U.S. DEPARTMENT OF DEFENSE

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

BUSINESS MEETING

TUESDAY
APRIL 2, 2013

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

PRESENT
VADM MATTHEW L. NATHAN, M.D., USN, DoD Co-Chair
SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
JUSTIN CONSTANTINE, J.D., Member
CSM STEVEN D. DEJONG, ARNG, Member
RONALD DRACH, Member
TSGT ALEX T. EUDY, USAF & SOCOM, Member
CAPT CONSTANCE J. EVANS, USN, Member
KAREN T. MALEBRANCHE, RN, MSN, CNS, Member
STEVEN J. PHILLIPS, M.D., Member
DAVID REHBEIN, M.S., Member

ALSO PRESENT
DENISE F. DAILEY, PMP, Executive Director,
Designated Federal Officer
ANNE E. SOBOTA, Alternate Designated Federal Officer
MARY CARSTENSEN, Senior Advisor to the Secretary of the Department of Veterans Affairs
COL ANDREA CRUNKHORN, Office of the Assistant Secretary of Defense for Health Affairs
KAREN GUICE, MD, MPP, Principal Deputy Assistant Secretary of Defense for Health Affairs
REGINA M. JULIAN, MHA, MBA, FAHCE, Director, Military Health System Patient Centered Medical Home Division
WARREN LOCKETTE, MD, Deputy Assistant Secretary of Defense for Clinical and Program Policy
TERRY RAUCH, MD, Office of the Assistant Secretary of Defense for Health Affairs
JOSE D. RIOJAS, Interim Chief of Staff, Department of Veterans Affairs
MAJOR GENERAL DOUGLAS J. ROBB, Joint Staff Surgeon
TIMOTHY J. WARD, Deputy Director, Program Analysis and Evaluation Directorate, Bureau of Medicine and Surgery
A-G-E-N-D-A

Site Visit After-Action Review .............. 6

Office of the Assistant Secretary of Defense for Health Affairs Centers of Excellence Oversight Board ........................................ 78

Dr. Warren Lockette, SES

Office of the Assistant Secretary of Defense for Health Affairs Medical Home ............ 142

Ms. Regina Julian

Office of the Assistant Secretary of Defense for Health Affairs Urogenital Injuries .... 195

Dr. Terry Rauch and Colonel Andrea Crunkhorn

Department of the Navy M81 Engineering Process Improvements Using Industrial Approaches for Navy IDES and Comprehensive Combat and Complex Casualty Care (C5) ......................... 243

Mr. Timothy Ward

Office of the Assistant Secretary of Defense for Health Affairs Defense Health Agency Executive Office of Transition ................. 316

Major General Douglas Robb

VA-DoD Interagency Care and Coordination Committee (IC3) .......................... 387

Dr. Karen Guice and Mr. Joe Riojas, SES

Wrap-up, Preparation for Day 2 .......... 433
8:12 a.m.

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

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

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

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

MEMBER REHBEIN: Dave Rehbein, one of the seven non-DoD members.
MEMBER EVANS: Captain Constance Evans, Bureau of Medicine.

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

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

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

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

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

MEMBER DRACH: Ron Drach, non-DoD member.

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

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

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

During the west coast visits we had an opportunity to conduct recovering warrior focus groups at each location. We also discussed topics such as caregiver support,
non-medical case management, the IDES process, and TBI and PTSD services within the recovering warrior leadership.

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

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

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

We found that whether they were split up on areas geographically based by TRICARE region and adapting nurse case management, across TRICARE regions or sourcing the closest RCC due to them coming out of active duty bases.
We found that there were Cat 2 and Cat 3 servicemembers that require both medical and non-medical case management but were getting it piecemealed together conducted by their Guard units themselves.

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

MEMBER EVANS: Additionally we -- great visit, a wonderful facility and the Guard definitely trying to reach out to the members. But the lack of, again, the case management oversight and RCC. And then collaboration between the Guard, Air Guard and VA. That was interesting how they just recently started that collaboration process. And the VA, when we had an end brief by the VA seemed to feel as though DoD was very hesitant to get the
patients to them. They mentioned one service specifically but overall they were still trying to bring that collaboration together between the Guard and VA.

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

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

MEMBER EUDY: One of the key best practices I wanted to mention was the call center that they had for behavioral health concerns. Almost used as a crisis management where across the entire state, active Guard Reserve component anybody could call in and then be directed either to receive some local care or find the closest
mental health provider, behavioral health provider. And everyone acknowledged that. Even in the focus groups everyone said this resource is great, being able to call in. It's manned 24 hours a day. They said that was a great resource. And it was acknowledged by commanders also.

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

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

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

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

So if I could just ask if you had to -- and we'll cultivate all these as we progress to the recommendations over the summer. But off the cuff if you had to make one recommendation about what you saw there that they need from a
systems fix or they need an issue. You've talked about some of the good things they've had, and they had some good practices. But what's the wolf closest to the sled then at that place?

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

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

MEMBER EUDY: Correct, sir. One of the things that we continuously ask, especially at the Guard sites, is awareness of both TSGLI and SCAADL. When you have these Cat 3
servicemembers that are on that weekend duty and it ends up occurring.

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

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

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

I think that that's almost like an educational component for leadership that I'm not sure how we, how that gets transmitted to them. But I think that Guard leadership needs
to get a concept, an educational concept of transition plans.

CO-CHAIR NATHAN: Thank you.

Comments on Joint Forces Headquarters in Iowa?

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

(Laughter.)

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

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

And if I may speculate for a moment, the Army behavioral health folks were very highly skilled, very qualified doctors to include a psychiatrist, but they came to drill
with the Iowa Guard from a long distance whereas
the Air Guard people were embedded in the
community. And I think that kind of personal
contact with the behavioral health community in
the state was what was driving that big
difference. Because the Army folks were not
embedded in that community. They didn't have
the kind of personal connections and I think we
all know just how much personal connections
drive those sorts of things.

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

I want to make a couple of comments
to broaden some discussion here for a little bit
because not just in these three visits but in
some prior visits. Anecdotally we hear about
people coming into some of the CBWTUs that the
staff doesn't think are ready for that.
We talked to -- I talked to one soldier who said he was put in a CBWTU at his urging and it turned out later he wasn't ready. There is a group out there --

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

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

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

I just want to make a statement for the record that I hope when it comes recommendation time that we can devote some focus to making sure that people are assigned based on their medical needs, that where their
location assignment is being based on medical needs and not based on financial pressures, not based on a number of things.

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

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

MEMBER REHBEIN: Yes.

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

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

Once we left Iowa and came home Ms.
Dailey communicated that disconnect back to the Guard and to the VA both through some email to make, to urge them to close this disconnect. But that was about all we could do at that point because of the -- because of the separate locations and the out-brief actually coming in the middle before we had a complete picture.

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

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

When we met with the VA the impression I had was that they thought they were doing okay and that they weren't -- they didn't feel that they were obligated to report back all the details of the care and treatment that they provided, that it was up to the servicemember to
report back to their command. This was especially glaring in behavioral health issues where the VA felt that, well, I mean we cannot report back or we don't report back some major behavioral health issues to the command, that it's up to the command to figure that out. So there was this big disconnect, this big disconnect.

A couple of other issues related to the Guard behavioral health, Army Guard, is -- and I made some calls because I practiced in Iowa. There are two psychiatrists who trained in Iowa and then moved to I believe New York State who fly back every month to provide behavioral health care. And I don't know whether that's good, bad, or indifferent, but that seems a little -- a little obtuse basically to do something like that. Whereas the Air Guard said they had a list of 150 providers that they had no trouble getting their folks in to see. So that's something that needs to be looked at a little further.
The other areas that I noticed in Iowa which we see everywhere is that the families, especially the remote families and caregivers, are just out of the loop again. They're out of the information loop. They don't really connect. They don't know what's going on with their servicemember and that's an issue. And they actually said we wish they could be more proactive. The HIPAA rules again seem to be interfering and so forth.

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

And the final thing that I wanted to mention is that the medical packet responsibilities and the preparation of those seem to vary by the medical treatment facility. And sometimes these packets sit for more than 90 days and then they have to -- a lot of the testing
has to be redone because they've expired.

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

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

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

MEMBER DEJONG: Okay.

MEMBER REHBEIN: I believe there are VA people there but I doubt very much that
they're all at the VA facilities just simply because of the numbers, because of that brigade that deployed and came back. I don't think it's at the VA facilities.

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

MEMBER PHILLIPS: This wasn't -- my impression was this wasn't the case in Iowa. The reservist or the Guard would stand down but they'd still be drilling periodically. But they'd go to the VA for care, especially behavioral health care. And they would express some problems. The VA would not report these
issues. And I think perhaps this was related to the suicides that may or may not have been prevented. They would not express the behavioral health issues, report them back to the command. So these folks were just being sort of treated at the VA without anyone following up. And yet they were still drilling.

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

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

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

It sounds like at the minimum we're going to need some -- maybe a recommendation
about creating a steering committee or something, a matrix committee with representatives from all those places to get together and figure out how to better crosswalk what they're doing.

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

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

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

MEMBER EUDY: I think most of our concerns, and correct me if I'm wrong, Mr.
Rehbein, were addressed in the previous visits. I don't think there was anything outstanding that we saw at Arkansas that wasn't occurring at the other JFHQ facilities. MEMBER

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

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

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

CO-CHAIR NATHAN: What sort of footprint do they have in Arkansas size-wise?
Did you get a feel for whether it's robust or a small, discrete compared to your other visits, compared to the other experiences?

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

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

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

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

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

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

But they are managing large numbers on the Guard side for line of duties. It's extensive. And again, the Guard, National Guard Bureau has put a contract in place to manage those still open line of duties.
All of them run, I think National Guard at Carolina was the largest one running at about 12,000, 10,000 Guardsmen, Army Guardsmen, 2,000 Air Guard. Iowa and Arkansas were running about total 8,000 Guardsmen, 6,000 Army, 2,000 Guardsmen, Air Guard. So it was -- you saw a pretty big, robust organization in North Carolina and a little, and a smaller cohort of Guardsmen in Iowa and Arkansas.

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

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

MEMBER REHBEIN: Arkansas. The state surgeon and the director of psychological
health, both the Army and the Air side, that that was their experience. And their civilian providers had not received as much treatment in the evidence-based -- as much training in the evidence-based treatments as they needed, as they felt they needed to have.

CO-CHAIR NATHAN: All right.

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

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

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

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

I think we all at this table in this room recognize the pivotal role that the civilian, private sector, academic, DoD, VA
partnership has to provide to care for these folks. We're not going to be able to do it alone in the MTFs. We're not going to be able to do it alone in the VA system.

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

I recognize some people just make a practice of treating folks with mild anxiety or obsessive-compulsive disease, but a community can't tolerate that. A community is going to have to have an ambient level of expertise in treating post-traumatic stress, mild TBI and all the anxieties associated with long deployments and with long service. Otherwise these folks are going to wash up on their shores in homelessness and other things. So it really behooves the community to get behind things.
So I think this kind of high-altitude views that you all provide are very helpful in trying to shape and maybe reinforce community integration among the various sectors.

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

MEMBER PHILLIPS: Kind of an editorial comment, just my own personal impression. I've spoken to a number of psychiatrist and psychologist friends of mine, civilians, and I hear repeatedly that they've offered programs and packages to Guard and
Reserve and DoD facilities. And they said that there's a lot of -- not a lot, but there's resistance to accepting the civilian plans and programs. And I think it has to do perhaps with education, with not following DoD principles and so forth. I think both sides need to kind of look at what's going on and harmonize their efforts.

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

Part of is that sometimes the civilians say I'd like to offer you a Friday afternoon every week to help see your patients. Now there will be some weeks I can't and so. I've personally witnessed that where good intentioned civilian providers want to help us but they can't commit to a regular schedule or can't commit to a regular donation of time. And so it's almost worse putting a patient into their
care and then all of a sudden having the patient left alone to where we have to pick it up again. So that's some of the problem.

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

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

MS. DAILEY: In one of the civilian inroads, the point of contact that's been tasked by the National Guard Bureau in their contract, in their statement of work to develop that network of civilian providers is the directors
of psychological health in each state.

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

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

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

Joint Forces Headquarters North Carolina has a very well-developed mental health program. Alex mentioned it. They led their discussions with us in mental health with we spend $2 million a year out of our operational funds to support this mental health, this
integrated mental health. It's the only place we've seen it. And they led with the statement we spend $2 million a year. I'd rather give up a tank or an aircraft engine and keep these resources in my state.

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

That language and that channel has developed with the universities. It's not as well developed between the National Guard Headquarters and any of the VAs to date. It's a real specific set of requirements that they need to do those things, line of duties, MEB packages, evidence for ratings for the VA. And
so they can set up that and control that with the universities through their MOAs.

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

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

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

And I think we need to set up standards and practices that these systems can work together and move back and forth and harmonize. So that the sum will be greater than the parts.
CO-CHAIR NATHAN: I have a four-letter word for you that's going to be pivotal to that and it's IEHR, the integrated electronic health record. And if we can get that going and there's great push as you know from the executive branch and there's some pull by the military, the VA and the DoD. But if we can crack that nut and get to the point that would solve the problems where the VA sees a patient and doesn't really have an incentive to try to confer back the information on the patient. It would be there for the command. Under privacy rules based on what you can see and can't see depending on who's looking at the mental health record. But that's really the crux of it.

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

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

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

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

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

They had opted to have a program where if one of their PTSD treatment programs, if someone dropped out it initiated a contact specifically from providers. And since we had
heard in other places and sort of statistically that the dropout was connected to poorer outcomes a response -- this is the first place we've seen a specific response that says if someone drops out we find out why.

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

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

It's unclear. There are two different philosophies of what a nurse case manager does. One is that nurse case managers make appointments and I was not super clear on when the nurse case manager doesn't make appointments what the other collateral duties were.
And I think that lacking the appointment-making that the servicemembers didn't really know what their nurse case manager did either. They seemed sight unseen. They were not the go-to person and they were this nebulous, they were there but nobody knew what they did or why they should contact them.

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

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

It was kind of surprising. That was the first place we've ever heard that. But they
were very I thought more engaged with their, what did they call them there? Their squad, their line person.

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

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

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

CO-CHAIR NATHAN: A couple of questions then. Because you're correct, almost
everywhere the nurse case managers are celebrated not only by the command but by the recovering warriors themselves, and the families. And the families.

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

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

CO-CHAIR CROCKETT-JONES: Yes, we did. We saw that there were sometimes big delays in folks getting their own appointments. That the only function that we saw the nurse case
manager have was when someone had tried repeatedly, and it had to be repeatedly. It couldn't be just a one-time thing. They would go back to the nurse case manager and say they told me it will be 6 weeks. And then the nurse case manager might step in, trouble-shoot and get that appointment time down to something more reasonable.

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

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

CO-CHAIR NATHAN: You all had been
there? The first time? Okay. Again, just this is sort of inside baseball. About a year ago Pendleton really wrestled with primary care for their wounded warriors. The warrior, the Wounded Warrior Regiment believed it was up to the MTF to be providing primary care or sending primary care providers to the regiment for help. And the MTF believed no, this is a Marine Corps organic unit. You should be hiring your own, paying for your own primary care thing.

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

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

Now, I did hear one best practice which was they've got a pilot study where they're
measuring what they do in their behavioral health patients. They're looking at the results. They're sending out to everybody on the net what works and what doesn't work. And so they're one of the few places that I think is trying to find out, try something, see if it works, get the results and then share those results with everybody on the net so that you change the level of practice which is something that's sorely needed. So I think that's goodness.

Any other comments about Pendleton?

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

We've had problems with Pendleton and the problem is that case managers are part of the team but again the RCCs, they work for the
Marine Corps, they work for the regiment. And that's who they turn to as the primary go-to, their RCCs. And so even my own Marine counterpart on the team here, we've had that conversation.

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

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

And the case managers have expressed some concerns at Pendleton. The 26 to 1 ratio we, if you look at BUMED's instruction they are well within the ratio. If you look at Navy Medicine West instruction they should be 20 to 1. And so we've been on the phone with them to
say if you have an instruction that says 20 to 1 for your region then you have to be 20 to 1. And so they've realized that after the visit.

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

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

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

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

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

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

CO-CHAIR CROCKETT-JONES: Yes.

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

CO-CHAIR CROCKETT-JONES: One of
the things I recall from the focus groups, from
the servicemember focus groups was that when
they got a section leader who was -- when they
could keep a section leader for a while that
section leader worked really well for them. You
know, when they're -- but that there was some
turnover issues so that they felt just when they
were starting to get into a groove of transition
and comfort, trust issues handled, then they'd
lose people. So continuity was definitely
something I recall from the servicemember group.

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

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

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

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

I am remembering correctly, aren't I?

MEMBER EUDY: Yes, ma'am.

Regarding -- and this whole approach in all services for section leader, squad leader, cadre members and command members. I would ask the task force to look at creating a recommendation for those that are in those specific positions whether that's a leadership position all the way down to the line NCOs.
For the Army it's having a combat patch on your right shoulder, giving a delineation amongst your brothers and sisters that I've been there and I've deployed. I've seen those things.

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

CO-CHAIR NATHAN: Good point.

Anything else?

MS. DAILEY: Let me do a time hack here, ladies and gentlemen. We can go into your break at 9:15 if you'd like but we do have a hard stop at 9:30 to bring in Dr. Lockette. So we are
currently at time line about 5 after, 10 after, 7 after. So pace yourselves, please.

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

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

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

I've often wondered personally about the east and the west model and how that best works for reservists. We did get some feedback from them that a lot of them just, they
They want to go home. They want to get care in their home community, whether that's VA or whether that's civilian side, they just, they want to go home.

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

They provide transportation to appointments but because of logistical, or because of liabilities they do not provide transportation from housing to anywhere else. So they are required to -- and none of them really have a car unless they bought it on their own. They're required to get themselves from the dining facility home and from home to their place of duty to make it to their appointments on their own.
And whether that's on a crutch, whether that's on wheelchairs, whether that's on -- however they have to do it, a lot of times it's a half mile or more on crutches.

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

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

MEMBER EUDY: Sergeant Major, to follow up on your comment. We had discussed this while we were there. One way I think it could be recommendation-wise is as the Army has done with those soldiers that are in theIDES population, opening up SFAC services. If some
of the same counter services of Safe Harbor were available for those servicemembers at the med hold east and west because the majority of them will end up going through the IDES process. And for some of them it is an extended period of time so they're not finding these resources out on their own and they're dependent on a yeoman or a med NCO or a med chief to facilitate these questions when that individual isn't trained to the level that the folks at Safe Harbor are.

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

And I think the ADA-compliance thing was really concerning because there were stairs, there are like three flights of stairs. And for some people that's just not possible for them.
I mean they obviously did it. And then I think having one of them be a driver.

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

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

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

MEMBER DRACH: The -- TRICARE came
up as being very confusing to the reservist in terms of when it kicks in and when it kicks out.

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

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

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

And one of the concerns that the senior reservist brought up was being so far away from their families. There was only, I think there was about 13 in the focus group and I think only one had his family members with him in San
Diego. And several of them had commented about they'd like to be transferred back closer to home. And that wasn't happening.

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

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

But again, I think it was -- I think the Navy looks at this -- I'm not speaking on
behalf of the Navy in my capacity now, but I think they look at this as we have a very small group of people.

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

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

Because I think some of these folks get excited about going to San Diego thinking I'll be there a few months. How bad can it be. I'll be in a beautiful garden spot of the
country. And then after 6 to 9 months I've peaked on the fun meter. I want to be back with my family or whatever. So I really think the one thing they can do there.

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

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

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

CO-CHAIR CROCKETT-JONES: Can I ask
a question? What was the average length of stay for those folks?

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

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

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

But I'm thinking there is a serious disconnect for people outside of medical expertise and even anyone who -- I think there is a serious disconnect to say we're going to keep you here for 6 months to a year but you're not that serious. You're not serious enough to warrant extra resources. I think that that is a serious conflict of purpose.
CO-CHAIR NATHAN: But Suzanne, I think that it's not just medically driven, it's administratively driven. In other words unlike somebody who works in a private sector and gets hurt these folks are being evaluated for whether they can return to duty or not. And so what happens is they may have an orthopedic injury that is borderline. Maybe they can get it to the point of returning to duty, maybe they can't.

Part of our problem is -- and I agree with you. I think it's a failed concept where we say we're going to move you from your home across the country and because of administrative reasons we're going to house you as an outpatient while we work through 6 to 9 months your leg injury or perhaps your TBI or your PTS and decide in 6 to 9 months whether you're able to return to duty because you want to. Or we're going to put you in the LOD system and we're going to get you in theIDES system and we're going to give you a medical disability and/or a medical retirement.
So I think a lot of the reasons for the military people to spin their wheels for so long is we're sitting there trying to decide if we can get them back in or back out. The byproduct of that is we leave these folks in a sort of isolated environment without a lot of creature comforts and accoutrements.

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

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

I think the biggest problem is we just compartmentalize these folks away from
their families and away from their support systems. And then we tell them it's going to take a while.

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

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

And again, we saw some people in all these places which were just singing the praises of the place and felt that it basically saved their life
or gave them a new lease on life. But the overarching sentiment was just not happy when I got here and they haven't done anything to make me any happier. And so I think that the concept that's been mentioned that I really believe is a good one is how do we get these people back in the process closer to home.

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

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

I guess the one thing that this place and others though, some places more than others is the orientation. And I think you mentioned
that of who does what. Like what is an RCC, what is a nurse case manager. What is a behavioral health -- is that the person to go to. It seemed to be the person to go to because they were the most involved. But I do think, I was surprised at that model working so well and that they seemed to be major engaged.

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

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

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

If you're going to need an extended plan of care regardless of which physician is
providing that, that you go on a minimum day's
worth of orders. And I think we need to look on
that as a task force to establish that so we don't
run into all the issues that come with falling
off of orders.

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

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

MEMBER MALEBRANCHE: Well, I think
part of this was they had just all moved into this
large, new facility. And they had not yet
coalesced in a lot of areas because it was still
new and there wasn't like a lot of signage even
where people were and they were still waiting for
some physicians. I think that was part of it. So they had not all worked together. The groups that were in the past still did. So to even know that oh yes, I think they're down there but we just got here. So I think that was a huge part of it. But then too it was such a large group that you wonder now in the future what that's going to mean. Is it going to stay this way or will they start doing some of that. So I think the same groups that worked well together before are probably going to continue. But you need to -- we don't know how the other pieces might.

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

But there was some discussion against the members of because their population is so high, it's the largest WTB that's within
the nation, and their population of behavioral health is so high, you know, we're looking at the resources and the availability of what they have there and making sure that they can properly commit to that large of a group of behavioral health. So not exactly sure why it fell in like that but that seems to be their population.

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

And the other thing, I might sound like a broken record, but family members felt largely uninformed and leadership always
convinced that they were reaching all the family members. This is almost universal. Everywhere we've gone leadership is pretty certain that they have great contact with family members and family members that we talk to feel largely uncontacted.

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

CO-CHAIR NATHAN: That's a great point. If you could predict almost one thing you could do ahead of time at any of these visits it would be to tell the command you don't have the connectivity with the families that you think you do. And because most of them are all shocked at the end.
When they hear the family focus groups are saying nobody cares about me, or nobody contacts me, or nobody lets me know what's going on they're stunned. And a lot of times I believe it's because they're relying too heavily upon the active duty member, upon the warrior themselves to be the conduit to the family. And they underestimate, or overestimate actually that the warrior is connecting with the family. And the warrior is petitioning the family.

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

In the interest of time we'll table Elmendorf for right now and maybe come back to it later today or find some time in the morning. Let's take 10 minutes and we'll make it up. I guarantee you, Denise, we'll make it up as the day goes on.
(Whereupon, the foregoing matter went off the record at 9:29 a.m. and went back on the record at 9:38 a.m.)

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

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

So, I'm an academic so I'm used to
talking and giving conferences as opposed to a forum such as this. So please forgive me if I have any faux pas here.

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

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

So the Centers of Excellence Oversight Board has actually been reviewing a number of programs and I think to have a discussion about how the centers of excellence or the CoEs function there also needs to be a perspective of what these centers of excellence
So the questions from the task force are listed here. You know these. And over the course of my talk I will highlight the question to make sure that I answer each specific question that you have given.

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

So, within the federal milieu if you were to talk to people about centers of excellence there is not a common understanding as to what they are. So for example, if you go to the National Institutes of Health they will tell you as a federal agency they manage centers of excellence. And they have very specific centers of excellence that have been congressionally mandated much in the way that DoD has. But their primary purpose is research. So these are the centers of excellence that have been established by
statutory mandate for the National Institutes of Health. So when you come to DoD depending upon to whom you are speaking a center of excellence, a person may have a predisposed mind-set that the program is primarily the management of a research portfolio.

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

So you already have two. You have a research center of excellence focus, you have a clinical disease center of excellence. And
the reasons why these centers are engendered by each of these parent organizations is given here, either to improve the clinical quality of care or to improve the research.

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

So as an empirical scientist having viewed these types of centers of excellence the
first question that we had or we should ask is when we're told to establish a center of excellence or when someone requests the designation of center of excellence is it helpful to be a center of excellence.

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

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

Well, it's interesting. If you look at -- this paper was published in Cancer in 2005. If you look at the care that you get when you go to a cancer center of excellence you can show better surgical morbidity for operative procedures that you've had related to cancer.
But what's interesting is if you look at the same cohort of patients the outcome, the overall cancer morbidity and mortality is not improved. So do we say that these centers of excellence have been effective?

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

In this paper that was published in the Journal of the American Medical Association just a couple of weeks ago it turns out that your outcome does not appear to be any better if you have your surgery done at a hospital that has
been designated as a center of excellence as opposed to one that has not been.

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

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

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

And I just want to spend some time on this slide because this shows the difference between centers of excellence within the
Military Health System and that which is happening in the rest of the country.

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

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

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

Sometimes we have a center of excellence that was driven primarily by
congressional interest. But it's not always clear what the need or the specific need that was driving the congressional interest that resulted in statutory language.

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

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

But I think the most important role that we have is to ensure that the centers of excellence are a value proposition, that they're meeting a definitive operational requirement, that it is improving the healthcare of the
service member, and that it's helping that these services be done in a cost-effective manner.

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

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

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

We also asked the services to let us know whether they think there is a particular unmet need that would benefit from having a critical mass that leads to a center of
Then I'll talk about some of the other activities we have such as reviewing the leadership of the centers of excellence through the services' executive agents and the unknowns that are coming in the future as we move to a new health agency.

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

DR. LOCKETTE: Sure.

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

DR. LOCKETTE: Well, I'm not sure. I would think primarily it would be the congressionally mandated centers of excellence because those resulted from particular concerns of the wounded warriors. So I will comment upon that but I want to make sure that in terms of the Centers of Excellence Oversight Board that we
understand the full activity of what's been occupying our time as you'll see in the next couple of slides.

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

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

And then once that charter has been established through that center of excellence's internal workings and has the approval of the executive agent it comes to the Centers of Excellence Oversight Board where we want to make
sure that there was the appropriate service buy-in from each of the services for the centers.

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

And again, this is the focus today but I do want the Oversight Board to understand that. And I think it's important for the public to know that if there are other areas, and particularly among wounded warrior care, that are not receiving attention that can be brought to the Center Oversight Board for discussion with the services, for discussion of establishing a center that has the critical mass to take on the responsibilities for whatever that particular question is.
You know, it's kind of like Clausewitz and friction of war. You really don't know what your problems are going to be until you're in the midst of them. So there is the option there that if there are other particular issues associated with the wounded warrior that is addressed -- all those factors that I mentioned previously that could be addressed by a center of excellence, there's the option for that to come forward.

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

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

I talked about all of these
different centers of excellence. Again, the CONOPS, the board has approved. They're off and running. They tell us they'll be in full operational capacity by 2013. But to let you know as you can see that we've got the congressionally mandated centers of excellence and then we have others that came from within the community.

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

And then there are some centers that say, you know, we really don't want to be
MHS-wide, Military Health System-wide. Let us rethink about our desire to be a center of excellence.

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

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

So what mechanisms exist to systematically translate the results from centers of excellence into policy? Well, there is some duplication. One of the things that the centers of excellence do is come up with clinical practice guidelines, for example, in behavioral
However, there's also a Health Executive Council between the DoD and the VA that has a working group to establish clinical practice guidelines. So we ask the centers of excellence to ensure that these are not working groups that have duplication of effort.

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

So this is the primary mechanism by which --

CO-CHAIR NATHAN: Warren, have you
seen any examples of that?

    DR. LOCKETTE:  Pardon me?

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

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

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

    Another question was, again, Matt, I apologize.  I'm going to slightly deviate because this is something very close to my heart.  It says how important does the Oversight Board believe dedicated research
funding is for centers of excellence? Well, the question was too inexact for me to answer.

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

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

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

And are you old enough to remember Senator Proxmire from Wisconsin? He used to
publish the Golden Fleece Award. And I can't take credit for this but there was a wonderful scientist, Julius Comroe, who wrote a mystery and asked what did these six titles have in common.

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

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

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

Finally, what have we seen at the
Oversight Board's view in terms of impediments to the effectiveness of the centers of excellence? In other words, when we review the annual reports from the congressionally mandated centers of excellence things that will come up will be limitations as to why they reached a certain level of effectiveness but could not go further. So these are things that we're hoping the centers of excellence can work through.

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

Now, we've seen the way ahead. The infectious disease community has been able to have a common IRB. But the role -- I mean if you follow institutional review board for the use of human subjects in research or animals in
research, if you follow -- right now they're trying to rewrite the common rule that guides institutional review boards and there still is not agreement as to what that new common rule should look like. So I think that would facilitate if the centers of excellence were able to be empowered to designate common IRBs.

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

We have not seen that the centers of excellence have uniformly been protected from
sequestration or reductions in budget to particular programs within the DHP, within the Defense Health Programs. So I think human resources is probably the greatest challenge.

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

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

I'll give an example. When again the Air Force has had a longstanding modeling and simulation but the other services have not necessarily been in agreement with how the center of excellence for modeling should be done or what exactly the role for that centers of excellence should be in terms of the acquisition
of goods and services with the theory being that
if the services are able to pool their purchases
that there would be a reduction in cost. But yet
the individual services would like to maintain
some autonomy.

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

We find this particularly true, for
example, with the cancer center of excellence.
You can get great cancer care at Walter Reed.
They have established a center of excellence.
But does that mean that if we have a patient who
is a reservist on active duty who is in Missouri
or Oklahoma and has to have cancer care therapy
we could bring them to an MHS center of
excellence. But because of where they're
I think one of the most important things that the four congressionally mandated centers of excellence does or should be doing is moving the basic science research into clinical outcomes. And this process is known as translational research.

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

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

You know, we talk about DHP programs, Defense Health Programs being Program
6 dollars. Some of the basic science research and clinical research that we do is covered with what are known as Program 6 dollars, and some of the centers of excellence have had difficulty in accepting Program 6 dollars to support Program 6 kinds of activities that they do.

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

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

Now, my response has been that if a graduate medical trainee is also engaged in basic science research that their ability to think analytically and empirically is enhanced
and actually makes them a better clinician.

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

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

Nowhere in the community, or actually if you look at the measures of effectiveness for behavioral health providers the established and agreed metrics are how quickly the patient is seen and whether their
prescription is refilled in a timely fashion. That doesn't really tell me whether the patient's behavioral health.

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

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

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

The literature reports -- there was a wonderful paper published in the Journal of the American Medical Association 3 years ago that in
mild to moderate depression antidepressants are no more effective than placebo in the treatment of mild to moderate depression. So why do we have so many patients on antidepressants in the Military Health System?

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

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

So I think this, you know, what's going on in the purchased care sector drives a lot of our behavior in the Military Health
System. And there's really no way to insulate the thought processes for the kinds of output that the centers of excellence have from those kinds of biases.

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

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

We -- probably 2 months ago we received a presentation about just a variety of CoEs. And again, some -- it seemed very repetitive. And so we struggle with are we meeting what the American public want with their dollars, is it cost-effective and are we seeing
with the research the clinical outcomes that we want to see in our military system.

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

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

They've been doing these centers of excellence a lot longer than we have. And so at first I was rather chagrined when I would say to a center director is what you're doing
cost-effective and I really couldn't get a granular answer.

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

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

Now, I think it's rather disingenuous to say number of patients seen. Because really what the bottom line to me as a clinician and I think what your primary concern is is that servicemember or beneficiary better off. I mean that to me is the most important question.
MEMBER CONSTANTINE: So do you ask them that?

DR. LOCKETTE: I've asked them.

MEMBER CONSTANTINE: At the clinics?

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

And in fact one of the things, and you can ask Gina Julian who's the next speaker on the patient-centered medical home that's speaking after me where we have behavioral health practitioners that are going to be embedded. And I'm saying what is the measure of effectiveness. You really have to agree and measure this.
So, but for reasons that are unclear to me there is tremendous pushback. Maybe Dr. Lockette is uninformed and it's not as simple as it appears to me. But frankly I think simply doing something such as the PHQ-9 and seeing how a clinic scores before and after a behavioral health practitioner is embedded improves. I'm going to hear from behavioral health practitioners, I just know it.

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

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

I can tell you that for good or ill they are sight unseen to the end user. I mean
except for those that provide some clinical care. But it becomes very hard anecdotally at least for me personally to give much value.

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

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

And historically looking at centers of excellence as a model I have to wonder what ever made someone think that a centers of
excellence model is -- I mean when I first heard
of the nurse case management model and case
management I wondered why we decided that was a
model and I actually got some research and data
that explained it. I felt much better about the
concept.

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

CO-CHAIR NATHAN: Suzanne, let me
see if I can frame it a little better so that
Warren can. So remember that if we were the
American Cancer Society or if we were the
American Heart Association how we might view
centers of excellence might be a little
different. It might be what is the cost of
keeping somebody with congestive heart failure
functional and what is -- but we're the
Recovering Warrior Task Force. And we are
focused on the care, the management and the
transition of the recovering servicemember and their families who have been wounded, ill and are injured.

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

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

But from our perspective of the recovering warriors centers of excellence we believe were stood up either rightly or wrongly, many by Congress, by mandate of Congress, by
somebody's pet project saying I'm very concerned about the number of visual injuries that are occurring in the wounded warrior. And I want to make sure that people who are getting their eyesight affected by these head injuries and by this trauma is getting the best visual care. Whether that be generated by the Mayo Clinic or whether it be generated by Walter Reed Bethesda how are we cultivating the best care to give servicemembers who have impaired sight the best care possible. So that not only are they getting it at Walter Reed Bethesda but they're getting it at Fort Hood, they're getting it at Anchorage, they're getting it anywhere else.

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

When asked what is your raison d'etre our raison d'etre is to do just what this
guy Nathan said which is to find the best practice either generate it among ourselves or as you said go out and find it, the processes, and cultivate what we believe should be the state of the art for the recovering servicemember who has a psychological health issue, a behavioral health issue, a visual impairment, a hearing impairment.

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

But here's the million dollar question. When we have asked them when you cultivate these best practices, when you find something that you think is a winner how do you get it into policy? How do you get that translated, your term, translational research or translational acquiring of process. How do you get that so it becomes practice in the MHS, in theory an organization, unlike the civilian counterparts, that we have command and control
over. And we can dictate how they practice. You elucidated that with getting rid of Seroquel as a sleeping agent.

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

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

So I like this jointness but I'm not sure it's getting us anywhere. Because when we asked the visual center of excellence have you got any examples of things where -- oh yes, absolutely. We've learned through going back and looking at records and cultivating data and seeing best practices that the current way of...
treating an eye injury acutely is wrong, that we need to be doing it with a non-compressive bandage using a serrated aluminum eyepatch.

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

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

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

So I said well, where is Health
Affairs involved in this? Where is the policy piece that Health Affairs will be the Tito that sort of brings these Balkans together, the services, and knock some heads and say here's your new policy. We really haven't figured that part out yet.

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

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

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

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

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

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

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

I mean, I know the Seroquel because
there were complaints from one of the services and it came up to us as that there was not service concordance for this policy. And we said fine, we understand. Then this needs to be a Health Affairs policy.

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

CO-CHAIR NATHAN: Okay, but let me -- I'm creating problems for myself because what we're going to do as the Recovering Warrior Task Force is going to have me standing with my heels clicked in front of my seniors. So I get it. But what the Recovering Warrior Task Force is hearing you say is because of service
autonomy, because of service parochialism and
because of bureaucratic issues best practices
are not necessarily making it into policy.
That's what we're hearing you say. And you
know, what are you going to do about that?

DR. LOCKETTE: Again --

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

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

Similarly for our measures of
effectiveness for behavioral health
practitioners is that we will ask and have asked
the Defense Centers of Health -- for behavioral health to tell us what should be the metric of effectiveness for a beneficiary that's seeing a behavioral health provider.

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

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

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

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

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

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

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

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

DR. LOCKETTE: I agree. So I would like to get what those best practices that are not being translated are. Cite me an example where there's a best practice that has not been
promulgated other than the eye which I will go back and ask why the Army has been refractory to do that. But tell me what those best practices are that are not getting promulgated.

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

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

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

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

I asked for verification of this from the eye. Fifty-four contractors to build
the registry. Where do I think most of the money for that center of excellence is going? Okay. So how do I get a center of excellence to tell me whether this is cost-effective if this is their primary focus?

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

I'm trying to get my head around this but it seems to me that if the centers of excellence aren't required to report up, aren't required to give recommendation for best policy on a specific timely basis, every quarter, twice a year, something, if they aren't -- if that
isn't something for which they are accountable
I don't see why it is of any benefit to give them
extra money separately than we could just give
services to do their own thing.

MEMBER EVANS: The Oversight Board.

So the Oversight Board. Oversight means that
you have the ability to say, you know, resources,
what's working, recommendations through that
service. So you have a representation from each
of the services on this Oversight Board.

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

Because what we are seeing is that
it's not making it from with the research down
to the folks at the ground, to our warriors.
That's what we're seeing. And we want to see --
if you're saying you're spending $20 million on
a registry, okay, fine. But what success are you seeing with that registry? And that should be going back to you.

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

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

And so one of the discussions we're having here, Warren, from our task force is how do we metric this. How do we monitor this? We recognize that there's some nebulousness on
this. And for all we know this registry is going
to save eyesight 5 years or 10 years from now as
they collate the data. And it may be a long tail
before it gets something.

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

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

I don't think this model is ever
going to work well until the services take
ownership. Until the services step forward and
say these are the things we need to do our job better and you in the center of excellence can help us by providing some of those things, like they did the eye shield.

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

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

But I really think that in order to make this system work well the services have to
buy in. The services have to take ownership.
The services can't be out there as a reluctant user, as feeling like something is being forced on them. That's -- I don't think that's going to work. I don't think human nature will allow that to work.

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

CO-CHAIR NATHAN: So let's just finish up, Warren, if you would. Your response then sort of to the generalized concern that there may not be the connectivity between the services and between Health Affairs to capture whatever -- whether they're worth their cost or not is an issue. But if they do generate things do you feel the mechanism exists and do you feel
it's robust enough and do you feel it's pulsing
the system enough to create practice change,
policy change.

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

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

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

So don't misunderstand not having
the cost-effective data to say that there have
not been accomplishments. Okay?

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

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

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

MEMBER PHILLIPS: Basic question that might help me. Do the centers of excellence understanding their diversity both
scientifically and administratively is there commonality related to standards of terminology? Is there a common IT system or a way that they communicate with each other through a listserv or something that will connect them more robustly? Standards of medical terminology? I mean different services have different terminology for the same things. Do we have basic UMLS, Uniform Medical Language Systems terminology and so forth that everybody agrees upon? Or is that an issue as well?

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

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

The genesis for these going to the
services were the following. When the NICoE was built and was to be staffed the Defense Center of Excellence was the executive agent, the DCoE.

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

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

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

So Warren, we thank you. Again what you've articulated as where we are now is where the Cleveland Clinic was 30 years ago when they
decided to produce outcomes. They were the first major organization that said here, we're going to publish how well we do when we fix hearts. Up to then nobody had done that. And the Cleveland Clinic and then everybody else said uh oh, we better publish too because we're not doing good.

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

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

And so you've educated us. Hopefully we imparted some passion to you. And we thank you very much for your time.
DR. LOCKETTE: Thank you.

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

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

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

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

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

But we really look forward to this.
And I think all of us are fans. So please, take it away.

MS. JULIAN: I had to hit my timer on. I have to talk into a microphone. Usually that's not something anyone ever asks me to do. It's the first time I've been here to brief you and I'm really glad. I'm very passionate about this topic as well. I was born a military beneficiary. Both my grandfathers retired from the Army, my father retired from the Army and I retired from the Air Force just 2 years ago. So I am definitely a customer of our system.

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

So basically we're just going to go into a brief background about what it is, where we are in our implementation in the Military
Health System, some of our goals which we always have to keep in mind because those are driven by other people as well, and what does PCMH look like in an MTF and how is it different than before. And then we'll discuss a little bit about how that impacts our recovering and our wounded warriors.

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

It's a cornerstone of the Accountable Care Act. And one of the -- but regardless it's just good medicine. So what Dr. Lockette always likes to remind me, he says I don't know if you remember Dr. Marcus Welby, that show. Of course I do.
And so he was accountable for the care. So we're trying to get away from this episodic where you don't see the same provider and you go there for strep throat and then you go to someone else later on. So you want a family physician or provider for your patients.

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

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

You know, if you see a physician or provider four or five times a year that's not a lot of time. So we want to be able to integrate
with you and get at those underlying causes of your disease and build a relationship that's based on trust.

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

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

We want to coordinate care -- I know that's very important to this group -- across the full spectrum of care. That's into specialty
care, your admissions, other kind of behavioral health and other specialties. We want to coordinate that care.

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

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

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

And this is something we're having to work on in the military and the private
sector. Healthcare in the private sector is reimbursed based on you come in, you get sick and you get paid. So we want to try to change the payment to keep the patient well, or to get the patient well. That's a very important shift for the whole country and for us as well.

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

And the results were very good. And based on that and because of the things that we wanted to do which is to maintain great patient satisfaction and we wanted to increase the effectiveness of evidence-based medicine and the use of it we decided, well, we will use the model, the patient-centered medical home model of care based on what our patients tell us they
like, what we think that we need, where we think we can affect change and health outcomes. This is what we want to go with.

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

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

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

But one of the things that was very important is we meet often, we develop trust and
develop a team ourselves. And part of that was
we haven't canceled -- they're twice a month.
We haven't canceled a meeting in 33 months now.
We know each other so well that when someone
breathes right before they speak we know exactly
who's going to talk. But that's the kind of
collaboration you need to get to where we are.

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

A really important part of this
policy was to select an outside entity to
recognize or rate our patient-centered medical
homes. And we decided to use the one that's most
well known, the National Center for Quality
Assurance that has six standards and many
different elements. And they relate to care
coordination and access and all those principles
I showed you on that first, on that page of the seven principles of PCMH.

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

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

So one of the questions I know I must have gotten right was what are the numbers and names of the policies that guide patient-centered medical home in each of your services. So what you see here, and I won't read them to you, but we have the policy memorandum that established everything I referenced on the
slide before, and then we have the Army op order, the BUMED which is the Bureau of Navy Medicine instruction and the Air Force instruction.

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

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

Primary care has always been under the spotlight. And what we always were told is
well, we need our teams to be healthy because of deployments and PCS's and we need to have a standardized team.

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

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

But we realized when we got together, put our justification together, we were able to justify the funding. However,
funding isn't free. It came with requirements. And those what you see here are -- we're held accountable to these measures.

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

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

And so that was -- what that is is a change in culture. To get to those numbers even in a military system with deployments and everything required a huge change in our practice patterns and in our expectations and
everything that we did, it was a change in culture.

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

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

So we look at that. Each service has their own satisfaction survey. And then we have a standard one at TMA. And what we just
were able to pull out in the last few days is compared to the national benchmark our patients have felt satisfied with their ability to access acute and routine care 18 to 23 percent respectively better than the national benchmark. Now, we still want to do better but that tells us we're heading in the right direction.

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

You mentioned integrated behavioral health. That is part of our funding. That is part of our model is that our patient-centered medical homes have embedded behavioral health.
We're in the process of hiring and training each one of those people. It's very important.

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

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

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

In the old days you'd have to go in, make an appointment to get a prescription refill
for an allergy medicine you've been on for 10 years. We don't want you to do that anymore. We want to reduce the number of face-to-face visits but still increase your relationship. And we'll talk about secure messaging in a second.

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

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

It's going to require a sea change -- Navy term -- to get away from the current fee-for-service paradigm which is what we employ. We measure how much care we do to people
and that's how we reward our providers. And we have to migrate to a system that rewards for wellness and health.

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

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

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

So it requires us to be able to do
better with our data to not only look at what we're doing and who's doing it but how well we're doing it. Are we being cost-effective and are our patients getting healthier. And that is really the big area that we're working on now in the Military Health System.

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

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

And we look at a lot of those measures and you can't ever look at one. We've developed kind of a composite which is a mix of
continuity and access. But what you're getting at is what am I sending downtown that I may have capacity for. And that's one of those -- that's why we have to improve the capacity of our MTFs and maximize it. Requires the cultural transformational change but keep the care in-house that we can do.

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

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

And so he had open appointments.

NEAL R. GROSS
COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
(202) 234-4433
WASHINGTON, D.C. 20005-3701 www.nealrgross.com
They're able to open up their enrollment at the 359th medical group. And they're not sending as much downtown. So an important measure is what care is going downtown now.

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

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

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

(Laughter.)


MS. JULIAN: It was a great article.

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

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

So here we are paying for care twice. What do I mean by that? We have funded these MTFs and hospitals and staffs and everything yet over 50 percent of the care is being paid for in the private sector. So we're paying for it twice.
Part of that's because we've been at war for over 10 years. We've been heavily deployed. We've had to send patients out. We've had to displace them. But most of that is, as Regina is alluding to, is the fact that we've lost our ability to become primary care managers. We have allowed the specialty sector to gain our patients. And the one thing the military has going for it is primary care management.

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

So in that article I alluded to what we found at Bethesda which is significantly decreased admissions to the hospital, significantly decreased emergency room visits,
increased patient satisfaction and decreased purchased care costs. We can do it now.

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

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

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

And medical home is designed to
thwart all of that by giving our patients a phone they can call anytime of the day or night and connect with somebody on that team who can either defuse the issue or send them to an emergency room if necessary. So that's really access and confidence that you can be seen is the big game-changer in patient-centered medical home.

Sorry, didn't mean to steal your thunder.

MS. JULIAN: No, that's great. You know, I said that we'd made our goal for 3 months. That -- we were about 25 percentage points below that with PCM continuity when we started. So to have this huge system of 435 primary care practices seeing 3.4 million people, 60 percent of those patients seen in the last few months have been seen by their own provider. And that includes if you're enrolled to a resident. Our top patient-centered medical homes are above 78 percent. The top last 4 months running has been internal medicine at Naval Hospital Pensacola at over 90 percent followed by Naval Hospital Oak Harbor.
And again, this required leadership from the commanders to say when your patient walks in, even if you are doing admin time you're going to see your patient if they need to be seen that day. And that's what it took.

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

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

This next year we're leaning forward
more. And right now I have 157 undergoing recognition.

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

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

And so everyone really dislikes me when they start the process and I'm sure my name is taken not too well. But at the end what we hear from people is they say gosh, you know, that was a lot of work but it was really worthwhile because it helped improve our practices. And
we're doing things now that we really didn't know that we had the systems to do and things that really help our patients and our patients really like. So I'm happy to hear that, especially since we have 157 going through this year.

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

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

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

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

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

This is very important. So we have secure messaging now. That is a secure way for you to contact your provider. And this isn't just your provider, it's the other members of the team as well. So the case managers, the
embedded behavioral health, but the main relationship is between the provider and the patient.

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

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

Now your provider is not going to always answer you instantly but you can send something 24 hours a day. And several of our providers have said that when they were deployed they had this. This was a really important tool. Somebody was deployed on a forward hilltop somewhere and they were able to contact them through secure messaging. And they're still able to follow those same patients because...
of continuing medical issues. So we think this is a really important tool to increase that relationship beyond the four walls of the MTF.

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

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

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

So some of the other things that are
rated by NCQA and that we're requiring people to document in the medical records is to collaborate if necessary with the entire family.

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

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

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

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

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

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

You know, if any of you have read any of Atul Gawande where he talks about we're really smart but we have 15 minutes and we may not
remember X, Y and Z. Now your whole team is going to be involved with you to collect information that -- some of these key things, height, weight, exercise. We're looking at some of the other guidelines, maybe sleep and a general sense of health, alcohol use. And if you test positive on any of these things such as depression which Dr. Lockette mentioned earlier then you move onto the next level and in accordance with the clinical practice guidelines you get the next type of care. So it's not left up to I hope my provider remembered the right thing to do but we're going to try to prompt it.

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

We have one service we're still trying to finish off but by the end of the year.
everyone's going to be using Tri-Service Workflow. This is a way if we're using the standardized tool and doing it the same way on every team now we're collecting information. And now we can get at our outcomes and everything else.

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

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

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

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

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

They help coordinate the specialty appointments. They're reachable by the patient and hopefully the family member. I heard some discussion about maybe we need to work better in
that area. And they arrange things like handicap placards, home health, any kind of additional services that the patient needs.

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

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

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

We used to call those TMCs, Troop Medical Clinics and it was a lot of sick call and cattle call you had heard it pejoratively called. Now those are being recognized this year. They're transforming really quickly into
patient-centered medical homes.

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

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

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

Air Force wounded warrior care. They're really mostly seen in the patient-centered medical homes. The Air Force has fewer proportionally recognized at this time.
but they're 100 percent level 3. And they will finish up in 2014.

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

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

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

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

And so we have funding for that.
And they have spent -- they have also bought in addition to the regular primary care staff care coordinators, LPNs on those teams to coordinate care in the Marine-centered medical home.

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

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

CO-CHAIR NATHAN: Questions?

Issues?

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

MS. JULIAN: I would have to look at
that. But we have online comprehensive care plan builders for different conditions. And they -- this is what the patient has, this is what they need. If you send me that or someone does I can send you what our plan looks like and we can compare. I am just not sure. Yes, ma'am?

MEMBER EVANS: It's different.

MS. JULIAN: Okay.

CO-CHAIR CROCKETT-JONES: I would just like to say anecdotally I've seen this change in the clinic where my family gets care and it seems to be changing dramatically for family care especially with the idea of a holistic approach. I'm not sure we're seeing it as clearly -- at least anecdotally I'm not seeing it as clearly translated in the Warrior Transition Units, especially this sort of cultural change that your family matters to your health. So I would love to -- if there's a way. I'd love to know how you're going to measure that or try to impact it, you know, increase the collaborative sort of concept. I mean I think
you would have to find some way to measure it in order to increase it. So just, you may not have that now, that may be something you're going to go back and consider, but I would be interested in knowing about that.

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

What are we doing at the front end? So they answer that they're satisfied is that's part of what we're trying to get to and we talk about at my webinars for NCQA recognition. It isn't just a pencil-whipping exercise, I always say. This is what you have to do. This gives us the guidepost. There are specific standards
and elements that you have to meet for must-pass elements in NCQA to increase the family collaboration and communicate. And you have to document it in the medical record.

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

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

So, but one of the things that maybe as you're looking, and especially where you have displaced warriors when their families may not be in the vicinity is part of the PCM education of asking. And then maybe educating the warrior as to what the benefit might be of having your family. Because there seemed to be some
disparity of how people were approached or embraced or not.

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

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

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

I think that that's going to be very important because I think we didn't see a lot of
that this time and perhaps -- of course we went
to one of the biggest WTBs where a lot of people
were displaced. But -- and in some cases we
heard from families that they were told not to
be present. So it's kind of interesting the --
you know, it's the full gamut. But I think it's
an education piece.

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

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

In our more mature patients in our
medical homes we do have the family areas. And
patients and families are welcomed. And we are seeing changes like that. And I'm glad to hear you say that you have noticed that.

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

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

We find that not everything that's wrong with you is physiologically, or your healing isn't just, you know, your cells and everything mending, it's your support structure. And your family may be some of the people in the unit with you or it may be your husband or wife or whomever. And we need to -- if we are really going to be holistic we need to keep that in mind. I think that's a great suggestion.
CO-CHAIR NATHAN: One point. And we need to start closing up because we're pushing on the time envelope. But yes, the whole country should be interested in this because this is going to bring down the cost of care. And the fact that it's not a fad because Intermountain Health, Geisinger, a lot of the multi-million dollar thousand-member HMOs have gone to the medical home model.

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

Now, as you heard Regina talk about, the Army and the others are starting to roll out this into their Warrior Transition Units as well. But yes, the families have been partitioned from this ahead of other families.
And so we need to move into that.

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

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

I went down to the old medicine clinic. It's busy like a pizzeria on a Friday night, people screaming, yelling, I got two patients backed up here, I've got three.
I went over to medical home. Nobody there, quiet, mood music. And I said to the staff, I said where are all the patients. And they said oh, we're taking care of them electronically. And I said well, it's not medical home, it's home alone. And I said now -- and people say where are the cost savings. I said now you can enroll more patients. And they go oh, we didn't really think about that part.

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

And the one thing you didn't mention which is our younger patients love this model. Our older patients do not. Our older patients want to come in and see the doctor or drive in and see the pharmacist, hand them their pills. Where the 20-year-old soldier or sailor wants everything done electronically, wants it mailed to them and we're going to go to virtual care.
So medical home is tapping into this virtual care
where the only reason you need to drive in to the
hospital is for your provider to either touch you
because you need to be touched, hear you because
they need to listen to something, or see you
because you have something they need to see with
their eyes. Otherwise we can eliminate at least
50 percent of the reasons any of us go see the
doctor if we have competent medical.

And that's what's going to bring the
families of the warriors engaged, when we
connect with them robustly electronically and
their person can then -- remember the biggest
problem we have now is they can't hear the
provider. In medical home they can text their
provider or send something by web-based
communication and the provider if it's working
right within 24 hours will get back to them and
say I'm so sorry you're not feeling well, or I'm
so sorry you're feeling disenfranchised, or I'm
so sorry you're feeling as though you're not part
of the care plan. Let's get you in here and talk
about that. That's where I think the gravitas of this all lies. So thank you.

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

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

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

CO-CHAIR CROCKETT-JONES: Thank you, Ms. Julian. Are we ready for our next? Or
do we need a minute?

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

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

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

DR. RAUCH: My focus will be specifically on an overview of our medical research and development program largely within the Defense Health Program. And I'm going to
start with the big picture and then narrow it
down to focus on polytrauma and GU injury.

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

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

Within the MHS we deliver care on a
coordinated continuum of care. And our research strategy is also based on the continuum of care construct where we will have research investments on prevention, on screening and diagnostics, on treatments and on rehabilitation and reset back into the force or back into civilian life.

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

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

CO-CHAIR NATHAN: Dr. Rauch in the interest of time I think we are all very -- we
understand what your goals are and where you're trying to get. We probably need to public the gravity of your presentation into what you're doing and how you're doing it.

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

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

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

It's important for everybody to understand that we have a joint planning and execution approach. And I use "joint" in the
federal sense, not in the -- it's beyond the tri-service sense.

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

I said before that with respect to GU injury probably the largest area that will contribute to that will be clinical medicine and rehabilitation and specifically regenerative medicine and also probably some -- a little bit of transplantation also.
These are -- within regenerative medicine these are our five focus areas. I will say that GU is the newest in that until now we have really not had a significant research investment in GU injury.

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

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

DR. RAUCH: Yes, sir.

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

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

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

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

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

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

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

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

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

Thank you.

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

I will say a little bit, just a brief piece on something complementary to the
regenerative medicine approach to urogenital injuries and that is transplantation.

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

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

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

I did say that I would wind up with some translational activities and so this is how you basically take a look at a portfolio and you see how balanced your portfolio is from basic research. We measure these by what we call technology readiness levels or TRLs. And so
what you will see, the lower the TRL the more
basic science approach it is. And then the
higher the TRL when you get into TRL 7 and 8 and
9, 9 you basically have a fielded product.

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

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

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

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

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

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

And now it's becoming quite common for on a given protocol like Peter Rubin up at Pitt has a protocol to do facial reconstruction
with autologous fat grafts. He now normally includes a co-investigator out of the MHS. So I mean, we're trying to move in that direction.

CO-CHAIR NATHAN: Thank you.

DR. RAUCH: Thank you.

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

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

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

DR. RAUCH: I'll give you my
perspective. No one has a problem with it. I think it's just more facilitating the networking in the professional community. And exchanging getting our principal investigators up at Hopkins.

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

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

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

And then there were the niche people who were very good at what they do. Maybe a surgeon in Chicago does nothing but eye
reconstruction that we don't do in the military. It took us a while to understand that they could help.

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

So I think we're getting better at it but it's mostly been because of the real push from the chief of staff of the Army and the commandant of the Marine Corps really pushing on us and saying look, I know there's better mousetraps out there. And so with people who
are expert at the friction point like Dr. Rauch,
I think we're facilitating better lubrication of
getting folks out there.

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

And that concludes my presentation.

I hope I did --

MEMBER EVANS: Excuse me, sir.

Right here.

DR. RAUCH: Yes, ma'am.

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

We had a couple of patients that we
had to go back and say okay, he needs to get into the MTF system, make that referral. Or is that the right process when the Wounded Warrior Regiment identifies someone?

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

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

MEMBER EVANS: Yes sir, that's
fair.

DR. RAUCH: Any other questions?

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

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

As an aside I'm also the chair for the Army for the Face and Hand Transplant Advisory Boards. And so if you've got any more particular questions about vascularized composite allotransplantation we're more than happy to fill in some of the gaps on that as well.
So this is a follow-on really from Dr. Rauch's slides, a little bit more detail with a little bit more specifics on the broad area announcement, what MRMC is doing for research.

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

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

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

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

So, who has the lead? It is really a compendium of folks. It's both MRMC. It's also Office of Naval Research very collaboratively working together. As Dr. Rauch already said JPC-6 and JPC-8 working together to develop that broad spectrum for research and then translating it into clinical practice with AFIRM and with the face and head transplants in
And they are now talking phallic transplantation working with Johns Hopkins and several other leads in the nation. Right now it's still notional but they are looking for potential transplant candidates. And the JTAPIC down here that I already talked about.

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

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

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

So the committee asked about the
targeted supports for who is doing the medical and non-medical training. And there's pieces of this answer over the course of the next couple of slides.

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

Currently, specifically in regards to hand transplantation Johns Hopkins now has privileges at Walter Reed and some of the Walter Reed surgeons are looking at privileges at Johns Hopkins. And so getting that, and we're looking at that being the course, the norm, especially
as we start to withdraw from the area of operations and we come back and the war wounded come down, how we maintain those skill sets over time.

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

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

COL. CRUNKHORN: Sure.

CO-CHAIR CROCKETT-JONES: The folks that I have talked to who are dealing with these injuries don't really have much doubt that they're getting pretty much the best medical care that is available globally. Feel pretty confident in that.

They feel completely unprepared, uneducated and in an unbelievable fog when it comes to the expectation management for moving
forward with normal sexual relations or getting as close to normal, what will be their normal.

Fertility, they don't understand. They don't feel their necessarily getting the most proactive fertility care and plans and responses. They feel that no one's willing to talk to them when they have questions. No one knows who has the answers and nobody really wants to talk to them.

About all of this, the sort of real-life, you know, this is great that we are looking at doing the best care that we can for the physical injury. But this is -- the actual maybe nexus of import for these folks isn't just going to be how much can we restore, have we restored it, now that we've restored it.

It's also what should I be prepared for and the huge behavioral health element of now these spouses have to talk to each other and there is -- these are big, big issues with serious separation of expectations. I know the spouses are saying I want to move forward and
normalize my life and I still want to have a sexual life with my partner regardless of what the physical limitations are. And I want someone to tell me how to make that happen. And I want someone to tell me what to expect. And I want lots of education. And I want someone -- I want people to just talk to me about it.

And you've got lots of fear and identity issues going on with the servicemember who's injured who maybe doesn't want to talk about it because there's so much fear and unknowns.

And the one line that struck me is actually on the next slide. I believe this is coordinated with mental health participation. This is -- that is -- that is pretty much, there you go. That's where the experts stand is we think somebody is doing this. That is the sense that every family member I've talked to who has any connection to this issue, that is exactly the sense they have is that the people who they turn to for expertise, the people who they are relying
on for like their whole lives going forward maybe think somebody is doing something. Do you see what I'm saying?

CO-CHAIR NATHAN: Absolutely, but I was under the impression they recently started a program called intimacy counseling.

COL. CRUNKHORN: Yes sir, and that's the next slides down. So this is a little bit distributed across. And there is no named behavioral health support or counseling package.

And so when I went to behavioral health and I asked them about this particular aspect of care their response was that as part of trauma, rehabilitation, behavioral health is a standard of care.

So "believe" -- and I apologize, that's my bad editing. As I was gathering the information on this is that we can go back and we can confirm that's happening. It is everyone's expectation that it is happening. And so that's very sloppy language on my part.
CO-CHAIR NATHAN: But Suzanne, I think your point's well made. But I think there has been. And it's not universal. I think it's mostly been borne at Walter Reed Bethesda --

COL. CRUNKHORN: Yes, sir.

CO-CHAIR NATHAN: -- for that need, for the families saying. Because I just had a case on my desk the other day of a Marine couple who fell through the cracks. They didn't get the intimacy counseling. And so the next person they talked to was the commandant of the Marine Corps. So the next person he talked to was me.

(Laughter.)

CO-CHAIR NATHAN: And so I researched this and said what's going on and they educated me about the intimacy counseling that apparently covers most of these areas that you're concerned about. What can you expect in the future, how can we preserve your fertility, how can we harvest your sexual tissue for childbirth later or reproduction later, all these things.
They had missed this one couple and so they went back and made sure they engaged them, what are your options, what transplantation for regeneration, for prosthetic device, for plastic surgery.

So I do think -- I'm not trying to steal your thunder but this is what I was told.

COL. CRUNKHORN: Sir, go ahead, please.

CO-CHAIR NATHAN: Okay. But am I being truthful here?

COL. CRUNKHORN: Yes sir, that's exactly it. And I was going to try and find my notes. I know there's urology who goes the wounded warrior clinic. Urology is embedded across the Walter Reed campus in every place where these amputees and these traumatically devastatingly injured young men, and mostly young men, are located. And so they're there and they're accessible.

I don't know that if we need a named, stand-alone, stove-piped program specifically
for this. But this is, they've already identified this at Walter Reed as being a gap. And I would have to go back and check and see whether or not SAMC which -- and then San Diego have parallel programs in place. But this appears to be very comprehensive.

And then what's on the next slide is what they're doing for provider education. Because again, this is not just standing up a special program for this particular cohort. This is about making sure it's institutionalized and it's sustainable and that as the uniforms in particular retire or PCS or move on that the rest of the staff at Walter Reed, this is so indoctrinated and so embedded into the DNA of the organization that we do this as a matter of course. And I think that's what you're getting at. People shouldn't fall through the cracks.

CO-CHAIR CROCKETT-JONES: Yes, I frequently felt in talking to folks that it wasn't necessarily that the resource wasn't there, but that providers, whoever they wound up
being comfortable with talking to were -- either
the provider was not comfortable as soon as they
hit the sexual intimacy discussion, and because
of that could not connect them well to the
resources that are out there.

And I'm not sure that having a
particular lead is helpful either because you
still, you're dependent on who winds up being the
person that they're comfortable talking to.

But it should -- I think that what
I was seeing was that there was so much
discomfort in talking about this subject from
the providers as well as some of the
servicemembers. And probably if they weren't
talking to me who is another spouse that might
be true of a good number of the spouses too that
this has so many sort of cultural flags and you
know, it feels like throwing a hand grenade into
a room for a lot of these folks if they're going
to bring up this subject.

CO-CHAIR NATHAN: This looks like
an effort here, this slide, to try to increase
the comfort level and the ambient knowledge of
the staff that are going to be treating these
patients.

COL. CRUNKHORN: And break down
those barriers. And I will say one of the things
that the urologists asked me to make sure that
I brought up today is that it's not just the
trauma. The trauma patients are the most
compelling and certainly the most devastatingly
affected by the issues.

But there are a host of issues
related to TBI, PTSD and medication related to
dysfunction that are probably even less
recognized and addressed. And so this is an
area, unfortunately it's a little bit of a growth
industry, that we need to get folks comfortable
talking about these issues, and not just the
servicemembers but the spouse. So I think this
is a great initiative, again, brand spanking new
that needs to get replicated and propagated.

MEMBER CONSTANTINE: Ma'am, I want
to go back a slide that you have on there about
a $25,000 grant which I'm aware because I work with the SemperMax Fund. And my understanding was that that grant was from the Bob Woodruff Foundation to Tim and Shannon Maxwell so they could host one of their conferences with, and I guess there's some providers also, but really it's for the families who are going through what Suzanne just described. Because this -- and they had one as recently as late last year.

And so because these services aren't addressed, and maybe it sounds like you're rolling something out, but I guess here it says that this grant from a private group to -- American donations to provide training to clinical providers in the hospital. And that seems backwards to me if that's accurate.

COL. CRUNKHORN: I can go back and confirm that fact and double-check and make sure that that's not a misprint and that it should be in fact the patients.

MEMBER CONSTANTINE: I would just say --
COL. CRUNKHORN: Sure.

MEMBER CONSTANTINE: -- we're relying on the generosity of the war effort, people involved in the war effort to train our providers.

But even so, the point is that it's the private sector or the 501(c)(3) sector who's having to stand up to provide this counseling and train these families. And we've seen that across the board with the Wounded Warrior Company. I really hope that we can get ahead of the power curve on this and start taking a leadership role more than we already are.

And reaching back and finding people who are injured in the last 10 years who have this because a lot of times we don't do that. We say okay, well from here going forward. But these people will have these problems forever.

COL. CRUNKHORN: One of the initiatives that the Army surgeon general is working on is on this operating company model where we're standardizing care across the Army...
footprint.

And one of the things that the urology consultant is trying to push forward are urology CPGs, clinical practice guidelines. And so this would be one of those things you'd want to embed.

And those clinical practice guidelines are all DoD-VA because really they're probably not DoD patients, they're probably VA. So we would have to make sure we're handing warm hands -- holding hands with the VA in order to make sure we capture them.

CO-CHAIR NATHAN: I think it's an evolutionary -- I'm not excusing the time line but I think it's an evolutionary path.

We first encountered people with bilateral above-the-knee amputations. And at first those were -- "novelty" is the wrong word, but they were unusual. And we figured out ways to use multidisciplinary teams to get them back walking again.

We encountered people who were
triple amputees, people with severe head injury. And the GU part was an afterthought because we were so engaged in just trying to get people walking and up and about again.

And now we've gotten to the point where if somebody comes in with bilateral above-the-knee amputations we recognize the tremendous time it's going to take for rehabilitative process but we have a system down.

We can look them in the eye and say we're going to get you up on legs again. We're going to get you running again. And it may take a year, year and a half, but we'll do that. So that's almost -- second nature is too trivial but it's become a codified process.

Now that we've sort of got that out of the way and the process fixes for that out of the way we now look and turn our attention to the more spiritually and emotionally debilitating injury which is that of genitourinary trauma and dysfunction. And so now we're starting to throw
our energies into that.

    Probably should have done it at the beginning and looked at it and said what other injuries are going on but I think we were so confounded by multiple amputations and having to figure out how to put the teams together to deal with those at one time.

    So I'm not excusing the fact that this is late coming to the game but I'm explaining it a little bit. Because what we're seeing now is an energy in GU injury both from a process fix and a counseling fix that we offered to amputees 15 years ago, 15 years ago.

    Because 15 years ago if you came in with an amputation we had 10 people come out of the woodwork who had had amputations, we had support groups. We talked to you, what you'd expect. We told you what the latest therapy was. We talked to you about the various prosthetics that are available. We talked to you about limb salvage or limb amputation and whether you choose one or the other. And you
knew everything about that 10 or 15 years ago. We're now just getting to that point in GU injuries because we're starting to recognize the number of the population unfortunately that's afflicted with this and the numbers out there.

And as you say, Justin, I think the real answer is we're going to go back to people who sort of -- we didn't mention this 10 years ago and now bring them back in and say look, we've been ignoring this for 10 years. Do you have a problem? We're very happy because you're on your legs again and you're moving under your own steam but we didn't take care of all your issues.

I'm sorry, go ahead.

COL. CRUNKHORN: No sir, that's spot on. Our entire focus at the start of the war was on saving lives and until we really optimized the life-saving aspect of it this took a backseat. And now it's more about quality of life. And 2009 was the first year we had a quad amputee who survived on the battlefield. And
actually it happened to be Brandon Morocco who just had the bilateral hand transplantation up at GHU in December.

And so in the genitourinary in the civilian sector as well this is all cutting edge, it's all pushing the envelope for what we're doing on both sides nationally.

So we owe it to our servicemembers. We need to get there. It's recognized and we'll move as fast as we can. I appreciate the insight. That's good.

CO-CHAIR CROCKETT-JONES: I think if we looked at it the same way we looked at how for the physical loss sort of the industry of adaptive sports has exploded. Well, urogenital loss has a less comfortable and obvious parallel reality. And medically getting someone to a point where they feel comfortable and have -- aren't going to have traumatic constant problems that's great that we've solved that. But we need that same parallel path of functionality and quality of life in the same way we sort of
have jumped into that. And I'm glad to see that
this is beginning. I hope it moves fairly
quickly.

COL. CRUNKHORN: Fingers crossed.

For the counseling part I think that can. But
I think honestly, Dr. Rauch briefed about the
regenerative medicine and the transplantation.
And that unfortunately is going to take time.
And truly what I think a lot of our young men
would like, optimal recovery of function, it's
going to be what's in the research realm.

CO-CHAIR NATHAN: The frustration
is 100 years from now, everybody would agree in
100 years ago it'll be common practice to figure
out how to simply regenerate an organ,
regenerate a limb, regenerate a penis. Fifty
years from now it'll be -- transplantation won't
be just a chip shot and it'll be an ambulatory
procedure that's done somewhere.

The frustration for the young Marine
or soldier or sailor or airman now is boy, can't
we do it in 5 years instead of in 50 years. And
that's all. So we know we're going to get there. We know that face transplants, organ transplants are all going to become basically common procedures. We just don't know how long it's going to take to get there. And that's where the hurry is.

COL. CRUNKHORN: Yes, sir. And so actually this was my concluding slide. We kind of skipped, right. The only thing I really had was behavioral health. And the evolving director of psychological health for DoD and each of the services will have a component or a parallel director of psychological health certainly will be one of those things we could park within that forum and have that standardization across the organization take place.

CO-CHAIR NATHAN: And the only other -- not the only other, one of the significant other emotional issues to families even before deployment is harvesting of reproductive tissue. And TRICARE sort of got
sideways with that a little bit and at first just sort of retreated to the bureaucracy saying it's not a TRICARE-covered benefit which is probably the wrong thing to say.

So now I think they're looking at their policy. Maybe you can -- do you know what the policy is now? First of all, harvesting and storing. A soldier has a devastating injury at the battlefield. They lose their reproductive organ. And then there's a question of harvesting sperm right then and there and then storing it at government expense, freezing, the whole thing you would, and then doing in vitro fertilization down the road. Do you know where we are on that?

COL. CRUNKHORN: So I have bits and pieces of it. And we could certainly get something more comprehensive for you.

So the bottom line is right now in theater there's nothing for harvesting right away. But sperm can persist, it just may not be as high of quality.
And so I spent a fair amount of time in the fall talking with the urologists at Walter Reed and SAMC about this particular issue. And at the end of the day we talked about actual sperm donation before deployment at the SRP site. And then talked about coning it down to just potentially EOD, the explosive ordinance disposal, military police, infantry, the guys out on patrol who are most exposed if we really are talking about a cost-benefit analysis. We could do that and make a policy for that.

And then on reverse SRP as they come back you choose either to continue to pay out of your own pocket for that sperm to be stored ad infinitum or the contractor is authorized to destroy the sperm.

There were concerns about what are we going to do for egg harvesting for women. And when we went back and looked at what data we have, and the data is not that easy to mine, there don't appear to be any women who lost egg capability who didn't also die because that would be a very
devastating abdominal type of injury. So we felt comfortable having it only be men.

And then that -- there appears to have been a parallel effort actually up within DoD. And so we hit a tactical pause after the new year and we have not come back to revisit that.

But we did talk about it. We actually drafted up a policy for TMA to look at doing that. It would require NDA language and will require funding which of course is always a hurdle. Not that it's not the right answer.

CO-CHAIR NATHAN: Maybe. Because I'm not sure it'll be a problem or not. Congress is very interested in this. Certain factions of Congress are very interested in maintaining the reproductive capability of our soldiers and warriors who go into battle.

So I think the question will be -- I think the tough question will be it's where you draw the line for who gets it pre-deployment. In other words, should an MA who's patrolling in
Djibouti be qualified for it, or should it just be somebody going into kinetic battle. Those will be sort of qualifications that will have to be discerned along the way.

COL. CRUNKHORN: And right now I think probably the biggest challenge for TMA is the definition of who's entitled to any of that reproductive persistent services. It's all in only married servicemembers. And so if you crosswalk that with who's actually having the devastating dismounted injuries they're not necessarily all married. They're very young. And so that -- and again it goes with everything else, the cost-risk benefit and the -- getting the language and getting the legislation passed.

CO-CHAIR NATHAN: Well, when you have a chance if you could send us back whatever you think the latest and greatest comprehensive policy is.

COL. CRUNKHORN: Yes, sir.

CO-CHAIR NATHAN: And Dr. Guice is coming in a little later. We may corner her and
just ask her, you know, drive-by, ambush on what's going on there.

Any other questions for the gang?

Going once, going twice.

CO-CHAIR CROCKETT-JONES: Well, then we get to break for lunch. Thank you both very much.

MS. DAILEY: Thank you, Colonel Crunkhorn and Dr. Rauch. We had to split this requirement and one-half of it got down to Colonel Crunkhorn a little late so I'm very appreciative of the work you've done to prepare for this. Thank you. And thank you, Dr. Rauch, very much.

(Whereupon, the foregoing matter went off the record at 12:34 p.m. and went back on the record at 1:09 p.m.)

CO-CHAIR NATHAN: Welcome back from lunch. We're now going to hear from Mr. Tim Ward who is the deputy director of Program Analysis and Evaluation for the Navy Bureau of Medicine and Surgery.

NEAL R. GROSS
COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
(202) 234-4433
WASHINGTON, D.C. 20005-3701 www.nealrgross.com
Tim will be presenting information resulting from the Department of the Navy IDES site evaluation. He'll also be updating the task force on information regarding the Comprehensive Combat and Complex Casualty Care program also known as C5. This is a program the task force was first briefed on during the installation visit to San Diego in April of 2011. You can turn to Tab F to view Mr. Ward's information. Tim, go ahead. It's all yours.

MR. WARD: Good afternoon, everyone. Can you hear me okay?

CO-CHAIR NATHAN: Yes.

MR. WARD: So my name's Tim Ward and as Admiral Nathan said I work for BUMED M81, that's Program Analysis and Evaluation. We have a modest-sized effort dedicated to performance improvement based on the leadership that we've been provided by Admiral Nathan and others to put this little group together. Upon request we'll go out and look at certain processes within Navy medicine and see if we can
make them work a little bit better, can we make it go a little bit faster, can we improve quality or improve the cost structure, those kinds of things. What I'll do today is just give you an example of some of those. And of course the three examples here are the ones that are all focused on the IDES process.

Before I do that though I just have to kind of tell you a little bit of background. So I'm an industrial engineer and I have to start out with an analogy so forgive me if I digress for just a minute. I think you'll see the point as we go through this.

This is a picture from 1908. This is a Henry Ford factory. And at the time in 1908 this was called a job shop. Each one of these tables, there was a team of people that would build a car from bottom to top at that one location. It was about six people all together working as a team to build one car. As it says on the slide here they performed tasks in a variable order, no defined time expectations.
If you didn't finish something today you'd just come back and start it again tomorrow.

Extremely highly skilled craftsmen. They carved the wheels, they stitched the leather, they formed the transmission, they did everything. They bent the metal. It was a very, very high level of craftsmanship to build one of these cars. And of course low volume, one at a time.

So in 1908 this factory could produce about 30 cars a year. If you equate it to today's dollars it was about $500,000 to buy a car.

As you might imagine the quality of the cars wasn't so great. There's a lot of variability in the process. And if you wanted to get your car fixed you had to go back to the six people who built it because they were the only ones who really knew how to build it.

And if you and I both walked into this factory and bought a car on the same day when we came back 6 months later to pick it up my car
might be 2 inches longer or 2 inches shorter than yours. It wasn't the same thing. So that's a job shop.

You're going to hear me say job shop a little bit later and I think you'll figure out why if you don't already know. But let's fast forward to 1920.

And so now we have the production line. And so in a fairly short period of time the entire process by which cars were made by Henry Ford changed. We now have a well-defined sequence of tasks, strict time performance requirements.

The staff is still very, very skilled but they have more limited skills. They're focusing on a smaller range of tasks than they did previously. And of course repetitively and high volume.

So what happened when we changed the process, when Henry Ford changed this process? We went from a factory that could produce 30 cars a year to a factory that could produce 250,000
cars a year. We went from quality that was
abysmally poor to a much more standard approach
and the quality improved dramatically. And of
course the price dropped by orders of magnitude.

Okay, so I just needed to tell you
that because you need to understand that I am an
industrial engineer and this is kind of my
background. This is where I'm coming from.
And so the real point of the program that Admiral
Nathan has set up is for us to take these kinds
of methodologies and see how they can be applied
to medical practices and in this case of course
today the IDES process.

So here's kind of a description of
the overall IDES process. I'm sure you've all
seen this before. And so today I'm going to be
talking about the three on the left. First the
MEB, Medical Evaluation Board, then the PEB.
Then I'm going to go back and talk about the
treatment process and that's the C5 program in
San Diego. The three on the right are out of
scope for today's discussion.
So a few more words on the process that we use when we talk about performance improvement in Navy medicine. It's a very collaborative approach. So we have a team of industrial engineers, a reasonable staff, about six of us at BUMED and then we have contract staff as well from the Johns Hopkins Applied Physics Lab that we'll use as well.

It's hand in hand with the hospital staff. It's data-driven and it's bottom-up. So we collect electronic data from any electronic system we get our hands on and if we can't get it electronically then we're going to go collect it ourselves. And so it's very, very data-driven, very analytical in its approach.

And we're focusing on near-term implementation. This is not about writing reports about how you should be doing things. This is about agreeing with the staff on what a desired future state might be and then implementing that future state over a short period of months.
So basically the approach is focused on solid analytics and then change management. As you can imagine from the Henry Ford slides those first group of craftsmen, how do you think they felt when Henry came up with the idea of having them work on an industrial production line? They weren't exactly enthusiastic about it I'm sure. And so there are some change management issues that we have to face all the time.

In terms of timing these projects typically are about 5 months in duration. The first step is called a scoping step. That usually lasts a few days, 3 or 4 days onsite where we just try to get our arms around the scope of the project.

And then there's a diagnostic phase which is about 8 or 10 weeks long and that's followed by actually implementing the things that we've agreed to implement.

So I'm often asked, well, why does the diagnostic phase take so long? Why 8 or 10
weeks? Why can't you do that in 3 or 4? And the answer is it's not just about the data collection.

I guess the philosophy here is that people will fight pretty hard for their own idea. And so even if we have a good understanding of what we think they need to move forward with, what process they need to move towards, we're not going to tell them that. We're going to tell them that sort of Socratically. We're going to ask a lot of questions, we're going to give them comparative data, we're going to suggest things that other people did and let them arrive at what they think that best practice is.

Because if it's their idea then they'll buy in and we'll get much better implementation. The quote I kind of remember is "A man convinced against his will is of the same opinion still." We have to have them be convinced and the best way for them to be convinced is for them to have it as their idea.

So that's it for background slides.
Now I'll talk a little bit about the Medical Evaluation Board within the Navy.

Here are the questions that we received from the committee. So how many sites? Basically this was done at Camp Lejeune, primarily at Camp Lejeune. It was about a 4-month project at Camp Lejeune. Followed by a couple of weeks of consulting at Camp Pendleton as well. Some of the ideas were immediately applicable to Camp Pendleton. What did we learn across the sites? Well, every place we looked, what do you think we saw? We saw people doing different processes. There was really not a whole lot of similarity between locations.

All the rest of the questions here I'm going to get to as we go through the slides. But if I forget anything please feel free to remind me.

So, this again, we're looking at the MEB process. And if you break the MEB process down into more detail that's really what's described here. Someone has to refer the
patient into the IDES process. Then there's a PEBLO consult. That's followed by setting up a VA appointment and then VA medical evaluation. Then there's a narrative summary and a package is put together for forwarding to the PEB.

The goal here is 100 days. Fifty-five of those days are with the VA and that's really out of the scope of what we can do within Navy medicine. So we focused on the 10-day PEBLO counseling and then the narrative summary process at the back end.

In addition to that narrative summary what goes to the PEB is a non-medical assessment as well, the VA's assessment and then any related medical documentation.

So this is kind of a before shot. This is one of the desks of a PEBLO when we got started, you know, got paper.

So if you remember back to that first Henry Ford slide this is a job shop. This individual was being asked to do everything. They had to coordinate with the VA, they had to
work with the narrative summary and put together
the package for the PEB. They had to go around
and collect all the consults. They had to
interview the patient and counsel the patient.
They had to do everything. This is a craftsman
business. And so you come to work
every day and you see this on your desk. Where
did I leave off on the package on the top? The
rework, the amount of time it takes to get back
up to speed on where you left that package. So
at the end of the day you've worked all day long
but only three or four packages have moved off
your desk. And it's just as bad or maybe even
worse than it was when you started. So that's
where we started.

As you can understand I think things
are done in no particular order. We don't
follow something industrial engineers like to
call FIFO, first-in first-out. There's no time
expectations of when a package needs to move onto
the next location and there's very little
tracking and visibility.
If we look at more in statistics the top chart there shows the variation in turnaround time for finishing the initial consult with the PEBLO. A lot of variation but not unusual for some patients to spend 70 days before they finish that intake process, that initial consult. The average was around 20-25 days but a lot of variation.

In the bottom, that's a narrative summary, the chart. And that shows that we're averaging about 45-50 days to get through the back part of the process. And again, lots of variation. So all typical things that you would see in what we call a job shop. Not following FIFO, no separation of tasks, unclear expectations. And if someone goes on leave all that paper on their desk sits there until they come back. And limited management visibility.

So we studied these two processes. And what conclusions did we come to? When I say we, it's not the industrial engineers now, it's the people involved with this process. So it's
the PEBLOs, it's the folks onsite that are defining what the future state is and what they want to do.

And one of the conclusions that we came to was that we could divide up these tasks between counseling and administrative. Administrative tasks are a little bit easier, doesn't -- it's not quite as hard if you don't have to interface with the patient so much.

So if we divide that up that should make things a little bit easier. And then we can lay out the space differently so that we have first-in first-out processing, FIFO as I mentioned. We can minimize the setup and rework, improve visibility of the cases and have clear time expectations so that we can manage to those.

Here's the assembly line kind of diagrammatically. The PEBLO or the person that does the counseling at the beginning and at the end is the same person. But in between there's three different admin staff, one responsible for
collecting and printing, obtaining all the proper documents and assembling the record, another one coordinating with the VA and the third coordinating the narrative summary and putting together the package for the PEB. So here we've divided up the tasks in very clear lines of authority and we can pass the packages forward.

Physically in changing the space, this is kind of what it looked like. And it may sound sort of trivial but this process here, if you go this way, this is all administrative. So patients don't go back this way. We start here at the first administrator and move on. So packages here are getting ready to be shipped to the PEB.

Over here, these are the PEBLOs that are interviewing patients. So the patients go this way but the patients don't come back here. And so we basically tried to minimize disruptions and allow the administrative staff to do their tasks in order. And you know, few
disruptions, FIFO processing, clear time expectations.

Oh and by the way, nobody can put any files in any file drawers. You have to keep all the files you're working on on your desk. So the lieutenant, Lieutenant Cook who is monitoring this whole process, she could walk through in an instant and see where the bottlenecks were. They were on the desk. So if someone was slowing down or something wasn't working quite right it's visual management. You just walk past a desk and you see what's going well and what's not going so well.

And then here we are a few weeks later. This is actually, this slide is sort of the after slide on the top there. Initial counseling, we got that down to 5 days. And the narrative summary down to 2 days with very, very minimal variation. So you could be assured that when a package got to that point in the process it moved forward quickly.

I mentioned again the same
management techniques that were put in place to allow this to happen. And that's really all I wanted to say about the MEB process. Any questions?

MEMBER CONSTANTINE: Sure. How were you able to get the NARSUM reduced so significantly?

MR. WARD: Well, basically it was a matter of coordination. We had that, the person who is responsible for that, when a package came back from the VA and now it was time to do the NARSUM they had a provider that they needed to coordinate with. They knew who that was.

And the expectations for that physician of how fast they would turn that narrative summary around was well known, managed. There's a lot of attention from the CO, the XO and of course there's quarterly reports of all the COs and XOs for the region, so a lot of oversight to make sure that the providers were completing those narrative summaries in a timely way.
They were dictating them. And so the transcriptionist had a day to turn it around. And by the way, putting most of the things that needed to go together in the package to the PEB were already done so we're just waiting for that last piece and off it went.

And we had a very energetic lieutenant who was keeping an eye on the whole thing and managing it. That's really all it took.

MEMBER CONSTANTINE: Thanks.

CO-CHAIR NATHAN: Tim, the QA of the process. In other words, the good news is we know that we used an assembly line approach and basically using the same amount of people were able to really increase the throughput. What was your QA on those that came back with -- you know, that were bad rounds?

MR. WARD: I am actually going to cover that in the PEB.


MR. WARD: But the answer is, the
easy answer is it went up, it went up
dramatically. A lot of the reasons why it went
up was because of the process we put in place
here. But a good part of the reason was because
of better feedback with the PEB. The
coordination mechanism, the handoff between the
MEB and the PEB wasn't that great. We improved
that and that's really the part that
dramatically improved the quality of the
packages that the MEB was providing to the PEB.

CO-CHAIR NATHAN: Thank you. Like
any good attorney I would never have asked a
question I didn't know the answer to already.
So I appreciate the answer.

Justin, to your point, it highlights
the differences between the services a little
bit because in the Navy system, for the Navy and
Marine Corps the provider who takes care of the
patient dictates the NARSUM whereas in the Army
there's a central group of MEB providers who
don't see the patient who dictate the NARSUM.
And each service kind of likes its own way for
various reasons.

But that has increased the accuracy of ours because it doesn't get kicked back because there's a disconnect between the person who's advocating for the patient, their provider, and the person who's counting on that record, that electronic record to dictate the NARSUM.

MEMBER REHBEIN: So as things leave the MEB and go onto the PEB it's all electronic.

MR. WARD: I wish it were true. No. It's three phone books and it's being mailed so we're not quite there yet. There are some portions of this at the PEB have been digitized and so the coordination between the PEB and the VA is electronic. But you'll see, I mean the mountains of paper are still with us. That will take a little bit longer.

Again, I think the focus here for all these projects is near term. You know, we want to implement change on the ground and be out of there in 3 or 4 months. I think the entire time
on the ground in the PEB from diagnostics through implementation was 4 and a half months. So it's near-term focused.

Okay, so onto the PEB. Of course it's really the Navy and Marine Corps Physical Evaluation Board so forgive me for not stating that on the slide.

Based on the work that we did in the MEB I often wondered looking at Camp Lejeune, I'm watching the mail go out and we've got these huge files going out every day. And I know there's a lot of hospitals in Navy medicine and they're all going to the same place. I envision that warehouse scene at the end of the Raiders of the Lost Ark. You know, where are they going and what's that look like.

And I never thought I'd see but then we were asked to go to the Navy Yard and take a look. And the first thing I saw there reminded me a lot of the Lost Ark movie.

So here it is, the PEB. This is the focus where we'll talk about next. I think that
it's kind of important for me to point out that simply applying these standard industrial engineering techniques have demonstrated that we can speed the process, we can improve the quality.

And the second half of this chart as far as I know really hasn't been looked at very much. I know from looking at the BBTS, the transition phase, there's a lot of time there now. It seems like there may be some opportunity in other parts of the process beyond the ones that I'll present to you today.

This slide is a -- we've process-mapped a process for the PEB. We call this the A to K chart. It starts at A there with MEB package arriving at the PEB and it ends when the whole file is packed up, put in a box and sent off for long-term storage. So that's A and that's K.

The purple parts are the parts that are really done by the PEB folks. F and I are done outside. F is done by the VA and then I is
the member's decision to accept or not accept the rating that they've been provided. So we got a good understanding of what the process was and that's kind of described here.

And here's a similar slide to what you saw earlier for the MEB. This is one desk in the PEB. And the dedication of these staff and their ability to work is amazing to me. I don't know how you come to work every day when you know what your office looks like, when it looks like this.

They're doing an amazing job. They're really working very hard. But we have a concept that we industrial engineers like to segment things up into value-add and non-value add. And when a file is sitting next to your desk and it's not being worked on, well that's just wait time. That's non-value add. The value-add is when the person is doing something with it.

And so if you look at all the material here and how much time it takes for the
person to actually process a record and how much
time it waits for that person to be able to
process the record, that's the non-value add
type. And the ratio between value-add and
non-value add here is very, very high. And so
that's something that we should be able to
influence.

You can also imagine that every once
in a while there will be an inquiry, you know,
where is someone's case file and it's a fire
drill to try to find that case.

So we looked at the three parts of
the process that were in the PEB's control. I
should mention that the person that divided it
up this way and basically the PM for this work
is in the back of the room, Tim Link, an
industrial engineer who works for BUMED.

What we found, what actually Tim's
team found was that at the beginning part of this
process from when the package arrives through
adjudication took 34 days. Once we received an
answer from the VA if the patient was deemed to
be unfit until we were able to notify the PEBLO back at the MEB was 21 days. And then it was 6 days -- if the member accepted the results it was 6 days to notify the service headquarters. Of course if the member didn't accept the results then we skipped back to D and we start the formal board process.

Since most of the patients were adjudicated in an informal way that's the process we focused on. We have not looked at the formal board process yet. So, but about 70 percent or so of the patients went through that informal process and that's where the majority of the wait time was so that's what we focused on initially.

And here's some -- kind of the before statistics. Again, until we get a package off to the VA, 34 days, and then back from the VA to the PEBLO back at the MEB, 21 days.

Same story from the MEB. Intake process was variable. There was an informal rework process between the PEBLOs and the MTF.
What Admiral Nathan said earlier, if a package went up to the PEB and it wasn't complete how do we tell the people at the MEB what's missing and how do we get that information back in the file. It was informal. So rather than -- if someone at the PEB knew who the PEBLO was at Camp Lejeune they'd call them up and say hey, you forgot about this signature, and maybe you got the person and maybe the person wasn't there.

And so it was not tracked, very informal, and things would wait. We didn't want to report that a case came up that was not so good so we'd leave that on our desk and wait for that person to respond. And so incomplete and missing items, those cases weren't being tracked, they weren't visible to management and a lot of time could be lost in that process.

Weren't following FIFO. I mentioned all the other things. A lot of interruptions. So, the PEBLOs from the MEB, from the facilities would be calling. And I actually was there at lunchtime one day and you
know, no one else was around so the phone at one desk rang and the person wasn't there. So then the phone next to them rang and that person wasn't there.

So clearly everybody at the MEB knew who was where and what the phone numbers were but how can you get any work done if your phone's ringing all the time? So we had to kind of get on top of some of those issues.

And to cut to the chase, here are the things that we came up with. And again, this is global "we." It was really the folks working in the PEB who came up with these ideas.

So standardize the MEB package content. We sent a checklist, developed a checklist and sent that out to all the MEBs. So now when they send a package up to the PEB there's a checklist on top and all the boxes are checked so we know that everything is in there. The narrative sum is there, signatures are there, all the dates are there and the package should be good to go.
MEMBER CONSTANTINE: I wanted to ask you about that because I thought there was a table of contents or maybe there is a checklist on there. But these files are so huge, I assume that whoever's sitting on the MEB or PEB relies on the NARSUM to a great extent, right? But are they going through all those folders?

MR. WARD: Yes sir, they have to go through the folders. And in fact that's one of the intake functions. There's a recorder function. So after the package arrives and we date/time-stamp it to say yes, this package is here.

Then a recorder has to actually go through all that material, put tabs on it to say it -- was there a mental health consult? Okay, well that's here, put a little tag there. And they basically tag the whole package to make sure that it's all there.

MEMBER CONSTANTINE: I wonder why that wasn't -- I kind of thought this earlier when I saw a little bit of the process, why that
wasn't done on the front end. When the person puts the file together to send in why don't they go ahead and put those tabs in as they're putting the file together?

MR. WARD: Well, I'm glad you asked that. You know, what we've been talking about of course was a standard package so that every package looks the same. And there's a three-ring binder with all the tabs in it.

And if it's got to be in paper then every package submitted to the PEB should be the same. If you needed a mental health consult that's Tab G. If you needed an orthopedic consult that's Tab H. It's all in the same order, all in the same place and it should -- you could probably cut out almost a day in the recording function just to read through the package and tab all that stuff to make sure you've got it all.

MEMBER CONSTANTINE: I think right now it's chronological, right? Which doesn't really do much for you unless you know exactly
what you're looking for. But unless you're that
guy's doctor you don't know where it was.

MR. WARD: It's all over the map,
you're right. There's some opportunity there.
And of course the staff in the PEBLO, just to go
a step further, you know, why stop with the tabs.
Why don't you have a template so that the docs
can actually, you know, we can give them a heads
up in performing the NARSUM and doing the input
that they need. How far down that road of
standardization can we go? Right now it's not
standard. So there's a bit more rework. But at
least the folks in the MEB can assess a package
and make sure that it's complete before they send
it to the PEB, and that alone dramatically cut
down the amount of rework and the phone calls and
all the rest that went back and forth between MEB
and PEB.

And then of course there are still
some and so we developed a little case tracker.
So it's a little database. When a package comes
and it is incomplete the recorder function has
to put the information for that package in a database. What's incomplete about it. That is available to the management. That is sent back to the people at the MEB and so we can really facilitate that process of rework to make sure we get a complete package and we're able to process it relatively quickly.

If the PEBLOs have a question they now call one number. It's a hotline. They don't call all the desks and interrupt everybody. And one person is responsible for answering the hotline that day and everybody else is working.

There is some electronic transfer of information between the PEB and the VA. It's not the complete package but the PEB decision about fit and unfit, the non-medical assessment of the CO and the NARSUM are scanned and that scanned information is sent off to the VA for the rating function.

And the rest here is pretty much the same as you've seen previously. You know,
establish time expectations, set rules and
responsibilities. And then one of the other
problems was that when you finish a case will
there be any follow-up and actions required. So
they didn't want to actually get rid of the
material and send it off to long-term storage.
They'd keep it at the PEB for a period of about
6 months or more.

So you can imagine the back of the
room was filling up with boxes. And so every
other week now they're packaged on a pallet and
off they go. And that just alleviates a lot of
square footage and a lot of excess handling of
materials so we can move on.

The bottom of the slide here on the
left, that shows you that checklist that I
mentioned that now goes on the top of every
package from the MEB submitted up to the PEB.
And again it's great, it's very simple but it
does eliminate a lot of rework.

And on the right this is a report
right out of the tracker. This is a slide from
Quantico. And it shows you how many cases were submitted from this location up to the PEB that had problems, and if there were problems what were they. You see that there was two incomplete/missing signature. And another one as well. So we can track the errors, we can give feedback to the MEB and just basically speed the process.

And this is the conclusion. So within a relatively short period of time, actually look at the X axis here, those are weeks. So really within a modest number of weeks we were able to cut the intake process from 34 to 11 days, cut the VA to PEBLO notification from 21 to 9 days, and then cut a day off of the response to the headquarters as well. Grand total 36 days.

They process 8,205 cases a year. That's 295,000 wait days that were cut out of this process, or 809 man-years in about 4 and a half months.

Questions?
CO-CHAIR NATHAN: Tim, this is a question that I actually don't know the answer to. Where did we -- didn't we petition a PEBLO in some of our bigger areas where we do a lot of these to do nothing but be the consultant to the PEB for cases to relieve the other PEBLOs from getting calls about their cases?

MR. WARD: You mean at the MTF, sir?

Yes. So in the places where there's a lot of workload like Pendleton and Lejeune, that's exactly right.

CO-CHAIR NATHAN: Because your IEs found that a PEBLO, even the assembly line PEBLO who had done the counseling on an individual was getting called by that individual saying hey, my board's at the PEB, can you tell me how it's doing. And that PEBLO would have to stop what they're doing and call the PEB and try to do it in the middle of interviewing other patients or other warriors.

And so we took a PEBLO and said your job today is to be the PEB guy. And when
somebody comes in to ask a question about where their board is even if you didn't do it, you get their name, you call the PEB and you get an answer back to them. That's all you do today. Let the other PEBLOs who are preparing cases just concentrate on that.

MR. WARD: Yes, sir. I couldn't have said it better myself. The industrial engineers I work with, I get a lot of grief because I use the same analogy all the time. I say the fire department and the bus line. They're smiling at me back there already. They've heard this so many times.

One of the things that tends to really mess up processes are when you mix things that should be done in a routine standard way, in a scheduled way, with things that have to be done emergently.

So imagine a bus line that's going from stop A to stop B and in the middle of the route somewhere it gets a call to go to a fire. Well, nobody's going anywhere on time today, and
by the way, you probably didn't respond to the fire very well either.

We don't mix fire department functions with bus line functions. The bus line needs to go on time every day and the fire department needs to be standing ready to take care of that unexpected event.

And so that's part of what you were talking about, sir. We have to figure out how much of that random arrival of information needs, of requests are going to come in. We resource that and that stands alone from the folks who are doing the day-to-day bus line job, the standard job.

And that really does -- I can give you lots of examples in healthcare about operating rooms and emergency departments and all kinds of areas where that philosophy kind of holds true. And it certainly holds true here in the PEB.

MEMBER PHILLIPS: Two quick questions. Have you been able to or do you plan
to follow up to make sure that this is sustainable? And is the process scalable?

MR. WARD: So, yes, we do have a sustainment function where we go back and look and we have gone back to the PEB periodically, about every 2 months or so.

The real trick to sustainment is an IT system that gives you the metrics. Now, for -- in our MTFs we have more control over that than we do at the PEB. So the Pentagon IT department has developed a management tool to track and keep visible all these things in the PEB but it has not been implemented yet. They're still going through the authority-to-operate loops to put the thing on a Navy system. So that's going a little bit more slowly than we would like but it's coming.

In the MTFs we have gone to Pendleton and Lejeune only. I think there's been a lot of discussion and it's a small world in Navy medicine so a lot of this has just kind of morphed everywhere else. But I think maybe there is
some opportunity there to do it in a more
standard way and make sure things are keeping
track.

Looking at the systems, the data, it
looks good. We're able to respond in the MEB
process. We're able to respond in under 100
days. So I think the process is under control.

MEMBER PHILLIPS: And is it
scalable? I assume it is but I mean if the
volume triples or quadruples it'll still work do
you think?

MR. WARD: Yes, sir. I think -- if
I go back to that slide that had the stick
figures, you know, the five stick figures. It's
important to put the correct process in place but
then you need to resource it. How many can they
do in a day. We've got those statistics. So
when do you need to add a second production line
if you will. How many do you need, how many
people on that do you need. That's part of the
analytics. And so it's really not rocket
science at all. It's totally scalable.
CO-CHAIR CROCKETT-JONES: Denise,
which of the locations that we have been to --
I can't quite bring it to memory -- were the
pilots for the digital -- turning the entire
caseload into a digital product. Where were we?

MS. DAILEY: San Antonio.

CO-CHAIR CROCKETT-JONES: Never
mind. If it was San Antonio then --

MS. DAILEY: The Air Force PEB and
MEB process at San Antonio were the electronic,
the e-file, one of the e-file pilot sites for a
case management system that they want to use
through the whole system.

CO-CHAIR CROCKETT-JONES: So are
there any Navy sites that are on that same pilot
or is that an Air Force-only?

MS. DAILEY: Well, the PEB at the
Navy Yard was on that pilot but asked to be taken
off if I remember correctly. It was not working
for them. And I don't know the other locations.
It might be -- I won't speculate on what the other
locations were.
CO-CHAIR NATHAN: Again, I always preface this because sometimes it sounds parochial because we like -- are proud of the fact the Navy was the first one to hit their numbers and get within spec first. We attribute a lot of that to yourself, Lieutenant Cook who was just, you know, looked like the guy in Ben-Hur holding the whip over the Greeks who were rowing the boat.

But the analog was, and this is where we sometimes get a little different from the Army. And the Army -- I always preface this. The Army, to answer your question, when it comes to economies of scale we pale in comparison to the number of Army records out there. In other words, the Army wounded warrior population and the IDES population compared to the Navy is much, much bigger. So they really have a huge monolith to get their arms around.

That said, the initial criticism of the Army was that when they were getting behind, like doing shop work, jobs work, they just simply
asked for more people to do more of what they were already doing.

And we kept saying, you know, rather than ask for 1,000 more people to throw at this why don't you look at significant process change. And again, what we talked about was who dictates the NARSUM.

And there is -- once you get an MEB group going that really knows what they're doing and can get good electronic fidelity from the AHLTA record you can dictate a NARSUM although it did cost them some problems where they got kickback from the PEB.

And the other was the Army, when they would do the MEB looked at all conditions, all ratable conditions, not just those that are unfitting, whereas the Navy dictated a NARSUM with just unfitting conditions for service continuation knowing that the VA would eventually process the remaining conditions.

So those were some of the differences in process. But as a result of this
the Navy and the Marine Corps got down within spec at their 100-day mark for the MEB and the 295 for the PEB rating.

MR. WARD: Yes, sir. With no additional resources.

CO-CHAIR NATHAN: With no additional resources. Because when you're out at sea all you have is the crew itself.

MR. WARD: Any other questions on the PEB? Okay, then I'll move along to the C5, Comprehensive Combat and Complex Casualty Care. This is from San Diego. So, here are the questions that you asked about the program. Have there been any changes that have occurred after your visit? I think you'll see some.

The point of this project was not actually to -- it was to implement change but it was basically to develop a better understanding of what are all the component parts within C5 and how do they function together. So I think these questions, other than question 4, we'll answer
along the way. But I want to come back to this what are the major challenges question at the very end.

Admiral Faison, this is a quote from Admiral Faison before we started the project in the scoping. Identify the benefits and resource requirements of C5 program to enable -- to ensure continued world-class rehabilitation care for wounded warriors and family members and other C5 patients in light of probable volume and funding fluctuations. So that's the problem and it was very clearly and succinctly stated by Admiral Faison.

This project was about 10 months long so it was longer than a typical project. It just has a lot more moving parts to it. And we had to develop some interesting tools to help manage this process as part of the project.

So there's three tools that were developed. One is called the FACET, the Forecast and Capacity Evaluation Tool. This is a resource-planning tool. Then there's
something called the PMA, Program Management Aid. This is a tool that is basically used for case management. All the notes and everything are kept in here and the handoff between case managers is facilitated.

I'm not going to go over the Program Management Aid today. Basically that's about an hour discussion to walk you through all that but I'd be happy to do that at another time or give you a demo of it or whatever if anybody is interested.

I'm going to focus on the FACET because that's sort of a higher-level tool. And then I'm going to show you just a little bit of this guide for patients with lower limb amputations. So I'm going to focus on 1, a little bit on 3. I'm skipping 2 but I'll be happy to talk about that at another time or give you whatever background information you might need.

So, what is the FACET? Well, we have to anticipate appointment demand. We have
to understand what the provider capacity is. We need to know about the patient population. How many people are arriving, how many patients are arriving, what's the timing, what's the case mix. Those are all the variables that we deal with on the input side.

And what we want to know when it's all over is we want to know how many providers do I need, how many rooms do I need, how much money do I need. What are the resources that I need to run the C5 program.

And that's -- we didn't know all that. The C5 program was sort of built a piece at a time over the course of 6 or 7 years. And so now we've got a great program that's up and running, but how do we sustain it and how do we resource it sufficiently but not excessively moving forward.

So, to design this FACET tool for resource planning the first thing we had to do was categorize patients into meaningful groups.

And to give you -- just every one of these steps
here, there's a lot of work behind each one of these things, a lot of statistical analysis.

Identifying and defining patient categories, that's like developing the diagnostic-related groups, the DRGs. I mean we had to look at all the patients that had passed through the C5 program, divide them up into categories that were clinically meaningful because if they are clinically meaningful we're not going to have any great discussions with any of the providers. But they also had to have a resource component to them as well. They had to have similar resource utilization. So just coming up with those categories was no small task.

And then we had to summarize the patient episodes of care. Well, some of those episodes, some of the parts of the episode are on the inpatient and so you use Essentris. A lot of is on the outpatient, that's AHLTA.

But there's also -- there's also lab results, X-rays, all kinds of ancillary services
that have to be taken care of. There's this data from the surgical scheduling system. There's probably 17 or 18 different IT systems that need to be put together to allow us to summarize the episode of care. And I'll show you a little bit about that in a minute.

Understanding provider capacity is also not a small task. Studying arrival patterns. Studying patient case mix. And then combining all those things into a tool that is easy for anybody to pick up and use, that was the goal and that's what we built.

So patient categories. I've eliminated a lot of description about how we arrived at these 10 categories, all of course with clinical involvement. But here are the big 10. These are the 10 patient types that are treated in the C5 program. Bilateral amputations, unilateral amputations, other amputations, TBI, gunshot wounds, multiple fractures, you can see the list.

And then what do we need to know for
each one of these. Well, we need to know what services each one of these patient types consume and in what order. What's the timing of it and how long does it take them to recover and those kinds of issues.

So here is an example of a bilateral amputation episode of care. We kind of call this the DNA chart. But what you see is for this patient type there were 56 bilateral amputations that were processed through the C5 program. Fourteen clinical areas on the lefthand side. And what you see here color-coded across time, so this chart goes out to about 3 years but most of the care for these patients really is within the first 2 years. And actually the vast majority is within about 18-20 months.

But the red means that they're getting more than three appointments per week, orange is two appointments per week, yellow one appointment per week. And so you see physical therapy on the top there, huge amount of physical therapy for the first 30 weeks or so of a
bilateral amputation patient. And you get the idea.

So we have now been able to categorize and really define the care pattern for bilateral amputation patients across 14 different clinical areas across time that were treated through the C5 program.

And so this is not the average. This is the 70th percentile. For resource planning purposes if we designed everything for the average then half the patients would arrive to not have enough resources. So we err on the side of being a little high. So we want to set it at the 70th percentile.

And given this now you can use these charts, this description of the care that's been provided to anticipate the future. When the next patient arrives that's a bilateral amputation patient how many resources are they going to consume. Well, we now have a really good idea of that number. And we can put that into a little model and we can use that to predict
resource requirements in the future.

Questions on this? Here's another one. This is multiple limb fractures. Same idea but totally different resource utilization.

And then the last one is gunshot wounds. Again, a lot less physical therapy. But what's interesting to me anyway I thought was if you look at the mental health they're okay in the beginning but right about 30 weeks or so is when the majority of gunshot patients need more mental health services, more care in that arena. So patient care patterns differ and we've been able to characterize all those. So we've got this type of description provided for each one of the 10 patient types and we can now have a really good idea when a new patient arrives. Or if we want to talk about the future, what if something happens in North Korea and we get patients that are going to be of different categories. We can understand what the resource consumption of those patients will be.
MEMBER REHBEIN: I would expect that some of these patients would have fit into more than one category. How do you characterize care in those cases? Because TBI and bilateral amputation seem to me a number of the providers would be the same.

MR. WARD: Yes sir, you're right. And so we try to use the method that the DRG, Fetter and Thompson used in the eighties to develop DRGs. It's the one that's going to have the highest resource consumption. That's the one that dictates the patient category that that patient is put in.

And so, and of course this is a statistical game. So the larger a sample we have the more confident we are. And we don't need to be that precise. We want to be a little bit -- we want to estimate -- overestimate just a little bit but not too much. And that's why we set it at the 70th percentile.

So for resource planning this is a great tool. What is an individual patient going
to do? That's hard to predict. That's pretty much impossible to predict. But for resource planning this is pretty good.

Okay, the next slide talks about provider capacity. How many -- when you have a case manager how many patients in the C5 program do they visit in a week. What about EMT, internal medicine, mental health. So we had to do a lot of statistics on provider utilization and build that into the model.

With the war in Afghanistan in particular the summer months are the most active. And most of the patients, I mean almost all the patients don't arrive at San Diego first, they're processed through Walter Reed and then to San Diego. So there's a lag and you see that bump there around August-September. That's when the majority of the patients were moving to San Diego. They'd finished some care and now they're basically moving forward in rehabilitation. And so that's when they get to San Diego.
That changed from year to year. We had 5 year's worth of data to look at these care patterns. And so this is actually a 5-year moving average.

But you can actually look at any individual year and there is variation in there by year. The amount of change and variation in the arrival pattern has a great deal to do with resource consumption. So it's important to understand how it changes.

And then here's just a few slides to kind of walk you through how this tool is used. It's something you put on your laptop. It's a spreadsheet type tool.

And so this is the first screen. You get to choose whether or not you want to restrict the population to just those that -- just those patients that use physical medicine and rehabilitation services or the total population. In the C5 program there were a lot of patients that were screened and then not admitted to C5. So should this patient go
through the C5 program. That screening would happen in C5 and then many times, no, they would not be placed in the C5 program. And so if you want to include that work you'd use a total population number or choose total population or you could on the top here as we've done this example restrict the population to those patients that required a great deal of physical medicine and rehabilitation.

Next screen then. When you're done with that the next thing that pops up is you get to decide what the annual arrival rate will be of new patients. That's in the top box there and we've placed 200 here.

And then you get to decide that arrival pattern, that seasonal pattern. And there's several things for you to choose from or you can actually build one yourself if you don't like these options. But in this case we're going to use the 2011 arrival pattern.

And then thirdly you get to decide, the user gets to decide on the case mix. So you can
use the historical information on that mix of the
10 different patient types, how many of each, or
you can go on the bottom here and you can adjust
it any way you wish.

So if a planner, someone who's
talking about resources thinks that in the next
war we're going to get more bilateral amputees
or more TBI or more this or that or the other
thing you can adjust the tabs in the bottom here
and run them out and see what happens to resource
consumption.

And this is just a summary tab. So
this summarizes all the parameters that the user
has put into the model and then off we go.

So this is the output. What it
shows you is the number of providers in FTEs for
each 1 of the 14 clinical areas. And the graph
here shows the utilization of that provider type
across time over the year. So a physical
therapist, we expect a jump in physical therapy
between August and September. We can actually
see how the need for physical therapists given
all the parameters we put in fluctuates and varies across the year. And of course that's an artifact of the seasonality that we talked about earlier.

So now, previous to this tool there was really no way for a planner to look forward and say hey, this is what's happening, this is what I think I'm going to get downstream. How many physical therapists am I going to need? How many case managers am I going to need? What do I need to plan for? And now we have a tool that allows us to do this.

And what's really, to me what's really important about this of course is that getting back to Admiral Faison's question, what are the resource requirements to maintain the viability of the C5 program moving forward. We now can estimate those numbers very accurately.

MEMBER EVANS: So, and I may get in trouble, but the question that I have is that do -- this started, we started C5 probably, what, 5-6 years ago. And it was because of the war,
because we needed to move the Marines closer to the west coast to the base and provide that care in San Diego. So I would think we would do a look 5 to 10 years from now.

Are we, DoD, Navy medicine, is this the business we want to be in. Because we started this because of the war. Is it cost-effective? My favorite term.

And again, I don't know, but it's just a question. I understand Admiral Faison's wanting to sustain this but is this the business we want to sustain or is this something that we want to shift. VA really is our rehab.

So it's a good question that I think 5 to 10 years do we stay in the rehabilitative medicine. Is it sustainable or is that something that civilian or VA should be looking for moving.

CO-CHAIR NATHAN: I think it's a great question. We've been wrestling with that. You know, before the war we used to get criticism for having physiatrists on the staff
to take care of chronic stroke patients because those should be transferred to a rehabilitative facility, not -- MTFs shouldn't be in that business.

An interesting dilemma which specifically, Tim, is you may or may not know about the C5 in San Diego is they went through a period of time there where they were really taking heat because they were not hitting their marks at all getting wounded warriors into prosthetics.

And they couldn't get the prosthetist to come in and do the fittings. They were way behind. It was taking weeks and months. There were letters coming left and right to the CNO, the commandant of the Marine Corps. They were coming to me. They were yelling at me. So I'm a good leader, so I yelled at Forrest.

And come to find out here was the problem. So a lot of these people, Connie, were being discharged from the C5 and they were going
to go to the VA for care.

Now, if you were the VA and you were going to get in the prosthetics business which most VAs do because vets that had amputations since time began but mostly elderly vets who have ischemic peripheral vascular disease, diabetes who lose a foot or a leg or something, you know, that kind of thing.

Where would you put the center of gravity in southern California if you were the VA of your prosthetic rehabilitation? L.A. That's where the population is. It's huge VA. So you'd put your prosthetics thing in L.A. because you have a few in San Diego but you have this huge population of vets in L.A. who are coming to get their amputations taken care of.

So they didn't have anybody in San Diego. So they kept coming back to the C5 because they'd go to the small VA in San Diego, relatively small, who said we've never seen prosthetics like this. These things are, you know, we can't do that.
And so they'd tell the soldier you need to get in the car and drive to L.A. And the soldier said I'm not driving to the VA in L.A. I'm coming back to the C5. I dare you not to take care of me. And we did of course and it backed everything up.

So then the VA got very, very energized about this. And to their credit the VA said look, let us help you hire on the VA payroll some prosthetic experts to put at the C5 and working with VA patients which is I think that sort of joint partnership makes sense. The numbers came down and Forrest hired some more physical therapists.

But it begs the question. At some point when all this stops being acute injury, God willing, and we end up with just chronic rehabilitative and restorative care which amputees need a tremendous amount of, the readjustment and refittings and new prosthetics and those kinds of things, whose business is that.
Right now it's been all our business because aside from the VA polytrauma centers which are amazing the average VA is not equipped to handle a high load of these kind of new type things coming along. So we've sort of figured it out on our own and kept them in our system equilibrating with the VA.

As the pressure comes, and it will. I think our next speaker will allude to some of that when he comes in to talk about the Defense Health Agency. As the pressure comes for the military treatment facilities to downsize, to get smaller, to stop -- to not being as robust as they are and figure out how to be more concentrated and supporting just war-fighting we have to wrestle with who's going to take care of these.

I don't know if, Karen, you have any philosophical thoughts about it from the VA standpoint.

MEMBER MALEBRANCHE: Well, I guess one of the things that has come up before in the
VA and continues to is the military has a lot of experimental prosthetic devices that are -- companies are going to the military I think in hopes of promulgating that. And the VA doesn't necessarily have that. And like you said, not everywhere.

So sometimes then when veterans start out in a place like the Walter Reed and then they go to a little tiny place in Oklahoma there is not the people there at that VA to take care of that device without having to send it back. I mean, there's a lot of those sorts of issues.

The VA though has always prided itself on being the rehab piece of doing all this. But like you said, the centers where we have and the population that we have has been different.

But what's interesting I think is that some of these younger vets now are incentivizing our older vets who say you know, I don't think I want this wheelchair. I think I want the running leg, the swimming leg, the
this. I mean there are some interesting things that are coming from this.

But I think it's also a matter of the economics and the research and what we can and cannot do. And we don't give five different legs that they might get here in the D.C. area at a place where we don't have someone to work it.

And there is I think even some new devices, I'm thinking in Texas somewhere too that we have people that are getting fitted for these. But then when they go back to their home who's going to help maintain? They can't be mailing this back. So there are some of those issues I think that are a big concern.

CO-CHAIR NATHAN: No, it's a great philosophical question. And I've teased Forrest Faison, the commander out at San Diego, about being the colonel in Bridge Over the River Kwai.

If you remember that movie the whole point in building this massive architectural
wonder was to tear it down at the precise moment
the enemy were going to cross it. And at the end
he couldn't bring himself to do it because he'd
built it and he was so proud of his prisoners who
had built this bridge he could not destroy it
even though it was going to help the enemy if he
didn't destroy the bridge.

There may become a time when we have
to sort of relegate the C5 to, you know, mothball
status. I hope that day comes because it means
we no longer need that kind of acute -- yet it
does an amazing rehabilitative service for all
kinds of things. So I think it'll always be
present, the question is how much it drops to a
surge status. And I think it'll be an
equilibrium of that.

Amputations at the end of the day as
I tell most civic groups, there have been less
than 1,500. If you're one of those 1,500 who
have suffered a single or a multiple amputation
then the numbers are immaterial to you. To you
that's your whole life and I get it. That's
1,500 too many.

But we have that many TBI and PTSD patients being produced every month. And so I think what we're going to be doing is training our guns more on the behavioral health and the TBI over the long run as the amputations equilibrate and go back into a more normal loss from a motor vehicle accident, motorcycle accident, that kind of thing.

Tim, keep going.

MR. WARD: Well, so on that point, sir, so we have actually done some of the math. And if you want to maintain the C5 program of course the real bottleneck is the prosthetist. And how do you -- how many prosthetists do you need and how do you ensure their currency.

And the answer is well, you can't have one, that's a single point of failure, so you've got to have at least two. And two is kind of on the edge, but if it's two supported by enough prosthetic techs that's good. And so you can actually use the tool I just showed you to
back into the number of patients that you need to maintain the skill set in San Diego.

And it looks like, you know, we're still running some of the numbers but it looks like the answer is about 40 new patients a year that would be amputees that would be sufficient to keep everybody busy in the gait lab and the PT.

And so if the decision is made that this is a viable program that we want to maintain we need about 40 patients a year, new patients a year coming through the program of a similar character in terms of the injuries that they sustained to the historical C5 patients.

CO-CHAIR NATHAN: And that works for me but you have the CFI in San Antonio which is going to need a throughput. You have the MATC at Walter Reed which is going to need a throughput. And so again where is the center of gravity for amputation, traumatic limb salvage going to occur.

MR. WARD: Right. And actually
that's my last slide, on this subject, anyway.

MEMBER EVANS: We're actually utilizing this too at San Diego. So we're using this currently.

MR. WARD: So we have briefed this to the folks at Walter Reed and San Diego and to the VA here in D.C. as well. This tool is based on the care patterns that were provided in San Diego. We have not done the statistical homework on what care was provided at Walter Reed or at Brooke Army.

So there is some, you know, are the care patterns the same? Are they different? How different are they? This tool right now is not easily ported to another location. With some statistical homework it could be but right now that hasn't been done yet.

CO-CHAIR NATHAN: I was just talking to my co-chairwoman here but one of the things we may do for this to maintain currency, the same way we're looking at trying to maintain currency in level 1 trauma support is what
they're doing in San Antonio where they have an
MOU with the city where they're a level 1 trauma
center and take care of people who are non-DoD
beneficiaries for trauma that are brought to
them.

We may end up doing the same thing
with some of these places where we will then make
a deal with the state or the city and say that
19-year-old who's not in the military who loses
his leg or her leg on a motorcycle or to a gunshot
wound or to something else, we'll take care of
to try to maintain some currency. So
there's all kinds of things we can look at in the
future. Necessity is the mother of invention.

MR. WARD: And so the question of
what should the overall MHS capacity be for
treating amputation patients in the future,
that's a key question.

We have three locations right now,
mainly three locations. What do we want that
future state volume to be.

It turns out we did the math on
purchased care workload and other things that happened outside of the war wounded. There's about 180 MHS beneficiaries every year that are below the age of 65 that have a traumatic amputation for other than a vascular problem. So it's not diabetes, it's not age-related. And so about 180. But that's probably not enough to run all three programs.

And by the way, earlier this morning you were talking about patients who wanted to get closer to home. If you want to be in the C5 program you've got to be in San Diego. And so to somebody who has a traumatic event like that happen somewhere else do they really want to move to San Diego for a year and a half, 2 years? So there are issues like that to resolve.

But anyway, we have the math, we know the numbers. The decision about how to maintain this capability throughout the MHS, that's on the table.

Okay, I wanted to go over one more small thing and then I'm done. I've got about
three or four slides to go.

So this is a slide that just shows you the -- it's a guide for patients with lower limb amputations. I think one of the things that always intrigues me is do the patients understand their process.

Do they understand where they are and where they're going and how long it's going to take and what can they expect. And what we found was that there's a lot of very well-intended folks but the information is very diffuse and it's very hard for patients to figure it all out. So can we put it all in one place.

And so the list on the left there are the different sources. And there's more than that, but there are a whole lot of sources of information that patients who had had a traumatic amputation can access. And what we did really was put it all in an iPad tool so they can page through it and access it at will.

So here it is. This is the iPad screenshot. And then there's the table of
contents. And you click on a button and it moves you to the page.

And all the web -- so if there's another site like the VA/DoD CPGs for lower limb amputation that's on a website, click on the button. If it's web-enabled you go off to that website. So all those links are in it.

But here's kind of the slide I think sort of summarizes it. It takes patients through the process what they can expect in terms of protective healing, pre-prosthetic training, prosthetic training, and then return to a higher level of functionality and activity. And click on the button and it takes you to more definitive information about each one of those phases.

MEMBER REHBEIN: Sometimes iPad means iPad and sometimes iPad means mobile device. Can you tell me which one you're referring to?

MR. WARD: Well, this is actually for an iPad. It could be for any mobile device though because it's just PDF files with the links.
in there. So it could be on any -- I don't think you could make it work on a phone. The screen's not big enough. You wouldn't be able to read it. But yes, it's any mobile device. And that's all I have.

GENERAL ROBB: Admiral Nathan along the lines of what you were just talking about of maintaining currency in the end of war years as far as who's going to be the keeper of the scrolls, keep the power line burning.

There is a discussion on a request for the Defense Health Board to look at that issue of maintaining again a core competency if in fact we decide that's what that is for polytrauma rehab, primarily for amputees coming out of primarily from actually Retired General Franks. And so we're in the process now of teeing that up in that request to go through P&R to actually have that up.

And then again, precisely what you said. You know, what are the branches and sequels for maintaining currency competency.
Where should the standard of gravity be? You know, can we afford to have three currently or do we collapse to one and then all three services rotate through and then have the ability ultimately to expand in case we get into a conflict like this.

So all these questions are being asked right now. And again we're going to have the folks look at that to kind of maybe give us some research and some homework to figure out where we need to go with that.

So again I appreciate that question because I think it's going to tee us up what we need to do as we lay down currency competency not only for trauma care but for polytrauma rehab and several other things as we call it in the end of war years.

CO-CHAIR NATHAN: Thank you, General Robb. Appreciate that. Any other questions for Mr. Ward?

CO-CHAIR CROCKETT-JONES: Thank you, Mr. Ward. I think the task force now has
a 15-minute break.

CO-CHAIR NATHAN: Why don't we try to, if it's okay with you, make up a little bit of time, take 10 minutes.

(Whereupon, the foregoing matter went off the record at 2:24 p.m. and went back on the record at 2:36 p.m.)

CO-CHAIR CROCKETT-JONES: At this time we welcome Major General Douglas Robb, the Joint Staff Surgeon under the Offices of the Chairman of the Joint Chiefs of Staff. Major General Robb is providing us an overview of the Defense Health Agency and its impact on recovering warrior care. The information can be found under our Tab G. I'm going to turn it over to you now.

GENERAL ROBB: Well, thank you all very much for the opportunity again to give you all an update on where we are on Military Health System governance reorganization and reform.

Now, the good news is that if I get out of bounds Admiral Nathan who's been a part
of this can get me back on track. And so he probably knows as much about this as I do primarily because again of the three services he is a leader and they're prime players in where we're going.

And so this is a good news story. I know there's a lot of angst out there because any time you reorganize and you have a status quo you're comfortable with it even if you're not happy with it, but you're comfortable with it. And so we're going to talk about where we think we need to go.

I'm going to do something that's non-standard for me is I'm going to pretty much read off the script here only because again this is new. It's somewhat complicated at times, can be if you don't understand it. And I want to make sure I cover everything. And number 3, and Admiral Nathan knows me better than anybody. I can get off piece pretty quick. And so that'll allow us to stay on the trail.

So I am currently the Joint Staff
Surgeon, primary medical advisor to the Chairman of the Joint Chiefs of Staff. And I was asked to co-chair along with Dr. Guice -- again, as you know, she's the Principal Deputy Assistant Secretary of Defense for Health Affairs who will be speaking to you next about the IC3. We were asked again to come up with a transition plan for MHS governance. So next slide, please.

So my purpose today is to update you on these several topics. It won't be as long as you think but these are all the primary issues that we need to talk about. I'll give you a high-level overview of the current healthcare system. It's always good to know where you start, and then keeping the end state in mind. And then what it means for the Defense Health Program. And then I'll give you a brief background history of the governance and how it has transformed from 2 years ago to today through a series of memorandums from the Dep Sec Def. And then lastly I'm going to describe how the new transformation impacts the recovering warriors.
which I think is key for you all to understand. And then from there I'll hand it over to Dr. Guice who then will talk about the Integrated Care Committee, or the IC3. So next slide.

Here's the bottom line. We know healthcare costs are increasing, both in complexity and cost. And as you know that complexity drives cost. So at the heart of the issue is the fact that the Department, the Department of Defense, must be able to sustain an effective, an efficient, but just as important relevant healthcare system which improves cost containment and unity of effort, all leading to better health, better care, better readiness at a reduced cost. Where have you heard that before? Quadruple aim.

Now, additionally and as we're living that dream every single day in the last really 12 to 24 months the future fiscal considerations and the broader crisis is of course a fiscal crisis that are facing our nation, the Military Health System must do their
So this slide gives you the main four big reasons for the growing care and healthcare, but primarily TRICARE costs for the Department of Defense. These include an increase in new eligible beneficiaries. So the population is going up so therefore you multiply that by head count per cost, our costs are going to go up.

You've got expanded benefits. So the benefits, the amount of benefits, the type of benefits and who we cover have increased primarily over the last decade. You've got TRICARE for Life now, TRICARE Young Adult, TRICARE Retired Reserve, TRICARE Reserved Select and also increased prescription benefits. And all those again have evolved over -- again, Admiral Nathan was chair primarily over the last 10 years so it's a different environment than when we first started practicing medicine.

Additionally you've got not only an increased number of folks covered and increased
benefit but you've got increased utilization across both our military treatment facilities, what we call the direct care system, and also the TRICARE network or the purchased care system. And we're seeing that specifically in emergency room visits, orthopedics and mental health visits.

And finally, healthcare inflation is what it is and it is higher than the general inflation rate. Any questions on that slide? Next slide, please.

So many of you all have seen this slide at least that have been part of the MHS governance reform initiatives for the last 2 years.

We refer to this as the planet or the solar system slide. It represents the Defense Health Program, or the DHP, budget by O&M activity groups. The blue circle over there on your right reflects the pure management activity dollars as a small percentage as you can see of the overall Defense Health Program budget.
So when everybody talks about well just eliminate some management, see how many people you can save, that's small dollars compared to where the dollars are being spent and that's in the direct care system and on the network. So what you really want to do is create a system that affects those circles downstream, either curb the cost or decrease the cost.

So reducing the cost in the military healthcare system requires a focus on the cost in that big red circle. Particularly in that direct care system our MTFs and the private sector care or the network TRICARE system.

To affect those costs at the core of the new governance model that I'm going to describe to you is a shared services approach and the implementation of what we're going to call enhanced multi-service markets. And you go what's that. Well, we'll talk about it.

So now a shared services approach will increase the effectiveness and the potential efficiencies in all areas of cost in
the red circle. MHS shared services approach provides an extremely attractive potential would turn on relatively small investments.

As an example, right now you've got Army, Navy and Air Force all separate contracting systems save for, well pick something, linen, you know, or hazardous waste disposal. In fact you may have even within a particular service, you know, you may have multiple contracts doing the same thing. So it makes intuitive sense if you do the business case analysis, remember, we're going to do that for each one of these product lines that a centralized contracting potentially, potentially may be the way to go. And so this Defense Health Agency with the shared service portfolios that you see will give us an avenue to do that, one, give us the authority to, and number two, give us the ability to.

Then also let's talk a little bit about the multi-service markets and how they're affecting direct care and the purchased care
systems in the red area. And again, I'll talk about where those locations are.

But there's six what we're going to call enhanced multi-service markets and they include the National Capitol Region. A lot of folks know that as JTF CapMed today. And they represent our largest medical centers as you can imagine. And they also are the bulk of our graduate medical education which makes sense because they're at our largest medical centers. And that's where our specialty care is.

And these multi-service markets execute about 35 percent of our direct care costs. And they serve our largest and more concentrated beneficiary populations.

So where are those locations? National Capitol Region, San Antonio, Colorado Springs, Hawaii, Fort Lewis, Puget Sound, and I'm missing one. Bobby, what's the sixth one? No, San Diego is a single market which is going to behave like a multi-service market. Tidewater. I'm sorry, Portsmouth. Spoken
like a true Navy man. So big house on the east coast, yes.

So, how are we going to do that? Well, primarily we're going to do it by how we're going to manage the budget to support what we're going to call 5-year performance business plans. So what we're going to do is again it will be policy and then through execution that these markets.

Right now if you're in San Antonio the Air Force has a budget and the Army has a budget and they collaborate on how they want to deliver care. But then the money then flows back down through the services. So the plan is that they will create a single business plan. Doesn't mean they're not going to take care of the Air Force product lines and the Army product lines, but then the lines that cross, okay, the money's going to flow that way and earmarked that way. So you can see it's going to force a better integrated delivery care system for those markets. Next slide, please.
So you say hey, Doc Robb, you talked about this before. And the answer is yes, we have. Yes, we have. There have been 18 studies since 1946 I think into `48 on MHS governance.

Now about one-half of them recommended a more unified organizational construct such as a unified medical command. And just under one-half of those recommended a more centralized authority for delivering shared services or a Defense Health Agency-like entity. And there were a couple of them that said keep as it is.

But it wasn't until our most recent MHS task force in 2011 where the previous 17 studies, they were not able to gain the consensus nor the effort required to implement the large governance transformation that we are currently experiencing.

Those 2011 task force recommendations and now the most recent MHS governance implementation planning team -- I'll talk about that -- the leadership from both the
Department and the services have agreed upon and are now implementing the vast reforms to MHS governance that will have a positive outcome on cost effectiveness, collaboration and we hope overall efficiency.

What is key is that we intend to maintain this momentum and work towards full implementation with a proposed full operating capability date of October 2015. Next slide, please.

So here's how we got to where we are today. So the current MHS governance reform initiative began in June of 2011 with a Dep Sec Def memo directive to stand up the task force on MHS governance which delivered its final report to the Dep Sec Def in September of 2011.

The task force recommendation to the Defense -- actually, the task force recommended a Defense Health Agency model for overall governance and recommended the enhanced multi-service market model for providing budgetary management authority for the six
identified multi-service markets to include the National Capitol Region.

Subsequent to that, March 2012, the Dep Sec Def memo planning for the reform of the governance of MHS which was based on the task force on MHS governance recommendations directed the establishment of the Defense Health Agency, the six enhanced multi-service markets, and the transition of JTF CapMed to the NCR Medical Directorate which will be a subordinate organization, by the way, of the Defense Health Agency.

And then further directed the standup of the MHS Governance Implementation Planning part two. Next slide. Part three.

So in January of 2013 the MHS Governance Implementation Planning Effort presented their implementation planning recommendations to the Dep Sec Def. So after compliance with the FY 2012 NDA language the Dep Sec Def signed the 11 March 2013 memo, implementation of Military Health System
governance reform, and he directed the implementation. Now, directed the implementation of the MHS governance reform in accordance with the FY `13 NDA language. So there we are. That's how we got to where we are today.

So we are now in the implementation mode and from the March 2013 memo and we have begun the transition implementing those recommendations. Next slide.

So here's our way forward. So the Department as you can see is committed to MHS governance reform as depicted on this slide. The MHS governance reform began -- it will begin, actually it has begun with pre-IOC in the spring of 2013. So that's where we are today.

And as you can see from this the pre-IOC includes selection of DHA director, the standup of the MHS governance transition team, which has already been done, and a completed assessment of the 10 shared services which we are in the process of doing now. And we'll talk
about what those 10 shared services are here in a moment.

Initial operating capability will occur in October of 2012 with the standup of the DHA as a combat support agency which will be responsible for the designated shared services.

Now, ASD Health Affairs reorganization will also be implemented by this time. And we'll talk about what's going to entail. And then the six eMSM's or enhanced multi-service markets will stand up to include the transition of JTF CapMed to the NCR Medical Directorate under the DHA.

In October of 2014 the enhanced multi-service markets will be executing, monitoring and evaluating their 5-year business performance plans and the NCR Medical Directorate will be fully operational under the DHA again as an enhanced multi-service market.

By October of 2015 the DHA, Defense Health Agency, will be fully operation-capable, FOC.

So let's reminisce just a little
bit. Much like the Defense Logistics Agency of 25 years ago the Defense Health Agency will face similar challenges. There will be an evolutionary process from a far-reaching Department strategic initiative to a more relevant world-class medical support organization whose ultimate goal is to provide second-to-none medical readiness support to the war fight while delivering better care, better health at a reduced cost to our 9.7 million beneficiaries worldwide.

And as you are acutely aware, and as I mentioned before, in this era of fiscal realities the MHS has the responsibility to the Department and the medical organizational reform is a must-do. So let's get into the details of what it's going to look like. Next slide.

So here's the notional reorganization for OSD Health Affairs. And you say it looks like it does today. Not really, all right? Not really.
What you're doing is you're removing the dual hatting of the ASD Health Affairs, Assistant Secretary of Defense Health Affairs, and the director, the TRICARE Management Agency. So most ASDs are policy only. And again over time our organization has morphed into a combination of policy and execution. And I mean, for reasons that were there.

And so here's an opportunity while we created this thing called the Defense Health Agency, an opportunity to set that right. So as part of the MHS governance planning team's efforts the Health Affairs work group evaluated the current functions of Health Affairs and the TRICARE Management Agency and they recommended how policy and execution should and will align in the future. So they recommended through the current dual hatting policy of policy and execution in Health Affairs with TMA being the execution arm in Health Affairs be separated with the standup of the DHA.

The intent is for Health Affairs'
focus to be on policy development but they will work with the Defense Health Agency to ensure proper execution of Health Affairs' policies and the TRICARE health plan.

Health Affairs is going to be still responsible for advising DoD leadership on all departmental health matters and be responsible for policy development, approval and oversight. Policy development, approval and oversight, while executing the ASD Health Affairs fiduciary responsibility as a Defense Health Program appropriation holder.

Note that the warrior care policy and oversight will remain as the Deputy Assistant Secretary of Defense, the DASD. I know a lot of folks have been asking that question.

Now the following slide is going to depict the transition of the current TRICARE Management Agency and the healthcare plan and the other TMA execution responsibilities to the Defense Health Agency. Next slide.
So here's the Defense Health Agency organizational structure. So, the Defense Health Agency will deliver the TRICARE health plan. It exercises the direction and the control of the NCR Medical Directorate. So you're going to see here, here's Warrior Care Programs. And down here you see here's the TRICARE health plan and here's the NCR Medical Directorate. So I'll step you through these.

And it provides the shared services listed on the slide for the services medical departments. So one of the groups was what are the shared services, what is the core of what all three services do that might be better served with a more centralized approach. And that's what these are. TRICARE health plan, pharmacy programs, medical education and training, medical research and development, health information and technology, facility planning, public health, medical acquisition with a small A by the way, and budget and resource management.

So that's the initial start.
So right now each one of the services either does those in parallel or does those in silos. And it makes sense that this core here can provide standardization, decreased variance, hopefully increased efficiency which it should and we really hope decreased cost which again it should. That's why we're doing business case analysis on each one of these product streams. And they will deliver that to the services.

So this is not the Defense Health Agency shared services, this is the services' Defense Health Agency. That's the way I look at it. That's the way I look at it. This is not the Defense Health Agency or Health Affairs Defense Health Agency. This is the services' Defense Health Agency.

Now, the Warrior Care Program, something I think folks are going to be interested in this room here, their execution now will fall under the Healthcare Operations Directorate. Remembering that from the
previous slide the Deputy Assistant Secretary of Defense for Warrior Care and Policy will continue policy development, approval and oversight and execute again the fiduciary responsibility for those programs.

Now the Defense Health Agency will be led by a 3-star. And again it's going to be designated a combat support agency.

Now, what does that mean? The 2011 MHS Governance Task Force recommended the designation of the DHA as a CSA, combat support agency, to ensure that the chairman, okay, the combatant commanders and the services were properly supported by this new agency.

And you say how is that so. Well mainly because the way it's going to be set up is you don't see this but here's the chairman's organization. There's a dotted line that goes right to this guy's -- he can put his finger in his chest as we say and say hey, you're not supporting my services. Or DHA goes back to the chairman and says hey, the services aren't
playing.

So it's a good relationship. It's the same relationship DLA has, DIA and all the other groups. And they are required every 2 years to submit again a status of support and for the chairman to comment on you are or are not supporting again our enterprise.

Now, the DHA is organized to manage those shared services that will transition from the three service medical departments and TMA. The ongoing shared service assessment process applies objective analysis and ensures proper consolidation of services that will either reduce the cost on the direct healthcare system -- remember we were talking about those two big blue balls over here, those two big planets -- and into a minimized variance across the MHS.

Now we're going to specifically talk about the NCR Medical Directorate. That will provide -- the NCR Medical Directorate will provide the authority, direction and control over the Walter Reed National Military Medical
Center and Fort Belvoir Community Hospital and their satellite clinics. And then the director will receive specified support services from the Defense Health Agency. Next slide, please.

Now, what are these multi-service markets? And I talk about this because for the folks that aren't military in the room C2 is command and control, command and control. This is a relationship to ensure strategic alignment, not command and control as you have many times in military organizations.

And you say well, where's the authority? The authority is around the money flow because money sometimes trumps -- no, I'm just joking. But money does drive behavior, money does drive behavior.

So the Multi-Service Market Work Group recommended that out of the MHS Governance Task Force we identified 14 potential multi-service markets. And I apologize. Multi-service markets means where two or more services within a catchment area which is
usually a 40-mile catchment area, TRICARE catchment area, reside.

So San Antonio -- Air Force, Army. Tidewater -- Air Force, Navy is the big man on campus. Air Force is there with Langley and then you've got Army presence also. You look out at Hawaii, of course you've got a large Army footprint, you've got a large Navy footprint and you've got a medium-sized Air Force footprint. You go out to Colorado Springs, you've got a large single Army base but you've got four Air Force bases out there. So you can see where the opportunity for more direct collaboration and integrated delivery is there.

Then you go to San Diego which is actually in an extremely large market as far as volume and also Fort Bragg, another extremely large market as far as volume, but those are considered single-service markets. However, their expectation is that they will play by the same business rules as far as performance, business performance rules as the multi-service
markets. So if you add those to the six multi-service markets you're going to get upwards, up to 45 percent of our direct care costs.

Now, the enhanced multi-service market manager and their staff is going to oversee the respective markets as an integrated delivery system as we said before and they're going to direct the collaboration, input into 5-year business performance plans. So working from the bottom up let's talk about how this is going to work.

The enhanced multi-service market manager, so let's just pick San Antonio for example. Okay, you've got 2 -- either a 1- or a 2-star down there. They're going to alternate, the Air Force and the Army will alternate being the lead down there. The staff will remain the same but they'll put together this 5-year business plan and then that market is expected to live by that 5-year business plan. So they're going to be accountable
to this Multi-Service Market Governance Council as we call it. So they're going to build these plans and then we're going to have this thing called the Medical Deputies Action Group which are going to bless those plans. And then if there's any issues they work up through -- everybody knows what the SMMAC is today, Senior Medical Advisory Council, right here.

Now this organization out here is new. That's new. And that is called the Military Health System Executive Review. And we've added that because we wanted more line involvement in senior Military Health System strategic decisions and initiatives. And that is going to be the service vice chief's forum for the DoD leadership input into the strategic transitional and the emerging issues facing the multi-health system, the Defense Health Program and the DoD.

So we're hoping that that MHSER as we call it is going to provide a forum for improved line medical partnerships and inform
MHS corporate decisions through the enhanced line understanding of the MHS financial realities as we talked about on that second slide and the challenges.

But more importantly it's a mechanism for senior line input into the transformational MHS governance decisions. So we've already had that first meeting and they've already blessed off on this MHS governance way ahead. So we have buy-in on where we're going. Next slide.

So here's the impact of the MHS governance reform and the DHA to the recovering warrior. So what you'll see is these governance reforms may impact the recovering warriors primarily through the establishment of the Defense Health Agency and the standardization and the consolidation of common clinical and business process into a cost-effective and efficient shared services. These transformations will improve the experience of care as well as access to care across the MHS.
enterprise through more efficient and cost-effective practices.

    Now, the next briefing that you're going to get which is the VA/DoD warrior care coordination or the IC3, that's primarily where the rubber meets the road. And I'm going to tee up Dr. Guice. She's not here yet. So this is the big enterprise that we're doing to again deliver more cost-effective, efficient and more relevant healthcare.

    But the IC3 which I think is primarily what you all are as interested in as anything, and I was also a co-chair of that task force also, is where the rubber meets the road. And that's where we're going to connect the DoD and the VA together. One mission, one policy, one plan. One mission, one policy, one plan.

    And what we had going on before was -- okay, she's not here. I'll steal her thunder. So what was going on before was we had a lot of good people doing a lot of good work but in an asynchronous manner, in an asynchronous
manner.

So you had two departments, the Veterans Affairs and you had Department of Defense doing some good work. I mean not perfect work, but pockets of good work. But they weren't synchronous.

And then you had within the DoD Army, Navy, Air Force and Marines not necessarily, at times, at places they were, but not across the board in asynchronous manner. You even add in the Department of Veterans Affairs doing care services and benefits, individually maybe doing some good work but in an asynchronous manner.

And so what we're going to build, and she's going to talk about that, and kind of all this was all coming together was when you think about common doctrine or common strategy. And I share this with you because you can think about it before Dr. Guice gives the briefing.

So let's use the military as an example. The President says here's our national security strategy. There's the end
state. There's the overall guidance.

Then the chairman takes that overarching guidance and then he adds the joint support to that plan. And then the Army, the Navy, the Air Force and the Marines all synch their plans up to the chairman's plan which is then synched to the President's plan. One mission, one policy, essentially one plan.

So what you saw was there was no overarching guidance for the DoD and the VA. I mean we kind of thought we knew where the end state as but there was no overarching guidance. So we're going to create the first interagency departmental guidance. So you can talk about that.

And then the DoD's plan needs to synch up with that. The VA's plan of course has to synch up with that. And then you're going to have a common operating picture, common operating plan. You're going to get this whole brief across the board which we don't have before that cuts across all four services, two agencies
and again the three what I would call portfolios of the VA.

And so that's going to be, again, a fascinating piece of where the rubber meets the road and then integrated again with the Defense Health Agency and better delivery of care, integrated care, through the enhanced multi-service markets. All of that going together, again.

And in your interim report that you had about a year and a half ago or so, a year ago or so, we took those line items through the IC3 and some of it from this and matched them up on where are the gaps, where are the seams, you know, where are the redundancies and where do we need to go. So, next slide.

I believe that's it. So that's a high-speed pass through the MHS governance reform, organizational change, specifically focusing on a couple of areas again for this group. Where does the wounded warrior and what is the recovering warrior current policy and
execution. Where are they going to be transitioned to in this new organization. And with that I'm opened up for questions.

MEMBER MALEBRANCHE: General Robb, on the mission and structure you have the National Capitol Region Medical Directorate. And then you have in the enhanced service market, that's a separate one. What's the differentiation and what's that -- there's nothing under the box. I mean what's behind the box? What's that mean?

GENERAL ROBB: Okay, so let's go back.

MEMBER MALEBRANCHE: Okay, that far right, the National Capitol Region Medical Directorate. That's separate in and of itself, but it's also part of the multi-service market, National Capitol Region. What's the differentiation of that?

GENERAL ROBB: Okay, so that's a good question. I could be evil and ask Admiral Nathan to answer that question but I won't do
that.

CO-CHAIR NATHAN: He just wouldn't like the answer he gets.

GENERAL ROBB: Yes, that's right.

CO-CHAIR NATHAN: But I do want to thank you because even though you consider this a high-speed pass everybody needs to know he was speaking about twice as slowly as he normally does.

GENERAL ROBB: Yes, yes.

CO-CHAIR NATHAN: And so we're grateful for that.

GENERAL ROBB: That's because I had to read. But that's a good question.

Now, so we mentioned that there's six multi-service markets. And again they're defined by assets in a geographical location. So you've got, again, we've got Puget Sound, Hawaii, Colorado Springs, San Antonio, Portsmouth.

Now they're all what we would call traditional multi-service markets in the sense
that there's two or more services sharing that area and then they're going to have a multi-service market staff. The money's going to flow initially one way then over time we will create a flow of money that's earmarked towards what we call the 5-year business plan.

Some of them are going to be individuals. Like Hawaii will be led by the Army. Puget Sound will be led by the Army. Portsmouth will be led by the Navy. San Antonio will rotate leadership between the Air Force and the Army because they have -- both have very large equal mission population footprints. So for equity.

And Colorado Springs, that multi-service market lead director will rotate between the Air Force and the Army. Again, Army has a very large facility but a large base, but the Air Force population and the mission set there is almost equal there. So that again they will rotate.

Now, let's get -- what about the National Capitol Region? Okay, now, Walter
Reed National Military Medical Center and Fort Belvoir Community Hospital through a series of decisions that begin with BRAC, transition through JTF CapMed organization to execute the BRAC.

A decision during that time was to make those hospitals joint hospitals and not service-led hospitals. Hang with me here. So now Bethesda is not a Naval hospital and Fort Belvoir is not an Army hospital because if they were it would be exactly like the other multi-service markets as far as organizational.

But since they're joint hospitals and we have chosen to keep them joint hospitals they have to belong to somebody. That was the question. Who do you hang those two organizations onto?

So we created the thing called the NRC Medical Directorate, transitioned JTF CapMed to the NCR Medical Directorate. Right-sizing the overhead staff because BRAC is done. Now we have to put it somewhere. Because
it's a joint organization it's got to be hung on a joint organization. So you can hang it on a COCOM which by law you could, like NORTHCOM, but that doesn't make a lot of practical sense. So we chose to hang it because it made geographical location and the product lines were more congruent with what it is. We hung it on the Defense Health Agency. So that will be -- but the market, okay, just like that could have been a Navy hospital, could have been an Army hospital. Then you have all these smaller forces Army hospitals. Even though it's still going to behave like a multi-service market. But it's just going to have a different organizational construct. But it will be executing a 5-year business plan just like San Antonio, Tidewater or Pacific Northwest and Hawaii.

CO-CHAIR NATHAN: Along with the regional facilities.

GENERAL ROBB: Yes, yes.

MEMBER MALEBRANCHE: Okay, I have
another question, one more to tag onto this. What happened to North Chicago in all of this? Which is a federal facility. Where do they fit in the structure? They're still under healthcare operations in there somewhere?

GENERAL ROBB: Who do they belong to now? They belong to -- it's still a Navy hospital.

CO-CHAIR NATHAN: Still Navy.

GENERAL ROBB: Still Navy, yes.

MEMBER MALEBRANCHE: So it's still Navy. It's not one of the markets.

GENERAL ROBB: In this construct, in this large organizational reorganization they're not at that level per se, no. But what we learn from them --

CO-CHAIR NATHAN: You've got a VA hospital.

GENERAL ROBB: Right.

CO-CHAIR NATHAN: You've got a Navy hospital. They happen to co-locate at the same building. They share services. They have MOUs
and MOAs that allow them to do all kinds of things together. They jointly man the wards, they jointly man the ICU. Like England and America separated by a common language they are separated by separate EHR which is the bane of their existence, VistA and AHLTA, and that's where we're working very hard to figure out how to use Janus and other things to try to put them together. But they are both separate facilities that answer to their separate bosses.

So at Bethesda the soldier or the sailor or the airman working there answers to a boss who runs that facility. But the sailor working at FACC answers to the Navy boss whereas the VA staffer answers to the VA boss.

GENERAL ROBB: It's another -- it's another continued trial run of is there merit. And we continue to -- that's a whole other briefing, you know, the merits of does that make sense to continue to look at are there efficiencies to be gained, et cetera, et cetera, from that quote unquote "marriage" up there at
Chicago, yes.

CO-CHAIR CROCKETT-JONES: Okay. I have a couple of questions. One's totally nitpicking. Isn't Anchorage also a multi-service?

GENERAL ROBB: Right. So it was 1 of the 14, yes. Yes, it was.

So what I didn't have up there was the criteria that they used to choose the 6 out of the 14. So there's a lot of different ways we could have done this but we did it with population, volume, primarily at the inpatient centers and there were a couple of other things. So there's three or four or five criteria and I apologize for not having them in the top of my head that kind of made a cut line where you saw. So the larger markets kind of rose to the top.

Now, and as we roll this out and try to get it right we figured let's go after the 35 percent or 45 if you count Fort Bragg and Balboa, let's go after that first. Instead of transitioning the entire MHS multi-service
markets at once, let's get it right. Let's go for the biggest bang for our buck initially and then -- but you're right. As soon as we learn the lessons learned the sooner we get this going right and in the right direction we will expand the same ROE or business case analysis to and then the business performance plans to the -- again there's another -- 8 and 6 is 14. There's another eight of them out there. Yes, ma'am.

CO-CHAIR CROCKETT-JONES: Just one of the reasons, we were just there and that made me think of it. And also because their remoteness drives so many special concerns that I'm wondering if this multi-service market, the model you're suggesting might not -- might not actually help them out.

The other question I had is is there a plan on the lead for that Defense Health Agency lead, that 3-star you indicated, is that going to be a rotating through the services or is that just going to be an appointed position or what is their plan for that?
GENERAL ROBB: Okay, so what that will be. In fact there's going to be -- several of these are going to be joint positions. One, probably this one, probably this one and then this one. Military as opposed to SES.

So the answer is there's a joint -- for joint billets there's a joint process. And it is a nominative process. So just like DLA, DIA and all these other, the COCOMs, combatant commands, there is a nominative process. And so the services can choose to submit a name and just like we do today we have two actually rotating nominative positions. One of them is TMA, TRICARE Management Agency deputy director. That's a nominative. My position is a nominative position. It historically rotates, historically. But there are times when services have other needs and they may choose to skip a cycle or some will say who they want. It just depends.

But it's a nominative process. Just like most of the joint staff physicians,
they don't always rotate. They can rotate. Sometimes a service takes through deals over time. We'll see how it matures. But the answer is yes, it will rotate.

CO-CHAIR NATHAN: And Doug, if I could just add a little bit to the first question, just clarify it. Remember, the reason the multi-service markets enhancement is being put into place is that in theory they're not operating in that catchment area at peak business efficiency. One service is doing its thing that may not make sense for the whole area while the other service seeing care may not make sense.

A hypothetical example. One hospital has an -- a Navy hospital has an extra dermatologist and is using that extra dermatologist to be the QA coordinator, in charge of valet parking and other things.

GENERAL ROBB: That's not how it is.

(Laughter.)

CO-CHAIR NATHAN: The Army hospital
next door is desperately short of a
dermatologist. And so they're sending all
their dermatology out to the private sector.
Whereas if the two had an overarching business
plan and could look at dermatology in toto for
the area they would then make business
decisions.

That in reality may not go down easy
with some of the services. Some of the services
may say you're kind of impinging on my autonomy
and the way I like to operate my business.

That's where the E for enhanced
comes in. Enhanced is a euphemism for I've got
a big stick and I'm going to make you do it,
services. And all the services are going to
have to capitulate to some extent because all
three services at different areas are working
together.

In Anchorage it's a little less
service parochial because they're all in it
together, meaning that the Army and the Air Force
are really, there's a small contingent of
personnel at Elmendorf. But they're mostly
driven there by the market economy of what's
available completely in the military and what's
not. And so the footprint there, it doesn't
mean you couldn't do it. It just means it
doesn't have the amount to be gained
percentage-wise by making better overall
business decisions in that market with its small
inpatient production than you do in San Antonio,
Portsmouth.

GENERAL ROBB: But over time the
same business performance plan process will
migrate out to the other -- so that the entire
system is as efficient as we can.

And again, to try to piggyback on
Admiral Nathan's example. There will be -- we
can see in the future that remember, our MTFs
exist, military treatment facilities, primarily
they're inpatient facilities. They exist for
-- the primary reason is so that we can create
platforms, readiness platforms for our
healthcare providers to become as current and as
competent as possible to execute the contingency mission.

So, what I call, it's a currency and competency model which is why our graduate medical education is there to large facilities. Just like in the civilian sector, you know, the larger the volume, the larger the acute care, the better the experience for graduate medical education.

They also serve, again, to take care of the garrison-based populations and the beneficiaries that we've been asked to take care of, again, soldiers, sailors, airmen, Marines, their families.

So when you look at it that way, and the Air Force has kind of evolved. Not because I'm Air Force, I'm joint now, but I've watched the Air Force. Because of the way their bases are set up they don't have the large populations to support the large medical centers like they used to because medicine has changed. There's no 10-bed community hospitals left anywhere in
America unless you live in western Wyoming.

So what happens is the Air Force now gets their currency and competency in other people's houses. So that's why you see with BRAC down in San Antonio it's a different model than up here. But they have the exact same footprint, inpatient footprint to drive a currency and competency model. But they actually have employment inside Brooke Army Med Center. Twenty years ago that would have been unheard of.

We have a large footprint, about one-third of Landstuhl Regional Medical Center's delivery of inpatient care are Air Force providers because all our large hospitals over there, like Weisbaden and the other places, are gone now.

So we get our currency and competency, when I say "we" the Air Force gets their currency and competency to support the contingency response for Europe inside an Army hospital called Landstuhl Regional Medical
Center. And then they share staff. They actually share the senior staff but it's commanded by an Army person.

So I see that maybe to be the future. So that Balboa may say hey, if I had an extra surgical or EMT team I could generate this much recapture and the Navy may have -- and the Army may have an EMT team that is not as productive as some other place and they wish they could -- higher currency and competency rates. They may choose to put them inside. They may advertise a vacancy.

I could see in the future where we start plugging holes in other people's houses for currency and competency. I don't know, Admiral Nathan, does that? That's kind of the thought process of where do I get currency and competency to fulfill the readiness requirement. At the same time if I'm doing that, the way I do that is I recapture from the direct care -- on the network into the direct care system. So where can I balance my assets
to get the most recapture.

But what that really drives, it drives our costs down, but it drives our readiness and our currency and competency up.

Admiral Nathan, comments on that?

CO-CHAIR NATHAN: I think you're spot on, Doug. We are -- our system is skewed currently. We have MTFs that are understaffed and under capacity and overrun with patients and patients are spilling into the private sector.

And we have other MTFs of all three services that are really the Maytag repairman and are sitting there just waiting for the phone to ring because there aren't enough patients in the market, or the penetration in competition with the private sector is too great. And we can throw more staff, we can build prettier buildings, but we're not going to entice anymore. So we're looking very hard at how we can right-size our facilities.

Expanding what Doug was saying, medicine has changed now. It's more ambulatory
than it ever has been before. So many of our MTFs across the services are small ones. They're only in one inpatient business primarily. What is that inpatient business? Any guesses? Babies. They're delivering babies. So it's not uncommon to go to one of our small hospitals and say what's your census and they'll say it's three and a half. You'll say a half. Yes, a newborn.

And so we have to decide if we want to maintain the overhead. We have some hospitals where the ICU census is one or two per day, patients per day. So you can't make a business case for that. But like General Robb was saying, you can't make a readiness case for that. You're not maintaining your current competency as an ICU team if you're taking care of just one patient a day. You're not seeing enough of illness and acuity to do that.

Yet we have other ICUs in other facilities that if we could double the staff would double the load. And so we're going to try
to redistribute.

Now, there's a couple of things that stop that, that could stop that. One is political pressure. Go to a particular representative of a particular state and when you try to close the missile base whether it makes sense or not you're going to get some heat. If you try to close an air base, an Army base, you're going to get some heat. If you try to close a hospital you're going to get some heat.

And then the second is the line themselves. The line officers, line leaders as much as they want to save money and medical, some of them like having their own sort of dedicated inpatient facility right there on the base because they can control that. They can control the quality, they can put their finger in somebody's chest who wears a uniform, who works for them.

And so on the one hand they're saying medicine, you've got to get cheaper. But don't take my inefficient hospital away from me
because I really like it. And so some hard
questions are going to have to be generated.

But what's happened is these
questions which have always been around for the
last 20 years have finally become realistic and
on the front burner because the cost of medical
care now in the DoD I think is legitimate. I
think people are getting value for what we spend.
But it's inefficient and it is going way too
high. And it's going to eradicate the
discretionary spending of DoD if we don't get a
handle on this.

And so we talked about medical
centered home today which is a big change in the
way we're going to manage our patients. General
Robb has talked to you about the multi-service
markets which we're going to build in a much more
business-centric way rather than
service-centric way.

All these represent change to people
who if you're long in the tooth like I am, you
know, it's hard. But on the other hand you
cannot fly in the face of what we think is progressive change.

And whenever you turn on the radio and you listen to an ad by Kaiser that talks about on my mobile phone I changed my appointment, I made a new appointment, I got my lab results, I sent a note to my doctor and I scheduled my mammogram, that's what we're in competition with. And if we don't meet and exceed that expectation we can't expect our patients to want to enroll to us. So we're busy doing that.

And the shared services. Everything Doug said is absolutely true. There's no reason we should have three separate service IT programs, three separate pharmacy programs, three separate facility planning programs.

The hard part is how do you decide how much the DHA serves as policy and how much do you decide it gets execution and ownership rights. Because the very same line leaders who say I am all for standardization but nobody
better tell my Air Force commander how to run his pharmacy or her pharmacy. And so again they're going to have to reconcile themselves to what the CONOPS is going to be.

MEMBER EVANS: I'm just looking at where we look at the structure and depiction of warrior care programs. And working with the IC3 I find this warrior care programs. When we talk about politics and line involvement and who has oversight of processes when it comes to our warrior care this little area right here is very concerning only because we have problems we're trying to -- when we talk about change, you know, everyone says go to warrior care programs. But I'm not sure if they truly have the authority or where they -- and I see we've kind of moved them further down on the --

GENERAL ROBB: Further down from what?

MEMBER EVANS: I believe they used to be directly under -- and I'm not sure. It may not be.
GENERAL ROBB: Remember it was policy and execution were combined in the old model. So there's still a DASD. So back here, go back here. So they're still here. Policy is still at the same level. It's still a special interest item so it's still at DASD. Okay?

Now the execution, remember, the execution was to blend it inside of TMA. So we're going to consolidate a little bit more and it's going to be dropped into the healthcare ops there. I mean there's work to be done on that. We don't have all those line by line yet.

But the answer is the execution is going to be separated from the policy. But my vision, having been part of the IC3 task force creation and seeing where they're going to go I'm going to tell you where money is to be made we execute that one mission, one policy, one plan. We get that, what I call that competency checklist right. This group here -- well, let's go forward one. Okay, right here. Okay, what you're going to see, that community of interest.

NEAL R. GROSS
COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
(202) 234-4433
WASHINGTON, D.C. 20005-3701
www.nealrgross.com
And again you're going to hear from Dr. Guice. That community of interest is what's going to draw the integration together. Okay?

And I'm not so sure who's going to be leading who to be honest with you. My thoughts, and Karen was part of that group. I'm not so sure they're not going to be leading the thing and we're going to be following. We'll see. We'll see. But I understand your concerns and that's the part we're going to work with.

I see these guys, how do I advance position these folks right here, whoever -- the whom, number one, and then how to best support the vision of the IC3. Comprehensive plan really is what it's going to be. Community of interest of which there will be an integral part of one.

MEMBER REHBEIN: Sir, coming at this totally from the outside I just need to clarify a couple of things. One, the -- okay. The WTUs will still belong to the Army. Wounded
Warrior Regiment will still belong to the Marines.

GENERAL ROBB: Yes.

MEMBER REHBEIN: But if they fall inside of one of these eMSM's their healthcare will be delivered by the Defense Health Agency. That doesn't --

GENERAL ROBB: No, no, no.

CO-CHAIR NATHAN: Only at Walter Reed and Belvoir. Because Walter Reed and Belvoir are the only two MTFs in the whole Military Health System which will be carved out of their services and put under a joint oversight of the Defense Health Agency. Every other MTF in the world will still belong to its parent service.

GENERAL ROBB: Yes.

CO-CHAIR NATHAN: So the commander or the director at Walter Reed Bethesda who used to report -- at Walter Reed used to report to the Army Surgeon General, Bethesda the Navy, and so forth. Now the combined commander/director of
Walter Reed Bethesda will report ultimately to
the DHA, to the 3-star who is the Defense Health
Agency director.

Bremerton Hospital, Brooke Army
Hospital, SAMC medical center, San Diego, David
Grant out in Fairfield, Travis, will report to
their services and be on the hook to their
services.

GENERAL ROBB: So and I think that's
a good question. It's confusing. Because
really what we're talking about is the business
plan.

But right now each of the three
services, four with the Navy doing it for the
Marines, are historically now creating their
current 3-year business plans.

So again I'm going to use a for
example. In Tidewater. So Portsmouth is -- I
don't know where they are in the cycle but
hypothetically speaking the Navy is creating
what historically is a 3-year business plan that
really is for Portsmouth Hospital only. Going
up through the Navy channels.

Then they aggregate that at regional, de-conflict, push it up to BUMED. Then they take that, give it to Health Affairs, say here's how much I want to execute military medicine, Navy medicine.

In the Tidewater at the same time Langley Air Force Base First Fighter Wing Hospital, is creating their 3-year business plan for the Air Force hospital which will then be aggregated in Air Combat Command which then will go up to AFMOA which will then go up to the Air staff. And then Eustis I guess would be there in the Tidewater area would have theirs going up through the Army channel.

Now, what we just agreed upon, sir, what your deputy agreed upon whether he informed you yet or not is that --

(Laughter.)

CO-CHAIR NATHAN: Maybe he's not my deputy anymore.

GENERAL ROBB: He's leaving anyway,
right. So the middlemen made a good call that
day, sir, was the fact that all three of them
agreed that the next step we need to do, because
now we're saying you need to create as a market
a 5-year business plan. So as you can imagine
you just can't turn that one off and start the
new one. What they're going to do now is
collectively bring, say, Eustis', Langley's and
Portsmouth's individual plans which they're in
the process of creating, we're going to bring
them together, de-conflict them and then
notionally apply them to what would now be the
futuristic 5-year business plan. So that's,
we're working our way through that.

So that's -- but the care will be
delivered --

MEMBER REHBEIN: By the service.

GENERAL ROBB: Correct, but it's in
an integrated system now as opposed to stovepipe
system. Now, that's not to say that those
multi-service markets -- and Tidewater was
probably as good as anybody. They weren't
already doing notional or volunteer collaboration anyway. But when the rubber met the road there were times when they wanted to do initiatives that may have been better, not only good for the Tidewater area but better for the enterprise. But as service chose to use those assets somewhere else that better served the service and not the enterprise. And so this organization here combined with the multi-service markets is going to force us to do something we've never done before and that's in an open forum de-conflict and ask the services to make the case on what about me is better than what's better from the enterprise. And then ultimately Health Affairs will funnel or channel the dollars where they think is best for it. There may be times when the service does win but we never had an opportunity where you debated that in an open forum about what's best for the enterprise and these multi-service markets.

Now all the services realize it's going to be give and take at times. There's only
winners and losers. But I would argue unless as an enterprise we have to get stronger, more effective, more efficient, more cost-effective, more relevant, and we have to preserve and enhance our readiness projection platforms. Or it doesn't matter what the service thinks because that's ultimately what we need to do is provide -- I mean we have an incredible track record in this last conflict of providing, again, highest quality care. But that's becoming very expensive. Remember there's a tale to the lowest mortality rate in the history of warfare, and there's a tale to the lowest diseases non-battle injury in the history of recorded warfare.

And so in order for us to continue to be viable we've got to get better at preserving those platforms. And the only way we're going to do that is in a collaborative manner. And I will again defer to one of the surgeon generals who's got a large stock in where we're going.
CO-CHAIR NATHAN: I mean at the end of the day, you know, some people treat this like the parable of the pig and the chicken that are walking down the road and they're both hungry and they're talking about breakfast. And the chicken looks over at the pig and says how about ham and eggs. One of them contributes, the other one is all in.

And I think that we all recognize, my counterparts as well, that we have to look beyond our service parochialisms within our catchment areas and make some compromises which some could be painful. An example. Maybe we'll have somebody who goes to a service hospital who's been put there to be the director of something to groom them for executive medicine so they're in a leadership position. Yet they hold a valuable skill that nobody else has in that catchment area. And the market manager looks at them and says I'm sorry, I know you're training to be an executive officer, but I really need you to practice your trade of
rheumatology or cardiology because that's what I'm short of. Unless your service can send another one of you out here to do that I need that because it doesn't make business sense.

Where does this get sideways with the services? The readiness option. For instance, if Jack Welsh were here he would look at the spreadsheet of military hospitals and he would say what's your inpatient census, what's your outpatient load, okay, got it. Close this one, close this one, close this one, close this one.

Let's take a hypothetical example, 29 Palms. Twenty-Nine Palms does not have a very robust inpatient service. You can't make a business case to keep 29 Palms alive. But yet it's the closest thing around. So do you turn to the military commander who runs that base, the Marine Corps general, and you say are you okay with then if your Marines get hurt on the battlefield we're going to have to put them in an ambulance to send them an hour and 10 minutes
down the road to the nearest hospital that can
take care of them. He's going to say hell no.
I'm willing to pay for that contingency. I'm
willing to pay for that.

And so that's where we have to
wrestle at the DHA level, at the SG level, at
every level with how much readiness are we
willing to pay for. Because there's a cost.
And I believe that most people are willing to pay
for it as long as they believe the readiness
gives them return on investment. So that's
where we are.

MEMBER REHBEIN: If I may, looking
for cost savings. Do you envision then that in
these enhanced multi-service markets you may
have one service hospital taking care of all the
baby deliveries and another service hospital
having another specialty?

GENERAL ROBB: We do it now, San
Antonio. We -- before they did the BRAC
movement they had a division of labor between
Wilford Hall Medical Center and then Brooke Army
Med Center. They did. They divided up OB, they
divided up peds. There was a Venn diagram where
you had these services were here, these services
were here and these were shared services. Because depending on your population you figured
out what was the best use of resources and then
one was the size of the population service. So
they did that. There is precedence exactly for
what you just said. Yes. Yes. Yes.

CO-CHAIR NATHAN: Anything else?

GENERAL ROBB: Give us a tough one.

One mission, one policy, one plan. I'm setting
you up, Dr. Guice. One mission, one policy, one
plan.

CO-CHAIR NATHAN: All right. Well
Doug, as always, thank you for an informative
discussion on a difficult subject. And I think
I heard Dr. Guice is here. Great. Okay, so we
can take a few minutes break here. Let's see,
what have I got, 3:44. Okay, so let's take a
15-minute break and we'll be back at 1600.

(Whereupon, the foregoing matter
went off the record at 3:44 p.m. and went back on the record at 4:00 p.m.)

CO-CHAIR NATHAN: Okay, well we'll go ahead and get started. It's a real pleasure to welcome and introduce Dr. Karen Guice who is the Principal Deputy Assistant Secretary of Defense for Health Affairs and Mr. Joe Riojas who is the interim chief of the staff for the Department of Veterans Affairs today.

Clearly the positions and the authority levels that they represent send a great signal to the task force of how seriously we take this DoD-VA interagency care coordination as they talk about -- as they are the co-chairs of the Interagency Care and Coordination Committee, otherwise known as IC3.

They'll provide the task force with an overview of that and discuss the IC3 efforts that are relevant to recovering warrior care. And also joining them today I believe will be Ms. Mary Carstensen who is the senior advisor to the Secretary of the Department of Veterans Affairs.
And you can find their information under Tab H. 
So Dr. Guice, welcome and thank you.

DR. GUICE: Well, thank you very much. So it's a pleasure to be here. It's good to see so many familiar faces and some new faces too. As I was a member of the task force for a little while and then when I switched over to DoD I had to leave you guys and come do the job that I'm doing now. But I'm really delighted to tell you what we've been up to with regards to VA-DoD warrior care coordination.

As you all know this has been a topic of some concern in a variety of GAO reports and even in some of your own reports about some of the confusion, some of the roles and responsibility conundrums and the many calls to kind of sort this out, figure it out and do something better in the future. So that's what we're really trying to do.

We tried to make this effort a very high-level effort. So we'll go through some of the governance structures in a little bit. But
we really wanted to focus on getting people who could represent their equities, make decisions and move things forward at a very high level. So I'll talk to you about that as we go forward.

Mr. Riojas has joined me here. He is -- my co-chair used to be Mr. Gingrich. Mr. Gingrich retired last Friday and this is the newbie. So we welcome him and I'm glad that he was able to join us today.

So we're going to talk a little bit more about kind of where this started. Secretary Shinseki and Secretary Panetta established a joint task force in May 2012 to kind of say would you just kind of get to ground truth on warrior care and coordination and what are we doing, what do we need to do better. Actually General Robb was part of the leadership of that task force and was of great help and value to the committee in trying to figure this out.

First they reviewed a lot of the recommendations that had been made and a lot of the problems that had been identified by a
variety of reports. And then this common and recurring theme which you all have heard over and over again that because we have multiple case managers, multiple care coordinators, no clear lines of roles and responsibilities it leads to enormous confusion for families and for servicemembers who are just really trying to concentrate on getting better.

You all have heard stories. You know, I have so many case managers I don't know what to do with them. I don't know what they all do therefore I can't use them in a smart way. Or they all come in and give me a business card and I've got a 3-foot stack of business cards. I'm your case manager for X. I'm your case manager for Y. And I can't remember and I can't figure it out. And I just put the cards over here and I can't deal with it.

So this was part of our task was to figure out ways to do this better, to make sure that the handoffs between the two departments are indeed those warm handoffs that we talk
about.

And as you all know the entire process is a little bit more complicated because wounded warriors frequently while they're still wounded warriors on the DoD rolls move between the two departments' health systems for their care depending on what their needs are. So we move them back and forth and back and forth based on their requirements and their needs for their healthcare which is a really good thing because both departments have excelled in certain areas. And that's a good thing, making sure that we provide that coverage.

But when we do that we do lots and lots of these handoffs, and sometimes they're warm and sometimes they're skipped. So how do we do that better?

A lot of the confusion came talking about the Federal Recovery Coordination Program and the Recovery Coordination Program. A lot of people said fix those problems, fix that, fix that, thinking that that was actually the entire
problem.

We thought maybe it is and maybe it isn't, and that was some of the things that the task force actually helped us to define, how much of a problem as opposed to how much of a problem was -- or whether that was just a symptom of a larger problem.

So, we talked a little bit about leadership. Full interagency participation, representatives from health, personnel and benefits. So this is really both clinical and non-clinical case management care coordination. It doesn't matter if you're the clinical care coordinator or the non-clinical care coordinator, this was a way to actually pull all of those communities together because they all share elements of these handoffs and information-sharing about how to get someone what they need in a timely way.

We had four approaches to the tasks. You can see them there, the community of practice, the comprehensive plan, policy and
oversight, and then sustainment.

    So first of all, the community of
practice. This was the recognized need that we
really just needed to form a community of
practice, both clinical and non-clinical. Share best practices, learn from one another, move things forward.

    This is hard enough when you're
dealing with one department but now we're
talking about two departments. So how do we do
that and make sure that there's a viable
community of practice between the two
departments that helps achieve the aims that we
really want to get to.

    Comprehensive plan. Well, as many
care coordinators as there are, there are
probably as many comprehensive plans. Every
case manager -- care coordinator will construct
a recovery plan or a comprehensive plan. So
pretty soon you've 12 case managers and 12 plans.
How does the recovering warrior know which one
is relevant, which one they should pay attention
to, which one should they scrap?

    So if we're going to make these really viable tools to help individuals achieve what they need to achieve then we've got to do that better. So how do we have a focus on a single comprehensive plan between the two departments that actually gets somebody where they need to go? And how do we as two departments deal with that and figure out ways in which to make that a reality?

    Policy and oversight. Well, this was a really interesting one. I think the team defined about 127 different policies between the two departments. So how do we actually take those policies, rationalize them, balance the needs of what we need to do and make one policy.

    Now we probably won't actually be able to pull that off because we've got policy police on either side in each department that like formats in a certain way and we've got lawyers who want things done in a certain way. But as long as the DoDI which governs the DoD and
provides instructions for the field on how to do things, and the VA Directive say the same thing, define things the same way and allocate accountability and responsibility the same way we achieve the same end. So that's probably what we're going to have to do from a very functional, practical way. We're going to have to do it differently in format for the two departments. But it can read the same and mean the same, and that's a key thing.

And then how do we sustain things for the long term? How do we continue to fund programs? How do we continue to make sure that we're doing the right thing over the long haul to make sure we're still doing the right thing.

All right, so the task force, their initial findings are kind of listed on here. It's not because we don't have dedicated people. We do. We have people who go to work every day and work their hardest to get the maximum outcome of their day. They work hard, they take good care of people, so that wasn't an issue. It
wasn't that we had bad people out there not doing anything. We've got good people and they're doing great stuff.

But we sort of let a system grow up that was asynchronous and dis coordinated. So how do we bring some coordination and synchronicity to that?

The collective efforts by both departments were well-intentioned. A lot of it grew out of necessity, fix this now kind of thing, and we did. We threw programs together and put people in those programs and told them to go do this. And we did that over and over and over and over again to where we have now about 47 different programs who all say they do things very similar or at least components of the same thing. And that's something that we need to take a look at.

We have diffuse governance and oversight lacking fixed responsibility, accountability and a common voice. Well, we first start out by just looking at the structure
of the JEC, the Joint Executive Committee as you all are well familiar with. And you know we have a Health Executive Council and we have a Benefits Executive Council. Health deals with health, Benefits deals with everything that's benefit but health. Clinical care coordination, non-clinical care coordination. They didn't talk. So part of this was because of the way we were structured. And once you kind of understand how that happens and then how those little silos grow up then you can kind of figure out, okay, now how do we actually break those down and create a structure that pulls this community of practice together that I talked about a little bit earlier and puts them in a way that it can pull from those two supporting organizations, be responsible to the JEC and deliver what we know we need to deliver.

There was no common integrated comprehensive plan. VA didn't have a way to see the DoD plans, DoD didn't have a way to see the VA plans. It's all about information, all about
getting people information so they can do their job better and the wounded warrior can get the things that they need in the order in which they need them to maximally recover. So it's -- the premise is quite simple but we sort of executed it in a very asynchronous and kind of complicated way if you think about it.

And then we knew we had suboptimal transitions in the coordination of care, we knew that. And no single point of contact for patient and families at any given time, and that's something that you guys heard over and over and over again.

All right, so what did we do after we got the report from the task force? Well, we decided that what we really needed, we really needed the Secretaries to articulate what their vision was for this particular activity.

And the Secretaries said that they expect one mission, one policy and one plan. Common interagency guidance driven by an overall, overarching formal interagency
governance structure — and I'll talk about that in a minute — interagency community of practice, single comprehensive plan, sustainable model, and then using a lead coordinator concept which we'll talk about. I think the entire memorandum was provided to you all so you can actually read the entire content of the paper.

All right, now how does this square with what you all have recommended? Because you all have thought about this a lot too. It wasn't just that the task force stumbled to this. I mean we had some guidance and some concerns raised by you and GAO. So how does what you all have put forth as your recommendations match with what the task force identified and where we're going to go?

So the first thing you recommended was publish timely guidance to standardize the care. Ensure there's sufficient numbers of case managers available in a variety of places. So that's sort of in our way of matricing this,
that's where the one policy will help, help guide that, help define it, help standardize it and help enforce it. We will have that one single policy that will govern what we do.

Your other series of recommendations, standards, oversight and guidance for the CRP and the CTP. Services adopt a common comprehensive plan. The services ensure that families can access that plan. That's the one plan concept. Between two departments one plan for one person. Not 12, not 15, 1 that we both share, that we both see, that the patient sees, the family sees, they use it, they understand it and they can access it anytime they need to.

Your other two recommendations that are relevant were to develop meaningful qualifications, skills and training, and then to standardize and define the roles and responsibilities. That's kind of driven through the one community. We have one community, they agree on how they're going to do
things. We put that into policy and drive it that way. So that's kind of how what you've recommended fits with what we see and what we're recommending.

One of the things obviously is you need to have a governance structure that works and that addresses the problems and pays attention to the solutions until the problems are solved.

So we proposed an Interagency Care Coordination Committee, the IC3, under the JEC. It's not in the HEC, it's not in the BEC, it's its own freestanding thing, immediately responsible to the JEC. That was the way we could actually bring the non-clinical and the clinical together in a way that made sense with a governance structure to get action at the highest level quickly.

Okay, now that we've got a governance structure what are we doing with it? The community of practice, what they're doing is their goal is to introduce a model of care
coordination that increases clarity and reduces confusion. That would be a really good thing as we've all recognized.

What they're focusing on right now is implementing something we call the lead coordinator feasibility assessment. This was the idea that out of all the case managers you have and all the care coordinators you have one of them would be designated lead at any one point in time.

That lead would change depending on where you were physically and in the point of your recovery. So if you're in a hospital your lead coordinator would be most likely one of your clinical case managers and that makes sense. Having someone who understands that clinical location, knows the clinical providers, can help pull all of that together. Doesn't mean that all of those other case managers and care coordinators go away, it just means that now they are organized under a lead case manager or care coordinator who will help de-conflict what they
do for the patient. So again, one point of contact for the patient and the family who can then organize the baseball team to bring their best to bear for the member.

Now when they leave that hospital and they're out in the community and they're at home and recovering you may have a designated non-clinical case manager as the lead coordinator who will do the same thing. But in sort of the organizing, making sure the non-clinical stuff as well as the clinical stuff, making sure the appointments get made, making sure that the clinical case managers stay involved as they need to, make sure that those other people who are trying to get you things to make your life easier, to make your recovery better are pooled and harmonized. So that we sort of get away from 12 case managers, don't know who they are, they change every time I change my location, they change every time I -- so we're trying to actually de-conflict that.

Not get rid of a bunch of programs.
This is about harmonizing them and getting the information more streamlined for the patient.

We began the assessment at Walter Reed and the VA Medical Center in D.C., in Richmond in January and we're collecting a lot of information about how it's working. We've got a lot of -- obviously when you do a feasibility study you're looking for those things that are, you know, how do we figure out who the lead coordinator is? Who gets to designate the lead coordinator? How does that work? How does that lead coordinator actually really, really, seriously communicate with all those other case managers? How does that work? Who fills in that single comprehensive plan? Who uses the checklist?

So it helps us kind of refine all of those little details that are deadly if you don't do a feasibility study. We want to make sure it works. We've tried a lot of things over the past few years and some worked and some didn't. But what we don't want to do is add more confusion.
We want to add clarity and organization to what's currently being provided.

Interestingly enough a lot of the case managers have said we've sort of been doing this anyway, kind of informally we've been doing it, but it's really nice to have a structure. So we're trying to make sure we give them the right tools that they need, that they are coordinating the care, that we figure things out.

And we've made some fairly interesting discoveries along the way. And I think it's been a really good thing. So we're rounding up the information from that and then we will figure out what we need to put into place to make it better and work better. And then eventually if our hypothesis is correct we will be promulgating the program throughout the country.

Okay, the comprehensive plan. All right, we said one plan. Okay, well that's easy to say. The art is how do you actually pull that off.
So what we're doing is creating a single tool where we will have the comprehensive plan that will be accessed by all of those who need to access it because they have a need for the information that's in it.

It will be role-based access. You can see what you need to see in order to get your work done. So clinical, non-clinical, they'll all be able to see this. The lead coordinator will probably be the one who's authorized to actually implement and put things in there.

We came up with this wonderful idea that really what we needed was a checklist. Kind of like when you clear base you have to go through a checklist and get people to sign off that yes, you turned this in, and you're not delinquent at the library and all of those kind of things that you all have to do when you clear -- post your station.

So we took that concept and came up with an interim solution which is a smaller, truncated checklist for us to kind of again
validate that it works and then a much longer,
more complicated checklist that will eventually
form the foundation of what we're talking about
in sort of our generation 2 of the comprehensive
plan.

So what we're doing now is we applied
for JIF funding and were given some money for the
next 2 years to actually make this a reality. So
working with our IT partners about how we
actually then create that visibility of the
single plan for all the programs that need to see
it and how that's actually going to work. So
we're very excited about that capability and the
generosity of the departments to give us some
money to do it. But we think that's really key,
have one plan.

Okay, policy and oversight. These
guys had to read all those policies and kind of
understand where there's duplication, where
there are gaps, where there are things that we
can smooth and make a little bit better. So
they've been doing this really deep dive in all
of the departments' -- both departments' policies on care coordination and case management to really understand what we need to be doing.

And they are working on an overarching interagency guidance. As I said it's probably going to be two but they'll say the same thing and that's how we'll fix the need to have different formats for both departments in terms of how policy is actually promulgated and written.

So as soon as the policy gets finalized then they will move into kind of oversight of the policy and make sure that the execution of policy is working like we expect it to, making sure that the outcome that we believe will happen actually happens. And if there are things that need to be changed or refreshed or redone in a certain way that we do that in a very timely way.

We don't just put, okay, policy on the shelf, check, done, walk away. We're not
going to do that. We're going to make sure that it gets implemented and if it doesn't get implemented the way that we think it should be implemented figure out why. And we're going to try to make sure that we get the outcome that we believe will be the result of having this policy in place.

Okay, so this kind of gives you our time line at the top. You can see our to-do list over there on your left, my right. And you can kind of see where we have kind of scoped out what we need to do over the next couple of years and out into the future to kind of make this vision a reality.

And that's it. So I am happy to answer questions. Mary Carstensen is here. I guess Mr. Riojas had to go back. Since he's new he's got probably a whole lot of work to do. But we're happy to answer questions. Several of the members of the team are sort of coming and going. Doc Robb just walked out. Maybe he'll be back. But we're happy to talk to you more
about this. What we'd like to do is actually come back in the fall when we know a little more and we've been able to finish our feasibility, understand what we need to fix and kind of put that next generation of how we're going to do the lead coordinator out there.

CO-CHAIR NATHAN: Well, Dr. Guice, it's certainly all goodness. Pretty hard to argue with the concept. The pragmatic implementation is going to be the long pole in the tent, herding all the various cats across the agencies. There may be questions on that in particular.

But I'm curious as to one of the things we hear a lot about in the military is also our -- in the Department is how much are we engaging with the private sector, the academic sector. How much are we sharing back and forth between the VA and/or the DoD and places like the RIC in Chicago or UCLA. And we do intersect in those places at Operation Mend and other organizations that sort of formed benevolently
de novo where we now trade patients and whatever.

Is there any thought given to widening the aperture in a way that also creates something that not only encompasses the DoD-VA transition point but oversight into case management into the private sector?

And the reason I ask is our line leaders, our warrior leaders at times will come to us and say you're not utilizing some of these niche specialists enough. You're trying to let the VA or the DoD system fix things and it's not that your heart is in the wrong place but you don't have some of the expertise that some of these places have carved out.

We talk about the TRICARE benefit, and what we can and can't afford, and what we can and can't do, and what we should or should not do. Any thought to that as we have you here to talk about sort of this overarching look at how we manage the care of our warriors?

DR. GUICE: Sure. To me knowing what is out there in the private sector is part
of the toolbox of the case managers and care coordinators. So part of it is making sure that they know what's out there to remind people on the recovery team that there is availability of this or there's availability of that. So part of it is just the education of the care coordinators. But that's that one community, and working on that and making sure people have visibility about what's available for individuals as they go through their recovery.

For us to take on the private sector case management would be a daunting task and we just -- it's a bridge way, way too far. However, I think that as we kind of define this space for us we might be showing the private sector a way of doing business that then they can adopt as we move forward in the Affordable Care Act and how do we actually really do case management care coordination in the private sector.

So we have an opportunity here which is kind of unique. In the private sector no one pays you to do case management and care
coordination. It is done as a part of kind of more of a global fee.

And then that's part of the dilemma in the private sector. It also changes. You know, if you're hospitalized your care coordinator case manager waves goodbye at the door. So we might be actually modeling some tools and some ways of doing business between two departments that would be helpful for the private sector.

But I think that knowing of those programs that your line leadership has identified and certainly has become aware of over time, that's really making sure that our case managers and care coordinators understand that those resources are there and how they can leverage those to the benefit of the individual that they're trying to care for.

MS. CARSTENSEN: Just to add onto that. We did include TRICARE in our first community of practice as we were developing this whole process because we knew that we had -- that
we were outsourcing some of our services. So that is something that we've been considering as we work through this.

And I think just to reiterate this is really somewhat of a paradigm shift. I mean it's not facility-based case management, it's not episodic case management or discharge case management. We are really talking about coordinating care and services over a very long period of time for some of these clients.

And that is a different look and a different approach than what we see with our civilian counterparts. So I do agree, I think we're going to see some difference, some learning here that's going to be very informing for ACA and for other efforts.

MEMBER PHILLIPS: To follow up on the admiral's question, and I may not have the numbers exactly right but I've read that roughly 20 percent of veterans use the VA. And then the other 80 percent either mix or go elsewhere.

And related to future plans, again,
is there anything in the works that is addressing
to try and keep the veterans in the VA, to
do more to become more efficient and
cost-effective?

DR. GUICE: I think we'll ask VA to
comment on that. But I think that the issue is
that we have done a tremendous amount through the
TAP program. I think there are more of this
generation of veterans who've signed up for
healthcare in the VA than there have been in
previous -- after previous conflicts.

We do know that those who leave the
military service and are retired either because
they are 20 years and retired or because they
leave for medical retirement, we do give them
TRICARE. And frequently they will get care in
VA when it's useful and helpful or come back to
the Military Health System depending.

It's kind of based on their
preferences as to where they think they're going
to get the best care for whatever is their
particular problem. We know that a lot of the
guys with amputations come back to the DoD just because that's the relationship they've had. You know, they know their prosthetist and they know their rehab med. So they will kind of gravitate there. So it's going to be a balance and it will sort itself out over a period of years.

But we're also doing a couple of things. Both departments have engaged in something called a modernization study. So the Department of Defense is doing one, the Department of VA is doing one. And at the end of that we're actually going to sit down and say, okay, show me your card hand and we'll show you our card hand and we'll kind of match up where we've got capabilities and capacity differences.

The VA has not made a big investment in OB care. We have. So are there ways that we can actually share patients that way? And I know that's already going on in San Diego where the VA is sending women veterans to Balboa for
care and delivery. That makes sense from a total government perspective. So are there more places where we can do that.

So this DoD-VA comparison about what's the capability and capacity here for VA, what's the capability and capacity there for DoD and are there ways that we can do smarter partnering that will actually leverage the best that the government has to offer for our servicemembers and veterans.

MEMBER PHILLIPS: What I was driving at, and it will come as no surprise to anybody in the room, is that if we could figure out a way, and perhaps this committee can continue to push it, is to harmonize the health information transfer between the three sectors, the DoD, the VA and the private sector, which would make that process I think a lot easier.

DR. GUICE: You're absolutely right. And so I'm sure you all have read all the press about the electronic health record and how the departments are either doing that well or not
doing that well. It kind of depends on the day of the week and who you're reading.

But the interoperability of data is the most fundamental thing that we can do. It is the thing that will actually make the interoperability of health information between the two departments and the private sector work.

It is not necessarily about the computer that sits on your desk or even the software that delivers the information. You know, you think about we all go home and we turn on the TV and we all see the same program. But we all don't have the same TV. That's because the data standards drive the way that you are presented with the picture.

So the more we can standardize that the better off we'll be, particularly in that private sector care where we really need that. And we need that information. DoD relies on the private sector to a much greater extent than the Department of Veterans Affairs, and that's for a reason. Sometimes it's because we don't have
a military treatment facility in an area or we don't have the right capability or capacity in an area, so we really do need to rely on that. And then we have a huge retiree population who live all sorts of different places and they need access to care. So it's how we actually do that data interoperability.

And we're working very hard through the IEHR project to actually make the data -- using data standards make it standardized and interoperable. And the more we push the ONC and HHS to come up with the standards that's a good thing for all of us.

MEMBER PHILLIPS: Thank you. I just wanted to get that on the record, that we're all on the same page.

MS. CARSTENSEN: Just also, just to comment on the utilization of the VA. About 30 percent of veterans use VA healthcare. Thirty percent are eligible but have -- are using some other source for healthcare, like Dr. Guice said, many multiple eligibilities and maybe an
employer-based insurance plan. And then about 30 percent of veterans may not be eligible for care based on the legislative rules associated with that. So those are the numbers.

I think that part of what we're also experiencing within the task force and what we're working towards is those handoffs. And Secretary Shinseki would often say, you know, what our work generates in DoD.

And so somehow we need to know who they are because it doesn't just happen that we know. And so they have to be transferred over to us. And that's really what we see as this community of practice, the value that it's going to bring to us is the relationships for those warm handoffs.

Some of our initial work showed that about half the time we weren't doing that. And so this is an opportunity for us to again create the tools and the mechanisms, the policies, the processes to assure that happens.

And that our folks can make informed
choices so that perhaps that isn't their right choice or isn't the best choice for them and their family. But we need to make sure that it's an informed choice.

MEMBER MALEBRANCHE: I think one other piece that we're trying to do in trying to get them, Dr. Phillips, is what -- the PDAs and the PDHRAs. You know, when they're still active duty they can't enroll but they can register. So there is a huge outreach effort on behalf of the VA. And I think in a couple of site visits we've noted where they were done at the military facility.

So we try to register the servicemembers so that we know who's coming and we can do a little outreach to them so when it's time they can enroll. So we're trying a lot of different venues in terms of outreach. But you know, you always have to know who your population is and that's something we don't. You're right, there's a lot of that electronic piece that will be helpful if they don't choose to go elsewhere.
So that's another venue.

CO-CHAIR CROCKETT-JONES: How will case managers -- with this idea of a lead coordinator and transitioning and knowing who the next one's going to be. I want to, in like a particular instance, for instance when there's an institutional sort of philosophy that's different.

Like for instance, we see a lot of folks when they are in treatment for PTSD or other behavioral health they -- certain medications are used, multiple medications are sometimes used. And then they get to the VA eventually and part of that transition involves a lot of anxiety itself because they really don't know what to expect.

But when they get there there is a different set of medications. They have to switch over. There's a different philosophy about polypharmacy. We heard both servicemembers and family members and even OIF/OEF program directors all with concerns
about this sort of differing institutional philosophies about what's the best practice. And I sort of wonder if this is going to be a bump in the road for this continuum of a lead coordinator or similar thing.

DR. GUICE: So I think part of that is being worked on the clinical practice guidelines. We have a DoD-VA clinical practice guideline working group and I know that they've addressed some of these issues and are coming up with that shared joint approach. So there will be the consistency of the clinical practice guidelines.

Then there needs to be the oversight to make sure the clinical practice guidelines are implemented and adhered to, and that we get the outcome that we want. So we're working through kind of some of those particular issues.

And hopefully what you picked up from General Robb's presentation is Health Affairs as it de-hats the dual hatting and becomes policy and oversight, that the function
of following up and making sure that things are implemented so that we get the outcome that we wanted when we developed the policy, to make sure that that actually works. So that's how at DoD anyway we're going to make sure that we build that oversight piece in just to make sure that we're getting things right. Because I think that probably has been missing from some of our -- the policy oversight tandem that really needs to exist. So I think moving to the new structure will actually afford us that opportunity to make sure we don't miss that important role of OSD.

GENERAL ROBB: I'd actually follow onto your answer on that on the CPGs. It's that much like in the trauma community where we change behavior in the trauma community with clinical practice guidelines.

So we have this thing called the Joint Trauma System and across all three services now we have a joint organization down in San Antonio that through data-driven we now
have clinical practice guidelines that now are the standard of care for the delivery of trauma care which we didn't have before. So that's a mature organization that's done there.

We have a cyclic process where you collect data, analyze the data, drive performance improvement, i.e., clinical practice guidelines, collect the data, analyze the data, drive performance improvement. And so what you're seeing right now through the Defense Center of Excellence for -- the DCoE, Defense Center of Excellence for Traumatic Brain Injury and Psychological Health is they're setting up a very similar paradigm to live in.

And again they're not as mature as the trauma community was before the war and of course actually grew up during this current conflict. And so they're going to have the same concept where they're driving data collection through a registry, they're going to analyze it, drive performance improvement, clinical practice guidelines, and continue to do that
cycle.

And that -- and because of the way the organization is set up is that, remember, you've got the Department of Defense and the VA both that are sub-portfolios of that organization. So they're much like you see in their continuum, like you see in the trauma care continuum down in San Antonio you're seeing that relationship develop as now the DCoE matures.

And so Dr. Guice is talking about how do you drive that. Because remember we weren't practicing -- when you trained at Yale and you were taught to do trauma this way, and you were trained at L.A. County you were trained in shock trauma. But now we've got a consortium in the Department of Defense where these, the clinical practice guidelines, they drive the way we treat in theater trauma care and our outcomes again are incredible because of that.

And I see that same transfer of process to occur in the psychological health, PTSD. And it's not going to happen overnight
but we are well on our way of going in that direction. Dr. Guice, does that kind of help back that up?

   DR. GUICE: Absolutely. Now, you know, what you're articulating is a level of frustration about how the practice of medicine is different depending on where you are. And that's not any better out in the private sector. It just is.

   The other thing that we want to make sure that we do is once clinical practice guidelines are actually promulgated or you know, you've got a chance, or a recommended change and a better way of doing something it takes about 10 years for that actually to get implemented.

   We hope that we will not wait 10 years, that we can actually use some of the tools that we've developed to actually make sure that we get those in place and that we start reinforcing that this is what the community of practice in this case for psychological health has agreed that this is the way to do business.
So we're hopeful that we can get all of these things in place.

But it always seems a day late, a dollar short to patients and families when you recognize that we've needed to do this for a while. But it does take a while to work through this what's the best science, what's the best practice, what's the best way of doing it. And getting everybody to agree to a similar way of doing business. And then implementing it and redoing your business processes to accommodate doing the business in a new way.

CO-CHAIR NATHAN: Other questions? Issues? Concerns? Well, thank you both. Clearly the clinical practice guidelines are sort of invisible to the patients and to the beneficiaries and yet they make a tremendous difference in both patient safety, efficacy and the latest and greatest.

One of the recurrent themes that we hear from people who come before us in site visits is trying to get as close to one-stop
shopping as possible from families and from warriors who are looking for some sort of continuity and connectivity where they're not handed off to person to person, to agency to agency.

So this is -- we're clearly on the right path here trying to find a person who starts with them at the beginning of their travels and stays with them through their travels, who doesn't say, "Oh, you're case 48-TAC-B, I've heard about you," but says "How are you doing, Joe? I'm your lead coordinator. I'm going to stay with you while you transit the DoD, the VA system."

And especially those people out there in the hinterlands who are really dependent on either their small local facilities, federal facilities, or the private sector for care.

DR. GUICE: So I just want to make sure that you don't leave here thinking that there's going to be a single lead coordinator
who's going to stay with the patient forever.

The lead coordinator will change depending on where the individual is and their needs at the time. What we have put into place now is a system of accountability for making sure things get done.

So rather than 12 case managers and 12 -- and you never know who did what, now we've got a lead coordinator. It's their job to make sure that the handoffs are smooth, that the information gets -- it's a single point of accountability.

CO-CHAIR NATHAN: The point is the warm handoff.

DR. GUICE: Yes, absolutely.

CO-CHAIR NATHAN: And we've heard success stories in some of the pilot programs where an individual has left Walter Reed and has gone somewhere else and a new lead coordinator has called them up without having to be called and said I know you're here, I know you've arrived, I know your case, I talked to so-and-so,
welcome to this area.

That's success. That's success, as opposed to the patient having to -- or the family having to show up at the doorstop and say who do I see. I used to be followed at Walter Reed and now I need to be seen at this VA. So I think -- that's a small pilot but boy, is that, you know, a phone call, $1.95. Care manager, $85,000 a year. A warm handoff, priceless. So I think we're getting there.

Anything else? Well, thank you very much, Dr. Guice, Dr. Carstensen. It's a pleasure having you here today.

I think that's our agenda for today. For those of you who are worried about coming tomorrow I won't be here so that may sweeten the pot a little bit and you may decide to show up. But hopefully in my stead will be General Stone and General Mustion. And I think you have a robust activity planned.

Suzanne, any comments before we close today? Steve?
MEMBER PHILLIPS: Just are we going to do Elmendorf or do we want to hold that till tomorrow?

CO-CHAIR NATHAN: Why don't we hold that till tomorrow and we'll talk when everybody's fresh. Because that's probably about an hour, 2-hour conversation. I'm just kidding. Yes, I'm just kidding. All right, thank you everybody.

(Whereupon, the foregoing matter went off the record at 4:46 p.m.)