

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

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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

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

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

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

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

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

22 MEMBER KEANE: Lieutenant Colonel

1 Keane, representing the Marine Corps Reserve.

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

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

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

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

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

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

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

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

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

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

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

22 The first installation visit in

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

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

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

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



1 that impact the wounded, ill and injured  
2 population.

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

11 Due to weather they cancelled the  
12 scheduled installation visit to Hunter Holmes  
13 McGuire VA Medical Center, and the Polytrauma  
14 Rehab Center in Richmond, Virginia, the  
15 Portsmouth Naval Hospital in Portsmouth,  
16 Virginia, and the MEDHOLD East in Virginia.  
17 That visit will be rescheduled for 4 through  
18 5 March.

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

22 And let's begin, if we could, with

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

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

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

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

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

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

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

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

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

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

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

22                   CHAIR CROCKETT-JONES: Yeah, I'd

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

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

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

22           Families suddenly have this moment

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (No response.)

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

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

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

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

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

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

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

1 VA mission at the same time.

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

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

22 The other thing that I found that



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 DIRECTOR DAILEY: Yeah. Fort  
16 Hood, the --

17 CHAIR CROCKETT-JONES: And that  
18 was the --

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

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

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

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

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

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

1 very good.

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

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

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

1 paperwork process, and that sort of thing.

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

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

14 CHAIR NATHAN: Soft Crossroads.

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

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



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

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

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

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

19 CHAIR NATHAN: Yeah.

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

22 CHAIR NATHAN: And we've invited

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

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

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

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

22                   At SOCOM, I was very impressed

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

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

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

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

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

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

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

22 But again, it highlights how, if

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

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

16 Other comments about the Tampa  
17 area?

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 (Whereupon, the meeting in the  
7 above-entitled matter went off the record at  
8 9:16 a.m. and back on the record at 9:34 a.m.)

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

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

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

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

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

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

1 familiar with the Vision Center of Excellence.

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

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

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

1 responsibilities of this center.

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

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

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

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

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

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

22           We provide leadership and advocacy



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

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

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

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

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

13                  We work closely with the other  
14                  Congressionally mandated Centers of  
15                  Excellence, the Defense Center of Excellence  
16                  for Psychological Health and TBI, the Hearing  
17                  Center of Excellence, and the Extremity and  
18                  Amputation Center of Excellence.

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

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

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

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

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

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

1 develop the clinical recommendation.

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

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

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

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

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

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

16                  DR. LAWRENCE: Right.

17                  CHAIR NATHAN: Many times, which  
18                  these are interconnected.

19                  DR. LAWRENCE: Right.

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

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

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

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

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

22 And the neurosensory aspects,

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

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

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

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

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

5 CHAIR NATHAN: Tunnel vision, as  
6 it were.

7 DR. LAWRENCE: Exactly. Karen.

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

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

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



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

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

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

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

22 But we have, it's been an open,

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

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

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

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

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

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

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

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

22 And then from there we collaborate

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

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

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

21 CHAIR NATHAN: Okay. Thank you.

22 MEMBER PHILLIPS: A question.

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

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

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

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

22 Okay. So we divide eye injury or

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

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

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

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

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

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

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

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

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

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

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

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

19 DR. LAWRENCE: That's a very good  
20 question. And it's something we are trying to  
21 address. And we've put a clinical  
22 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.

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

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

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

22                  And my colleague I was working

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

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

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

22 And so, that's the age group of

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

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

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

17 DR. LAWRENCE: Right.

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

1 we'll get to that.

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

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

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

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

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

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

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

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

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

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

19 DR. LAWRENCE: Yes.

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

1 DR. LAWRENCE: Yes. Not all --

2 CHAIR NATHAN: Salaries are  
3 competitive?

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

7 CHAIR NATHAN: Okay.

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

10 CHAIR NATHAN: Right.

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

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

1 care.

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

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

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

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

21 DR. LAWRENCE: Correct.

22 CHAIR NATHAN: Okay.



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

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

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

19 DR. LAWRENCE: Okay.

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

1 DR. LAWRENCE: Okay.

2 DIRECTOR DAILEY: So we're good on  
3 time.

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

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

13 DR. LAWRENCE: Yes.

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

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

18 CHAIR NATHAN: This is --

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

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

1 DR. LAWRENCE: Okay.

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

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

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

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

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

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

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

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

18 DR. LAWRENCE: Sorry.

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

21 DR. LAWRENCE: Right. Sorry.

22 IOC, I apologize, in the beginning of Q3. And

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

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

11 We use other data sources, like  
12 registries like the Joint Theater Trauma  
13 Registry, and the Combat Trauma Registry. And  
14 all of those data sources dump into the  
15 Defense and Veterans Eye Injury and Vision  
16 Registry. As of January 8th we had almost  
17 23,000 unique patients enrolled into the  
18 vision registry.

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

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

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

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

14 DR. LAWRENCE: Thank you.

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

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

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

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

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

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

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

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

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

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

22                   CHAIR NATHAN: So, you're going to



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

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

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

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

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

1 then can be followed longitudinally every  
2 time.

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

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

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

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

5                   DR. LAWRENCE:   And we've been able  
6                   to get VA providers and DoD providers that  
7                   have been working together on this since, what  
8                   --

9                   FEMALE PARTICIPANT:   2008.

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

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

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

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

1 articulate it.

2 DR. LAWRENCE: Yes.

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

11 DR. LAWRENCE: Right.

12 CHAIR NATHAN: Okay. Next.

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

16 DR. LAWRENCE: Absolutely.

17 Absolutely.

18 MEMBER PHILLIPS: Terrific.

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

1 is a clinical recommendation that we worked  
2 with DCoE.

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

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

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

22                   We've been working on initial

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

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

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

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

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

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

13                    CHAIR NATHAN: No, we understand.

14                    DR. LAWRENCE: Okay.

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

18                    DR. LAWRENCE: Right.

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

21                    DR. LAWRENCE: Correct.

22                    CHAIR NATHAN: Your Center of

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

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

10 DR. LAWRENCE: Yes.

11 CHAIR NATHAN: Got it.

12 DR. LAWRENCE: Yes.

13 CHAIR NATHAN: Thank you very  
14 much.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

1 VCE partnerships and collaborative  
2 relationships, and to increase the quality,  
3 quantity and consistency of VCE  
4 communications.

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

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

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

21 (Videos played)

22 DR. LAWRENCE: So these were two

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

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

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

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

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

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

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

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

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

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

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

22 There are 67 funded research

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

7 We have established and chair an  
8 interagency research scientific steering  
9 committee. We have chaired the Clinical and  
10 Rehabilitative Medicine Research Program,  
11 CRMRP, the JPC, Joint Programmatic Committee-  
12 8, which is auditory, vestibular and vision  
13 committee.

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

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



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

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

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

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

1 '13, we had a symposium on telemedicine in the  
2 DoD and VA. And American Academy of  
3 Ophthalmology, that's the largest  
4 Ophthalmology meeting in the world.

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

12 When the Boston Marathon bombing  
13 occurred, we knew that there would probably be  
14 eye injuries. And yes indeed, there were. We  
15 were on the phone to the providers at several  
16 of the medical centers where the victims were  
17 taken. We had weekly conference calls,  
18 putting together our oculo-plastics and retina  
19 doctors in the military with the Harvard  
20 affiliated doctors, and BU affiliated doctors.

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

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

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

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

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

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

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

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

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

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

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

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

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

20 DR. LAWRENCE: Yes.

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

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

6                     DR. LAWRENCE: Oh, okay.

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

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

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

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

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

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

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

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

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

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

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



1 their academic standing.

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

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

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

16 DR. LAWRENCE: Yes.

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

1 are received?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 DIRECTOR DAILEY: And two minutes,  
4 Dr. Lawrence.

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

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

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

22 I've already talked about

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

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

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

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

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

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

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

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

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



1       advancements and everything is circulatory?

2                       That the ideas are coming around?

3       That administratively things are working

4       through? Or is it, the brain doesn't know

5       what the hands are doing? So would that be a

6       benefit to be a sitting member of that?

7                       DR. LAWRENCE: I guess that's --

8       We are invited, and we speak. And we're

9       freely allowed to speak. And I've raised my

10       hand and been able to speak. So whether the

11       Directors of the COE should be voting members

12       when, I don't know. Whether an oversight

13       board, the people that are being overseen,

14       should be voting members.

15                       So I guess that's not for me to

16       decide. But I will say that they've been very

17       open in the past. There's also talk, and you

18       may have heard that the COEs may be moving out

19       from under the individual Services. I think

20       that the MHS is thinking about where the best

21       place for these COEs to be, whether they

22       should be under DHA or not.

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

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

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

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

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

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

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

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

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

17 DR. LAWRENCE: Absolutely.

18 CHAIR NATHAN: -- in the retinal  
19 exam --

20 DR. LAWRENCE: Absolutely.

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

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

3 CHAIR NATHAN: Okay.

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

11 CHAIR NATHAN: Yes.

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

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

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

3 CHAIR NATHAN: Very good.

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

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

9 DIRECTOR DAILEY: Okay.

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

12 DIRECTOR DAILEY: Okay.

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

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

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

3 DR. LAWRENCE: I have a son at  
4 Yale.

5 CHAIR NATHAN: Okay. All right.

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

8 CHAIR NATHAN: All right. Thank  
9 you again.

10 DR. LAWRENCE: Thank you so much.

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

14 (Whereupon, the meeting in the  
15 above-entitled matter went off the record at  
16 10:51 a.m. and back on the record at 11:03  
17 a.m.)

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

22 CAPTAIN KASS: Yes, sir.

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

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

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

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

1 we --

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

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

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

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



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

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

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

1 felt that they should achieve.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 So I think that it is as important  
5 that we pay attention to our clinical  
6 productivity as it is pay attention to the  
7 research productivity that we deliver.

8 Because I think, really, to separate one from  
9 the other will shortchange what we're able to  
10 do. So that is the foundation on where we're  
11 moving forward in.

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

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

1 the window to dementia.

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

5 So we address those early on, so  
6 that we can actually intervene more quickly,  
7 and target that individual's problems.

8 Combining integrative medicine, such as ART  
9 therapy, acupuncture, animal assisted therapy,  
10 as examples, with traditional therapies, then  
11 enhances insights into the symptoms and the  
12 causes of suffering for that individual.

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

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

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

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

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

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

22           CAPTAIN KASS: So the second

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

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

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

18 Our overall staffing plan is for  
19 117 total FTEs. We're currently at about 72  
20 percent staffing. The civilian staffing is  
21 only at 64 percent. And the area where we're  
22 taking the most significant, I guess reduction

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

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

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

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

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

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

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

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

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

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

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

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

13                   CAPTAIN KASS: Yes, sir.

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

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

22                   CAPTAIN KASS: Yes, sir.

1 CHAIR NATHAN: Okay.

2 CAPTAIN KASS: Dr. Kelly.

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

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

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



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

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

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

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

1 go forward.

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

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

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

13 DR. KELLY: Okay.

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

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

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

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

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

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

22 Even at that time our

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

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

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

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

1       circumstances.

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

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

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

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

1 original plan.

2 CHAIR NATHAN: Okay.

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

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

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

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

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

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

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

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

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

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

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

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



1 four week intensive model.

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

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

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

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

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

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

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

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

22 And finally, the other important

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

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

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

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

1 our outcome metrics.

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

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

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

17 DR. KELLY: June 24th, 2010.

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

22 DR. KELLY: We've seen

1                   CHAIR NATHAN:   About TBI.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 CHAIR CROCKETT-JONES: Yes.

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

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

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

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

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

1 the year to come.

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

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

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

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

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

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

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

17 CHAIR NATHAN: So, Sara --

18 CAPTAIN KASS: Yes, sir.

19 CHAIR NATHAN: Questions 7 through  
20 10, really the spirit of them. If you could  
21 frame your answers in this spirit. The Task  
22 Force is aware that numbers of people with



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

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

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

18 CAPTAIN KASS: Yes, sir.

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

21 CAPTAIN KASS: Export that.

22 CHAIR NATHAN: -- export that in

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

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

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

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

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

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

15 CAPTAIN KASS: Yes, sir.

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

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

22 But in the discussions about

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Mr. Fisher, unannounced I am told,



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

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

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

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

1 told, toward the end of this coming summer,  
2 2014.

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

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

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

22 And for Intrepid Spirit Camp

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And as more of these satellites

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

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

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

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

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

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

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

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

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



1 have access to, a couple of times.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1       made. Does anybody have anything else to add?

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 great while they were at NICoE?

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

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

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



1 patients.

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

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

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

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

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

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

11 (Whereupon, the meeting in the  
12 above-entitled matter went off the record at  
13 12:12 p.m. and back on the record at 1:01  
14 p.m.)

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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.

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

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

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

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

1 ICU nurse.

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

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

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

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

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

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

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

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

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

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

22 And we need to gather that

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

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

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

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

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

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

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

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

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



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

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

10 So we should be about pushing  
11 evidence based practices. And then as we know  
12 what they are, making everything again to sort  
13 of translate that knowledge into practice.

14 And then within my first week in  
15 my brief turnover with my predecessor, Captain  
16 Paul Hammer was my one time I went to the  
17 SMMAC, and he provided the overview of DCoE's  
18 program evaluation that they had done on  
19 roughly 140 -- you have a question, sir?

20 MEMBER DRACH: Yes, Captain,  
21 before you move on.

22 CAPTAIN STOLTZ: Please.

1                   MEMBER DRACH: I know that you all  
2                   have had a relationship with SAMHSA, probably  
3                   since very much the beginning. Do you have  
4                   any relationship with the National Institute  
5                   on Disability and Rehabilitation and Research?

6                   They just put out, I guess in mid  
7                   December, early December a notice in the  
8                   Federal Register that they're setting up an  
9                   advisory, I think it's called an advisory  
10                  council, a research advisory council, RRAC.

11                  I forget what the RR stands for.  
12                  One of them is research advisory council.  
13                  Rehabilitation Research Advisory Council.

14                  And one of their goals, or one of  
15                  the roles they see is counsel taking on is  
16                  giving advice on the counsel for research,  
17                  what kind of research should be done on  
18                  disability.

19                  And when I read the Federal  
20                  Register notice, I was thinking is there some  
21                  way that you all, or DoD in general, would be  
22                  willing to or able to collaborate with this

1 new RRAC?

2 Now the caveat is that the RRAC  
3 will be stood up, depending on the  
4 availability of money. So it may or may not  
5 come to fruition. So just something to get on  
6 your radar.

7 CAPTAIN STOLTZ: Well we  
8 appreciate that comment. And we definitely  
9 are involved with the rehab component. I  
10 personally have not had interface with them  
11 myself. I don't know if we can --

12 DR. CERNICH: Yes, sir. So we do  
13 meet with NIDRR, both in my capacity with VA,  
14 we collaborate firmly with NIDRR for the TBI  
15 model systems.

16 But we also, Ms. Helmick and I  
17 both sit on some research advisory committees  
18 at MRMC related to some of the consortia  
19 awards for TBI.

20 And so we're also in conversations  
21 with them there. We've also looked at with  
22 MRMC in looking at how we help them with the

1 gap analysis piece, whether we should stand up  
2 an advisory council.

3 And what we're doing right now as  
4 part of the work that we're doing with them on  
5 knowledge translation is determining what  
6 counsels we would have to set up and what the  
7 mechanisms would have to be for that.

8 And as you know, there's a lot of  
9 regulations around setting up federal advisory  
10 councils. And so you have to do that very  
11 carefully within a research process,  
12 especially when there's acquisitions involved.

13 CAPTAIN STOLTZ: Okay, so I  
14 appreciate your question, sir. Anyway, when  
15 I was here in my first week and the SMMAC was  
16 briefed on where we were with the program  
17 evaluation of roughly 140 or so psychological  
18 health programs, there was obviously  
19 tremendous interest in that.

20 And for good reason. Many of you  
21 remember the time not too long ago where there  
22 was a whole bunch of money that was thrown in

1 to starting programs relating to psychological  
2 health and TBI care.

3 And so a lot of programs started  
4 up, and there was a desire now that we knew  
5 that the money was going to be shrinking, how  
6 do we know which programs worked, which ones  
7 didn't, what components were more effective.

8 And so DCoE undertook that. And  
9 there remains a tremendous amount of interest  
10 in that. So that is one of the core functions  
11 that we were doing last year, and if anything,  
12 we're stepping up services on it this year.

13 And then the last thing that's  
14 very, very important to me because I came into  
15 DCoE and I learned pretty quickly, boy,  
16 they've put out a lot of good products.

17 But before I came to DCoE I didn't  
18 know what they were. And so how many  
19 providers are there out there that are not  
20 aware of all these wonderful things that DCoE  
21 has produced? And so how do we get these  
22 things out to more of our providers.

1                   And so we are stepping up our  
2 emphasis on penetrating through on that level  
3 so that all the work that we did, we can start  
4 to experience it, having a positive impact on  
5 patient outcomes.

6                   So this is the last slide I have  
7 before going into answering all of your  
8 questions that you had for us. These are just  
9 some things that we do that impact the system  
10 of care.

11                   How do you know if something's  
12 effective or not if you don't have a way of  
13 measuring it? And if you have a lot of  
14 different programs that, first of all they may  
15 not even be measuring anything.

16                   But then if they are measuring  
17 something, what they're measuring is very  
18 different from program to program and then you  
19 can't compare.

20                   So one of the things we're doing  
21 to impact the system of care is coming up with  
22 tools that standardize outcome measures and

1 system performance, and even ways to measure  
2 cost across the board so that we can begin to  
3 better understand the effectiveness of various  
4 programs.

5 We already talked about the  
6 program and evaluation. We've already talked  
7 about the importance of sort of the book ends  
8 piece of research, having good input, as well  
9 as the importance of translating the completed  
10 research to the field.

11 And then there are three joint  
12 incentive funds projects that DCoE is  
13 currently doing that I think will impact the  
14 system of care.

15 There's an awful lot of chaplains  
16 in the DoD and the VA. And there's a lot of  
17 people that like to go to them as opposed to  
18 formalized behavioral health providers.

19 Chaplains have confidentiality.  
20 And how well do we work together, and how well  
21 trained are those chaplains to deal with some  
22 of the common issues that walk in the door of

1 behavioral health providers?

2 So we have a pretty extensive  
3 training going on now with chaplains that we  
4 think will make the link between behavioral  
5 health providers and chaplains better, as well  
6 as chaplains more effective in what they're  
7 doing as they're dealing with our  
8 servicemembers.

9 The problem solving training and  
10 primary care settings. That's pretty much  
11 connected to medical home.

12 That's pretty much taking  
13 advantage of people that might, again, be  
14 reluctant to see and go through a formal  
15 evaluation with a behavioral health  
16 professional, but will come in and see their  
17 doctor, have easy access to learning a process  
18 that can help them deal with the issues  
19 they're facing in their life that can help  
20 them get better and hopefully prevent them  
21 from developing more severe psychological  
22 symptoms.



1                   And then the last thing of the  
2                   practice-based implementation network in  
3                   mental health, this is a project aimed at  
4                   identifying 10 to 15 or so different sites  
5                   where we will work with them, help them better  
6                   track, in particular, their PTSD cases.

7                   What are the barriers, what are  
8                   the obstacles, what can we do to have that be  
9                   more effective? And by working very closely  
10                  with these sites and having them do things  
11                  we're suggesting and working with them, we  
12                  hope to make some significant progress there  
13                  that can then be expanded to other sites  
14                  throughout the MHS.

15                  So now we are to your responses to  
16                  questions. And of course, the first question  
17                  has to do with those 11 PH and TBI programs  
18                  that were studied by RAND in 2011. And what's  
19                  the outcome of the eight remaining  
20                  evaluations? And next slide please. And so  
21                  think you can see that those are all pretty  
22                  close to being completed.

1           You know, data analysis, one's  
2 still writing a report, waiting security  
3 evaluations. And we're giving you what we  
4 think will be when they'll all be completed.

5           And then sort of the main outcome  
6 of that was this, we found in that first  
7 program evaluation where we looked at roughly  
8 140 programs that many of those programs did  
9 not have any good evaluation internally.

10           And what the RAND study has  
11 produced is four different manuals that go  
12 about telling people that have a program  
13 internally how they can build in their own  
14 self monitoring of that program, how they can  
15 build in process improvement, how they can  
16 build in evaluating themselves because then  
17 you have a stronger program.

18           Then you're engaging on better  
19 understanding how effective you are and if you  
20 try certain things to change it, whether or  
21 not it improves it.

22           So those four manuals were just

1 released by RAND, and we're hopeful that many  
2 people will utilize those. It's not real  
3 complicated program evaluation.

4 The stuff that we do at DCoE is  
5 far more sophisticated and involved. But it's  
6 much better than just starting a program and  
7 coming up, well this is what we're going to  
8 try to do and not have sort of a structured  
9 approach to your own type of evaluation.

10 So the next question has to do  
11 with developing standardized measures for TBI  
12 care. So you can see that we do in fact now  
13 have two that are approved.

14 We worked with the services to  
15 come up with those two. Initially there was  
16 some debate about other measures. Many of  
17 these are already in use.

18 But we reached a consensus in  
19 collaboration with Health Affairs and all the  
20 Services about what these should be. They  
21 were then briefed.

22 I briefed them and then Colonel

1 Hinds, the Director of DVBIC, together we  
2 briefed them to the Policy Advisory Council.  
3 And they agreed with them. And supposedly now  
4 they're being written into policy.

5 In addition to that, in September,  
6 Dr. Woodson wrote policy on three  
7 psychological health measures that are now  
8 mandated through the MHS, one for anxiety, one  
9 for PTSD and one for depression.

10 And all of these instruments are  
11 very easy to use. They're short, only take a  
12 few minutes.

13 I think many of you might be  
14 familiar that the mechanism is through the  
15 Behavioral Health Data Portal, which is an  
16 Army product that is currently throughout the  
17 Army medical system that's also in the process  
18 of spreading throughout Navy and Air Force.

19 And that will hopefully be  
20 completed sometime this year to at least get  
21 many of them on. So it's a very convenient  
22 way to implement what has been signed into

1 policy.

2 So the next question was 1C and  
3 talking about the relationship between DoD and  
4 VA. And this is really a tremendous success  
5 story. If we can go to the next slide.

6 So if we see that first bullet  
7 where we have 300 vet centers now that can  
8 treat active duty servicemembers. And I've  
9 got some numbers here I can quote for you that  
10 450,162 have received services at these vet  
11 centers.

12 I mean, that's 40 percent of the  
13 people. This is vet centers that frequently  
14 are staffed by peers, peers that are doing  
15 well, that served overseas.

16 It's been cited as a success story  
17 by the U.S. Medicine Institute for Health  
18 Studies. And I'll quote one of the things  
19 that they said, that the VA Vet Centers have  
20 proven to be a best practice model in  
21 fostering peer to peer relationships for those  
22 with combat stress disorders.

1                   The best way to overcome concerns  
2 about stigmatization is through person to  
3 person contact with someone who has recovered.  
4 So tremendous success here with this.

5                   But that's not the only way that  
6 we are cooperating with the Veteran's  
7 Administration. And we have other things on  
8 the next slide.

9                   So you know, the Senior Oversight  
10 Counsel came up with a DoD/VA integrated  
11 mental health strategy. They divided it up  
12 into 28 different parts. DCoE had the lead on  
13 16 of those parts.

14                   And as you can see that those  
15 parts are put into those four categories,  
16 everything from the integration of mental  
17 health into primary care, which is very much  
18 one of the best ways to reduce stigma because  
19 if you can get somebody into primary care and  
20 you have behavioral health nearby, right  
21 there, then maybe it's much easier to get them  
22 into that as opposed to getting a more formal

1       consult, and then going somewhere where  
2       they're getting a full eval, vice just  
3       responding to the question of the primary care  
4       provider that they saw.

5               Lots of working together to ensure  
6       quality and continuity of care and evidence  
7       based approaches to PTSD.

8               You know, with the stigma, if you  
9       have a person that has a problem and finally  
10      breaks through that, and then goes sees a  
11      provider that doesn't help them very much,  
12      well that just is not very helpful at all.

13              So a lot of effort has gone into  
14      people working very hard to establish what are  
15      the most effective treatments in getting that  
16      word out so we don't have people that are  
17      struggling finally break through that barrier  
18      and then not get help.

19              And I will tell you, I think this  
20      is very important, many of these cases are not  
21      easy cases. I'm somebody that's treated an  
22      awful lot of people with PTSD.

1                   But I will tell you those  
2                   returning from Iraq and Afghanistan frequently  
3                   had the most complex and difficult to treat  
4                   PTSD that I have ever encountered.

5                   And there's numerous reasons for  
6                   that. One is that there's multiple traumas as  
7                   opposed to one trauma. Two, that that is of  
8                   course a war where you had to stay hyper-  
9                   vigilant a great deal of the time because your  
10                  enemy was not in uniform. You didn't know,  
11                  there could be a civilian walking around.

12                  Three, you knew when you left you  
13                  were going to have to come back again, which  
14                  then made it more difficult for people to say  
15                  ah, it's over. I can then relax, now I can  
16                  explode. Sort of keeping on that sort of  
17                  hyper-vigilance.

18                  You know, the psychological  
19                  strategy to use when you're in combat is not  
20                  the psychological strategy to use when you're  
21                  trying to heal from the trauma of combat.

22                  And many servicemembers can't make



1 that adjustment when they know they're going  
2 to go back and forth between deployments.

3 So this is very difficult, and it  
4 makes it all the more important that we do  
5 everything we can to train our providers to  
6 handle those kind of very difficult cases.

7 DIRECTOR DAILEY: Captain Stoltz?

8 CAPTAIN STOLTZ: Yes.

9 DIRECTOR DAILEY: Can I just also  
10 interject here very quickly. I didn't see in  
11 here, and I know this is not an exhaustive  
12 list, but I would like to bring to your  
13 attention that military community and family  
14 policy has two non-clinical sources for family  
15 members.

16 One is their Military Life Health  
17 Consultants that they've got an expensive  
18 contract out on. And they also are providing  
19 Military One Source counseling.

20 And I just want to put that on  
21 your radar. And in maybe your future slides,  
22 if you're doing any work with them, those are

1 also gateways as you noted for people kind of  
2 breaking through those barriers.

3 And so some time spent with them  
4 or collaborating with them on, again, our  
5 expensive contracts at Military Life Community  
6 Policy, MCFP and PNR has let out might be  
7 worth your time also.

8 CAPTAIN STOLTZ: Oh, absolutely.  
9 And we've certainly been in touch with them.  
10 And again, as I mentioned at the beginning, we  
11 see it as very, very important that we do this  
12 outreach and make those connections and work  
13 together.

14 So perhaps we should move on to  
15 the next slide. This again is more stuff that  
16 we're doing to DoD and VA partnering. We do  
17 have the In-Transition Program. And I  
18 actually have some numbers here.

19 So that in 2013, we had 1,671  
20 people call. Now these are folks that may be  
21 leaving military service, may be transitioning  
22 to VA for the first time, maybe even just

1 changing duty station.

2 But they're in a bit of a  
3 quandary. They have this number, they call it.  
4 We've had tremendous success with this. And  
5 this of course is very important for those  
6 that are familiar with the whole concern about  
7 suicide.

8 We know that all too often they  
9 can occur when people are in a state of  
10 transition. This is a very important service  
11 that we offer, and people have been  
12 extraordinarily pleased with it. We are very  
13 well networked with how to help these people  
14 that may be in a bit of a limbo.

15 I mentioned the JIF Projects  
16 before. Moving Forward is a website that is  
17 specifically geared to help people that again  
18 that are in transition, literally moving from  
19 one place to another.

20 We do a lot of things for families  
21 as well. We have a parenting site that's very  
22 helpful. And then we have, and you'll hear me

1 talk several other places about these things  
2 called mobile apps that are downloaded onto  
3 smartphones.

4 And DCoE has done a tremendous  
5 amount of this. That's a major thing that our  
6 T2 branch of DCoE does. And I can't tell you  
7 just how important this is.

8 I see it very much as the wave of  
9 the future. So many people are downloading  
10 large numbers of these and utilizing these,  
11 and finding it to be a very helpful tool for  
12 them.

13 Everything from a mood tracker  
14 that's sort of a self evaluation to sort of  
15 having your own mobile coach with you and many  
16 others, and then there'll be others listed as  
17 we move along.

18 MEMBER REHBEIN: Captain, may I  
19 interrupt for just a moment?

20 CAPTAIN STOLTZ: Please do.

21 MEMBER REHBEIN: The previous  
22 slide, the In-Transition Program up there, one

1 of the things the task force has continually  
2 been concerned about is getting the right  
3 information into warriors hands at the right  
4 time.

5 How do they find out about that  
6 In-Transition Program? Does their current  
7 mental health provider give them that  
8 information before they leave?

9 Someone that's going to  
10 potentially utilize that program, how do they  
11 know it's there?

12 CAPTAIN STOLTZ: Well, it's in  
13 many different places. And on the web, for  
14 one. But yes, go ahead.

15 DR. CERNICH: So one is if they  
16 call, let's say our outreach center, that's  
17 one of the ways that they could get networked.  
18 The other is that we have extensive contacts  
19 with care managers within the system through  
20 our outreach office.

21 And so we do regular contacts with  
22 them to let them know about the In-Transition

1 service and to have them avail themselves of  
2 that.

3 The highest utilization is really  
4 between duty stations. So if somebody is  
5 moving from one duty station to the other,  
6 there's care management coordination.

7 And then the other piece of it is  
8 even when you get that person to the duty  
9 station with a warm hand off, part of it is  
10 coaching them into care because they've got to  
11 get a new provider, they've got to reestablish  
12 trust.

13 And even if you've already told  
14 the story for that person and reviewed the  
15 chart, it's still making sure that they make  
16 that first appointment. So it's the coaching  
17 into care part that's been the real success.

18 The other thing is with DoD and VA  
19 as part of this, this actually grew out of the  
20 integrated mental health strategy, one of the  
21 other pieces of it is that we have really good  
22 connections with VA care management,

1 particularly in the OEF/OIF/OND Care  
2 Management Office.

3 And so the lead for In-Transition  
4 actually was an OEF/OIF Care Manager in the  
5 VA. So he's very well networked with that.  
6 And he lets folks know about that.

7 And mental health also has  
8 highlighted on their national calls, and we  
9 have it highlighted on the OEF/OIF/OND Care  
10 Management calls on a regular and routine  
11 basis.

12 So within all of those  
13 communities, what we've really tried to do is  
14 highlight that this is a program that is  
15 available to help folks move between.

16 We're not trying to replace  
17 another care management system. We're also  
18 very well aware of the Lead Coordinator  
19 Program and the other care management programs  
20 ongoing between DoD and VA.

21 So this is a service to help coach  
22 somebody through that transition rather than

1 being the specific care management, if that  
2 makes sense.

3 MEMBER DRACH: Ma'am, when you say  
4 the care managers, does that include the  
5 recovery care coordinators and the federal  
6 recovery care coordinators?

7 DR. CERNICH: Yes, sir. So all  
8 this is doing is helping, and specifically  
9 usually if they have an FRC or an RCC, if we  
10 get involved, we then coordinate with them to  
11 the best extent possible.

12 We're not going to take over that  
13 FRC or RCC lead in any way, shape, or form.  
14 That's not our role. Our role here is if we  
15 get a reach out from a care manager who says  
16 I have a patient with PTSD. They're moving  
17 from Fort Carson to Fort somewhere else. I  
18 need to hook them up with care. Can you help  
19 me identify? We have identified sources of  
20 transition, we get them hooked up with a  
21 provider.

22 And then we work, we have



1 behavioral health coaches that essentially  
2 work with that servicemember to keep them  
3 connected and to get them to go to that first  
4 appointment.

5 MEMBER DRACH: So is this  
6 incorporated into the RCC training?

7 DR. CERNICH: I believe it is,  
8 sir. I would have to verify that for you. I  
9 know our outreach program has worked with the  
10 FRCs, the RCCs, the RCCs that are in DVBIC  
11 also to help with TBI where they can.

12 And they're also working with  
13 OEF/OIF/OND Care Management. So they're very  
14 well networked into how those systems work.

15 MEMBER EUDY: Mr. Drach, I was  
16 just at the auditing, the annual audit of  
17 their curriculum course, and yes it is heavily  
18 involved.

19 Both TBI and PTSD are spoken by  
20 subject matter experts, along with the various  
21 resources, and then what the role is for the  
22 non-medical care manager, or RCC to then get

1 their servicemember to those services. It's  
2 very heavily involved.

3 CAPTAIN STOLTZ: Next slide. So  
4 this is about our engagement with the SMMAC.  
5 Next slide. So this may not look like it's  
6 answering the question.

7 So since my first week here and  
8 being part of that program evaluation brief,  
9 I have not been asked to brief to the SMMAC,  
10 and I haven't felt a great need to do so but  
11 would be happy to do so if asked.

12 But I do feel a lot of support  
13 from MHS leadership. I have no concerns or  
14 complaints. This is our organizational chart  
15 that chose how our three centers are part of  
16 the Defense Center of Excellence and how we  
17 are an executive agency under MRMC up in Fort  
18 Detrick.

19 We have regular contact with  
20 General Carvalho. He gets a sitrep from us  
21 on a weekly basis. And certainly in my early  
22 phases, I had opportunities easily available

1 for me to work with the leadership in health  
2 affairs and get guidance from them.

3 So I don't feel a need to have  
4 more engagement with the SMMAC, but would be  
5 happy to do so if called upon.

6 I will tell you that in the  
7 beginning, as I was struggling, trying to  
8 figure out DCoE's role and I did have a chance  
9 to talk to Dr. Woodson and told him I was  
10 trying to come up with clear language about  
11 that.

12 And he looked at me and he said  
13 you are the single point of accountability for  
14 psychological health and TBI. And I found  
15 that to be very helpful. I have embraced  
16 that. The staff knows that. We have put it  
17 on various things.

18 And so when the White House calls  
19 Health Affairs, when the press calls, when  
20 Congress calls, all of those things, we are  
21 the ones that then get the call from there.

22 And we feel good about that. We

1 are energized by it. And we understand that  
2 when it comes to these issues across the MHS,  
3 we are it. And we're glad to be it. And we  
4 feel like we have support from the many  
5 leaders we have above us.

6 CHAIR NATHAN: Rich, going back to  
7 that slide, I wonder if it shouldn't be more  
8 of the reverse, a dotted line up through the  
9 executive agent, and a solid line up through  
10 the Centers of Excellence.

11 I realize that the AdCon all comes  
12 from the executive agent. But what is your  
13 interpretation of the oversight board and its  
14 ability to facilitate what you believe is the  
15 way ahead, your policy recommendations, your  
16 guidances, your removing of redundancies, your  
17 collaboration with the other Centers of  
18 Excellence?

19 Well, I think that's a great  
20 question, and we could spend an awful lot of  
21 time talking about it because there's  
22 certainly been a lot of things going on.

1                   So I'm aware that all kinds of  
2 things are being explored. Whether the CoE  
3 oversight board is still going to exist or not  
4 is, I think, sort of a question that's up in  
5 the air.

6                   I have been personally asked to  
7 chair a task force to bring together reps from  
8 nine different Centers of Excellence and talk  
9 about alignment issues with them, talk about  
10 standardizing a definition of what a Center of  
11 Excellence is, what's the best way to set it  
12 up.

13                   There has certainly talk about  
14 DCoE and some other Centers of Excellence  
15 moving over to be under DHA. And if it moves  
16 under DHA, would it fall under the research  
17 directorate or would it fall under healthcare  
18 operations?

19                   So there are all different kinds  
20 of ongoing discussions there. I do think  
21 personally it would be extraordinarily helpful  
22 to clarify at least what the core competencies

1 are, the core functions are of a COE because  
2 I can tell you again, when I came here again,  
3 not paying much attention to what DCoE and  
4 NICOE and the other Centers of Excellence were  
5 and then trying to figure that out.

6           There is just an awful lot of  
7 confusion and I think not a clear  
8 understanding. I also think there's a  
9 tremendous amount of merit into having  
10 basically a hub of people that would serve  
11 quite a few of the CoEs on all sorts of  
12 things.

13           So like, if we're looking at cost,  
14 if we had a health economist that could do  
15 that for a bunch of CoEs as opposed to have  
16 each one have to do one.

17           So my impression is that how much  
18 longer we're going to stay with MRMC is very  
19 much up in the air. And how much other CoEs  
20 are going to stay where they are is up in the  
21 air.

22           My hope is we find an efficient

1 way to join a lot of them together so that we  
2 can get better utilization, more effective  
3 utilization of the resources we have, because  
4 I'm certainly aware that we're under financial  
5 constraints in the future.

6 I don't know if that answered your  
7 question.

8 CHAIR NATHAN: Well, I think the  
9 State of New Jersey would have welcomed your  
10 answer a couple of weeks ago because it was  
11 very eloquent and ginger, sort of stepping  
12 around the issues because I'm going to push on  
13 you a little bit.

14 You're doing back flips because  
15 you're watching all this cooperative stuff  
16 between the VA and DoD. You're doing back  
17 flips because you know what your job is. Your  
18 job is to be all things psychological health  
19 and TBI for the DoD, or at least represent  
20 that.

21 And then when I ask you, and then  
22 you tell us that you haven't briefed the SMMAC

1 and you're not really engaged with the SMMAC.  
2 That's not your responsibility, that's the  
3 SMMAC's responsibility.

4 And so I look at the next rung and  
5 I think okay, well if you're not talking to  
6 the SMMAC, you must be getting rudder orders  
7 or you must have a robust interchange to do  
8 translational action of what you think is the  
9 best way forward with the oversight board.

10 And you say yes, you know, I don't  
11 know if the oversight board's going to be  
12 around. We don't know. It's kind of good.  
13 I mean, you gingerly park the bus on top of it  
14 and then kind of rolled over it.

15 And then you say, but you know,  
16 and I don't know what's going to happen to  
17 MRMC and if that's. so I'm trying to find out  
18 who do you work for?

19 I mean, you go to Dr. Woodson and  
20 he tells you you've got it. You're all things  
21 psychological health. But are you going to  
22 him and saying to him, are you going to the



1 Army?

2 Army's your Executive Agent. Are  
3 you going to the Army SG and saying listen,  
4 there's real problems with this policy or this  
5 policy or we're not doing enough in this or  
6 we're not investing enough in this, or we  
7 noticed that there's two redundant streams of  
8 research going on here and here and we need to  
9 coalesce those? Who's your action person?

10 CAPTAIN STOLTZ: Well, it's  
11 primarily General Carvalho. He's the one  
12 that gets the detailed reports every week. He  
13 very much is aware of what's going on. And  
14 then --

15 CHAIR NATHAN: He's not coming to  
16 the SMMAC and changing policy at the SMMAC  
17 level. I mean, I know Joe and he does a lot  
18 of good work.

19 But he's not a frequently present  
20 entity representing your interest at the  
21 SMMAC. And you've just told me he's not  
22 really representing them at the Oversight

1 Board.

2 CAPTAIN STOLTZ: He's not a member  
3 of the Oversight Board.

4 CHAIR NATHAN: Right.

5 DR. CERNICH: Well actually, sir,  
6 he is a member of the Oversight Board. I  
7 think the challenge, though, is the Oversight  
8 Board has not had a meeting since September of  
9 this year.

10 They meet quarterly, and we were  
11 supposed to have a meeting. We haven't had a  
12 meeting. So the CoE Oversight Board hasn't  
13 met to give us guidance from that perspective.

14 And I say that because I  
15 transitioned that to Captain Stoltz just for  
16 one meeting. So his ability to say the rudder  
17 check from that, even over the past year, even  
18 in those quarterly meetings, it was just  
19 trying to establish who were the CoEs and what  
20 their potential functions were.

21 And we had just gotten to  
22 potentially how we would measure our return on

1 investment, and we haven't had a meeting since  
2 then.

3 The other mechanism that we've  
4 used to inform policy in recent days, and I  
5 say recent in the past month, is with the new  
6 DHA governance.

7 What we've really tried to do, and  
8 I think is in our slides, is look at the  
9 medical operations group, the Policy Advisory  
10 Council and some of the other lower level  
11 guidance bodies and working our  
12 recommendations to policy through them to go  
13 through the established governance structure  
14 in DHA.

15 And we've made General Caravahlo  
16 aware of that, and he has been very supportive  
17 of it. So that's the way we've pivoted. Some  
18 of the governance issues were very unclear to  
19 us, I think as they were unclear to a lot of  
20 people, for four to five months.

21 So now what we've tried to do is  
22 really engage with the bodies that are saying

1 we're the Policy Advisory Council, we're the  
2 ones that oversee operations.

3 We're still trying to figure out  
4 who does exactly what. But I think we're  
5 learning that process in the same bruising way  
6 that other people are learning it.

7 CHAIR NATHAN: Okay. Not a bad  
8 answer because what you're saying is don't pay  
9 attention to the guy behind the screen. The  
10 new way ahead is we're really going to work  
11 with the DHA, which is this consolidated  
12 agency that focuses on policy.

13 And they will, as a member of the  
14 SMMAC, and they are. The DHA is represented  
15 by both Dr. Woodson who is the guy in charge  
16 of the DHA over Doug Robb who makes things --

17 So that's fine, that's fine. You  
18 understand my question that DHA ain't showing  
19 up on your slide there. And you just told me  
20 it's really the DHA who's going to sort of,  
21 you know, get me through this.

22 Dr. Woodson shows up as the

1 Assistant Secretary of Defense. But not the  
2 DHA.

3 DR. CERNICH: Yes, sir. And this  
4 is the alignment that we had previous to the  
5 change in governance. So we need to modify  
6 the slide, obviously.

7 The only other thing that I will  
8 say, too, is that in the past, the other piece  
9 that we don't have on the slide is the  
10 coordination with the services. And that we  
11 do more informally and then bring it to the  
12 governance bodies.

13 CHAIR NATHAN: Well, that's  
14 supposed to be the SMMAC.

15 DR. CERNICH: Well, right. But  
16 I'm saying before you get to the SMMAC, you've  
17 got to work with the behavioral health line,  
18 you got to work with the --

19 CHAIR NATHAN: MDOG, DMOG, M-I-C-  
20 K-E-Y.

21 DR. CERNICH: All those guys, yes.

22 CHAIR NATHAN: But I just think

1 that again, one of the sore points for the  
2 Task Force --

3 DR. CERNICH: Absolutely.

4 CHAIR NATHAN: -- is, and this is  
5 a compliment, you have a reservoir of  
6 amazingly talented, passionate people who look  
7 for ways to remove redundant capabilities and  
8 efforts and put gravitas and focus on those  
9 that need the most import.

10 And we always wonder how do you  
11 effect that? How do you effect change since  
12 you're supposed to know everything that's  
13 going on, including how long to cook a soft  
14 boiled egg.

15 How do you effect that change?  
16 And so what I'm hearing is the DHA.

17 CAPTAIN STOLTZ: Well again, I  
18 don't have control over that. But there's  
19 certainly discussions underway that would lead  
20 me to believe that that's where it's heading.  
21 But that's obviously far above me.

22 CHAIR NATHAN: Okay, because what

1 you have said is, and again, I come here to  
2 praise Caesar, not to bury him. But what I've  
3 heard is the Oversight Board is kind of  
4 vestigial at this point to you.

5 It's not really functioning as  
6 something that's providing a transmission from  
7 your engine to the rear wheels.

8 CAPTAIN STOLTZ: That's accurate,  
9 that's accurate.

10 CHAIR NATHAN: And that may be  
11 because of the aurora borealis, I don't know.  
12 But it's not doing what it's supposed to do.  
13 And then you're not really engaged in the  
14 SMMAC, right?

15 And you're working through MRMC,  
16 which is great because Joe Carvalho is not a  
17 shrinking violet and he will, if he hears  
18 something that's significant enough, he will  
19 kick in the doors of the services and do  
20 something about it.

21 That's more of an informal  
22 arrangement than a formal arrangement. And so

1 we're still trying to get our arms around what  
2 your formal arrangement for making change in  
3 the Department of Defense for all things TBI  
4 and psychological health is.

5           And what I hear you saying is  
6 we're still finding our footing in that. And  
7 if it was bad and now we're getting better,  
8 okay, got it. But we've been finding our  
9 footing in that for, well since you were stood  
10 up.

11           And so that's the concern. And by  
12 the way, that's on me. I'm a Surgeon General.  
13 I sit on the SMMAC. I should be asking these  
14 questions at the SMMAC as much as I'm asking  
15 them here.

16           And I'll beat myself up in that  
17 arena. But still, we're just still trying to  
18 get some traction on the good work you do.

19           CAPTAIN STOLTZ: Okay, well I  
20 appreciate that. And I guess the one thing I  
21 want to say is that when I have interacted  
22 with senior folks and I have brought forward



1 things, they have been very receptive.

2 Even though at times I didn't even  
3 know that there was a medical operations group  
4 until relatively recently and that something  
5 should go through there, and even though it  
6 was the first time that I ever presented to  
7 the Policy Advisory Council.

8 But when stuff is sent forward, it  
9 is well received. It is confusing to us  
10 exactly, you know, what should go where but we  
11 are finding our way.

12 But there seems to be a lot of  
13 interest and an encouragement for us to keep  
14 coming up with products. Another question,  
15 sir?

16 MEMBER MALEBRANCHE: I don't know.  
17 I think the General and I might have the same  
18 question. How are you resourced? What agency  
19 resources you? And is it the Army, is it  
20 Health Affairs?

21 CAPTAIN STOLTZ: The Army.

22 MEMBER MALEBRANCHE: Okay. The

1 Army totally? And then you're also resourced  
2 with people from the VA. Just three at this  
3 point. I see Dr. Cernich mentioning?

4 CAPTAIN STOLTZ: Yes, yes.

5 MEMBER MALEBRANCHE: So when you  
6 need people, then you go to the Army. You  
7 don't go --

8 CAPTAIN STOLTZ: That is correct,  
9 ma'am.

10 CHAIR NATHAN: So every Center of  
11 Excellence was aligned with a service to be  
12 their executive agent. You just heard from  
13 the Vision which was the Navy.

14 And so because somebody has to,  
15 somebody who's in execution status has to be  
16 able to give them a funding line, work through  
17 their departmental issues to help hire and do  
18 all those things.

19 So that's a theory. So they're  
20 the executive agent. So that black line there  
21 that weaves through the Army down there is  
22 really, I consider it to be an AdCon line,

1 administrative control line where you get all  
2 your administrative support from.

3 But in theory, the Army is not  
4 supposed to be carrying your water for getting  
5 change done based on the good work you do and  
6 what you find and research and collate in  
7 psychological health.

8 Nor is the Navy supposed to be  
9 carrying the water for the Visual Center of  
10 Excellence. Yet, we do sometimes because we  
11 don't have, in my opinion, a viable  
12 alternative to really make a difference.

13 And the Oversight Board was  
14 created to do that. The Oversight Board was  
15 the uplink to the SMMAC, right, where all  
16 things happen. Right? Go figure that one  
17 out.

18 But nonetheless, that was the  
19 theory. And so what I'm hearing here is you  
20 could, I don't mind. I didn't know if you  
21 were going to come in here and tell me thank  
22 goodness for the Oversight Board. Without

1       them, boy, we wouldn't have, you know,  
2       something to really get this stuff we're  
3       thinking of out there in the real world.

4                   And you haven't said that. Both  
5       you and Dr. Cernich just said well, the  
6       Oversight Board met in September and it's  
7       supposed to meet again and I don't know if  
8       they will or not.

9                   And it's kind of up in the air  
10       whether they'll be around or not. And we  
11       don't really miss them because they don't  
12       really do much.

13                   And so Houston, we have a problem,  
14       okay? And again, we've been doing this too  
15       long, and we've got to get serious about this.  
16       All the Centers of Excellence are too valuable  
17       a commodity to simply have you doing good  
18       work.

19                   And I'm glad people are receptive.  
20       You know, I would hate to hear you say you go  
21       to me or the other SG's or somebody in the  
22       government and you say we've got some new

1 ideas for TBI and they go I'm not receptive.

2 They're all very receptive. You  
3 should be asking, the last thing you should  
4 say as you thank them for their time and walk  
5 out the door is what are you going to do about  
6 it?

7 And do you know how to do  
8 something about this, and how are you at least  
9 going to get these ideas in front of a group  
10 of people who if you think this is a good idea  
11 can turn this into action, because you've got  
12 probably the toughest road to hoe of all the  
13 COEs because you've got all these shoots  
14 coming up all over the country and the world  
15 of people who have their own better idea of  
16 how to build the mousetrap for TBI and  
17 psychological health born out of the passion  
18 of wanting to fix things and born out of the  
19 pressure from Congress and then the rest of  
20 the country saying fix this yesterday.

21 And so everybody's got their own  
22 sort of cottage idea of how they're going to

1 do it. And you were created to kind of broker  
2 those and say here's where the money should be  
3 spent. Here's where the research should be  
4 focused, here's where the action should be  
5 targeted.

6 And you've come up with a lot of  
7 those things. I think if I asked all five of  
8 you what are some things we need to be  
9 changing tomorrow and the way we do this, you  
10 would give me some best practices, which you  
11 have between the VA and DoD, which are great.

12 And then you would say but aside  
13 from those here's, like, five things we think  
14 should happen tomorrow that could change the  
15 way DoD approaches this.

16 And if I said great, how are you  
17 going to get them done, you're kind of going  
18 to just hunch your shoulders and go well,  
19 hopefully Joe Carvalho will get those done  
20 for us. That's not his job.

21 MEMBER MUSTION: Sir, if I could  
22 maybe ask the question in a different

1 perspective. You mentioned earlier that Dr.  
2 Woodson said you are the single point of  
3 accountability.

4 So does that wiring diagram enable  
5 you to exercise that accountability, that task  
6 that you've been given effectively and  
7 efficiently?

8 And I say that going back to what  
9 you said your current focus is, which is  
10 strengthen, collaborate, blah, blah, blah. I  
11 guess what I'm looking for, how are you able  
12 to effectively execute the accountability  
13 mission that Dr. Woodson has given you given  
14 that design?

15 CAPTAIN STOLTZ: That's a great  
16 question. And --

17 CHAIR NATHAN: And you've only  
18 been here since May, so if you want to phone  
19 a friend, you can.

20 CAPTAIN STOLTZ: Well I'm sure, I  
21 have to tell you, I'll answer and then I'll --  
22 and I have great friends over here, by the

1 way. And I very much concur with Admiral  
2 Nathan's comment about what a good staff we  
3 have.

4 So I would tell you that I think  
5 it's murkier than it ought to be. And I think  
6 this is the set up we have, and the people  
7 involved in that set up, it's working as well.

8 But it's not as clean as it ought  
9 to be. And I think that's not only true for  
10 DCoE, I think that's probably true for other  
11 Centers of Excellence.

12 And I think that there probably  
13 should be some commonality with the Centers of  
14 Excellence so that we can solve the problem,  
15 or at least a number of them, solve the  
16 problem not just for DCoE, but for the other  
17 Centers of Excellence so that who reports to  
18 who could be clarified.

19 You know, what is an executive  
20 agent? You know, we're the only Center of  
21 Excellence that have that designation. And  
22 there's some murkiness around there.



1                   And yes, so it does put General  
2                   Carvalho, who's in charge of so many things,  
3                   in sort of a difficult situation. But this is  
4                   what we had.

5                   And I wasn't here very long at all  
6                   before with the creation of the DHA there was  
7                   all this talk about how we may well move over  
8                   there. So we understand it is in transition.  
9                   So many things are in transition.

10                  We're dedicated to pushing forward  
11                  with this knowing, in my opinion, it's likely  
12                  to fall under a cleaner structure than it's  
13                  under right now.

14                  MEMBER MUSTION: So okay, in  
15                  listening to your response, so what you  
16                  basically have just said is you've been given  
17                  a mission that you can't execute given the  
18                  construct that you're operating within.

19                  CAPTAIN STOLTZ: I could say we  
20                  could execute it better if the lines, because  
21                  I could tell you a variety of things that  
22                  we've executed since I've been here.

1                   So somehow we've gotten them into  
2 policy, we've got them through the system and  
3 have made the connection. So I wouldn't say  
4 we can't execute it.

5                   I would say there's a way of  
6 setting it up that we could move more full  
7 speed ahead.

8                   MEMBER MUSTION: I think you have  
9 some semi-formal and informal connectivity  
10 among the services where you have some shakers  
11 and movers from the services who are either  
12 part and parcel of your DCoE or are close to  
13 it.

14                   And then they take that and they  
15 go out and they sort of germinate some of  
16 those ideas and they change it. And you talk  
17 to the NICoE.

18                   And we've heard from one other CoE  
19 that says you have a pretty good collaboration  
20 with them. You know what they're up to, they  
21 know what you're up to.

22                   So I think that all helps. Just,

1 we all learn something, we'll let you move on  
2 with your briefing in just a second, but we  
3 all learn something from these. Okay, we  
4 learn a great deal from you. Here's what  
5 you're going to learn from me or from us.

6 Up until this minute, the SMMAC,  
7 right, this erudite group of leaders of the  
8 Senior Military, Medical Military Advisory  
9 Counsel was under the impression, and I think  
10 I speak for my colleagues on the SMMAC, that  
11 the Oversight Board was what you needed to  
12 connect your ability.

13 And I tell you, this Task Force  
14 was under the impression, because that's the  
15 last people, people who have been speaking to  
16 us in the past told us that the Oversight  
17 Board was what the doctor ordered in order for  
18 you to get your ideas into practice.

19 That's what our impression was at  
20 the SMMAC, okay? So you know, this is not  
21 panning out. So we need to go back and look  
22 at this because too much of it still remains

1 in flux.

2 And you're getting things done by  
3 moral assuasion or persuasion more than you  
4 are by an actual line, which is what General  
5 Mustion is getting to, more than you are by an  
6 actual military or federal line of command or  
7 ownership that helps you execute your mission.  
8 End of speech.

9 MEMBER MUSTION: I have one other  
10 question.

11 MEMBER PHILLIPS: May I ask the --

12 MEMBER MUSTION: I'm sorry. I was  
13 just going to ask one other question. From an  
14 executive agent perspective, have you asked  
15 for resourcing or do you require resourcing  
16 that the executive agent has not provided that  
17 you're authorized?

18 CAPTAIN STOLTZ: Well, the major  
19 thing has been personnel. Like many others,  
20 we've had a slight decline in the number of  
21 approved billets that we can hire to and it's  
22 very competitive.

1                   So to that extent, did we get  
2                   everything we want? No. But I wouldn't  
3                   expect us to given the environment that we're  
4                   in.

5                   MEMBER PHILLIPS: To follow up on  
6                   some of the comments, the final Jeopardy  
7                   question. Being in the trenches, could you  
8                   all articulate or suggest some language that  
9                   this task force can use a recommendation to  
10                  help to achieve that seamless command  
11                  structure?

12                  CAPTAIN STOLTZ: Yes, we can. And  
13                  I would just like to give it a little thought  
14                  as opposed to spew it out right now. But we  
15                  would be happy to do that.

16                  MEMBER PHILLIPS: Of course, thank  
17                  you.

18                  CAPTAIN STOLTZ: Okay, so I think  
19                  we're ready for the next slide. Okay. So  
20                  here are some things related now to TBI as  
21                  well as psychological health.

22                  And so our first response is

1 focused on changes to psychological health  
2 therapies. And of course, the one that's on  
3 most people's minds is frequently PTSD because  
4 again, it's so difficult for some of the  
5 reasons I've already stated.

6 But here is what some of the  
7 research is showing is that there's two  
8 therapies that seem to be more effective than  
9 the others, exposure therapy and cognitive  
10 processing therapy.

11 There's some positive stuff out  
12 here that the sooner you can get to somebody  
13 and have them express what happened, the less  
14 likely it becomes a chronic condition that  
15 turns into PTSD in order for it to be formally  
16 diagnosed with PTSD.

17 The symptoms have to last for at  
18 least 30 days. And then it shows that some of  
19 these therapies actually treat other things in  
20 a beneficial way. Those are the --

21 CHAIR CROCKETT-JONES: May I ask  
22 you a question real quick?

1                   CAPTAIN STOLTZ:  Yes.

2                   CHAIR CROCKETT-JONES:  Is the EMDR  
3 no longer on the evidence based treatment  
4 list?

5                   CAPTAIN STOLTZ:  It's still on the  
6 list, but it's not coming across as strong.  
7 Some people might even refer to that perhaps  
8 as an exposure therapy.

9                   And that while you're doing the  
10 eye movement stuff in front of the person,  
11 you're asking them to hold inside of them the  
12 trauma.

13                   So what we know basically is this,  
14 that if you have inside of you turmoil,  
15 flashbacks, nightmares, whatever it is, these  
16 reminders about something that is very painful  
17 to you so that your immediate reflex is to  
18 push it away, that ultimately and then that  
19 becomes a chronic condition that really  
20 interferes with your ability to function.

21                   Ultimately, the way to solve it is  
22 to find a way to get it out and not leave it

1       inside, and find a way that the person can  
2       actually welcome that stuff as opposed to  
3       constantly try to avoid it.

4               Avoidance does not work. So  
5       there's a variety of exposure therapies that  
6       try to do that. And to some extent, EMDR  
7       tries to do that, as well.

8               CHAIR CROCKETT-JONES: And is the  
9       emergence of ART, the new therapy that we  
10      recently heard about, has that come on your  
11      radar, or is it --

12              CAPTAIN STOLTZ: It's on our  
13      radar. And it's a combination of existing  
14      ones. And we have not seen any definitive  
15      studies, unless they're very recent, that show  
16      us.

17              But we are paying attention to  
18      that, we're aware of that new therapy. But  
19      the underlying dynamics remain the same, and  
20      there's a variety of ways to sort of get  
21      there.

22              We also understand that the best



1 treatment for one is not the best treatment  
2 for all. I think we have to have multiple  
3 models in front of there.

4 Some people, for example, they  
5 really do benefit from some of these sort of  
6 complimentary things. So some people, you  
7 know, the meditation, the yoga, the  
8 mindfulness, the relaxation, even physical  
9 exercise sometimes is beneficial to folks.

10 Other people don't respond too  
11 well to sort of those complimentary things.  
12 But I think that pretty much covers that  
13 slide.

14 And then the next one refers to  
15 practices related to TBI. Where are we on  
16 time?

17 DIRECTOR DAILEY: We have an hour.  
18 You had a two full hour block.

19 CAPTAIN STOLTZ: Okay, good.

20 DIRECTOR DAILEY: So you know,  
21 pace yourself.

22 CAPTAIN STOLTZ: Okay, all right.

1 Great.

2 DIRECTOR DAILEY: Take a breath.

3 CAPTAIN STOLTZ: Great. But let  
4 me go down to the bottom one first because the  
5 bottom one, I think, is really highly  
6 significant. And it just came out last week.

7 And you know, for a long time, and  
8 of course 80 percent of TBI is mild TBI. And  
9 for the longest time, what did, you know, the  
10 primary care and other kinds of practitioners  
11 tell people when they had a mild TBI?

12 They would tell them to go home  
13 and rest and come back in a few days. It was  
14 sort of a generalized thing.

15 Well if you tell a young person,  
16 and it was mentioned in the Vision Center's  
17 brief about the average age being 24 and we  
18 know a large part of our military is young, to  
19 go home and rest, what are they likely to do?

20 They're likely to maybe sit on a  
21 bed and play video games or do other things on  
22 the computer. So they're not engaging in

1 cognitive rest. And they are actually doing  
2 things that they think they're following what  
3 their provider said. It's actually likely to  
4 make them worse.

5 And so for two years, DVBIC worked  
6 with outside agencies, outside the military,  
7 experts on TBI, as well as all the services  
8 and many others, and has finally released and  
9 come up with a document that is very, very  
10 specific about dividing up rest into physical  
11 rest, cognitive rest, and then balanced rest.

12 So you know, if you're dizzy and  
13 you have those kind of things, when can you  
14 walk up the stairs. And it's very, very  
15 specific, detailed, gradual.

16 How many minutes a day at what  
17 stage, and then only after you complete this  
18 should you go to the next stage. This is the  
19 first of its kind, incredibly detailed way of  
20 healing from a mild TBI.

21 And we are certainly familiar with  
22 many cases where because that has not been

1 followed by patients and hasn't been specified  
2 to that level of degree, that many patients  
3 are actually doing things that are harming  
4 themselves and allowing these symptoms,  
5 whether they be balance problems or headaches  
6 or whatever to go on much longer than if they  
7 would engage in this very progressive return  
8 to activity that will allow them to heal  
9 faster.

10 So this is a major, major thing.  
11 Just came out last week. I hope you see it  
12 advertised and out in the media in a variety  
13 of ways.

14 CHAIR NATHAN: So that brings me  
15 to the question, what's your plan on getting  
16 it out there?

17 MS. HELMICK: Sir, thank you for  
18 the question. We have a communications plan  
19 with its multi-vectored. We are looking at  
20 the lay press. Our senior leaders have been  
21 informed of this.

22 In terms of our targeted state

1 quota audience, which is providers, we have  
2 multiple platforms working with our service  
3 TBI program directors, for the Navy, Captain  
4 Jack Tsau. And the other three services have  
5 their own program directors.

6 So we are already taking orders  
7 for this for hardline copies, as well as it's  
8 posted today. We plan to leverage the DVBIC  
9 network, the 11 military treatment facilities  
10 that are part of the DVBIC network.

11 We have ambassadors within those  
12 11 MTFs to function as the proponents for  
13 this, both as an educational paradigm to teach  
14 other providers on site and to take a regional  
15 approach.

16 And we'll also leverage our  
17 regional education coordinators throughout the  
18 DVBIC network to achieve that, as well. So  
19 our media and press piece, our MTF providers  
20 are our number one stakeholder group.

21 And then we also plan and have  
22 lots of interest with the NFL and professional

1 sports, the NCAA and even at the high school  
2 federation level to take a look at this  
3 progressive return to activity tool.

4 CHAIR NATHAN: So thank you, and  
5 congratulations on obviously a well thought  
6 out and robust communication and socialization  
7 strategy to get this out there so that people  
8 will be aware of it all the way from the  
9 civilian sector, the sports world and for this  
10 group, the recovering warriors.

11 I would argue that, because you  
12 believe this is going to be a sea change,  
13 don't you Rich? I mean, this is going to  
14 represent a real change in, for some people,  
15 their ability to recover from mild TBI.

16 CAPTAIN STOLTZ: I'm very hopeful  
17 that that will be the case. I think if we can  
18 get it out to all those practitioners out  
19 there that don't know that much about TBI and  
20 have this degree of specificity, it could  
21 really have a very positive impact.

22 CHAIR NATHAN: So that's

1 encouraging. I would argue if you had a  
2 better connectivity to the Department of  
3 Defense through a dotted or solid line, let's  
4 roll the tape back when we decided that the  
5 best way to deal with concussive care was to  
6 take people out of the environment and to put  
7 them in a quiet environment and to use certain  
8 metrics to determine when they could go back  
9 to duty.

10 We did more than just socialize  
11 that. We did more than just a robust  
12 communication plan. We created the DODI, and  
13 we said you will do this. And that got passed  
14 out.

15 If it's one thing the military's  
16 pretty good at is giving orders. And they may  
17 be good and they may bad, but people hear them  
18 and obey them. And that's how we changed  
19 concussive care in a matter of weeks, in a  
20 matter of weeks.

21 So if you had the kind of  
22 connectivity that we could make a, I'm not

1 saying this should be a DODI, but it almost  
2 sounds like it.

3 It almost sounds like the kind of  
4 thing that if there's enough agreement, then  
5 this isn't sort of a, you know, to one  
6 person's liking.

7 But there's consensus among the  
8 subject matter expert across the spectrum, VA,  
9 military, academic, private sector, sports  
10 specialists that this is the way to go.

11 This should be socialized, but  
12 this should also be directed. And that's  
13 where we're lacking right now because this  
14 should be brought up for consideration.

15 Now Joe Carvalho may be doing  
16 just that. He may be coming to us and saying  
17 I need you guys, Dr. Woodson, I need you to  
18 make this a DODI. But again, this is my  
19 concern about your current wiring diagram.

20 CAPTAIN STOLTZ: Thank you. So we  
21 have a number of other things up there sort of  
22 in keeping with some of the prior things that



1 were mentioned.

2 The need for sort of a multiple  
3 systems assessment is very important, the  
4 interdisciplinary part is very important. I  
5 think there's more evidence to support that.

6 And that's pretty much what's  
7 mentioned on those slides. We also came out  
8 with, and I think this was actually mentioned  
9 in the Vision Center of Excellence brief that  
10 we worked with the Vision Center of Excellence  
11 and came out with some guidelines there.

12 We also came out with a guideline  
13 of when do you do neuro-imaging after a TBI,  
14 under what circumstances? So you don't want  
15 people to over utilize that or underutilize  
16 it.

17 And again, this is a thing through  
18 collaboration with multiple people we came up  
19 with an answer to I think that very  
20 significant question, and that's been  
21 released.

22 So this is a slide that gets into

1 what our telehealth and technology folks do a  
2 lot of, these mobile apps. And it gives you  
3 pictures. You know, most of our people in  
4 service have a smartphone with them 24 hours  
5 a day, seven days a week.

6 They use it a lot. And I'm not  
7 going to go through all of them and tell you  
8 what they do. But I'm going to tell you about  
9 one that's going to be released soon, and we  
10 hope to really push this one very hard because  
11 I think, again, it could have a real impact.

12 And it's called the Virtual Hope  
13 Box. And so if you're feeling down, stressed  
14 out, a little bit upset about something, at  
15 your wits' end, sort of losing it for a while,  
16 what this app does is it has on it quite a bit  
17 of content aimed at sort of helping you out.

18 It has humor in there, something,  
19 humor's a very wonderful tool to have. It has  
20 a lot of sage advice, it has a lot of verified  
21 things related to depression in general that  
22 are helpful thoughts to have and think.

1                   But the thing about this product  
2                   that makes it somewhat unique is it allows  
3                   people to put into stuff that they want to put  
4                   into it to customize it for them.

5                   So our hope is that many of our  
6                   providers actually download this app, and that  
7                   when our providers are treating people, that  
8                   they let them know about this app.

9                   And you know, all of this is  
10                  available for free, of course. And that the  
11                  provider and the patient can work together to  
12                  come up with what can you put in here that  
13                  will help you?

14                  Is it a picture of your children?  
15                  Is there one special thing that you can say to  
16                  yourself that really works for you? I've  
17                  certainly worked with patients that that's  
18                  very true for. But what it is varies from  
19                  patient to patient.

20                  So the fact that you can customize  
21                  it and the fact that this can be, you know, so  
22                  many young people today sitting down and

1 talking to one person face to face for fifty  
2 minutes is not what they're used to doing a  
3 lot.

4 But to the extent that we can  
5 start reaching out to help meet these folks  
6 where they're at and engage in some electronic  
7 transfer of information, work together, I  
8 think this will be very, very helpful.

9 So that's our application due out.  
10 All of these things, they have ways of self  
11 monitoring. So if we go back to TBI, it would  
12 be a way for you to, on a regular basis, say  
13 whether you're having a headache or not and on  
14 a scale of one to ten, how severe that  
15 headache is.

16 And then it tracks all that  
17 information for you. So it can become sort of  
18 a self observant thing that helps you gain  
19 insight into your own behavior over time as  
20 long as you get used to using the app on a  
21 somewhat regular basis.

22 So we think that these tools are

1 very effective. We think they're very  
2 helpful, and we think that they're things that  
3 our servicemembers today are going to end up  
4 using a lot.

5 And already, we have evidence that  
6 a number of these have a very high level of  
7 downloads.

8 COLONEL CAMPISE: Sir, if I could  
9 just add to that?

10 CAPTAIN STOLTZ: Yes, please.

11 COLONEL CAMPISE: I'm with T2.  
12 Sixty six percent of our active duty members  
13 are under the age of 30, and 52 percent of our  
14 reservists. Those are our digital natives.

15 Those are folks for whom  
16 technology is something they were raised with  
17 and it comes second nature to them. And we  
18 would consider it cultural incompetence if we  
19 went out and tried to treat African Americans  
20 or Hispanic or Cambodians or somebody else  
21 without learning about their culture.

22 Yet we do that with our own folks.

1 We have young people that are coming to their  
2 providers saying I've been on the web and I  
3 found this app. What do you think about that?

4 And for the most part, our  
5 providers are unfamiliar with what the young  
6 digital natives are bringing to them. So  
7 really, there's a great deal of hope for us to  
8 use this really as expansion of our clinical  
9 services.

10 And we find people that were  
11 unhappy with typical clinical therapy. And  
12 they go out and use one of the apps like  
13 Breathe2Relax and they find that an app is  
14 very helpful to them.

15 And then in the course of using  
16 that, they learn about virtual therapy. And  
17 so they realize that maybe they're not  
18 comfortable with face to face, but if they can  
19 do it virtually, they're very comfortable with  
20 that.

21 And so I think that we have a lot  
22 of hope in using technology. It's not the

1 solution to every problem, nor is it the  
2 solution for everybody out there.

3 But for those for whom technology  
4 is the answer, it's really malpractice if  
5 we're not at the gate to meet them when  
6 they're knocking at it.

7 MEMBER DRACH: If I could? Have  
8 you or are you planning on doing any outreach  
9 to the veterans and military service  
10 organizations to make this information  
11 available to them to help get it out?

12 I think your main focus is on  
13 active duty. But you know, once these  
14 individuals get out --

15 COLONEL CAMPISE: Yes, virtually  
16 everything that we create, we also do with the  
17 VA's PTSD Centers. So they're actually co-  
18 created.

19 MEMBER DRACH: Yes, but you know -  
20 -

21 DR. CERNICH: So sir, the other  
22 piece of the outreach, and I can say this from

1 the VA perspective, the National Center for  
2 PTSD is very engaged in the community outreach  
3 efforts. And I know Karen is very aware of  
4 our community engagement efforts through  
5 mental health.

6 One of the things that we've done  
7 through the summits, through VA, and I'm not  
8 here representing VA, but one of the things  
9 that they have done is make community groups  
10 and veteran service organizations and military  
11 organizations aware of all of the resources  
12 that we have available.

13 We've briefed these to the  
14 American Legion. We've briefed these to  
15 disabled veterans. So these are very, very,  
16 very well socialized.

17 And the other piece that VA can do  
18 that you have some limitations with on the DoD  
19 side is we can also do popular press in a  
20 really targeted way.

21 And so when some of these have  
22 come out, particularly the PTSD Coach, that's



1 our highest utilization both on the DoD and VA  
2 side. That was publicized internal to DoD by  
3 our DoD partners, and VA did the public  
4 outreach campaign and the community engagement  
5 with the military and veteran service  
6 organizations.

7 So we do try to get these as far  
8 out as we can in as many ways as we possibly  
9 can. And this is a joint effort that we've  
10 had for the last four years. And so the  
11 Concussion Coach, the PTSD Coach, the PE  
12 Coach, all of those are jointly done between  
13 VA and DoD.

14 CAPTAIN STOLTZ: So this is asking  
15 us to summarize how we've improved the lives  
16 of our servicemembers. And this is what I  
17 wanted to put up here first.

18 I mentioned to you before about  
19 our emphasis on program evaluation. And  
20 certainly, we want to make sure that we are  
21 doing our own program evaluation and assessing  
22 ourselves.

1                   So DCoE has a strategic plan, and  
2                   this is the one slide that sort of summarizes  
3                   our strategic plan. And we know what we're  
4                   trying to do and where we're trying to go.

5                   And if I can just take you to the  
6                   left hand side of that, you can see that we  
7                   have objectives for ways that we develop our  
8                   balance score card and see how well we're  
9                   doing with marshaling the financial and  
10                  personnel resources that we have, how well  
11                  we're enabling the people, assisting their  
12                  career development, their morale and so forth.

13                  And then how well are we excelling  
14                  at the three major things that we do,  
15                  education, clinical and research? And then  
16                  the ones at the top are really the most  
17                  important ones because they're how well we are  
18                  serving our customers, having an impact on  
19                  care.

20                  And I really do see our primary  
21                  customers as being, you know, servicemembers,  
22                  veterans, and their families because we are

1 here to serve them and help them as they  
2 struggle with all the things that go with  
3 deployment and being in harm's way and  
4 separation and so forth.

5           So if we go to the next slide,  
6 what you're going to see is the way we've  
7 answered the question about our most important  
8 accomplishments in 2013 is to take those four  
9 objectives at the top of our strategic plan  
10 and put some things under each of those  
11 categories.

12           So if we focus first at just the  
13 C1 category. So we have a PTSD toolkit that  
14 we came out with. So this is something that's  
15 not just for a person that has PTSD. It's got  
16 some educational materials in there for family  
17 members.

18           It helps people know what the  
19 symptoms are, how to recognize them, gives  
20 them some guidance on the various treatment  
21 options that are available, tells them a  
22 little bit about what recovery would look

1 like, some common co-occurring conditions.

2 So we think that's a helpful tool.  
3 We have one for TBI, which I mentioned before  
4 that we came out with to assist with the  
5 management of visual dysfunction after having  
6 a TBI.

7 You see up there the registry. Of  
8 course, Vision has set the way with that. We  
9 have received word just recently that we now  
10 have funding for us to do a PH/TBI registry.  
11 We see that as very good news.

12 We concur with what Dr. Lawrence  
13 and Patty was saying about how beneficial they  
14 believe that registry will be and how it will  
15 greatly assist with research and have us  
16 better understand what's going on out there.

17 So we're very excited about that.  
18 We've been pushing that for a long time, but  
19 it looks like we're going to make a lot of  
20 progress on that this year.

21 We do follow 75 active research  
22 protocols on both psychological health and

1 TBI, and I don't want to go through all of  
2 those by any means.

3 But it has to do with, you know,  
4 for example, which cognitive rehab treatments  
5 are more effective. We have so many different  
6 research things, we could be here a long time,  
7 including longitudinal research which I think  
8 is very important as well.

9 And then, of course, you see up  
10 there our research translation strategy which  
11 I talked about before. And there our  
12 relationship with MRMC has actually been very  
13 helpful because of course they do an awful lot  
14 of research up there.

15 And we have formed a much stronger  
16 bond with them in a ways that help us better  
17 identify and have them work with us on both  
18 the front end and the back end of the  
19 research.

20 If we move to the C2 slide, got  
21 lots of things there. I mentioned before  
22 about we have these working groups that occur

1 all the time. I mentioned about how we were  
2 the lead for these DoD/VA mental health  
3 strategy actions. Made lots of contributions  
4 there.

5 And just one example there. So  
6 one of those had to do with gender issues.  
7 And one of the gender issues that came up was  
8 of course more heavily on the female side, but  
9 effecting definitely both genders was sexual  
10 assault and how much and what can DCoE do to  
11 assist with sexual assault.

12 So we thought of all sorts of  
13 things. But we said hey, rather than again,  
14 us be a think tank and do what we think's  
15 best, let's call the experts in.

16 So we got together with the  
17 leadership of SAPRO and said look, this is  
18 obviously a huge issue. What ways would DCoE  
19 best be able to help?

20 And they told us, well our  
21 experience is what we would really need, if  
22 you could provide guidance out there for the

1 providers, whether they see the patient in the  
2 emergency room or see them in some type of  
3 counseling that are either a perpetrator or a  
4 victim of sexual assault, if you could give  
5 them some guidance, that would be  
6 extraordinarily helpful.

7           So we've developed an outline for  
8 this. And we are working closely with SAPRO  
9 to develop this. Apparently there's a  
10 tremendous need out in the field for this that  
11 we were previously not aware of.

12           But that's how these things sort  
13 of evolve from one project to another and how  
14 it leads to further improvements. And then  
15 I've already talked, I think, about the Joint  
16 Incentive Funds before, so we can go to the C3  
17 part.

18           And we've mentioned the mobile  
19 apps that we just talked about. Now we do  
20 some reports. So we do surveillance of TBI  
21 worldwide numbers.

22           And we provide a report on the

1 direct and purchase care quarterly report for  
2 all TBI related medical encounters, both in  
3 CONUS and OCONUS.

4 We also produce a quarterly report  
5 that presents the blast exposure and  
6 concussion incidents report information. We  
7 analyze it and give historical comparisons to  
8 that and we send that up.

9 Suicide has been mentioned before.  
10 We put together that report and sent it off to  
11 DSPO. And then it's mentioned down there the  
12 various seminars and conferences and webinars  
13 and sort of the whole educational part.

14 So we had a resilience virtual  
15 conference that was attended by over 1,100  
16 people this past year. And then we had one on  
17 TBI that was attended by over 1,200 people.  
18 And our webinars are monthly. The wonderful  
19 thing about these is they have CE units  
20 attached, most of the times with that.

21 And so with so many people needing  
22 CE units, that helps us get quite a few



1 people. We've had some of our webinars get  
2 very large numbers of people chiming into  
3 that.

4 And then finally on that last  
5 quadrant there, I've already talked quite a  
6 bit about the program evaluation stuff. And  
7 then the one thing I haven't mentioned is I  
8 haven't talked too much about the care  
9 pathway.

10 We suffer from a lack of  
11 standardization of documentation. So right  
12 now in the electronic medical record,  
13 providers have the option of free texting in  
14 all sorts of things.

15 So if we have a bunch of providers  
16 seeing PTSD patients, it's very hard for  
17 people to go in and be able to determine what  
18 kind of treatment are they doing, and very  
19 hard to pull data to really figure out.

20 So one step again is to get  
21 regular use of the same outcome measure, which  
22 I believe we have nearly accomplished. We

1 have it mandated that it be used at least upon  
2 initial diagnosis and then before the patient  
3 is discharged.

4 We have in place processes where  
5 we're going to be asking that it be used  
6 basically every visit unless it's more than  
7 once a week. We have a whole variety of  
8 metrics that are currently, I think, in the  
9 final stages of making their way through the  
10 system.

11 But if all you have is that, and  
12 you're not sure what kind of treatment's going  
13 on, or even if you say you're doing a  
14 particular treatment, what specifically are  
15 you doing?

16 It's very hard for us to learn as  
17 much as we could as if we had a standardized  
18 way of doing that. So we are pushing hard to  
19 get a standardized way of doing a pathway for  
20 PTSD.

21 We have some pretty intense  
22 dialogue going on at the moment. Looked like

1 we had consensus at one point.

2 Now that seems to be falling apart  
3 and I'm scheduled to follow up with the  
4 Medical Operations group in order to help get  
5 some of their guidance and work that issue  
6 with the services so that we can solve this  
7 issue of a lack of standardization of  
8 documentation in a way that I think will  
9 really have a positive impact of us better  
10 understanding what's happening and then better  
11 understand which is working better and which  
12 is working not as well.

13 CHAIR CROCKETT-JONES: Just to  
14 interject here, this is a particular issue  
15 that we have found in at least one of our  
16 installation visits that there was some  
17 awareness that even though contracted  
18 providers or civilian providers have been  
19 trained in evidence based treatment, that  
20 either when treatment changed or when another  
21 provider became familiar with a patient, it  
22 became clear that they had not received

1 evidence based treatment, that they had  
2 received talk therapy that hadn't really  
3 addressed post traumatic stress.

4 And so this is something that has  
5 just recently come to the forefront here for  
6 the Task Force. So I'm glad I'm not going to  
7 have to, like, introduce this idea.

8 This seems to be a method, but  
9 you're just getting traction. You have not  
10 had consensus yet on how to sort of document  
11 some sort of treatment provisions?

12 CAPTAIN STOLTZ: I thought we had  
13 consensus and then I found out that we didn't.  
14 And now I need to regroup. But the bottom  
15 line is --

16 CHAIR CROCKETT-JONES: Who are you  
17 trying to get consensus with? That's my first  
18 question.

19 CAPTAIN STOLTZ: From all the  
20 services.

21 CHAIR CROCKETT-JONES: From the  
22 services?

1                   CAPTAIN STOLTZ: From all the  
2 services so then I can then take it forward.  
3 So we had one way of documenting it, basically  
4 a name form. And I'm not sure how many people  
5 are familiar with what that is.

6                   But basically a structured form so  
7 that any time you had a case of PTSD, you  
8 must, must, must use this form. And again,  
9 trying to make sure it worked first through a  
10 pilot site.

11                   And when you use that form, you  
12 are forced to say what you're doing, what form  
13 of evidence based treatment you're doing as  
14 well as then when you get into the  
15 documentation exactly what you're doing within  
16 it so then you can easily pull the data.

17                   So that was one way of doing it.  
18 But now there's another alternative that's up  
19 there that is being advocated. And so I'm in  
20 the process of regrouping to try to see if we  
21 can get a consensus.

22                   And if I can't, then I'll send it

1 up with a majority report and a minority  
2 report and see how it moves forward because I  
3 really believe this is extraordinarily  
4 important that we need to know what's taking  
5 place and how effective it is because right  
6 now I can tell you how many people are  
7 diagnosed with PTSD, but if you ask me how  
8 many are getting this treatment or how many  
9 are getting that, I really can't figure that  
10 out. And that impedes progress.

11 DIRECTOR DAILEY: And Captain  
12 Stoltz, if it's any assistance to you, the  
13 Task Force has made recommendations exactly to  
14 those points of standardized data collection,  
15 standardized outcomes to all the services.

16 If you need leverage, if whatever  
17 value they are to you, pull them up and wave  
18 them in front of the faces of your compliers  
19 and not compliers and say this has to be done.

20 CAPTAIN STOLTZ: Thank you. Okay,  
21 so Question 5 had to do with changes outside  
22 of DCoE. Boy, I think we already hit upon

1 that, and I think we're now expected to come  
2 back to you and I haven't had too much time to  
3 think about it since we last talked about it  
4 to offer anything.

5 But I've got that. Again, it is  
6 my belief that if we can clarify what Centers  
7 of Excellence are supposed to do and what they  
8 should be driving for, I mean, I have my views  
9 on that.

10 But how much of this is uniform,  
11 and then how do we organize them in a way that  
12 they will be most effective and efficient  
13 doing these things. I think that will help  
14 us.

15 And then we've already addressed  
16 the governance issue and how it's my personal  
17 opinion not optimal at this time. But I think  
18 the players involved have been doing the best  
19 they can given the situations that they're in.

20 CHAIR NATHAN: Who is usually at  
21 the Medical Operations group?

22 CAPTAIN STOLTZ: When I was there

1 the one time, it was General Potter was the  
2 chair, General Thomas was there. Admiral  
3 Moulton was there, and Mike Dineen was there.

4 And then there were several people  
5 there that were civilians that I had never met  
6 before and their names escape me at the  
7 moment.

8 CHAIR NATHAN: How often are they  
9 getting together?

10 CAPTAIN STOLTZ: Weekly.

11 CHAIR NATHAN: That's probably  
12 going to be your best source of traction for  
13 the near term. But again, those are folks  
14 that you rely on their interest, good will,  
15 and that of their service to either pick up or  
16 not pick up what they bring back from those  
17 things that are operationally relevant.

18 And we don't really have yet a  
19 coordinating common denominator to sort of  
20 make this stuff go. You're clearly good at  
21 the receive mode.

22 In other words, somebody comes to



1 Dr. Woodson and says hey, I hear that ecstasy,  
2 which is a horrible, horrible recreational  
3 drug can actually be wonderful, its basic  
4 metabolite can actually be wonderful for  
5 people with PTS. Are you going to do that in  
6 the military?

7 So he has one person, he can turn  
8 to you. And he can say quick, I need your  
9 take on whether this is good stuff or not. So  
10 you're perfect for that.

11 What's not so good is if he then  
12 says you know, I think it's not a bad idea.  
13 Let's go ahead and do some pilot studies with  
14 this metabolite. Go ahead and do it.

15 You're going to say well that's  
16 not my job. I don't execute. You know, my  
17 job is to tell you what we think direction you  
18 should be going. So then he needs to bring it  
19 to the SMMAC or whatever. So these are the  
20 challenges we have.

21 CAPTAIN STOLTZ: Okay.

22 MEMBER MALEBRANCHE: Admiral, one

1 of the things I didn't understand. Who was  
2 supposed to have been or who is on this Center  
3 of Excellence Oversight Board?

4 CHAIR NATHAN: Who what?

5 MEMBER MALEBRANCHE: Who are the  
6 members of the Center of Excellence Oversight  
7 Board.

8 CAPTAIN STOLTZ: The Chair was Dr.  
9 Lockette. And I remember Admiral Bruzek-  
10 Kohler, retired Admiral Bruzek-Kohler being --  
11 I was at one of these meetings --

12 DR. CERNICH: Right. So it's  
13 Chaired by CNPP. And then there's a  
14 representative from each of the services, a  
15 representative from MRMC, a representative  
16 from USUHS and a representative from what was  
17 JTF CatMed, which is now National Capital  
18 Region.

19 And then there was representation  
20 from HBNFP, representation from FHPNR, and I  
21 believe that that was it.

22 MEMBER MALEBRANCHE: And this was

1 all prior to DHA?

2 DR. CERNICH: This was all prior  
3 to DHA. And I had asked about this because we  
4 had due out to come to them with a return on  
5 investment approach for potential  
6 Congressional reporting, and then an annual  
7 report requirement that they were asking for  
8 that was going to be in addition to the  
9 regular reporting that we do through the HEC  
10 and through our regular Congressional report.

11 So we were supposed to come back.  
12 And when I asked, it was uncertain at the  
13 time, and I haven't received follow up,  
14 because there was a working group evaluation  
15 board that met as part of the DHA realignment.  
16 So we haven't received any notification at  
17 this point.

18 MEMBER MALEBRANCHE: Okay. So one  
19 thing that does still occur is that the  
20 Centers of Excellence report to the HEC, which  
21 reports to the JEC, which then contributes to  
22 the Joint Strategic Plan.

1                   So that is a mechanism for some  
2 things to occur. And it looked like one of  
3 the things you talked about, to make sure that  
4 stakeholders were ensured aware of products  
5 and services to increase utilization.

6                   So that's one of the venues.  
7 There's no DODI or VA or any kind of joint  
8 other than clinical practice guidelines joint  
9 instruction, correct? And there's no joint  
10 metric per se?

11                  DR. CERNICH: There are. So we  
12 participate in -- do you want to answer this  
13 or do you want me to? So for the HEC, there's  
14 the Psychological Health and Traumatic Brain  
15 Injury working group.

16                  And DCoE is represented on that  
17 working group. And they just actually added  
18 this year, we had lacked traumatic brain  
19 injury representation on that group.

20                  So the services were allowed to  
21 either elect a psychological health  
22 representative or a TBI representative. And

1 it impeded the work in some ways because there  
2 wasn't equal representation.

3 So VA had sort of split their  
4 representation, psych health and TBI. DoD had  
5 limited representation. Now the  
6 representation is equal and we have subgroup  
7 meetings.

8 So we do have the TBI metrics.  
9 Actually, I worked with Ms. Helmick a while  
10 back to draft those, and we have some meetings  
11 upcoming to enact those metrics.

12 And then for the psychological  
13 health group, there are a number of different  
14 task forces and panels even outside of the  
15 HEC. So there are metrics under that, and  
16 there are also metrics that we're working on  
17 under the Interagency Mental Health Task  
18 Force.

19 So those are the two places that  
20 we are interacting for the mental health work,  
21 one pursuant to the Executive Order, the other  
22 to the Joint Strategic Plan.

1                   MEMBER MALEBRANCHE: Okay. So  
2 there's no policy --

3                   DR. CERNICH: No, ma'am.

4                   MEMBER MALEBRANCHE: -- out?  
5 Okay. Well then there can't be an  
6 implementation if there's not a policy. Thank  
7 you.

8                   CAPTAIN STOLTZ: Okay, so I think  
9 we're best practices in PTSD. And next slide.  
10 So I jumped the gun and told you about the  
11 pathway. And I think that that's clearly a  
12 very, very important thing.

13                   And I would say that the goal is  
14 to at least try it out and make sure it works  
15 first. And then if it works, to then adapt it  
16 to things like major depression and the other  
17 high volume ones so that we do this not just  
18 for PTSD but other high volume things.

19                   And therefore we would come up  
20 with the exact same sort of paradigm, whatever  
21 we hopefully finally agree on for PTSD, we use  
22 a similar way of doing that for the other

1 major high volume disorders.

2 In addition to those metrics that  
3 have been written into policy, the one for  
4 anxiety, PTSD and depression, we have roughly  
5 40 metrics that, as I mentioned earlier, that  
6 are going through final stuff with Health  
7 Affairs that coincide with the Quadruple Aim.

8 And we're very close. There's  
9 been a lot of work done on those. And we  
10 think that when those are done, some of those  
11 should be written into policy that will again  
12 make it so that people have to use some of  
13 these things at a certain frequency in order  
14 to measure things, and we get a better handle  
15 on what's going on.

16 I think we've talked a lot about  
17 the mobile tools, and so I think that's it for  
18 that slide. Before opening up to questions,  
19 just a final comment.

20 I think DCoE is very aware that  
21 this is a very important time. We're about to  
22 have a major change. Hopefully deployments

1 are down.

2 We know that the number of  
3 servicemembers on active duty is going to  
4 decline. We know we're going to have probably  
5 large numbers of people leave the service.

6 We also know what happened to  
7 Vietnam Veterans. And we know that way, way,  
8 way too many Vietnam Veterans after they got  
9 out of the service had a very rough time, very  
10 high volumes of chronic PTSD, PTSD that lasted  
11 decade after decade after decade.

12 We know about incredibly high  
13 levels of suicide amongst those Vietnam  
14 Veterans well after they were discharged from  
15 service. We know that we had roughly well  
16 over two million people deployed in these wars  
17 in the Middle East since 2002.

18 We want to make sure we do  
19 everything we can that we don't have a repeat  
20 of what happened to the people that went to  
21 Vietnam because these are people that  
22 obviously put their life on the line, put



1 themselves in harm way, put their families in  
2 all sorts of difficult circumstances.

3 We are dedicated to doing  
4 everything we can to help them with these  
5 issues. And I have so many wonderful staff  
6 that their heart and soul is into what we do.

7 And that's why we make the best of  
8 where we are, no matter what those  
9 circumstances are.

10 And we look forward to solving  
11 some of the issues that you brought up to make  
12 us even more effective and efficient because  
13 we see this as an incredibly important mission  
14 and it's very much an honor for us to be part  
15 of having the possibility of having an impact  
16 on the lives of people that are clearly at  
17 risk given the circumstances that they have  
18 been put in to defend our country.

19 So with that, I will open it up to  
20 any questions you have.

21 MEMBER REHBEIN: Sir, I would like  
22 to come back to the DVBIC, the new guidelines

1 that came out, the communication plan you were  
2 discussing a few minutes ago because, as the  
3 Admiral says, inside the military community,  
4 if it's of that importance, a DODI is the way  
5 to go.

6 How do we handle that out in the  
7 VA system and in the TRICARE community because  
8 so many of our reservists and National Guard  
9 folks, that's how they get their healthcare.

10 And they're falling off airplane  
11 wings and they're in truck accidents and  
12 they're receiving concussions. How do we get  
13 those kinds of guidelines into those  
14 communities? Is that part of the plan?

15 MS. HELMICK: Sure. So just to  
16 comment about the DODI. We are very excited  
17 to be able to influence policy at that level.  
18 And through the DTM navigating over to a DODI  
19 for the management of concussion of the  
20 deployed setting, I think that showed that  
21 it's a template that's do-able. And it got  
22 fastly enacted.

1                   We have concerns about the other  
2                   COCOMs. CENTCOM has been the primary executor  
3                   of the DODI, of management of concussion in  
4                   the deployed setting, which as we evolve the  
5                   clinical guidelines for care for concussion in  
6                   the deployed setting, we would incorporate  
7                   this progressive activity, return to activity  
8                   paradigm into all of the deployed setting as  
9                   well as the non-deployed garrison setting.

10                   But just as an aside since I have  
11                   the microphone, we would absolutely welcome  
12                   the opportunity to indoctrinate what we've  
13                   learned about TBI over these last 12 years and  
14                   to be able to effect change through all  
15                   COCOMs, and that DODI if course does mandate  
16                   the establishment of a program in all COCOMs.

17                   In terms of specifically purchase  
18                   care environment, which in the TBI world is  
19                   about seven to nine percent of all TBI care  
20                   that's given in the military health system is  
21                   through the purchase care paradigm.

22                   So 93 percent or so we do direct

1 care. Being able to influence those TRICARE  
2 providers is something that is on our radar  
3 screen. It's been more difficult to penetrate  
4 than obviously the military health system.

5 For the VA sector, we have five VA  
6 medical centers within the DVBIC network. So  
7 just as I mentioned that we used, we would  
8 like to leverage our ambassadors within the VA  
9 systems of care, which the four polytraumas  
10 are four of the five that DVBIC has, would be  
11 one conduit as well to ensure that they are  
12 disseminated widely, and that they are  
13 implemented.

14 MEMBER MALEBRANCHE: If I might  
15 just insert one second here. One of the  
16 things Mr. Rehbein brings up is something that  
17 also we've encountered with the DoD and VA  
18 with the interagency care coordination piece.  
19 And at the current time, DoD is creating a  
20 DODI, and VA is creating a directive. And we  
21 are doing a joint MOU in hopes of someday  
22 being able to do joint policy. So that's one

1 venue.

2 But just, as you were saying this  
3 and talking about this, it just cued in my  
4 mind the need, even more, for that ability to  
5 do that, which agencies have not done before,  
6 the two. So that would be something fairly  
7 new. So I don't know, Dr. Cernich, what --

8 DR. CERNICH: No, the only other  
9 thing to say is that of the three positions  
10 that VA has at DCoE, I'm serving in one and  
11 acting as the other. So as the VA TBI  
12 liaison, my other part of my job is to work  
13 with DVBIC. And so I get them the SMEs from  
14 VA to work with on their committees.

15 The other piece that I do is when  
16 the guideline comes out, it goes to -- there's  
17 a part of this that's primary care, there's a  
18 part of this that's specialty care. So I work  
19 very closely with the primary, the patient  
20 aligned care teams which are similar to  
21 medical home, they disseminate the guideline  
22 through their networks.

1                   We also have a dissemination plan  
2 through polytrauma. We also will then  
3 probably do a joint webinar; we have that  
4 capability for our providers. Those are  
5 extremely well-attended by our specialists.

6                   And then the other thing that we  
7 have thought about on the VA side, and which  
8 is in the Joint Strategic Plan, is how to make  
9 providers aware of non-combat TBI and how to  
10 manage it. You know, the focus for us has  
11 been on combat-related TBI. But 80 percent of  
12 the traumatic brain injuries that are suffered  
13 within the military are non-combat.

14                  And so, one of the points in our  
15 Joint Strategic Plan is how do we educate our  
16 providers, especially our primary care  
17 providers and our emergency room providers  
18 about traumatic brain injury that is non-  
19 combat? And how do we get practice guidelines  
20 in their hands to help manage those folks as  
21 they come in. And this is one of the  
22 potential products that we're going to be

1 looking at within the Joint Strategic Plan  
2 metrics to move forward.

3 DIRECTOR DAILEY: Something that's  
4 not in this briefing here, but just how  
5 closely they're adhering to making you the  
6 single point of accountability.

7 Task Force did three  
8 recommendations that were -- one was for  
9 standardization and publication of  
10 standardized processes for PTSD. The other  
11 recommendation was standardization,  
12 publication of process for TBI. These are all  
13 recommendations last year. Did they filter  
14 down to you to answer? Have you seen?

15 MS. HELMICK: Yes.

16 DIRECTOR DAILEY: So you are the  
17 point of contact for four, did I see you do a  
18 four, ma'am?

19 MS. HELMICK: Yes, it was  
20 recommendation number four for TBI. Sorry,  
21 yes, we've seen them and responded. Yes.

22 DR. CERNICH: We responded

1 directly to four.

2 DIRECTOR DAILEY: Okay.

3 DR. CERNICH: Three went to CMPP  
4 was the lead for three. So four, we were the  
5 lead, and Colonel Heinz coordinated with the  
6 services for the implementation plan for that  
7 recommendation. Three was through CMPP.

8 DIRECTOR DAILEY: Okay. Good,  
9 very good. I appreciate that and that is very  
10 helpful in reinforcing your statement that  
11 you're the single point of contact for  
12 psychological health issues, empowered by Dr.  
13 Woodson.

14 Again, great track record on the  
15 DTM for care of concussive injuries in-theater  
16 and the subsequent DODI that came out. I  
17 can't tell you how many times we went to the  
18 field, talking to TBI clinics, and heard them  
19 say game-changer, game-changer over there  
20 since 2011. Those DODIs were game -- were  
21 categorized as game changers by the clinicians  
22 and the TBI directors out there. So that was



1 a pretty high standard you set for us.

2 What's the next, are you going to  
3 put out another DODI? Are you currently the  
4 lead on another DODI? Are you writing a DODI?  
5 I see heads going this way over there. Are  
6 you taking the lead on anything else that  
7 would be a policy statement? Or did someone  
8 else pick that up in Health Affairs?

9 DR. CERNICH: Do you want us to  
10 take that one? Okay.

11 MS. HELMICK: When the 84 percent  
12 known TBI occurred in the garrison setting,  
13 when that data came out about two and a half  
14 years ago, there was excitement to launch a  
15 garrison DODI so that we could effect change  
16 in the same way that we were in process of  
17 doing in the deployed setting.

18 Individual service directors had  
19 varying levels of consensus on whether that  
20 was necessary and whether or not that would be  
21 supported by their command. And we spent  
22 quite a bit of time on our weekly quad service

1 call -- we meet as a TBI community every  
2 Thursday, discussing, trying to come to some  
3 coalescing of moving forward with a Department  
4 of Defense instruction on garrison care.

5           And we did not get there. There  
6 were services that were concerned about the  
7 requirements. There were services concerned  
8 about the 24 hour rest period. And other  
9 factors, too. But in general, we were unable  
10 to reach consensus. And when that became  
11 evidently clear, the Army moved out on their  
12 service-specific garrison policy, which was  
13 published as an ALARAC last year. And then  
14 subsequently, the Navy did the same. And it's  
15 in final draft form, about to be released.  
16 The Marine Corps took a preventative stance  
17 and delivered a MARADMIN in 2012.

18           And the Air Force at this time,  
19 related to their numbers, have chosen not to  
20 proceed forward with a service-wide policy.  
21 So although there was discussion, much  
22 discussion about a DODI for garrison, or even

1 a DODI that was TBI both deployed and non-  
2 deployed setting, we were unfortunately unable  
3 to accomplish that.

4 DIRECTOR DAILEY: Very helpful.  
5 Very helpful. Our recommendation, one of the  
6 recommendations last year was the TBI  
7 recommendation for the MTF setting is what we  
8 called it, beyond the battlefield. So, very  
9 helpful. Thank you.

10 MEMBER DEJONG: One last question  
11 I've got, and to take what Mr. Rehbein said a  
12 little bit further, the National Guard and  
13 Reserve group that -- and sir, you had  
14 mentioned it -- and even the individuals that  
15 have transitioned out of the Army and now are  
16 doing non-TRICARE care, a lot of National  
17 Guard individuals are on a civilian market.

18 And some of what we hear back  
19 through our focus groups is that they can't  
20 find civilian providers that have the military  
21 knowledge or the good work that you all do  
22 doesn't filter down through that.

1                   So are there any mechanisms that  
2                   you have or that you're allowed to have or  
3                   that you can do to help filter that into the  
4                   civilian sector and into the communities where  
5                   the soldiers that have transitioned out,  
6                   sailors and marines and another large group of  
7                   National Guard and Reserve individuals are  
8                   looking for care but can't find it.

9                   CAPTAIN STOLTZ: So there is the  
10                  Center for Deployment Psychology that used to  
11                  belong to DCoE and is now under USUHS. And  
12                  their primary mission as I understand it, and  
13                  I have met with them, is in fact to focus on  
14                  educating providers out in the -- that are not  
15                  in the MHS on how to be more aware of the  
16                  kinds of issues that military families and  
17                  servicemembers or former servicemembers face.

18                  And so that is an organization  
19                  that that's a big part of what they do. So we  
20                  have interfaced with them some, but we haven't  
21                  taken that on in light of their role.

22                  DR. CERNICH: The other mechanism,

1 sir, that we have and that we're going to  
2 utilize a bit more, hopefully this year, are  
3 threefold.

4 One is the White House initiative,  
5 the Joining Forces Initiative. One of the  
6 emphases in that initiative is to get  
7 information to community providers about  
8 military-relevant medical issues, specifically  
9 in psychological health and traumatic brain  
10 injury. So, that involves agreements with I  
11 think over 50 professional organizations of  
12 Allied Health and Health Professionals. Also,  
13 they're trying to create some GME content for  
14 the medical schools that would be mandatory.  
15 And so, we're helping with generating some of  
16 the content that will go into that so a  
17 community provider will be aware of that.

18 The other piece of it is that  
19 we've collaboratively worked through the  
20 Integrated Mental Health strategy on a  
21 community provider toolkit. And that is up on  
22 a website now. It's hung, so if you want to

1 get that to your community contacts in the  
2 armories, it has military culture training, it  
3 has training on military specific conditions,  
4 how they may vary from a civilian presentation  
5 and what other questions to ask, even down to  
6 asking the person if they ever served in the  
7 military because that is something that a  
8 provider does not usually ask in their first  
9 point of contact. And making sure that you  
10 understand that that may affect some of the  
11 things that are coming to the forefront for  
12 that person at the time.

13 The other mechanism that we do try  
14 to utilize is not only through the Joining  
15 Forces, but sometimes in partnership, is to  
16 let folks know about us through the Yellow  
17 Ribbon Program. So we try to do general  
18 outreach and our outreach team is there. So  
19 the In Transition program will be there and if  
20 they can't locate a TRICARE provider, if  
21 they're using civilian providers, we do make  
22 efforts to help them locate a provider that

1 might be of use to them. And we also work  
2 with the VA to encourage them to potentially  
3 avail themselves of VA services, especially  
4 services specific to military sexual trauma,  
5 since those are free and you don't even have  
6 to be, in many cases, eligible for VA  
7 healthcare to access those.

8 So there are a number of ways that  
9 we are trying to do that, even in our work  
10 with SAPRO, that's one of the things that  
11 we're doing is not only working with the  
12 providers within the military health system on  
13 how to provide care, but then potentially  
14 linking to VA so that if they're not willing  
15 to avail themselves of the care within the  
16 Military Health System, they can access VA for  
17 that.

18 So we're trying in many ways, in  
19 any way that we can think of, in mechanisms  
20 that we have to do that outreach.

21 MEMBER DEJONG: No, that's great.  
22 One of the things that we do look at is

1 there's a large portion of that group that I'm  
2 speaking of is remote even from VA.

3 And also what we're looking at is  
4 with the downturn of deployments and the  
5 reserve forces being taken off of most  
6 deployments, the Yellow Ribbon programs are  
7 going away.

8 So when you're looking at venues  
9 of getting this out, you know, I think it's a  
10 collaboration of National Guard Bureau and a  
11 few other things. But it sounds like it's on  
12 the forefront, so thank you very much.

13 MEMBER DRACH: Kind of a follow-up  
14 to that. I was on a panel at the American  
15 Public Health Association conference in Boston  
16 in November. And sort of a rhetorical  
17 question, at least at that time, came up and  
18 it was along these lines. Is the civilian  
19 community going to be ready for and be able to  
20 provide psychological health services to  
21 returning warriors, 5, 10, 15, even 20 years  
22 from now?



1                   So when you're discussing that, it  
2                   made me think have you talked to APHA or will  
3                   you reach out to APHA and the CDC, because the  
4                   APHA conference was sort of under, I think  
5                   under the broad umbrella of CDC. And it seems  
6                   to me like that would be two very, very good  
7                   organizations to help get the word out to the  
8                   community.

9                   CAPTAIN STOLTZ: I completely  
10                  agree. And I think we're at that time when  
11                  that really is very important to make sure  
12                  that that gets done.

13                  CHAIR NATHAN: Anything else?  
14                  Well, thank you. Don't mistake our  
15                  frustration for pessimism. I think most of us  
16                  feel, at least in the federal sector, that the  
17                  glass is certainly half if not three quarters  
18                  full instead of a quarter empty or a half  
19                  empty.

20                  But we're determined to see it  
21                  fill all the way up. And we know that there  
22                  is good work being done in lots of places.

1 And we're not getting the visibility of it.

2 We rely on you to do that.

3                   There's a philosophical judgment  
4 that has to be made, which is, are you  
5 established as a center of excellence to be an  
6 advisory group to the services, who can pick  
7 and choose what you have to offer, or are you  
8 established as an overarching agency to  
9 provide the Department of Defense a  
10 collaborative approach to something which the  
11 services should be required to adopt?

12                   I am of the latter. I believe  
13 that when it comes to non-military unique  
14 environments, a military unique environment  
15 would be please don't tell me how to treat a  
16 heart attack at sea because what you tell me  
17 may not be practical at sea. But in garrison  
18 TBI, or in combat wounds, or the exposure of  
19 PTS from anything else, I believe that a  
20 sailor and a soldier and a marine all suffer  
21 basically the same affliction, as well as an  
22 airman.

1                   And so I sign up to do what you  
2                   tell me is the best way forward. My job is to  
3                   try to figure out how to execute what you tell  
4                   me is the best way to treat the patient. If  
5                   you tell me the best way to treat the patient  
6                   in garrison for TBI or for mild TBI is, by  
7                   consensus, the best way to do it, my job is  
8                   not to tell you why I can't get that done as  
9                   a service. My job is to make that happen. If  
10                  you wait for the services to collaborate  
11                  together on these things, it ain't going to  
12                  happen in many instances, even though we're  
13                  all motivated for the best for our people.

14                  Thank you for reminding us that  
15                  you do so many more things besides just the  
16                  kinetic aspects of trauma from warfare and  
17                  from TBI in garrison and in combat.

18                  The example of the military sexual  
19                  trauma or sexual assault advice to the SAPRO  
20                  is incalculable. We do a great job of  
21                  educating our providers on how to collect  
22                  specimens, on how to perform exams, and on how

1 to be advocates for victims of sexual assault.

2 But we haven't really provided a  
3 collaborative psychological algorithm for how  
4 to deal with what's going to happen from a  
5 psychology standpoint as opposed to just the  
6 advocacy standpoint. And so you're very  
7 timely there, and very much appreciated.

8 So barring those questions, and a  
9 little bit on the lighter side, I would just  
10 ask you, has there been any studies on the  
11 psychological, long-range effects of one  
12 service beating another service for 12 years  
13 in a row in football?

14 (Laughter.)

15 I'll take that as a no, and if you  
16 have any free time, you might want to pursue  
17 that.

18 CAPTAIN STOLTZ: That's correct,  
19 sir.

20 CHAIR NATHAN: So thank you very  
21 much for coming today.

22 CAPTAIN STOLTZ: Thank you, thank

1       you.

2                       DIRECTOR DAILEY: Fifteen minute  
3 break. We're back at 3:15 please.

4                       (Whereupon, the foregoing matter  
5 went off the record at 2:59 p.m. and went back  
6 on the record at 3:17 a.m.)

7                       CHAIR CROCKETT-JONES: Okay. We  
8 now welcome Ms. Cynthia Gilman, Director of  
9 Public-Private Partnerships with Henry M.  
10 Jackson Foundation for the Advancement of  
11 Military Medicine. Ms. Gilman will provide an  
12 overview of the Veteran's Metrics Initiative  
13 and discuss the Initiative's role in improving  
14 recovering warrior care.

15                      We have this briefing under Tab F,  
16 and I'm going to turn it over to you to  
17 introduce anyone else who's presenting.

18                      MS. GILMAN: Well, thank you very  
19 much, and thank you to Task Force for this  
20 opportunity. We are really honored to be here  
21 today. My name is Cynthia Gilman.

22                      I'm joined by my colleague, Katy

1 Hussey-Sloniker, who is the Program Director  
2 for the Veteran Metrics Initiative that we'll  
3 be talking about this afternoon.

4 But first, let me, if I may,  
5 introduce you to our organization, for those  
6 who are not familiar with The Henry Jackson  
7 Foundation. It is a 501(c)(3) organization  
8 founded about 31 years ago, and  
9 congressionally authorized to serve as an  
10 interface between civilian and military  
11 medicine, and to support the work of the The  
12 Uniformed Services University of the Health  
13 Sciences.

14 We support over 1,000 military  
15 medical research and education programs around  
16 the world. And the vast majority of the  
17 dollars that flow through the foundation  
18 annually are federal in nature. So, the  
19 dollars that come in the door have particular  
20 uses already assigned to them, which obviously  
21 leaves very little in the way of discretionary  
22 spending.

1                   And that's the reason why we  
2                   created what we call The Center for Public-  
3                   Private Partnership. We stood it up about  
4                   four years ago. It is a center within the  
5                   foundation. It is not a separate legal  
6                   entity. But unlike the balance of the  
7                   foundation, CP3 as we shorthand it, operates  
8                   exclusively to date on private funds. And we  
9                   do that because we believe it allows us to be  
10                  a bit more agile, and enables us to bring  
11                  together collaborators whom are otherwise  
12                  difficult to pull together, particularly when  
13                  federal funds are being used.

14                  Our focus within CP3 is to create  
15                  and sustain public-private partnerships to  
16                  advance the long term health and well-being of  
17                  servicemembers, veterans, and their families.

18                  The Veteran Metrics Initiative,  
19                  which we'll be speaking about in some depth,  
20                  started about four years ago. And it began  
21                  when CP3 started working with communities and  
22                  community based organizations that were

1 dedicated to helping servicemembers and their  
2 families transition out and come to their  
3 communities and reintegrate home.

4           And what we found was that there  
5 were a lot of things that communities did not  
6 know. They had tremendous goodwill, and  
7 tremendous desire to help, but they really  
8 didn't know where to focus their efforts or  
9 their resources. They also did not know how  
10 to assess if what they were doing was making  
11 a meaningful difference. And we realized that  
12 this issue of how do you measure if an  
13 intervention is going to be effective in terms  
14 of outcomes is a really difficult undertaking.  
15 And the more we looked into this, the more we  
16 realized that the communities were not alone  
17 in not knowing how to do this. So we decided  
18 to step into this space and this is where we  
19 are today.

20           What we determined the problem to  
21 be is how do you measure what works. And  
22 what we did was we pulled together a series



1 of different subject matter experts, some of  
2 whom are in the room, who actually came to  
3 our office and started brainstorming around  
4 this question of what do we need to be  
5 measuring? How do we determine what it is  
6 that is going to impact long-term outcomes in  
7 the veteran population that we all are  
8 dedicated to serving?

9           So in bringing our subject matter  
10 experts together, we thought it was very  
11 important to recognize that our  
12 servicemembers become veterans who go home to  
13 communities. So we have to bring everybody  
14 to the same table so that we can work  
15 collaboratively. We also have discovered  
16 that there are more than 45,000 community-  
17 based organizations that exist to try to help  
18 in this veteran transition reintegration  
19 space. And there are more than 10,000  
20 websites available to veterans and their  
21 families. At this point in time, the veteran  
22 transition continuum, which for purposes of

1 our work, we define as the period right  
2 before separation from service and then three  
3 years thereafter, when the person then goes  
4 home.

5           Currently, these interventions are  
6 assessed purely based on conjecture and  
7 anecdotes, not on evidence-based data. And  
8 there is no standard that we have been able  
9 to identify that exists, that allows folks to  
10 uniformly know what to measure, or how to  
11 measure, correlations between interventions  
12 and outcomes.

13           So, we identified that there is  
14 this need to develop standard outcome  
15 metrics. Again, the focus really is on  
16 outcomes. There are a lot of efforts  
17 underway and a lot of folks are actually  
18 collecting process metrics, programmatic  
19 metrics, how many did you serve, how many  
20 clicks on the website?

21           But what we really want to know  
22 is, how did this intervention impact the

1 quality of life, the health, the well-being  
2 of the person who utilized the intervention?  
3 When I say intervention, I'm using that as a  
4 term that can include a program, a service,  
5 what have you.

6 We determined, again through many  
7 conversations, that our metrics have got to  
8 be data-driven, based on evidence-based  
9 science, and that ideally, the DoD, VA and  
10 civilian academia and industry all should  
11 collaborate and work together in developing  
12 the metrics that we're focusing on in order  
13 that we can increase the likelihood of there  
14 being a common vocabulary so that we're  
15 ultimately able to compare apples to apples  
16 and, at the end of the day, have uniform,  
17 universal adoption.

18 Now we realize, and we've just  
19 heard, there are a lot of efforts underway to  
20 develop metrics at this point in time. And  
21 by no means do we suggest that this program  
22 is meant to be the be all and end all of

1 metrics development. On the contrary, what  
2 we are, though, emphasizing is the need for  
3 DoD, VA and civilians who are working in this  
4 space to be communicating together so that we  
5 don't end up with a bunch of siloed,  
6 different metrics being developed.

7           So our goal became pretty clear,  
8 after all of these different discussions,  
9 that what we were going to set out to do was  
10 to develop evidence-based metric tools that  
11 could be used by whomever would like to use  
12 them to guide the effective interventions  
13 along the separation, transition and  
14 community reintegration continuum of  
15 servicemembers, veterans and their families.

16           So that was our goal. But we also  
17 realized that it's a lofty and difficult  
18 goal, and that there is no one study, or one  
19 way to tackle this goal that's going to get  
20 us to where we want to be right off the bat.  
21 So what we said is, okay, let's pull together  
22 the experts in this country, recognizing

1 there's a lot of experts in this country.

2           So let's identify those who are  
3 working in this space, maybe not exactly on  
4 point, but at least related to the work that  
5 we're doing, and pull them together to the  
6 extent that they're willing and able, and  
7 build and sustain different teams of  
8 strategic, scientific and stakeholder  
9 advisors representing DoD, VA, philanthropy,  
10 veteran organizations, veteran and family  
11 advocates, and pull them all to the table to  
12 help us work in collaboration with subject  
13 matter experts who will do the bidding, in  
14 essence, of the work that our advisory group  
15 says needs to get done.

16           So what we've done is we've said  
17 to our stakeholders, what do you need? What  
18 questions do you need to have answered? And  
19 then we have built a team of researchers  
20 who've come together and we've said, these  
21 are the questions we need you scientists to  
22 answer. If you want to publish in your peer

1 review journals, that's fantastic because  
2 that makes it credible and reproducible and  
3 so on and so forth. But at the end of the  
4 day, we need translational research that can  
5 be used by our stakeholders to make the  
6 lives of veterans and their families better.

7           And we have, in reaching to our  
8 scientific research community, said we need  
9 you at all times to adhere to scientific and  
10 theoretical approaches and methodologies from  
11 multiple disciplinary fields in order to find  
12 evidence-based solutions for us. So again,  
13 we have identified different researchers  
14 representing a whole host of different fields  
15 who have sat with us at the table for over a  
16 year without a penny coming their way, but  
17 because they are really committed to what it  
18 is that this group has taken on.

19           So here's our management model.  
20 We serve as the TVMI Director, Henry Jackson  
21 Foundation and CP3. We are the conveners.  
22 We do the administrative work and we,

1       importantly, go out and get the funding. The  
2       funding that we are seeking at this point is  
3       100 percent private. And again, our goal is  
4       by using private dollars, to be able to use  
5       those funds pretty quickly with a minimal  
6       amount of strings attached. We also have  
7       stakeholder advisors, strategic advisors, and  
8       a scientific advisory committee that is  
9       tasked with overseeing the science that our  
10      scientists will be doing.

11                 We've, as I mentioned, recognized  
12      that no one research project is going to  
13      answer all of our questions. But instead, we  
14      need to be able to design a series of highly-  
15      integrated research undertakings that will  
16      inform each other, all of which will drive  
17      towards achieving our goal of developing  
18      these tools that can be used to assess the  
19      efficacy of interventions on outcomes.

20                 We currently have one project,  
21      which is Project 1, which is underway.  
22      Project 2 is in the process of being

1 developed and hopefully launched pretty  
2 quickly. 3, 4, 5, et cetera, are projects  
3 that will follow on and we've depicted them  
4 as we have because we want to show they don't  
5 need to be running sequentially. They can  
6 run concurrently as well.

7           Let me tell you very briefly, if I  
8 may, about our Project 1. It is a  
9 crowdsourcing and data visualization project.  
10 It is being led by a principal investigator  
11 at USUHS. And the goal is to use

12           crowdsourcing and data visualization  
13 techniques in order to go out into social  
14 media and capture millions of pieces of  
15 natural language text that veterans and their  
16 family members are pushing out through  
17 Twitter, public-facing Facebook pages, blogs,  
18 RSS feeds, taking that massive amount of data  
19 and then analyzing it through algorithms so  
20 that we can identify, what are the veterans  
21 talking about? What are they saying their  
22 concerns are and how are they using language?



1           So that when we go back to them in  
2           some of the follow on studies that we'll tell  
3           you about, we can make sure that we are  
4           asking them questions in a way that they're  
5           understanding our questions, and that we  
6           understand their answers. This is a project  
7           that again, was 100 percent privately funded.  
8           As I mentioned, it is being led by USUHS, and  
9           it is scheduled to be wrapped up next month.

10                    Research Project 2 is called  
11           Common Components of Success, and that is  
12           what I would like to spend the bulk of our  
13           time discussing. The goal in this particular  
14           project, and I think it was alluded to in the  
15           last talk by DCoE, is that we want to be able  
16           to identify what are the common components  
17           across the interventions that veterans are  
18           actually using after they separate from  
19           service, that the evidence shows are  
20           associated with successful outcomes.

21                    What we are not looking at is, we  
22           have no interest in grading any particular

1 program, and I'll discuss that a little bit  
2 more later. Our focus is in the components  
3 of the programs themselves. Our desired  
4 outcome from this particular study is to  
5 create a menu, if you will. And it's a menu  
6 that can be used by a variety of  
7 stakeholders. The menu will have a list of  
8 common programmatic components that appear in  
9 the different programs that the veterans  
10 report that they utilize, and then we will  
11 have across from the different components,  
12 associated outcomes, positive, neutral and  
13 actually, negative.

14           And that's one of the issues that  
15 we really want to look at. Are there aspects  
16 of particular programs that may actually  
17 inadvertently be driving negative outcomes?  
18 So that's something that's very interesting  
19 to our research group. We are in the  
20 process, right now, of just going out and  
21 talking to private sponsors. And this is a  
22 research undertaking that has been about a

1 year in development. We have nine co-PIs  
2 working with us representing seven different  
3 organizations, and here they are.

4 So, again we're in the center  
5 because we are the group that is constantly  
6 out there nagging everybody don't forget the  
7 meetings, don't forget to send in your  
8 materials. We have US Army Public Health  
9 Command, United States Military Academy  
10 representing DoD. We have three VA  
11 researchers. Penn State is represented with  
12 two researchers and ICF International, you  
13 may recognize one of the names, Dr. Suzanne  
14 Lederer, PhD is one of our PIs who's been  
15 with us from the beginning.

16 CHAIR CROCKETT-JONES: Can I ask  
17 you a quick question? Does your research  
18 separate out the general veteran from  
19 veterans who are leaving after being  
20 designated wounded or injured?

21 MS. GILMAN: It will. And I will  
22 be talking a little bit more, but you raise a

1 great point. The research is broader than the  
2 focus of this task force. So what we are  
3 going to be looking at are all departing  
4 servicemembers, and then we're going to be  
5 putting them into different categories of  
6 different demographics, and that's probably  
7 our most important demographic, but it's not  
8 the only.

9 As I mentioned, we have strategic  
10 advisors. And this is a group of folks whose  
11 names you may well recognize. They have,  
12 Secretary Peake has been with us from the  
13 beginning, as has General Schoomaker, and  
14 General Roudebush. They have been the ones  
15 who are helping us in terms of thinking about  
16 the strategic approach we need to take, as  
17 well as helping make connections along the way  
18 to get over bureaucratic hurdles that,  
19 shockingly, we encounter from time to time.

20 We have a scientific advisory  
21 committee. And again, these are the  
22 individuals who are looking at the science

1 that's being proposed. For this particular  
2 study, our first scientific advisory committee  
3 will be in Bethesda next week. And we'll have  
4 all of our research and all of our scientific  
5 advisory committee members there in person.

6 And we have a team of stakeholder  
7 advisors. The list that you have is just a  
8 partial list. It's growing, truly, by the  
9 day. We are delighted by the attention and  
10 interest that people are expressing.

11 We have a big tent and we want as  
12 many people who are as interested in working  
13 collaboratively to come on in and be engaged  
14 because again, we as the Project Director  
15 have, you know, in talking about the authority  
16 that was discussed in the last panel, we have  
17 zero authority, none. The only way we're able  
18 to get all these folks around the table is by  
19 being somewhat persuasive and convincing folks  
20 that this would be a good idea, and it seems  
21 to be working so far. So that's why we have  
22 really tried to identify the people who are in

1 this arena and invite them to come in and  
2 participate.

3 The research team has worked, as I  
4 mentioned, for the past year. They have  
5 developed six research questions that they say  
6 they will be answering at the completion of  
7 this study, although they say there will be  
8 many more that are spun out of the study as  
9 well.

10 The first one is, how well are  
11 veterans reintegrating across domains? We  
12 want to be looking not only at the health of  
13 the veteran population, but we want to look at  
14 how they're they doing socially, economically,  
15 financially, in their families, spiritually,  
16 et cetera.

17 Are there sub-group differences in  
18 reintegration outcomes? How are our wounded,  
19 ill and injured doing compared to the rest of  
20 the population? How are the women doing? How  
21 are officers versus enlisted? How are four  
22 years and out versus twenty years and out, and

1 so on and so forth. How's the Guard and  
2 Reserve, big piece of the study.

3 And we want to know how do  
4 reintegration outcomes vary over time. We  
5 want to look and see, are people doing pretty  
6 well the first three months, six months after  
7 they get out and maybe there tends to be a  
8 real drop-off? Ideally, down the road we're  
9 going to be looking for tell-tale warning  
10 signs so that we can look at different ways to  
11 intervene. This particular study is not an  
12 intervention study. It's purely  
13 observational. But we're going to be looking  
14 for trends that we may see along the way.

15 We want to know what types of  
16 programs are the veterans actually using? We  
17 said there's 45,000 plus of them, and that's  
18 just in the community, but that doesn't even  
19 include the VA and the DoD. And by the way,  
20 it is perfectly fair for us to be looking at  
21 DoD and VA programs too, as a part of this  
22 study. And I will tell you how we'll be doing

1 that, but the primary focus really is the  
2 community-based organizations and what they're  
3 providing.

4 We want to know, are the veterans  
5 using sports programs? Are they using peer  
6 mentoring? Are they going to mental health  
7 programs? Are they using those electronic  
8 devices that are out there and seemingly cool?  
9 Are they using them? And what program  
10 components are the predictors of reintegration  
11 outcome success over time?

12 Again, that to us seems to be  
13 really at the core of this. If we can  
14 identify what aspects of programs the evidence  
15 show drives success, then particularly as  
16 resources become more scarce, programs may  
17 become fewer, we can then really have a better  
18 understanding of where do we need to be  
19 putting our time, attention and resourcing?

20 And finally, we want to know what  
21 individual characteristics of those individual  
22 veterans are influencing the impact of



1 programmatic components. Just as important to  
2 us as what programs are you using, and what  
3 components are driving your outcomes, is maybe  
4 you're not using any programs at all and  
5 you're doing just great. So we want to be  
6 looking at, or you can have, high-performing  
7 veterans, low-performing veterans. And then  
8 look to see, are those high-performing  
9 veterans correlating with a common form of  
10 component that may, in fact, be associated  
11 with why they are performing well?

12 So our study design is as follows.  
13 It is a five year study. There are two  
14 different sub-studies that comprise the study.  
15 They are depicted in two different colors.  
16 The yellow is representative of what we call  
17 our Outcome sub-study. And purple is our  
18 Program sub-study. And each of them will be  
19 running concurrently.

20 But let me explain, if I may, how  
21 the study is going to operate. In year one,  
22 we will be spending the year doing lots of

1 preparatory work. Actually, there's been a  
2 lot of preparatory work that's been done for  
3 the past year, but then we'll spend another  
4 year doing a deeper dive into the literature  
5 review, into instrument design, looking to see  
6 what are the other folks out there, some we've  
7 already heard from, others we haven't. What  
8 have they already designed? What are they  
9 using for their metrics so that we can -- to  
10 the extent, validated metrics measurements  
11 already exist -- we can use them if they make  
12 sense, and then we can adapt them as need be.  
13 We will need to be getting our regulatory  
14 approvals and we'll need to be doing study  
15 recruitment.

16 Our study on the longitudinal  
17 outcomes study is as follows. We are looking  
18 to recruit 7,500 active duty servicemembers  
19 and Guard and Reserve, who are within zero to  
20 ninety days of transitioning out of active  
21 service. And what we would like to do with  
22 those folks who will be representing all of

1 the services, so 1,500 from Navy, Army, Air  
2 Force, Marines Corps and 1,500 Guard and  
3 Reserve. We want to recruit them to the study  
4 at T1, which is in that zero to ninety days  
5 pre-separation period. And we want to assess  
6 their well-being at baseline.

7           And again, the well-being  
8 assessment tool is a tool that's going to be  
9 developed during that first year. But it is,  
10 in essence, to be looking at how is this  
11 person doing across a whole host of domains,  
12 to include physical and emotional health,  
13 financial security, family, so on and so  
14 forth.

15           And then we will be visiting with  
16 these folks again every six months thereafter  
17 for a period total of three years after they  
18 leave service. So we're going to be tracking  
19 their well-being as they go home and  
20 reintegrate. We will also, at each one of  
21 these points in time where we connect with  
22 them, ask them what kind of program and

1 service are you using? And we will just  
2 collect the information that they give us. So  
3 they will identify for us what we're calling  
4 Veteran Utilized Programs, or VUPs.

5 We will take the list of those VUPs  
6 and our Outcome sub-study team will hand that  
7 list to our Program sub-study team. And our  
8 Program sub-study team will get busy looking  
9 at the list of programs that the veterans  
10 themselves say they're using, and start  
11 breaking them down into their component parts.  
12 They'll do that by looking at websites that  
13 discuss the different programs, doing  
14 literature reviews to see if anything has been  
15 written about them, contacting the different  
16 programs directors, so on and so forth.

17 So, for instance, if Sergeant  
18 Jones, now Veteran Jones, says he is using an  
19 Acme Fly Fishing Program, Acme would be  
20 identified as a VUP. The Program sub-study  
21 group would look at that program and say,  
22 okay, here are the component parts. It is --

1 and I'm making these up because this may not  
2 be what the component parts are, but for  
3 purposes of discussion -- outdoors, physical  
4 activity, one-on-one relationship between  
5 Sergeant Jones and the fishing guide, who by  
6 the way happens to also going to be a veteran  
7 of the same era.

8           And so you'll see, what we are not  
9 looking at is how does Acme Fishing do in the  
10 life of this individual. But we are breaking  
11 it down into component parts and compiling all  
12 of these different components across programs  
13 together. And then we will look to integrate  
14 the data between how our folks are doing and  
15 the components that they're utilizing. So  
16 that's the very simplistic way of saying what  
17 it is that our research team wants to do.

18           We want to be able to look at, as  
19 I mentioned, our high-performing veterans and  
20 say, is there commonality among components  
21 that they're using? Are there some folks that  
22 are doing poorly and we see that there is a

1 common component that, in fact, may be  
2 associated with those negative outcomes? Are  
3 there people, again, who are functioning great  
4 and doing nothing? And what does that mean?  
5 So that's the kind of analysis, by doing this  
6 integrated data set, where we will be doing  
7 lots of coding between the different  
8 individuals who are being surveyed and the  
9 different programs and the components that  
10 they utilize.

11 Yes.

12 MEMBER DRACH: Can you go back a  
13 minute to the continuum? So you're going to  
14 be looking at 7,500 active duty, zero to  
15 ninety days out.

16 The continuum says that you'll be  
17 looking at transition and community  
18 reintegration up to approximately three years  
19 thereafter. So if I'm reading this correctly,  
20 this is a three-year project or longer?

21 MS. GILMAN: It's a five-year  
22 project.

1 MEMBER DRACH: Five-year.

2 MS. GILMAN: The first year is the  
3 preparatory work. Three years will be spent  
4 then doing the data collection. Actually  
5 that'll go through year four. Year five is  
6 the final number crunching and the analysis.

7 MEMBER DRACH: So you will or will  
8 not be able to gather any data on services,  
9 programs utilized post-discharge, or will you

10 MS. GILMAN: We will because in  
11 fact we think those will be the majority of  
12 what we are collecting. The only survey piece  
13 that's going to happen pre-discharge is at T1.

14 That's within the zero to ninety  
15 and we anticipate at that point when we ask  
16 them what kind of programs and services are  
17 you utilizing, it'll probably be a TAPS  
18 program of some sort or something else DoD  
19 related.

20 But then after is what we're really  
21 going to be collecting the bulk of the time.  
22 Once they go home are they still using what

1 the DoD is providing or the VA is providing.

2 MEMBER DRACH: Thank you.

3 MS. GILMAN: Yes, any other  
4 questions? So we were asked why we think this  
5 is unique and we do because, for a few  
6 reasons.

7 We think because it is involving  
8 all of the different services to include  
9 Garden Reserve and we are looking at multiple  
10 sub-groups, as I mentioned before, the  
11 wounded, ill and injured.

12 We'd looking at folks who have been  
13 deployed and haven't, who've had combat  
14 experience and haven't. So really looking  
15 across broad demographics.

16 And also I should mention, one of  
17 the things we're really interested in looking  
18 at is where are these folks going home?

19 Are they going to rural  
20 communities? Are they going to urban centers?  
21 Are they going to places where there is a lot  
22 of connectivity with VA facilities or DoD



1 facilities?

2 Is there a large military  
3 population around them or not? And how is  
4 that going to correlate with their outcomes as  
5 well? So that's another really interesting  
6 piece to our group.

7 Again, we think that there will be  
8 rich data that is collected. We also think  
9 it's interesting to be able to start to  
10 understand with all of these programs out  
11 there, what are people actually doing?

12 Are they doing it online? Are  
13 they, you know, do they want their one on one  
14 peer type relationships, which are much more  
15 expensive.

16 These are the kinds of questions  
17 that a lot of the private funders really want  
18 the answers to because as they're developing  
19 programs they need to answer to their boards  
20 where should they be putting their resources.

21 We think that it will be pretty  
22 ground breaking research in that we don't

1 think that there's anything out there at this  
2 point in time quite like this.

3           There are certainly other  
4 longitudinal studies and other studies that we  
5 would love to be able to correlate with if it  
6 makes sense to do so.

7           We are looking to be highly  
8 collaborative and interdisciplinary, and the  
9 fact that we have been able to pull not only  
10 DoD and VA together, which I think all of you  
11 have done a fantastic job of doing more  
12 collaborations among agencies, but pulling the  
13 civilian side in as well.

14           And we are not shy about bringing  
15 in industry because we are a 501(c)(3) and  
16 we're not using government funds. We have  
17 much more flexibility on the ability to work  
18 with the private sector and people within the  
19 private sector we want to work with.

20           And we anticipate being able to  
21 rapidly and broadly disseminate the findings  
22 and the data.

1                   There will be the ability of our  
2                   core researchers to do some preliminary  
3                   publishing on the work that they do, but then  
4                   because HJF will be the owners of the data we  
5                   will, subject to making sure that the data is  
6                   compliant with IRB requirements and PII type  
7                   issues, we would like to make this data as  
8                   broadly available as possible to interested  
9                   researchers who can demonstrate that they can  
10                  put it to good use so that we can get it out  
11                  there as broadly as we can to make this data  
12                  used and advance the science as quickly as  
13                  possible.

14                  And finally we were asked to  
15                  discuss the intersection between our work and  
16                  what it is that this task force does. We put  
17                  up both of our goals breaking them down.

18                  Yes, your population of focus is  
19                  the recovering warrior. Ours is all  
20                  transitioning servicemembers to include  
21                  recovering warriors.

22                  Your purpose, and I don't mean to

1 marginalize, and if I'm not stating anything  
2 correctly or broadly enough my apologies in  
3 advance, but in essence assess the  
4 effectiveness of DoD programs and policies.

5 Ours is to measure evidence-based  
6 effectiveness of interventions on veteran  
7 outcomes, writ large irrespective of who may  
8 be providing those interventions.

9 Our focus is on the spectrum of  
10 transition continuum well being interventions  
11 across multiple domains. So again where you  
12 all are looking while folks are predominantly  
13 still on active duty, our focus is when  
14 they're getting off active duty and going  
15 home, and the three years thereafter.

16 And our goal is to be able to  
17 develop these metric tools to help guide the  
18 use of resources owned by DoD, VA and civilian  
19 communities, to maximize the return on  
20 investment, if you will.

21 So one of the thoughts, a key party  
22 that we believe will be wanting to use the

1 menu will be, for instance, a private sector  
2 funder who has their door knocked on daily,  
3 ten times a day saying support me, support me,  
4 support my organization.

5 Currently they have no way of  
6 assessing other than, kind of what their gut  
7 tells them, or what the organization tells  
8 them about the efficacy of that particular  
9 organization.

10 We believe that by giving them this  
11 menu, through this particular study, they'd be  
12 able to say okay if you want money let's go  
13 through your program, let's look at the  
14 component parts.

15 Oh you've got three out of ten that  
16 are shown to be effective. You've got nine  
17 out of ten that are shown to be effective.

18 So now we have a measurable tool to  
19 allow funders to be able to drive the change.  
20 And we really do believe that funders will be  
21 the ones who will drive this change, at least  
22 on the community side.

1                   And finally we just wanted to give  
2                   you an idea of what our cost is. We are  
3                   anticipating that this study should be about  
4                   \$8.3 million.

5                   It's interesting when we present these  
6                   dollars, some people say oof, that seems like  
7                   a lot of money, and others say eww that's not  
8                   enough money.

9                   So we figure that we're probably  
10                  doing something right if nobody agrees. And  
11                  as we said, we are out now talking to the  
12                  private funding community looking for support  
13                  and we've got a lot of interest that we're  
14                  really delighted by.

15                  So that concludes our presentation.  
16                  Would be happy to take any questions anyone  
17                  may have?

18                  CHAIR CROCKETT-JONES: Do you have  
19                  any academic partners?

20                  MS. GILMAN: We do. So we have  
21                  been working with Penn State University. Our  
22                  three different VA researchers all also

1 represent academic institutions. Boston  
2 University, Texas. Katy help me, help me.  
3 Katy is my brain for these sorts of things.

4 MS. HUSSEY-SLONIKER: So Boston  
5 University is one of the VA. Texas A & M is  
6 another. And University of Texas, San Antonio  
7 Health Science Center is the third.

8 MS. GILMAN: And then USUHS is very  
9 involved with us. On this particular study,  
10 they are not at the table, but they are very  
11 involved in scientific oversight.

12 CHAIR CROCKETT-JONES: Just also --

13 MS. HUSSEY-SLONIKER: And as well  
14 on the Scientific Advisory Committee we have  
15 the University of Southern California, School  
16 of Social Work. So the Director of The Center  
17 for Innovation for Veterans and Families.

18 CHAIR CROCKETT-JONES: I'd just  
19 also, there is a lot of veteran intervention  
20 services groups that are located on college  
21 campuses that sometimes go under the community  
22 radar because they have sort of a different,

1 they have yet another sub-group population of  
2 veterans who are pursuing academic, not  
3 industry, necessarily as their -- It's one of  
4 the reasons I asked.

5 MS. GILMAN: So like The Student  
6 Veterans of America, we've talked with them.  
7 And they're, we think a real important group,  
8 on this educational side of the house,  
9 absolutely.

10 MEMBER MALEBRANCHE: So on your  
11 population, is this study a traditional study  
12 in that you're following a veteran or a  
13 servicemember as that person over time?

14 Or are you following, it says  
15 population, it looks like individuals, but you  
16 are talking programs. So are you identifying  
17 them like you do in a study by a number or  
18 something, but it's individual over time on  
19 how they do for outcomes?

20 MS. GILMAN: Yes. So we are doing  
21 a couple things. We are following individuals  
22 over time to assess their outcomes. We're



1 following individuals over time to ask them  
2 what programs and services they use, because  
3 we think those may change over time.

4 So we're going to continue to  
5 collect more names of these VUPs. And we will  
6 also, as we're getting more names of the VUPs,  
7 continue to gather data on more VUPs.

8 MEMBER MALEBRANCHE: Okay, and then  
9 you mentioned that the data is owned by The  
10 Jackson Foundation?

11 MS. GILMAN: Right.

12 MEMBER MALEBRANCHE: But is that  
13 data then available to DoD and VA? Or I mean  
14 it's going to be openly--

15 MS. GILMAN: Right.

16 MEMBER MALEBRANCHE: -- kind of  
17 used that way?

18 MS. GILMAN: Absolutely. We would  
19 love DoD and VA to use the data as they would  
20 like. And then again we've got the DoD and VA  
21 researchers who are at the table with us.

22 VA has been very engaged with us

1 from the very beginning so we think that  
2 they'll be all over the data, which we're  
3 really pleased about.

4 MEMBER PHILLIPS: Question. What  
5 mechanism are you going to use to recruit  
6 people? Are you going to send out emails, go  
7 to a post, or how are you going to do it?

8 MS. GILMAN: Great question. Lots  
9 of discussion. So originally we wanted to  
10 recruit in person at the different  
11 installations, at the different TAPS programs.

12 And then we started crunching the  
13 numbers and realized that not only would that  
14 be cost prohibitive, but just the logistics of  
15 getting on to all of the different  
16 installations from all of the different  
17 services.

18 So we have decided instead to  
19 approach this through the DMDC, Defense  
20 Manpower Data Center, and to access our study  
21 population that way.

22 By reaching out, identifying them

1 across demographics, our statisticians and  
2 others will be the ones who are going to be  
3 tasked with figuring out who we should reach  
4 to, how many to reach to in order to be able  
5 to recruit our 7,500 number figuring there  
6 will be attrition along the way and so on and  
7 so forth.

8 And then we plan to incentivize  
9 people to participate financially. And the  
10 incentives we anticipate will go up  
11 incrementally the longer they stay with us.

12 MEMBER PHILLIPS: Are there going  
13 to be any exclusion criteria like folks with  
14 less than honorable discharges? Are you going  
15 to look at recruitment incentives or why they  
16 joined up? I'm just asking.

17 MS. GILMAN: No, it's a great  
18 question. There was definitely discussion  
19 about the - do we want to get into the less  
20 than honorable discharge arena.

21 I'm not sure that the jury has  
22 completely resolved that issue yet. Though I

1 think the consensus was let's not go there  
2 because we've got to get going.

3 And there's so many different ways  
4 that we can slice and dice this then we put  
5 that in the category of for the moment it's  
6 just too hard.

7 Similarly, along those lines, we  
8 wanted to be able to reach to family members  
9 as well, but too hard at the moment. But we  
10 would like to be able to put them into one of  
11 our follow on studies pretty quickly, with one  
12 exception.

13 For the wounded, ill and injured  
14 population, if the servicemember, veteran  
15 isn't able to respond for his or herself,  
16 family member would be able to respond, or  
17 caregiver, on his or her behalf because we  
18 absolutely want to capture that demographic in  
19 the study.

20 MEMBER DRACH: Will you be looking  
21 at employment, such as, did you go back to the  
22 job you had before you went in? If not, why

1 not?

2 Did you get a job? How soon after  
3 discharge? Are you still with the same  
4 employer? Have you been promoted? Those  
5 kinds of things?

6 MS. GILMAN: So that really goes  
7 back to the measure and the measurement  
8 instrument that our team is going to be using.  
9 It hasn't been designed yet.

10 At this point in time there is a  
11 well-being model that the research team on the  
12 outcomes sub-study side is very interested in  
13 following. It was a model that was developed  
14 by CNAS.

15 One of the lead authors is now over  
16 at RAND. They developed a very comprehensive,  
17 we think, definition of what is well-being,  
18 what is wellness because we want to look  
19 across all these different domains.

20 What they have not done though, is  
21 themselves developed the measures on how do  
22 you assess, you know, employment. And in fact

1 they have chosen not to use the term  
2 employment.

3 They're using the term vocation.  
4 But that is all first year type of work that's  
5 going to get done. So what we're looking for  
6 at this point in time is we want to say we've  
7 got the funding in place, let's go.

8 And then all of this will get  
9 developed in year one, to answer those kind of  
10 specific questions.

11 MEMBER REHBEIN: Yes that was going  
12 to be my comment too. You talk about  
13 successful veteran outcomes, but quantifying  
14 success is a real can of worms because  
15 success, what for me is success might not be  
16 for somebody else because of the difference in  
17 expectations.

18 So I think that's going to be a  
19 significant challenge. Good luck with that  
20 one.

21 MS. GILMAN: Yes it is. And which  
22 is why we have no interest in trying to

1 reinvent any wheels to the extent anybody DoD,  
2 VA, civilian, academia has created something  
3 already.

4 We're reaching to them again, like  
5 the CNAS/RAND folks and they are stakeholders.  
6 Both CNAS and RAND are very active within our  
7 stakeholder community so that we can tap into  
8 their expertise, and others.

9 CHAIR CROCKETT-JONES: Well thank  
10 you Ms. Gilman. Thank you very much.

11 MS. GILMAN: Thank you. I  
12 appreciate the opportunity.

13 CHAIR CROCKETT-JONES: You ready  
14 Denise? I know you wanted to present some  
15 recommendations from other committees. Do we  
16 need a break first?

17 DIRECTOR DAILEY: Yes, let us. I'm  
18 sorry guys I need one so I'm going to go out.

19 CHAIR CROCKETT-JONES: Okay.

20 DIRECTOR DAILEY: I'll be right  
21 back. They are going to cue up my briefing  
22 and then we'll, we'll go.

1                   CHAIR CROCKETT-JONES:   Okay, very  
2                   good. Ten minutes.

3                   DIRECTOR DAILEY:   Five minutes.

4                   CHAIR CROCKETT-JONES:   Five  
5                   minutes.

6                   (Whereupon, the foregoing matter  
7                   went off the record at 4:00 p.m. and went back  
8                   on the record at 4:05 p.m.)

9                   DIRECTOR DAILEY:   Okay ladies and  
10                  gentlemen. This is a continuing series of  
11                  briefings that Dr. Phillips wanted us to look  
12                  at in helping us craft recommendations for the  
13                  end of this year.

14                  So in October I went through a  
15                  framework of what areas might have holes or  
16                  gaps of the Task Force's charter items that we  
17                  haven't made recommendations on, or that we  
18                  could move forward and make recommendations  
19                  on.

20                  So the gaps, what has been covered  
21                  and what has not been covered, and a framework  
22                  from him on items which might even be outside



1 the box of the Task Force, but that need  
2 harmonization.

3 And that was his word,  
4 harmonization. So he recommended in that  
5 framework to us that we take a look at the  
6 reports of the major committees and agencies  
7 that have made recommendations on the wounded,  
8 ill and injured.

9 So the Research Team, I assure you,  
10 did most of this work. There are a lot of  
11 reports that have been done. So we had to  
12 cull that down a little bit.

13 And we're going to take a look at  
14 recommendations from the major committees.  
15 We're going to look at the status of those  
16 recommendations. And we're going again try  
17 and see what the gaps are.

18 What's been implemented? What  
19 hasn't been implemented? So I am going to ask  
20 you, would you please Steven? Okay, so we'll  
21 talk a little bit about how we do incorporate  
22 these findings into your reports.

1                   Long story short, when you come up  
2 with a recommendation, the research team does  
3 a literature search. And they find other  
4 reports that have made a similar  
5 recommendation

6                   And they utilize the information  
7 and the data, and they incorporate it into  
8 your findings to add substance to your  
9 findings.

10                  So you don't get briefings on every  
11 report that has come out in the last ten  
12 years, or five years. But the research staff  
13 has got a pretty good purview of what's out  
14 there and brings it into your recommendations.

15                  No, the next slide. All right, so  
16 I've kind of gone through this slide already.  
17 We are going to talk about the major reports.  
18 We are going to talk about the recommendations  
19 of those reports.

20                  And we're going to look for what's  
21 been implemented and what hasn't been  
22 implemented. Maybe have a little discussion

1 about why haven't been implemented. Are they  
2 still important?

3 Can we add something to that body  
4 of knowledge? Is it a direction for  
5 recommendations that you want to go down?

6 Okay, next one. Okay, so also covered this a  
7 little bit.

8 This is some of the specifics that  
9 talks about what we have, and how we do this  
10 research for you. We send out what's called  
11 an RSS feed, and you get that on a quarterly  
12 basis.

13 You get two items per topic area,  
14 the charters topic areas. The research team  
15 sends out to their topic leads, like, ten  
16 articles, or ten reports. But what we send  
17 out to you is probably the two most relevant  
18 items that came in on that RSS feed.

19 So we have a way to get you very  
20 focused information, but the people who are  
21 studying this topic get it much broader. And  
22 that's what this slide is talking about.

1       Okay, next slide.

2                   All right, so I have a line here  
3       that says since FY '11, that means since we  
4       started the task force, we have been through  
5       a series of reports. We have looked for the  
6       most relevant ones.

7                   And over these last three years we,  
8       The Task Force Research Team, picked out 13  
9       major reports that have come out since 2007.  
10      And again I had to limit it, so I took these  
11      last six, seven years from 2007 to 2013, so  
12      last seven years.

13                  Thirteen major reports and they are  
14      listed here. In the back of this briefing the  
15      13 major reports and all of their  
16      recommendations are listed.

17                  So if you are interested in what  
18      the recommendations of the 13 major reports  
19      have been from these last seven years, you'll  
20      see a Word document of about ten pages that  
21      lists all of those recommendations.

22                  So then out of this 13 we then pick

1 the top five reports. And we are going to go  
2 over the top five reports, their  
3 recommendations, and somewhat a subjective  
4 evaluation of whether those recommendations  
5 from those five reports have been implemented.

6 And again, from that we're going to  
7 come to a slide that talks about what hasn't  
8 been implemented. Is there a place for us in  
9 that space for recommendations for the task  
10 force. Okay, next slide.

11 This slide, real quick, talks about  
12 where we have pulled in other recommendations  
13 for the Task Force's recommendations over the  
14 last three years. Next slide.

15 So these are the slides, these are  
16 the five reports that we have selected and  
17 their recommendations that we are going to  
18 look over.

19 So The President's Commission on  
20 Care for America's Returning Wounded, Ill and  
21 Injured Servicemembers commonly referred to  
22 the Dole-Shalala.

1                   This next one, which is commonly  
2 referred to as The RAND Report, basically put  
3 a stake in the ground on what it's most, many  
4 relevant findings.

5                   Ms. Gilman mentioned that she's got  
6 RAND working with her on her research. But  
7 this report, if you remember we commonly say  
8 12 percent to 20 percent of returning combat  
9 servicemembers will be experiencing PTSD.

10                  This is the report that that came  
11 out of. That's been a real stake in the  
12 ground for measuring PTSD rates among the  
13 combat.

14                  So significant reports, one of the  
15 reasons why we selected it. The Franks  
16 Report, this was an internal Army report  
17 actually.

18                  And I'm not even sure it's ever  
19 been fully published, but it had a number of  
20 significant recommendations in the area of  
21 IDES. So we thought it was going to be  
22 relevant here.

1                   The next report is, and I think Ms.  
2                   Gilman also mentioned this one. This is The  
3                   Center for New American Security and it is  
4                   kind of a think tank event.

5                   We selected it because it was  
6                   actually kind of out-of-the-box thinking from  
7                   a non-DoD entity. And it had some interesting  
8                   recommendations which I have, we really  
9                   couldn't assess very well, but I wanted to  
10                  show them to you.

11                  And then the last one we got a  
12                  briefing on last fall was the first report  
13                  from The Institute of Medicine on  
14                  Psychological Health. Okay, next one.

15                  All right, so Dole-Shalala, Dole-  
16                  Shalala made six, I thought it was seven, but  
17                  I think number two is broken down into two  
18                  recommendations.

19                  The Dole-Shalala recommendations  
20                  were kind of a broad framework for moving  
21                  forward much of what we see in our culture of  
22                  wounded warrior care now.

1                   And of course the first one is the  
2                   Comprehensive Recovery Plan and the status for  
3                   that, although we can argue about whether  
4                   people know about it or not. It's out there.

5                   It is a part of the wounded care  
6                   culture without much doubt. How well it's  
7                   implemented at various locations is debatable,  
8                   but it's a part of our culture, so, well  
9                   inculcated.

10                  The second one is an IDES  
11                  recommendation and I call it The Cultural  
12                  Change of the IDES Concept, changing the  
13                  benefits, changing the way we look at  
14                  disabilities.

15                  And this one didn't get traction,  
16                  so under my status here I have no checkmark.  
17                  Now it's broad. It includes some things that  
18                  have happened, but the genesis of this second  
19                  recommendation, which is a culture change on  
20                  how we evaluate disabilities, how we assign  
21                  benefits, did not make it into our current  
22                  lexicon of care and disability evaluation.



1                   The other, Post Traumatic Stress,  
2           I put a check on this because we can agree  
3           there has been a lot of work done on post  
4           traumatic stress. Just a bevy and we got a  
5           good look at it today.

6                   So I put a check by that. Support  
7           for Families, I put a check by that. I don't  
8           think any of us are satisfied yet about the  
9           status of families, the level of information  
10          they receive, how well they are inculcated.

11                  And you know, anybody uncheck these  
12          boxes anytime if you want to leave them open.  
13          But I did bring this one in to being well  
14          worked by the Department of Defense, if not  
15          efficiently worked.

16                  And then the last one, the number  
17          five, transfer of records between services,  
18          transfer of records between DoD and VA.  
19          Probably another one where you'd kind of like  
20          to say no, not really. But not neglected.

21                  Not worked well, but not neglected.  
22          Not kicked to the curb. It's been worked.

1       Whether successfully or not is subjective and  
2       I am happy to uncheck these blocks at any  
3       time.

4                   And the last one was, I do find the  
5       last one kind of ironic. As we heard today,  
6       you know The Bethesda Hospital, now Walter  
7       Reed National Military Hospital, is  
8       overmanned.

9                   One of the big emphases of Dole-  
10       Shalala was to make sure they didn't shut down  
11       Walter Reed, fire everyone and then have to  
12       start up again at Bethesda.

13                   And really, you know, five or six  
14       years later what you have is an over manning  
15       and an imbalance, but that was the outcome of  
16       keeping everybody on the books and not having  
17       a gap in service providers.

18                   So Dole-Shalala six, seven, however  
19       you want to look at it. The one that's really  
20       not been worked is the culture change in the  
21       IDES benefits disability evaluation.

22                   Not that a lot of work hasn't been

1 done there, but that culture change and how we  
2 are going to evaluate disability is not in a  
3 discussion.

4 All right, so RAND is our next,  
5 these are RAND's recommendations. Increasing  
6 cadre, again I put checks on these because we  
7 have seen a lot of data on how this is moving  
8 forward.

9 Again, subjective, I can take them  
10 off at any time. But again, these are not  
11 recommendations that aren't being worked.  
12 They are in the discussion, so to speak.

13 Seek care, this is the stigma  
14 recommendation, and to eliminate stigma.  
15 Psychological health, how to get people to  
16 care. Again a lot of work is being done in  
17 this area.

18 Evidence based treatment, number  
19 three. Number four, invest in research.  
20 Again, lots of recommendations, lots of work  
21 done on these recommendations, so they are not  
22 lacking in evidence.

1                   They are not lacking in work by  
2 other committees. Our value added to these  
3 groupings of recommendations might not, or  
4 might add to the weight, but are we adding  
5 anything new? Next one.

6                   And we move on to The Franks  
7 Recommendation. So, a lot of things the  
8 Army's done to implement The Franks  
9 Recommendation's specifics. This was a  
10 tactical, was both a tactical report by  
11 General Franks and a strategic report.

12                   And the strategic piece being  
13 number two, which was a national dialogue on  
14 establishing paradigm shifts away from our  
15 current system.

16                   And then recommendation three,  
17 transforming the compensation and disability  
18 evaluation processes to address rehabilitation  
19 and transition back to either uniform or  
20 service in the military.

21                   I didn't put checks there. Not a  
22 lot of progress on this lane, again. We've

1 got command emphasis on getting through the  
2 PB, MEB, a tactical recommendation.

3 I think I am going to agree that's  
4 there. And then we are also educating cadre,  
5 bringing people, informing them, and this was  
6 also relevant in the USAR and The National  
7 Guard.

8 So again, somewhat subjective on  
9 this one. If you don't think we're there on  
10 that one then, you know, I can uncheck that  
11 block. But it's talked about. There's policy  
12 out there.

13 It's got programs and money.  
14 Whether it's been effective or not is again,  
15 subjective. All right. And then we had some  
16 more recommendations by Franks, yes. NARSUMs,  
17 you know, we talk about NARSUMs.

18 We've made recommendations on  
19 NARSUMs, legal assistance. In many ways this  
20 is very gratifying here to look at these  
21 recommendations and see how much work has been  
22 done.

1                   And you're also reinforced a lot of  
2 these recommendations. So many of these are  
3 worked, working, or worked and not working.

4                   And next slide we'll talk a little  
5 bit about, I didn't check these for The Center  
6 for New American Security. They were very  
7 broad. And they were very strategic in  
8 nature. A whole new definition for caring for  
9 our wounded warriors was this first one.

10                  Now I'm not sure that it hasn't  
11 been addressed by President and Mrs. Obama's  
12 initiatives on coming home. She's done a lot  
13 of work on The Coming Home Program.

14                  Not sure that we aren't addressing  
15 it answering this one with the President's  
16 initiatives. I don't think we're fully  
17 satisfied with number two, which is the  
18 partnership between us, DoD, VA and the  
19 civilian environment.

20                  It's not that we don't see a lot of  
21 collaboration between DoD and VA, but are we  
22 seeing enough collaboration with the civilian

1 entities such as the non-profits that Ms.  
2 Gilman just talked about.

3 The colleges that we have visited  
4 and saw the collaboration down in Tampa. So  
5 this one has a lot to do with our outreach to  
6 the civilian community, not necessarily  
7 intergovernmental.

8 And I think three has been addressed  
9 very significantly. And a lot of the language  
10 in three is captured in the current Inter-  
11 Agency Care Council, so three has got some  
12 traction in DoD and in VA.

13 A lot of the language in this  
14 recommendation is captured in the IC3 language  
15 that we are continuing to kind of punt to, to  
16 fix some of the inter-agency issues we see.

17 All right, now The Institute of  
18 Medicine's study had to do with psychological  
19 health. And so the questioning here is we've  
20 done a lot of work on psychological health, a  
21 lot of agencies have done a lot of work on  
22 psychological health, do we have more work to

1 do for our recommendations in the areas of  
2 psychological health?

3 I didn't check this first one, but  
4 I do think that the most recent DVBIC,  
5 clinical practice guidelines that we were  
6 circulating among the task force, kind of  
7 answers number one.

8 Now I did this briefing back in  
9 October and we were just circulating that  
10 information this week. But I do think that  
11 this collaboration on the clinical practice  
12 guidelines not only for TBI, but also for  
13 psychological health, has been answered.

14 And I could put kind of a check  
15 here with some confidence. Number two talks  
16 about increasing the number of psychological  
17 health providers in both the VA and the DoD.

18 We've made recommendations along  
19 that several times. I think last year we kind  
20 of came to the conclusion that the amount and  
21 the training is satisfactory.

22 Effectiveness, evidence based



1 treatments, metric outcomes is where, as of  
2 last year, you all wanted to put your  
3 emphasis, but this train has moved along  
4 enough that we think numbers are probably good  
5 and training is in place.

6 It's all there. How well it's  
7 working is again subjective. So three is very  
8 similar. Recruit, hire, train. We kind of  
9 think they have that down.

10 Again your emphasis has shifted  
11 from those premises to measure, evaluate  
12 effectiveness, determine what's working and  
13 what's not working.

14 Then they also talked about, number  
15 four is very big one that I think is being  
16 answered by IC3. So items that are checked  
17 kind of have got a lot of work behind them.

18 We can see success over the time  
19 period of these major recommendations. They  
20 are repeating themselves in many of these  
21 recommendations in different language and  
22 different vernacular.

1                   So what, if we look at all these,  
2                   what is unimplemented? Are there trends  
3                   across all of these that are unimplemented?  
4                   Do we have a place to make a recommendation  
5                   about unimplemented recommendations?

6                   So when you look at them, these are  
7                   the ones again, I came up with. This is the  
8                   generational change to IDES. Again not seeing  
9                   a lot of work in this area, although a lot of  
10                  work is being done in IDES.

11                  There is no one seriously looking  
12                  at a different disability benefits system.

13                  (Off microphone comment)

14                  DIRECTOR DAILEY: Yes. No traction.

15                  (Off microphone comment)

16                  DIRECTOR DAILEY: Yes, I do. If  
17                  you, I am happy for, yes --

18                  CHAIR CROCKETT-JONES: I think  
19                  that, yes, I think that there is a lack of  
20                  political will. There is a lack of traction.  
21                  There is a cost benefit, you know, wall that  
22                  we hit.

1                   But I think that there also is sort  
2 of a cultural component of this, which is, I  
3 know that we, as we've gone around and looked,  
4 you know servicemembers feel like the process  
5 is confrontational and somewhat punitive.

6                   And I think that there is a portion  
7 of the population that wants to keep it that  
8 way. You know I think that that's part of why  
9 there is no traction for change is because  
10 there is a sense of who deserves benefits.

11                   Do you see, do you see what I'm  
12 saying? And so I think that this is a really,  
13 really hard one that I'm not saying that we  
14 shouldn't make recommendations in this.

15                   I think that in this area we  
16 should, you know, leaving our voice with  
17 however the task force feels, voicing it  
18 regardless of how it might be received might  
19 be important.

20                   But I do think that this is one  
21 that has a number of reasons why it is not  
22 going to get traction.

1                   MEMBER PHILLIPS: I was looking at  
2                   it from a little different point of view  
3                   though. I don't disagree with what you are  
4                   saying. I think there have been a lot of  
5                   technical issues that have been stumbling  
6                   blocks for this to occur.

7                   The lack of harmonization or  
8                   integration of electronic health information  
9                   within the DoD and the VA, not so badly within  
10                  the VA, and also between the DoD and the VA.

11                  And hopefully with the new effort  
12                  to create a single, or a harmonized,  
13                  electronic health record with health  
14                  information transfer, might make it easy then  
15                  for people to go back and say well you know,  
16                  we have all the information now.

17                  There are a lot of duplication and  
18                  similar things that both groups are doing,  
19                  even though we may have different outcome  
20                  expectations or recommendations.

21                  I think we could, you know, look at  
22                  a way to make this a better system. And I

1 would, you know, encourage us to consider sort  
2 of a recommendation along those lines, related  
3 to the fact technology now while going forward  
4 will permit us to make this a better single or  
5 integrated system whether it's on the VA side.

6 I mean there is a lot of thought  
7 that the DoD should not even be doing this. So  
8 I think we have an opportunity to at least  
9 have a say in what's going to go forward.

10 (Off microphone comment)

11 DIRECTOR DAILEY: Okay. And then  
12 this, the other areas that I left unchecked,  
13 had to do with the very, you can change the  
14 slide, had to do with this harmonization  
15 between agencies and non-profits.

16 So these are a lot of the  
17 recommendations that came out of the CNAS  
18 study about interweaving all of these efforts  
19 together and creating better bridges and  
20 crossroads into the civilian environment.

21 This is where their emphasis had  
22 been on. And think we all can agree there is

1 a lot of work being done in the DoD/VA piece.

2 But as we've seen in Tampa, when we  
3 were out at Utah with the community based  
4 warrior transition unit and their work with  
5 the rehabilitation center, there was a lot of  
6 harmonization of their efforts and our efforts  
7 that have not gotten traction.

8 And I think this is also a part of  
9 your concern Dr. Phillips, that we are  
10 utilizing these resources in the civilian  
11 sector.

12 CHAIR CROCKETT-JONES: Yes, The  
13 National Ability Center out in Utah was that,  
14 it was that example. And yes we certainly  
15 have seen sort of anecdotal, or grassroots, or  
16 localized collaboration and partnerships but  
17 they all seem to have had to overcome  
18 obstacles from above as far as the DoD goes.

19 You know even, then in some cases  
20 it's almost like the DoD was the obstacle to  
21 making those partnerships happen. And that is  
22 a concern.

1                   I mean there are other places we  
2                   have seen it, but isn't that what we've heard  
3                   from folks that have been trying to make these  
4                   sort of local collaborations, is that the, you  
5                   know, DoD makes it difficult rather than, yes.

6                   MEMBER PHILLIPS: No, I agree. I  
7                   mean it's an issue that people address but we  
8                   haven't really attacked it. When you think  
9                   about roughly 22 million servicemember  
10                  veterans being provided care, roughly 50  
11                  percent of that care is outside of the VA  
12                  system.

13                  And so, you know, when half of the  
14                  people are being, I don't want to say ignored  
15                  because they're not, but not within capture,  
16                  then I think that creates difficulty.

17                  DIRECTOR DAILEY: So, went through  
18                  these five reports, looked at what's been  
19                  worked real hard and what hasn't been worked  
20                  real hard.

21                  And so subjective assessment brings  
22                  us to this kind of universal dialogue about

1 disability, benefits, how do we allocate  
2 fairly and what's a new paradigm for doing  
3 that.

4 And then how do we strengthen the  
5 ties with our civilian partners, and bringing  
6 our civilian non-inter-agency, non-  
7 governmental partners into caring for the  
8 servicemember and the veteran.

9 So those are kind of the gaps that  
10 I would leave you with as you, as we go into  
11 our last meeting, which will be in February.  
12 It's not our last meeting. It's our last  
13 information gathering meeting.

14 And I'll have time in that meeting  
15 where we'll review what we went over in  
16 October, talk about some recommendations that  
17 you've voiced already.

18 We'll review this and we'll kind of  
19 set the stage for the next meeting, which will  
20 be in May, for how do you want this last  
21 report to look? Questions? Okay. Thank you  
22 very much. I will see you all tomorrow



1 morning at 8:30. Is that right 8:30?

2 CHAIR CROCKETT-JONES: 8:30.

3 DIRECTOR DAILEY: 8:30, 8:30.

4 CHAIR CROCKETT-JONES: That's what  
5 you have on the sheet so I am living by it.

6 DIRECTOR DAILEY: And that's when  
7 we're doing it, 8:30. I know, you know, I  
8 usually have in here at 8:00 cracking the  
9 whip, but I gave you all a half hour now, so.

10 (Off microphone comment)

11 DIRECTOR DAILEY: I know, I know.

12 Yes.

13 CHAIR CROCKETT-JONES: It's too  
14 cold to make anybody get here at 8:00 I think.  
15 So 8:30's great.

16 DIRECTOR DAILEY: Oh yes, me too.  
17 It's too early. Okay, thank you. And you  
18 know, it's your last year, ladies and  
19 gentlemen. I'm cutting you all this slack, I  
20 know. Thank you.

21 (Whereupon the meeting was  
22 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.



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Court Reporter

**NEAL R. GROSS**

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