UNITED STATES DEPARTMENT OF DEFENSE

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

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BUSINESS MEETING

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MONDAY
JANUARY 14, 2013

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

PRESENT:

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

ALSO PRESENT:
AMBER BAKEMAN, Research Staff
JOHN BOOTON, Operations Staff
LaKIA BROCKENBERRY, Operations Staff
BARCLAY P. BUTLER, PhD, Director, DoD/VA Interagency Program Office
DENISE F. DAILEY, PMP, Executive Director
THOMAS J. DEGRABA, MD, Deputy Director, NICoE
COL DONALD GAGLIANO, MD, MHA, Executive Director, Vision Center of Excellence
JOHN HEGGESTAD, Operations Staff
JESSICA JAGGER, PhD, MSW, Research Staff
CAPT. SARA M. KASS, MD, Deputy Commander, NICoE
JAMES P. KELLY, MD, FAAN, Director, NICoE
CAPT ROBERT KOFFMAN, NICoE
MARY LAWRENCE, MD, MPH, Deputy Director, Vision Center of Excellence
SUZANNE LEDERER, PhD, Research Staff
STEPHEN LU, Operations Staff
MATT McDONOUGH, Research Staff
DAVID McKELVIN, Operations Staff
HEATHER MOORE, Operations Staff
BILLIE J. RANDOLPH, PhD, PT, OCS, Deputy Director, Extremity Trauma and Amputation Center of Excellence
ANNE SOBOTA, Operations Staff
JIM WOOD, Operations Staff

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

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

8:09 a.m.

MS. DAILEY: Ladies and gentlemen, we are going to start our meeting. I have a number of members who will be coming in later in the morning. In fact, we have one individual with a household emergency. But I would like to bring the task force to the table and turn it over to Ms. Crockett-Jones, if you would, please.

CO-CHAIR CROCKETT-JONES: Certainly. Good morning, everybody. Thank you for attending the January business meeting. We have some notable events, and I'd like to mention these before we go on.

We have three new task force members, Vice Admiral Matthew Nathan, our new DoD co-chair; Major General Mustion, who is not here yet. Is he coming later today?

MS. DAILEY: He flew in this morning. He's probably landing right now. And then they're going to -- my staff will

zip him over here from the airport.

CO-CHAIR CROCKETT-JONES: Very good. And Technical Sergeant Alex Eudy, from the U.S. Air Force Special Operations Command, who some of us have already met on an installation visit. Congratulations on your appointments. And we're excited to have you all on the team.

We also have the pleasure of congratulating Justin Constantine, who was promoted to Lieutenant Colonel in the Marine Corps Reserves as of January 1. Congratulations. You know we all think you deserve it.

And as our new DoD co-chair, I invite Vice Admiral Nathan to address the task force members with any opening remarks he wishes to make.

CO-CHAIR NATHAN: Thank you, Suzanne. Well, it really is a pleasure to be here. It's, for those of you -- I've read all of your backgrounds. And for those of

you who may be familiar with mine, prior to this job I was the Commander at the National Naval Medical Center.

And then was working to create the synergy of bringing Walter Reed and Bethesda together. So just as I got there is when they started putting the first shovel in the ground to build the place.

I remember, in the middle of the construction and the zenith of the war, and the casualty rate was coming in. And I had a procedure, a minor procedure. And they were putting me out. And they said, Skipper, is there anything you want to say before we put you out? And I said, just wake me up when the damn place is built.

But I, basically, during that time was involved and engaged, and looking at and dealing with, both on the personal level, the tactical level and the strategic level, of returning wounded warriors.

It gave me a very good look at

some of the differences that exist among the services, and among the VA, among DoD, in our approach to wounded warriors, ill, injured, the families, and the communities that are affected.

You can't be around these folks, and again, I'm humbled to be in your presence. All of you have credentials and/or experience, and/or backgrounds that I can only speak to, but I can't completely empathize with.

So I recognize that there are people here who have intrinsic personal issues, and have dealt directly in their own lives or in their family's lives with this.

All I can do is try to learn from you, try to be your advocate, try to tap into your collective wisdoms and experience. And use that along with this group to try to make a difference in what is a very, very complicated emotional issue.

I was at a Tank recently. The

Tank is where the Joint Chiefs of Staff meet. And we were talking about wounded warrior paradigms. And some of the problems that exist in supporting wounded warriors, not only strategically and through a national referendum. But tactically on the family to family issues.

And we basically summarized it by saying it is probably the most complicated care dynamic during and before and after injuries and illness, of any population of the most deserving population in the world, under the most scrutiny of any population in the world. And so we have our work cut out for us.

And I think that I'm in the receive mode to learn more and more about what we do here, how we do it. How we can somehow thread commonality to many of the applications and resources that exist.

And just one quick story that I would tell elected leaders, and senior

military personnel, and representatives who would come through. And they'd ask me, well what changes had you noticed for wounded warrior care, both in the medical care and the non-medical support over the years?

And my answer was, when I first got into this business, and this was before Bethesda. This was taking care of wounded warriors in Portsmouth and other places, six to ten years ago. Families would complain that they didn't know where to go.

They had no real resource. They were sort of left in the lurch. Who was going to come into the room and tell them who was responsible for helping this, or what agency could do that?

And now, five years later, the families say, or ten years later the families will say, well, the good news is that 20 people have walked into the room every day and handed me their business card. Each agency got this and this and this. And if my

husband's big toe hurts, call this person. And if the pay for the meals doesn't arrive, call this person. We don't know who to call. There's too many people. We feel we're overwhelmed.

And so we still need to, I think, find a collective synergy that can make it simple, and make it easy. And provide confidence to the people, not only who live near Richmond or Tampa or Bethesda, but those who live in the rural and suburban areas of the country who sometimes feel that they're left out.

So I'm very much looking forward to trying to link arms with you and lean in on this. Say from the outset that, again, I'm humbled by the collective experience, wisdom, and personal interaction that many of you had with these issues. It is the spirit of these men and women who have served, and the families.

We are going into our eleventh

year of war. A wounded warrior that is affected today, in my experience, is in even more dire straits, because they've been exhausted for years.

You go out to Walter Reed today to the families, and they're different than the families that we saw five years ago. The families that are affected now have had many years of recurrent deployments, exhaustion.

And now if they become severely wounded or ill, they have even less reserve than they did five or six years ago, to cope with some of this. And so I think that this is a critical effort that we're in.

The last thing I'll say is, and this is an elephant in the room that I think we need to deal with. The fiscal uncertainties. The obvious one, which is the Sword of Damocles, the sequestration that's hanging over us.

The military health system is reorganizing in a way that's unparalleled in

the last 50 to 100 years. There's going to be a creation of a Defense Health Agency.

The flagship hospitals at Walter Reed and Bethesda are now going to be compartmentalized out from under the services. They will no longer be under Navy or Army purview. But will be under the purview of the Defense Health Agency, which will report to the Assistant Secretary of Defense for Health Affairs and the Undersecretary of Defense for Personnel and Readiness.

So that represents a big change itself. And that's an effort to create a more joint approach to care, and find synergy, efficiencies, and savings. So we have to work that scenario.

There's going to be the creation of what's called Enhanced Multi-Service Markets, which will affect places like Portsmouth, Brooke Army Hospital, or the San Antonio Medical Centers, San Diego, Madigan,

our major medical centers.

Many of our main casualty receiving and treatment facilities will now be under Market Service Managements, which again will be under service purview, but have a more collective approach to them. So we're really sort of standing the whole place on its ear.

And we're hoping that we're going to find efficiencies and gains out of this. But the ground is shifting beneath our feet as we walk on it in military medicine right now.

And as we try to partner with the other organizations, and that's what I think is so critical about this organization, is tying it up.

I always get nervous when -- or I'm always somewhat frustrated when people drop names. I don't believe in doing that. When I was talking to President Obama a couple of years ago when he first --

Actually, it was probably about four years ago when he came into office for the first time, and was walking around making his first visit to Walter Reed. He was asking about the hand off and how we do that, between the Department of Defense and the VA.

And at the time I said to him, if we went to my office at Bethesda we could get on the computer screen. And using what's called TMIP, I could show him real time care occurring to a sailor on an aircraft carrier in the South China Sea.

I could show him the lab results. I could show him the results of the physician's notes. I could show him in real time what was happening to a sailor ten thousand miles away in the middle of the sea.

I told him I could not show him what was happening to one of our people who was at the VA, eight miles away. That the electronic records had not yet merged. And we had no visibility.

And that the number one complaint from our warriors when they went to the VA system was not that the care wasn't good. The care was passionate, the care was good. There was gaps because they didn't have the records.

And so those are the kind of things that I think we have to solve and we have to highlight. And we have to highlight the differences between the services as well. Some of them are culture specific, and I get that. But other times there are, I think there are best practices between services that aren't shared.

And I think we can do that as we look at that. So again, I'll just conclude by saying I'm humbled to be here. I'm passionate about this. And I do it because of the spirit. I'm infected by the spirit of these amazing men and women who serve their country.

And this, my actually last little

sea story. But I tell it everywhere I go, about the spirit of wounded warriors. We had a Marine at Bethesda about three years ago. He had come in, he had lost one leg below the knee, and would eventually go on to lose one hand.

He had arrived -- As you know, the big change in this conflict compared to previous wars, Viet Nam, World War I, II, Korea, Viet Nam, where the average medevac time in those facilities from the theater to the states was 45 to 60 days, before somebody seriously injured would get back to the states.

And as you know now, the average is three to four days. So the families often arrive at the same time as the wounded warriors do. The families are taken back. They haven't had time to adjust. They're sort of caught flat footed by this, by the time they jump in the car, go to the airport, and we fly them to meet their loved one at

Bethesda or San Antonio or San Diego.

Anyway, this young man, this Marine was in the bed. And he had just arrived the day before. His family had arrived that day. He had a little boy with him, his wife was with him.

The little boy looked at him and said, "Daddy, are we still going to Disney World this summer?" And this was in the fall. He was supposed to come back in about the spring. And he came back early because he was wounded.

And he didn't know what to say to his little boy. And, you know, his wife started tearing up, and the little boy started tearing up. And I said, "Look, this is in the summer, this coming summer?" He said yes.

I said, "Look, you're going." I said, "Not only that," I said, "You'll be able to get around. And you'll be able to ride every ride. I know it. I've seen it.

That's how it works." And so everybody was very happy.

And the Marine kind of motioned me to him. And I bent down. And I said, "Marine, I'm not making this up." I said, "With your injuries you'll be back on track under your own steam." He said, "Sir, it's not that." He said, "I didn't like those rides before I got hurt."

So this is the kind of spirit that we have to advocate for and preserve and make a difference for. So I look forward to doing that with all of you. Thank you very much.

CO-CHAIR CROCKETT-JONES: Thank you. I'd like to have us go around the table and conduct introduction. Since we have new members, I ask that everyone provide a little more detail than the quick introductions we do at some of the business meetings, including mentioning your time on the task force and the individual representation and

interests you have in your work on the task force.

And I'd ask the new members to provide some historical information about yourselves, so that we can get to know you better. And right now, that's going to put you in the hot seat. But I guess we'll go around and start with Mr. Rehbein.

MEMBER REHBEIN: Thank you for allowing me to be the guinea pig. My name's Dave Rehbein. I've served on the task force since its inception. And have been very pleased to do so, and very encouraged by the progress that is being made on a number of our recommendations.

I really spent my life in a dual career, because I am a research scientist in the material science physics area at Iowa State University, which operates a Department of Energy laboratory. I worked there.

The other half of my career was my avocation through the American Legion

serving veterans, not only those coming out of the military, but those that have been out of the military for a number of years. To include eventually being elected National Commander of the American Legion in 2008.

I am now semi-retired from the University, working part time there. And doing this, and feeling like I've taken another part time job. And that's not what I intended to do when I retired. But that's my background.

And I would like to just say a word of welcome to the new members on the task force. You're replacing good people. But I have no doubt that you will provide equally as valuable a service.

MEMBER EVANS: Good morning. I'm Captain Constance Evans. I'm with the Bureau of Medicine Case Management. Background, 26 years this month in the Navy.

Past two years, probably three years now, worked with the wounded warriors

over at Walter Reed. And I tell you, that was a eye-opening experience.

And I think the SG spoke well of how we see the warriors every day. We saw the warriors every day, and listen to some of the concerns.

And I think, just being a member of the task force and knowing the history of knowing how our families and our warriors want to be integrated back into society. But just meet a lot of obstacles out there. I think this is the right group to make those obstacles go away.

So my two to three years of working over at Walter Reed, learning all the services, the differences, the culture differences, this has really brought that together. And I appreciate you allowing me to be a member for the past year. Next month will make one year of being on the task force.

MEMBER PHILLIPS: I'm Steve

Phillips. I've been a member of the task force since its inception. And I'm honored and pleased to be here. The makeup of the task force is incredible.

There's a tremendous diversity and tremendous intellect. The staff is beyond reproach. They actually have set us off in the right direction. And keep us focused.

I'm a physician. I practice cardiac surgery. I lived in Iowa for 30 years. I now work at the National Institute of Health, National Library of Medicine. I run a division over there. This is official duty for me. And so I take it very seriously.

And in many respects I can use the resources of my parent institution to support these efforts. We've come a long way, but we really still have a long way to go. I appreciate everything that has been done by our service members.

I'm a Vietnam veteran who was a reservist until 1993. And hopefully in the next year and a half or so, we will be able to get some of these things done.

MEMBER KEANE: Lieutenant Colonel Sean Keane. I'm part of the Marine Corps' Wounded Warrior Regiment. My day job I work at the VA. I'm the Marine Corps liaison to the VA. Work in our non-medical case management for our wounded, ill, and injured Marines.

I've been on the task force since inception. And my full time job here on the task force is taking care of Captain Evans, keeping her in line.

MEMBER EUDY: Technical Sergeant Alex Eudy. I'm representing both the Air Force and Special Operations Command. I come to the task force as a ground operator from Special Operations.

Was wounded in 2009 serving with Marine Special Operations. And just

redeployed, actually last year, after return to duty in a non medical case management role for our forces at Bagram. So trying to provide a different perspective.

But my mission being on the task force, I'm able to get that ground operator perspective from the majority of our wounded, which come from our enlisted corps and our middle ranks of the enlisted corps. Especially coming from a return to duty perspective. I know what it means to fight to stay back on duty.

So with that, I've had three years of experience dealing as a liaison with our families from all services. I've been blessed to have that joint knowledge of seeing all these policies and procedures, how each one is written differently.

And so it's nice to be able to walk in and have that joint perspective. I'm very blessed in that manner. But I look forward to being able to provide that. And

to be that voice for our junior enlisted force that's out there. I'm just very fortunate to be here. Thank you.

MEMBER CONSTANTINE: Good morning. I'm Justin Constantine. I'm here because of my background as an attorney. Currently, I work as an attorney with the FBI on a counter-terrorism team. I've had other federal jobs on Capitol Hill and Department of Justice before that.

Like Alex, I have an understanding of the wounded warrior mentality, because I was shot in Iraq in 2006. And as you heard, still in the reserves. I am in the IDES process now facing, experiencing a lot of challenges that we've heard about from other wounded warriors and their families who have spoken. So the program still needs a lot of work.

And I've been here since the inception as well, and have been very happy to be a part of this. I think we're doing a

lot of good work. As we all know, even if we do the work here, there's so much that needs to be implemented at the lower levels, that I hope we can really make and effect some change in that department.

CO-CHAIR CROCKETT-JONES: And I'm Suzanne Crockett-Jones. My husband is an Army Infantry officer who was wounded in 2004 in an air ambush in Ramadi. He was physically injured.

And really, before that in his deployment to Afghanistan in 2001, he really started having issues with post-traumatic stress. But Iraq sort of sealed that deal.

He also has been diagnosed with traumatic brain injury. I remember when that was first being discussed, because this has a been a particularly long road for us. It wasn't even on the plate when he first came back.

And I found out, you know, how many times he actually lost consciousness and

was obviously concussed, and hadn't -- it's pretty shocking. Yes, he definitely had a TBI. It took him forever to deal with that.

But anyway, I have been on the task force since it began. I have a very special interest, obviously, in families and how they experience this process. My husband recently completed his IDES and retired in July.

He was fortunate, and began a job again within five days of his retirement. So I've seen how the rehab works. And it has worked fairly well for him. Although we may not stay on that path.

He's already discovering that his diagnosis makes for some complications in being employed. So we're going to go through every wrinkle that we look at, at this task force, it seems we're going to experience in this family.

I'm happy to be here. I am amazed at the talent and intellect, and

experience of this task force. When I first arrived, I was sure that somebody would fire me immediately if I opened my mouth.

And I'm happy to say that that hasn't been true. That this is a real problem-solving task force. That people can be heard. And I'm very proud of this task force and the work here. And I'm just thankful that I'm still here and still working on it. And we're still trying to tackle it.

We're good. Normally during this time we discuss site visits. And we have had some. But I think instead we need to review the recommendations, especially since we have some new members here. And the response, Tab B in your briefing books.

We'll wait until tomorrow to do the site visit review, after the public forum. So if we can go to Tab B and look at the recommendations and responses. We have received responses to last year's

recommendations. And those are in Tab B.

MS. DAILEY: Ladies and gentlemen, I'm going to walk you through the recommendations at this time. But I would also, before we start this, I would like to take the opportunity to introduce the staff.

Sorry, ma'am, I didn't put it in red on your script. But I would like to take the opportunity to introduce the staff so that you know who the players are in this room.

And I'm going to start back here right behind you, sir, ma'am, with our research staff. And I'm going to let them introduce themselves. And we'll just start at the left and go down the line there.

MR. MCDONOUGH: Good morning, everyone. My name is Matt McDonough with the research staff. I've only been on for three months. So I'm relatively new. But I'm excited to be here. I have a Masters in Anthropology. And I'll be primarily working

on the focus group analysis.

DR. JAGGER: Good morning. I'm Dr. Jessica Jagger. I've been on the staff since we started. And I'm the research director, happy to serve as your research director.

Topic lead also on non-medical case management and units and programs. And do most of the lead analysis work on Congressional activity, Legislative affairs, and policy.

DR. LEDERER: Hi. Dr. Suzanne Lederer, Deputy Director of the research team. And I'm specializing in the reserve component issues as well as transition outcomes, and whatever else is necessary.

MS. BAKEMAN: Good morning. My name is Amber Bakeman. This is my second year working with the research team and the task force. I have a Masters in Clinical Psychology.

I've worked with Defense Centers

of Excellence and I just returned back from Minnesota. Out there I was serving with Americorps, and worked at the Veterans Treatment Corps out there, and just accepted a position at Walter Reed as a recovery care coordinator.

MS. DAILEY: So this is our research team, ladies and gentlemen. I'd now like to introduce our operations team.

MR. BOOTON: Hello, everyone. I'm John Booton, Director of Operations. I'm going to pass you all to Jim.

MR. WOOD: Good morning, I'm Jim Wood. I'm the hard copy records manager for the recovering warrior task force.

MS. MOORE: Good morning. I'm Heather Moore. I'm the event planner. I'll be on all the trips. This is my second year, third round of installation visits.

MS. BROCKENBERRY: Hi, I'm LaKia Brockenberry. I'm the executive assistant. I am proud to say that I have been with the

task force since its inception back in 2010.

MS. SOBOTA: I'm Anne Sobota. And I'm the alternate designated federal officer for the task force.

MS. DAILEY: Sir, if I drop dead, Anne is here to take over all my functions.

MR. McKELVIN: Good morning. I'm David McKelvin, technical writer here for the task force. Just started probably about six months ago with the task force. But I'll be in charge of all the correspondence and communication that goes out.

MR. LU: Hi. My name is Stephen Lu. I'm essentially the resident techie here. And I'm the web developer, I coordinate outreach, and I also manage the social media.

MR. HEGGESTAD: Good morning. I'm John Heggestad. I'm the budget analyst of the task force. I deal with supplies and any other little thing that comes up around the office. I get the grunt work sometimes.

Don't mind doing that. I appreciate what we can do for the task force to support it.

MS. DAILEY: And this gentleman here changes pretty much every week. But he is our transcriptionist. We hire a company to come in and do a transcription of our meetings.

All right, ladies and gentlemen, I would like to take this opportunity to go through the 2012 recommendations. And as we received the DoD responses last Thursday actually.

And I'd like to remind everyone that according to our Congressional charter, at 90 days DoD has a requirement to respond to Congress with, using the legislative language, "with an evaluation of the task force's recommendations."

At 180 days they, DoD, has a requirement to submit to Congress the implementation plan. So we were fortunate enough, like I said, last Thursday to get a

copy. These have gone to Congress.

And a reminder, again they're responding to Congress. They're not responding to the task force. And we track this information so that we can understand where our recommendations are, what their status is. Again, we are making recommendations. It's up to the Department of Defense to implement, concur, non concur.

And we will start with number 1. This very first recommendation had to do with the implementation, the writing, and publishing of two DoDIs and one AFI. And as of today the AFI, the Air Force's policy has been written. So we have a partially concur on this statement.

They're still working on the E2I and the OWF DoDI. So these are still in the writing, researching and developing stage. So this first recommendation, Air Force has published its wounded warrior non-medical case management AFI, they call it.

MEMBER EVANS: Denise, so why did they partially concur with it. The intent is to publish, right?

MS. DAILEY: Correct. The partially concur is one of them has been accomplished. The other two have not been accomplished.

MEMBER EVANS: All right. I think they should have concurred and then given a time frame of -- but I mean, I think once the report comes out -- do we have an opportunity to respond to the report?

MS. DAILEY: The services will be coming to the table in February to walk through the recommendations that deal specifically with the services. Now an actual response, we do not formulate and craft an actual response to the DoD evaluation plan or implementation plan to Congress.

MEMBER EVANS: Okay. It should have been a concur with a time line of when

the other two would be -- and we did recommend when the report came to the facilities, we recommended a concurrence on through all the DoDI, but just a time line of when all of them would be published.

MS. DAILEY: So in your Tab B, on the other side of these PowerPoints, is DoD's response. So on page -- it's right behind the cover page that looks like this. If you'll keep flipping, you will see this logo.

And so their full response was: "DoD's intent is to provide additional guidance on the E2I initiative and the OWF in clinical case management, as part of the implementation plan."

Now I do believe they're talking about the 3 March, 180 day implementation plan to Congress. The other highlighted guidance that Air Force recommended be published, the AFI was published on the 21st of June.

CO-CHAIR CROCKETT-JONES: The

office that's responsible for writing those DoDIs, is that the policy office that we have been briefed from before?

MS. DAILEY: Correct.

CO-CHAIR CROCKETT-JONES: Are they --

MS. DAILEY: Warrior Care Policy is responsible for the E2I and the OWF, Operation War Fighter, program, yes.

CO-CHAIR CROCKETT-JONES: Are they on the schedule at all to talk to us later this year?

MS. DAILEY: Yes. The other one we will get a briefing on today, and we'll be able to talk with the individuals who are writing it, is the Medical Case Management. The directive type memorandum expired Friday. And we have the crafters of the new DoDI coming to talk to us tomorrow afternoon.

So on number 2. We explained in our findings and our recommendations that there is still confusion about the roles of

the RCCs, the federal care coordinators. The Department of Defense has initiated a task force that is going to address this.

In fact, Ms. Malebranche and Captain Evans are serving on it. It's called, or was called -- let's go to "is called." It's currently called the Integrated Care Coordination Committee. And they are working on streamlining the roles of our various care providers.

And they've described it as pretty aggressive to try and streamline this process. So we are expecting, and they are anticipating some information that will be relevant by the March time frame. And will include that in the implementation plan also, provided it's ready.

MEMBER KEANE: Ma'am?

MS. DAILEY: Yes.

MEMBER KEANE: I'm also on that task force. I don't know if you knew that.

MS. DAILEY: Oh, okay. No, I did

not. I appreciate you bringing that to my attention. Good. Am I on track there? You are anticipating a product or being able to influence, publish, bring to table your recommendations in the March time frame? I don't want to put my members on the spot here. I've asked, and will ask for a formal briefing from this --

MEMBER EVANS: Right. And we've submitted, we have a plan. But to be honest with you, I'm not sure if that, if the inter-agency, DoD/VA is addressing this recommendation specifically.

We have some recommendations that went up to the JEC and they were approved. SECDEF and SECVA signed off on the mission statement or the intent letter.

But again, this particular recommendation did not make it to the final report. And so I'm not sure. I don't want to put myself out there. But I don't think we're addressing this issue.

MEMBER KEANE: I'm on that tiger team that's specifically trying to define FRC and RCC. And again, I don't know where it is, as far as has it left. We haven't had a meeting since December.

MEMBER EVANS: Right. So again I think it will be, I think we need to have the co-chairs of the IC3 come brief the recovering warrior task force on the recommendations that went before the JEC.

CO-CHAIR NATHAN: Not only brief that there is guidance being published. But what is the metric to determine that is occurring at the deck plate? In other words, what is going to be their measure of effectiveness?

It's one thing for us to publish something that says, you will not cut the blue wire, you will only cut the red wire. How do we go out in the field and find out that they are only cutting the blue wire? So that would be something we would want to hear

back as well, is how they're going to measure their effectiveness.

MS. DAILEY: Yes, sir. Good. The next recommendation has to do with what the task force called a Recovering Warrior Bill of Rights.

We asked commanders, and we directed it this year to the DoD level, to provide guidance to the field on treatment and care of recovering warriors when they're in their line units, and when they're in the units that are specifically designed as transition units, WTUs, wounded warrior battalions.

So they concurred with this recommendation. And DoD -- and I keep saying "they." "They" is DoD. WCP, the Warrior Care Policy office compiled and synthesized these responses.

So "they" is DoD/Warrior Care Policy. They said they would be providing further guidance and would be providing

guidance to the field.

Number 4 was a task force vision for the future. The acknowledgment and discussion last year revolved around understanding that the war was going to wind down. The significant level of expertise in both the VA and the DoD needed to be preserved.

And so your fourth recommendation was for both DoD and VA to find a way, should partner with the VA to further promote inter-agency collaboration and co-locate/integrate the rehabilitation centers that both, and the capabilities of both departments. And then this would continue to facilitate seamless transition.

But the vision here was a plan in which they would have a way to bring the VA rehabilitation capabilities, and the DoD capabilities together for a long term preservation of the capabilities that have been developed over the last ten years. DoD

concurred with this. However, they didn't provide any other information other than a concur.

Number 5 is a controversial recommendation, one of our more controversial recommendations. Concern expressed in Recommendation 5 by the task force is that again, intrinsic capabilities developed in the Warrior Care Policy Office, which is a new entity, less than five years old.

And the task force's discussion on this and recommendation to DoD is that this office's functions be captured in legislation. And DoD non-concurred with this, saying, not a requirement, not necessary.

We're here and we're doing our functions. And we have the correct level of leadership. So this was a non-concur on Number 5.

Number 6 was about Twenty-Nine Palms. We've made two visits out to Twenty-

Nine Palms. Lots of good things happened between the first one and the second one.

As a task force, and as a member who went out to Twenty-Nine Palms, we wanted to re-emphasize that Twenty-Nine Palms is a major platform for deployment for the Marine Corps.

And a decision on the Marine Corps' part to keep a detachment there, instead of sending wounded warriors to San Diego at the regimental headquarters, the West Coast battalion headquarters and the larger unit at Camp Pendleton.

And if you're going to keep a detachment there, the task force wanted to enforce, reinforce that necessary resources have to be committed to this. We need your deployment platform that the Marines operate at Twenty-Nine Palms.

Some of the specifics included including more transition assistance. And they have, since then, put a transition

coordinator in, a VR&E representative there, just as a example. And in the February meeting there the Marine Corps will also talk to us about this recommendation.

All right. And we're on to extending TAMP. You can see DoD is going to look at this. The discussion of the task force last summer was about extending TAMP for one year, versus the current six months.

And we were, had gotten significant feedback that the TAMP period was just too short. Put that in our findings. You all voted to extend it for one year.

This is a TMA, a TRI -- excuse me, this is a TMA and a TRICARE issue. And so the fact that it would be under review and require some review by the analysts and policy makers is not unusual.

When you, anything we do with TRICARE, ladies and gentlemen, you have to anticipate it may even take legislative actions to change. Because much of the

TRICARE care for our service members is embedded in law.

All right. Next slide, yes. Excuse me. This was our recommendation about ensuring that 100 percent of your behavioral health providers are receiving care, are receiving the proper training and evidence based treatment. And are able to provide that evidence based treatment to service members.

You also wanted to extend this to ensuring that in the primary care clinics, that providers in the primary care clinics were able to identify post-traumatic stress syndrome. And were aware of proper procedures for further referral into the behavioral health lanes.

So you have a concur on this. However, DoD has some concerns. And they kind of spread your answer out a little bit to talk about further evaluation.

But your intent here was to

ensure your primary providers have been trained in evidence based training. And that your primary care providers and you primary care clinics are able to identify PTSD symptomology, and refer it into behavioral health.

Along with that, you wanted a more clear audit trail on successful outcomes for PTSD evidence based treatments. So in your next recommendation you really want, and voted to recommend to the Department of Defense that they are auditing PTSD evidence based treatments for outcomes.

Are they being successful? Are the treatments being utilized in accordance with the clinical practice guidelines? And you pretty much have the same answer here you had on the first one. Some of these things are in place. It doesn't appear to be doing systematically.

But the culture of a metric, as Admiral Nathan talked about for evaluating

success of these programs is what you have been advocating.

CO-CHAIR NATHAN: We'll hear from, I think, Jim Kelly and the NICoE today. And NICoE mainly deals with TBI, but also overlaps into PTS and PTSD.

This is, I think, and I'm just bringing my perspective as the new guy. This has been one of the real problems of good intentions. There is a variety of ways that PTS and TBI is being treated throughout the medical continuum, to include the private sector, academic sector, and the federal sector.

This gets at the heart of trying to find a collaborative approach that can be measured across the spectrum. Right now you're not able to do that. Because the way they treat patients in San Antonio is somewhat different than the way they treat patients in Washington, DC, which is different than the way they treat patients at

UCLA or in Madigan.

So I think one of the things we have cut out for us is to figure out how to provide impetus and resource oversight, so that best practices are disseminated.

This is why the NICoE was created, was to try to find the test kitchen, if you will, for the franchise that's going to find the best recipes that make the most difference. And then disseminate those, share those, branch those out into satellite NICoEs, which are going to be stood up in seven places around the country.

But our big problem is that we don't have a best practice that's been agreed upon and bought into by all the services, and the Department of the VA. So again, when we talk about everybody should get the clinical practice guidelines, we've got a bigger problem than that. We've got to first agree on what those are.

And I think that's going to be

one of the things we're going to, I think we should throw our weight into, is to force the services to really come together on what best practices are and clinical practice guidelines are across the spectrum.

MEMBER EVANS: Just a quick question. So would that be NICoE? We also have DCoE coming in to speak. So I think the confusion too, who has the responsibility of making sure when they look at the practice guidelines and disseminating, would that be NICoE or DCoE?

It should be interesting to clear that picture so when we have, when we make the recommendations for next year we'll know who has that overarching responsibility.

CO-CHAIR NATHAN: Right. And part of the problem as you know, Connie, is DCoE was stood up to be a policy agency, without a lot of execution authority. And the NICoE is all about execution.

And so DCoE is a think tank that

assimilates these centers of excellence, and comes out with policies on what they should be doing. But there was always a missing step there to get DCoE to the execution phase. How does DCoE then execute these?

Case in point, you call up San Antonio, and you say, send your patients to the NICoE because we think we have the best TBI and PTS algorithms. And San Antonio says, thank you very much, but we do it pretty well here ourselves.

And you say, well do you do it like they do it at NICoE? Don't know, don't care. We have our own world here and it works pretty well.

And so that's changed by some external pressure applied by the former Vice Chief of Staff for the Army, who said, you guys are going to get on board. But that's the problem we had. And DCoE has no execution authority over the services in that regard.

And so I really think, and again, not to advocate the new changes that are coming, but this is part of the genesis of the Defense Health Agency, which is being created, which will then have some cognizance over all the services and the way they provide this care.

So I think we're heading in the right direction. But again, I would offer up to the task force that one of our major problems is there is passion everywhere. People's hearts are in the right place.

But there is not coherence across the spectrum of what the clinical practices should be. And that's true in the civilian sector as well.

So we're looking for ways that we can create one stop shopping, just as much as a family would like to have a 1-800 recovering wounded warrior number to call to ask them about VA benefits, DoD benefits, how long you cook a three minute egg, whatever.

Medical personnel need to know, just tell me what you think the clinical practice guidelines are and I will follow them. But so far, all I have is my local instructions.

MS. DAILEY: Number 10, ladies and gentlemen, takes us into the non medical case management arena. The recommendation of the task force was to have a single recovery plan.

Your language specifically addressed a comprehensive recovery plan, which the RCCs used and the CTP, which is the nomenclature of the Army's Comprehensive Transition Plan. DoD has, concurs with this.

They are, and have moved it into the same team that we talked about earlier to address this, the Integrated Care Coordination Committee is working on this.

Number 11, ladies and gentlemen, we're talking about getting access to whatever document this is, the CRP. And the

concern was with the CRP, the document used by the recovery care coordinator.

The CTP family members are gradually being able to get their hands on that, input it with their service member. The Army's making some progress in that area.

Your recommendation here was directed to the CRP, which is not interactive. And it is mostly a document that's to be downloaded when you need to hand it to a family or service member. So service members just --

Your recommendation was to get more access on that CRP to the family members. Sorry, ladies and gentlemen. Seven o'clock in Colorado. Time to wake up. But access, family involvement in the CRP was the intent of this recommendation.

And again, it was mostly aimed at those services using the CRP. And that's why the language there is the Navy, Air Force, and the Marine Corps.

Number 12, ladies and gentlemen, is a pretty complex recommendation that you were very interested in getting on the books. And it was basically a more forward definition of the second category, Category 2.

And it is designed in your recommendation to cover areas of Category 2 service members who did not have RCCs. They may have nurse case managers, but RCCs or, well we'll use RCCs, were not assigned. So their nurse case managers were pulling up a lot of the non medical case management piece.

And if they were reserve component they were being brought back on active duty orders. And again, for medical purposes. But they were not getting non medical coverage. Or if they were in the reserve component and had to be brought back.

Let's say their PTSD hadn't manifested until the third or fourth month, and they were then put on Title X orders, and

put under the care of a nurse case manager, and assigned to a military treatment facility.

Again, the non medical case management piece was not being covered. Or in the, and then you wanted to ensure that, for example, in the Army there are, you know, ten thousand people in a WTU. But the other ten thousand people are in the IDES.

And your recommendation was designed to get those individuals in IDES who had a diagnosis of PTSD. This recommendation was designed to get individuals in IDES, not in a unit, who were diagnosed with PTSD, non medical care management, in anticipation that they would be leaving the military.

And that they had access to some of the resources that your WTUs or your wounded warrior regiment members, Marines, had. So it's a comprehensive recommendation here, and complex. And DoD non concurred.

And your number 13, ladies and

gentlemen, you are -- The vision here was to extend the RCC training to all non medical care providers. You felt strongly that it was a good baseline for all your service members.

And your recommendation was to extend it to all non medical case managers, including the Army and their squad leaders. That's correct, right word, squad leaders. You had a partially concur on this.

They obviously agree training is good for everyone. I don't think they were fully prepared to extend the RCC program across all the services and all the current non medical case managers.

MEMBER PHILLIPS: Denise, I'm sorry. Can we go back to Number 12?

MS. DAILEY: Yes.

MEMBER PHILLIPS: That was a hotly discussed issue. And we reviewed it repeatedly. And my question is, will we be able to hear from them in a timely fashion as

to their rationale for maintaining the present system?

MS. DAILEY: Yes, sir. We're going to put them on the March agenda. So we will have an opportunity. That is when the implementation plan is due to Congress.

So they will have, theoretically crafted the final implementation plan in their final responses to Congress on these recommendations. Number 14, ladies and gentlemen --

MEMBER REHBEIN: Before we go on, Denise.

MS. DAILEY: Yes.

MEMBER REHBEIN: If I may, I want to be clear on some language in my head. In Number 1, DoD partially concurred. And there the partial was because it was in progress but not completed. In Number 13, where they partially concur it means they only agree partially with our recommendation. Is that correct?

MS. DAILEY: Correct. Number 14 is where we moved into several, 14, 15, and 16 where we've moved into several family recommendations, ladies and gentlemen.

We continued to be concerned in your discussions that family members were not getting information they need, because there are HIPAA requirements to protect the service members information.

Your intent here was to establish the fact that family members can be trained. There's information that can be provided to them that does not violate the service member's HIPAA and right to privacy, or information he does not want to share with his family.

And there's still a significant amount of information a family members require that are not HIPAA related. And you, in this recommendation, urged DoD to move down the road of providing that information, instead of allowing HIPAA to be an obstacle

to family members receiving information that they needed.

And DoD concurred with this one. And they stated, in the implementation plan they will address DoD card holders and DoD non card holders information requirements.

And in 15 you are very concerned still about identifying one single point of contact, particularly for the family member. This is still more about a family member recommendation. And so in this one you really wanted that family member to have one single point of contact. DoD concurred with this one.

In 14, ladies and gentlemen, excuse me 16, you have identified in the IDES process the PEBLO as a single entry point for working with the families, for those individuals going into the IDES process.

And you identified that this is point where you think family members should be getting a briefing on changes to

entitlements that they may incur upon leaving the military. And you identified in this place that service families should be getting briefings on their further or possible changes to their current entitlements.

Let me note for the record, Major General Mustion has arrived. And we will -- I'm going to continue through the recommendations. And then we'll do more introductions. Good. Thank you, sir.

Number 17, another point for the IDES process. Again, you wanted your family members to know. And you kind of broke these out.

A specific EFMP recommendation here for the PEBLO to address, to ensure that family members who have exceptional family members who are leaving the military, who are in the IDES process, understand that this particular benefit will not be available to them in post DD214.

Number 18, ladies and gentlemen,

was designed to address reserve component currently serving in a WTU. In a WTU, not a community based warrior transition, but in a WTU, or at the MEDHOLDs. It is the Navy MEDHOLD East and MEDHOLD West, or any reserve component members currently separated from their family members.

This recommendation was designed to address the need to ensure families stay together during these long separations. Warrior transition unit reserve component, WTU, not in their community based, may be in that organization for a year, and be separated from their family.

MEDHOLDs also make a choice about leaving and being in MEDHOLD East or MEDHOLD West, and their families staying at their original location. So these are tough family decisions.

And your recommendation here addresses trying to keep these families together. Give them more opportunity to be

together. Better conditions to be together during these separations.

You got a, there was a non concur on re-naming the National Resource Directory, recommendation number 19. They are going to continue to market it, and are not convinced that a new name will be helpful in that area.

Your recommendation Number 20, ladies and gentlemen, addressed a closer integration between the non medical care management teams and your installation family service centers.

Now every service has kind of a different name for it. The Air Force Family and Airmen Center, the Navy Fleet and Family Center. So they're different names. So I'm going to just generalize them by saying the family, the installation family centers.

A more structured relationship between your non medical care management teams and these family centers, family service centers. For example, possibly

first, top of the line, first of the line services, someone in the family center trained, possibly RCC trained.

So that when someone comes into the family service center one person in there has had RCC training. They get that family, and that service member get front of the line services from them.

And your vision here was that in many ways your services are going to be dropping off. The war's winding down. And the repository for care of the family needs to be maintained, and that the family service centers is the place to do it. So this recommendation went to kind of formalizing those relationship.

Now in the Army we know that you have the SFACs. And there's a significant amount of talent in an SFAC. It's not, doesn't need to be replicated in every service, an SFAC in every service. But the recommendation is there be a repository of

care for the wounded, ill and injured in your service family centers.

The Air Force has a very good model for this. They in fact co-locate with their airmen and family service centers. They've trained individuals. And the airmen and family service centers have a checklist of things when a wounded warrior comes in that they are required to cover.

So that was kind of the model you would like to have seen implemented in the other services. And in fact, we're seeing much of it. We were at Navy Safe Harbor. They've been aligned under the Navy N1.

And the Marine Corps has been aligned now under the Marine Corps 1, I use the term one, personnel services. So you see it going in that direction. This recommendation would be kind of formalizing these relationships.

Twenty-one is very similar to recommendation 12. It goes to your reserve

component getting centralized case management. Instead of having to navigate, if they're still in their communities, and if they're not in a WTU, getting case management, medical case management to the reserve component.

And we are going out to San Antonio. We are going to look, or follow up on the briefing they gave us back in March, on centralized case management for the reserve component. Managing them in their communities and creating a system for managing them when they are not in a WTU or an MTF.

Twenty-two is similar to that. You wanted to cover -- A couple of situations that we saw was the rapid issuance of Title X orders for getting your reserve component back on active duty. Or continuing those orders if they need to stay on active duty for another session.

Again, these are both DoD

concurs. And I don't have any visibility from the reserve component on this concur, what does this concur mean to them? And how would they implement the concur?

And 23 was a very specific recommendation. We just, you wanted to see that the reserve component leaving the WTUs is pretty much an Army recommendation is out processing. We're talking about post DD214, leaving the military.

Recommendation number 23 talks about them out processing through their unit. Going back to their unit instead of just walking out of the military without out processing.

Recommendation 24 is a little more complex. And I want my research staff to keep me straight here. Section 551 of the NDA, really, we had hoped it would be addressing non federal intern opportunities. Is this right, Jess? Okay.

And in their response they're

talking about transition assistance program eligibility, which was published on November 21st. So this is a concur. But Jess, did we look over that publication on the 21st?

Does it address? It doesn't address non-federal -- Yes, sorry. It does not address non-federal internship opportunities. This addresses the updating of the transition assistance program.

So the response to us was a directive type memorandum, published on the 21st of November about transition assistance. The incorporation of the VOW Act, covers this NDAA.

But we have looked through it and it does not. So we still haven't cracked the nut in the opening and clarification of guidance for non federal DoD internship programs.

Twenty-five is a VR&E recommendation, which is to ensure that the legislation that expanded VR&E is carried

out. In fact, we actually saw this at Colorado. VR&E has a very good stronghold in the Colorado, Fort Carson area.

Everyone who goes through IDES gets a VR&E briefing. So we see it being implemented. DoD concurs on this one. And we are seeing it in the field. It had been established for a year out in Colorado. But when we were at Walter Reed they just got someone hired on 1 October. So the implementation of this recommendation is in various stages.

So 26 kind of goes back to 24. Twenty-six talks about updating transition assistance programs. The transition assistance program DoDIs, and this was your recommendation, which was to update the DoDIs. They had not been updated since 1994.

And so your recommendation 26 went to updating transition assistance program to incorporate the VOW to Hire Heroes Act. And there is a lot of activity on this.

They did publish a directive type memorandum, not a Department of Defense instruction. They did publish that on the 21st.

And again, recommendation 24, they're saying that that directive type memorandum covers the non federal internship piece. But again, we're going to have to circle back around on the non federal internship piece.

Because I don't think that directive type memorandum covers or clarifies that issue for the field. But they have concurred, they have made steps in this recommendation to update a 20 year old recommendation.

Yes, a 20 year old DoDI with the DTM. And they will need to follow up with DoDIs and DoDDs to bring the VOW Act, and to bring transition assistance program into its current compliance with the recent legislation.

Twenty-seven, ladies and gentlemen, is a non concur. We understand this recommendation is not popular with the Department of Defense. This is the recommendation to create the co-chairs of the JEC.

The co-chairs of the JEC would be both the Deputy Secretaries of the VA and the Deputy Secretaries of the Department of Defense. Now currently the JEC is co-chaired by the Deputy Secretary of the VA and the Undersecretary of Defense for Personnel and Readiness. That's written into law.

And our request was that Congress make those two positions who chair the JEC be co-chairs of each agency. DoD non concurs with this.

This number 28, ladies and gentlemen is our -- We've seen a lot of what's being done again in the IDES process about minimizing individuals who come into the IDES process and then are returned to

duty.

Our observation in the field is that there are processes out there that are capable of bringing those numbers down. And the recommendation was designed to encourage the Department of Defense to continue to try and work who should be in the IDES process and who can be returned to duty without expending the resources in the IDES process.

The individual electronic records, a case or a single individual electronic record was your recommendation in number 29. This is the, your vision here was that one folder, so to speak, containing all your IDES records should be in the electronic format. And it should be available to everyone in the IDES process.

DoD gave us a relatively long answer on this. There are a number of initiatives right now ongoing to package this IDES paperwork in one location, accessible to everyone, to transmit it electronically.

They have a number of initiatives, pilot projects going on to do that.

So there was a concur on this. And you can read the text. There is a number of acronyms and locations where they are testing this out.

Number 30 was your recommendation to ensure that their IDES survey is used to improve the system. You have in this recommendation several points that you make to say, once you get a result in this area, satisfaction for example, turn that around and change your system to improve those results.

Or if you're getting very low responses in certain areas, take that survey and turn it around to improve performance in that area. So your intent here was to focus that IDES survey on improving the process.

And they concurred with that. And they outlined several areas that they are going to be doing that. And we'll track that

one. I don't have my IDES subject matter expert here today. But we will turn the results around as they change that survey. And we can talk to you about how that's being done.

Thirty-one. Terminal leave should not be utilized in the IDES time line. You got a non concur on this one. And they're really trying to measure all the points. And how long it takes not only the DoD, but the VA, to get through this complete IDES process.

So there was a non concur here. They want to count that time in there. And they want to maintain these IDES standard time lines and bring together the resources that are needed in their services to meet those time lines.

We recommended in 32 have a joint board for the, modeled after the Physical Disability Board of Review. This recommendation is also in legislation. So

concurrent with our recommendation they have a review process going on to look at the feasibility of doing this.

Thirty-three, we are, you were concerned about the PEBLO staffing ratio. And its true ability to meet the requirements of the service members. Keeping it lined up with the true workload, versus a formula which is in place in DoD.

So they are looking at their PEBLO and PEBLO satisfaction rates. So there was -- So they gave us some language on what they're doing here. Again, this was also requested by the staffing study. So WCP is doing a staffing study on PEBLOs.

Thirty-four was the MEB contact, 100 percent MEB contact. And you had a partially concur on this, yes. DoD's commitment here is to make sure that the services have all the information they need, make sure that the services know that the MEB outreach is outlined in their DoDI for IDES.

And then the response is to let the services, you know, staff and man these positions to the capability that they have within their service.

And ladies and gentlemen, we're on the last one. This was a vision and recommendation on your part that the warm handoff is most effectively achieved when a service member is leaving the Department of Defense, and is smoothly integrated into the VA.

So this one captures what we call the warm hand off. And your discussion centered around, the earlier service members know about their VA benefits, and the earlier service members understand what the VA can do for them, the better this warm hand off will go for every service member.

Now this is kind of a lesson in how we want to frame our recommendations here. The intent and the discussion was about incorporating the VA into leadership

training, basically. Your initial, your interim and your senior leadership training.

So that there was some introduction to service members early in their career about the VA, its programs, transitioning service members to these programs.

And the partially concur here, the partially concur does not address your recommendation or part of the recommendation that says, the earlier the integration into the lexicon of a service member's knowledge, that the VA occurs, the better.

So the part where you wanted to talk about, or wanted to include in the service program's training, information about VA, kind of got left off the table in this response.

What they did concur, what the concur here is on, is the single log on for service members at the beginning of their service, for the VA and eBenefits accounts.

So it addressed everyone getting a VA log on when they come in the services. That's a requirement. So everyone has access to eBenefits the day they walk in the service.

And so this kind of checked the block here that they are complying, or they've started the process of integration for service members, by ensuring they have a log on to VA's accounts, and they can access eBenefits as soon as they come in the military. They're doing this sign training and getting into the VA benefits piece when they're at their basic training.

So your portion here about, you know, exposure in early training, intermediate training, and senior training for your service members and NCOs and leadership was not addressed. But the single sign on, the access to VA accounts at basic training was addressed.

All 35, ladies and gentlemen, and

their current status. Again, this was DoD's evaluation of the task force recommendations. The 90 day, as legislated, evaluation. At 180 days there is an implementation plan due to Congress. I am going to give you all a break. Our first briefer will be here at 9:45 a.m. Questions? Sir.

CO-CHAIR NATHAN: Briefly, because I want to get to the break. But if you could help me understand what the sense of the task force was in terms of a common operating resource for recovering warriors?

What I mean by that, you have a lot of things here which speak to creating situational awareness among warriors and their families, as to what capabilities exist, what resources exist. You have a lot of impetus here to create, remove differences, and create standardization.

If you call the air lines, regardless of what your issue is, you've lost your luggage, you need a refund, you're not

sure your flight's going to work. You dial one number and they get you there. You go on a web page and you'll eventually get there.

One of the common complaints that I've heard -- And again, I'm educating myself here, I'm not lecturing. I'm interested in what your sense is. One of the common complaints I've heard is, why don't we have -- And I've heard this from several senior staffers at Congress.

Why don't we have a 1-800 recovering warrior number that somebody can call? And they may be referred back to a local person. But they'll be told who in their locality has the information they need, or a policy.

And the reason I ask that is because that would also force the DoD and the Department of Veterans Affairs to find congruency in their policies if they have to be responsive in a national resource for that.

So where were those discussions over your last year or two, as far as trying to find coherency? And if you think I'm all wet, please tell me I'm all wet. But this is based on families that I talk to that tell me, there's just so much stuff out there. But I don't know if one hand knows what the other is doing.

CO-CHAIR CROCKETT-JONES: Well I can say from our installation visits and from personal experience, that yes this is, you're right, it's systemic, that most families feel this way.

My personal take on what I've learned since working with the task force is that there is, each service feels that they are providing that for their service members. And that the National Resource Directory was meant to be an on line version of that one stop, go to place.

So far, the research staff can correct me if I'm wrong, we've had zero

service members or family members who have ever heard of the National Resource Directory, or know what it does when they're told about it.

So we are, this is something that the task force has been concerned with. But there's been a, sort of a service culture obstacle. And a lack of connection, information availability.

MS. DAILEY: And you are correct, sir. I'm sorry, General Stone, I apologize. Go ahead.

GENERAL STONE: Sir, I think year one there was substantial debate between the services on what's the right model. With the Army taking a much different model than the Navy or the Marine Corps, or the Air Force. And frankly, a very high cost model of a separate command.

Year two evolved somewhat based on recommendations. You can see them, the 2011 recommendations. Some best practices

that were identified in an attempt to bring things together. It still is an extraordinarily difficult program across all services to negotiate their way through.

Discussion's ongoing now between VA and Department of Defense on unification of who is the advocate. And almost every place we go the families discuss with us how confusing this is. They have multiple people there to help them. But yet, who is in charge? Who is really in control of this?

If this was as easy as a 1-800 process of, here's where you are in this system, here's where you need to go, it would be welcome. It would be welcome to families.

The Army has gone a bit down the road of a smart phone application, that literally a recovering warrior can go into and say, here's where I am in that process. And here's who the advocate for this phase is. But what you're seeing I think still is the evolution.

And we had substantial debate as we prepared the 2012 recommendations, of how big or how small do we go. And what you see is a lot of small nuances of the system, trying to identify. But there's not the big piece here of do we really have this thing right or not.

CO-CHAIR NATHAN: And, Rich, I think it settles on the point of whether the task force -- And again, some of this is world hunger. And I understand that.

But where the task force settles on accepting from DoD that there are significant inherent service culture differences among the way recovering warriors are percolated through the system.

Some of the recommendations you talked about, you know, the Army traditionally task organizes its wounded warriors into a command and control structure different than the Marine Corps.

The Marine Corps' basic

philosophy is the medical personnel can have my wounded warrior for as short as is humanly possible. And then I want them back into their, either back to their unit or out of the Corps. Because I, the Marine Corps, want to maintain integrity over them.

The Army says, we're going to transfer you to the command at the medical facility. And you'll belong to them. And it creates differences in the approaches. People ask if it's right or wrong? It's just different.

And so do we determine, do we, have you had conversations as to creating a forcing function? To basically say to the services, you're going to need to find more congruence. You're going to need to find a more -- And you know there's efforts in that regard.

But have we come down that point? Saying, we respect the service cultures. But they allow too much transformity in the

system. This is why we have differences in the IDES rates right now. This is why the different services have different approaches to the IDES.

Different services have different approaches to the footprint of personnel that have to be -- There are best practices that the Army has done that I truly believe the Marine Corps and the Navy should emulate, and vice versa. And it's not happening.

And where is the forcing function to make that happen? As opposed to just standing back and saying, well every service has its own thing. And it sort of saw its own level. So I don't expect to solve that now. I'm trying to just educate myself, and see where the task force has sort of settled on that.

GENERAL STONE: So we have identified best practices. Those are often expensive practices. And there was substantial debate in 2011, before the report

of whether those models were in fact sustainable.

We had special interest in areas like Twenty Nine Palms, where 90 percent of the Marines who were on profile were still in the line. And whether we found substantial dissatisfaction with that system. Yet dramatic improvement and satisfaction when they went into the wounded warrior regiment. That was repeated again in 2012.

So as you look at best practices as separate from the recommendations, I think you'll find identification of areas that are potentially able to unify. And one of the things we might want to look at this year is how we would unify those best practices, and recommend across the DoD.

MS. DAILEY: I'm going to give you all a break. Our next speaker, Colonel Packer is standing by. We'll start at 9:45 a.m. Thank you.

(Whereupon, the above-entitled

matter went off the record at 9:40 a.m. and resumed at 9:48 a.m.)

MS. DAILEY: So we can start. I'll have all my members take a seat please and we will begin with an introduction. Let's go.

CO-CHAIR CROCKETT-JONES: Okay. We would like to welcome Lieutenant Colonel Mark Packer, the Executive Director of the Hearing Center of Excellence, which serves to improve the health and quality of life of service members and veterans, through the prevention, medical treatment, and research of hearing loss.

Lieutenant Colonel Packer will provide program updates since their last briefing in December 2011 and discuss research activities over the past fiscal year. We have his briefing under Tab C of our binders. And I'll turn it over to you. Thank you.

LT COL PACKER: Thank you, ma'am.

It's a pleasure and privilege to be here to present to you all today. I appreciate the opportunity. As you see in the overview slide, our plan is to introduce, and the purpose the Hearing Center of Excellence.

As start, I'd like to just relate an anecdote. We recently sponsored a NATO meeting in our backyard in San Antonio at the Center for the Intrepid.

And to a tee our European allies, were very much taken in by the environment. The American spirit to buy 600,000 stones to provide for and build such an edifice.

And then to see the recovering warriors in a concentrated location, receiving rehabilitation and reintegrating into their lives, was very much lost on them, as that doesn't happen in their countries.

And so to see this kind of effort revolving around our wounded is a, very impressive, not only to me, as a Director for the Hearing Center, but also to our

colleagues who are trying to look at the reintegration of troops with auditory injury, which happens to be an invisible injury and sometimes easily overlooked.

We'll review the status since we last spoke in December of 2011. I'll want to talk about staffing, goals and objectives, strategic plan updates, the registry developments, hearing aid implant purchase standardization, and the IRB.

And then talk about the research productivity and dissemination as discussed, with the consideration for policies and changes. And I feel that we are well on track to hit the full operating capability mark by the end of the calendar year.

So prior to you talking about the recovering warriors, I think it would be a good idea to talk about the warriors.

Prior to the injury, hearing is an extremely important sense. And hearing as a sensor, is valuable and important for the

ability to hear and communicate.

It's critical to the safety of our troops. It's central to effective command and control. It's a vital component for mission accomplishment. And it aides in developing the mission goals and the team perspective.

It's a key consideration in force manageable, when you look at the injury numbers, they are staggering. This year we have 148,000 original, unique cases of tinnitus. And over 90,000 cases of hearing loss. That's 2012.

Over the course of the decade we have a million cases of tinnitus, and 800,000 cases of hearing loss. So the Congressional mandate to look at this injury is well warranted.

We do have capability to prevent. We have education and training in place. There are hearing protective devices that are functional and tactical. Communication

devices that help integrate the communication aspect into the prevention.

These are not always the most readily used, or are perceived as useful. And so there is work to be done to apply these preventive measures and to continue to look at the upgrade and usability.

However, readiness for military service requires both function and prevention. So the military paradox with the hearing injury is that we need to communicate in a loud environments, and yet we have to protect against loud environments. And so that is a difficult problem to solve.

Moving on, just briefly remind you that Executive mandates, so the Center of Excellence for Hearing was established in 2009. The Secretary of Defense required the development of a center to look at the scope of injuries that we're seeing.

It was delegated to the lead component of the Air Force. And the basis of

the hearing center is that, it is to be a collaborative center with involvement of the VA, with academia, industry, and international partners.

It is to develop a registry to identify and to track incidences of injury. And then to use the registry data to encourage and facilitate the conduct of research, develop clinical practice guidelines and best education practices.

The hearing center mission then is to heighten readiness, and to improve the health and quality of life of members and veterans.

The focus and the scope relates to the continuum of care, and the overall scope of injury. The hearing center overview is to establish an auditory vestibular central, collaborative network, related to prevention and care.

So a hearing health improvement network or a practice based research network,

that will incorporate the clinical and research interests, to develop the background and foundation to provide for these injuries.

We're to provide efficiencies and coordination of clinical care to integrate into systems and agencies that don't readily talk, and to facilitate that smooth transition of care.

The organizational chart flows down from joint councils and committees, through the Senior Military Medical Advisory Council, through the Air Force Surgeon General as the lead component. And our Air Force's Medical Operations Agency has incorporated the Hearing Center of Excellence as a new directorate.

We have been placed as a tenant organization within the Lackland Air Force Base, Wilford Hall Ambulatory Surgery Center and have developed a Memorandum of Agreement to accommodate that tenant situation.

So this is just a visual graphic

of what we feel a full operating capability would look like for our network. We have currently medical centers, and research labs that do outstanding work. And they have influence within their own spheres.

We have VA centers that are co-located and taking care of members and veterans with hearing loss and auditory injury. But to this point, we have not had the network established to the point where we do much practical collaboration.

As you can see at the top left, in the green and yellow, we feel that at full operating capability we will have reliable, valid flow of data. The aim is the Auditory Injury Module of the Joint Theater Trauma Registry.

The registry is what we consider our data in. And then through the hearing center functions, we analyze the data and we send it back out, in a give and take system. By directionally useful with the VA systems.

The clinical resources we hope to standardize, and to develop the mechanisms, and we'll talk a little bit later about this, to identify and track injuries. The DOEHRS system, the Defense Occupational Environmental Health Readiness System, is our surveillance tracking system.

We have developed the infrastructure and the reporting systems to share this information with the VA. And there's a data use agreement that calls out this system of record to open the door to the VA who really needs this data.

The auditory research program development is a way to provide the gaps and enhance the steering capabilities of the research programs. The data use agreements that will oversee these infrastructures and to maintain the share ability.

So basically we feel that the at full operating capability the DoD and the VA, auditory sciences and departments, will be in

full communication and be able to track a continuous movement of patients.

At the same token, we've worked with the other Centers of Excellence very collaboratively, and feel that when someone goes to war and has a blast injury, their ear's not the only thing that is blown up.

But the way that ear, or the hearing loss, or the tinnitus, or the central auditory processing disorder, relates to other injuries, visual loss, or proprioception loss or pain, chronic pain management, affects the quality of life.

And the injuries compound each other and there are unique syndromes that develop based on these injury patterns. And we feel that, that's important to work together strongly with the other Centers of Excellence to develop that understanding, characterize these injury patterns.

So we feel that the attributes of full operating capability include the active

registry system. Includes a bi-directional data sharing agreement, standardization of the hearing systems and acquisitions.

The DIACAP process, the Defense Information Assurance Certification Process is nearly complete for the Air Force to be able to take audiogram data and digitally manage that. Send that into a centralized system so that we can share that more readily.

Once that is complete, then we plan to push that to the other services and have that as a more useful data flow for ourselves and the VA.

The hearing center is becoming the one voice that you see in the third, or the fourth bullet. I think that we are being called on consistently by Health Affairs and by the services to answer questions related to auditory injury and hearing loss.

And I think that collaboratively within the Department of Defense and strongly

with the VA, we have a group of advocates and subject matter experts that can answer the mail.

The DoD VA Transition of Auditory Care defined. We're working strongly with the VA at this point to develop those reporting systems and to standardize the acquisitions process. And to develop the epidemiological studies that will maintain that data flow.

The DoD HCE Prevention plan is ready to launch this quarter. We are working strong. We're pleased to have Colonel Retired Kathy Gates in the audience, who is back on board and helping us to develop this program. She's been instrumental in the Army to develop readiness programs and to help with this process.

And we're excited about the prevention campaign, which not only will look at modifying behavior of individuals, but also cover the breadth of the institutions

and to develop the policies, and plans, and procedures, and processes that will maintain hearing protection as a priority.

We feel that identifying processes, strategic communications to engage in DoD acquisitions is important. Weapon systems are loud and we need to be up front in the development to mitigate out noise. We are working with the Defense Safety Oversight Council to develop some of these, mitigation strategies.

We're real excited about this final bullet, the fitness, Auditory Fitness for Duty effort, is an effort to standardize the way we look at the boarding processes for individuals.

We want to be able to couple hearing ability, with hearing, with mission performance. And I think that as mentioned before, hearing is a readiness issue.

It really does go hand-in-hand with mission performance. We're not out

there on an island. We're out there as teams and we need to be able to communicate effectively.

There are several studies in past years that have looked at tank operators and shown that their ability to acquire targets sufficiently is enhanced when they can hear.

When their hearing drops to H2 levels, then they are less effective. It takes more time to acquire targets, and their survivability goes down.

Similarly we have recent studies that show promising results, where at West Point, cadets on the paint ball team, engage each other in war scenarios with hearing loss simulators.

And the ones with hearing intact get more paint on others and less paint on them. The ones with hearing loss, you get the opposite.

So we're looking at cataloging, and characterizing hearing critical tasks,

and developing sound catalogs that will help us to develop speech and noise parameters that will go with an audiogram, to develop the coupling of the performance and the hearing ability.

So updates since December. Our Executive Director position has been concurred by the Assistant Secretary of Defense for Health Affairs. And so I am again honored to be in this position.

I feel like we have a good collaborative effort that helps support this. We're excited that FY12 was filled with contractors that have filled our directorates, to act functionally in their alliance.

The Registry Development is on course and where as to this point, we've had transitional leverage teams working to develop registry strategies.

Now I have a dedicated team of experts with a military systems backgrounds

that are looking at a multi pronged, parallel tracked approach.

The execution of the Prevention Campaign, again is assisted by a prior Army audiology consultant, DoD Hearing Conservation working group lead. And we're excited to have her aboard and working with our hearing conservation teams to develop this prevention strategy.

The Clinical Rehab Directorate is lead by a former senior military neurotologist. Research Directorate is lead by the Hearing Center of Excellence chief scientist.

And the research coordinators are spread out around the region to help facilitate and encourage the conduct of research, by over seeing and developing the administrative processes that will allow clinicians to get into the research game.

Continuing on with staffing, the services have agreed to place a military, a

senior military audiologist within the headquarters.

That will allow us to use them as a touch point for the services, to help develop the educational priorities, and the readiness platforms, and the policies, and procedures that will maintain the hearing strategies that will improve outcomes.

Civil service positions are in the process. We have the first four in classification right now. Hoping to be able to hire against these in this upcoming quarter.

And we have active support from the lead component, through the Air Force Medical Operations Agency, and the 59th Medical Wing at Lackland. MOA has been developed and signed. And we feel very comfortable in that tenant organization.

So moving on, to update on the goals and objectives. We'll go through these through our directorates, starting with

Prevention and Surveillance.

I think that again we, looking at the Strategic Communication Plan and the Prevention Plan, it is on track. These plans have been developed as of August 2011.

And are in the execution phase. We have our web site out, and we have social media setup to reach out and to interact with members.

We have the screening questionnaires, sampling military populations to ensure that we are focused and on track with the needs of the individuals.

There, and we'll talk about that a little bit later. There's been some obstacles that have posed, not threats, but have been somewhat road blocks needing to be overcome.

The Fitness for Duty standards has been identified and clarified. And we are working to develop the studies that will identify the speech and noise tests that will

act as that performance couple.

As well as to catalog the sounds and to make this service generic, so that we have the ability to look at anyone in any uniform, and be able to predict how they will perform in their duties.

Moving on to the Clinical Care and Rehabilitation. I think that the DIACAP effort, again for standardizing the resources and equipment, and the audiology clinics is on task.

We again, should have the Air Force approved for the off-the-shelf software products that will allow the clinical audiogram to be digitized and sent to a registry data base. With the plans to move that into the other services shortly thereafter.

I'm going -- Clinical Practice Guidelines is an iterative thing. We've completed work with the Defense Center of Excellence for Psych Health and TBI, in

relation to dizzy patients. And we have a CPG roadmap that further outlines the needs and the gaps in our clinical care.

Vestibular problems are an issue. And the standardization of resources and therapies are being looked at and analyzed across the system.

Currently we're looking at VA strategies that have been successful for tinnitus and extending the outreach to bring their educational programs for tinnitus on line to our web site.

And to utilize some of the outreach methods that they've developed to be able to manage the number one injury, or the number one disability that we're seeing, tinnitus.

MEMBER STONE: If I could ask a question?

LT COL PACKER: Yes.

MEMBER STONE: What is the form that you use to promote the clinical practice

guidelines across the services and what compels the services to accept those CPGs?

LT COL PACKER: We're currently working with the DoD offices that are the entry gate for CPG development, to vet the needs for the CPG development.

And then through the, we have a chartered group called the Auditory Research Working Group that is staffed by clinicians and scientists that helped to develop the gaps and the needs that we put forward toward the CPG development.

Developed that through the subject matter expertise outreach and then used the end product, the tool, to place on our web site and use with the outreach media to develop the education.

MEMBER STONE: And so it would be up to the services then to go to your web site and either accept the clinical practice guideline or not?

LT COL PACKER: Yes, and in

addition to that, we have a Joint Defense and Veteran Ideology Conference that is held annually. And for example some of these developments we have presented to the clinical end users, to develop their understanding.

We've had the, we've sponsored the Military Vestibular Assessment Rehabilitation Conference annually, which helps to promote these standardization into, and institute them into the learning process.

So that we build the bench of upcoming clinicians to develop that within the education, the Residency of Fellowship Programs.

MEMBER STONE: So this, you exist separate from the services. You have a memorandum of understanding that allows management from the Air Force as the lead agent, or the executive agent. You have subject matter experts, but the promotion of these areas of excellence, is by consensus,

not by DoDI?

LT COL PACKER: Correct.

MEMBER STONE: Okay.

LT COL PACKER: Correct.

MEMBER STONE: Thank you.

LT COL PACKER: Thank you. And that's great clarification. We do have DoD working groups that we hope to be able to utilize as the one voice to implement the policies that will be over arching, but correct.

The development and the education is separate from that, and we hope to be able to institutionalize this and codify the findings. But that's a work in progress.

MEMBER MALEBRANCHE: I guess to tag onto that. You are under the Health Executive Committee, or chartered under the Health Executive Committee, correct?

So for the VA part of the clinical practice guidelines, is this not brought back to the Health Executive Council

as an outcome or one of your products from this?

Is it not, I'm just wondering, you know, General Stone if that goes through, because we do a lot clinical practice guidelines through the HEC, and I'm just wondering, does this go back through that mechanism at all?

LT COL PACKER: It hasn't to this point. And I'll tell you again, being an iterative process we have goals and ambitions. We've crossed this bridge once now.

We have several others we're looking at, but not complete. And so, so the clinical practice guideline outcomes will need to be discussed and looked at as to how they are implemented.

MEMBER STONE: Yes, I think this is a basic weakness of the system. In that you develop the Center of Excellence, you put a whole bunch of really smart people into it.

They foster consensus, they foster some really good research. Sometimes it's duplicative of other research going on within the services. That's a problem.

But there is no system in place that takes the recommendation of any of these Centers of Excellence and really brings them back into the VA and the DoD clinicians in a formal manner for acceptance.

MEMBER MALEBRANCHE: I hear you, I was thinking about the clinician part, because I know we contribute. We would, we have been trying to, with the HEC, put things into a Joint Strategic Plan. Because we always have to feed the Joint Executive Council.

And this would be one of those things where sharing this jointness, but I see getting back to clinicians is different than getting back to Congress, in that sort of report.

MEMBER STONE: So here is an area

of massive disability long term. Post, during and post service, that is crying out for preventive measures. And I think one of the things we need to get a hold of is, how do we take these recommendations and do a forcing function?

Please do not take this as critical in any way, you know, we stand this up in 2009. We're here in early 2013. We really need a method by which whatever good work you're doing, is brought back in, debated by the services and the Department of Defense.

And then either accepted or not accepted in order to foster, really prevention, rather than responding to the loss, really prevention of these injuries that seem so wide spread.

LT COL PACKER: I agree with you and not taken as criticism, but construction and I think those are good points. That is our goal, is to place prevention first and to

develop the strategies that will change behaviors.

And to educate leadership and provide the policies. And so taking that into the Joint Strategic Planning and taking it to the Joint Council, I think will be important.

MEMBER MUSTION: Can I ask a question also? In line with General Stone's comment about the clinical practice guidelines.

Is the center established, am I reading that right, that the center's established Fitness for Duty as it relates to hearing, by MOS, AFSC and rating?

And are those binding on the on the services? Or do we have the same challenge, where it's a collaboration and it's not a force directed? Here's the minimum standards you have to maintain, to retain this particular specialty or AFSC?

LT COL PACKER: Well that's a

good discussion and I can backup to a more general picture. I think that the Hearing Center of Excellence from our perspective.

We were stood up without necessarily the mission or the authority to overtake any hearing conservation programs, to run any medical treatment facilities, or to engage in the research programmatic discussions.

And yet we have a strong interest in all of that. And so what we have done in our organizational setup, is to become that integrating body to take the subject matter expertise, and to integrate that into the appropriate circles.

Now getting back to your question. I think we have been engaged in developing the standards through the MEDPERS objectives. And we've been involved with the Medical Standards Working Group, the Exit Working Groups.

Been involved in touting the need

for an exit audiogram, which is now established across the DoD. So I think that we are being looked at, as the voice for Hearing and Audition. And we're trying to respond in our capacity.

And I think that for example, the DoD Hearing Conservation Working Group is a collaboration of the services, including the consultants, that can take the information that is discussed and analyzed, back to the services, to institute the recommendations.

That doesn't always work perfectly, and there are various standards at this point. A lot of those standards that we're dealing with are not evidence based, and so this Fitness for Duty effort is trying to develop the research that will show the evidence that will promote better standards of care and prevention.

And so, these are extremely good points. We need to have the proper touch points to really institute these as

instructions, duty instructions, that will make a difference now and forever. Any other comments or --

CO-CHAIR NATHAN: Part of the genesis of this, as you all know. Congress got very concerned that there was these, this myriad of injuries and impacts, auditory, visual, that the military was not keeping step with advances in the academic and civilian sector.

And how were we going to do that? So the Centers of Excellence were mandated. And as you said, Rich, they were mandated to find policy congruency but with no stick to implement that across the services.

If you talk to Dennis Cortese, who was the former CEO of Mayo, he likes to say that from the time a new practice methodology is discovered, a new drug, or a new procedure, it takes approximately 15 to 17 years before it gets itself into general practice.

And the good news about the military is we have a thing called an order. Where we can write an instruction that simply says, this is how you'll do it now. We don't have to win the hearts and minds of the rank and file provider. We just have to tell them, this is the new standard.

So we really need to be looking for mechanisms, and again this may be where the DHA comes in. At least where the new Health Affairs as it finds its equilibrium, comes in.

These probably -- what is your uplink to that Health Affairs, to TMA, to the policy branch of the military and medical service? What is your uplink to them, to get them to create this as policy?

LT COL PACKER: We're working through the Offices of the Accession Standards. The Force help protection community has helped with the acquisitions process for us.

The personnel and readiness folks have helped with this, standardization policies for accessions, and for readiness, and for answering some of the GAO mail. So we do have several belly buttons to that world.

But at this point, we've probably been preparing the ship for a battle, so to speak. We've been developing the organization and the networks that we hope to put into play to work some of these lines.

And hope to be not only a clearing house of information, you know, through different strategies in communication, but also to be able to create the institutional changes that will continue these through policies.

CO-CHAIR NATHAN: And I get all that, that's nice. But I think maybe we ought to consider having a representative from Health Affairs come to us and tell us what their game plan is for connecting the

engine to the rear tires.

I don't see it. I don't see a drive axle here to do that. And I'm putting myself on report, because Navy's executive agent for the Visual Center of Excellence which we'll hear from after you.

And again I think it's great. I think the glass is half full. The services are doing something. They're putting people like yourself and others in the collaborative forum.

Funding it, allowing you to research what's going on in the literature, to collaborate with networks and academia, and then partner among yourselves to find best practices and a new clinical guideline for accessions, for discharge.

Trying to work with VA and provide congruence, so that everybody gets the same sort of disability rating, depending on what they do and the same standards. So that's all good stuff.

The plan is, we don't have a mechanism for you to implement it, for you to execute it across the things. You've got, you're business plan is hope right now, that the services will sort of think this is --

You can lead a horse to water, but making him wear the hearing aid is a whole different thing. So I think we need to get Health Affairs in here to tell us, you know, what their vision is for transmission of COE policy.

LT COL PACKER: Thank you. And those are points that we felt --

MG STONE: Let me just say one thing first of all. I'm always impressed when an Air Force guy uses a Navy thing of preparing a ship for battle. We're going to hear this in all the Centers of Excellence, and we've heard it before.

And I think one of the opportunities we have here is to prepare recommendations that really sort of drive the

system. This is an, and look we in the Army have eight of these executive agencies that we lead.

And certainly we get a lot better understanding of what recommendations and direction are coming out. But it still isn't connected in any driving force to develop in DoD policy, DoD directives.

And so the suggestion from Admiral Nathan of bringing Health Affairs in and saying, how do you envision the future of this? Or the new Defense Health Agency, how do you envision this to drive the question?

All we're looking for is that this really good work gets a chance to be vetted in a very timely manner with all the services, for the benefit of the beneficiaries.

LT COL PACKER: Points well taken. And thank you for that. Point in case is that we have for years tried to discuss developing hearing as a readiness

program, and to develop standardization of acquiring basic, basic, trainee, accession audiograms, that will help the VA.

And we've cycled through various tenures of leadership, and are starting over from scratch again. So that timely manner and that point of contact would be extremely helpful.

And it may be a little bit easier to implement standards of care, so we, hearing is a world that is largely driven by emerging technologies. And we've been able to identify and elevate practices within that world.

So, totally implantable hearing aids, we have the DoD otologists trained to deliver. We've implemented a new low risk, non surgical means of bone conduction hearing performance, et cetera.

So those types of things are easy to identify and to sell within the medical community without policy changes. And some

of those continuing programs under clinical care and rehab will continue.

Moving on to Global Outreach. One of the highlights here is the Hearing Aid Purchasing Standardization Draft Regulation, has been helpful. There's a method identified to allow DoD acquisition strategies to utilize VA acquisitions methods.

And by having all services order hearing aids and implants through the common source of the Denver Acquisition and Logistics Center of the VA, will save money. And provide the accountability and the access for members with hearing loss to these aids in a timely manner, that is unprecedented.

And this is another issue that has kind of taken a couple of years to get through. The Defense Logistic Agency has had trouble looking at the, allowing the thought of using the VA systems. There's a policy

that disallows us from using VA acquisitions. We need to get a waiver. It's an annual waiver event.

So these kind of things, this in particular has been vetted through Health Affairs and been presented to the Health Executive Committee, and a solution should, the policy letter is drafted and awaiting signature. So I think that's a win for us on that one.

I'm going to move on in the interest of time unless you have questions about the Global Outreach. I think that part of our outreach strategies have been implemented through the web and social media. And developing the partners with the VA and industry.

But the heart of our organization, I think is this Registry Development. And this drives the evidence that will base the future of clinical practices. This will tie us to the VA.

And this data in, and will allow for the analysis that really promote the opportunity to improve hearing. And both prevention and rehabilitation.

We have multi pronged effort going towards developing the registry. We're working with the Vision Center of Excellence to look at the Federated Registry infrastructure.

Working in parallel to that, we're undertaking the DIACAP process to create the digital data and standard resources across the DoD.

And we are working with the Health Services Data Warehouse to look at some immediate outcomes that we can use for clinical care. We're hoping that this will be ready for prototype and functional by the end of this calendar year.

The Research Agenda, we have developed an auditory research working group based after the AHRQ recommendation for

practice based research networking. Invited the clinicians into the research worlds.

It's a collaborative network of seven, or excuse me, six acoustic research labs in the seven military treatment facilities. And part of the premier of VA auditory research sites.

The network has, and I think in the following slides we'll see the productivity of the research network to date. We've found that the research world has been fairly siloed in its application.

Trying to, as we do, clear the surrounding noise so that we can understand the main issues. But sometimes that cleans things up to the point where it's not as practical or useful for the members that we're seeing.

And so we'll address the research here. One thing to point out, the formal approval of a single IRB has turned green for us. We're excited that we're able to do

multi site projects now and to speed up the process of research by utilizing multiple sources to look at the same question.

So the Joint Strategic Plan in progress --

MEMBER STONE: Before you leave your research. Where does your research funding come from? And what method do you use to develop financial plans to support that?

LT COL PACKER: We do not have research funding, and so our work in the research world has been to integrate the clinicians and the labs with the research worlds.

And I've got a couple of slides that outline that a little better, if I can move on towards those, I can point that out I think.

Going through the Joint Strategic plan, the next couple of slides just show these are basically organizational. And I

think we're on the way to completing the setup, with the final one pending.

Develop a comprehensive plan for the registry utilization to encourage, facilitate research development of best practices and clinical solutions. So we're still marching through that registry development process.

And to highlight that a little bit, again that's the center of our NDA requirements. The key accomplishments is that information security process is well under way.

Again we hope to have the Air Force approved at Lackland this week. We hope to be able to then extend that to the Air Force as an enterprise, and into the other services, to collect that digital data for the audiometer for clinical care.

Again the parallel tracks are, working with Vision Center of Excellence to develop the infrastructure for the Federated

Registry, as well as looking at in-roads with the Health Services Data Warehouse for clinical management. Collaborating with the VA's Hearing Loss Repository in Denver, to share this data.

The DOEHRS surveillance system has been, we've been able to help modify their system for validity, and for efficiencies. And have created the reporting mechanisms. So we're waiting for the signature on the Data Use Agreement, so that we can share that with the VA. Hope to have that soon.

Moving on. We talked a little bit about the Hearing Aid Implant Purchasing Program. The DoD standardization of hearing aid devices can take advantage of the VA bulk purchasing power. Their processes are in place. It's an online registry system.

And through discussions with Health Affairs, and through the Health Executive Council, we've had the interactions

to be able to develop the in-roads.

The waiver process for DoD to purchase through the VA is in the works. The policy letter for instituting this practice across the DoD is awaiting signature.

The Centralized Institutional Review Board is something that we're hoping to have accomplished by the end of this calendar year.

Joint collaborative research requires IRB approval from every engaged research facility, which sometimes slows down the process to receiving IRB approval over the course of sometimes, two years or more.

A single IRB provides for the subject safety and ethics oversight, but allows for the progression of these multi site projects.

In the hearing world, sudden hearing losses or central auditory processing disorders, or some refractory forms of tinnitus, cannot receive subjects for studies

at a single site, in a meaningful time.

So developing this strategy to look at these, to collect a few patients at several different facilities can really enhance and speed up the process of research to define the evidence.

So MOA was developed with MRMC and we've had a kick off meeting, after a signature. The agreement we have, FTE in place to facilitate that, and we've had a protocol pushed through there successfully at this point. So we feel good about that.

The Research Productivity and Dissemination, and sir, I'll get to your question with the next couple of slides. This just shows that we still are in our infancy.

We've been working to develop the organization and the network. We have the research coordinators to provide the administration across the system. We brought the clinicians together with the research

teams.

So now we have the ability to rely on folks that aren't necessarily hounded by providing RVUs. We have access to develop grant proposals, IRB development, to help manage and coordinate the research projects as they're developed. To write the white papers and to apply for funding within the system.

And this has been successful over the last year and a half, with the announcements that have come out from the funding agency.

So where as we don't have RDT&E budget or funds, we are having some success working together with the VA, working with the different services, working with academic partners to develop productivity with this administrative backbone.

We at the same time have developed sub-work streams out of the Auditory Research Working Group. To try to

standardize outcomes measures. The Pharmaceutical Intervention for Hearing Loss, and the Auditory Fitness for Duty Work Groups are an example of that.

The promising preventative medications and rescue medications that may preserve hearing and, or correct hearing loss, are looked at in various manners with the different dosages, different time frames, and different longevity.

And so if we can up front, at least get the teams that are doing the research to agree on standard practices, to develop the outcomes measures in a coordinated effort, then I think that we'll be able to compare those studies against each other. Whereas now, they are somewhat meaningless.

The Auditory Fitness for Duty Group, we talked quite a bit about. Along the same lines, I think that we have worked with the other Centers of Excellence to try

to develop the understanding of these multi sensory syndromes.

The injuries that not only affect hearing, but also affect vision, and extremities, and chronic pain issues. These members have syndromes that need to be characterized, and we can't do that by siloing our efforts into one specialty.

The Chronic Effects of Neurotrauma Consortium is an effort to try to work with other specialties, other COEs, the VA, and academic partners to develop a network to broaden the outcomes of the research that is done. So that we can avoid the duplication and create some efficiencies.

The goal is to again, standardize outcomes. Enhance clinical involvement that will point to translational focus. Facilitate administration and collaboration through the research network that is setup. And then to build the bench to institute the research mind set into the residency programs

and fellowship programs of the DoD.

So that we have interested clinicians that want to take care of the patients clinically, but also look at the problems and develop the solutions.

So this is our coordination stream. I think that you can see across the top that, you know, as service members transition into veterans, there is a spectrum of injury and a continuum of care that is often times broken down and isolated in our research.

We look at performance. We look at prevention. We look at acute care. And we look at rehabilitation separately. We, the research programs are broken up into military operations, into combat casualty care, chronic rehabilitative medicine.

We have funding agencies within each of the services. Within the VA, through NIH, and so our effort is not necessarily to fund and sponsor research, but to facilitate

it. And to do this, I know that this is a busy slide, but this how we are set up.

And as you can see, if this is our interest, and our Auditory Research Working Group with the subject matter experts, we also have gaps in each of these corresponding arenas.

And we hope to provide the integration between the funders-of-research and the doers-of-research, by creating the dialog that helps to steer and plan programmatic events.

The portfolio management, we just contracted a research coordinator to develop a comprehensive portfolio, a comprehensive understanding of all that's going on in the hearing imbalance world.

To work with these different RADs, the research activity directorates, to help them understand what the gaps are, so that they can prioritize that into their programs. And then the centralized IRB

solution down here.

So we work with the services, and with academia and industry at a tactical level. At a subject matter expert level, where as they touch base with them at a strategic level.

I think that this interface here, the integration, provides an enhancement of their systems. And it allow us to not only help identify the problems, but also to pick up the translational tail, as these functions provide the research.

They can turn that back over to our clinical teams to put those back into the clinics, so we have a true bench to bedside establishment. Does that answer your question a little bit, sir?

MEMBER STONE: I think it gives a nice idea of why we're having trouble. Your funding is strictly for operations.

LT COL PACKER: Yes, sir.

MEMBER STONE: And was determined

by in the Congressional NDAA that established you, and provided ongoing funding. Right?

LT COL PACKER: Correct.

MEMBER STONE: It gives you, your personnel.

MS. DAILEY: I don't believe you're getting direct funding from congress. While that was one of the initial issues, you were aligned under services, in order to ensure a funding stream.

LT COL PACKER: Correct.

MS. DAILEY: Okay. All right.

LT COL PACKER: Yes. But also correct that it is O&M funding, it is not research dollars.

MEMBER STONE: Okay. So it is up to your experts to hope, using Admiral Nathan's word and yours, to hope that you can convince those people with funding dollars in the individual services to support you?

LT COL PACKER: Yes. It is. Now we have models that show success with this

type of strategy. In the VA, we're working with the -- looks like you have a question for me -- you want to --

MEMBER STONE: No. I'm giving you an opportunity to redesign the system, to be really direct. How would you redesign this, to allow you to move much quicker, rather than having to cajole to get to the level of success you would like? Or is this the way it ought to be?

LT COL PACKER: I think we're making a best fit out of what it is. Yes, we're trying to work within the system as it is. You're right, it would be helpful to have dedicated research dollars. We've had trouble.

We served on a committee that looked at the five year planning for collaborative research at Fort Detrick, under Major General Gilman, just last month. And some of these issues were brought up, the P-6, P-8 fence.

And so that is one strategy that they plan to take up, so that we can have easier access crossing fund lines. Now we do not have a dedicated research fund line.

Which again, one of the last program reviews that we sat on for the JPC-8, the Clinical Rehabilitative Medicine Directorate, was fraught with frustration from my end, because tinnitus may never score well on programmatic reviews, on scientific reviews because the fundamental knowledge is not there.

We have theories but that doesn't translate well into science. You need to have science to write a good proposal that will be picked up for funding. Without that fundamental knowledge, I don't think that we will make a lot of progress.

One of the thoughts that we've been discussing. We've, part of this network development is that fundamental knowledge building, through a higher order animal

model. We don't have a great animal model tinnitus, is, as subjective experience. We don't have an objective means of identifying that clinically.

And so we feel that it would be helpful to have an animal model that would allow some of this syndromic characterization of the multi sensory, polytrauma, injuries. As well as to identify some of the hard to understand syndromes that we're seeing.

CO-CHAIR NATHAN: We understand that, what you're saying is the science hasn't caught up to the point yet where it creates a mandate for certain practices. But I'm going to ask you a more technical question. Or tactical question.

Is your funding at all fenced for Wounded Warrior care? Or linked directly to it, for ***GWAD10:44:39 or OCO? Is any of your funding, because I believe it comes through the services? It probably comes through the Army's executive agent, and I

don't know if it's being fenced. And why is that tactical?

LT COL PACKER: It's not.

CO-CHAIR NATHAN: Because if we don't figure a way out of sequestration, these kinds of things are going to be very low hanging fruit. And the only thing that's going to be protected, is going to be that money that's been earmarked and, or fenced for Wounded Warrior support care.

If the COEs have not, and to my knowledge they have not been. Then you got, we have problems. Because this is, you are, and what percent of your funding if any, comes from third party, that grants? Do you know?

LT COL PACKER: We're hoping to establish that, and so back to the research productivity, you see we're just still, we've had a couple of projects that have materialized.

And through this Grant

Development Administration Network, that's what we hope to leverage money through, grantsmanship, but it's just at the start.

CO-CHAIR NATHAN: Because the big problem we have now in our services, is in our R&D departments. And we're pretty big, but we're not nearly as big as the Army's footprint.

Is that so much of what we do as far as personnel hiring, and consultants, contractors, and even some GS personnel, are hired through grant money that we have, and perpetuity. Through federal agencies, that are giving us money from federal agencies to do research for them.

That money's going to dry up. And so the closest wolf to the sled right now in the DoD, MHS, is research dollars. That's the closest, that's the lowest hanging fruit.

Because as NIH, or another department of the Army, or the Navy, or the Coast Guard has given us grant money, to

study these things, and hire personnel, and do research, that may well dry up. And so research may die on the vine.

So I just want our group to understand what risk we are, what you are, in the coming evolution, and if we could find our way out of that or not. I just think it's important for our situational awareness to understand and our recommendations may have to be, to earmark some of your fundings for these COEs, to Wounded Warrior mandated programs.

LT COL PACKER: That's a good point. I think --

MS. DAILEY: We'll need to wrap here, Colonel Packer.

MEMBER PHILLIPS: Let me just ask a simple question from my understanding. So I'm assuming that all the COEs are operational. None of them are funded with research money or, so that's an area that we should address?

MEMBER REHBEIN: Can I address one thing for just a moment, Denise? Do we have time?

MS. DAILEY: Yes. And we'll get Colonel Packer to wrap after that.

MEMBER REHBEIN: Okay. Let me, the Advisory Boards that you've mentioned in a couple three places. Having experience in the Centers of Excellence that the National Science Foundation set up some years ago, they also had Advisory Boards that essentially had two functions.

One, was to help define and identify the problems, the work that needed to be done. But then the second function was once that work was done, once progress was made, they were expected to be people of influence, and in influential places that could help get, very much help get that progress implemented.

Even where you talk about the Fitness for Duty here, are your Advisory

Boards configured that same way? Or do they have that kind of responsibility that they can help get that implemented even though there may not be specific regulations?

LT COL PACKER: That is our plan. We have, the Advisory Boards are situated across the services, so that we have the consultants from the services in the planning phases and also to pick up, to create the policies that come out of the evidence based understandings that we achieve.

MEMBER REHBEIN: And are they of sufficient stature within each of those services to be able to actually accomplish those tasks?

LT COL PACKER: It's a constant battle. I think that one of the other issues that we have, is we work through medical lines. And to, which then have to, the priorities that we elevate through medical lines, have to be prioritized against the line requirements.

And so sometimes that's an easier sell than others. And we're, we see the need for prevention, we see the need for hearing as a readiness issue. We've been trying to work those issues for years. And it's been successful to some degree.

I think that hearing loss and auditory injury is becoming better recognized as a problem. When you look at the amount of DHP funding that we have for the Hearing Center of Excellence, and pit that against the billions of dollars spent in compensation. We're spending, you know, tenths of a cent on the dollar towards the solutions. And so it is a difficult thing to push those into line priorities.

MS. DAILEY: Could, can I get you to wrap up here?

LT COL PACKER: Yes, ma'am. Let me just --

MS. DAILEY: Very quickly.

LT COL PACKER: So in summary, I

think that considerations for policy changes that create rapid processes, standardize procedures, and policies across the DoDs.

The authorization for access to service members has been a, refer to that, there's a DTM-12-004 that inhibits the ability to reach out and get focus group feedback.

It requires a general officer sponsor and commensurate level of acceptance through the services to access these groups. And that has been difficult for our Prevention Campaign.

Again we talked about hearing is, needs to be a readiness issue. We need to have minimal threshold surveillance, not necessarily putting everybody into a hearing conservation program, but we need to have a basic testing thresholds to look at our members.

And we need to be able to make them war ready, by looking at their hearing

status, that improves efficiencies across the board.

We talked a little bit about some of this in research, the created development, the collaborative research and development agreements and the tech transfers are problematic and slow because they are service specific.

And sometimes they have to be repeated and duplicated. And then to push that into the VA is another hurdle.

Program 6, Program 8, dollar cross over, it doesn't cross. Strategic MOUs for MTF research here. And we have a golden opportunity to work with our VA sites nearby. And we don't do that because, we don't do that on a generalized basis because these understandings have to be recreated.

So for us to be able to be an implant center, so that we can treat veterans closer to home, is not happening. We're looking at that, but these generalized MOUs

for dual use would be helpful.

Interagency IRB reliance we've talked about. I'll just close with this last slide. The pending decisions and approvals we've talked some about. The POM cycle, we're not protected.

I think you'll hear Doctor Gagliano talk about the transition of taking the Registry Development to the Theater Functional Working Group, to try to house that under Wounded Warriors, to try to protect it as a resource, system of record.

The DOC DLA is nearing completion. The CPG roadmap, we had some discussion about that. We're moving fine here. Here's the discussion about the Theater Functional Working Group.

And then with the single IRB that's developed, we'll still need to develop these IRB agreements for institutional review for a second level assurance at regional sites where we want to do these multi site

studies.

So some of these are the issues that we're dealing with, and we're trying to solve those problems, and look at them as opportunities to really maintain the forward motion.

I think that we have, the plus in our system is that the clinicians and researchers have joined together and it is a strong advocacy group that really understands the problem. Knows the sciences and has the dedication to work towards the solutions for the Wounded Warriors that have auditory injury and hearing loss. And we think that will continue.

We thank you for your questions and for the opportunity to present to you. Any final questions?

CO-CHAIR CROCKETT-JONES: Thank you Lieutenant Colonel Packer. We'll take a break until 11, not quite 15 minutes.

MS. DAILEY: 11 o'clock, please

members if I can get you back.

(Whereupon, the above entitled matter went off the record at 10:54 a.m. and resumed at 11:03 a.m.)

CO-CHAIR NATHAN: Okay, we'll go ahead and get started. Continuing along the theme of the five senses, we've talked about hearing, and now we're going to hear from the VCE on Visual Center of Excellence.

So we welcome, Don how you been? We welcome Colonel Donald Gagliano, the Executive Director of the Vision Center of Excellence. And Dr. Mary Lawrence, Dr. Lawrence, how are you, the Deputy Director.

As a joint venture between the Department of Defense and the Department of Veteran Affairs the VCE advocates the development of prevention, medical treatment, and research of visual system disorders to improve the health and quality of life for service members and veterans alike.

Colonel Gagliano and Dr. Lawrence

will be updating the task force on their status since February of 2012 and discussing research activities over the past fiscal year. You can find their brief and there updates in Tab D of your binder.

Don, go ahead.

COL GAGLIANO: Thank you, Admiral. And, Ms. Crockett-Jones, thank you and distinguished members of the panel. Thank you for the opportunity to come and talk to you today about what we're doing at the Vision Center of Excellence.

Dr. Lawrence and I will be updating you together and there are quite a few members of the team in the audience. And on behalf of the team I hope to be able to do them some service in presenting to you the great work that we're doing at the Vision Center of Excellence.

We'd like to begin with a video, we created this video for a congressional briefing that we presented on September 26th

on the Hill. And it was designed to provide an informal opportunity to see the integration of the different stakeholders that we have engaged in the work that we're doing. I think it's an important point.

I'd like you to view this video, your feedback is of course welcome but we have shown this in a few different audiences and I thought it would be worthwhile to show it in this audience as well. If you'd start the video please.

VIDEO

MALE PARTICIPANT: I was deployed to Iraq in the summer of 2006 and we won an offensive operation in a town of Yusifiyah. We had been engaged with the enemy on the day before. My commander had given me the mission to take up a position on a corner of a compound.

It was right when I picked up the handline to tell my battalion commander to make the call that I was about to move and

that's when an 82 millimeter mortar round landed five feet over my right shoulder. Instantly I saw a flash and a loud blast of the mortar round.

I was knocked unconscious but deep down inside I was fighting, trying to wake up to stay alive. The mortar blast had broken my nose, it fractured my right cheek bone and enucleated my right eye. A fragment had went into my left eye.

After six weeks they were finally able to wean me off the sedation and at the time a family member had to be the bearer of bad news that I had lost my vision.

MALE PARTICIPANT: Second only to death people fear blindness more than any other event in their life. More than cancer, more than loss of any other sense. Loss of a limb, even paraplegia.

FEMALE PARTICIPANT: We can't replace the eye yet at all. There are numerous endeavors but as to repairing you to

be functional again exactly the way you were unfortunately we are not at that point.

MALE PARTICIPANT: So there's no prosthetics, there's no computer systems, there's nothing we can do to give a person back sight that they've lost.

FEMALE PARTICIPANT: Everything we do, whether it's our job, whether it's seeing our children, seeing our grandchildren, whether it's mobility. All of these factors are greatly impacted.

MALE PARTICIPANT: So vision is critical to life and having a brain injury in a large percentage of patients results in loss of vision or the inability to use your eyes to see. Even if your eyes are normal and haven't been injured.

People who have lost vision don't know how to deal with that and it's important to have a center, a place, where they can feel there's hope. Where someone will be there to take care of them. To help them

figure out how to regain their lives. And to bring back as much of the joy that they felt before they were injured to their lives.

FEMALE PARTICIPANT: One of the beauties of the Vision Center of Excellence, is that it's a joint Department of Veterans Affairs, Department of Defense enterprise.

Veteran Affairs has been providing blind rehabilitation for veterans and wounded warriors since 1948. Military closed their programs in 1947 and they were transferred to the Veterans Affairs.

And because of that we've had decades of experience to build up knowledge base, intervention techniques and to make sure that we're using the most advanced technology to provide rehabilitation.

MALE PARTICIPANT: In my opinion the Veterans Administration visual rehabilitation programs are the best in the world. There are inpatient facilities that have an incredible staff. And really an

incredible track record of rehabilitating the service men and women to the fullest extent that that individual serviceman or woman would like.

MALE PARTICIPANT: In the past the goal was just survival. What we're looking for now is a full life.

MALE PARTICIPANT: There's a tremendous amount we can do in the visual rehabilitation world to improve quality of life and to make people who have serious visual impairment really become functional within society in a way that they find rewarding and that they find improves their self esteem and their self worth.

We're not just looking at how can we make you able to walk across the street to how do you move forward to getting a degree and taking on challenges of with new communication tools that will allow people to truly live a fully functional life.

In order to better understand

what we're doing on the battlefield we have to know what's happening to individuals when they leave the service or they're transferred to the care of the Department of Veterans Affairs.

MALE PARTICIPANT: Registries, are I think personally one of the most important tools for physicians and for health care systems moving forward in the military, in the civilian world throughout the globe.

MALE PARTICIPANT: It gives us insights, and it's not the incidental event that occurs with one patient that helps direct our training and helps direct our education, it helps direct our experience.

It's the fact that we can look at multiples.

MALE PARTICIPANT: What they're doing in terms of developing a system that can follow patients, can follow problems, can follow events over many many years, analyze a complex data set and give you very clear

answers to very important questions is truly profound.

It's going to have an impact, not just here at the Vision Center of Excellence, it's going to have an impact throughout the country. The future of the Vision Center of Excellence is bright. We have an opportunity that has never been presented before.

We really can make a difference in people's lives. We really can find new ways of restoring vision and new ways of saving vision.

I hope that through the work that we do in the Vision Center of Excellence the loss of vision on the battlefield as we've seen it in the past few years, will be something that we will not see in the future.

MALE PARTICIPANT: Most of the soldiers I've taken care of, and I've been at Walter Reed since the beginning of the war and taken care of hundreds if not thousands of injured service men and women, is that

they're attitude is really actually incredible.

I think that's a testament both to medical care that they're receiving but also to testament to their motivation for doing that job that they're doing.

MALE PARTICIPANT: To be born free is an accident, to have lived free is a blessing, and to die free is an obligation.

VIDEO ENDS

COL GAGLIANO: Of course I want to thank the incredible character, I thank Captain Castro and his incredible character. And the visual information office of the Navy for putting this video together.

We would like to now move into the discussion about where the program is and what are some of our accomplishments and where the program will go.

And to do that I'm going to ask Dr. Mary Lawrence to come and lead the presentation and the slides.

DR. LAWRENCE: Thank you very much, Colonel Gagliano, and the esteemed members of the recovery warriors task force.

It's a great pleasure to be here this morning and to give you a little bit of an update on what we've done since we were here last in February of 2012 and to highlight some of our accomplishments.

Next slide, oh I guess I do that myself. First I'd like to run through the agenda for our presentation.

First of all I'll go over some background information including discussing some of the magnitude of eye and vision injury in the last decade or so of conflicts. Go through the continuum of care.

I'd like to speak to the VCE mission and a map to the Recovering Warriors Task Force. Focus areas, our three mission areas will be discussed and some of our projects that are focusing on those three mission areas.

I'd like to then give you a status update on the vision research program, the vision registry, some staff and strategic communication. And some regional locations, specifically addressing some of the questions that you asked us.

I'd like to then highlight our stakeholder engagement and our collaborative efforts with other centers of excellence and then Colonel Gagliano will talk about some of the changes to enhance our mission and lead the next steps in discussion.

This is probably the most important slide in the whole deck. It is the magnitude of eye and vision injury. In the current conflicts eye injuries have accounted for approximately 15 percent of all battlefield traumas.

This has resulted in over 197,000 ambulatory and over 4,000 hospitalized cases involving eye injury.

If you look to the chart on the

right it describes in detail some of the areas of eye injury and the numbers associated with them.

In addition to eye and orbit and eyelid injury we have as many as 75 percent of all of our traumatic brain injury patients are suffering from visual dysfunction that affects their quality of life.

This has been reported in two peer review studies out of VA hospitals, one of them the Hines Rehabilitation Center in Chicago. And the other in Palo Alto, the blind rehab center there.

So 75 percent of TBI patients have visual complaints and visual dysfunction. The majority of our injuries are in the 20 to 24 year old, mostly males.

And the most important take away from this slide is that the consequences of these injuries to our warriors will be with us for decades.

Most of our injuries are in their

early 20s, they are expected to live for many decades and we will need to care for them the best way possible.

The continuum of eye care starts with surveillance and prevention and readiness for our warriors. Then of course screening, diagnoses, and treatment including medical and surgical interventions.

And then finally rehabilitation and reintegration. Rehabilitation to get back to work and to be reintegrated eventually into society as a productive, fully functioning citizen.

We're dividing the vision trauma into two categories. One is ocular trauma which will include the globe, orbits, and eyelids.

And the other, the brain trauma, the TBI associated vision dysfunction including the optic nerves. The visual processing areas of the brain, cranial nerves and would include visual field loses too.

The Vision Center of Excellence mission is that we lead and advocate for programs and initiatives to improve vision health, optimize readiness, and enhance quality of life for service members and veterans. This was approved by the Center of Excellence oversight board in January of 2012.

The next slide is really a table to map the focus areas of the Recovering Warrior Task Force on the vertical axis to our three mission areas on the horizontal axis. Our directorates are divided into several areas.

One of including clinical care integration, the next education and training. Research and surveillance and rehabilitation and reintegration. This falls very nicely into the Recovering Warriors Task Force focus areas.

I'll say that all of our work is supported by data and analytics for the

development of evidence for performance improvement and to guide our research initiatives.

Our biggest area in terms of the data analytics is the vision registry project which I'll talk about in a few minutes.

So the first of our mission areas to improve vision health, I've highlighted here some of our programs that I'd like to just quickly review for you that are focusing on improvement of vision health.

In terms of ocular trauma, we've divided these slides up into two segments of the ocular trauma and then the TBI associated vision dysfunction.

In terms of ocular trauma the VCE has expanded its monthly worldwide ocular VTC to include the VA Polytrauma centers. This is a very exciting program, it's done in a case presentation format.

Providers from the whole globe call in to talk about cases much like a grand

rounds presentation. But it's a very free flowing and the providers who are doing the initial surgeries in the combat support hospitals are getting feedback all along the way to the military treatment facilities in continental U.S. as well the VA Polytrauma centers.

So they get feedback of how the patients are doing and vice versa. It's been very well received and it is amazing how much we've learned in terms of process improvement and feedback to our providers.

The VCE is also hoping to define the functional requirements for a joint VA DoD electronic eye node for the integrated EHR. And that's an important initiative.

We are able to bring together VA and Department of Defense providers across all the provider categories of eye care including optometry, ophthalmology and vision rehab.

The VCE has led the way for the

inclusion of Fox shields into the individual first aid kits. The IFAKs, as they're called are currently deployed with a Fox shield in both the Navy and Air Force units and we're working hard to have it be in all of our service members individual first aid kits.

The Fox shield, for those of you who don't know, is just a little metal shield to provide support. Any other system in the body if there's a laceration you put a pressure patch on.

Well a pressure patch on a eye is devastating. A pressure patch on an eye can turn an eye that is salvageable to be able to have some useful vision, into an eye that is not salvageable and is going to end up in a bucket in an operating room. So this is extremely important to help save the vision of our wounded warriors.

The picture on the bottom right, you see a soldier being bandaged and you see the bandage being put around the patient's

left eye. And if you look at you say, probably no Fox shield, but interestingly the patient has on glasses and I know it's a small picture.

So the card and the glasses of course provide that support so that the bandage being put around is not actually going to put pressure on the eye. So in the absence of a Fox shield that was a good way to go.

And this was in a large part due to Dr. Robert Mazzoli, retired Colonel. Robert Mazzoli efforts every day throughout the system reminding people to not put pressure on the eye as we're taking care of our injured eyes.

CO-CHAIR NATHAN: Dr. Lawrence?

DR. LAWRENCE: Yes.

CO-CHAIR NATHAN: So what was your mechanism then to get the Fox eye guard into AMALs for the Navy and the Air Force?

DR. LAWRENCE: Retired Colonel

Robert Mazzoli really was working that through his contacts, although he's an Army Colonel.

CO-CHAIR NATHAN: Prophet Without Honor.

DR. LAWRENCE: Probably Colonel Gagliano could talk about that a little bit.

CO-CHAIR NATHAN: So based on our conversation with the last group that came in here we're concerned with how you find good science and best practices as you collaborate among yourselves and among academia and the private sector. And how those get transmitted and implemented into practice to make a difference for warriors at the scene of the injury and as they recover.

So we want to know when you have successes like this were you able to change the practice patterns of trauma or warrior care in the military, what was your vehicle for doing it?

COL GAGLIANO: If I may answer

that question. We identified this as an issue in working with the joint theater trauma registry team. We have a CPG that is used, it's one of the 33 CPGs with the JTS, used to be the JTS not the Joint Trauma System.

And at looking at the registry data of the JTTR identifying whether or not shields were being used appropriately we found that there was actually a lack of use in some situations. Usually it's a new provider or new group coming into an area.

We had it added to the audit alerts for the performance improvements of the the JTS and the JTTR. So we were engaged with them because they were the only existing entity that was monitoring the battlefield care at the time.

Now we're doing the same thing, but I like to think they're doing survival and we're doing vision survival using that model.

So we've carried that to where we can tell whether, by looking in the TMDS and the other data sources whether or not we're using the Fox shields if there's a need for educating providers. So that was the first place.

And then we realized in some cases there was a lack of availability in the theater. And there also was a lack of clear identification that this would be a requirement in the program of instruction for the medics that were deployed on the battlefield.

We started addressing that predominately using the CoTCCC, the Committee on Tactical Combat Casualty Care, as our entry point. And their relationship with the defense health board.

We were able to get both of those modified through the CoTCCC accepting that as one of their initiatives. They then pushed for the Defense Medical Material, DMMA, I

think it is, or the logistics group to identify this as a need.

Working with the combat developers of each of the services. Then that's why we're still finalizing it with the Army. In getting that identified as a requirement for the IFAK.

And we went back with the CoTCCC to look at the program of instruction. Changed the PHTLS military components so that it actually reads that the use of shields in eye trauma is a requirement.

So that's basically how we moved the system forward and how we've had it initiated.

MEMBER STONE: So then why has Army lagged Navy and the Air Force implementation?

COL GAGLIANO: I don't know that I can answer that. I'll probably answer by saying we started working with Jim down at the director of combat developments earlier

than any other service.

But it's just the process I think. That takes a little longer. I don't think there's any fault, I think it's just the way the change process flows.

CO-CHAIR NATHAN: I don't think there's any one person to blame but there's fault. In other words, if a soldier loses an eye tomorrow because he or she is incorrectly bandaged where the Navy person lying 50 clicks away gets the proper bandage. There's a Houston we have a problem.

So again, it's not any individual but again, this group is empowered to try to figure out how to remove those.

And what's intriguing to this, inquiring minds want to know how you, an Army Colonel, and the champion that you mentioned before, an Army Colonel has done such a great job of getting this into the Air Force and the Navy. So that just tells me that there are systems issues.

Not bad people, good passionate people, just systems issues that need to be overcome. And we want to help you mow down, that's why we're critically interested in how when you find good science and you change the game in eye care and injury prevention and treatment, how that gets transmitted rapidly to the services.

COL GAGLIANO: Yes, sir. I agree, concur.

DR. LAWRENCE: The Army, Air Force, Navy and VA are all completely separate medical systems I think is what you're saying.

MEMBER STONE: We got that part. So how should the system work to assure uniform availability of this technically across the services to those in need.

DR. LAWRENCE: This is one of the things actually we have on our Slide 17, if ways.

MEMBER STONE: Would you like to

go to that now?

DR. LAWRENCE: It's up to you, what would you like?

CO-CHAIR NATHAN: The crux of what we want from you is how we can translate what you discover, what you find, what you determine as best practice into the best care for the recovering warrior in the acute or convalescent stages.

That's what we want from you, so that should be the center of what we discuss.

COL GAGLIANO: Yes, sir. And I would say the route we had to follow was circuitous as even a best description of it. But we were focused on using the path that seemed to at least get us to the end point. In the absence of any other path.

On Slide 17 we talk about the ability to act as an agent for change for the services and, you know, on behalf of the service members and the veterans and the families. And we've had this as an issue

previously.

I heard you mention before what is it that connects the engine to the tires. Where's the transmission and the drive train. And that's what's really missing here.

We work through consensus at the moment and we build consensus predominantly with organizations at that are empowered. I don't believe we are empowered at the moment to makes change or act as change agents.

What does that look like, I heard General Stone ask previously, are you working through consensus or a DoDI? We've had the DoDI, we think, and maybe perhaps the VHA directive care. And I know that's an area that you're involved with and how can we if we discover that there is some program that should be initiated that will help us raise the bar on care.

There is no authority to enact that at the moment. I hate using the word

authority because everybody gets shied away from that. So we wrote down here enabling, us to act as agents of change.

And it isn't about owning, it's about guiding and directing and our mission kind of says that we lead and advocate programs.

MEMBER STONE: The Department of Defense is in the midst of military health system transformation in which we attempt to figure out what the new authorities are of a defense health agency versus the services.

I'm deeply respectful of subject matter experts, I'm also respectful of the authorities of the surgeon generals to advocate on behalf of their services.

What venues should be constituted that would finally connect all of these centers of excellence to a forum that would allow consensus to be reached and then uniform application.

Rather than simply a relationship

based because of the respect that we all hold the two of you, and your teams, a relationship based process. How should this look in the future as DoD redesigns it's defense health program?

CO-CHAIR NATHAN: I'll answer that for you. I think really we need to, as we embark on the new organization and General Stone, where health affairs is going to reinvent itself under policy with the DHA under execution. What's lacking?

Right now you've been empowered by the good will of the services and the people who stock the first aid kits to implement this.

And you're still waiting to get over some of the bureaucratic hurdles of the Army, which will undoubtably get there too. But that's the good will mechanism.

And we're looking for, and this is why I think we need health affairs to come in and talk to us about how they see their

role. And maybe they need something more than they have currently to implement this kind of thing. There should be some sort of empaneled advisory board where you can bring best practices to and they have the horsepower and are empowered by Title 10 and other authorities to implement this across the services.

I think that's currently what's lacking. And now that we're in this state of flux where we're trying to find our new footing with the defense health agency and the unification of some shared services I think the time is ripe to be able to put these things in. To move these things faster than whatever.

And so far it catches the ear of somebody. It catches the ear of a secretary of something or other that's empowered. Or it catches the ear of the White House. And then we get a note saying do it.

But we don't have a codified

system that allows you to, if I said to you who are you going to call to this put into the services tomorrow.

You'd say well I'll probably call all my buddies in each service that I know who might be connected. That's the best you've got.

COL GAGLIANO: That's exactly right, sir.

CO-CHAIR NATHAN: So we need a more codified approach where you can have a venue where these things can be brought into a board that can say yea or nay. But if they say yea it then becomes a DoDI and we move out.

DR. LAWRENCE: Admiral, one of the things I wonder, if we haven't used it well enough perhaps, is the Health Executive Council. We have reports and things come in but actually action items out of there have not in the past been a lot.

But one of the things, and I

think this group is going to get a report at some point on the interagency care coordination council.

One of the things that group has been charged with is for the three services in VA to come up with a single overarching policy and try to figure out how to get a DoDI and a VA directive in one. And that's got about 30 days.

And I know Captain Evans and Colonel Keane and myself are working on that. And that is some venue to think about for future.

CO-CHAIR NATHAN: Yes, and the SG's, Surgeon General is I believe are ex officio members of the HEC. But health affairs is a member of the HEC.

And so again, the question should be how can we help Health Affairs when they hear this at the HEC, the Health Executive Council. Or the JEC or the BEC, to move these things into execution phase.

COL GAGLIANO: So we presented this issue in April at the HEC and were asked to come back in June, presented it again, about the enabling authority. We used the word enabling documents because the word authority was removed and I know that that has implications.

And Secretary Woodson asked that we take this, not to the COE advisory board for determination and we've been trying to get it on the agenda for the last few months. There's been some other priority efforts in COA advisory board.

And again, I'm not even sure that's the right place to bring it. But I will just add that we've brought visibility, we did have concurrence from both Bob Jesse, who was representing the Undersecretary at the time, and Secretary Woodson to take this forward for further discussion.

DR. LAWRENCE: Should I move on? Thank you. Sort of on the same topic, on

the TBI associated vision dysfunction, we're developing consistent based clinical recommendations.

We're putting together SMEs, Subject Matter Experts from VA, DoD and private sector and academia. And again these clinical recommendations have the same approval difficulties. It's the same approval environment.

In terms of optimizing readiness an ocular trauma the VCE is co-hosted a symposium, a working group to develop a road map for the use of simulation and eye care and education.

And simulation of course is really the wave of the future in terms of training our providers to be the best ready to take care of injuries.

And we're also working with Harvard Medical School to develop an ocular trauma mannequin. It also reduces the need for the use of live animals in surgery

laboratories, so that is another advantage of moving ahead on those initiatives.

The VEC has been a leader in the APEL, the Authorized Protective Eyewear List initiative. And of course prevention is worth a pound of cure. And wearing the protective eye armor is critical for our forces.

Just as a little aside I had the opportunity to meet Ehud Barak the Israeli Defense Minister last year. And I was able to visit both an Air Force and Army station in Israel. And the Israeli army does not wear these eye armor even in situation where they probably should.

So we, as the United States military are much better at protecting our forces with APEL.

In terms of TBI associated vision dysfunction the vision care services coordination services initiative is something that we do to help facilitate appropriate

referrals for anybody with an eye or vision injury across the DoD, VA and private sector.

Most of our work of course is VA and DoD and the DoD does not do blind rehab so patients do need to be transferred over across the departments to the Department of Veterans Affairs for blind rehabilitation and then back. These are active duty service members.

And we also helped provide a referral to a private sector, actually Johns Hopkins, just late last week for one of our injured soldiers at Walter Reed.

In terms of quality of life, the vision care services coordination really does link service members and veterans to diverse vision services throughout the military health service, VA and other federal and civilian agencies.

We have established several stakeholder work groups to assess technology camps for service members and veterans.

And we have produced two critical updates, published in Federal Practitioner which is a circulation of about 35,000, goes to all federal providers. Some of the issues facing people with visual impairment as a result of their service.

The pictures, the picture on the left is a picture of U.S. Navy Lieutenant Brad Snyder. He was the U.S. paralympic team winner of two gold medals in London in September of 2012. And one silver medal.

Interestingly he won his gold medal, the 400 meter freestyle on the one year anniversary of the IED injury that blinded him.

We have coordinated his care across the system and he is a really wonderful success story for getting back his life after a blinding injury.

The picture on the right is of a veteran working at the American Lake Rehab Center near Madigan in Tacoma, Washington.

You'll see he's got a baseball cap on; this is very typical of TBI patients.

They're very light sensitive, sensitive to glare. And they often walk around with baseball caps and of course he's got good glasses that are perfect for the distance he is away from the computer which is quite close.

The computer screen is enlarged; you can see how big the letters are. And you can see there's a reverse black/white color inversion on the computer terminal there. And that's very typical of TBI patients because the white screen causes a lot of glare.

We've worked with consensus panel development for practice recommendations for the care of these TBI-associated visual dysfunction patients and we're establishing a critical clinical research priorities.

In terms of our research program which we have titled the Vision Research

Program, VRP, our goal is to foster innovative and relevant research based on several focus areas. Vision dysfunction after concussion injury, TBI, protection against environmental hazards. Modulating the ocular response to injury. Total robotics and simulation. Modulating ocular response to disease. Ocular and visual restoration, and refractive surgery and education and training.

The VRP is a requirement space program, it includes 42 research grants in 17 states and two foreign countries including UK and Israel.

We've divided a lot of the research programs into two slides here so the next two slides. The treatment of traumatic visual injury and visual restoration.

In terms of traumatic visual injury there's a current portfolio of 17 active projects with an amount of a little over $22 million.

Projects include designing ocular membrane patches and adhesives for primary management of ocular trauma and bio-compatible membranes to guide ocular reconstruction.

Our performance highlights, there have been 21 presentations, 14 publications and two patent applications from some of this research.

And the top right is looking at a wound healing of the cornea using contact lenses. This is in an animal model and the bottom, if you can see, there's a corneal scar here centrally which might be typical, you'd see with shrapnel. And looking at some wound healing capabilities for corneal injury.

In terms of vision restoration, current portfolio is 14 active projects, $18.6 million. Projects including assessing regenerative capability of bandage lenses which self-adhere to the surface of the eye.

And you can see the contact lenses above in the two top pictures.

And sensory substitution strategies for enabling the perception of visual information. The bottom two pictures are pictures about the brain port. I don't know whether any of you have heard of that.

We often call it the lollipop. And what happens is a little camera is in the glasses and a processor converts the vision image into impulses that are sent through an electrode array to a device that is put in on the patient's tongue.

The sensory stimulation to the tongue is eventually converted, after six to eight weeks of training into a visual stimulus and on PET scans and occipital cortex which is the part of the brain that accepts visual impulses light up. And this is obviously in connection to the tongue.

It's pretty amazing technology. There are a lot of other vision restoration

projects out there.

The registry after all these interesting clinical projects that I've talked to you about, the vision registry might seem a bit bland.

But this is, as Dr. David Park, the American Academy of Ophthalmology said, and Dr. Ron Hopping from the America Optometric Association, stated in the video this probably the most important thing for developing longitudinal outcome analyses of our vision-injured service members and veterans.

And will support prevention, mitigation, treatment, and rehabilitation of the injuries and disorders of the visual system.

In the interest of time I think I won't spend too much time on this except to say that our timeline -- we had a pilot effort was approved in September of 2010.

And now as of last month we have

the vision registry pilot has been classified as an ACAT IV program. That time frame is 15 months and it usually takes four to five years for an IT program to reach that status.

We've been working really, really hard and we have made some great achievements on the vision registry so that we can really have some good data analytics to move ahead with the care of our service members and veterans.

CO-CHAIR NATHAN: Dr. Lawrence, what is your mechanism for, and maybe you're getting to it in the next slide. But for networking with sister centers of excellence eye institutes, world-class places in Boston, Palo Alto, Durham, Zurich, that are doing avant-garde, new cutting edge things.

How do you stay abreast of that and how do they work with you?

DR. LAWRENCE: Well, a lot of it's personal communications. We have our ear to the rail. And we have good

collaborative relationships with academia.

CO-CHAIR NATHAN: So the NICoE this afternoon will tell the folks that what they do is they have funding, some of it governmental, some of it private partner, where they host conferences. And they invite the leading researches and authors from various TBI, PTS centers of excellence throughout the world in private and academic sectors, to come and share what's new in a symposium.

And they sort of leverage patriotism to get these folks to come and talk about what's late and great. Do you have funding lines for that? Are you able to host conferences or bring people in or host symposia?

DR. LAWRENCE: Most of our funding in that arena has come actually from the VA. And our first few years, we hosted two big symposia on visual dysfunction related to TBI. And that was in

fiscal year 2009. And then in fiscal year 2010 we hosted another dual sensory, so hearing and vision loss that last one was in San Antonio. And we had academia, very much what you're talking about.

Of course in this environment with travel and conferences and post the GSA debacle, there have been very severe restrictions and cutbacks.

In August of 2011 we were able to do a very small conference looking at certain aspects of visual, it was really not a conference; it was a working group.

To get together SMEs from across private sector, academia, VA and DoD together to talk about technology gaps and sports adaptation and driving and some of the other issues that are facing our service members and veterans.

And then in fiscal year 2012 we did not have any funding to have any of those kind of activities. We continue to work on

those working groups. Leveraging other technology with VTCs and conference calls and emails.

So we're really trying to move ahead despite the current environment we're working in.

CO-CHAIR NATHAN: Thank you. And I appreciate your passion on that. The concern is that there's somebody right now doing something in a lab or a research center or a university that's a better mousetrap, and we don't know about it.

DR. LAWRENCE: The biggest eye research meeting in the world and with researchers from truly global eye research, is the ARVO meeting, the Association for Research in Vision and Ophthalmology, and that is the largest eye and vision research meeting in the world.

We have been able to attend that and Colonel Gagliano has given a big well attended talk at that about some of our DoD

initiatives encouraging some of the best and brightest minds in the world to focus on some of the issues that we, the Department of Defense and Department of Veterans Affairs really want to focus on.

It's I think at 6:00 a.m. and many researchers don't get up at that time often but it's packed. Standing room only the last two years.

And so I think that we've really made big efforts, I've been in academics and Colonel Gagliano has run several of the big research institutes across the DoD. So we're very well connected, thank goodness, in that arena.

Okay. Staffing and strategic communications. Our staffing is virtually the same between February 2012 when we had the honor of coming here before you last year and now, 14.6.

In terms of strategic communications, VCE website was transitioned

to the consolidated health.mil website. And we have several updates that are planned for this summer for health professionals only link. And to synchronize all vision-related messages across the enterprise.

Tools to develop external partnerships in that may be leveraging the health professionals only link. And to reach all of our stakeholders.

We want to be 508-compliant and we want to be actually put a plus there because we want to be better than just compliant.

We want to really have people who are visually impaired use our website and tell us what can make our website easier for someone with visual impairment to navigate.

We are building a suite of VCE communication materials, including an annual report that we'll have out in the next couple of months. A strategic communications plan and an update to the VCE strategic plan

planned to come out this summer.

In terms of regional locations, we've had presence here in the national capitol region since fiscal year '09. Currently we have two offices, one in Crystal City, just down the road here with proximity to the National Center for Telehealth & Technology or T2.

And then another office up in Bethesda at the Walter Reed National Military Medical Center that just opened in the spring of 2012.

And of course that has wonderful proximity to the National Intrepid Center of Excellence, or NICoE. Uniform Service University of Health Sciences and NIH, National Institutes of Health.

We have a small office that two people share at Tacoma Madigan Army Medical Center that has proximity to the American Lake VA Blind Rehab Center and the VA Puget Sound Health Care system.

And we are hoping to open a presence in San Antonio at the San Antonio Military Medical Center. And that would have some co-located or at least proximity to the Hearing Center of Excellence at the Extremity and Amputation Center of Excellence, the surgical research and the center for the intrepid.

MEMBER STONE: Dr. Lawrence.

DR. LAWRENCE: Yes.

MEMBER STONE: You discussed the fact that the Department of Defense does not do blind rehabilitation. As the Department of Defense develops additional traumatic brain injury centers, additional centers of excellence around its system, how should we view the relationship to visual rehabilitation for the traumatic brain injured across our system?

DR. LAWRENCE: Vision rehabilitation for the TBI patients is different than the more traditional vision

rehabilitation, blind rehabilitation, we call it in the VA.

The visual dysfunction, often a TBI patient will see 20/20 on an eye chart and yet they can't read. They are very much bothered by bright lights in a work environment.

Bright lights driving, so if they're living in a northern climate and they're trying to get home from work at 4 o'clock in the afternoon and headlights are on they may not be able to drive. Many of them have difficulty with tracking and microstrabismus.

And so the visual dysfunctions associated with traumatic brain injury are very different than the typical vision loss we see with eye injuries. And both the VA and the Department of Defense are grappling with this.

And we are working on clinical recommendations for the first ever, clinical

recommendations for vision dysfunction related to TBI.

MEMBER STONE: So you're the experts then that do visual rehabilitation as part of traumatic brain injury then exist within the Department of Defense or solely within the VA?

DR. LAWRENCE: I don't know how to answer that. It's not really my decision but I think that would make sense.

MEMBER STONE: We've made a decision that you appear comfortable with that blind rehabilitation is solely done within the Veterans Administration health care system.

Should we, as we develop the additional traumatic brain injury centers, partner with the VA or should we develop additional capacity for brain injury rehabilitation?

COL GAGLIANO: Sir, I think the former is the correct solution. Because it

keeps the capability in alignment with the long term outcome. And I'm not a big fan personally of long term rehabilitation embedded in the DoD.

As a matter of fact VA's rehabilitation capability was started in 1947 when the Army ophthalmologists and at the rehabilitation center forced the function of starting that first blind rehabilitation center.

And that has grown as a capability. It was because there wasn't really a good system for sustaining it. And I don't think we need to relearn that lesson.

But I do believe that there is the opportunity to actively embed VA capability as we have done at Walter Reed. When I first took this job one of the first questions asked of me on the Hill was, why do blinded service members get better care when they're in the VA system than they are in the DoD system.

And the point they were trying to get at was vision rehabilitation starts fairly early in the polytrauma centers but it doesn't start fairly early in our, like, CFI or MATSI centers.

So we brought in that capability to the MATSI at Walter Reed so that the initial phases of blind rehabilitation can occur while people were rehabilitating from their amputation or extremity injuries.

I think there's a good model, there's still some work to do, because the DoD does not recognize blind rehabilitation as a specialty.

They can't document on their own in the health record. They have to go through an occupational therapist or another care provider.

And there are some occupational therapists who are very good at vision rehabilitation occupational therapy, as well as physical therapists. It's a new growing

sub-specialty.

But having this blind rehabilitation capability embedded in the VA and integrating it is another chance for us to capitalize on the capabilities of both systems.

CO-CHAIR NATHAN: So we've got to wrap up pretty soon. But what I hear General Stone asking and I hear you saying is, you do not believe there is unmet need in the DoD care system for blind rehabilitation.

COL GAGLIANO: I do not. But maybe you need to shift some resources at times as we evolve the system. But I don't believe that it will result in an unmet need.

CO-CHAIR NATHAN: So any unmet need that you perceive should be migrated as a joint process with VA?

COL GAGLIANO: Yes, sir.

CO-CHAIR NATHAN: Got it, okay, thank you.

DR. LAWRENCE: I think we feel

that way because there's also economies of scale. Why have two systems?

Next slide is our stakeholder engagement.

MS. DAILEY: I'm going to need you to wrap. So maybe we can --

DR. LAWRENCE: Why don't we move, I just wanted to say here that service members and veterans are the center of everything we do. And that is our absolute focus.

The next slide just speaks to our collaborative efforts for these injuries from the last decade of conflicts. And I'll move to Slide 17 and I'll let Colonel Gagliano --

Thank you very much for the opportunity to be here this morning and here's Colonel Gagliano to talk about the last slide.

COL GAGLIANO: Thank you, Mary. So we've talked a bit about this slide. The number two issue is really about what gives

the ability for the centers of excellence, I'm not speaking just about the Vision Center of Excellence. I think all of us have the same struggle to act as change agents across the system.

The first bullet addresses what I think has been the real strength of the VCE and that is the integration of VA and DoD. Not just in language or in title but in action.

Dr. Lawrence is an ophthalmologist in the VA and at the moment about half of our staff is from the VA. And we fully integrate expertise to a common goal of the Vision Center of Excellence.

The last one talks about something that Dr. Packer was referring to in trying to facilitate opportunities for education for research, in particular clinical research and the centralized IRB process that he's described that we fully endorse and hope to actually cap piggyback on

the work that he's done with that.

Because you cannot move from the research program that Dr. Lawrence described to an actual implementation without some means of working through the acquisition and market approval process for these great devices, great therapeutics that we have evolving from our research program.

We have to be full participants in that case. And you're not going to be able to do that without some means of conducting multi-center clinical trials. That's part of our big initiative in the next couple of years to evolve that.

I just want to make one more point. We talked about vision as a program for readiness. Right now the refractive surgery program is, I think, the only surgical intervention that is performed on service members to enhance their readiness.

Vision readiness is a critical component of battlefield readiness. And

those of you who have had refractive surgery can clearly testify to that.

We stay actively engaged with that program and the results of what they're working on. And that's one of our key areas of research that we are working at.

With that, I'll conclude and open for any questions if we have time.

CO-CHAIR NATHAN: Thank you very much. The research you're doing with the being able to put sensors on the tongue and have them eventually communicate to the occipital lobes that translate into visual sensation is amazing.

And what I've learned from that is if I stick my tongue out at somebody now I can tell them I'm just trying to see them better.

COL GAGLIANO: I know I'm out of time but you know I was in London with an exchange with the Blinded Veterans Association. I do want to acknowledge Mr.

Michael O'Rourke, who's in the audience representing the BVA.

They have been a very strong associate partner, a stakeholder. It's one that we're lucky to have a VSO that is really dedicated to vision. And they have helped us a lot in so many ways.

But we made an exchange visit with blinded veterans of the UK and the blinded veterans of the U.S. and I was asked to accompany them.

And we had a visit to Moorfield Eye Hospital, one of the leading hospitals in the world. And the Air Force, UK Air Force ophthalmologist in the audience asked if we were going to fund the concluding part of that project.

It was almost passing through the FDA final approval. And they were stranded, they were not able to move it forward and the answer is yes. It was one of our selected research projects to continue to push.

Because it is really the only current method for vision restoration other than implant. Other than surgical methods. There's wonderful opportunity in the future that's happening. But they were looking for us to help fund that.

So they in the UK and the company brain port could actually bring this to final FDA approval. That's the impact that we've been able to have with our research program.

MS. DAILEY: Thank you, Colonel Gagliano, thank you, Dr. Lawrence. I hope to see you again next year with more good information.

Ladies and gentlemen, we are at lunch right now. I know some of you have phone calls you need to make. Need some privacy so I'd like to ask everyone to move either to the lunch room, my staff will take the members down to the lunch room.

And I would like the rest of the room cleared out, please. And we will see

you back here at one o'clock. And Dr. Billie Randolph will be here to talk to us.

(Whereupon, the above-entitled matter went off the record at 12:07 p.m. and resumed at 1:01 p.m.)

MS. DAILEY: So ladies and gentlemen, we have, we'll be starting here in just a minute with Dr. Randolph. But what I would like to do right now as we wait on Admiral Nathan, is I would like to do introductions for those individuals who were not here this morning.

So I would like to go around the table. And we'll start with Mr. Drach. And if you would introduce yourself and we'll put you on the record for us, if you please. And a little more detail like this morning, Tech Sergeant Eudy doesn't know you. Major General Mustion doesn't know you, so a little more detail than, I'm Mr. Drach.

MEMBER DRACH: Thank you. My name is Ron Drach. I'm one of the non-DoD

Members and I'm retired from the Department of Labor a couple of years ago. And I'm doing my own consulting and am very, very pleased to be here. I'm sorry I missed this morning.

CO-CHAIR CROCKETT-JONES: No, I think you have to include he's also the repository of a lot of information on not only Department of Labor activities, but other vocational rehab opportunities. And he's a gold mine. So don't let him get away with that little introduction.

MEMBER MUSTION: I'm Major General Rick Mustion. I'm currently the commanding general of the Army's Human Resources Command down at Fort Knox, Kentucky. And I apologize for being late, but I got stalled by the weather a little bit last night and again this morning.

In a prior life I was the Director of Military Personnel Management for the Army and the Pentagon where Rich Stone

and I were battle buddies. In going back, I served as the CG of the Army's Physical Disability Agency in a prior life.

And then Denise and I crossed paths when I was Dr. Chu's military assistant a number of years ago when he was the Undersecretary for Personnel Readiness when I saw the first chart about the cost of the defense health program and how it was going to bankrupt the Department of Defense. And so that's kind of my background.

MS. DAILEY: Major General Stone, you weren't here this morning. We didn't have a chance to introduce you.

MEMBER STONE: I'm Rich Stone. I'm the Army's Deputy Surgeon General. I'm a Reserve guy by commission. Been back on active duty now for three years, in this billet for the last two and a half years. And physician by training and although I have not gotten much chance to practice for the last number of years.

MEMBER MALEBRANCHE: I'm Karen Malebranche and I was with the Army for 30 years. I've been now with the VA for ten. I'm the Director for Interagency Health Affairs and been on the task force like this now going on my second year.

And happy to be here. I apologize also for being late. And I'm going to apologize in advance that I seem to be playing tag team with Captain Evans here, so.

CO-CHAIR CROCKETT-JONES: Okay. We're going to hear from Dr. Barclay Butler, the Director of Interagency Program Office. The IPO focus is, no. Where are we? It's not mine, is it? He's here. I don't, I'm like missing a page or something. Here we go, extremity trauma. That's yours.

MALE PARTICIPANT: Just in time.

CO-CHAIR CROCKETT-JONES: Yes, you saved me.

CO-CHAIR NATHAN: Dr. Randolph.

DR. RANDOLPH: Yes, sir.

CO-CHAIR NATHAN: Welcome. Thank you for coming back to update us. As everybody here knows, there are two major signature injuries that affect our wounded warriors.

Extremity injury with amputation and loss of function. And that's become very prevalent as a result of better body armor and as a result of much better on-scene stabilization of life threatening injuries so people are surviving with loss of extremities that never have before. And the other is the traumatic brain injury part and parcel of post traumatic stress as well. The quote-unquote invisible wounds of war.

So today we welcome Dr. Randolph who's the Deputy Director of the Extremity Trauma and Amputation Center of Excellence. The EACE is a joint effort between the Department of Defense and the Department of Veterans Affairs to promote excellence in care and research related to traumatic

extremity injuries and amputations.

Dr. Randolph is going to provide us an update on the status since February of 2012, and discuss research activities over the past fiscal year. You can find her updates in Tab B of your binder. Dr. Randolph, thank you very much for being here today.

DR. RANDOLPH: Thank you, Admiral Nathan, Ms. Crockett-Jones and other distinguished members of the Recovery Warrior Task Force. It's certainly a pleasure for me to be here this afternoon and to be able to update you on the work that's being done in the Extremity Trauma and Amputation Center of Excellence.

Because my DoD counterparts are located in San Antonio, Texas, and were unable to be here, I have asked that we try to dial them in. We just did a sound check. They can hear you and can assist with any questions that I might not be able to answer.

Mr. Shero, did you want to make a comment?

MR. SHERO: Thank you, Dr. Randolph. And I just wanted to express my gratitude to the Recovering Warrior Task Force and you ladies and gentlemen for your interest in the Extremity Trauma and Amputation Center of Excellence and again to thank Dr. Randolph for providing this briefing this afternoon. Over.

DR. RANDOLPH: All right. Thank you. This afternoon's agenda is up here. We believe that we've covered all of the information that you've requested for this briefing. But if something is not clear or you don't feel that we have covered it sufficiently, please don't hesitate to ask.

Like I said, we're trying this with Mr. Shero and hopefully if necessary he will be able to answer any questions that I can't. As Admiral Nathan said, we've had a number of major limb amputations since this conflict, these conflicts have begun. As of

January the 2nd, there were 1,581 individuals who have suffered major limb amputation.

The chart before you shows a breakdown of these patients that have been treated within the three individual advance rehabilitation centers. Some of the patients, as you can see if you add up the numbers at the bottom, have been treated at more than one of the centers, meaning initially starting perhaps at Walter Reed in Bethesda, then being transferred to San Diego.

There are currently 257 of these amputees that are receiving care in one of the three centers right now. And nearly 1,200 of them have already transitioned into the VA and are receiving care in the VA. So we think that's a very positive thing and we are working very closely together to ensure this continuum of care.

Two hundred and seventy five of these amputees or roughly 17 percent have

suffered a major, I mean upper limb, major amputation. And of the number the 1,581, 491 of them are multiple amputees of which 44 have sustained triple amputation and five have lost all four limbs.

This map shows the DoD and VA amputation care sites. We have the Military Advanced Training Center in Bethesda. The Center for the Intrepid in San Antonio and the Comprehensive Combat and Complex Casualty Care in San Diego. The stars are not showing up on, I hope they are on your maps. Okay. They're coming in, sorry.

We also have the seven VA regional amputation centers, including the Service member Transitional Advanced Rehabilitation Program, the, go back to the pointer here, the STAR program in Richmond that is directed by the VA Amputation System of Care, Medical Director, Dr. Webster.

The priority for the patients in the STAR program in Richmond for the VA are

the service members that have sustained amputation along with another injury, such as traumatic brain injury. There they receive not only ongoing medical rehabilitation, but vocational rehabilitation as well and a work program. So we're very proud of that program. Focus again is trying to get these service members ready for reintegration into the community and into the work force.

In addition to the seven regional amputation centers, there are 14 VA polytrauma amputation network sites. These are located in the, identified by the yellow stars. I'm sorry, the blue stars.

And we have three additional sites that are proposed and have been tentatively approved for funding this year. They are San Antonio, San Diego, and Salt Lake City. The VA has identified the additional funding for these sites to bring them to the polytrauma amputation network site status because of the increased need in

the community for the transitioning service members and the Salt Lake City site because of the osseointegration trials that are set to begin this year.

We envision the Extremity Trauma and Amputation Center of Excellence as the nation's premier source of information for the mitigation, treatment, rehabilitation, and research for service members and veterans with traumatic extremity injury. And we accomplish this by implementing a comprehensive strategy and plan for conducting clinically relevant research fostering collaboration across a broad spectrum of national and international entities.

Our lines of focus, our lines of effort are focused on research and surveillance; clinical care which encompasses treatment, rehabilitation and mitigation; global outreach informations, informatics and information technology as well as leadership.

CO-CHAIR CROCKETT-JONES: Can I ask you a quick question? Do you all consider your urogenital loss to be part of your, under your umbrella?

DR. RANDOLPH: I'm sorry, ma'am. What was the first part?

CO-CHAIR CROCKETT-JONES: Do you all consider urogenital losses to be under your umbrella?

DR. RANDOLPH: No, we do not.

CO-CHAIR CROCKETT-JONES: Okay.

CO-CHAIR NATHAN: I think that's a great point too because I'm sure most of the members of the task force are aware and the stats vary, but now with the dismounted mission in Afghanistan, the fact that most people are losing their limbs as a result of direct impact from the ground as opposed to in vehicles.

And it's more common now to have multiple amputations than it is to have a single amputation from previous parts of the

conflict. About 15 to 20 percent of the people who sustain these severe amputations, usually bi-lateral lower extremity amputations, about one-fifth also experience a completely debilitating genital, urinary, either loss of function or loss of anatomy.

And so there's been a great effort by the urology groups working with the trauma surgeons to try to figure out preventative measures and then restorative measures.

DR. RANDOLPH: I agree. It is a good point. I made a note here I need to check to see how we can, you know, if there is a way to collaborate with urology to enhance that, so.

MEMBER STONE: So the Army about a year and half ago completed a complex battle injury task force work. And you're welcome to share that report.

DR. RANDOLPH: Okay. Thank you very much. Have to be coordinated up here to

do this. All right. The next slide just depicts our operational authority documents. The Duncan Hunter National Defense Authorization Act in FY 09, authorized the establishment of the Joint Center of Excellence.

The Army was designated an Army medical department, the lead component for the EACE in 2009. The decision was made in 2011 to locate the EACE executive office in San Antonio. We submitted a concept of operations and that was approved in January of 2012.

Mr. Shero was appointed as the director of the EACE in January of 2012. And once the VA approved the four staff members to support the EACE in early 2012, I was appointed as the director the end of July.

This slide is just showing the EACE governance and reporting chain going up both the VA and then the Department of Defense with the governance in the middle.

This is the current defense health program level of funding that's been secured through the POM process. As you can see it's fairly consistent across the years.

This is our EACE organizational chart showing the executive office, which I said was in San Antonio, but is not depicted. My office is in Crystal City and I've actually been co-located with the Vision Center of Excellence, which we do a lot of collaboration between the Centers of Excellence. And we felt it was important to have a member of our team in the DC area.

So I am located in Crystal City. We have the Clinical Care or the EACE executive office, let me go back; there are six DoD positions in there, two VA, myself and an administrative assistant. We have the four divisions. The Clinical Care which will have a DoD and VA deputy director for the Clinical Care.

We have the Clinical Informatics

and Technology. We will have two personnel in that division. The Global Outreach and we will have two personnel. And finally we have the Research and Surveillance division which you can see we will have researchers in the three advanced rehabilitation centers. So clinical researchers embedded in those three advanced rehab centers in Bethesda, San Antonio and San Diego.

This division is by far our largest division. And it's not only because we're congressionally mandated to conduct research, but because we truly believe that our practices need to be evidence-based. We have currently about half of the positions filled.

We're working through some of the HR issues including establishing an MOA with Fort Irwin to facilitate the hiring at C5. We actually did get good news on Friday in that we were approved to fill that position there. So we have someone actually in the

facility research director position at San Diego.

Many of these positions, it doesn't reflect here, are at different stages of the hiring process. Some of them we're negotiating pay right now. Others are interviewing. Jobs have been announced. So we are closer then this slide depicts to filling many of these positions.

Within the Research and Surveillance there are four focus areas. We feel that there is a need first to define and document the problem. We want to look at basic sciences research. We also want to look at laboratory based applied science, advanced technologies what works, what doesn't work, short and long-term functional outcomes assessments.

And then we want to monitor both the short-term and the long-term health and wellness of our patients. And this we know requires close collaboration between DoD and

VA because as you heard earlier, 1,200 of these have already transitioned to the VA for their care.

You asked about our research, productivity. Certainly our priority has been to embed these clinical researchers, get them hired and put them in the three advanced rehabilitation sites.

Once we've done that or we're doing that, we're focusing on the act of study progress. We want to make sure that they're leading to scientific presentations and peer-reviewed publications. And we use these as our productivity metrics.

In FY 12 there were 22 abstracts presented as either platform or poster at two local, 17 national and three international scientific conferences. And there were 31 peer-reviewed publications. And so we're very proud of the fact that this has increased significantly since FY 11 and especially with as many vacancies as we have.

We have 72 studies currently ranging from proposal to manuscript submission right now. These are some of our partners that we are actively engaged with to produce this research. They are human performance labs at each of those centers already. We're certainly working with them. The US Army Medical Research and Materiel Command, the VA and the Joint Center of Excellence for Battlefield Health and Trauma Research in San Antonio.

You asked about the tool box and the functional outcomes. We are working diligently with patients and clinicians across the three centers as well as the VA. What are the clinical questions that we need to address? And then to identify normative data, reliability and validity of these outcome measures.

We have made a lot of progress in identifying what are the areas that we want to focus on. Our clinical efforts and the

ongoing studies and the ones that have already been accomplished are helping us to validate these results for an active duty service member population.

Studies have been distributed across the three centers to make sure that we are able to validate the research data that's collected. And to date we've developed a summary of outcome measures most used, those that are frequently used, those that have been validated, and those in the validation process.

And this publication is pending the return of the primary author who is in Afghanistan that was deployed as she was doing this. So as soon as Colonel Ann comes back we will get that publication out.

What are the other things that we have been doing to try to enhance the care and the collaboration between DoD and VA? There was an effort between the Providence VA and an investigator at CFI which validated a

community reintegration measurement tool within the population of military patients.

This was actually published this year. This hasn't, this has not been done before in the population military patients. DoD and VA also developed a collaboration guidebook for health care research. We will be updating that annually to ensure that we're capturing all of the information that will help researchers on both VA and DoD to collaborate on research efforts.

We did, we completed a laboratory- based study between three VA sites and DoD, the DoD site, the Center for the Intrepid on the DEKA arm. Many of you may be familiar with the revolutionizing prosthetics and what DARPA has funded to develop upper extremity prosthesis.

In fact, we had one on 60 Minutes a couple of weeks ago where they were showing the computer brain phase. Well one of these arms is the DEKA arm. And we've now

optimized that arm through the laboratory studies and we are now going into, as of late FY 11, we, I'm sorry, FY 12, we have started the take home study. And CFI is also participating with two of the VA sites to do the take home study.

So the information that we will get out of this take home study will lead to a final version of this arm and hopefully will improve the options for our upper extremity amputees. Again, it's about 17 percent of the amputees have suffered upper extremity amputation. Many of our upper extremity amputees still wear a body powered prosthesis. Some use the Mio-Electric prosthesis.

And many of them frankly have already abandoned their prosthesis. And a lot of that is their dissatisfaction with the technology. And so we're very, very hopeful that this will and we've gotten great response from the people who have worn it.

They absolutely loved it. So hopefully we will be able to work out all of the final elements that are needed bring this arm to market and to get it on our veterans and service members.

The DoD and VA, a couple of years ago, actually produced the clinical practice guideline for lower extremity amputation. We will be putting a group together to relook that because as you know we've amassed an inordinate amount of information in the ten years that we have had folks being injured and improvements in the rehab and the technology.

So we will be putting together a group to look at that and to make sure that is being updated. But we're very, very excited because we together went before the evidence- based practice group we asked for an upper extremity clinical practice guideline for upper extremity amputation. And we were approved.

And so we felt that this was very much needed. We knew that we were competing against things like urinary tract infections and upper respiratory infections. But we were successful. We have had a group of champions that have been meeting weekly. We have developed our questions that the contractors will be searching.

We've put together a group of subject matter experts and we will be having an actual face-to-face meeting the end of July. And we're hoping that within, you know, a year or two, 15 months we will have this published. So very, very exciting. We went back --

MEMBER STONE: Dr. Randolph, if I could interrupt you for a second?

DR. RANDOLPH: Sure, Mr. Stone.

MEMBER STONE: We're very appreciative in the extraordinary advances in the acute rehabilitation of these service members. I wonder if you can provide some

insight as to what the lifetime needs of these individuals will be? Based on previous advances in prosthesis, what can we expect 15, 20, 30 years down the road for the needs for these service members?

DR. RANDOLPH: You can expect that the cost of technology is going to increase. And we were asked to put together in the VA some numbers looking at what would the costs be. And for an upper extremity somewhere around $1 million to $2 million over their lifetime just for their prosthesis alone.

We know that they are three to five times more likely or have more medical conditions that require care. So we have, and in looking at that we have assigned amputation care coordinators in the VA to help manage this group of patients in terms of coordinating with primary care because they really do have a lot of other medical problems that bring them in.

We, you know, things like transportation needs and home modifications. And they're living longer and it's going to require us to look at how we can one, prevent a lot of the things that we have seen in the past such as the weight fluctuations, inactivity, reintegration.

And we've had several reports from the OIG and the VA that have looked at, you know, what are their current needs and how satisfied are they with their care? And you know, the OIG made some recommendations in terms of primary care and making sure that we're very integrated with them between our amputation system of care and primary care to take care of them.

The database, the clinical informatics and technology, the database, the amputee database that is the Legacy System. We are currently working to improve this system. And the current architecture until which time we can bridge to the registry. At

the same time that we're working to improve our database, our Legacy architecture, we are working with the Force Health Protection and Readiness division to develop the EACE registry.

While the back end is the enterprise system and I'm sure you've heard about this in the previous two talks it's populated from data feeds from various sources. Each of the centers of excellence is responsible for their front-end architecture. And we are currently working on that right now. We are developing our functional requirements. Once these are developed then we turn it over and they develop the technical requirements and the acquisition process.

As far as our website we do, have been approved for our presence on the health.mil website. We believe that, and we anticipate that we will have a strong web presence by the end of this fiscal year.

So as we stated previously, our concept of operations was approved by the Center of Excellence Oversight Board in January of 2012. We have developed an Army Manpower Concept Plan. It is currently being staffed in the Army Medical Command prior to submission to the Army.

We have hired VA and DoD staff. It's ongoing. It is our priority. Fourteen of the 41 requirements have been hired. Our initial operating capacity, capability of 50 percent has not yet been attained, but we are close. Our budget of $5.5 million a year is in the POM and out year funding has been requested.

The executive office again has been, it's already now co-located with the Army Medical Command headquarters. And we believe that we are meeting all requirements of the NDAA FY 09 Act.

What is the way ahead for the EACE? Certainly we want to enhance the

collaboration. And so looking at things like joint policy recommendations as new technology is introduced, how do we bring that in to the facilities? Do we just go out and buy the new technology or do we identify centers where we can best look at this technology, the benefits before purchasing it across the board?

As for new and evolving research collaboration, we have not had a joint DoD, VA, IRB in the past. And so what we would like to do for the research is to propose having a joint DoD, VA. Therefore, we could do research across, if we have one research study and we want to look at it in multiple VA facilities as well as DoD, we, I have been talking with the head of research for VA.

We have been talking with Medical Research and Materiel Command. We think this is possible and we are trying to move ahead with setting up some recommendations for how that would occur. I think that would really

facilitate looking at the patient across the continuum of care as you said, General Stone.

We want to make sure that we are able to follow them and then to be able to make more accurate projections about what their needs are. We certainly want to focus on integrating our staff in these treatment centers. We want to leverage technology such as the movie technology, video teleconferencing, telerehabilitation, telemedicine to enhance our communication and collaboration.

One of the things we're looking at right now is establishing the video teleconferencing between the staff at the advanced rehabilitation centers and the VA to which the service member is transitioning. Having that kind of face-to-face meeting before they get there with their physicians, with the staff that's going to be taking care of them. And so hopefully we can get some of these processes in place.

The hand and face transplantation we're assisting in the development. Both Mr. Shero and I have been part of the DoD, VA group looking at this. We want to make sure that we foster staff and patient education and then certainly improve the access to transplant services when appropriate.

These are all still considered research protocols for DoD and VA both. But we certainly want to make sure that our staff have the education and the knowledge to be able to talk to our patients that may require these services or may desire these services. And so hopefully whatever we can do to improve that is certainly our goal.

Access to care. We want to facilitate DoD, VA sharing opportunities. And some of you may be aware that we have the joint incentive funds. We've used those. We established an agreement between the DC VA and Walter Reed where we shared staff. And that was very successful.

We are also looking at other collaboration certainly between the San Antonio VA Medical Center and CFI. The San Diego VA we were out earlier in December, Mr. Shero and myself along with VA and DoD representatives, looking at those facilities and how we can facilitate getting these patients cared for most effectively.

We certainly want to explore options for retaining those clinical and research expertise. I think that's an ongoing dilemma for all of us. How do we retain this as the conflicts slow or we bring out troops, what do we do in the future? And I think that's foremost for both VA and DoD because we certainly, we have amassed like I said, a tremendous amount of information. We want to make sure that we were able to retain that.

We want to increase our external partnerships with civilian organizations and academic institutions. How do we, you know,

who are the people that we want to partner with? And how do we, you know, ensure that the gaps that we've identified we're best addressing with the most appropriate people. And that's very important again.

And certainly, expedite publication of research findings to inform clinical practice. And one of the things with publications, peer-reviewed publications, I mean we do the poster and the platform presentations. But the publications take a little bit longer, as you know.

So one of the things that our research that we're doing to try to facilitate getting this information out sooner is, you know, looking at the studies that are ongoing.

If we have some, you know, with the findings and ensuring that on our calls with the DoD and VA staffs that we are putting those findings out there, that we're talking about them, we're discussing them and we're

improving our clinical care by doing that.

The other thing is we hold, we're holding our first call, or our first DoD, VA kind of grand rounds call this week. We, our plan is to hold these monthly. It's another way to get the research findings out there and things that are clinically relevant for both DoD and VA across the nation.

And again, it says throughout the world. That's where our global outreach comes into play. And we definitely want to share our findings with our partners. With that I thank you, Admiral Nathan, Mrs. Crockett-Jones, this task force members and between myself and Mr. Shero or Mr. Mundy, who's our chief of staff, we'll try to answer any questions.

CO-CHAIR NATHAN: Dr. Randolph, I'd like to ask you, what is going to be sort of the final concept of operations for taking care of these service members who are going to have the high tech prosthetic devices but

be located in their final discharge locations into the non-centric VA system?

I recognize 1,500, most of these service members with amputations have been concentrated in the Southern California area. And even that has its problems because the VA appropriately built its amputee reservoir in West LA where the population with diabetes and peripheral vascular disease was and now most of the amputees that need these sophisticated services are residents in San Diego.

And I compliment the VA because they're hiring people in San Diego to partner along there. But is the plan going to be to mobilize these folks when they live somewhere in maybe central Iowa or in upstate New York to a center of excellence or is it going to try to bring up the sophisticated ambience of prosthetic care in that local VA?

DR. RANDOLPH: The plan is to, you know, bring up that local VA. And the

other thing that I have to say is that the VA has over 600 contracted vendors by which we use to provide the technology in addition. So while the VA has 157 facilities not all of them actually even have an O&P service.

And so we've done a lot of training, equipment has been purchased. I know that I've been with the VA for four and a half years now. There's been a tremendous effort ongoing and I think that will continue. You're seeing that with the three new polytrauma centers being proposed.

That means additional dollars are going in there to have dedicated resources to be able to provide that. So, yes, you know, any technology that is commercially available they're going to have access to that.

I would say that as someone who's cared for amputees most of my life and we have some amputees here in the group, the whole idea of trying to mobilize that patient and take them to where that technology is,

you know, becomes, you know, a burden after a while in that, you know, they need to develop a local connection where they can get their prosthesis fixed very quickly.

If they have problems, they start to get breakdown, you know, they have a problem with their socket, they need to get seen right away. And so the VA is really working to do that. So in addition to those 14 polytrauma amputation network sites, we have dozens of more what we call amputation care teams.

These are people that are trained throughout the VA facilities in working with their local O&P providers that are contracted with the VA. We will be able to continue to provide that care. I am part of a group that is right now looking at, we put out a request for information.

We're looking at putting out a, we will be putting out a proposal to have the entire O&P in the VA assessed. And that will

be done this year looking to see where we need to increase resources, et cetera. So more to follow on that. Right now that's still in the, I'm still part of the team and we're still drafting that final statement of work for that contract.

CO-CHAIR NATHAN: Thank you.

DR. RANDOLPH: Yes. Any other questions?

MEMBER EVANS: Just a quick question on, so if you look at Walter Reed and look at, since I'm Navy and I know San Diego's length of stay and when I was assigned to Walter Reed there's a difference in how long the amputees of the length of stay or recovery at Walter Reed and San Diego. Same type of injury, so maybe a bilateral Walter Reed, bilateral San Diego. But the San Diego member seems to go back and reintegrate into the community a little bit faster than Walter Reed.

So it would be nice to have a

standardized across all three of your facilities and to include the VA so when we talk to the families at the deck plate level we can say your average, unless, you know, bearing variance or complications, but your average length of stay should be, you know, for a bilateral about 12, 16 months.

So that way the families have an expectation at the beginning, we're trying to do this catch up towards the end. And it just creates a lot of confusion at the deck plate at the treatment facility.

DR. RANDOLPH: I will take that. But that is noted and we have looked at that and will continue to try to track the patients and their length of stay. Some of these patients may have started at Walter Reed. So that was like one of the things when I first looked at some of the numbers.

I'm like okay so this was a lot shorter out in San Diego, but not realizing that they'd been treated at Walter Reed

initially for six months of their rehab and then they get to San Diego, they only have, you know, three more months. And so, you know, having been there at Walter Reed during the early days of the conflicts and seeing the amputees come, you know, I think we've learned a lot.

We are much, in a much better place by far than we were then. And I think looking at the number of days is going to be, you know, a metric that we really need to assess how, you know, effective our rehab strategies are.

And, you know, what are the differences? Why does this work better? Is it how we introduce the prosthetic technology? Do we start with body powered and then go to, you know, like Mio-Electric for the upper extremity or do we start with Mio-Electric and then teach them the body?

Things with the upper extremity do we teach hand transfer, you know,

dominance? You know, if they lose their dominant upper extremity do we teach, you know, transfer of that because we spend time doing that or do we just put the prosthesis on them and have them use that as their dominant hand?

That's what we're hoping some of this upper extremity clinical practice guideline will help us sort through and to do that. And with the lower extremity, you know, we start all the time do we start them in the C-legs or do we start them on a mechanical knee? Do we, you know, put them into the X2's or do we go back to the C-legs?

And I think that having these clinical researchers embedded in these facilities will really help us kind of sort through some of that so that we can finally start to put out recommendations. And then we're comparing apples to apples and not apples to oranges in terms of stays.

But I do think, you know, I

remember being there and running the rehab there at Walter Reed. And the patients well how long is my son going to be here or how long is my husband going to be there? You know, you can't just keep saying it all depends on him or her, you know.

I think, that there's plenty of, that we can do and hopefully as we bring these people on and we start to expand a little bit in the EACE, you know, hopefully we'll work with folks just like you and to try to say where are the other needs? We're looking at the clinical gaps right now, the research gaps.

But what are the other things that we should look at. And I'll make a note as soon as I finish speaking.

MS. DAILEY: I'm sorry, sir. Can I get one alibi? Your question number six, you did cover it. And in one of the slides. Can I get you to go over question number six again? I'm not sure --

DR. RANDOLPH: I'm not sure I have the questions right here.

MS. DAILEY: Sorry, the functional outcome assessment toolbox.

DR. RANDOLPH: The functional outcome assessment tool box. So, yes. So we have identified what are the measures that are most currently used, I mean the functional outcomes.

What are the ones most frequently used? Which are the ones that are sometimes used? And then which were the ones that have been validated? And which are the ones that need the validation?

We're putting that, it's been put together in a report. Again, unfortunately, the person writing the report was deployed to Afghanistan. I was not on board when, but we will get that as soon as possible.

But the bigger thing is we have that information and we've already distributed out and that's part of those 72

ongoing studies, what are the things that still need validation. And those have been distributed across the three centers.

And those are the studies that are underway. So, yes, we are continuing to do that. This tool box will then form kind of the basis for our templated notes and then our registry because we all want to be capturing the same information.

What are the functional outcomes that we think are important? Then we want to be able to pull that information from the patient's record so that we will be able to look at over time how effective our rehab and treatment strategies have been.

MS. DAILEY: Thank you.

CO-CHAIR NATHAN: Actually one more alibi, now thinking about it. One of the problems that you talk to trauma surgeons about it and trauma orthopedists is making the decision for limb salvage, visa amputation. This becomes a critical issue

for some, not many.

But some of our wounded warriors who try to hold on to their limb for as long as possible, they end up in hind sight probably going the wrong direction because they become narcotic dependent, inactive, they gain weight, they become depressed and they end up in a downward spiral.

And so we've seen sort of a sea change over the last several years where orthopedists are getting to be more in tune with this and trying to be more aggressive in getting somebody who probably has no hope of recovering their leg into that.

Do you have any comments in that regard? Do you see that as a central theme that this task force needs to be worried about at all or is this being handled very well within the orthopedic trauma and amputation community?

DR. RANDOLPH: You know, I don't know that I'm qualified to comment on that.

I do know that, you know, I work very closely with my orthopedic counterparts, limb salvage certainly high on their list. They want to be able to save those. And Colonel Vickie down at San Antonio and many other fine surgeons whether at Bethesda or C5 are certainly working to do this too.

I know that there are ongoing efforts. I'm not sure that, you know, again there was a recent, there's been recent articles and media coverage of the IDEO brace as one example. So we are working to develop new technology, new orthotic technology that will allow us to control those rotational movements, maybe have less pain, let them be more active because you know, as you know, I spent 29 years in the Army too.

We're very active, we like to be going and there's nothing like an injury that makes you, even if you didn't run before, want to run again. And so it's important that we try to work with them and get them as

active as possible just with the endorphin release and pain control there. So I think that work is being done.

I know that I have sat on some committees looking at the research proposals. I know that it is receiving funding. We're definitely looking at, you know, how can we replace nerve? How can we replace muscle and certainly bone? So I think that the funding is there and I think but probably the best --

MEMBER STONE: Would you quantify this population who have, and first of all please, is there an agreed upon definition --

DR. RANDOLPH: No, there is not a --

MEMBER STONE: -- of late amputation after attempts at limb salvage? If there's not, could you tell us about the size of this population?

DR. RANDOLPH: I think I will probably have to take that one for record unless, Mr. Shero, you want to talk about, do

you have an idea the size of the population? I think the first thing is there's not an agreed upon definition and you know, for what constitutes limb salvage. John or Jim, are you there?

CO-CHAIR NATHAN: I think it's an art right now, to some extent. I think it's the partnership between the patient, the warrior, and the orthopedist. The orthopedist saying maybe in time you'll know when it's time to sort of fold and let us take the limb so that you can get on with getting mobility again and exercising again.

I think we've done a better job in the medical genre, both in the military and outside, of educating orthopedists in, to not necessarily hope against hope that somebody is eventually going retain them because we're seeing that people then end up with downward spirals in their life if we wait too long. But it's a great question, Rich.

I think some of our most emotional patients have been those that have been very active, have undergone horrendous limb damage to the extremity and the family is just beside themselves, and you used to deal with these folks, Connie, beside themselves because the individual's laying in bed requiring constant pain medication, won't exercise, getting depressed, but yet doesn't want to lose the limb.

And so I think we're getting the psychosocial, we're getting better at this psychosocially. But I think it's still a tough problem.

MEMBER STONE: You bring up or at least you touched upon the use of artificial mechanical exoskeletons. Is there anything that you'd like to give the committee on that either verbally or in follow-up?

DR. RANDOLPH: You know, I'll provide it in follow-up. But with the IDEO and other exoskeletons that are, you know,

coming to market as well, I do know that the one study that was published on the IDEO there was about 50 percent of the group that wore the IDEO that were considered limb salvage that were contemplating amputation prior to the study. And they actually elected not.

So, you know, in my mind if we can just save one then that's a success. And I think that we just need to keep exploring other options whether it's the rehabilitation, it's the technology, unweighting them, you know, better narcotics control definitely, but certainly pain management. And then reintegrating them.

I know that we've worked very hard to get like the adaptive sports equipment through. And DoD is now providing that. VA provides that as well. We try to get them enrolled in these different programs where they are, you know, more active and I think we'll continue to try to see that. And

those are not just for the amputees but for the extremity trauma as well.

CO-CHAIR NATHAN: Thank you very much, Dr. Randolph. It may behoove us at some point in the future to have, if you've not had already, a brief from the AFIRM Coalition Group, which is the armed forces coalition for regenerative medicine. And this is centers of excellence including Wake Forest and others that are getting together --

DR. RANDOLPH: UCLA.

CO-CHAIR NATHAN: UCLA, getting together and looking for ways to regenerate tissue, including transplantation. But that would dovetail nicely onto what you've told us today. Thank you.

DR. RANDOLPH: Right. And for the record I will take back the exoskeletons and provide more information to the group on that.

MS. DAILEY: Good.

DR. RANDOLPH: All right. Thank you, sir.

MS. DAILEY: Thank you very much. Do we have our ten minutes still in our time frame?

CO-CHAIR CROCKETT-JONES: We do have a break right now.

MS. DAILEY: Ten minute break then, thank you.

(Whereupon, the above-entitled matter went off the record at 1:57 p.m. and resumed at 2:15 p.m.)

CO-CHAIR NATHAN: Okay, I think we have a quorum. I'm going to, after Dr. Butler's presentation, I need to go across the road to the Pentagon to brief the four stars on the transition, the MHS transition. But let me just say and I'll be back here bright eyed and bushy tailed in the morning. I don't know if that's encouraging or discouraging to you.

But I've certainly appreciated

this conversation and it's everything I thought it would be, Madam Co-Chairman, which is an amazing eclectic group of corporate expertise from various sectors coming together talking about some big rock issues in recovering warrior care. And so it's been very educational for me. And once again I want to thank you for the opportunity to serve on this task force.

Without further ado, we'll welcome outside of James Brown the hardest working man in show business, Dr. Barclay Butler who has really a big task which is to herd all the cats and dogs basically in informatics and electronic health records which is where we need to be in the Department of Defense. And the good news is we've made some real headway.

But anybody is anybody in health care these days is all in and invested in trying to get to an integrated electronic medical record. We need it, if for no other

reason, just to increase the continuity of care between our various system in the VA and the DoD and then ideally into the private sector as our patients migrate in and out of there.

And Dr. Butler was brought on to basically try to make sense out of the Rosetta Stone and put an IPO together and do just that. He is the director of that interagency program office. He brings focus to full interoperability between the Department of Defense and the VA regarding the development and implementation of an electronic health record, an integrated EHR with systems capabilities and initiatives.

Dr. Butler will provide us an update on the status of that since Mr. Wennergren's February 2012, briefing. And he'll discuss the program activities over the past fiscal years. You can find Dr. Butler's update in Tab F. So Barclay, without further ado, the floor is yours.

DR. BUTLER: Thank you very much, sir. Sure appreciate it. And thank you so much for the invitation to come and to be able to brief you on the Interagency Program Office, the IPO, and where we are on the integrated electronic health record, the iEHR.

And I understand that this is actually one of the task force legislative mandates to assess how are we doing in the IPO and how are we doing in bringing the iEHR to both the DoD and the VA? And that will be the purpose of my briefing today, is to give you that update and then by all means interrupt me at any time to drill in to ask any questions that you might have.

I'd be very happy to address those at any time through the talk. The primary objective then will be to update you on our deliverables, our accomplishments, and challenges over the last year to provide you a status on our initial operating capability

the IOC.

That initial operating capability is what we call our iEHR platform. And we used the term platform because it is that initial capability, those capabilities that come out of our first and second increments, that become the platform where additional applications can they be put on top of it.

The platform really constitutes all of those capabilities that include infrastructure, security, our electronic service bus, our service oriented architecture, all of those things that we need to get in place plus some initial clinical capabilities that proves the end to end deployment and architecture of the iEHR.

From that the following increments, three through six bring additional clinical capabilities over time. I will give you an update on the overall iEHR and VLER Health. And I emphasize the health side of VLER in that this program has program

management responsibilities over the VLER health side of it, not the VLER benefits side.

That really is the mission of the entire VA. And our job is to connect the iEHR data into the private sector so I can pull data back. And I'll describe that a little bit more and describe to you the relationship between VLER Health and the IEHR.

I'll give you an update on our, as I mentioned, our capability sets number one and two and then provide you a listing of some of the challenges that we have and some help that you may be able to provide. The secretaries met on December 6th and then again on the 10th of January.

And I'll tell you I couldn't ask for a more interested secretarial support from both the VA and the DoD, just tremendous support. I get to meet with them on a quarterly basis and they're tremendously

interested in how we're doing. I'll tell you to have almost a program management review at the secretary level is quite unusual and I really appreciate the interest that they've got.

They did charge us to meet or beat our schedule. And I have some decisions that are coming out of the 10th of January discussion with them that we can talk about near the end of our presentation today.

What I'll do is I'll talk about all the things we had accomplished through this last year and then address any changes to that near the end. I will say that this is a, the scope of the iEHR covers about 20 million beneficiaries, over 211 hospitals between the DoD and the VA and over 350 thousand care providers across both enterprises.

Let me address the three missions that we've got. We've got the integrated electronic health record, the iEHR, where our

job is to modernize both the Legacy EHR's, electronic health record capabilities in both departments using a common health record. The goal is to get that common health record across both departments.

It's really the same patient database, right. It's the same patient, when the service member raises their hand and becomes inducted clear through the time where they receive final benefits. We will replace the DoD's CHCS and AHLTA systems. The CHCS is their order entry system and the AHLTA is really their clinical note.

And we will replace components of the VistA system. And I don't say we're replacing all of the VistA system and that is because the VistA is really a system of systems.

It has over 300 different components and lots of business applications within the VistA system itself. We will be though replacing the electronic health record

components of the VistA system and then connect up the new iEHR into the rest of their business systems.

On the virtual lifetime electronic health record, VLER Health, this is that White House initiative for the exchange of data between DoD, VA, other federal agencies like Social Security for example and private providers all based on national standards. We will be exchanging and are exchanging health benefits, administrative information as well as personnel records and military records.

And to date we've got four joint sites. I'll show you those a little bit later in the briefing as well as the VA has gone ahead and continued the deployment and has not 12, but now 14 locations where they're operating.

MEMBER KEANE: Sir, I have a quick question.

DR. BUTLER: Yes.

MEMBER KEANE: I work at the VA and since Ms. Malebranche isn't here, I'm going to ping the VA. They're not very information sharing for veterans. They love our information that we have on Marines, but they're hesitant to provide information on veterans. Is this going to be a two-way street of information sharing?

DR. BUTLER: Yes, it is. And I'll, the way VLER Health works is it becomes the communication link, the communication channel to the private sector. And there are two ways to get that data in and out of the private sector.

If you're a doc office, in a doc office, a couple of docs working together, in that case we use the direct system. The direct system is essentially secure e-mail between the hospital and the docs offices. So the consult goes out, the doc's now authorized to treat and then the secure e-mail comes back and that then becomes part of

the overall patient record.

When you have facility to facility discussions, so for example the patient up at Fort Drum needs to go to Syracuse, for example, then it is a query and retrieve. We're going to send a patient request for a consult to the facility. The facility sends back they've got availability. They then treat the patient and then the data comes back into the iEHR.

So there's two ways facilities and direct. And, yes, the goal there, as you know about 60 percent of the DoD patients are treated out in the managed care support contractors. And about 70 percent of the VA are treated outside of the VA.

Now not all of that is fee for service, as I'm sure you know. But that's a lot of patient record data that we're losing. And the goal here is to have that complete continuity of care record so that we can have access and actually improve quality of care

because they have that overall record.

So the answer is, yes. The goal is to improve that continuity of care record to improve our overall quality of care.

I do have a third mission though and that's that lead, oversee and manage, manage those things that are related to the iEHR. And I know you probably talked about some registries in your last briefing. Well this is where data for those registries likely resides already in the iEHR on Legacy systems.

And because the iEHR will have that overall continuity of care record, when we're looking at providing care for specialty populations then that data then comes out of the iEHR into those registries. They then do their treatments, develop their treatment protocols. Then their treatment protocols likely can come back into the iEHR.

So we have an oversight role, not an execution role, but an oversight role on

how do you exchange data? How can we get protocols back into the iEHR for improving quality of care? One of those missions, one of those oversight missions is the James A. Lovell Federal Health Care Center.

This is where we engaged in October 1st of 2010, to combine both the North Chicago Veterans Affairs Medical Center and the Naval Health Clinic of Great Lakes merged into the Captain James A. Lovell Federal Health Care Center. And I will talk a little bit more about that. I understand you're headed out to visit them shortly. And I'll give you some perspectives on what role the IPO has in the JAL FHCC.

Let me spend the next couple of slides, tons of text here identifying the accomplishments that we have made. I'll just hit a couple of them on each slide. But if there's something in there you want to talk more about, please interrupt me and I'll go ahead and drill down into that.

So the first one is where are we and what have we accomplished in the iEHR proper, the integrated electronic health record? And probably the most important thing is we defined that program base line. That means we've got our requirements, our architecture and tremendously important our design now and we've got a life cycle cost estimate.

We just finished an initial design review where we had over 300 participants across both the DoD and VA. And we addressed over a three day window, the designs of our infrastructure, our security, our master patient index, our pharmacy, laboratory, immunization, our electronic service bus are still in efforts.

And that's all based on the requirement sets that we've got from our clinicians. A number of years ago as a medical CIO, we were combining the composite health care system in the national capital

area. And I can't tell you how hard it was back then to get the clinicians to agree to a common set of business practices.

I can remember taking radiologists and putting them in a room and taking away all their food and water in order for them to come to an agreement. Well, I will tell you I can't tell you how pleased I am that in a joint way across the services and in a combined way across the departments, how well the clinicians are working to develop these common business practices.

And I'll use one example where in pharmacy we now have 38 different business flows that are agreed upon by the clinicians across both departments in the services that then will allow us then to go out and compete that effort with our vendor community.

We do have single sign-on and context management that's being deployed. And I know this sounds very technology focused. But it really is focused toward

that clinician. Single sign-on allows that clinician to sign on once in the morning and then use their common access card or their PIV card and move from station to station to station.

And their session then translates with them instead of spending, believe it or not, between six and ten minutes getting a sign-on event accomplished which is time away from the patient, they plug in their CAC or PIV and about 10 to 20 seconds later their session is up. And that returns a considerable amount of time to that patient/provider interaction.

Context management is really a patient safety issue. So as the doc moves from room to room to room, they saw a patient Debbie in the first room and patient Mike in the second room and Pete in the third. When they change the name and when they're with Pete to Pete, all of the applications all immediately change to Pete's applications.

So they're not by accident looking at some other patient's data while they're trying to treat the latest patient. Very important, context management to our patient safety. We've got that now configured and we're starting to deploy that. I'll show you a picture a little bit later on, on how that deployment's going.

We do have requirements for our lab pharmacy identity management access control and our presentation layer capabilities. We have our development test center, our DTC, up and operating. I know that sounds like it's really early in the cycle.

We have initial operating capability coming in around the September of 2014 time frame. But I promise you this is the time where you want to have your test centers up and operating bringing in your Legacy systems, bringing in your net new capabilities.

And the key thing is having this identified data in data sets that are large enough so you can actually exercise and test your systems. So many systems come near the time to deploy and they're not properly tested.

And that adds an unusual length of time to the overall deployment. So I'm pleased to see that our development test center and our development test environments, including DoD and VA systems around the country, all link together in a virtual way so that we've got an initial operating capability test center.

We do have our data management strategy and our road map developed. This is our common information or operability framework. It's all about the data, right. If I can have mapped, normalized data across both departments, that's how you accomplish this single continuity of care record. That's how you get an iEHR.

That is continuing to be developed. We've got the initial pieces of that completed and we're now doing some data mapping, normalizing the data on a VA site in Salt Lake City. This then takes the VA unique data and maps it into the common information of operability framework, which is also what the DoD is using.

The DoD has accomplished this mapping over the last number of years. I think it took three to maybe four years to get that accomplished. And that's done for them. We're now engaging that in the VA side first testing at Salt Lake City and then to our initial operating sites in Hampton Roads area and in the San Antonio area.

We did complete our systems engineering plan. For the engineers in the audience that is the road map, this is how you get things done. That's the common operating framework for a program management shop. And then I'm actually quite pleased to

see that the technical specification package, along with our architecture documents are not only complete, but they are up on the web.

This is a little bit unusual in a program management on the government side in that everything that we finally get a signature on we put out to industry. Industry's got more information now then they have ever had. And what this really does, it allows us to further leverage the thinking and the work of industry.

I'm not surprising them at all by coming out with a request for a proposal and asking them to respond to a tremendously large effort over a three, four week period. I'm giving them months to think about it and then my RFI's and RFP's come out, give them a couple of cracks at that apple.

Continuing along on our iEHR, I do have my Service Oriented Architecture Master Catalogue completed. These are those common services that we will use for example

for patient identity management, that all applications will use. So it's write once, use many.

Our portal framework assessment is completed. We did pick an open source vendor for our portal framework. This is where the clinicians have a common view of the data across both departments. Yet it is configurable for a particular specialty care for example.

So we will build the starting screens for each of the specialties. But then with, allow the docs and nurses and admin folks to configure those to their specific business cases.

We have engaged DISA in creating our medical community of interest, our network, and security capabilities here. This is a huge lesson learned coming out of North Chicago. In fact, this is something that you'll still see in North Chicago.

North Chicago has three network

domains. It's got the military health system domain, the Navy domain, and the VA domain. And I'll tell you it's very difficult to get medical data flowing across all of those domains, across all their firewalls and from doc to doc, from a Navy doc to a VA doc. It becomes problematic.

The lesson learned was don't do it that way. Have a single medical enclave so that any doc in any department can communicate straight with another doc in another department. Again, it's that common patient data that we've got. And that's what we wanted to exchange.

I mentioned our Health Data Dictionary Mapping contract award. We award this to an SDVOSB. And that is nearing its first deliverable out of Salt Lake City. And this is where we're taking VA data and normalizing it to our common information interoperability framework.

On the VLER Health side, we are

working with the Office of the National Coordinator and to help them define their HealtheWay, their eat health exchange interoperability specs of the, the DoD and VA have been working quite a lot with those organizations in order to help define what those specs are and build their gateways.

And now we're continuing that effort. If you are familiar with the concept of the nationwide health information exchange, that has now evolved to become the eHealth exchange. So just do that mapping in your own minds and where you see eHealth exchange think of the Legacy NwHIN.

We are working with different health information exchanges around the country. I'll show you a list of those and assisting them in adopting the eHealth exchange efforts both on the direct and on the exchange sides so we can exchange data with the, with those organizations.

The Joint Executive Committee,

the JEC, gave us a go decision to go ahead and deploy VLER Health. And they said that we have to do this in such a way that we maximize our return on investment, our ROI.

In order to do that we've created some models to identify what communities do we see out of both the DoD and VA where we're having a lot of our patient population go out into the private sector for care, number one. Number two; where are all those communities and do they have mature health information exchange networks? As you know, there are some out there that are quite mature; MedVirginia for example is one of them. And others that they just don't exist.

Third are the care providers in the private sector ready for this? Have they signed their data use agreements? And if all those line up then that becomes an area where we will invest our energies and efforts to assist in that exchange, help those populations in those communities come up in

the VLER Health area.

On the James A. Lovell Federal Health Care Center, we have a number of accomplishments where the IPO was responsible for the IT, the Health IT portion of that overall effort. We've got a common graphical user interface called the Janus deployment. That's out in James A. Lovell.

We have orders portability that we have in common between the two and consults. We have been exchanging lab data, pharmacy data, and radiology data. We have enhanced our Single Patient Registration. This is where, this is the only facility where we have this, where we have joint registration across both departments. Something that we will need a little bit later on and our folks are working to have that joint registration across both departments.

To share with you what James A. Lovell accomplished, they kept both Legacy

systems, both the DoD systems and the VA systems operating. And their goal was then to exchange data between them and provide seamless care. And they have been able to accomplish this and are continuing to ramp up on additional areas of exchange in the normal business flow in providing care to patients.

Then on the Clinical Information Requirements Division, this is where we have been able to begin our assessments of measuring how well the IPO is doing in terms of our initial operating capability in a clinical effectiveness study. We've got clinical requirements now submitted for our clinical physician order entry, our CPOE and our clinical decision support, our CDS.

What's important about CDS is it's not just the drug allergy interaction, certainly very important, but, which we consider to be kind of low level systems kind of checks. But it is bringing the clinician information as the clinician's going through

their SOP note as they are treating the patient.

What kind of information can I bring them based on the information that they're already seeing? And in fact Admiral Nathan mentions some friends of his were, they've got an iEHR that shows who in the institution is highly skilled in this area that you are now treating this patient on. So you have an immediate source, a name, and a phone number to call. What is a relevant, the most relevant, recent literature that's out there? These are the kinds of capabilities that we want to bring our docs.

We do have deployment management templates coming out of the CIRD. The number one reason that EHR's have trouble in deployment is they don't manage the change management part of it. We found that you can't come too early.

If you come a year ahead they said yes, yes, but when is it really coming.

If you come too late in the cycle you catch them by surprise. So it's about at that six month window where you start engagement and then it becomes, at about the 90-day window, where you bring in training, initial training and then refresher training. And then over the shoulder during deployment. A pretty nice deployment plan for each of our facilities.

We have an issue out at JAL FHCC having to do with our two pharmacy systems. And this is where we don't have the good drug allergy checks that flow in a timely manner between the systems. They do flow, but a patient can go from one clinic to the next and the data may not catch up to them.

So you could have the first provider treat in one way, the second provider treat and not be aware what the first provider had prescribed to them. So we are working with the JAL FHCC. We've got a solution that we have identified and we're

starting to work that solution. And I think that over the next couple of months we'll be able to provide that solution to North Chicago.

Our Technical Division, this is our infrastructure group, again we released that technical spec package out into industry. They know exactly what our specs are in terms of our infrastructure. We've released an RFI to have them comment back to us. And we've got those comments.

I mentioned that Health Data Dictionary Mapping and our, we defined what we meant from the technical perspective on our technical feasibility for our initial operating capability. This is kind of the nuts and bolts, the core of the infrastructure that we're building for the iEHR.

What are our concerns? I'm going to address most of these, if you don't mind. And I need your help on a lot of them. We

do have unique department business operations and program execution. And let me address both of those.

First, on the clinical side and you'll see this out at James A. Lovell, and I'll use pharmacy, I'll continue to discuss pharmacy, you've got policies on the DoD side and policies on the VA side that just don't line up with each other. Admiral Nathan knows more about this than I do that's for sure.

And it has to do with for example a pharmacy tech in one department is authorized to dispense but on the other department they're not authorized to dispense. So how do you manage this in a joint environment where you've got both pharmacies and pharmacy techs all working together? I think that we need to look at these capabilities, these policies across both departments.

And we're seeing, we're actually

seeing these for the first time up at James A. Lovell. And I think you'll be interested to see the progress that they've made on a number of them, but some that we still need to make.

We do need to normalize data across both departments and that's in that Health Data Dictionary Mapping that we're using. I think we have a model to get that accomplished and we have a model that I think we can accelerate that in a dynamic mapping.

Once we finish it in Salt Lake City we're going to test this more, dynamic mapping and bring that up to James A. Lovell. And I think that will go a long ways to assisting them in their pharmacy issues with drug allergy interactions.

We've got to have a sufficient requirements baseline. That means those things that, it's not only the shall statements, but it is the use cases, those scenario driven, descriptive capabilities

that are required in order to complete our clinical business cases. And those are then accentuated by user stories which are a lower level, more shall-statement focused.

We need information assurance and accreditation, as you know, is different among the departments. We really need that single information assurance policy and accreditation procedures so that when one department accredits the system it's accepted by, not just across the services, but across both departments.

Contracting policies are different and they are different in the world of agile development. Agile development is a process that we're using in the IPO that allows us to lock in the cost and schedule, but we actually vary our requirements.

And if you think about that, that makes our contracting officers a little bit nervous when you vary requirements. But what we're saying is that given a cost and

schedule we can have requirements that corrode over time that are no longer applicable and the clinical business process owner can pull out that requirement and enter in new requirements to support this very short time of innovation that we find in medicine.

We do have a cost sharing memorandum of agreement and we need to implement that every step of the way when we hit a new effort, a new engagement, a new aspect of that cost sharing, we've got to hammer out all those responsibilities between the two departments. Along with that would go a shared fund.

I think we need a shared fund, a joint incentive fund, like fund, where both departments put their dollars into a single pot and then the IPO is responsible for executing that mission coming out of that single pot. Right now I've got five appropriations across both departments. And

if you can imagine trying to report on all the different aspects of those five appropriations, it becomes untenable.

It's too difficult to report those up in both departments, when both departments have very different requirements for reporting. So I think I can give you a better total cost of ownership coming out of a joint shared fund.

We do have restrictions coming out of the National Defense Authorization Act of 2008, that says the DoD can't expend funds in a covered department unless that department will certify that they will do their cost accounting according to DoD measures. Well, you know DoD measures are pretty thick.

And other departments are not willing, the VA included, to certify that they will follow all of not only the FAR but the DFAR. And that restricts me from using vehicles, contracting vehicles using DoD

dollars and contracting vehicles on the VA side that would be quite appropriate to use for the IPO, iEHR mission.

This would be solved if the DoD would waive the requirement. And they have gotten along as far as they can in that waiving process. I think it's become harder and harder as we go on. Or it would work well if the VA would certify.

Thirdly, it would work well with that joint incentive fund, that shared fund. I think that's the real answer is that shared fund that explicitly removes the NDAA certification requirements. Continuing resolutions, as you know those are always an interesting effect on programs along with potential sequestration.

So what will we accomplish by 2017 and why will it take between now and 2017 to get this done? The question I get from Congress and other senior stakeholders is why does it take five years to get this

done? And let me share with you about seven or eight reasons here.

First, is it's a tremendously complex undertaking. It is a joint departmental effort. Unique requirements across both departments. We've got clinical engagement here. Each of our capabilities, I'll show you a capability chart in a minute, each of those capabilities is like a program in itself.

So it's like I'm managing six different programs here. Each of those programs have 30 plus projects within them. It gives you an idea of the complexity of the scope. I can't rip and replace, all right. Unlike a bank, for example, that buys another bank they go in and rip out the old system, they bring in the new system, they transfer all the accounts, you're done.

I can't do that in the health care sector. I've got to be able to take my net new clinical capabilities and run them

through my Legacy systems in order for those business processes, those checks and balances to continue to work. That adds cost and risk. I do need those common standard business practices that we're getting to. But I'm telling you it's tough to get there. It's lots of clinicians spending time, lots of hard time to get that accomplished.

Large scope, I told you 18 million patients, 440 thousand care providers, 211 hospitals, 229 data centers. If you think about that 229 data centers that we will consolidate down into nine data centers with about 34 virtualization sites that are closer to the facilities.

Significant downsizing and I think significant cuts in costs here as well as increases in reliability. Because I'm doing that downsizing in the data centers that means I'm essentially replacing the infrastructure across the board in both departments. Now I'm going to ride the same

physical network, but I'm changing the logical networks.

I've got to operate in mobile. I mean who would accept an iEHR today that wasn't mobile. But additionally has to be deployed and operate in remote and in disconnected environments. Those are the two pieces that are very unique as you know better than anybody the operations, in the area of operations.

Single medical network, I talked to you about that. And that was the big lesson learned coming out of James A. Lovell Federal Health Care Center. We are working with DISA to get that accomplished. I'll have initial operating capabilities by October of '13. And then that sets me up for adding my applications and my infrastructure on top of the single medical network by the time I finish my iEHR platform in 2014.

This is what that initial operating capability, that iEHR platform

looks like. On the right hand side you see here this our Hampton Roads area. And these are the capabilities I'll be bringing to it, single sign-on, VLER Health, my mapping strategy, my test centers, my presentation layer, my service-oriented architecture and my enterprise service bus, identity management and then three clinical capabilities, lab, immunization and pharmacy.

And I'll do that both in Hampton Roads and in San Antonio, both of the separate regional sites and I'll bring capabilities to fix the pharmacy up in the James A. Lovell. So it becomes two years, two sites, two clinical capabilities and fixing our Chicago pharmacy.

This is what the iEHR looks like. This is the overall program where in this column, this is what I've got right now today. I've got, you know, two separate systems, unique business practices among both departments. I've got ad hoc mapping. I've

got multiple data centers. And that's the condition that you see. Two separate systems operating across both departments.

My initial operating capabilities is in the center column where I'm focusing in on the direct care. Bring in that single common graphical user interface. But now we've got common business practices, common data centers, a common infrastructure and a common operating picture.

The final operating capability covers the rest of them, the rest of the capabilities, my payers, providers. Again, my single interface system cutting across all of my capabilities, those 54 joint capabilities. I'll show you in just a sec. Assistance capabilities, those 54 joint ones, a single sign-on, context management, graphical user interface.

My increment two is my presentation layer with lab, immunization, pharmacy, clinical decisions support, order

services, clinical documentation, and all the infrastructure to support it. Increment one and two becomes my iEHR platform of which I build applications on top of that.

Five year effort to get FOC. Eighteen million patients, 22 medical centers and as I mentioned 211 different hospitals. And here's those stats for you, on the right hand column here.

Who we serve? You know it's the service members, veterans and their families. You know better than I who we serve. What do we do? It's those three missions, iEHR, VLER Health and anything that oversees, lead and manage that is related to the iEHR.

And why do we do it? This is this bottom line here. How do I improve this value proposition? And that value proposition is how do I increase quality care for every dollar expended? And that's the measure of success for each one of these efforts that we undergo, each one of these

capabilities.

This is the history. How did the departments get to where they were right now? And I know you can't read this. But let me just show you up here. Here's the composite health care system that it took eight years to get done. And here's AHLTA that took six years. That's about 14 years across both of them.

I don't have a similar break in VistA, but VistA took about 14 years to get where it is now. And we're being asked now to create, as of October 27th, that single integrated electronic health record and we're being asked to do it in a five-year window. Well that's, this is like version one. This is version 2.0, in six years they want version 3.0 in five years. And I think we can get that accomplished.

So what's our overall approach? Our overall approach is to take a Best of Breed solution and line that up with not only

open source and government off the shelf systems, but also commercial systems looking for what is that system that is the most mature and most effective in the clinical environment.

Where the pros are certainly this open source capability, where we look to the open source in order to pull in mature, open source software and I'll give you one example, in the medical imaging space there is a company out there called Mirth. And Mirth provides all of these image manipulation routines. That is believe it or not, an open source product. And all of the large vendors use it. We will certainly be using an open source solution in our imaging side.

The cons are, is the governance side. Governance becomes highly complex. You have to have both departments deciding not only on the clinical capability that you will go forward with, but then manage that

across both business processes.

Contrast that to a Best of Suite solution where the clear benefit is speed of implementation bringing an amount of clinical capabilities to bear right away. The cons are these top two, which are the hardest ones, is that it gives us vendor lock.

That means I'm stuck with a particular vendor and will have to effectively do another rip and replace, if this were the philosophy, in about ten to 15 years. And data lock. Unless I can extract the data, if I can extract the data, I won't have this data lock.

Data lock means that I'm using the vendor's data model and I really don't have access to that data. And this is all about the exchange of data. I've got to have access to the data model.

So unless the Best of Suite solution provides us relief in terms of these two up here, vendor lock and data lock, I'd

be hard pressed to select that. But I would tell you that we are looking at this as a potential solution. The secretaries have very recently, on the 10th of January, asked us to look at this.

This is our iEHR platform. I will show you on the top side this is our first increment and this is our increment number two joining around the fall of '13, the fall of this year. This is our single sign-on and context management that we're deploying out now in San Antonio, Portsmouth, Tripler, Landstuhl and this is the ability for that, really to return time to the patient provider interface.

Increment two is primarily focused in on infrastructure ending up with these three clinical capabilities, lab, immunization and pharmacy along with computerized physician order entry, clinical documentation and clinical decision support in our initial operating capability in

September of '14.

On the development side I had mentioned that both departments have their own program management schema. And we have decided that we actually would combine these into a single schema that the IPO uses. On the top half here I've got the DoD's business capabilities life cycle, the DoD BCL, which is a DoD 5000 like process, but it provides us with the ability to add in agile development.

Agile development allows a very cyclic, incremental type of development where as I mentioned allows us to pull out requirements that are no longer valid and bring in new requirements during the development cycle. This is very high level program focus. As you can imagine the DoD is very focused in on the overall program management capabilities.

The VA has a system called the, called PMAS, Program Management and

Accountability System. This is a very project focused oriented management schema and we will use for each of our projects within a capability, we'll manage those under PMAS. So PMAS is the project management piece and BCL is the overall program management piece.

Each of our increments will be managed at the high level of BCL. Each of the capabilities within an increment will be managed under PMAS. And let me show you those increments. So for example on increment two we've got access, control, and identity management. That's identifying who is who. Each of these will be managed under the PMAS system as they all will.

Here's our portal framework. Here's our order services documentation. This will be managed overall under the BCL, the DoD's BCL. What's difficult about this schedule is if you look at what we're doing say between 2014 and 2015 in this window

here, as other windows, I'm likely working on 30 plus capabilities at any one time. And that's where the complexity in this schedule lies.

It's a fairly compressed schedule. I mean if you were to ask me, it's because I've got overlap. In increment two, I'm finishing up the development of these capabilities and then I'll get my full deployment decision and then continue to deploy those. Meanwhile I'm building, I'm in the middle of building increment three and I'm starting planning and execution development of increment four.

So you see a lot of activities across any number of increments. And there's where the complexity lies. And the complexity lies in the compression of the schedule. The only way you can possibly do this is by an agile approach, not a waterfall approach. And that's our primary mitigation is using agile development processes.

So why can't I just take an application and just get it out there in front of the clinicians? Well, here's why. We have an N tier; it turns out to be a five tier architecture where I start with my common information or operability framework. And I have to have some of this up and operating in order to roll it through my data centers. And I've got nine data centers.

I need a couple of those operating from ILC in order to have the data centers operating I need my common services broker, my enterprise service bus and my service oriented architecture. And then I can put on laboratory, immunization, or pharmacy on top of that and light it all up with a common graphical user interface.

I could say for example do document management right now and get it deployed. But what would I put it on top of? I need this infrastructure, this whole infrastructure and pieces of it in order to

deploy this out to the ILC sites.

So how do we affect that value proposition? It's by improving those patient safety and clinical outcomes. That's where we're focused in every one of these. Reducing waste from unnecessary tests, diagnostic accuracy improvements, treatment guidelines, build protocols, treatment protocols within the iEHR system.

I think there's pretty good data out there that tells us that it takes upwards of 14 years for a clinical protocol to be adopted. If we put them within the work flow they get adopted much more quickly.

Public health and assessment using our data warehousing systems, admin costs and continue to improve efficiencies. Our current state two independent systems leading to this future state where I've got DoD and VA shared data and single applications across both departments including clinical decision support and a

single graphical user interface.

So how about VLER Health. We've talked a little bit about that already. And as I mentioned the JEC gave us that go decision. I won't repeat this, but they said go ahead and deploy this. And I talked about the return on investment that they've asked me to look at in order to pick the sites.

The services in the VA are working together on those models so they can pick those sites where we have not only a number of patients going out in the private sector, but as I mentioned those mature health information exchanges and providers and institutions that have accepted the data use agreements coming out of the Office of the National Coordinator.

This is what VLER has accomplished to date. Out in San Diego, they have this C32. C32 is a reporting structure that is common and accepted, common standard for reporting including drug allergy

sensitivities, medications, person identification. And that's been deployed out in San Diego, Navy Med out in San Diego, as well as Kaiser Permanente.

And you can see these are our four pilot sites, our joint pilot sites. And what we have accomplished in September of 2010, November, March of 2011 and September of 2011. And we will continue this deployment now with the JEC's decision to deploy nationwide.

This picture shows you the three TRICARE regions along with where we currently have VLER Health deployed where this orange color talks about both DoD, VA and private sector exchanges, here and here. And VA private sector exchanges in the red. And VA private sectors with direct, that means down to single doc offices in the blue.

This picture shows you our private sector production sites by name and location, just exactly where we are and where

in this blue is our three way exchanges, DoD, VA, and the private sector. And the red is where VA is communicating with the private sector in a two-way exchange.

These are the sites where we've got those eight two-way pilots, actually that's increased now where I've got 14 total between VA medical centers and the private sector facilities. And here are the locations where VLER Health is operating.

This is the architecture that we use for VLER Health. We are using the NwHIN, the eHealth exchange that is operated by the Department of Health and Human Services. DoD and VA were instrumental in helping this overall design.

This is where we have Department of Defense through its gateways as well as the VA through its gateways running through this NwHIN cloud where these private sector providers have agreed to operate by the data use agreements and they've built their own

gateways to connect into DoD and VA systems.

So the DoD would say what patient do you have? Do you have, you know, Jimmy Jones? And the private sector says I've got him. And the DoD would then say, well what data do you have? They would respond I've got this data. And then the provider would say well of that list of data you got I only want this set here. And then that would be exchanged with the VA or DoD providers.

At James A. Lovell Federal Health Care Center, as I mentioned this is that one of a kind facility. Both departments got together to operate this single hospital. Our role at the Interagency Program Office was to provide joint information technology, health information technology solutions to combine and safely interface both the DoD and VA systems. And it is serving both active duty members, veterans, and their beneficiaries.

It was established in October of

2010, 146 thousand beneficiaries, 400 hospital beds, 150 of which are acute care. Nine hundred outpatient visits annually. More than 2,900 employees.

So in December of 2010, is when we completed the infrastructure data center, built the single patient registration, as I mentioned, to have that patient reg across both departments. And we created that single sign and context management first out at James A. Lovell, which is now being deployed across the DoD.

Later on in 2011, single order entry for orders portability for radiology and our single graphical user interface which was then modeled here and is further being deployed now from a, through a secretarial decision out to the polytrauma sites. Later in 2011, our single order entry for laboratory and then continuing with order entry with consults management.

And with that let me open it to

your questions.

CO-CHAIR NATHAN: Barclay, I'd like to ask you, you know, your, the roll out of this or the continued evolution of an iEHR which is I believe, most of us believe critical to solvent care between the two systems, is dependent on getting out of a CR which we're in for the foreseeable future and somehow finding our way out of a sequestered budget that would take some of these evolutionary ways of doing future business. This doesn't preclude what, if we stop doing this today, it doesn't preclude us from doing business as usual.

We just know that business as usual is not as optimal as an integrative health record with the VA and a virtual connection to the private sector to not see each other's health records but to be able to transfer data about the patient back and forth. Your comments on that.

DR. BUTLER: Yes, sir. Coming

out of the secretary's meeting on the 10th of January they are acutely aware of the issues that you just raised. And so what they have done is they've asked the IPO to look at different ways that we can accelerate the interoperability, that common data sharing even among the Legacy systems as they exist right now.

So even in the event of a sequestration and significant cuts in the DoD that would have an impact on our ability to execute, we are focusing in on the interoperability of data which then allows our docs and nurse providers to see that common data across both departments.

So first and foremost, accelerate the exchange of data among Legacy systems so we potentially avoid the situation that you addressed. The second issue is, they asked us to look how could we significantly cut costs of our integrated electronic health record. Now when the IPO was rechartered in

October of 2011, along with that came a number of secretarial decisions.

For example, we will use Best of Breed. We will use service oriented architecture. We will have an enterprise service bus. We will have a common information or operability framework. We'll have abstracted data and abstracted application programming interfaces.

All that led to, the only way, the industry cannot respond to that. Industry has nothing like that. So that led to a Best of Breeds solution. We have to build it. If we can relax some of those, not all of them certainly, but some of them, then I can go to a Best of Suite solution and dramatically increase the amount of clinical capabilities I can bring to the clinicians early on, number one.

And I can likely deploy it at a significantly reduced cost because industry already has it out there. Now the danger

there, as I mentioned, is that vendor lock and that data lock. If I can extract the application in the single layer then I've broken the vendor lock. What that allows me to do is in ten years I could pull that vendor out and bring in another Best of Suite.

I can break the data lock by extracting the data as well. We haven't yet made those decisions. We have to assess what industry can do here. But I'm optimistic that we'll be able to provide this capability and I think significantly reduce our initial projected costs of a full Best of Breed solution going to a hybrid solution where we have a clinical core that is tightly integrated along with Best of Breed applications on the outside. Still becomes a platform where applications can be brought in.

CO-CHAIR NATHAN: So to segue on that, so thank you. You've shown some

mechanisms as to how we might be able to proceed in the face of these physical challenges. Let's say we roll the tape forward, we get there.

We're talking about a new integrated health system about where the DoD and the VA has to compromise and come together, forfeiting some of their existing infrastructure with AHLTA and with Vista. It's sort of reminiscent of the chicken and the pig walking down the road and they're deciding what to have for breakfast and the chicken says why don't we have ham and eggs? It looks like the DoD's given the ham and the VA's given the eggs. Do you foresee, are you optimistic that we can really undo the wieldy monster known as AHLTA?

DR. BUTLER: Yes, I do as a matter of fact. And in fact I think that the easier paradigm is turning off CHCS and AHLTA because the DoD has been very careful to define those boundaries. CHCS is what it is.

You can count the number of capabilities it has.

And they are all identifiable and their interfaces are identifiable. Similarly for CHCS. That leaves me then with that common data, the clinical data repository that I can interface in this architecture. So I actually think it's easier for the DoD to effectively do a rip and replace if I shorten that time frame.

Industry now deploys an EHR at a hospital, maybe their second or third or fourth site in about three month window. Their first site takes about a year. Once they get those practices down they can really rapidly deploy it. I think we can bring that to the DoD in a similar fashion.

The VA though is a different animal, there you go. And where their Vista system is a conglomerate of applications that are layered and layered and layered, it I hesitate to even say it's a platform. And I

say that because for example, when they bring in a commercial off the shelf application and I'll use laboratory it's taken a number of years to get that interfaced and operational.

If it takes a number of years as contrasted to a number of months, I hesitate to call it a platform ready to be interfaced with practiced Best of Breed solutions that are out there. So I think the VA will actually have a harder time and it's our job in the IPO to help them through that to leave that, to identify where those interfaces are and to bring in that new core if in fact the VA decides that they will go forward with a new core iEHR.

CO-CHAIR NATHAN: Thank you. Other questions.

MEMBER PHILLIPS: I was going to say this is a daunting task at least. And if you can accomplish 50 percent of what you presented, I think you should be, you know, congratulated. These huge Legacy systems,

what are you going to do with AHLTA? I mean you mentioned you're going to replace AHLTA which, great. But what are you going to replace it with?

DR. BUTLER: Yes, we were, we actually replace, remember the DoD's got, has a combination of two systems that present the overall integrated electronic health record, the current one, the Legacy one. It's the CHCS system, which is their order entry system and it's the AHLTA which is the clinical documentation system, right.

And the two communicate. I will keep the data. And I will replace both of those capabilities with the net new integrated electronic health record. I will replace order entry. I will replace lab, pharmacy, radiology, et cetera all the way down the list.

Master patient index, records tracking, managed care support, all of that will get replaced including the clinical

note, including the inpatient systems and the specialty systems as well. And every time I replace one of those systems I'll flip the switch on the Legacy system and say not that one anymore, but the net new.

And if we can get those deployed in hospital number three, four, five in the time frames that industry has proven that they can, then I think we have a very rapid deployment across the DoD system. But the data remains, right.

I will federate the data, which means that I will point back to Legacy data so when the clinician says I need to see Jimmy Jones data from three years ago because that's relevant to how I'm treating them today, then that data's available and displays on the net new system.

MEMBER PHILLIPS: A lot of information, I mean, for many reasons is scanned in.

DR. BUTLER: Yes.

MEMBER PHILLIPS: How, do you have a plan to deal with that? I mean how are you going to make that interactive?

DR. BUTLER: Yes, there's a considerable amount of data that's still in paper. And that's especially important to the VA when you look at benefit's adjudication. Before 1974, we still have a number of folks that are 100 percent paper record.

We do have to capture that data. I believe that the answer is intelligent scanning to get that captured. There are systems that are out there that can scan at incredibly high rates and recognize documents, categorize documents and get those compiled for later use.

You can do, with this intelligent scanning, you can look for fields and turn it into computable data. It's a harder task, but I think one that should be undertaken.

MEMBER REHBEIN: We're working,

in my other life out at Iowa State, we're working with a company that is able to take the old electronic publications and actually do some data searches on them, syntax sensitive, so that we can extract some data out of them that ordinarily an individual would have to sit down and read through them and try to understand that.

There's some real, there's some real advances going on out there. There are some things out there that are very, they're hard for me to understand, frankly, because now they're not only moving from our language into the pictographic languages and attempting to do the same thing. So there is some real capability out there.

CO-CHAIR NATHAN: Anything else? I would only add if you can accomplish at least 50 percent of this you shouldn't just be congratulated, you should be knighted. So thank you again.

DR. BUTLER: Thank you, sir. And

thank for your attention today. I certainly appreciate it.

CO-CHAIR CROCKETT-JONES: We have a 15 minute break and then we'll be back.

(Whereupon, the above-entitled matter went off the record at 3:21 p.m. and resumed at 3:33 p.m.)

CO-CHAIR CROCKETT JONES: Okay, now we welcome Doctor James Kelly, Director of the National Intrepid Center of Excellence, Captain Sarah Kass, the Deputy Commander, Captain Robert Koffman, the Deputy Director of Clinical Operations. But I see four people. CAPTAIN KASS: Yes, ma'am, we also have Doctor Tom DeGraba, who joined us today. He's our deputy director.

CO-CHAIR CROCKETT JONES: Thank you. Established in 2010, NICoE is a Department of Defense institution, dedicated to providing cutting edge services for service members and their families dealing with the complex interactions of mild TBI and

psychological health conditions.

We have information under Tab G in our binders for this presentation. And I'm going to turn it over to you all.

CAPTAIN KASS: Thank you, ma'am. Good afternoon everyone. I brought together the experts on our team here from the NICoE to speak with you today.

I believe we have about an hour. And we wanted to make sure that we addressed the ten questions that you provided to us. So we have crafted our presentation to specifically address those issues.

Many people have had the opportunity to come to the NICoE up to this point, or have some familiarity with it. For those who don't, if you have questions that aren't addressed in this, by all means let us know and we'll provide some additional general information.

But in the interest of time, and leaving plenty of time for question and

answer, we'll go ahead and just get started straight into the presentation.

As you know, like I said, we were given ten questions in the agenda. We have provided you a slightly reordered series for those questions, and that's just to limit the number of times we switch from presenter to presenter.

So with that said, I'll introduce Doctor Jim Kelly. Dr. Kelly has been the director of the NICoE since its inception. And so I'll let him start off our presentation to you today.

DR. KELLY: Thanks, Captain Kass, good afternoon, everyone. If we could turn to that slide right there, Slide 2, our overview and mission.

The vision of the National Intrepid Center of Excellence is to, as you see there, to be the nation's institute for TBI and psychological health conditions dedicated to advancing science, enhancing

understanding, and maximizing health, and relieving suffering.

The mission is to serve as, specifically, an institute, and I'll go into the difference between that and a clinic, dedicated to understanding complex comorbid traumatic brain injury and psychological health conditions by providing a comprehensive and holistic care with focused research, and exporting the knowledge that benefits a service member's families and society.

So the mission really is broken out into three parts, research, training, and education. And the clinical care that we provide in the building itself, many of you this is actually a free-standing two-story structure at Walter Reed Bethesda.

We actually are aligned under the Walter Reed Bethesda Hospital. We had previously, as many of you will recall, been a part of Defense Centers of Excellence as we

grew up in response to the NDAA of '08.

So without reading to you in detail each of the different pieces, what I really want to emphasize is the research mission, our research institute function, is the major thrust of the NICoE, as we call it, Institute at the present time.

We were intended, all along, to do a deep dive into the diagnostic work-up of the patients, and innovate in terms of treatment, and then get those lessons learned out to the MHS, and as you're aware now, through NICoE satellites, which are being built in two locations.

Those had been part of the plan, structurally, organizationally, from the very beginning.

And so what we do as an institute is looking at the pathophysiology of that comorbid state. Again the individuals that we're looking at have had a traumatic brain injury, and have psychological health

conditions in that same person.

This is different than just an isolated traumatic brain injury, or somebody without that neurological state who has PTSD.

But again, a huge part of the population who come back from the war zones, which was as we developed the concept of operations and developed the mission and vision, it was in order to hit that population specifically that had the comorbid neuropsychiatric condition.

If I may go to the next slide. The overview of our mission is consistent with NICoE's five year strategic plan.

Two imperatives for the organization, being advance the understanding of that comorbid TBI and psychological health disease state in order to improve diagnosis and treatment, and then also to influence improvements in the quality of care through partnerships across the MHS, the VA, and the civilian sector.

Next slide. The answer to how effective is NICoE and how do we know, in terms of the clinical piece, we actually follow six clinical evaluations that you see listed there.

And those are done on day one, and in the last couple of days before the individuals leave after their four week treatment program with us.

Those are well established previously validated scales that are filled out by the patient, sometimes in collaboration with a family member.

Satisfaction with life scale Neurobehavioral Symptom Inventory, a sleepiness scale called Epworth, a specific PTSD check list, the Dizziness Handicap Inventory, the Headache Symptom Inventory, if you will, the impact test, each of these have demonstrated qualitative improvement in the four week stay with us.

And the very next slide shows

statistically how that breaks out. So as you'll see in the first column there, we have the outcome measures listed again.

The second is the number of subjects in the program that have gone through, in this case, the four week program.

I should point out that when we started two years ago, as we were pointing out at the beginning, we were a two week program. That gradually grew to a three week program, and then ultimately a four week program as we learned that we could actually accomplish more if the patients were to stay with us just a little bit longer.

And we also found that they were more likely to share with us details of information and so forth that they otherwise felt reluctant to do so if they were just going to be there for a short span of time and then leave.

So we actually felt we could expand the project to four weeks. And it's

this group then that had gone through that four week project that we are currently, the program as it exists.

So you see the greatest number is 182 that have filled out the headache inventory, 181 for the other satisfaction with life and Epworth Sleepiness Scale.

The low numbers of the dizziness scale, and the Neurobehavioral Symptom Inventory for headaches in specific, are lower because not every patient has all of those complaints. And so the check list, if you will, or scale, isn't pertinent under those circumstances.

And as you can see, at the far right, statistically significant improvements along each of those measured outcomes, those standardized measures.

Next slide. We also look specifically at the satisfaction scales that the patients fill out. And the bar underneath, the overall table that you see

there, indicates an overall patient satisfaction score of 95 percent, indicating that they agree, or strongly agree, that this has been a positive experience for them.

And the positives in general, in terms of the written comments that we hear back from the patients include they enjoy the team approach.

And I should point out, as you'll hear shortly, the team is entirely co-located in the building. All of the members are in one location, which is not always the case throughout the MHS.

And then the team takes time to listen to me, and that they care. We hear that theme very often, that there's an empathic engagement between our staff members and the patients and family members that they may not always experience elsewhere.

And I think that's facilitated again by the co-location and the easy access that we have to the patients under the

circumstances of the building itself.

The negatives, the feedback we get is that the program, even at four weeks, for many seems that they need it to be longer, or they would like it to longer.

And they're concerned that when they leave they're going to back to care that has not been changed, and will be similar to what they experienced before they came to NICoE, so that it would be care as usual, if you will. Yes?

CO-CHAIR CROCKETT JONES: I'm just trying to understand something. So of the folks who have done the tests, the clinical tests, your max number on those is 182. But in responses on the effectiveness, am I right in seeing the number 13,000, or 17,000 as total responses?

DR. KELLY: Those are actually if you add up the responses in that particular survey.

CO-CHAIR CROCKETT JONES: So --

CAPTAIN KASS: The survey had multiple questions.

CO-CHAIR CROCKETT JONES: Okay. I see. So what I'm trying to, I guess, understand is what is the total number of patients that is reflected by this survey, or by that testing.

DR. KELLY: These are different, as you can imagine, so it's not exactly the same number. We actually have many more patients that have come through, 378 patients have actually come through NICoE.

But by the time we were actually able to gather the data, and in various time frames after the four week program was put together, these are the actual numbers that we have in each of these different kinds of inventories.

The n over at the far right of that column actually reflects more accurately what is the number that responded.

CO-CHAIR CROCKETT JONES: Thank

you. Go ahead, Mr. Drach.

MR. DRACH: Could you explain a little bit -- I know the negatives, your last comment, concern that they will return to care as usual. I'm reading that to say that the care as usual is substandard compared to what they were getting.

DR. KELLY: Well, I think we'd look at it a little bit differently. I think what they're seeing is the care is standard, where they are.

And this is a very innovative and intensive program. It's truly an intensive care model of a holistic, interdisciplinary team specifically aimed at that comorbid state. And until we get farther along with NICoE satellites and other influence throughout the MHS, it simply doesn't exist.

And so while they're receiving, in many ways, what is standard of care in other locations, what we're doing is innovative, more intensive, actually more

engaged on a day-to-day basis.

Just as a for instance, over the four weeks they have on average 104 hours of interactions with our providers. If you were to add that up, try to do that in the MHS, it would typically take a year and a half or two years to get that 104 hours with people, the specialists that we have.

MR. DRACH: Got it, thank you. But given the fact that there's a 95 percent satisfaction rate, and based on what you just said what, if any, potential is there of making this permanent.

DR. KELLY: We readily realize at the present time that this is probably a pretty expensive, and not the easiest kind of model to pull off.

In fact, we aren't fully staffed even at this point, and having been open for two years for seeing patients already. So it's hard to get the right personnel on board.

It's a difficult model to do in a location, unless you can dedicate the space to it. And the satellites, hopefully, will help us do that, because there will be that forcing function, if you will, of everybody being in one location and under one roof.

But the truth of the matter is, sir, that even in the private sector, where I've spent my previous years, there is no such model. Nobody has this.

This is an opportunity that the Defense Department has to innovate, and to apply the principles that we've all learned through our careers in the private sector, in the VA, and in the DoD, in a way that has lifted some of the restrictions and the obstacles.

And I think, under the circumstances, it's very effective because it doesn't have a lot of the systematic snags, and problems, and delays, and so forth, that others live with.

I certainly lived with it in the private sector. And this is a magical thing, to me, frankly. There's nothing like this that I've ever been able to put together in some pretty top tier academic centers that I've worked in. There's nothing like this.

MEMBER REHBEIN: The people that have gone through the program, have you contacted any of them, say six months after they've left the program to see what kind of permanent effects your program had?

Did they really go back to care as usual, or did the effects of going through your program stay with them and improve their lives?

DR. KELLY: Much like the rest of the MHS, and perhaps you've asked that question of others as well, there's difficulty in tracking individuals because of the continuous sense of being mobile, and changes of how you access people, and so forth. So we're just now getting to where we

have a more systematic way of doing that.

It has largely been an idiosyncratic and a small group of people we've been able to track, and have been contacting our clinicians that you'll hear from as to their interest in maintaining contact, and asking questions, and seeing how it is they can influence and advocate for themselves, which is a big piece of what we ask them and teach them how to do.

So that once they've gotten the skill sets that we help build with them over the four weeks, and the information about what has worked and what has not worked for them individually, they then are asked to influence the system outside.

And we hear about that either from their practitioners, and sometimes I do that when I'm elsewhere in the country, or they contact our practitioners for more advice and tell us how they're doing.

We have a database that's being

built and gathering that information right now in the recovery care coordinator fashion that's partnering with Defense and Veterans' Brain Injury Center.

But we're aligning the data sets so that what questions and outcome measures they're using are the same as ours, so that we can actually make sure that we're comparing apples to apples when we look at our program versus other programs, and so forth.

So it's a long answer to your question about what ought to be a simple explanation. Except we don't have a better way yet of tracking those individuals.

We are building it in so that at 1 month, 3 months, 6 months, 9 months, 12 months, and so forth, we will be able to access those individuals.

And to some extent, we're doing that now. But it's a fairly small and start-up part of our operations at the present

time.

The next slide. And again, how effective is NICoE in terms of education, and how do we know? Again, I had mentioned that part of what we do is education for wellness, and skill building, and self-management education modules for the patients and families.

Captain Koffman can speak in more detail in a minute to what those entail, and answer questions about that. But 40 hours is really quite a lot for individuals over a four week span of time.

And the patients, we hear later, very much appreciate understanding better what the nature of the problems are that they've had and they're facing, and what solutions there may be.

In collaboration with this very important initiative of our First Lady and Doctor Jill Biden joining forces, as you may have heard, that initiative was actually

partly rolled out right at NICoE on our Bethesda campus, engaging the educational systems in medicine, nursing, other allied health programs to raise their hands to be able to use the clinical approaches and educational modules that are useful in the DoD and VA, and make them applicable and disseminated throughout the private sector education system for healthcare providers.

So the joining forces model, if you will, is to engage the private sector with what is the military and veterans initiative around TBI and psych health. That was a very big piece of what it is we played a role in. And then I have, and other have, helped with a train the trainers, several modules of TBI and psych health education for the area health education centers.

These are Federally funded through DHHS, that actually are in 46 states, and serve as an infrastructure for health

education throughout the United States.

And so they already exist, teaching continuing education to healthcare providers. We're simply out there giving them the content that they need in order to do so.

NICoE itself has hosted 123 conferences, or training seminars, over the two years that you know we've been open, two of which are notable.

The CDC concussion definition working group is an ongoing project, which will end next year, where the DoD, the VA, and private sector entities in the academic world are coming up with one uniform definition of concussion, or mild traumatic brain injury that can then lead to a coding that everybody will be using, so that we can track what it is that's happening in each segment, the DoD, the VA, and civilian sector, in terms of concussion, which doesn't happen right now. It's a very important

project.

And then we had the MIT-NIH conference with some truly brilliant people, two of whom were Nobel laureates, in the building, talking about not only neurodegenerative disease, which had been an every two year project on an international basis.

But they asked to come to NICoE to bring the military research specialists in regenerative medicine, and traumatic brain injury as the model, into their thinking, so that they were looking at the synapse of the nerve cell, and how it is that actually can regrow and make additional connections after a trauma, after something has happened adversely to the brain.

And so they were bringing their science into the DoD thinking. And we were influencing them on an international level as well. It was just spectacular.

And then the other project is out

of the University of New Mexico. And Captain Koffman can elaborate on this as well, the project ECHO, the Extension for Community Healthcare Outcomes.

And we've been asked, and quite willingly participate in the DoD looking at how to use teleducation, teleconsultation, emanating from our very robust capabilities at the NICoE out to other locations throughout the DoD.

We've already done two and have additional ECHO projects planned to disseminate. And again, we have more information later if you'd like to hear about that.

Next slide, please. In terms of research, how effective are we? Again, answering that question, we have 15 IRB approved or pending research protocols at the present time.

We've listed a few of them there that I can certainly answer questions, or

Doctor DeGraba could answer questions about, if anybody has specific questions about what these projects really entail.

But then down below, in the little table you see that we have several in development, or in stages of data collection, and so forth.

We have nine peer reviewed publications in this span of time that we've been open, and 39 poster or podium presentations at national meetings. Next slide.

CAPTAIN KASS: So as the military leader of the group, I get to speak to the challenges and the frustrations that we face. And I think they're probably fairly consistent with some of the ones we hear from the other Centers of Excellence.

When the COEs were initially established and staffed, there was a lot of, for lack of a better phrase, beg, borrowing and stealing to get staff onboard to help get

the initial mission accomplished.

And that works to a point. But once you start to have those staff transition onto their next job, if you don't have an authorized manning document, it becomes much harder when you don't have the same political clout to refill those positions.

So two years into this endeavor, we are now facing many of our military staff PCSing. We still don't have a manning document.

And so that is one of the critical challenges that we face. Just in this year, we've had two key Army personnel PCS, and anticipate some additional losses in this coming summer.

So we're working with our leadership to push forward the idea of a manning document. But that's certainly something that's critical to future mission success.

MEMBER EVANS: So, Captain Kass,

is that under JTF CapMed, that's responsible for the manning document?

CAPTAIN KASS: Yes, ma'am. Right now Walter Reed Bethesda falls under JTF CapMed, so we'll work with them to get that manning document established.

In addition to that, I would say two other things in the same category as staffing. One is our civilian hiring process. I don't think I'm saying anything new when I say it's challenging and cumbersome.

And when you're trying to recruit top tier individuals to come be a part of your Center of Excellence, the delays that we faced with the civilian hiring process continued to hamstring us to some degree as well.

And one of the most notable pieces of that, honestly, has been the security clearance process. We nowadays can have people stuck in the security clearance

process for six months.

And you can't proceed to hire somebody new, because the offer has been made. And so you wait six months for that process to be cleared. And that presents significant challenges.

In addition to that, as Doctor Kelly has mentioned, we're setting up the NICoE network. So the NICoE Institute in Bethesda, and the nine satellites that have been proffered by the Intrepid Fallen Heroes Fund that will be built over the next few years, we've now taken on a new mission requirement to serve as the oversight and liaison for establishing that network. And those are additional manpower requirements that will need to be addressed.

Our second major hurdle that we face has to do with research, specifically research funding and then IRB. I know fairly quickly I'll dismiss the IRB piece of this.

I know other centers have looked

at single IRBs for the work that they're doing, because they're doing multi-site research. And we're in the process of establishing the same setup with a single IRB to serve as the source for human subject protection for all the research that will happen across this NICoE network.

And we're receiving support from JTF and Walter Reed to establish that. We'll also continue to explore MRMC, which I know some of the other Centers of Excellence have done.

But the funding is a more significant challenge for us. Again, I think at the initial establishment of the NICoE, the thought was in order to really function as an effective Center of Excellence, it needed to have approximately, many have estimated, $20 million a year for the research to really do the cutting edge research that needs to be done.

But there is no dedicated

research funding for the NICoE or the NICoE network. And so we face a situation of competing for grants, like other people, which is fine.

But then we face the challenge of not having the infrastructure to support execution of those grant dollars when we receive them.

Again, we continue to work with Walter Reed Bethesda and JTF to fix some of those processes, but the situation remains that we, at times, will receive grant dollars and then not be able to fully execute them, because of some of the bureaucratic challenges you face trying to get dollars executed in our system.

So those are the primary ones, the dedicated funding, and then once you have funding, moving it.

And the last one, I think Doctor Kelly also alluded to, which has to do with the traditional measures of productivity that

we have in our healthcare system, look at relative value units and how productive are you.

But when you're setting up a new model of care that includes an interdisciplinary approach to care, with very, very timely access to the next appointment that you need, the business rules of our current system don't support that.

I've been in meetings where people suggested that we just book all of our appointments through the traditional IRMAC system that we have at Walter Reed Bethesda.

We reschedule our patients on a daily basis, based on how they did the day before. Our nurses will meet with them at the end of the day and say what worked for you, what did not work for you. How do we have to shift things so that tomorrow we can address the challenges that you're still facing?

And that requires a flexibility

and agility that the traditional system just does not support.

Additionally, the standard measures of relative value units really aren't the measure of productivity here. So as we set up the NICoE network, and we looked to build these satellites, we really need to push for relief from the traditional RVU measures of productivity, and look at measures of quality and outcome, and patient experience.

Did this meet your needs? And are you doing better today than you were two months ago, two weeks ago, as a measure of success.

In addition to that, we do believe that we are a value add and a value commodity in the MHS. Because if you look again at those 18 months of trying to get appointments, if you're not getting better, that is not efficient use of the healthcare system.

Instead, if we can front load appointments, get people into a very intensive program, even if it's more expensive up front, we believe there's an opportunity to look at do we gain improvements in care that reduce costs in the long run.

So as some of the discussion about the outcome measures, besides looking at how patients are doing in their clinical measures at the six months, one year, and two year mark, we also want to look at decreased use of the ER, and decreased unplanned access to care, as measures of success of the program. Yes, sir?

MR. DRACH: Do you have any idea what the average time post entry of your patients?

CAPTAIN KASS: I'll let Captain Koffman answer that, because I think he's got better numbers. I'll tell you it's very wide, from a couple of months to 18 years, I

think.

CAPTAIN KOFFMAN: Indeed, there is really no modal delay in terms of between injury and presentation at the NICoE, because there are so many forms of head injury.

So typically if it is blast related, it is during the more recent years of war.

But many individuals have has head injuries through their training combatives, through high speed assault craft. So because the modal presentation of head injury is so broad, we see people with very chronic traumatic brain injuries, sir.

MR. DRACH: So am I hearing correctly that some of your patients are pre-9/11?

CAPTAIN KASS: Yes, sir.

MR. DRACH: Thank you.

CAPTAIN KASS: The next question we were asked to address was our clinical staff. And so what I've presented is part of

our standard brief of what is our clinical team, and who makes up our clinical group.

And so you see here, again, the patient is at the center, the patient and their family. But they are supported by a nurse, and then all of the different providers that you see on the outside of that ring.

The structure is set up to have three inner-disciplinary teams of core providers. Those core providers are the internist, the neurologist, psychiatrist, family therapist, and neuropsychologist.

And then the other providers would support all of the teams. So we have a robust interdisciplinary team making up a number of different folks.

If we look at our staffing then on the next slide, you asked specifically for clinical staffing. But I wanted to present the whole picture again, as an institute. Really it's about having all of these folks

onboard.

Currently we're staffed at about 72 percent of our projected manning. We have put a lot of emphasis towards the clinical staffing initially, so we're approximately 83 percent manned in the clinical realm. But directorates like education have taken the hit and are not nearly staffed where we'd like them to be.

At this point in time, the biggest impact of that is on burn-out of the clinical staff. We have a lot of our clinical staff working extremely hard.

And the patient population, in and of itself, can present challenges to work with on a daily basis, And then asking them to do it, and make up for the positions that aren't filled, certainly adds to their wear and tear. But I think it's also had a impact on our ability to fully execute in the research and education directorates in the way that we would like.

And then, as I said, the satellite oversight will only add to the requirements that we have here.

Next we're going to move on to referral patterns. And at this point I'll turn it over to Captain Koffman for pretty much the duration of the slides that we have here.

And the rest of us will help and answer questions. Captain Koffman serves as our department chief for clinical operations, and so is in the weeds on a day-to-day basis with clinical.

CAPTAIN KOFFMAN: Thank you, ma'am. You can see that we've had about 378 patients referred to the NICoE. By our concept of operations, individuals must have experienced a comorbid brain injury, in other words a typically mild or moderate TBI, most of them are mild TBIs, with some form of a psychological health condition.

And additionally, the individual

must be DEERS eligible, either active duty or under orders to come to our facility.

We've had somewhat of a disproportionate number of individuals coming, largely from the Marine Corps, and this is typically from Camp Lejeune.

And then from the Army we've had a disproportionate number of individuals coming from the CBWTU. Similarly, from the Navy, of those 77 sailors, the vast majority have been SF Seals from Virginia Beach or Dam Neck.

And so the story here really is success begets success. And for the facilities that we're getting folks from, they're actually sending quite a large number of individuals.

We have about a six to eight week wait for our month long program. We onboard five new patients a week. And as Captain Kass mentioned, this is a very accelerated and intensive program. Next slide please.

MS. DAILEY: I'm ahead of you. Real quick, you sourced it by location, any idea within those locations how they're being identified?

Are they being identified in the WTUs, obviously community based warrior transition unit, obviously case management teams are then referring them to you, I assume.

CAPTAIN KASS: I think we addressed that in this slide.

MS. DAILEY: Oh, I'm sorry.

CAPTAIN KASS: We'll try to get to that.

CAPTAIN KOFFMAN: We've tried to make it very easy for primary care providers to refer to the NICoE. We actually have a very simple referral package on the Web, accessibly through DCoE, which was initially our primary Web contact, or now through JTF CapMed.

But essentially the primary care

manager fills out a one page referral. And our triage body, our white team, looks at the merits of that particular referral.

And if the individual meets criteria, again, the presence of a traumatic brain injury with some form of a psychological health condition that is not responding to the current level of care, then they would quality.

And if fact, the vast majority of individuals we've seen have met those criteria. If the individual doesn't meet the criteria, or if it seems like there's other opportunities for our white team to work with the home station in terms of potential opportunities for intervention, either prior to the individuals coming.

Or perhaps that's all that's required is our white team is capable of making recommendations to the referring facility, or provider. And you can see of 13 patients, you can see typically our referrals

do come from primary care providers.

CAPTAIN KASS: I wanted to try to answer Ms. Dailey's question. Because again, as we looked at specifically what you asked about your interest in understanding if patients come as identified from PDHRA, or from their command, or family members, the challenge for us in that regard is that all of our referrals come from the MTF.

So these people have already been referred into the healthcare system. We did pull the records trying to go through the records to see if we could get back to the original source of referral. And unfortunately it was very difficult to define that in the medical record.

So I appreciate the interest of what you're trying to look at. Unfortunately, I'm not sure we're the best organization to answer that question, because we're, again, that tertiary care center that's getting the referral from the primary

care site, the primary site of medical care.

MS. DAILEY: No, I appreciate you taking it down one more layer there. And we ask this question usually at site level. And we were at Fort Carson just last week, and they're experiencing a similar kind of challenges on who and how they got the referral. So thank you, I appreciate the dig.

CAPTAIN KOFFMAN: Next slide. In terms of non-completion, non-completion through our four week program is essentially not a problem.

We've only had a couple of individuals who have had to return, because of legal issues. And we try and screen folks carefully to make sure that they'll be able to continue their four weeks while they're with us.

Those that have left, and importantly those that do, we really have a very elaborate discharge process where we

liaise with the home station.

And this is where the hand-off, to include an incredibly comprehensive discharge summary, is important. And again, this helps us set the stage for follow-up data collection.

Next slide, please. Doctor Kelly mentioned our interdisciplinary care. The opportunity that we have at the NICoE is really to extend this model -- which is a very front-loaded model of care early on, at least early on in the presentation of the individual -- to our facility, and share these best practices with ECHO.

As mentioned, ECHO is Extending Community Health Outcomes. And ECHO is the teleconsultative, telecollaborative service that we are developing with our NICoE satellites.

And indeed, we ultimately see many MTFs being able to dial in to this ECHO network and be able to discuss best practice

amongst the comorbid TBI psychological health sufferer.

We've started Project ECHO. We've had two successful collaborative efforts with two of our earliest NICoE satellites. And this is really going to be a best practice, we hope. It has been very successful at the University of New Mexico, where the availability of specialty care is similarly fragmented.

CAPTAIN KASS: I think, again, to add to that, I think in University of New Mexico the model for this was Hepatitis C. And it's a very algorithmic approach to a very well defined condition. So it really was just about getting people connected to the consultation from a specialist.

But I think where this is different for us is this is not nearly as crisp and clean as Hepatitis C, as far as the diagnosis. And then the treatment is much more complex, and much less algorithmic.

So when we get to the idea of how do you translate what you're learning at NICoE, and infiltrate the rest of the healthcare system, I think this is a key initiative in that regard.

Because I think this is where you start to talk about less so giving people access to expert consultation. It's about discussing best practices and then having those people then carry that on in their daily practice.

And so the more we're able to have as ECHO, the intent of that is a reverberation of what happens. That's why it's sort of the name ECHO was craftily created into the name. The goal would be that NICoE Institute in Bethesda would host a case-based conference where we talk about best practices with the satellite locations.

And then those satellite locations then have a similar teleducation

conference with the primary care community that they serve. And so that's the goal of that effort.

MEMBER EVANS: Right. So two of our recommendations, and one of them for the FY '12, and I believe you've seen the set for primary care and the behavior health providers, that they're trained.

And how are we tracking that they've received the training for post traumatic stress disorder. And then to carry that even a little farther, how are we looking at evidence base and ensuring that they're trained on the evidence based.

We're going back looking at records, or going back looking at the past, the care, and how we're spreading that out there to the field.

So I think we were talking about this this morning. How do we monitor the training of those in the primary care and behavior health, as well as how we assure

that they are looking or using evidence base in their practice.

CAPTAIN KASS: I think it's a big challenge. That's the answer. It is complex. I think others may have recommendations of how we do that.

I think as we think about Project ECHO and where we exist, some of those things is we're looking at where there aren't clinical practice guidelines, and where the evidence is just now being developed.

That's where, when you talk about it, and we'll talk about this a little bit more in a couple of slides, when you look at the confluence of TBI and psychological healthcare together, there isn't a CPG right now for that piece.

And so Project ECHO, and the recommendations that we will have, are at that cutting edge, at the innovative level.

But as those things become standard of care I think the key, and

especially as we start to look at the satellite locations and how we export how they do things, you have to have the audit process.

Where you go back in and say, okay, if we say you have to have an interdisciplinary team, how do we audit are they doing interdisciplinary care? Are they doing what we say in a concept of care? And unfortunately, the only way really is to go back and have somebody take a look externally.

CAPTAIN KOFFMAN: ECHO model is a little different from telemedicine in the sense that we don't assume the care of the patient at that teleconference.

This truly is a collaborative and instructive model where the case is discussed without patient identification. And so it really is something that a lot of individuals can dial in and learn from. And we're really excited about it.

MS. DAILEY: And real quick, I just want to highlight for the members of the task force, we've had four Centers of Excellence come in and talk to us today. And we'll have a fifth tomorrow with psychological health and TBI.

And as noted by our general officers and the questions they were asking earlier today, every one of them seems to have a different way to disseminate their cutting edge efforts, and disseminating the information and the research that they are developing.

And NICoE has presented another one to us. And they've packaged it and call it ECHO. But this of the fourth way we've seen the dissemination of these cutting edge practices coming out from the Centers of Excellence.

CAPTAIN KOFFMAN: Even though there's not a CoE specific for chronic pain, our pain service on the Walter Reed campus

uses the ECHO model very effectively to collaborate and discuss best practice with pain management.

And we're going to talk a little bit about best practice versus evidence based, because this is really where colleagues can really sort of help colleagues understand what emerging best practices are. Next slide please.

MEMBER PHILLIPS: I was, excuse me, I was saving this for the end. But since Ms. Dailey brought it up, and this is not really a question directed specifically at you, but we did hear from four different centers today. And I've heard some common issues, or common themes from all of you. One being staffing, manning document, two, a mechanism to deploy best practices, dedicated research funds, seeking a single IRB, and there may be some others that I left out.

And what I wanted just to bring

up, so I wouldn't forget it, because I have gray hair, is it better for you all to talk from a common voice, rather than for each Center of Excellence going after its own results? Is that possible? Is that something that we should be talking about?

I apologize for interrupting the train of your discussion, but I'm just wondering. And perhaps we could hear from some of the others later. Is that possible, so that you can achieve some of these common goals?

CAPTAIN KOFFMAN: Sir, to some extent that is being done, just so you know. So one of the efforts is a neurosensory consortium idea, if you will, of the very organizations you've been mentioning, including some that you've heard from.

So there would be one integrated approach with collaboration and a common data set, and common data elements, and all that sort of thing.

So it's fairly early because a lot of these are just now maturing. And, as you know, we're only two years old. But that's where we're headed, and largely that's the case, the limits then being the human experience of what the organ systems are that are involved.

So if somebody's working on peripheral vascular disease, or amputation, it's unlikely to fall within all the other aspects of what it is that we may be engaged in.

So there are intrinsic limits to that approach working. On the other hand, where they can work, that exact idea is what people are already spending some time doing.

MEMBER PHILLIPS: Good. No, I certainly understand that. Knowing there'll be a bureaucracy, you don't want to be five years down the road in a competitive situation with other CoEs.

CAPTAIN KOFFMAN: And I should

mention there is already a CoE oversight board that has been stood up, that you may know, that's looking specifically at efficiencies, and overlaps, and redundancies, and those sorts of things, and asking very tough questions as well, to answer your question.

MEMBER KEANE: I have a quick question. What is your current patient population?

CAPTAIN KOFFMAN: What is our current patient census? We have 20 patients a month. Right now we have a little bit of a lull from the holidays, that individuals are coming back from the holiday recess. And we'll be at our steady state, 20 patients a month.

MEMBER KEANE: The 20 patients a month and 44 clinicians, if you take out the ten percent that are researchers, 40 clinicians, so two clinicians for each patient?

CAPTAIN KOFFMAN: It is a very intensive program. And actually some patients will have more than two clinicians, depending on what their needs are.

And thank you, I'm going to actually talk about the sequenced care in the next slide, and our model, which really does front-load a lot of the intervention early on.

Virtually everyone who comes to us is suffering. They're suffering from chronic TBI with any number of psychological health conditions, typically PTSD.

But PTSD is perhaps one of the most comorbid psychological health conditions itself. So folks come to us. They're very complicated, they're suffering, and they hurt.

And because of the TBI, almost all of them have headaches. Pain is legion, in fact nobody comes to us without chronic pain, as well as some type of sleep

disturbance, or sleep disorder.

What we do, and this is why we stack those treatments early on, is that we sequence care in such a way that we can sort of control a lot of the symptoms, and manage the individual without necessarily chasing diagnoses.

We stabilize the individual, we make the individual comfortable, and that enables us to proceed with psych testing, neuropsychological testing, which typically is more valid than having individuals come in who aren't sleeping, who are on multiple medications, polypharmacy, who have severe pain.

So our front-loaded approach, and we can't say this for certain but this is what we're studying, is in terms of the chronicity of this very uniquely comorbid population, this is the way to manage individuals who've been suffering.

And keep in mind that we're a

tertiary referral center. We don't take individuals who just bumped their head last week and are having mild concussive symptoms.

These are individuals, and it's a somewhat pejorative characterization, it's not mine, but post concussive syndrome is also called the miserable minority.

Because those five or ten percent of individuals who go on to develop symptoms, every sphere, every aspect of their life is affected. And they're suffering in so many different ways.

So we really, we front-load this intervention in truly a patient and family centered approach. And about 20 to 25 percent of our patients bring their families for at least part of our care. And this is also critical, because the families are suffering as a unit.

And where there are no families we've had individuals bring parents, or siblings, or even support systems. And we

realize that the chronicity of this condition does not exist in a vacuum.

So it's very front-loaded, it's very holistic, it is very patient centered. And it's not an efficient model when you're teaching an individual how to overcome their own disability.

The only treatment really available for TBI is education. And again, you cannot educate somebody if they're not sleeping, if they're hurting, if every day they wake up and they don't want to learn what they need to learn in terms of lesson plans.

And so empowerment, and education, and self-advocacy is key, particularly when somebody becomes disaffected as all of our patients have.

So is this evidence based? And on the next slide, this is really the conundrum that we face. You can see the overlap between PTSD, TBI, and pain. I'm

sorry?

CO-CHAIR CROCKETT JONES: Before we get there, I know that this has occurred as a concern among some of the task force members. We go to installations and conduct focus groups. And the comorbidity, and the parallel treatment for PTS and TBI, we see this everywhere we go.

I think some of us are concerned that your environment is so specialized that, you just said something that made me think, that is almost the actual concern we have.

And that is since so much of the treatment is really about education, and about creating new habits, the big numbers that we see of these folks out there in the field they are not going to have the environment that you create.

And so a best practice, do you see what I'm saying? I think that to some degree we're a little concerned that the best practices that you generate don't translate

to the various installations, which don't even have some of the folks that you have available for your patients.

CAPTAIN KOFFMAN: So I think part of the answer, ma'am, would be if you look at a relatively isolated traumatic brain injury, without all the other, especially what we see, war related psychological stress related conditions.

Those have better, well accepted, and now in many cases long standing treatment approaches that ultimately engage the patient in an education as well, but also symptomatic relief with headache and sleep disturbance, and so forth.

Not everybody needs all of what we have. That's part of what we're about, is that tertiary care comorbid intensive project.

CO-CHAIR CROCKETT JONES: Yes. I hear what you're saying. I'm not sure you understood my concern. We see a lot of

people who probably need your care. We see a lot of people.

And my concern is that I'm not sure how we're getting those people into good treatment. I'm wondering what you all do to look at the patient population that's out there in all these MTFs, and all these various installations, to see how many people really do actually fall under what would meet the need for your care.

But they're never, never going to get, they're never going to hear about it. This is a serious concern and a dissonance. Because when we go around, some of the things that we ask folks is do you know what's available right where you are. And they don't know. And so --

CAPTAIN KOFFMAN: That's part --

CO-CHAIR CROCKETT JONES: -- do you see what I'm saying --

CAPTAIN KOFFMAN: I do, and I think --

CO-CHAIR CROCKETT JONES: -- my concern is that I'm not sure. I'm very concerned.

CAPTAIN KOFFMAN: We grew up as an organization to meet that need. And again, this is an institute model. It's not a clinic with a high flow through.

It's intended to create evidence, to the extent we can scientifically, and at least get lessons learned, which this interdisciplinary intensive model seems to be the first lesson learned, networks out to other organizations and influence them.

So we're trying, as you can imagine, to get traction in that fashion. Because we can appreciate the fact that we're often not helping the very individuals who are out there, and going back and forth between programs that often don't talk to each other, are on different parts of the base, and on, and on, and on, or even competing for resources, and personnel, and

so forth.

We know that. And so we are trying in what way we can to see, as best we can, what is the nature of the problem. What works, and how is it that under those circumstances we can roll that information out to the rest of the MHS and convince them to start doing it our way.

We don't really, unfortunately, have the authority to make it happen. If you can make that happen for us, that would be great. But you get it, you understand --

MEMBER EVANS: Right. And that goes back to the recommendation that we made. We really want NICoE, or someone, to have the authority, or the ability, to train the primary care providers, behavior health providers, out there at the deck, in the little bases that we have out there, on what is the best treatment. We need to have one organization taking the lead on making sure that the providers --

CAPTAIN KASS: Yes, ma'am.

MEMBER EVANS: -- set standards.

CAPTAIN KASS: I think we hear exactly what your concerns are. And we share some of those concerns.

As we look at two different issues, because we look at the demand that is out there. As we were asked to help look at standing up NICoE satellites in these nine locations, what we hear from many people is there isn't the demand. Why are we doing this?

I would argue there is plenty of demand. We are going to be in if you build it they will come mode, without a doubt. Because it is out there.

And I think as we look too, one of the questions we asked trying to demonstrate that was going back to the other organizations that do have some responsibility for tracking this patient population, and trying to partner with DCO

and DVBIC to understand not just what are the numbers of TBIs.

But how do we tease through the numbers of how many patients, what is the TBI population, what is the PTSD population, and where do they overlap?

I would completely, wholeheartedly agree with you that we don't have that system solved for tracking who those patients are. And there are needs.

And the first step is getting these practices out to those satellite locations. But that's a building.

And one of the mantras that I've often talked about with this is we have to remove luck and location. If a service member has a problem, remove luck and location.

Get them into the system that they need to get the care that they need, no matter where they're accessing it, and so whether it's the NICoE satellites, or other

MTFs that don't have a nice pretty building.

And the building matters, but it doesn't matter as much as the system in which we're approaching the patients, having time and an agile system to spend time with patients, instead of caring more about productivity.

If we can reach out and say for that defined population this is the system of care, I think it will make a very big difference.

To your point, Captain Evans, oftentimes you will hear from all the Centers of Excellence, we have three missions, research, education, and clinical care. And then the next one will come in and say we have research, education, and clinical care.

And we argue with each other a little bit sometimes of where those boundaries are, and where they exist.

And I would completely agree with you that we need to say you've got the rose

on your chest, okay, you're it. You are the group to do this. And we want to do whatever our part is in that.

We would argue, for the most part, that what we're focusing on is the comorbid TBI and psychological health. And I think that other organizations may have a robust infrastructure for the education part for TBI, and for psychological health.

And what we ought to be doing is helping to feed content to them so that they can then go out and execute.

But as you saw, my education director, and I have one person right now, so I don't know that we're robustly resourced to do the education. But we absolutely have a responsibility for feeding content to the people who will be doing the education.

MEMBER REHBEIN: So let me circle back to the referral patterns for a moment. Because you talked about specific places where you're getting a disproportionate part

of your population from.

Is that because there really are more in those locations, or is that because the providers there are more in tune with recognizing, in their population, who could use your services.

And that brings us back to the recommendation we were making on training, if that second one is the case.

DR. KELLY: Well, we can't really say for sure without the number counting system in place that there are more of them at any given location.

What we are learning is that certain high risk individuals, or not individuals but individuals in groups that have an op tempo that is so great, and/or multiple high risk activities that they engage in continuously, much like special forces and special ops groups do, those individuals are the ones who are now raising their hands, having been through or having

colleagues come through.

And we're hearing from them virtually everybody could benefit from coming to NICoE. They all look around at each other and say, holy smokes, you've got the same experience I had. You have to go to this place and help figure it out.

And then there's a flip side of that. The providers may be more in tune with that very population and the needs of that population.

But there's something else that we struggle with a bit, and I'll share, is that the people that are the elite forces tend to understand what we do and benefit from it pretty quickly.

They're more engaged in mindfulness, self engagements, and self advocacy, and all of the kinds of things that we do. And they pick it up very quickly. Because that's the way they are. They're built like that.

But what we struggle with is the logical extension of that thinking, of the referrals, if we just go in that direction, then we become only the elite forces place.

And I, for one, really don't want that to happen. I appreciate the fact that we are understood by them best, and that they seem to benefit, and we have these wonderful relationships.

But we can't, I think, we can't afford to just be perceived as the ivory tower where, again, back to the luck and location thing, where you've got a special in, and you get to go there.

The satellites will help, I think, largely in solving that particular predicament. But in trying to answer your question, I think that it's all of the things you mentioned all wrapped up. Bob, you may have something else.

CAPTAIN KOFFMAN: Sure. If I may, next slide, I want to sort of wrap up

the idea of evidence based treatment. I think that's what many of you are really concerned about in terms of how do we provide care.

I will tell you that our secret ingredients, if you will, of providing care, it's not so much what we do. But it's how we do it.

And the ingredients really are, I mentioned education, but it is empowerment and it is advocacy, your self-advocacy.

It's not so much a passive system in terms of having a patient, seeing them, and saying here, take this. But it's actually working with the individual so that sufferer is able to navigate a very tiresome system. And keep in mind that individuals with TBI are already very resource overloaded. And so try and set them up for success as they leave.

If I may, just to address this idea of best practice when it comes to

comorbidity, I had the opportunity to work on the DoD/VA Clinical Practice Guideline Blue Ribbon Panel for PTSD. So I know what is evidence based treatment.

The problem is that there are five different guidelines, one for PTSD, one for traumatic brain injury, one for substance abuse, one for major depression or depressive disorders, and another one for anxiety disorders.

There is not one guideline that handles the intersection, or the confluence of all of these. And that's really going to be NICoE's job, is to come up with a guideline. This is not a small number. By Doctor Lu's study at the VA, individuals who have had a lot of trauma in that middle section is 42 percent of the population.

So it's a little disingenuous for us to say what's evidence-based for TBI or PTS. But an individual with all of these is

an entirely different animal.

And that's really what our charter is, is to understand this one brain concept. And it's vexing because the brain is certainly the most complicated organ in the body.

But we do realize that there is a mandate to come up with a best practice when it comes to this complicated comorbidity.

DR. DEGRABA: To also answer the question, we recognized back in 2003 or 2004 that there were a number of patients who did well, who had the diagnosis of PTSD and the diagnosis of TBI,

But there were many more who, even with the best care being given and being in the right place at the right time, in the Washington D.C. area with the National Regional Medical Center and Walter Reed having lots of resources, these patients weren't getting better with the conventional therapies that were available to them,

particularly on an outpatient basis.

And so it was becoming clear that comorbid state wasn't just an overlap of two diseases, but in fact, they were synergistic in their effect.

And so the things that we were seeing told us that there were changes in the brain, or suggested that there were changes in the brain that told us we didn't understand the full pathology of what was going on.

And so one of the advantages that we haven't talked about much here today, but I just wanted to bring to your attention, one of the advantages of the model that we're trying to build is, first and foremost, a proof of concept.

Can those patients who have that comorbid state, and not only who are not getting better, but many of them are actually continuing to deteriorate, can we change the trajectory of their recover with a high

intensity model that we've created.

And the short answer is that we have. And some of the early data that Dr. Kelly has shown you demonstrates that even within a four week period those patients who are deteriorating start to recover.

And of course our effort, and our goal in the future, is to identify those and the things that are necessary to maintain that sustainability of recovery.

But equally important is, because we were able to have a high definition evaluation of this complex patient population at one time, we're able to be able to begin to develop an understanding of the patterns of the disease state, and be able to do the research to be able to tell us, hopefully early on, who those patients are and which therapies are working.

And so some of the research that is being engaged now is being directed at not only looking at the patterns of the disease,

but now starting to put a biological construct to it.

In other words, anatomical changes on MR, physiological changes on EEG and sleep studies, and biochemical markers that may be able to tell us who's responding to therapy. So that's another advantage of the NICoE product that we hope to also add into the productivity equation of something that then, again, can be exported out to our colleagues in the MHS.

CAPTAIN KOFFMAN: The last slide addresses the issue that four weeks is really not enough time to really definitively provide any of these evidence-based treatments.

And so what we do is we identify modalities that an individual most likely will be able to respond to when he or she goes back to their home station, and make those recommendations in our very extensive discharge recommendations in summary. That

concludes --

CAPTAIN KASS: And I think --

CAPTAIN KOFFMAN: Oh, I'm sorry.

CAPTAIN KASS: Just real quick to emphasize. I'm a family physician, I'm not a behavioral house specialist, but I learn a lot from these guys.

And my understanding is that the completion of evidence-based treatment for PTSD is not super high. And part of that is because of the hard work that it is to do that.

And part of our goal, also, is to look at what can we do to get people prepared and empower them to actually engage in that, and then complete PTSD evidence-based treatment.

So I think another metric that we can look at that is if the standard for completion of evidence-based treatment across the industry is 40 percent, are we able to get people into a position where they're

ready to engage when they go back home, and bring that completion rate higher than that.

So that's something we need to look at. Because I think that is part of what you guys do, Bob.

CAPTAIN KOFFMAN: And I think that's important to realize. You say how many individuals are practicing evidence-based treatment. We could probably get to a number, but how many patients are responding to evidence-based treatment is an entirely different question.

As Captain Kass was mentioning, for prolonged exposure the gold standard for PTSD, the dropout rate is as high as 40 percent, because it's a very provocative, very difficult, intensive treatment. And we realize that at the NICoE.

And so if we can provide stress innoculation, and other self-regulatory techniques to increase the likelihood of being able successfully receive treatment,

then we've done the patient a great service.

CO-CHAIR CROCKETT JONES: Is there any equivalent agency or program being developed at the VA for a holistic approach?

CAPTAIN KOFFMAN: Not at the present time. The Tampa VA, as one of the polytrauma centers, has an inpatient project that's looking at mild TBI with some comorbidity. But truly their model, and their staffing pattern, and their processes are really quite different.

MR. DRACH: If the four week time period is not adequate, what would be your ideal time frame for treatment?

CAPTAIN KOFFMAN: Somebody else try to answer that, because I have no idea.

CAPTAIN KASS: It's one of those things we struggle with. And I know the gentleman asked us about our staffing. We're seeing 200 patients right now a year. We could see patients longer, and then see 120. And I don't think from a public health

perspective that's the right answer.

What we need to do is create the system of care where we can provide recommendations for post-NICoE care, and be assured that those post-NICoE recommendations are executed, and then get the next group in. It's sort of a Mayo Clinic approach to an evaluation.

If we spend our whole time providing the care, Captain Koffman will see quite a few less patients.

And again, my understanding is that the right time for care, again, just because you say there's ten sessions for prolonged exposure, you can't just do those in ten days. There's just got to be time in there. And so it can be months for somebody to have that time.

MR. DRACH: You may have covered this, and I may have missed it. Are you using virtual reality therapy at all?

DR. KELLY: We have a research

project that uses that at the present time. But that's not quite ready for prime time in terms of a clinical intervention at the present time.

We're very hopeful that it will be, and there are also neuroimaging correlates to that, that the organizers at University of Southern California that we're partnering with have already shown and published our benefits. You can actually see the diminished metabolic demand of the amygdala in the brain with a model that they're using. And that's our partner in this research project that we're engaged in at the present time. But again, it's truly a research, and not clinical intervention at the present time.

MEMBER PHILLIPS: Along those lines, are you finding any biomarkers, changes in cortisol levels, or even PET identification changes there?

DR. KELLY: Tom will go into some

detail on that. But the answer is we're looking at it. Not anybody has it specifically, except in maybe a couple of early studies. But we are directly engaged in that project, and one of them in particular that Tom's engaged in.

DR. DEGRABA: Yes, and that is one of the keys that we hope to be able to start to unlock. If you have the concept of patients coming in, in a perturbed state, in a state that is not well, we talk about getting to wellness.

The question is what is wellness, and how do you measure that. Many times we use the scales to tell us that the patients are doing better. Our goal is to look at some changes in the physiological parameters as well as some biomarkers.

We're partnering right now with a group at Harvard, Herb Benson's group at Harvard, to take a look at epigenetics.

And a protocol that we're

currently writing for IRB approval is to look at the changes in genes with the utilization of wellness approach, mindfullness based and wellness approaches in our patients with post traumatic stress, to be able to identify those pathophysiological functions and those biochemical functions that are changed by the utilization of these therapies.

And this is the type of methodology that we anticipate using at the NICoE to be able to tell us more about what is those things that we think are directed towards wellness.

Some of the early data that has been found by their group has demonstrated changes using these mindfulness techniques in PTSD in inflammatory mediators, and inflammatory markers, as well as increase in mitochondrial respiratory chain activity, so actual increase in energy.

So when people say they use meditation to improve their energy, this may

actually be that biological construct. And we want to measure that in our patients so we can have a better understanding of biologically what we're doing for the patients as we utilize these techniques.

MEMBER PHILLIPS: The research indicators seem to be that's a direction to go into. Unfortunately, I wish we had a genetic profile on everybody just coming in before, so we can create some standards, just like we know blood pressure, and cholesterol levels. We're getting there. It's getting cheaper to do the genome.

DR. KELLY: And the longitudinal projects that are up and running are, in some ways, banking blood and so forth, so that you can actually, potentially down the road, do that very thing. But we're not quite at that stage of the science yet.

DR. DEGRABA: The other thing we want to engage in, and we are engaged in, that will hopefully move the field along

faster, is to partner with other agencies.

There's an initiative called FITBIR, the Federal Interagency Traumatic Brain Injury Research Working Group, who have been working since December of 2009 to create a national TBI psychological health database.

I sit on the steering committee for that body. And our interest is to collaborate with our colleagues at NIH, VA, and CDC, along with the DoD, to develop that database. We have the first version of that database. It currently is available right now.

Our goal is to try to create a data dictionary, so that when people do research in TBI across the country it doesn't matter whether it's DoD, whether it's academic partners, that the same language and the same types of tests, or a sufficient number of tests, are used so that data can be put into the database so that we can start capturing data.

As you know, looking at genetic data requires large numbers. And any one group would have a hard time filling that need.

But collectively, if we have the correct model to be able to capture that data, then we can make those advances. And we're dedicated in part of that effort to try to get that project launched now.

MEMBER EUDY: In regards to MTBI, as you've mentioned in your brief, I'm asking specifically for pre-NICoE. We had mentioned this at Fort Carson talking about the concussive care recovery centers.

And as the NICoE is seen as the knowledge base for further treatment down the road, have the services come to you, or do you go to the services helping them to standardize the care received at those concussive recovery care centers?

Because I know, across OEF for instance, at each location those quantitative

reasons for holding someone can be different at one location to another, based service-specific. While one may be managed by a PT, another may be managed by an TO, or neuropsych, whatever have you.

But I'm just wondering NICoE's involvement in that phase, since we're getting closer and closer to battlefield level of identification of MTBI, but treatment options as well.

DR. KELLY: Each of us here on the panel has been involved in helping with the determination of what those approaches should be, both in OEF and CONUS locations.

And so we're partnering with the very organizations that you're talking about. Fort Carson is one of them that I know best, because I'm on the faculty at the University of Colorado right up the road. And so I've engaged with them even before I took this job four years ago.

The truth of the matter is

everybody, just like you're saying, has a little different wrinkle.

And except for the fact that we are building these uniform data sets in order to suggest that there are specific approaches to diagnosis, and categorizations of diagnosis that should be looked at uniformly, and then we can measure the interventions that are useful under those circumstances, without that being the basic common denominator we're not going to get anywhere.

And so the NICoE influence has been engaged with us as individuals with the thinking across the MHS with the documents that you're aware of, and with the very organizations.

The problem is, even within the MHS, there isn't one uniform way of doing all of that, as you're pointing out.

And what we're trying to do is suggest that this intensive model for the individuals with that comorbid state that

we're still going to figure out, as best we can, is really the approach that ought to be rolled out in some other locations. And the satellites will help us do that.

MS. DAILEY: And Tech Sergeant Eudy, that's also a good question for the DCoE for psychological health and TBI. They probably have a better grounding on what they're doing to standardize that. And I think it's more in their lane too.

MEMBER EUDY: Yes, I just wanted to bring it up in reference to NICoE and everything, as far as knowledge resources and oversight of --

MS. DAILEY: But hold on to that too. Because you'll get a good answer from the PH and TBI guys tomorrow.

CAPTAIN KOFFMAN: When you do speak with DCoE, one area of very interesting and perhaps fruitful discussion is the utility of various CAM modalities, complementary and alternative medicine, or

now just all complimentary medicine, in terms of everything from sleep, to pain, to wellness in recovery for this population.

I know the various concussion recovery centers downrange utilize different CAM modalities. Everyone has their own idea as to what works within the CAM world. So I think that would be an interesting discussion to have with DCoE.

MEMBER EVANS: And Sara, I have to tell you the reason that we're trying to get NICoE to take the lead on a lot of this is because we hear from the patient how successful you and your staff are in treating PTSD, mild TBI, and how they have really, really, they do go back out and tell their friends.

And so it's by word of mouth, that they know your success. So we've had patients at Walter Reed Campus that complain that they couldn't get into NICoE, as you well know.

And so I think you have a really successful program. I think what the Recovering Warrior Task Force wants to do is try to get you more patients over there.

And then ensure how do we get the satellites to be, how do we get the patients to that type of care so that we can see more of a success rate with treating. But it's a wonderful program.

CAPTAIN KASS: Yes, thank you. I think that what's interesting is I've been in this job about a year and a half.

And one of the first things that I felt was really important for us to do to succeed, in again this influence in improvements on the quality of care, is to create partnerships across MHS to make sure that we're seen as a part of that Military Health System team.

Because unfortunately, success sometimes can put you at odds with other people. Because a lot of people want to wait

until there's a lot of evidence of what's working before they start to institute changes.

And I don't completely disagree with that. But it takes an awful long time sometimes to collect as much evidence as people want to change.

And so as we partner with, for instance, even the satellite locations, honestly there's sometimes a little bit of resistance. We think we've got this, why do we have to do it your way.

And I think one of the challenges that we face is that -- I have great clinicians who work at the NICoE, there's no doubt about it, and the equipment is cool -- but really, I think, one of the most important differences is that we get to work under a different health system.

We get to not be stuck in 15 minute appointments, and a scheduling system that doesn't allow that really agile, timely

access to care.

And so where we're able to say look to do it the way NICoE's doing it, or how can we export these things, we can't just ask them to do what we're doing without giving them all of the other support that we've been given to do what we do.

Because these are caring, compassionate providers all across MHS. But they're being hit with a 15 minute appointment, and get them through, and get him through.

And that's just not for the complex patient. That's not going to work. The old system isn't going to work. So it's really about a system change, is what we need to look at to really affect a change, I think.

MEMBER REHBEIN: I'm going to go back to my question about how you get most of your --

CAPTAIN KASS: Patients?

MEMBER REHBEIN: -- patients, for lack of a better word. Because what I'm hearing here now, frankly, disappoints me as far as the health care system is concerned.

Because what I hear a number of people saying is that it is the people suffering that are passing the word amongst themselves, and recruiting each other.

And then having, maybe I'm going to use too strong a word here, but then having to almost force their way past their local provider to get to you.

DR. KELLY: Sir, in fairness, it isn't quite like that. Because they don't get to us unless there is a primary care provider that makes the connection for us.

MEMBER REHBEIN: But the most effective way, I think, to do this, would be for that local provider to be looking for people to come into your program.

And it sounds like the people are having to go to the provider to try to

convince the provider to get them into your program.

DR. KELLY: We're still fairly young, and you can imagine that the awareness of who we are and what we can do is seeping through and getting out there.

And there are places where the primary care provider is, in fact, doing that, just as you're saying.

But the other piece of it is that they're also handling so many other kinds of things that it's really not entirely, the system isn't just built properly for that to work right under the circumstances.

I don't have a good answer for how it ought to be. But it's going to have to be a combination of people saying, look, I've got a problem here, breaking through stigma and being able to say, yes, you know what, I need that. I now know I need that, and actually then influencing or convincing, as you say, the system to get them the care

that they need.

Now one of the things, speaking to the earlier very forward in theater approach to this that Generals Corelli and Amos years ago advocated, was that if we think you had a TBI, something happened in theater, you're going to get evaluated right here and now.

And they look do those of us who've been doing it in the sports community for years and said we want it that way. We want it done like you guys do it standing on the sidelines.

And so what happens there is it's not even the clinicians, or the patients raising their hands. It's a commander, it's a buddy, it's a whoever, that says you are going to get evaluated, because it says so, right here.

This is the expectation in what had been the DTM, and is now a DoDI for the concussion management in theater.

That's better than we have in the civilian sector anywhere, including the NFL, which is, as you can imagine, kind of squeamish about this whole idea about whether they take the quarterback out or not, and lose the game.

So I think that in many ways the DoD, with its implementation of the kinds of forward thinking, and forward in life, all the way into the war zone, approach to this is extraordinarily positive.

I've been involved to some extent, and Bob's been there twice or three times, I've been there once, in looking at how this works and building the programs and the systems around that.

It's something that I think if we can take that and pull it into the CONUS locations, and have that kind of thinking infiltrate how we do it here, then we'll get where you're talking about.

And in fact, just so you know

about this, tomorrow you're going to see DCoE. And they are building a CONUS project that will have an equivalent, if you will.

My understanding is that it'll be equivalent to that in theater approach to how do you manage concussion when you think it may have happened, think it may have happened. Get that person the evaluation they need.

MEMBER REHBEIN: If you want the poster child for that you'll talk to Dale Earnhardt Jr. He voluntarily took himself out of the race car to get tested, and wound up not driving.

MS. DAILEY: And ladies and gentlemen, we do need to wrap. We've added 30 minutes to this and let the questions flow. But please wrap if you've got one more question.

CO-CHAIR CROCKETT JONES: Thank you very much. I know you obviously see we have a lot of interest here. And so thank

you very much for coming and talking to us.

DR. KELLY: Thank you all for your interest and attention, and for staying late with us in support. Yes, it's wonderful. Thank you.

CO-CHAIR CROCKETT JONES: And I think, do we have any business left for the day, or we'll be back tomorrow morning?

MS. DAILEY: We'll be back tomorrow morning, ladies and gentlemen, at 8 o'clock. And we'll start with public forum. And following that will be a review of our installation visit. So see you all here tomorrow morning, thank you.

(Whereupon, the above-entitled matter was concluded at 5:00 p.m.)