to work with the --

CHAIR NATHAN: MDOG, DMOG, M-I-C-K-E-Y.

DR. CERNICH: All those guys, yes.

CHAIR NATHAN: But I just think

that again, one of the sore points for the Task Force --

DR. CERNICH: Absolutely.

CHAIR NATHAN: -- is, and this is a compliment, you have a reservoir of amazingly talented, passionate people who look for ways to remove redundant capabilities and efforts and put gravitas and focus on those that need the most import.

And we always wonder how do you effect that? How do you effect change since you're supposed to know everything that's going on, including how long to cook a soft boiled egg.

How do you effect that change? And so what I'm hearing is the DHA.

CAPTAIN STOLTZ: Well again, I don't have control over that. But there's certainly discussions underway that would lead me to believe that that's where it's heading. But that's obviously far above me.

CHAIR NATHAN: Okay, because what

you have said is, and again, I come here to praise Caesar, not to bury him. But what I've heard is the Oversight Board is kind of vestigial at this point to you.

It's not really functioning as something that's providing a transmission from your engine to the rear wheels.

CAPTAIN STOLTZ: That's accurate, that's accurate.

CHAIR NATHAN: And that may be because of the aurora borealis, I don't know. But it's not doing what it's supposed to do. And then you're not really engaged in the SMMAC, right?

And you're working through MRMC, which is great because Joe Caravalho is not a shrinking violet and he will, if he hears something that's significant enough, he will kick in the doors of the services and do something about it.

That's more of an informal arrangement than a formal arrangement. And so

we're still trying to get our arms around what your formal arrangement for making change in the Department of Defense for all things TBI and psychological health is.

And what I hear you saying is we're still finding our footing in that. And if it was bad and now we're getting better, okay, got it. But we've been finding our footing in that for, well since you were stood up.

And so that's the concern. And by the way, that's on me. I'm a Surgeon General. I sit on the SMMAC. I should be asking these questions at the SMMAC as much as I'm asking them here.

And I'll beat myself up in that arena. But still, we're just still trying to get some traction on the good work you do.

CAPTAIN STOLTZ: Okay, well I appreciate that. And I guess the one thing I want to say is that when I have interacted with senior folks and I have brought forward

things, they have been very receptive.

Even though at times I didn't even know that there was a medical operations group until relatively recently and that something should go through there, and even though it was the first time that I ever presented to the Policy Advisory Council.

But when stuff is sent forward, it is well received. It is confusing to us exactly, you know, what should go where but we are finding our way.

But there seems to be a lot of interest and an encouragement for us to keep coming up with products. Another question, sir?

MEMBER MALEBRANCHE: I don't know. I think the General and I might have the same question. How are you resourced? What agency resources you? And is it the Army, is it Health Affairs?

CAPTAIN STOLTZ: The Army.

MEMBER MALEBRANCHE: Okay. The

Army totally? And then you're also resourced with people from the VA. Just three at this point. I see Dr. Cernich mentioning?

CAPTAIN STOLTZ: Yes, yes.

MEMBER MALEBRANCHE: So when you need people, then you go to the Army. You don't go --

CAPTAIN STOLTZ: That is correct, ma'am.

CHAIR NATHAN: So every Center of Excellence was aligned with a service to be their executive agent. You just heard from the Vision which was the Navy.

And so because somebody has to, somebody who's in execution status has to be able to give them a funding line, work through their departmental issues to help hire and do all those things.

So that's a theory. So they're the executive agent. So that black line there that weaves through the Army down there is really, I consider it to be an AdCon line,

administrative control line where you get all your administrative support from.

But in theory, the Army is not supposed to be carrying your water for getting change done based on the good work you do and what you find and research and collate in psychological health.

Nor is the Navy supposed to be carrying the water for the Visual Center of Excellence. Yet, we do sometimes because we don't have, in my opinion, a viable alternative to really make a difference.

And the Oversight Board was created to do that. The Oversight Board was the uplink to the SMMAC, right, where all things happen. Right? Go figure that one out.

But nonetheless, that was the theory. And so what I'm hearing here is you could, I don't mind. I didn't know if you were going to come in here and tell me thank goodness for the Oversight Board. Without

them, boy, we wouldn't have, you know, something to really get this stuff we're thinking of out there in the real world.

And you haven't said that. Both you and Dr. Cernich just said well, the Oversight Board met in September and it's supposed to meet again and I don't know if they will or not.

And it's kind of up in the air whether they'll be around or not. And we don't really miss them because they don't really do much.

And so Houston, we have a problem, okay? And again, we've been doing this too long, and we've got to get serious about this. All the Centers of Excellence are too valuable a commodity to simply have you doing good work.

And I'm glad people are receptive. You know, I would hate to hear you say you go to me or the other SG's or somebody in the government and you say we've got some new

ideas for TBI and they go I'm not receptive.

They're all very receptive. You should be asking, the last thing you should say as you thank them for their time and walk out the door is what are you going to do about it?

And do you know how to do something about this, and how are you at least going to get these ideas in front of a group of people who if you think this is a good idea can turn this into action, because you've got probably the toughest road to hoe of all the COEs because you've got all these shoots coming up all over the country and the world of people who have their own better idea of how to build the mousetrap for TBI and psychological health born out of the passion of wanting to fix things and born out of the pressure from Congress and then the rest of the country saying fix this yesterday.

And so everybody's got their own sort of cottage idea of how they're going to

do it. And you were created to kind of broker those and say here's where the money should be spent. Here's where the research should be focused, here's where the action should be targeted.

And you've come up with a lot of those things. I think if I asked all five of you what are some things we need to be changing tomorrow and the way we do this, you would give me some best practices, which you have between the VA and DoD, which are great.

And then you would say but aside from those here's, like, five things we think should happen tomorrow that could change the way DoD approaches this.

And if I said great, how are you going to get them done, you're kind of going to just hunch your shoulders and go well, hopefully Joe Caravalho will get those done for us. That's not his job.

MEMBER MUSTION: Sir, if I could maybe ask the question in a different

perspective. You mentioned earlier that Dr. Woodson said you are the single point of accountability.

So does that wiring diagram enable you to exercise that accountability, that task that you've been given effectively and efficiently?

And I say that going back to what you said your current focus is, which is strengthen, collaborate, blah, blah, blah. I guess what I'm looking for, how are you able to effectively execute the accountability mission that Dr. Woodson has given you given that design?

CAPTAIN STOLTZ: That's a great question. And --

CHAIR NATHAN: And you've only been here since May, so if you want to phone a friend, you can.

CAPTAIN STOLTZ: Well I'm sure, I have to tell you, I'll answer and then I'll -- and I have great friends over here, by the

way. And I very much concur with Admiral Nathan's comment about what a good staff we have.

So I would tell you that I think it's murkier than it ought to be. And I think this is the set up we have, and the people involved in that set up, it's working as well.

But it's not as clean as it ought to be. And I think that's not only true for DCoE, I think that's probably true for other Centers of Excellence.

And I think that there probably should be some commonality with the Centers of Excellence so that we can solve the problem, or at least a number of them, solve the problem not just for DCoE, but for the other Centers of Excellence so that who reports to who could be clarified.

You know, what is an executive agent? You know, we're the only Center of Excellence that have that designation. And there's some murkiness around there.

And yes, so it does put General Caravalho, who's in charge of so many things, in sort of a difficult situation. But this is what we had.

And I wasn't here very long at all before with the creation of the DHA there was all this talk about how we may well move over there. So we understand it is in transition. So many things are in transition.

We're dedicated to pushing forward with this knowing, in my opinion, it's likely to fall under a cleaner structure than it's under right now.

MEMBER MUSTION: So okay, in listening to your response, so what you basically have just said is you've been given a mission that you can't execute given the construct that you're operating within.

CAPTAIN STOLTZ: I could say we could execute it better if the lines, because I could tell you a variety of things that we've executed since I've been here.

So somehow we've gotten them into policy, we've got them through the system and have made the connection. So I wouldn't say we can't execute it.

I would say there's a way of setting it up that we could move more full speed ahead.

MEMBER MUSTION: I think you have some semi-formal and informal connectivity among the services where you have some shakers and movers from the services who are either part and parcel of your DCoE or are close to it.

And then they take that and they go out and they sort of germinate some of those ideas and they change it. And you talk to the NICoE.

And we've heard from one other CoE that says you have a pretty good collaboration with them. You know what they're up to, they know what you're up to.

So I think that all helps. Just,

we all learn something, we'll let you move on with your briefing in just a second, but we all learn something from these. Okay, we learn a great deal from you. Here's what you're going to learn from me or from us.

Up until this minute, the SMMAC, right, this erudite group of leaders of the Senior Military, Medical Military Advisory Counsel was under the impression, and I think I speak for my colleagues on the SMMAC, that the Oversight Board was what you needed to connect your ability.

And I tell you, this Task Force was under the impression, because that's the last people, people who have been speaking to us in the past told us that the Oversight Board was what the doctor ordered in order for you to get your ideas into practice.

That's what our impression was at the SMMAC, okay? So you know, this is not panning out. So we need to go back and look at this because too much of it still remains

in flux.

And you're getting things done by moral assuasion or persuasion more than you are by an actual line, which is what General Mustion is getting to, more than you are by an actual military or federal line of command or ownership that helps you execute your mission. End of speech.

MEMBER MUSTION: I have one other question.

MEMBER PHILLIPS: May I ask the --

MEMBER MUSTION: I'm sorry. I was just going to ask one other question. From an executive agent perspective, have you asked for resourcing or do you require resourcing that the executive agent has not provided that you're authorized?

CAPTAIN STOLTZ: Well, the major thing has been personnel. Like many others, we've had a slight decline in the number of approved billets that we can hire to and it's very competitive.

So to that extent, did we get everything we want? No. But I wouldn't expect us to given the environment that we're in.

MEMBER PHILLIPS: To follow up on some of the comments, the final Jeopardy question. Being in the trenches, could you all articulate or suggest some language that this task force can use a recommendation to help to achieve that seamless command structure?

CAPTAIN STOLTZ: Yes, we can. And I would just like to give it a little thought as opposed to spew it out right now. But we would be happy to do that.

MEMBER PHILLIPS: Of course, thank you.

CAPTAIN STOLTZ: Okay, so I think we're ready for the next slide. Okay. So here are some things related now to TBI as well as psychological health.

And so our first response is

focused on changes to psychological health therapies. And of course, the one that's on most people's minds is frequently PTSD because again, it's so difficult for some of the reasons I've already stated.

But here is what some of the research is showing is that there's two therapies that seem to be more effective than the others, exposure therapy and cognitive processing therapy.

There's some positive stuff out here that the sooner you can get to somebody and have them express what happened, the less likely it becomes a chronic condition that turns into PTSD in order for it to be formally diagnosed with PTSD.

The symptoms have to last for at least 30 days. And then it shows that some of these therapies actually treat other things in a beneficial way. Those are the --

CHAIR CROCKETT-JONES: May I ask you a question real quick?

CAPTAIN STOLTZ: Yes.

CHAIR CROCKETT-JONES: Is the EMDR no longer on the evidence based treatment list?

CAPTAIN STOLTZ: It's still on the list, but it's not coming across as strong. Some people might even refer to that perhaps as an exposure therapy.

And that while you're doing the eye movement stuff in front of the person, you're asking them to hold inside of them the trauma.

So what we know basically is this, that if you have inside of you turmoil, flashbacks, nightmares, whatever it is, these reminders about something that is very painful to you so that your immediate reflex is to push it away, that ultimately and then that becomes a chronic condition that really interferes with your ability to function.

Ultimately, the way to solve it is to find a way to get it out and not leave it

inside, and find a way that the person can actually welcome that stuff as opposed to constantly try to avoid it.

Avoidance does not work. So there's a variety of exposure therapies that try to do that. And to some extent, EMDR tries to do that, as well.

CHAIR CROCKETT-JONES: And is the emergence of ART, the new therapy that we recently heard about, has that come on your radar, or is it --

CAPTAIN STOLTZ: It's on our radar. And it's a combination of existing ones. And we have not seen any definitive studies, unless they're very recent, that show us.

But we are paying attention to that, we're aware of that new therapy. But the underlying dynamics remain the same, and there's a variety of ways to sort of get there.

We also understand that the best

treatment for one is not the best treatment for all. I think we have to have multiple models in front of there.

Some people, for example, they really do benefit from some of these sort of complimentary things. So some people, you know, the meditation, the yoga, the mindfulness, the relaxation, even physical exercise sometimes is beneficial to folks.

Other people don't respond too well to sort of those complimentary things. But I think that pretty much covers that slide.

And then the next one refers to practices related to TBI. Where are we on time?

DIRECTOR DAILEY: We have an hour. You had a two full hour block.

CAPTAIN STOLTZ: Okay, good.

DIRECTOR DAILEY: So you know, pace yourself.

CAPTAIN STOLTZ: Okay, all right.

Great.

DIRECTOR DAILEY: Take a breath.

CAPTAIN STOLTZ: Great. But let me go down to the bottom one first because the bottom one, I think, is really highly significant. And it just came out last week.

And you know, for a long time, and of course 80 percent of TBI is mild TBI. And for the longest time, what did, you know, the primary care and other kinds of practitioners tell people when they had a mild TBI?

They would tell them to go home and rest and come back in a few days. It was sort of a generalized thing.

Well if you tell a young person, and it was mentioned in the Vision Center's brief about the average age being 24 and we know a large part of our military is young, to go home and rest, what are they likely to do?

They're likely to maybe sit on a bed and play video games or do other things on the computer. So they're not engaging in

cognitive rest. And they are actually doing things that they think they're following what their provider said. It's actually likely to make them worse.

And so for two years, DVBIC worked with outside agencies, outside the military, experts on TBI, as well as all the services and many others, and has finally released and come up with a document that is very, very specific about dividing up rest into physical rest, cognitive rest, and then balanced rest.

So you know, if you're dizzy and you have those kind of things, when can you walk up the stairs. And it's very, very specific, detailed, gradual.

How many minutes a day at what stage, and then only after you complete this should you go to the next stage. This is the first of its kind, incredibly detailed way of healing from a mild TBI.

And we are certainly familiar with many cases where because that has not been

followed by patients and hasn't been specified to that level of degree, that many patients are actually doing things that are harming themselves and allowing these symptoms, whether they be balance problems or headaches or whatever to go on much longer than if they would engage in this very progressive return to activity that will allow them to heal faster.

So this is a major, major thing. Just came out last week. I hope you see it advertised and out in the media in a variety of ways.

CHAIR NATHAN: So that brings me to the question, what's your plan on getting it out there?

MS. HELMICK: Sir, thank you for the question. We have a communications plan with its multi-vectored. We are looking at the lay press. Our senior leaders have been informed of this.

In terms of our targeted state

quota audience, which is providers, we have multiple platforms working with our service TBI program directors, for the Navy, Captain Jack Tsau. And the other three services have their own program directors.

So we are already taking orders for this for hardline copies, as well as it's posted today. We plan to leverage the DVBIC network, the 11 military treatment facilities that are part of the DVBIC network.

We have ambassadors within those 11 MTFs to function as the proponents for this, both as an educational paradigm to teach other providers on site and to take a regional approach.

And we'll also leverage our regional education coordinators throughout the DVBIC network to achieve that, as well. So our media and press piece, our MTF providers are our number one stakeholder group.

And then we also plan and have lots of interest with the NFL and professional

sports, the NCAA and even at the high school federation level to take a look at this progressive return to activity tool.

CHAIR NATHAN: So thank you, and congratulations on obviously a well thought out and robust communication and socialization strategy to get this out there so that people will be aware of it all the way from the civilian sector, the sports world and for this group, the recovering warriors.

I would argue that, because you believe this is going to be a sea change, don't you Rich? I mean, this is going to represent a real change in, for some people, their ability to recover from mild TBI.

CAPTAIN STOLTZ: I'm very hopeful that that will be the case. I think if we can get it out to all those practitioners out there that don't know that much about TBI and have this degree of specificity, it could really have a very positive impact.

CHAIR NATHAN: So that's

encouraging. I would argue if you had a better connectivity to the Department of Defense through a dotted or solid line, let's roll the tape back when we decided that the best way to deal with concussive care was to take people out of the environment and to put them in a quiet environment and to use certain metrics to determine when they could go back to duty.

We did more than just socialize that. We did more than just a robust communication plan. We created the DODI, and we said you will do this. And that got passed out.

If it's one thing the military's pretty good at is giving orders. And they may be good and they may bad, but people hear them and obey them. And that's how we changed concussive care in a matter of weeks, in a matter of weeks.

So if you had the kind of connectivity that we could make a, I'm not

saying this should be a DODI, but it almost sounds like it.

It almost sounds like the kind of thing that if there's enough agreement, then this isn't sort of a, you know, to one person's liking.

But there's consensus among the subject matter expert across the spectrum, VA, military, academic, private sector, sports specialists that this is the way to go.

This should be socialized, but this should also be directed. And that's where we're lacking right now because this should be brought up for consideration.

Now Joe Caravalho may be doing just that. He may be coming to us and saying I need you guys, Dr. Woodson, I need you to make this a DODI. But again, this is my concern about your current wiring diagram.

CAPTAIN STOLTZ: Thank you. So we have a number of other things up there sort of in keeping with some of the prior things that

were mentioned.

The need for sort of a multiple systems assessment is very important, the interdisciplinary part is very important. I think there's more evidence to support that.

And that's pretty much what's mentioned on those slides. We also came out with, and I think this was actually mentioned in the Vision Center of Excellence brief that we worked with the Vision Center of Excellence and came out with some guidelines there.

We also came out with a guideline of when do you do neuro-imaging after a TBI, under what circumstances? So you don't want people to over utilize that or underutilize it.

And again, this is a thing through collaboration with multiple people we came up with an answer to I think that very significant question, and that's been released.

So this is a slide that gets into

what our telehealth and technology folks do a lot of, these mobile apps. And it gives you pictures. You know, most of our people in service have a smartphone with them 24 hours a day, seven days a week.

They use it a lot. And I'm not going to go through all of them and tell you what they do. But I'm going to tell you about one that's going to be released soon, and we hope to really push this one very hard because I think, again, it could have a real impact.

And it's called the Virtual Hope Box. And so if you're feeling down, stressed out, a little bit upset about something, at your wits' end, sort of losing it for a while, what this app does is it has on it quite a bit of content aimed at sort of helping you out.

It has humor in there, something, humor's a very wonderful tool to have. It has a lot of sage advice, it has a lot of verified things related to depression in general that are helpful thoughts to have and think.

But the thing about this product that makes it somewhat unique is it allows people to put into stuff that they want to put into it to customize it for them.

So our hope is that many of our providers actually download this app, and that when our providers are treating people, that they let them know about this app.

And you know, all of this is available for free, of course. And that the provider and the patient can work together to come up with what can you put in here that will help you?

Is it a picture of your children? Is there one special thing that you can say to yourself that really works for you? I've certainly worked with patients that that's very true for. But what it is varies from patient to patient.

So the fact that you can customize it and the fact that this can be, you know, so many young people today sitting down and

talking to one person face to face for fifty minutes is not what they're used to doing a lot.

But to the extent that we can start reaching out to help meet these folks where they're at and engage in some electronic transfer of information, work together, I think this will be very, very helpful.

So that's our application due out. All of these things, they have ways of self monitoring. So if we go back to TBI, it would be a way for you to, on a regular basis, say whether you're having a headache or not and on a scale of one to ten, how severe that headache is.

And then it tracks all that information for you. So it can become sort of a self observant thing that helps you gain insight into your own behavior over time as long as you get used to using the app on a somewhat regular basis.

So we think that these tools are

very effective. We think they're very helpful, and we think that they're things that our servicemembers today are going to end up using a lot.

And already, we have evidence that a number of these have a very high level of downloads.

COLONEL CAMPISE: Sir, if I could just add to that?

CAPTAIN STOLTZ: Yes, please.

COLONEL CAMPISE: I'm with T2. Sixty six percent of our active duty members are under the age of 30, and 52 percent of our reservists. Those are our digital natives.

Those are folks for whom technology is something they were raised with and it comes second nature to them. And we would consider it cultural incompetence if we went out and tried to treat African Americans or Hispanic or Cambodians or somebody else without learning about their culture.

Yet we do that with our own folks.

We have young people that are coming to their providers saying I've been on the web and I found this app. What do you think about that?

And for the most part, our providers are unfamiliar with what the young digital natives are bringing to them. So really, there's a great deal of hope for us to use this really as expansion of our clinical services.

And we find people that were unhappy with typical clinical therapy. And they go out and use one of the apps like Breathe2Relax and they find that an app is very helpful to them.

And then in the course of using that, they learn about virtual therapy. And so they realize that maybe they're not comfortable with face to face, but if they can do it virtually, they're very comfortable with that.

And so I think that we have a lot of hope in using technology. It's not the

solution to every problem, nor is it the solution for everybody out there.

But for those for whom technology is the answer, it's really malpractice if we're not at the gate to meet them when they're knocking at it.

MEMBER DRACH: If I could? Have you or are you planning on doing any outreach to the veterans and military service organizations to make this information available to them to help get it out?

I think your main focus is on active duty. But you know, once these individuals get out --

COLONEL CAMPISE: Yes, virtually everything that we create, we also do with the VA's PTSD Centers. So they're actually co-created.

MEMBER DRACH: Yes, but you know --

DR. CERNICH: So sir, the other piece of the outreach, and I can say this from

the VA perspective, the National Center for PTSD is very engaged in the community outreach efforts. And I know Karen is very aware of our community engagement efforts through mental health.

One of the things that we've done through the summits, through VA, and I'm not here representing VA, but one of the things that they have done is make community groups and veteran service organizations and military organizations aware of all of the resources that we have available.

We've briefed these to the American Legion. We've briefed these to disabled veterans. So these are very, very, very well socialized.

And the other piece that VA can do that you have some limitations with on the DoD side is we can also do popular press in a really targeted way.

And so when some of these have come out, particularly the PTSD Coach, that's

our highest utilization both on the DoD and VA side. That was publicized internal to DoD by our DoD partners, and VA did the public outreach campaign and the community engagement with the military and veteran service organizations.

So we do try to get these as far out as we can in as many ways as we possibly can. And this is a joint effort that we've had for the last four years. And so the Concussion Coach, the PTSD Coach, the PE Coach, all of those are jointly done between VA and DoD.

CAPTAIN STOLTZ: So this is asking us to summarize how we've improved the lives of our servicemembers. And this is what I wanted to put up here first.

I mentioned to you before about our emphasis on program evaluation. And certainly, we want to make sure that we are doing our own program evaluation and assessing ourselves.

So DCoE has a strategic plan, and this is the one slide that sort of summarizes our strategic plan. And we know what we're trying to do and where we're trying to go.

And if I can just take you to the left hand side of that, you can see that we have objectives for ways that we develop our balance score card and see how well we're doing with marshaling the financial and personnel resources that we have, how well we're enabling the people, assisting their career development, their morale and so forth.

And then how well are we excelling at the three major things that we do, education, clinical and research? And then the ones at the top are really the most important ones because they're how well we are serving our customers, having an impact on care.

And I really do see our primary customers as being, you know, servicemembers, veterans, and their families because we are

here to serve them and help them as they struggle with all the things that go with deployment and being in harm's way and separation and so forth.

So if we go to the next slide, what you're going to see is the way we've answered the question about our most important accomplishments in 2013 is to take those four objectives at the top of our strategic plan and put some things under each of those categories.

So if we focus first at just the C1 category. So we have a PTSD toolkit that we came out with. So this is something that's not just for a person that has PTSD. It's got some educational materials in there for family members.

It helps people know what the symptoms are, how to recognize them, gives them some guidance on the various treatment options that are available, tells them a little bit about what recovery would look

like, some common co-occurring conditions.

So we think that's a helpful tool. We have one for TBI, which I mentioned before that we came out with to assist with the management of visual dysfunction after having a TBI.

You see up there the registry. Of course, Vision has set the way with that. We have received word just recently that we now have funding for us to do a PH/TBI registry. We see that as very good news.

We concur with what Dr. Lawrence and Patty was saying about how beneficial they believe that registry will be and how it will greatly assist with research and have us better understand what's going on out there.

So we're very excited about that. We've been pushing that for a long time, but it looks like we're going to make a lot of progress on that this year.

We do follow 75 active research protocols on both psychological health and

TBI, and I don't want to go through all of those by any means.

But it has to do with, you know, for example, which cognitive rehab treatments are more effective. We have so many different research things, we could be here a long time, including longitudinal research which I think is very important as well.

And then, of course, you see up there our research translation strategy which I talked about before. And there our relationship with MRMC has actually been very helpful because of course they do an awful lot of research up there.

And we have formed a much stronger bond with them in a ways that help us better identify and have them work with us on both the front end and the back end of the research.

If we move to the C2 slide, got lots of things there. I mentioned before about we have these working groups that occur

all the time. I mentioned about how we were the lead for these DoD/VA mental health strategy actions. Made lots of contributions there.

And just one example there. So one of those had to do with gender issues. And one of the gender issues that came up was of course more heavily on the female side, but effecting definitely both genders was sexual assault and how much and what can DCoE do to assist with sexual assault.

So we thought of all sorts of things. But we said hey, rather than again, us be a think tank and do what we think's best, let's call the experts in.

So we got together with the leadership of SAPRO and said look, this is obviously a huge issue. What ways would DCoE best be able to help?

And they told us, well our experience is what we would really need, if you could provide guidance out there for the

providers, whether they see the patient in the emergency room or see them in some type of counseling that are either a perpetrator or a victim of sexual assault, if you could give them some guidance, that would be extraordinarily helpful.

So we've developed an outline for this. And we are working closely with SAPRO to develop this. Apparently there's a tremendous need out in the field for this that we were previously not aware of.

But that's how these things sort of evolve from one project to another and how it leads to further improvements. And then I've already talked, I think, about the Joint Incentive Funds before, so we can go to the C3 part.

And we've mentioned the mobile apps that we just talked about. Now we do some reports. So we do surveillance of TBI worldwide numbers.

And we provide a report on the

direct and purchase care quarterly report for all TBI related medical encounters, both in CONUS and OCONUS.

We also produce a quarterly report that presents the blast exposure and concussion incidents report information. We analyze it and give historical comparisons to that and we send that up.

Suicide has been mentioned before. We put together that report and sent it off to DSPO. And then it's mentioned down there the various seminars and conferences and webinars and sort of the whole educational part.

So we had a resilience virtual conference that was attended by over 1,100 people this past year. And then we had one on TBI that was attended by over 1,200 people. And our webinars are monthly. The wonderful thing about these is they have CE units attached, most of the times with that.

And so with so many people needing CE units, that helps us get quite a few

people. We've had some of our webinars get very large numbers of people chiming into that.

And then finally on that last quadrant there, I've already talked quite a bit about the program evaluation stuff. And then the one thing I haven't mentioned is I haven't talked too much about the care pathway.

We suffer from a lack of standardization of documentation. So right now in the electronic medical record, providers have the option of free texting in all sorts of things.

So if we have a bunch of providers seeing PTSD patients, it's very hard for people to go in and be able to determine what kind of treatment are they doing, and very hard to pull data to really figure out.

So one step again is to get regular use of the same outcome measure, which I believe we have nearly accomplished. We

have it mandated that it be used at least upon initial diagnosis and then before the patient is discharged.

We have in place processes where we're going to be asking that it be used basically every visit unless it's more than once a week. We have a whole variety of metrics that are currently, I think, in the final stages of making their way through the system.

But if all you have is that, and you're not sure what kind of treatment's going on, or even if you say you're doing a particular treatment, what specifically are you doing?

It's very hard for us to learn as much as we could as if we had a standardized way of doing that. So we are pushing hard to get a standardized way of doing a pathway for PTSD.

We have some pretty intense dialogue going on at the moment. Looked like

we had consensus at one point.

Now that seems to be falling apart and I'm scheduled to follow up with the Medical Operations group in order to help get some of their guidance and work that issue with the services so that we can solve this issue of a lack of standardization of documentation in a way that I think will really have a positive impact of us better understanding what's happening and then better understand which is working better and which is working not as well.

CHAIR CROCKETT-JONES: Just to interject here, this is a particular issue that we have found in at least one of our installation visits that there was some awareness that even though contracted providers or civilian providers have been trained in evidence based treatment, that either when treatment changed or when another provider became familiar with a patient, it became clear that they had not received

evidence based treatment, that they had received talk therapy that hadn't really addressed post traumatic stress.

And so this is something that has just recently come to the forefront here for the Task Force. So I'm glad I'm not going to have to, like, introduce this idea.

This seems to be a method, but you're just getting traction. You have not had consensus yet on how to sort of document some sort of treatment provisions?

CAPTAIN STOLTZ: I thought we had consensus and then I found out that we didn't. And now I need to regroup. But the bottom line is --

CHAIR CROCKETT-JONES: Who are you trying to get consensus with? That's my first question.

CAPTAIN STOLTZ: From all the services.

CHAIR CROCKETT-JONES: From the services?

CAPTAIN STOLTZ: From all the services so then I can then take it forward. So we had one way of documenting it, basically a name form. And I'm not sure how many people are familiar with what that is.

But basically a structured form so that any time you had a case of PTSD, you must, must, must use this form. And again, trying to make sure it worked first through a pilot site.

And when you use that form, you are forced to say what you're doing, what form of evidence based treatment you're doing as well as then when you get into the documentation exactly what you're doing within it so then you can easily pull the data.

So that was one way of doing it. But now there's another alternative that's up there that is being advocated. And so I'm in the process of regrouping to try to see if we can get a consensus.

And if I can't, then I'll send it

up with a majority report and a minority report and see how it moves forward because I really believe this is extraordinarily important that we need to know what's taking place and how effective it is because right now I can tell you how many people are diagnosed with PTSD, but if you ask me how many are getting this treatment or how many are getting that, I really can't figure that out. And that impedes progress.

DIRECTOR DAILEY: And Captain Stoltz, if it's any assistance to you, the Task Force has made recommendations exactly to those points of standardized data collection, standardized outcomes to all the services.

If you need leverage, if whatever value they are to you, pull them up and wave them in front of the faces of your compliers and not compliers and say this has to be done.

CAPTAIN STOLTZ: Thank you. Okay, so Question 5 had to do with changes outside of DCoE. Boy, I think we already hit upon

that, and I think we're now expected to come back to you and I haven't had too much time to think about it since we last talked about it to offer anything.

But I've got that. Again, it is my belief that if we can clarify what Centers of Excellence are supposed to do and what they should be driving for, I mean, I have my views on that.

But how much of this is uniform, and then how do we organize them in a way that they will be most effective and efficient doing these things. I think that will help us.

And then we've already addressed the governance issue and how it's my personal opinion not optimal at this time. But I think the players involved have been doing the best they can given the situations that they're in.

CHAIR NATHAN: Who is usually at the Medical Operations group?

CAPTAIN STOLTZ: When I was there

the one time, it was General Potter was the chair, General Thomas was there. Admiral Moulton was there, and Mike Dineen was there.

And then there were several people there that were civilians that I had never met before and their names escape me at the moment.

CHAIR NATHAN: How often are they getting together?

CAPTAIN STOLTZ: Weekly.

CHAIR NATHAN: That's probably going to be your best source of traction for the near term. But again, those are folks that you rely on their interest, good will, and that of their service to either pick up or not pick up what they bring back from those things that are operationally relevant.

And we don't really have yet a coordinating common denominator to sort of make this stuff go. You're clearly good at the receive mode.

In other words, somebody comes to

Dr. Woodson and says hey, I hear that ecstasy, which is a horrible, horrible recreational drug can actually be wonderful, its basic metabolite can actually be wonderful for people with PTS. Are you going to do that in the military?

So he has one person, he can turn to you. And he can say quick, I need your take on whether this is good stuff or not. So you're perfect for that.

What's not so good is if he then says you know, I think it's not a bad idea. Let's go ahead and do some pilot studies with this metabolite. Go ahead and do it.

You're going to say well that's not my job. I don't execute. You know, my job is to tell you what we think direction you should be going. So then he needs to bring it to the SMMAC or whatever. So these are the challenges we have.

CAPTAIN STOLTZ: Okay.

MEMBER MALEBRANCHE: Admiral, one

of the things I didn't understand. Who was supposed to have been or who is on this Center of Excellence Oversight Board?

CHAIR NATHAN: Who what?

MEMBER MALEBRANCHE: Who are the members of the Center of Excellence Oversight Board.

CAPTAIN STOLTZ: The Chair was Dr. Lockette. And I remember Admiral Bruzek-Kohler, retired Admiral Bruzek-Kohler being -- I was at one of these meetings --

DR. CERNICH: Right. So it's Chaired by CNPP. And then there's a representative from each of the services, a representative from MRMC, a representative from USUHS and a representative from what was JTF CatMed, which is now National Capital Region.

And then there was representation from HBNFP, representation from FHPNR, and I believe that that was it.

MEMBER MALEBRANCHE: And this was

all prior to DHA?

DR. CERNICH: This was all prior to DHA. And I had asked about this because we had due out to come to them with a return on investment approach for potential Congressional reporting, and then an annual report requirement that they were asking for that was going to be in addition to the regular reporting that we do through the HEC and through our regular Congressional report.

So we were supposed to come back. And when I asked, it was uncertain at the time, and I haven't received follow up, because there was a working group evaluation board that met as part of the DHA realignment. So we haven't received any notification at this point.

MEMBER MALEBRANCHE: Okay. So one thing that does still occur is that the Centers of Excellence report to the HEC, which reports to the JEC, which then contributes to the Joint Strategic Plan.

So that is a mechanism for some things to occur. And it looked like one of the things you talked about, to make sure that stakeholders were ensured aware of products and services to increase utilization.

So that's one of the venues. There's no DODI or VA or any kind of joint other than clinical practice guidelines joint instruction, correct? And there's no joint metric per se?

DR. CERNICH: There are. So we participate in -- do you want to answer this or do you want me to? So for the HEC, there's the Psychological Health and Traumatic Brain Injury working group.

And DCoE is represented on that working group. And they just actually added this year, we had lacked traumatic brain injury representation on that group.

So the services were allowed to either elect a psychological health representative or a TBI representative. And

it impeded the work in some ways because there wasn't equal representation.

So VA had sort of split their representation, psych health and TBI. DoD had limited representation. Now the representation is equal and we have subgroup meetings.

So we do have the TBI metrics. Actually, I worked with Ms. Helmick a while back to draft those, and we have some meetings upcoming to enact those metrics.

And then for the psychological health group, there are a number of different task forces and panels even outside of the HEC. So there are metrics under that, and there are also metrics that we're working on under the Interagency Mental Health Task Force.

So those are the two places that we are interacting for the mental health work, one pursuant to the Executive Order, the other to the Joint Strategic Plan.

MEMBER MALEBRANCHE: Okay. So there's no policy --

DR. CERNICH: No, ma'am.

MEMBER MALEBRANCHE: -- out? Okay. Well then there can't be an implementation if there's not a policy. Thank you.

CAPTAIN STOLTZ: Okay, so I think we're best practices in PTSD. And next slide. So I jumped the gun and told you about the pathway. And I think that that's clearly a very, very important thing.

And I would say that the goal is to at least try it out and make sure it works first. And then if it works, to then adapt it to things like major depression and the other high volume ones so that we do this not just for PTSD but other high volume things.

And therefore we would come up with the exact same sort of paradigm, whatever we hopefully finally agree on for PTSD, we use a similar way of doing that for the other

major high volume disorders.

In addition to those metrics that have been written into policy, the one for anxiety, PTSD and depression, we have roughly 40 metrics that, as I mentioned earlier, that are going through final stuff with Health Affairs that coincide with the Quadruple Aim.

And we're very close. There's been a lot of work done on those. And we think that when those are done, some of those should be written into policy that will again make it so that people have to use some of these things at a certain frequency in order to measure things, and we get a better handle on what's going on.

I think we've talked a lot about the mobile tools, and so I think that's it for that slide. Before opening up to questions, just a final comment.

I think DCoE is very aware that this is a very important time. We're about to have a major change. Hopefully deployments

are down.

We know that the number of servicemembers on active duty is going to decline. We know we're going to have probably large numbers of people leave the service.

We also know what happened to Vietnam Veterans. And we know that way, way, way too many Vietnam Veterans after they got out of the service had a very rough time, very high volumes of chronic PTSD, PTSD that lasted decade after decade after decade.

We know about incredibly high levels of suicide amongst those Vietnam Veterans well after they were discharged from service. We know that we had roughly well over two million people deployed in these wars in the Middle East since 2002.

We want to make sure we do everything we can that we don't have a repeat of what happened to the people that went to Vietnam because these are people that obviously put their life on the line, put

themselves in harm way, put their families in all sorts of difficult circumstances.

We are dedicated to doing everything we can to help them with these issues. And I have so many wonderful staff that their heart and soul is into what we do.

And that's why we make the best of where we are, no matter what those circumstances are.

And we look forward to solving some of the issues that you brought up to make us even more effective and efficient because we see this as an incredibly important mission and it's very much an honor for us to be part of having the possibility of having an impact on the lives of people that are clearly at risk given the circumstances that they have been put in to defend our country.

So with that, I will open it up to any questions you have.

MEMBER REHBEIN: Sir, I would like to come back to the DVBIC, the new guidelines

that came out, the communication plan you were discussing a few minutes ago because, as the Admiral says, inside the military community, if it's of that importance, a DODI is the way to go.

How do we handle that out in the VA system and in the TRICARE community because so many of our reservists and National Guard folks, that's how they get their healthcare.

And they're falling off airplane wings and they're in truck accidents and they're receiving concussions. How do we get those kinds of guidelines into those communities? Is that part of the plan?

MS. HELMICK: Sure. So just to comment about the DODI. We are very excited to be able to influence policy at that level. And through the DTM navigating over to a DODI for the management of concussion of the deployed setting, I think that showed that it's a template that's do-able. And it got fastly enacted.

We have concerns about the other COCOMs. CENTCOM has been the primary executor of the DODI, of management of concussion in the deployed setting, which as we evolve the clinical guidelines for care for concussion in the deployed setting, we would incorporate this progressive activity, return to activity paradigm into all of the deployed setting as well as the non-deployed garrison setting.

But just as an aside since I have the microphone, we would absolutely welcome the opportunity to indoctrinate what we've learned about TBI over these last 12 years and to be able to effect change through all COCOMs, and that DODI if course does mandate the establishment of a program in all COCOMs.

In terms of specifically purchase care environment, which in the TBI world is about seven to nine percent of all TBI care that's given in the military health system is through the purchase care paradigm.

So 93 percent or so we do direct

care. Being able to influence those TRICARE providers is something that is on our radar screen. It's been more difficult to penetrate than obviously the military health system.

For the VA sector, we have five VA medical centers within the DVBIC network. So just as I mentioned that we used, we would like to leverage our ambassadors within the VA systems of care, which the four polytraumas are four of the five that DVBIC has, would be one conduit as well to ensure that they are disseminated widely, and that they are implemented.

MEMBER MALEBRANCHE: If I might just insert one second here. One of the things Mr. Rehbein brings up is something that also we've encountered with the DoD and VA with the interagency care coordination piece. And at the current time, DoD is creating a DODI, and VA is creating a directive. And we are doing a joint MOU in hopes of someday being able to do joint policy. So that's one

venue.

But just, as you were saying this and talking about this, it just cued in my mind the need, even more, for that ability to do that, which agencies have not done before, the two. So that would be something fairly new. So I don't know, Dr. Cernich, what --

DR. CERNICH: No, the only other thing to say is that of the three positions that VA has at DCoE, I'm serving in one and acting as the other. So as the VA TBI liaison, my other part of my job is to work with DVBIC. And so I get them the SMEs from VA to work with on their committees.

The other piece that I do is when the guideline comes out, it goes to -- there's a part of this that's primary care, there's a part of this that's specialty care. So I work very closely with the primary, the patient aligned care teams which are similar to medical home, they disseminate the guideline through their networks.

We also have a dissemination plan through polytrauma. We also will then probably do a joint webinar; we have that capability for our providers. Those are extremely well-attended by our specialists.

And then the other thing that we have thought about on the VA side, and which is in the Joint Strategic Plan, is how to make providers aware of non-combat TBI and how to manage it. You know, the focus for us has been on combat-related TBI. But 80 percent of the traumatic brain injuries that are suffered within the military are non-combat.

And so, one of the points in our Joint Strategic Plan is how do we educate our providers, especially our primary care providers and our emergency room providers about traumatic brain injury that is non-combat? And how do we get practice guidelines in their hands to help manage those folks as they come in. And this is one of the potential products that we're going to be

looking at within the Joint Strategic Plan metrics to move forward.

DIRECTOR DAILEY: Something that's not in this briefing here, but just how closely they're adhering to making you the single point of accountability.

Task Force did three recommendations that were -- one was for standardization and publication of standardized processes for PTSD. The other recommendation was standardization, publication of process for TBI. These are all recommendations last year. Did they filter down to you to answer? Have you seen?

MS. HELMICK: Yes.

DIRECTOR DAILEY: So you are the point of contact for four, did I see you do a four, ma'am?

MS. HELMICK: Yes, it was recommendation number four for TBI. Sorry, yes, we've seen them and responded. Yes.

DR. CERNICH: We responded

directly to four.

DIRECTOR DAILEY: Okay.

DR. CERNICH: Three went to CMPP was the lead for three. So four, we were the lead, and Colonel Heinz coordinated with the services for the implementation plan for that recommendation. Three was through CMPP.

DIRECTOR DAILEY: Okay. Good, very good. I appreciate that and that is very helpful in reinforcing your statement that you're the single point of contact for psychological health issues, empowered by Dr. Woodson.

Again, great track record on the DTM for care of concussive injuries in-theater and the subsequent DODI that came out. I can't tell you how many times we went to the field, talking to TBI clinics, and heard them say game-changer, game-changer over there since 2011. Those DODIs were game -- were categorized as game changers by the clinicians and the TBI directors out there. So that was

a pretty high standard you set for us.

What's the next, are you going to put out another DODI? Are you currently the lead on another DODI? Are you writing a DODI? I see heads going this way over there. Are you taking the lead on anything else that would be a policy statement? Or did someone else pick that up in Health Affairs?

DR. CERNICH: Do you want us to take that one? Okay.

MS. HELMICK: When the 84 percent known TBI occurred in the garrison setting, when that data came out about two and a half years ago, there was excitement to launch a garrison DODI so that we could effect change in the same way that we were in process of doing in the deployed setting.

Individual service directors had varying levels of consensus on whether that was necessary and whether or not that would be supported by their command. And we spent quite a bit of time on our weekly quad service

call -- we meet as a TBI community every Thursday, discussing, trying to come to some coalescing of moving forward with a Department of Defense instruction on garrison care.

And we did not get there. There were services that were concerned about the requirements. There were services concerned about the 24 hour rest period. And other factors, too. But in general, we were unable to reach consensus. And when that became evidently clear, the Army moved out on their service-specific garrison policy, which was published as an ALARAC last year. And then subsequently, the Navy did the same. And it's in final draft form, about to be released. The Marine Corps took a preventative stance and delivered a MARADMIN in 2012.

And the Air Force at this time, related to their numbers, have chosen not to proceed forward with a service-wide policy. So although there was discussion, much discussion about a DODI for garrison, or even

a DODI that was TBI both deployed and non-deployed setting, we were unfortunately unable to accomplish that.

DIRECTOR DAILEY: Very helpful. Very helpful. Our recommendation, one of the recommendations last year was the TBI recommendation for the MTF setting is what we called it, beyond the battlefield. So, very helpful. Thank you.

MEMBER DEJONG: One last question I've got, and to take what Mr. Rehbein said a little bit further, the National Guard and Reserve group that -- and sir, you had mentioned it -- and even the individuals that have transitioned out of the Army and now are doing non-TRICARE care, a lot of National Guard individuals are on a civilian market.

And some of what we hear back through our focus groups is that they can't find civilian providers that have the military knowledge or the good work that you all do doesn't filter down through that.

So are there any mechanisms that you have or that you're allowed to have or that you can do to help filter that into the civilian sector and into the communities where the soldiers that have transitioned out, sailors and marines and another large group of National Guard and Reserve individuals are looking for care but can't find it.

CAPTAIN STOLTZ: So there is the Center for Deployment Psychology that used to belong to DCoE and is now under USUHS. And their primary mission as I understand it, and I have met with them, is in fact to focus on educating providers out in the -- that are not in the MHS on how to be more aware of the kinds of issues that military families and servicemembers or former servicemembers face.

And so that is an organization that that's a big part of what they do. So we have interfaced with them some, but we haven't taken that on in light of their role.

DR. CERNICH: The other mechanism,

sir, that we have and that we're going to utilize a bit more, hopefully this year, are threefold.

One is the White House initiative, the Joining Forces Initiative. One of the emphases in that initiative is to get information to community providers about military-relevant medical issues, specifically in psychological health and traumatic brain injury. So, that involves agreements with I think over 50 professional organizations of Allied Health and Health Professionals. Also, they're trying to create some GME content for the medical schools that would be mandatory. And so, we're helping with generating some of the content that will go into that so a community provider will be aware of that.

The other piece of it is that we've collaboratively worked through the Integrated Mental Health strategy on a community provider toolkit. And that is up on a website now. It's hung, so if you want to

get that to your community contacts in the armories, it has military culture training, it has training on military specific conditions, how they may vary from a civilian presentation and what other questions to ask, even down to asking the person if they ever served in the military because that is something that a provider does not usually ask in their first point of contact. And making sure that you understand that that may affect some of the things that are coming to the forefront for that person at the time.

The other mechanism that we do try to utilize is not only through the Joining Forces, but sometimes in partnership, is to let folks know about us through the Yellow Ribbon Program. So we try to do general outreach and our outreach team is there. So the In Transition program will be there and if they can't locate a TRICARE provider, if they're using civilian providers, we do make efforts to help them locate a provider that

might be of use to them. And we also work with the VA to encourage them to potentially avail themselves of VA services, especially services specific to military sexual trauma, since those are free and you don't even have to be, in many cases, eligible for VA healthcare to access those.

So there are a number of ways that we are trying to do that, even in our work with SAPRO, that's one of the things that we're doing is not only working with the providers within the military health system on how to provide care, but then potentially linking to VA so that if they're not willing to avail themselves of the care within the Military Health System, they can access VA for that.

So we're trying in many ways, in any way that we can think of, in mechanisms that we have to do that outreach.

MEMBER DEJONG: No, that's great. One of the things that we do look at is

there's a large portion of that group that I'm speaking of is remote even from VA.

And also what we're looking at is with the downturn of deployments and the reserve forces being taken off of most deployments, the Yellow Ribbon programs are going away.

So when you're looking at venues of getting this out, you know, I think it's a collaboration of National Guard Bureau and a few other things. But it sounds like it's on the forefront, so thank you very much.

MEMBER DRACH: Kind of a follow-up to that. I was on a panel at the American Public Health Association conference in Boston in November. And sort of a rhetorical question, at least at that time, came up and it was along these lines. Is the civilian community going to be ready for and be able to provide psychological health services to returning warriors, 5, 10, 15, even 20 years from now?

So when you're discussing that, it made me think have you talked to APHA or will you reach out to APHA and the CDC, because the APHA conference was sort of under, I think under the broad umbrella of CDC. And it seems to me like that would be two very, very good organizations to help get the word out to the community.

CAPTAIN STOLTZ: I completely agree. And I think we're at that time when that really is very important to make sure that that gets done.

CHAIR NATHAN: Anything else? Well, thank you. Don't mistake our frustration for pessimism. I think most of us feel, at least in the federal sector, that the glass is certainly half if not three quarters full instead of a quarter empty or a half empty.

But we're determined to see it fill all the way up. And we know that there is good work being done in lots of places.

And we're not getting the visibility of it. We rely on you to do that.

There's a philosophical judgment that has to be made, which is, are you established as a center of excellence to be an advisory group to the services, who can pick and choose what you have to offer, or are you established as an overarching agency to provide the Department of Defense a collaborative approach to something which the services should be required to adopt?

I am of the latter. I believe that when it comes to non-military unique environments, a military unique environment would be please don't tell me how to treat a heart attack at sea because what you tell me may not be practical at sea. But in garrison TBI, or in combat wounds, or the exposure of PTS from anything else, I believe that a sailor and a soldier and a marine all suffer basically the same affliction, as well as an airman.

And so I sign up to do what you tell me is the best way forward. My job is to try to figure out how to execute what you tell me is the best way to treat the patient. If you tell me the best way to treat the patient in garrison for TBI or for mild TBI is, by consensus, the best way to do it, my job is not to tell you why I can't get that done as a service. My job is to make that happen. If you wait for the services to collaborate together on these things, it ain't going to happen in many instances, even though we're all motivated for the best for our people.

Thank you for reminding us that you do so many more things besides just the kinetic aspects of trauma from warfare and from TBI in garrison and in combat.

The example of the military sexual trauma or sexual assault advice to the SAPRO is incalculable. We do a great job of educating our providers on how to collect specimens, on how to perform exams, and on how

to be advocates for victims of sexual assault.

But we haven't really provided a collaborative psychological algorithm for how to deal with what's going to happen from a psychology standpoint as opposed to just the advocacy standpoint. And so you're very timely there, and very much appreciated.

So barring those questions, and a little bit on the lighter side, I would just ask you, has there been any studies on the psychological, long-range effects of one service beating another service for 12 years in a row in football?

(Laughter.)

I'll take that as a no, and if you have any free time, you might want to pursue that.

CAPTAIN STOLTZ: That's correct, sir.

CHAIR NATHAN: So thank you very much for coming today.

CAPTAIN STOLTZ: Thank you, thank

you.

DIRECTOR DAILEY: Fifteen minute break. We're back at 3:15 please.

(Whereupon, the foregoing matter went off the record at 2:59 p.m. and went back on the record at 3:17 a.m.)

CHAIR CROCKETT-JONES: Okay. We now welcome Ms. Cynthia Gilman, Director of Public-Private Partnerships with Henry M. Jackson Foundation for the Advancement of Military Medicine. Ms. Gilman will provide an overview of the Veteran's Metrics Initiative and discuss the Initiative's role in improving recovering warrior care.

We have this briefing under Tab F, and I'm going to turn it over to you to introduce anyone else who's presenting.

MS. GILMAN: Well, thank you very much, and thank you to Task Force for this opportunity. We are really honored to be here today. My name is Cynthia Gilman.

I'm joined by my colleague, Katy

Hussey-Sloniker, who is the Program Director for the Veteran Metrics Initiative that we'll be talking about this afternoon.

But first, let me, if I may, introduce you to our organization, for those who are not familiar with The Henry Jackson Foundation. It is a 501(c)(3) organization founded about 31 years ago, and congressionally authorized to serve as an interface between civilian and military medicine, and to support the work of the The Uniformed Services University of the Health Sciences.

We support over 1,000 military medical research and education programs around the world. And the vast majority of the dollars that flow through the foundation annually are federal in nature. So, the dollars that come in the door have particular uses already assigned to them, which obviously leaves very little in the way of discretionary spending.

And that's the reason why we created what we call The Center for Public-Private Partnership. We stood it up about four years ago. It is a center within the foundation. It is not a separate legal entity. But unlike the balance of the foundation, CP3 as we shorthand it, operates exclusively to date on private funds. And we do that because we believe it allows us to be a bit more agile, and enables us to bring together collaborators whom are otherwise difficult to pull together, particularly when federal funds are being used.

Our focus within CP3 is to create and sustain public-private partnerships to advance the long term health and well-being of servicemembers, veterans, and their families.

The Veteran Metrics Initiative, which we'll be speaking about in some depth, started about four years ago. And it began when CP3 started working with communities and community based organizations that were

dedicated to helping servicemembers and their families transition out and come to their communities and reintegrate home.

And what we found was that there were a lot of things that communities did not know. They had tremendous goodwill, and tremendous desire to help, but they really didn't know where to focus their efforts or their resources. They also did not know how to assess if what they were doing was making a meaningful difference. And we realized that this issue of how do you measure if an intervention is going to be effective in terms of outcomes is a really difficult undertaking. And the more we looked into this, the more we realized that the communities were not alone in not knowing how to do this. So we decided to step into this space and this is where we are today.

What we determined the problem to be is how do you measure what works. And what we did was we pulled together a series

of different subject matter experts, some of whom are in the room, who actually came to our office and started brainstorming around this question of what do we need to be measuring? How do we determine what it is that is going to impact long-term outcomes in the veteran population that we all are dedicated to serving?

So in bringing our subject matter experts together, we thought it was very important to recognize that our servicemembers become veterans who go home to communities. So we have to bring everybody to the same table so that we can work collaboratively. We also have discovered that there are more than 45,000 community-based organizations that exist to try to help in this veteran transition reintegration space. And there are more than 10,000 websites available to veterans and their families. At this point in time, the veteran transition continuum, which for purposes of

our work, we define as the period right before separation from service and then three years thereafter, when the person then goes home.

Currently, these interventions are assessed purely based on conjecture and anecdotes, not on evidence-based data. And there is no standard that we have been able to identify that exists, that allows folks to uniformly know what to measure, or how to measure, correlations between interventions and outcomes.

So, we identified that there is this need to develop standard outcome metrics. Again, the focus really is on outcomes. There are a lot of efforts underway and a lot of folks are actually collecting process metrics, programmatic metrics, how many did you serve, how many clicks on the website?

But what we really want to know is, how did this intervention impact the

quality of life, the health, the well-being of the person who utilized the intervention? When I say intervention, I'm using that as a term that can include a program, a service, what have you.

We determined, again through many conversations, that our metrics have got to be data-driven, based on evidence-based science, and that ideally, the DoD, VA and civilian academia and industry all should collaborate and work together in developing the metrics that we're focusing on in order that we can increase the likelihood of there being a common vocabulary so that we're ultimately able to compare apples to apples and, at the end of the day, have uniform, universal adoption.

Now we realize, and we've just heard, there are a lot of efforts underway to develop metrics at this point in time. And by no means do we suggest that this program is meant to be the be all and end all of

metrics development. On the contrary, what we are, though, emphasizing is the need for DoD, VA and civilians who are working in this space to be communicating together so that we don't end up with a bunch of siloed, different metrics being developed.

So our goal became pretty clear, after all of these different discussions, that what we were going to set out to do was to develop evidence-based metric tools that could be used by whomever would like to use them to guide the effective interventions along the separation, transition and community reintegration continuum of servicemembers, veterans and their families.

So that was our goal. But we also realized that it's a lofty and difficult goal, and that there is no one study, or one way to tackle this goal that's going to get us to where we want to be right off the bat. So what we said is, okay, let's pull together the experts in this country, recognizing

there's a lot of experts in this country.

So let's identify those who are working in this space, maybe not exactly on point, but at least related to the work that we're doing, and pull them together to the extent that they're willing and able, and build and sustain different teams of strategic, scientific and stakeholder advisors representing DoD, VA, philanthropy, veteran organizations, veteran and family advocates, and pull them all to the table to help us work in collaboration with subject matter experts who will do the bidding, in essence, of the work that our advisory group says needs to get done.

So what we've done is we've said to our stakeholders, what do you need? What questions do you need to have answered? And then we have built a team of researchers who've come together and we've said, these are the questions we need you scientists to answer. If you want to publish in your peer

review journals, that's fantastic because that makes it credible and reproducible and so on and so forth. But at the end of the day, we need translational research that can be used by our stakeholders to make the lives of veterans and their families better.

And we have, in reaching to our scientific research community, said we need you at all times to adhere to scientific and theoretical approaches and methodologies from multiple disciplinary fields in order to find evidence-based solutions for us. So again, we have identified different researchers representing a whole host of different fields who have sat with us at the table for over a year without a penny coming their way, but because they are really committed to what it is that this group has taken on.

So here's our management model. We serve as the TVMI Director, Henry Jackson Foundation and CP3. We are the conveners. We do the administrative work and we,

importantly, go out and get the funding. The funding that we are seeking at this point is 100 percent private. And again, our goal is by using private dollars, to be able to use those funds pretty quickly with a minimal amount of strings attached. We also have stakeholder advisors, strategic advisors, and a scientific advisory committee that is tasked with overseeing the science that our scientists will be doing.

We've, as I mentioned, recognized that no one research project is going to answer all of our questions. But instead, we need to be able to design a series of highly-integrated research undertakings that will inform each other, all of which will drive towards achieving our goal of developing these tools that can be used to assess the efficacy of interventions on outcomes.

We currently have one project, which is Project 1, which is underway. Project 2 is in the process of being

developed and hopefully launched pretty quickly. 3, 4, 5, et cetera, are projects that will follow on and we've depicted them as we have because we want to show they don't need to be running sequentially. They can run concurrently as well.

Let me tell you very briefly, if I may, about our Project 1. It is a crowdsourcing and data visualization project. It is being led by a principal investigator at USUHS. And the goal is to use crowdsourcing and data visualization techniques in order to go out into social media and capture millions of pieces of natural language text that veterans and their family members are pushing out through Twitter, public-facing Facebook pages, blogs, RSS feeds, taking that massive amount of data and then analyzing it through algorithms so that we can identify, what are the veterans talking about? What are they saying their concerns are and how are they using language?

So that when we go back to them in some of the follow on studies that we'll tell you about, we can make sure that we are asking them questions in a way that they're understanding our questions, and that we understand their answers. This is a project that again, was 100 percent privately funded. As I mentioned, it is being led by USUHS, and it is scheduled to be wrapped up next month.

Research Project 2 is called Common Components of Success, and that is what I would like to spend the bulk of our time discussing. The goal in this particular project, and I think it was alluded to in the last talk by DCoE, is that we want to be able to identify what are the common components across the interventions that veterans are actually using after they separate from service, that the evidence shows are associated with successful outcomes.

What we are not looking at is, we have no interest in grading any particular

program, and I'll discuss that a little bit more later. Our focus is in the components of the programs themselves. Our desired outcome from this particular study is to create a menu, if you will. And it's a menu that can be used by a variety of stakeholders. The menu will have a list of common programmatic components that appear in the different programs that the veterans report that they utilize, and then we will have across from the different components, associated outcomes, positive, neutral and actually, negative.

And that's one of the issues that we really want to look at. Are there aspects of particular programs that may actually inadvertently be driving negative outcomes? So that's something that's very interesting to our research group. We are in the process, right now, of just going out and talking to private sponsors. And this is a research undertaking that has been about a

year in development. We have nine co-PIs working with us representing seven different organizations, and here they are.

So, again we're in the center because we are the group that is constantly out there nagging everybody don't forget the meetings, don't forget to send in your materials. We have US Army Public Health Command, United States Military Academy representing DoD. We have three VA researchers. Penn State is represented with two researchers and ICF International, you may recognize one of the names, Dr. Suzanne Lederer, PhD is one of our PIs who's been with us from the beginning.

CHAIR CROCKETT-JONES: Can I ask you a quick question? Does your research separate out the general veteran from veterans who are leaving after being designated wounded or injured?

MS. GILMAN: It will. And I will be talking a little bit more, but you raise a

great point. The research is broader than the focus of this task force. So what we are going to be looking at are all departing servicemembers, and then we're going to be putting them into different categories of different demographics, and that's probably our most important demographic, but it's not the only.

As I mentioned, we have strategic advisors. And this is a group of folks whose names you may well recognize. They have, Secretary Peake has been with us from the beginning, as has General Schoomaker, and General Roudebush. They have been the ones who are helping us in terms of thinking about the strategic approach we need to take, as well as helping make connections along the way to get over bureaucratic hurdles that, shockingly, we encounter from time to time.

We have a scientific advisory committee. And again, these are the individuals who are looking at the science

that's being proposed. For this particular study, our first scientific advisory committee will be in Bethesda next week. And we'll have all of our research and all of our scientific advisory committee members there in person.

And we have a team of stakeholder advisors. The list that you have is just a partial list. It's growing, truly, by the day. We are delighted by the attention and interest that people are expressing.

We have a big tent and we want as many people who are as interested in working collaboratively to come on in and be engaged because again, we as the Project Director have, you know, in talking about the authority that was discussed in the last panel, we have zero authority, none. The only way we're able to get all these folks around the table is by being somewhat persuasive and convincing folks that this would be a good idea, and it seems to be working so far. So that's why we have really tried to identify the people who are in

this arena and invite them to come in and participate.

The research team has worked, as I mentioned, for the past year. They have developed six research questions that they say they will be answering at the completion of this study, although they say there will be many more that are spun out of the study as well.

The first one is, how well are veterans reintegrating across domains? We want to be looking not only at the health of the veteran population, but we want to look at how they're they doing socially, economically, financially, in their families, spiritually, et cetera.

Are there sub-group differences in reintegration outcomes? How are our wounded, ill and injured doing compared to the rest of the population? How are the women doing? How are officers versus enlisted? How are four years and out versus twenty years and out, and

so on and so forth. How's the Guard and Reserve, big piece of the study.

And we want to know how do reintegration outcomes vary over time. We want to look and see, are people doing pretty well the first three months, six months after they get out and maybe there tends to be a real drop-off? Ideally, down the road we're going to be looking for tell-tale warning signs so that we can look at different ways to intervene. This particular study is not an intervention study. It's purely observational. But we're going to be looking for trends that we may see along the way.

We want to know what types of programs are the veterans actually using? We said there's 45,000 plus of them, and that's just in the community, but that doesn't even include the VA and the DoD. And by the way, it is perfectly fair for us to be looking at DoD and VA programs too, as a part of this study. And I will tell you how we'll be doing

that, but the primary focus really is the community-based organizations and what they're providing.

We want to know, are the veterans using sports programs? Are they using peer mentoring? Are they going to mental health programs? Are they using those electronic devices that are out there and seemingly cool? Are they using them? And what program components are the predictors of reintegration outcome success over time?

Again, that to us seems to be really at the core of this. If we can identify what aspects of programs the evidence show drives success, then particularly as resources become more scarce, programs may become fewer, we can then really have a better understanding of where do we need to be putting our time, attention and resourcing?

And finally, we want to know what individual characteristics of those individual veterans are influencing the impact of

programmatic components. Just as important to us as what programs are you using, and what components are driving your outcomes, is maybe you're not using any programs at all and you're doing just great. So we want to be looking at, or you can have, high-performing veterans, low-performing veterans. And then look to see, are those high-performing veterans correlating with a common form of component that may, in fact, be associated with why they are performing well?

So our study design is as follows. It is a five year study. There are two different sub-studies that comprise the study. They are depicted in two different colors. The yellow is representative of what we call our Outcome sub-study. And purple is our Program sub-study. And each of them will be running concurrently.

But let me explain, if I may, how the study is going to operate. In year one, we will be spending the year doing lots of

preparatory work. Actually, there's been a lot of preparatory work that's been done for the past year, but then we'll spend another year doing a deeper dive into the literature review, into instrument design, looking to see what are the other folks out there, some we've already heard from, others we haven't. What have they already designed? What are they using for their metrics so that we can -- to the extent, validated metrics measurements already exist -- we can use them if they make sense, and then we can adapt them as need be. We will need to be getting our regulatory approvals and we'll need to be doing study recruitment.

Our study on the longitudinal outcomes study is as follows. We are looking to recruit 7,500 active duty servicemembers and Guard and Reserve, who are within zero to ninety days of transitioning out of active service. And what we would like to do with those folks who will be representing all of

the services, so 1,500 from Navy, Army, Air Force, Marines Corps and 1,500 Guard and Reserve. We want to recruit them to the study at T1, which is in that zero to ninety days pre-separation period. And we want to assess their well-being at baseline.

And again, the well-being assessment tool is a tool that's going to be developed during that first year. But it is, in essence, to be looking at how is this person doing across a whole host of domains, to include physical and emotional health, financial security, family, so on and so forth.

And then we will be visiting with these folks again every six months thereafter for a period total of three years after they leave service. So we're going to be tracking their well-being as they go home and reintegrate. We will also, at each one of these points in time where we connect with them, ask them what kind of program and

service are you using? And we will just collect the information that they give us. So they will identify for us what we're calling Veteran Utilized Programs, or VUPs.

We will take the list of those VUPs and our Outcome sub-study team will hand that list to our Program sub-study team. And our Program sub-study team will get busy looking at the list of programs that the veterans themselves say they're using, and start breaking them down into their component parts. They'll do that by looking at websites that discuss the different programs, doing literature reviews to see if anything has been written about them, contacting the different programs directors, so on and so forth.

So, for instance, if Sergeant Jones, now Veteran Jones, says he is using an Acme Fly Fishing Program, Acme would be identified as a VUP. The Program sub-study group would look at that program and say, okay, here are the component parts. It is --

and I'm making these up because this may not be what the component parts are, but for purposes of discussion -- outdoors, physical activity, one-on-one relationship between Sergeant Jones and the fishing guide, who by the way happens to also going to be a veteran of the same era.

And so you'll see, what we are not looking at is how does Acme Fishing do in the life of this individual. But we are breaking it down into component parts and compiling all of these different components across programs together. And then we will look to integrate the data between how our folks are doing and the components that they're utilizing. So that's the very simplistic way of saying what it is that our research team wants to do.

We want to be able to look at, as I mentioned, our high-performing veterans and say, is there commonality among components that they're using? Are there some folks that are doing poorly and we see that there is a

common component that, in fact, may be associated with those negative outcomes? Are there people, again, who are functioning great and doing nothing? And what does that mean? So that's the kind of analysis, by doing this integrated data set, where we will be doing lots of coding between the different individuals who are being surveyed and the different programs and the components that they utilize.

Yes.

MEMBER DRACH: Can you go back a minute to the continuum? So you're going to be looking at 7,500 active duty, zero to ninety days out.

The continuum says that you'll be looking at transition and community reintegration up to approximately three years thereafter. So if I'm reading this correctly, this is a three-year project or longer?

MS. GILMAN: It's a five-year project.

MEMBER DRACH: Five-year.

MS. GILMAN: The first year is the preparatory work. Three years will be spent then doing the data collection. Actually that'll go through year four. Year five is the final number crunching and the analysis.

MEMBER DRACH: So you will or will not be able to gather any data on services, programs utilized post-discharge, or will you

MS. GILMAN: We will because in fact we think those will be the majority of what we are collecting. The only survey piece that's going to happen pre-discharge is at T1.

That's within the zero to ninety and we anticipate at that point when we ask them what kind of programs and services are you utilizing, it'll probably be a TAPS program of some sort or something else DoD related.

But then after is what we're really going to be collecting the bulk of the time. Once they go home are they still using what

the DoD is providing or the VA is providing.

MEMBER DRACH: Thank you.

MS. GILMAN: Yes, any other questions? So we were asked why we think this is unique and we do because, for a few reasons.

We think because it is involving all of the different services to include Garden Reserve and we are looking at multiple sub-groups, as I mentioned before, the wounded, ill and injured.

We'd looking at folks who have been deployed and haven't, who've had combat experience and haven't. So really looking across broad demographics.

And also I should mention, one of the things we're really interested in looking at is where are these folks going home?

Are they going to rural communities? Are they going to urban centers? Are they going to places where there is a lot of connectivity with VA facilities or DoD

facilities?

Is there a large military population around them or not? And how is that going to correlate with their outcomes as well? So that's another really interesting piece to our group.

Again, we think that there will be rich data that is collected. We also think it's interesting to be able to start to understand with all of these programs out there, what are people actually doing?

Are they doing it online? Are they, you know, do they want their one on one peer type relationships, which are much more expensive.

These are the kinds of questions that a lot of the private funders really want the answers to because as they're developing programs they need to answer to their boards where should they be putting their resources.

We think that it will be pretty ground breaking research in that we don't

think that there's anything out there at this point in time quite like this.

There are certainly other longitudinal studies and other studies that we would love to be able to correlate with if it makes sense to do so.

We are looking to be highly collaborative and interdisciplinary, and the fact that we have been able to pull not only DoD and VA together, which I think all of you have done a fantastic job of doing more collaborations among agencies, but pulling the civilian side in as well.

And we are not shy about bringing in industry because we are a 501(c)(3) and we're not using government funds. We have much more flexibility on the ability to work with the private sector and people within the private sector we want to work with.

And we anticipate being able to rapidly and broadly disseminate the findings and the data.

There will be the ability of our core researchers to do some preliminary publishing on the work that they do, but then because HJF will be the owners of the data we will, subject to making sure that the data is compliant with IRB requirements and PII type issues, we would like to make this data as broadly available as possible to interested researchers who can demonstrate that they can put it to good use so that we can get it out there as broadly as we can to make this data used and advance the science as quickly as possible.

And finally we were asked to discuss the intersection between our work and what it is that this task force does. We put up both of our goals breaking them down.

Yes, your population of focus is the recovering warrior. Ours is all transitioning servicemembers to include recovering warriors.

Your purpose, and I don't mean to

marginalize, and if I'm not stating anything correctly or broadly enough my apologies in advance, but in essence assess the effectiveness of DoD programs and policies.

Ours is to measure evidence-based effectiveness of interventions on veteran outcomes, writ large irrespective of who may be providing those interventions.

Our focus is on the spectrum of transition continuum well being interventions across multiple domains. So again where you all are looking while folks are predominantly still on active duty, our focus is when they're getting off active duty and going home, and the three years thereafter.

And our goal is to be able to develop these metric tools to help guide the use of resources owned by DoD, VA and civilian communities, to maximize the return on investment, if you will.

So one of the thoughts, a key party that we believe will be wanting to use the

menu will be, for instance, a private sector funder who has their door knocked on daily, ten times a day saying support me, support me, support my organization.

Currently they have no way of assessing other than, kind of what their gut tells them, or what the organization tells them about the efficacy of that particular organization.

We believe that by giving them this menu, through this particular study, they'd be able to say okay if you want money let's go through your program, let's look at the component parts.

Oh you've got three out of ten that are shown to be effective. You've got nine out of ten that are shown to be effective.

So now we have a measurable tool to allow funders to be able to drive the change. And we really do believe that funders will be the ones who will drive this change, at least on the community side.

And finally we just wanted to give you an idea of what our cost is. We are anticipating that this study should be about $8.3 million.

It's interesting when we present these dollars, some people say oof, that seems like a lot of money, and others say eww that's not enough money.

So we figure that we're probably doing something right if nobody agrees. And as we said, we are out now talking to the private funding community looking for support and we've got a lot of interest that we're really delighted by.

So that concludes our presentation. Would be happy to take any questions anyone may have?

CHAIR CROCKETT-JONES: Do you have any academic partners?

MS. GILMAN: We do. So we have been working with Penn State University. Our three different VA researchers all also

represent academic institutions. Boston University, Texas. Katy help me, help me. Katy is my brain for these sorts of things.

MS. HUSSEY-SLONIKER: So Boston University is one of the VA. Texas A & M is another. And University of Texas, San Antonio Health Science Center is the third.

MS. GILMAN: And then USUHS is very involved with us. On this particular study, they are not at the table, but they are very involved in scientific oversight.

CHAIR CROCKETT-JONES: Just also --

MS. HUSSEY-SLONIKER: And as well on the Scientific Advisory Committee we have the University of Southern California, School of Social Work. So the Director of The Center for Innovation for Veterans and Families.

CHAIR CROCKETT-JONES: I'd just also, there is a lot of veteran intervention services groups that are located on college campuses that sometimes go under the community radar because they have sort of a different,

they have yet another sub-group population of veterans who are pursuing academic, not industry, necessarily as their -- It's one of the reasons I asked.

MS. GILMAN: So like The Student Veterans of America, we've talked with them. And they're, we think a real important group, on this educational side of the house, absolutely.

MEMBER MALEBRANCHE: So on your population, is this study a traditional study in that you're following a veteran or a servicemember as that person over time?

Or are you following, it says population, it looks like individuals, but you are talking programs. So are you identifying them like you do in a study by a number or something, but it's individual over time on how they do for outcomes?

MS. GILMAN: Yes. So we are doing a couple things. We are following individuals over time to assess their outcomes. We're

following individuals over time to ask them what programs and services they use, because we think those may change over time.

So we're going to continue to collect more names of these VUPs. And we will also, as we're getting more names of the VUPs, continue to gather data on more VUPs.

MEMBER MALEBRANCHE: Okay, and then you mentioned that the data is owned by The Jackson Foundation?

MS. GILMAN: Right.

MEMBER MALEBRANCHE: But is that data then available to DoD and VA? Or I mean it's going to be openly--

MS. GILMAN: Right.

MEMBER MALEBRANCHE: -- kind of used that way?

MS. GILMAN: Absolutely. We would love DoD and VA to use the data as they would like. And then again we've got the DoD and VA researchers who are at the table with us.

VA has been very engaged with us

from the very beginning so we think that they'll be all over the data, which we're really pleased about.

MEMBER PHILLIPS: Question. What mechanism are you going to use to recruit people? Are you going to send out emails, go to a post, or how are you going to do it?

MS. GILMAN: Great question. Lots of discussion. So originally we wanted to recruit in person at the different installations, at the different TAPS programs.

And then we started crunching the numbers and realized that not only would that be cost prohibitive, but just the logistics of getting on to all of the different installations from all of the different services.

So we have decided instead to approach this through the DMDC, Defense Manpower Data Center, and to access our study population that way.

By reaching out, identifying them

across demographics, our statisticians and others will be the ones who are going to be tasked with figuring out who we should reach to, how many to reach to in order to be able to recruit our 7,500 number figuring there will be attrition along the way and so on and so forth.

And then we plan to incentivize people to participate financially. And the incentives we anticipate will go up incrementally the longer they stay with us.

MEMBER PHILLIPS: Are there going to be any exclusion criteria like folks with less than honorable discharges? Are you going to look at recruitment incentives or why they joined up? I'm just asking.

MS. GILMAN: No, it's a great question. There was definitely discussion about the - do we want to get into the less than honorable discharge arena.

I'm not sure that the jury has completely resolved that issue yet. Though I

think the consensus was let's not go there because we've got to get going.

And there's so many different ways that we can slice and dice this then we put that in the category of for the moment it's just too hard.

Similarly, along those lines, we wanted to be able to reach to family members as well, but too hard at the moment. But we would like to be able to put them into one of our follow on studies pretty quickly, with one exception.

For the wounded, ill and injured population, if the servicemember, veteran isn't able to respond for his or herself, family member would be able to respond, or caregiver, on his or her behalf because we absolutely want to capture that demographic in the study.

MEMBER DRACH: Will you be looking at employment, such as, did you go back to the job you had before you went in? If not, why

not?

Did you get a job? How soon after discharge? Are you still with the same employer? Have you been promoted? Those kinds of things?

MS. GILMAN: So that really goes back to the measure and the measurement instrument that our team is going to be using. It hasn't been designed yet.

At this point in time there is a well-being model that the research team on the outcomes sub-study side is very interested in following. It was a model that was developed by CNAS.

One of the lead authors is now over at RAND. They developed a very comprehensive, we think, definition of what is well-being, what is wellness because we want to look across all these different domains.

What they have not done though, is themselves developed the measures on how do you assess, you know, employment. And in fact

they have chosen not to use the term employment.

They're using the term vocation. But that is all first year type of work that's going to get done. So what we're looking for at this point in time is we want to say we've got the funding in place, let's go.

And then all of this will get developed in year one, to answer those kind of specific questions.

MEMBER REHBEIN: Yes that was going to be my comment too. You talk about successful veteran outcomes, but quantifying success is a real can of worms because success, what for me is success might not be for somebody else because of the difference in expectations.

So I think that's going to be a significant challenge. Good luck with that one.

MS. GILMAN: Yes it is. And which is why we have no interest in trying to

reinvent any wheels to the extent anybody DoD, VA, civilian, academia has created something already.

We're reaching to them again, like the CNAS/RAND folks and they are stakeholders. Both CNAS and RAND are very active within our stakeholder community so that we can tap into their expertise, and others.

CHAIR CROCKETT-JONES: Well thank you Ms. Gilman. Thank you very much.

MS. GILMAN: Thank you. I appreciate the opportunity.

CHAIR CROCKETT-JONES: You ready Denise? I know you wanted to present some recommendations from other committees. Do we need a break first?

DIRECTOR DAILEY: Yes, let us. I'm sorry guys I need one so I'm going to go out.

CHAIR CROCKETT-JONES: Okay.

DIRECTOR DAILEY: I'll be right back. They are going to cue up my briefing and then we'll, we'll go.

CHAIR CROCKETT-JONES: Okay, very good. Ten minutes.

DIRECTOR DAILEY: Five minutes.

CHAIR CROCKETT-JONES: Five minutes.

(Whereupon, the foregoing matter went off the record at 4:00 p.m. and went back on the record at 4:05 p.m.)

DIRECTOR DAILEY: Okay ladies and gentlemen. This is a continuing series of briefings that Dr. Phillips wanted us to look at in helping us craft recommendations for the end of this year.

So in October I went through a framework of what areas might have holes or gaps of the Task Force's charter items that we haven't made recommendations on, or that we could move forward and make recommendations on.

So the gaps, what has been covered and what has not been covered, and a framework from him on items which might even be outside

the box of the Task Force, but that need harmonization.

And that was his word, harmonization. So he recommended in that framework to us that we take a look at the reports of the major committees and agencies that have made recommendations on the wounded, ill and injured.

So the Research Team, I assure you, did most of this work. There are a lot of reports that have been done. So we had to cull that down a little bit.

And we're going to take a look at recommendations from the major committees. We're going to look at the status of those recommendations. And we're going again try and see what the gaps are.

What's been implemented? What hasn't been implemented? So I am going to ask you, would you please Steven? Okay, so we'll talk a little bit about how we do incorporate these findings into your reports.

Long story short, when you come up with a recommendation, the research team does a literature search. And they find other reports that have made a similar recommendation

And they utilize the information and the data, and they incorporate it into your findings to add substance to your findings.

So you don't get briefings on every report that has come out in the last ten years, or five years. But the research staff has got a pretty good purview of what's out there and brings it into your recommendations.

No, the next slide. All right, so I've kind of gone through this slide already. We are going to talk about the major reports. We are going to talk about the recommendations of those reports.

And we're going to look for what's been implemented and what hasn't been implemented. Maybe have a little discussion

about why haven't been implemented. Are they still important?

Can we add something to that body of knowledge? Is it a direction for recommendations that you want to go down? Okay, next one. Okay, so also covered this a little bit.

This is some of the specifics that talks about what we have, and how we do this research for you. We send out what's called an RSS feed, and you get that on a quarterly basis.

You get two items per topic area, the charters topic areas. The research team sends out to their topic leads, like, ten articles, or ten reports. But what we send out to you is probably the two most relevant items that came in on that RSS feed.

So we have a way to get you very focused information, but the people who are studying this topic get it much broader. And that's what this slide is talking about.

Okay, next slide.

All right, so I have a line here that says since FY '11, that means since we started the task force, we have been through a series of reports. We have looked for the most relevant ones.

And over these last three years we, The Task Force Research Team, picked out 13 major reports that have come out since 2007. And again I had to limit it, so I took these last six, seven years from 2007 to 2013, so last seven years.

Thirteen major reports and they are listed here. In the back of this briefing the 13 major reports and all of their recommendations are listed.

So if you are interested in what the recommendations of the 13 major reports have been from these last seven years, you'll see a Word document of about ten pages that lists all of those recommendations.

So then out of this 13 we then pick

the top five reports. And we are going to go over the top five reports, their recommendations, and somewhat a subjective evaluation of whether those recommendations from those five reports have been implemented.

And again, from that we're going to come to a slide that talks about what hasn't been implemented. Is there a place for us in that space for recommendations for the task force. Okay, next slide.

This slide, real quick, talks about where we have pulled in other recommendations for the Task Force's recommendations over the last three years. Next slide.

So these are the slides, these are the five reports that we have selected and their recommendations that we are going to look over.

So The President's Commission on Care for America's Returning Wounded, Ill and Injured Servicemembers commonly referred to the Dole-Shalala.

This next one, which is commonly referred to as The RAND Report, basically put a stake in the ground on what it's most, many relevant findings.

Ms. Gilman mentioned that she's got RAND working with her on her research. But this report, if you remember we commonly say 12 percent to 20 percent of returning combat servicemembers will be experiencing PTSD.

This is the report that that came out of. That's been a real stake in the ground for measuring PTSD rates among the combat.

So significant reports, one of the reasons why we selected it. The Franks Report, this was an internal Army report actually.

And I'm not even sure it's ever been fully published, but it had a number of significant recommendations in the area of IDES. So we thought it was going to be relevant here.

The next report is, and I think Ms. Gilman also mentioned this one. This is The Center for New American Security and it is kind of a think tank event.

We selected it because it was actually kind of out-of-the-box thinking from a non-DoD entity. And it had some interesting recommendations which I have, we really couldn't assess very well, but I wanted to show them to you.

And then the last one we got a briefing on last fall was the first report from The Institute of Medicine on Psychological Health. Okay, next one.

All right, so Dole-Shalala, Dole-Shalala made six, I thought it was seven, but I think number two is broken down into two recommendations.

The Dole-Shalala recommendations were kind of a broad framework for moving forward much of what we see in our culture of wounded warrior care now.

And of course the first one is the Comprehensive Recovery Plan and the status for that, although we can argue about whether people know about it or not. It's out there.

It is a part of the wounded care culture without much doubt. How well it's implemented at various locations is debatable, but it's a part of our culture, so, well inculcated.

The second one is an IDES recommendation and I call it The Cultural Change of the IDES Concept, changing the benefits, changing the way we look at disabilities.

And this one didn't get traction, so under my status here I have no checkmark. Now it's broad. It includes some things that have happened, but the genesis of this second recommendation, which is a culture change on how we evaluate disabilities, how we assign benefits, did not make it into our current lexicon of care and disability evaluation.

The other, Post Traumatic Stress, I put a check on this because we can agree there has been a lot of work done on post traumatic stress. Just a bevy and we got a good look at it today.

So I put a check by that. Support for Families, I put a check by that. I don't think any of us are satisfied yet about the status of families, the level of information they receive, how well they are inculcated.

And you know, anybody uncheck these boxes anytime if you want to leave them open. But I did bring this one in to being well worked by the Department of Defense, if not efficiently worked.

And then the last one, the number five, transfer of records between services, transfer of records between DoD and VA. Probably another one where you'd kind of like to say no, not really. But not neglected.

Not worked well, but not neglected. Not kicked to the curb. It's been worked.

Whether successfully or not is subjective and I am happy to uncheck these blocks at any time.

And the last one was, I do find the last one kind of ironic. As we heard today, you know The Bethesda Hospital, now Walter Reed National Military Hospital, is overmanned.

One of the big emphases of Dole-Shalala was to make sure they didn't shut down Walter Reed, fire everyone and then have to start up again at Bethesda.

And really, you know, five or six years later what you have is an over manning and an imbalance, but that was the outcome of keeping everybody on the books and not having a gap in service providers.

So Dole-Shalala six, seven, however you want to look at it. The one that's really not been worked is the culture change in the IDES benefits disability evaluation.

Not that a lot of work hasn't been

done there, but that culture change and how we are going to evaluate disability is not in a discussion.

All right, so RAND is our next, these are RAND's recommendations. Increasing cadre, again I put checks on these because we have seen a lot of data on how this is moving forward.

Again, subjective, I can take them off at any time. But again, these are not recommendations that aren't being worked. They are in the discussion, so to speak.

Seek care, this is the stigma recommendation, and to eliminate stigma. Psychological health, how to get people to care. Again a lot of work is being done in this area.

Evidence based treatment, number three. Number four, invest in research. Again, lots of recommendations, lots of work done on these recommendations, so they are not lacking in evidence.

They are not lacking in work by other committees. Our value added to these groupings of recommendations might not, or might add to the weight, but are we adding anything new? Next one.

And we move on to The Franks Recommendation. So, a lot of things the Army's done to implement The Franks Recommendation's specifics. This was a tactical, was both a tactical report by General Franks and a strategic report.

And the strategic piece being number two, which was a national dialogue on establishing paradigm shifts away from our current system.

And then recommendation three, transforming the compensation and disability evaluation processes to address rehabilitation and transition back to either uniform or service in the military.

I didn't put checks there. Not a lot of progress on this lane, again. We've

got command emphasis on getting through the PB, MEB, a tactical recommendation.

I think I am going to agree that's there. And then we are also educating cadre, bringing people, informing them, and this was also relevant in the USAR and The National Guard.

So again, somewhat subjective on this one. If you don't think we're there on that one then, you know, I can uncheck that block. But it's talked about. There's policy out there.

It's got programs and money. Whether it's been effective or not is again, subjective. All right. And then we had some more recommendations by Franks, yes. NARSUMs, you know, we talk about NARSUMs.

We've made recommendations on NARSUMs, legal assistance. In many ways this is very gratifying here to look at these recommendations and see how much work has been done.

And you're also reinforced a lot of these recommendations. So many of these are worked, working, or worked and not working.

And next slide we'll talk a little bit about, I didn't check these for The Center for New American Security. They were very broad. And they were very strategic in nature. A whole new definition for caring for our wounded warriors was this first one.

Now I'm not sure that it hasn't been addressed by President and Mrs. Obama's initiatives on coming home. She's done a lot of work on The Coming Home Program.

Not sure that we aren't addressing it answering this one with the President's initiatives. I don't think we're fully satisfied with number two, which is the partnership between us, DoD, VA and the civilian environment.

It's not that we don't see a lot of collaboration between DoD and VA, but are we seeing enough collaboration with the civilian

entities such as the non-profits that Ms. Gilman just talked about.

The colleges that we have visited and saw the collaboration down in Tampa. So this one has a lot to do with our outreach to the civilian community, not necessarily intergovernmental.

And I think three has been addressed very significantly. And a lot of the language in three is captured in the current Inter-Agency Care Council, so three has got some traction in DoD and in VA.

A lot of the language in this recommendation is captured in the IC3 language that we are continuing to kind of punt to, to fix some of the inter-agency issues we see.

All right, now The Institute of Medicine's study had to do with psychological health. And so the questioning here is we've done a lot of work on psychological health, a lot of agencies have done a lot of work on psychological health, do we have more work to

do for our recommendations in the areas of psychological health?

I didn't check this first one, but I do think that the most recent DVBIC, clinical practice guidelines that we were circulating among the task force, kind of answers number one.

Now I did this briefing back in October and we were just circulating that information this week. But I do think that this collaboration on the clinical practice guidelines not only for TBI, but also for psychological health, has been answered.

And I could put kind of a check here with some confidence. Number two talks about increasing the number of psychological health providers in both the VA and the DoD.

We've made recommendations along that several times. I think last year we kind of came to the conclusion that the amount and the training is satisfactory.

Effectiveness, evidence based

treatments, metric outcomes is where, as of last year, you all wanted to put your emphasis, but this train has moved along enough that we think numbers are probably good and training is in place.

It's all there. How well it's working is again subjective. So three is very similar. Recruit, hire, train. We kind of think they have that down.

Again your emphasis has shifted from those premises to measure, evaluate effectiveness, determine what's working and what's not working.

Then they also talked about, number four is very big one that I think is being answered by IC3. So items that are checked kind of have got a lot of work behind them.

We can see success over the time period of these major recommendations. They are repeating themselves in many of these recommendations in different language and different vernacular.

So what, if we look at all these, what is unimplemented? Are there trends across all of these that are unimplemented? Do we have a place to make a recommendation about unimplemented recommendations?

So when you look at them, these are the ones again, I came up with. This is the generational change to IDES. Again not seeing a lot of work in this area, although a lot of work is being done in IDES.

There is no one seriously looking at a different disability benefits system.

(Off microphone comment)

DIRECTOR DAILEY: Yes. No traction.

(Off microphone comment)

DIRECTOR DAILEY: Yes, I do. If you, I am happy for, yes --

CHAIR CROCKETT-JONES: I think that, yes, I think that there is a lack of political will. There is a lack of traction. There is a cost benefit, you know, wall that we hit.

But I think that there also is sort of a cultural component of this, which is, I know that we, as we've gone around and looked, you know servicemembers feel like the process is confrontational and somewhat punitive.

And I think that there is a portion of the population that wants to keep it that way. You know I think that that's part of why there is no traction for change is because there is a sense of who deserves benefits.

Do you see, do you see what I'm saying? And so I think that this is a really, really hard one that I'm not saying that we shouldn't make recommendations in this.

I think that in this area we should, you know, leaving our voice with however the task force feels, voicing it regardless of how it might be received might be important.

But I do think that this is one that has a number of reasons why it is not going to get traction.

MEMBER PHILLIPS: I was looking at it from a little different point of view though. I don't disagree with what you are saying. I think there have been a lot of technical issues that have been stumbling blocks for this to occur.

The lack of harmonization or integration of electronic health information within the DoD and the VA, not so badly within the VA, and also between the DoD and the VA.

And hopefully with the new effort to create a single, or a harmonized, electronic health record with health information transfer, might make it easy then for people to go back and say well you know, we have all the information now.

There are a lot of duplication and similar things that both groups are doing, even though we may have different outcome expectations or recommendations.

I think we could, you know, look at a way to make this a better system. And I

would, you know, encourage us to consider sort of a recommendation along those lines, related to the fact technology now while going forward will permit us to make this a better single or integrated system whether it's on the VA side.

I mean there is a lot of thought that the DoD should not even be doing this. So I think we have an opportunity to at least have a say in what's going to go forward.

(Off microphone comment)

DIRECTOR DAILEY: Okay. And then this, the other areas that I left unchecked, had to do with the very, you can change the slide, had to do with this harmonization between agencies and non-profits.

So these are a lot of the recommendations that came out of the CNAS study about interweaving all of these efforts together and creating better bridges and crossroads into the civilian environment.

This is where their emphasis had been on. And think we all can agree there is

a lot of work being done in the DoD/VA piece.

But as we've seen in Tampa, when we were out at Utah with the community based warrior transition unit and their work with the rehabilitation center, there was a lot of harmonization of their efforts and our efforts that have not gotten traction.

And I think this is also a part of your concern Dr. Phillips, that we are utilizing these resources in the civilian sector.

CHAIR CROCKETT-JONES: Yes, The National Ability Center out in Utah was that, it was that example. And yes we certainly have seen sort of anecdotal, or grassroots, or localized collaboration and partnerships but they all seem to have had to overcome obstacles from above as far as the DoD goes.

You know even, then in some cases it's almost like the DoD was the obstacle to making those partnerships happen. And that is a concern.

I mean there are other places we have seen it, but isn't that what we've heard from folks that have been trying to make these sort of local collaborations, is that the, you know, DoD makes it difficult rather than, yes.

MEMBER PHILLIPS: No, I agree. I mean it's an issue that people address but we haven't really attacked it. When you think about roughly 22 million servicemember veterans being provided care, roughly 50 percent of that care is outside of the VA system.

And so, you know, when half of the people are being, I don't want to say ignored because they're not, but not within capture, then I think that creates difficulty.

DIRECTOR DAILEY: So, went through these five reports, looked at what's been worked real hard and what hasn't been worked real hard.

And so subjective assessment brings us to this kind of universal dialogue about

disability, benefits, how do we allocate fairly and what's a new paradigm for doing that.

And then how do we strengthen the ties with our civilian partners, and bringing our civilian non-inter-agency, non-governmental partners into caring for the servicemember and the veteran.

So those are kind of the gaps that I would leave you with as you, as we go into our last meeting, which will be in February. It's not our last meeting. It's our last information gathering meeting.

And I'll have time in that meeting where we'll review what we went over in October, talk about some recommendations that you've voiced already.

We'll review this and we'll kind of set the stage for the next meeting, which will be in May, for how do you want this last report to look? Questions? Okay. Thank you very much. I will see you all tomorrow

morning at 8:30. Is that right 8:30?

CHAIR CROCKETT-JONES: 8:30.

DIRECTOR DAILEY: 8:30, 8:30.

CHAIR CROCKETT-JONES: That's what you have on the sheet so I am living by it.

DIRECTOR DAILEY: And that's when we're doing it, 8:30. I know, you know, I usually have in here at 8:00 cracking the whip, but I gave you all a half hour now, so.

(Off microphone comment)

DIRECTOR DAILEY: I know, I know. Yes.

CHAIR CROCKETT-JONES: It's too cold to make anybody get here at 8:00 I think. So 8:30's great.

DIRECTOR DAILEY: Oh yes, me too. It's too early. Okay, thank you. And you know, it's your last year, ladies and gentlemen. I'm cutting you all this slack, I know. Thank you.

(Whereupon the meeting was concluded at 4:35 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: January Business Meeting

Before: Task Force on Recovering Wounded

Date: 01-27-14

Place: Arlington, VA

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter