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

+ + + + +

MONDAY
JUNE 10, 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
CSM STEVEN D. DEJONG, ARNG, Member
RONALD DRACH, Member
TSGT ALEX T. EUDY, USAF & SOCOM, Member
CAPT CONSTANCE J. EVANS, USN, Member
LTCOL SEAN P.K. KEANE, USMC, Member
KAREN T. MALEBRANCHE, RN, MSN, CNS, Member
MG RICHARD P. MUSTION, USA, Member
STEVEN J. PHILLIPS, M.D., Member
DAVID K. REHBEIN, M.S., Member
MG RICHARD A. STONE, M.D., USAR, Member

ALSO PRESENT

DENISE F. DAILEY, PMP, Executive Director,
Designated Federal Officer
JESSICA JAGGER, Ph.D., Research Director
SUZANNE LEDERER, Ph.D., Deputy Research
Director

CONTENTS

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

8:11 a.m.

CO-CHAIR CROCKETT-JONES: Good morning everyone.

Thank you for attending our June business meeting. The primary focus of this meeting is to discuss our observations over the 2013 fiscal year and develop recommendations within specific topic areas.

Before we conduct our introductions, I would like to congratulate the Marine Corps for winning the Chairman's Cup in the 2013 Warrior Games conducted in May. This win marks the Marine Corps' fourth consecutive victory, which I think might be a little excessive. Job well done to all the servicemen and servicewomen who competed. I now ask that we go around the table and introduce ourselves. Why don't you start us off?

MEMBER KEANE: Lieutenant Colonel Keane, Marine Corps liaison to the VA.

MEMBER PHILLIPS: Steve Phillips,

NIH.

MEMBER EUDY: Technical Sergeant Alex Eudy, United States Air Force and SOCOM.

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

MEMBER EVANS: Good morning. Good morning Captain Constance Evans, BUMED case management.

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

CO-CHAIR NATHAN: Matt Nathan, Navy medicine, military co-chair.

MEMBER STONE: Rich Stone, Army Deputy Surgeon General.

MEMBER MALEBRANCHE: Karen Malebranche, Veterans' Health Administration.

MEMBER REHBEIN: Dave Rehbein, research scientist and past National Commander of the American Legion.

MEMBER MUSTION: Rick Mustion, representing US Army.

MEMBER DRACH: Ron Drach, non-DoD

member.

CO-CHAIR CROCKETT-JONES: I will note that Mr. Justin Constantine will not be joining us during this meeting, and Dr. Turner will be joining us by phone during tomorrow's session. I'll turn it over to you.

CO-CHAIR NATHAN: Okay, so over the next two days we're going to cover 12 topics, in which we'll discuss the possible recommendations for the 2013, or 2012 report. Denise, how are you going to label it?

MS. DAILEY: Thirteen.

CO-CHAIR NATHAN: Thirteen, Okay.

MS. DAILEY: Sorry.

CO-CHAIR NATHAN: Denise, this is a moment in history!

(Laughter)

CO-CHAIR NATHAN: I want this page bronzed and sent to the National Archives! As a Task Force, we have conducted fourteen installation visits and four information-gathering business meetings, which

will provide the substance behind our recommendations.

To further assist in facilitating discussion during the meeting, we are all seated in relation to our four topic groups, which are as follows: Restoring Wellness and Function, Restoring Into Society, Optimizing Ability, and Enabling a Better Future. Dr. Turner, Dr. Phillips, Lieutenant Colonel Keane, and Technical Sergeant Eudy represent the Restoring Wellness and Function Group. Captain Evans, Ms. Crockett-Jones, and Command Sergeant Major DeJong represent the Restoring Into Society Group. Mr. Drach, Mr. Constantine and Major General Mustion represent the Optimizing Ability, and Major General Stone, Ms. Malebranche and Mr. Rehbein represent the Enabling a Better Future group. Although members are assigned to a specific focus group, that assignment does not restrict anyone from advocating for issues in other groups. Topic group members will be called upon to facilitate

discussion on areas relating to their group topic. To further prepare for the discussions, I invite Ms. Dailey, the Executive Director, to provide the members a status of our previous recommendations. You can find these in Tab B for the FY11 recommendations, and Tab C for the FY12 recommendations in your briefing books.

MS. DAILEY: Good morning, ladies and gentlemen. We're going to spend the first hour refreshing our memory on our 2012 recommendations. If we get to our 2011 recommendations, we will also discuss those. As I mentioned in my email, I do want to give you some time as a group to look at prioritizing topic areas within your functional interest areas. Mr. Rehbein made this recommendation; I think we'll have time, we'll let you kind of get your heads together a little bit, and opportunity prioritize those topics under your areas will allow you to get to those that you have the greatest interest in, or you think fields the greatest need. But we're going to start off with,

I'd like everyone to move to Tab B, please, and in Tab B is our 2012 recommendations.

And we're going to do somewhat I call just memory refreshing, so that when we go through and we look at recommendations this year, we know the context that they have in relation to last year, and we aren't going to be repeating, or we know we can build on last year's recommendation, which might be similar to your interest or your finding this year. And also in keeping with Mr. Rehbein's very astute observation that we always start at 1 and are rushed by the time we get to number 35, I'm going to ask everyone, let's start at number 35.

So I'd like everyone to go to page 7. Page 7 of Tab B. And we're going to start a short discussion with recommendation number 35, because recommendation number 35 is a good example of some of the things this year we might want to take a closer look at, either doing or not doing.

Now, let's also review our timeline.

We turned in the report on the 3rd of September 2012. DoD provided a response around 3 December 2012. That met the Congressional requirement for the 90-day evaluation. At 180 days, DoD was supposed to have in place an implementation plan. That would have been around March. I had hoped to brief the implementation plan here. They have not completed their implementation plan. So I will talk here and wrap up for 2012 the service briefings to us in February. So I've rolled those in. But the actual implementation plan will be met at a later time period, or will be provided to Congress by the Department of Defense at a later time period.

So let's start with recommendation number 35. This was an overarching recommendation, and in it your intent was to urge the Department of Defense to move familiarization with VA programs farther into the lifestyle, farther into the lifecycle - or earlier in the lifecycle of a service member. And you also added in here the piece that individuals

should be enrolled in e-benefits. Now, you have a partial concur on this, because the e-benefits is a well -- pretty much well-known practice in the Department of Defense.

All the services have policies for enrolling individuals in e-benefits. So there's your partial concur, all the services outlined in February when we asked them this question, that they do have individuals mandatory, in boot camp, early in the life cycle of a service member, to enroll in e-benefits. Didn't get much traction with the putting of VA programs, familiarization with VA programs, as your intent was, farther in the servicemember's lifecycle. Putting it in primary leadership training at the first time an NCO will start training for leadership positions, or the captain's course at early junior captaincy and leadership, or the staff courses at mid, major, and 04, or at Senior Service College. Didn't get a lot of traction with that part of the recommendation.

You got traction with the

recommendation that had to do with e-benefits. I think this is also a good example about combining your recommendations this year. It does make for fewer recommendations, but it also allows us to kind of get to this "partial concur" piece, and if you don't split them out, you get a partial concur, and we track it for a while, but as we understand here, we kind of have a non-concur on most of this recommendation other than the e-benefits. So think about it as we're moving down the road, and we're crafting recommendations about keeping them discrete if we can. Again, I realize that combining them creates a recommendation -- fewer recommendations. So this one's a good example for that.

Our next recommendation, number 34. Again, you have a partial concur. Lots of the services are very -- and understand the importance of their MEBOPs, Medical Evaluation Board Outreach lawyers, have a lot of concurrence there, lot of individuals say "Yes,

we see their value." Did not get a lot of traction on mandating or putting in their policies that they would contact 100% of their service members, active and reserve. So you got some consensus around the importance of the lawyers. They still are providing and feel that the briefings they provide at the PEBLOs briefing, the opportunities that they are being referred to lawyers by PEBLOs is meeting the requirement.

Number 33. This is a concur, essentially, and it's also because Congress told DoD to do a PEBLO staffing. So this one's a concur for DoD should develop more accurate PEBLO working intensity staffing ratios. They are and do have study out for that.

The one right about it, 32, is a concur, but also because DoD was directed in the last legislation to look at a joint board at some point in the MEB/PEB process, so this one is also currently under review by the DoD.

Terminal leave, number 31, should not be included in the IDES timeline. This made

it up to the inter-agency working groups between DoD and VA, because it affects both DoD and VA, and this is a non-concur. They are going to continue to count leave time in there. They believe it gives them a more accurate reflection of when benefits are being delivered.

Number 30 is a theme that you all have developed over the last few years, which has to do with survey results. You feel that the survey results need to be turned around and reinvested in improving the system, so 30 reflects that theme from your review of the data, so this one, number 30 had to do with the satisfaction survey, the IDES satisfaction survey, which they stopped and started and they've made a commitment to take a look at reinvesting those results from the satisfaction survey and IDES back into improving the process. It's hard to assess right now, because they haven't done the satisfaction survey in the last year. They should be starting it back up this year.

The number 29 has to do with the IDES case management. Now, we were at San Antonio, where we saw the Air Force embracing, fully embracing the IDES case management, and utilizing it. So this is one pilot site, number 29, we saw the other pilot site which was right here in Washington at the Navy site was not going over as well. So you have a concur here essentially when we asked or recommended DoD to field a IDES case management package software. So there is a pilot on the ground. A pilot program, pilot study doing that. And we anticipate results in the fall. So that's a concur. Again, pilot studies may have good or poor results, and then if you're going and it doesn't work, if this particular software doesn't work, they've got to start back over again with another purchase, another pilot and study program. So that gets you to recommendation 2009 -- recommendation 29.

So on recommendation 28, the Task Force saw the high return-to-duty rate in the

IDES program. So your recommendation in this area was to continue to evaluate processes to ensure only those Recovering Warriors likely to separate enter IDES. Now, the services all have a different process for this. We've been briefed on them. The Air Force has RIAL, R-I-A-L. The Army has a process where they are also looking at individuals before they go into the IDES.

I apologize, I can't pull the acronyms and programs off the top of my head. But each service has got a program where they are looking at ensuring that the -- what had been at the time 20%, would be at least bring that return-to-duty rate down to a smaller number. So you have ongoing programs in each one of the departments for trying to do an assessment for individuals before they go into IDES, to reduce that point that had been until this recommendation, about the norm for each one of the services, for a return-to-duty when it entered on IDES.

So on 27, Congressional action is

required to establish the deputy secretary, the DoD, and VA as co-chairs of the JEC. We've got no traction on this one, and this is generally not a popular with the Department of Defense. When Ms. Crockett-Jones and General Green were up talking to the staffers last year, we brought it to their attention. We were clear about saying this is not one of DoD's favorite recommendations, however, it is regulation, requires Congressional action to bring the deputy secretary of the DoD into the JEC as the JEC co-chair.

And this came out of our 2011 recommendation, which we recommended that the SOC be consolidated, the Senior Oversight Committee be consolidated, rolled into the JEC. And the second part of that recommendation was that the JEC co-chair be the deputy secretary of the Department of Defense. We haven't gotten any traction with it in the DoD, but again, we brief it and continue to brief it to Congress, and it would be a Congressional action if it were to

happen.

Number 26. These are the transition assistance programs. DoDIs, Department of Defense Instructions, and DoD concurred that they need to be revised and updated. We do have the new DTM, which is 12-007. It implements the VOW Act. And this is, as number 26, again, it kind of falls into those themes you all have, which is you urging the Department of Defense to keep their DTMs updated and keep their policies current, to implement their policies in a form across the board. So DoD is in the process of updating 1332.35 and .36. They've got this new DTM that implements the VOW Act in 12-007. Now, if you'll notice, in your preliminary observations is that 12-007 has an expiration date on it also, so you have it in your possible options, recommendations, to keep that updated, and then continue to pursue timely publications of policy information.

Number 25. Again, in this one you are advocating for the VR&E program. You got help

this year from Congress. They extended the sunshine on this ability of a soldier, sailor, airman, or marine to take advantage of the VR&E benefits prior to their DD-214. The legislation allows service members to actively access the resources of the VR&E program. It would allow it to serve them prior to their departure from the DoD, and that puts them that much farther ahead than starting cold at DD-214+1. So Congress has been very generous in this area, expanding VA's resources well prior to the DD-214. And what you've asked here in number 25 is that DoD publish the appropriate guidance for getting service members into this program early on, and their access to it being captured in DoD policy.

Number 24 falls in line with number 26. This is the VOW Act, 551 actually is the legislation for expanding into internships, non-federal internships. Allowing internships, job training programs, prior to their departure or while they're in IDES or prior to their ETS or retirement. We had Mr. DiGiovanni brief us on

this; this is a Department of Defense policy coming out of Personnel and Readiness, the Readiness portion of Personnel and Readiness writing this policy. So we have a concur on it. DoD has to get the policy up. But there was a big, I do know that they're working on this, there was a big meeting last week where all the services were talking with Mr. DiGiovanni and Warrior Care policy office on implementation of this, and moving it forward. It's tough, ladies and gentleman, to get policy out, but your emphasis on this area is needed. There are a couple of them, and I don't think they've been written by now, if you have any lingering recommendations.

So. Number 23. This had to do with Service Members. Out processing through the WTUs and reconnecting with their state or reserve units. We wanted to ensure that they get outprocessed efficiently from the state, and from the reserve unit there's accountability. This in particular has to do if they have a DD-214, if they're leaving the service, they had

a medical retirement or a medical separation. The Army briefed us when they briefed us in February, and they said they thought, they are working this, they have got it in their three top actions to complete the warm hand-off back to the RC units, so this one is a concur and the Army gave us some detail on how they are trying to accomplish it.

Also in recommendation 22, we continue to be, and continue to see trouble getting or issues getting individuals back on orders or back on Title 10 orders to get medical care, if needed. It's not just in Army, but we see it in all the services, across the board in the services for the reserve component. This is kind of an overarching recommendation for the reserve component where you're trying to emphasize that Title 10 injuries need Title 10 care. The ease of doing that in the reserve component community is important to caring for those service members, reserve component service members injured during their

deployments or injured during Title 10. So this recommendation deals with trying to get Title 10 orders, line-of-duties, completed quicker for our service members, reserve component service members. The answer we got back from the Department of Defense is the Reserve Affairs, also the USDP, reserve affairs, that they are rewriting several of their policies on line-of-duties and the issuance of Title 10 orders. We'll have to get them in here next year. Again, it takes a while. We need to see the kind of tone and tenor of these changes to these two policies, and see if, in the end, that will serve as this requirement.

Also on recommendation 21, overarching recommendation for the reserve component. If they're not in a unit, like a WTU or a Wounded Warrior Regiment, and they're being managed in their communities, the recommendation here is there still needs to be case management of those individuals. There still needs to be a centralized case management.

We utilize the Air Force's program and policy as a best practice. Took the Air Force a little while to move that program along, so -- but we do think there are good models out there for managing the reserve component in their communities with centralized case management, with non-medical-care management, and this recommendation, number 21, urges that type of program to be set up.

The other program we recommended and highlighted as a best practice was the National Guard's program, where they had put contractors in the National Guard headquarters for managing line-of-duties. There are care managers there, and there are care coordinators, about a one-to-three ratio. So we talked about both these programs last year as centralized case management for the reserve component, reserve component in their communities, and asked Department of Defense to draw in, come together on a plan to manage the reserve component in their communities, by identifying some of these

best practices, or emulating the best practices of the other services.

Number 20. We are looking at number 20 for programs that formalize -- policies, papers, policies that formalize the relationship between the Wounded Warrior programs and their family community centers, or their family service centers. Airmen, Fleet, and Family service -- the Airmen and Family Service Centers. The Navy's Fleet and Family Service Centers. The Marine Corps, Family Service Centers. Now, Army's pretty much the only one who has a on-ground, dedicated one-stop shop for many services, and it is, and has a particular emphasis for taking care of families. So your thought process was to understand, was that the other services had not made the choice to do a SFAC, soldier and family assistance center, on campus for their wounded warriors, recognizing that not everyone's going to do that was Okay, but in the absence of that, Wounded Warrior programs in each one of the services should set

up a program with the family centers of the services where wounded warriors and their families will get front-of-the-line service, where they will get special attention, and, if in the long run we're talking about drawing down the specific wounded warrior program, someone has to know this information, someone has to have a knowledge base for SCATTER and TSGLI, and paying benefits, but the family centers are a likely location to house that knowledge. And so this recommendation centered around formalizing the Wounded Warrior Programs' relationships with the family centers and creating this go-to location for current services and possibly knowledge base for services when these current programs start to wind down. I have got some of it from the Marine Corps, they call it the SUB-VR, we are working on that policy, and I've gotten the feedback from the Navy. The Air Force did formalize their relationship in the publishing of their AFI. So there is some movement on this from the Marine Corps. They did

call me and say "Yes, we've got a line in the new policy that talks about the Marine Corps' utilization, the Marine Corps Wounded Warrior program utilization of the four sectors.

All right. Number 17, I think we're at number 17, right? 19. Go back.

(Laughter)

MS. DAILEY: I go through these pretty quick, ladies and gentlemen; you can just interrupt me. All right, so the National Resource Directory. We have data. We generally get a blank look from our service members when we ask them about it.

They haven't been in our surveys, but we call them mini-surveys. There has been some more acknowledgment through mini-surveys and the National Resource Directory. However, we're going to get a non-concur on this. They don't want to rename the National Resource Directory Warrior Care Policy Office, which is the DoD entity that owns it. And there's a Department of Labor entity that owns the

National Resource Directory. Can that come together on the new name? The Warrior Care Policy office has made a commitment to continue to market it to increase its awareness among the wounded warrior population, but right now we have non-concur on the new name.

Number 18. Number 18, ladies and gentleman, was also an overarching relationship. Had a lot to do with - it's for the reserve component. Again, it was - the Army kind of came to a head with the numeric and the Navy MEDHOLD, and the East and West coast. Well, a similar situation kind of develops in the Aarmy WTUs where when you're keeping your reserve component at a location that's not in their community, generally, unless they move their family there, they're going to be separated from their family. So this overarching recommendation also had to do with if you're going to keep them out of Wounded Warrior Regiments, battalion headquarters or detachment, or an Army WTU, or Navy, that whole

East and West, really need to be doing as much as you can to bring the families together within there. This is a separation on top of their prior separation, and I think as a group you kind of tend to think "They don't need to be in the WTU, put them back in their communities, management in the communities, and they'll be with their families."

But as we believe the services have done with the very most difficult cases, with the WTUs and the Wounded Warrior battalions and the VECs and the MEDHOLDS, then we also need to find ways to bring their families for visits, to have a way to put families up in a nice hotel so that there is some sort of opportunity to be a family again. All right. 17. You can see I'm starting to wind down a little bit. All right. 4, 17, 1. I've got less energy. We've been through 1 to 17 a couple of times, so all right. All right, in this particular recommendation, we talk about ensuring particularly family members who have a very helpful benefit, the Department

of Defense provides family of exceptional family members, which is respite care and case management for exceptional family members.

It's a benefit which is difficult to come by in the outside world, and it can be a significant impact on a family to realize that they will not be receiving this benefit anymore when they are discharged or retire. And the Task Forces' recommendation here is that specific ECHO, it's called ECHO briefing be provided for the individuals in the IDES program, for family members, so they know that the potential loss of this benefit could have, could be a significant loss for the family, and they need to prepare for this. We've got a concur on this; the Navy said they put it on their PEBLO checklist. All the PEBLOs have checklists, ladies and gentlemen, and they are working down those checklists and they brief service members. So we could ask them to add more opinions to that checklist, and that's not a bad option. I think it might be worth our benefit next year also, is to get that

checklist from each service, and maybe we could do a cross-walk on what they look like, what their gaps might be based on what we hear from the services. But all the services have checklists, and they're basically renewing the commitment. They're going to put it in their checklists.

Okay. Number 16. This is aimed at your family members, this is really an outreach to get family members into the IDES briefing, and when they're in the IDES briefings, for them to understand how the VA programs can benefit them and what's going to be the difference between DO and active duty and being a veteran. So number 16 is a real outreach on your part, recommendation on your part, get family members into the IDES briefing and for the IDES briefing to be thorough on what benefits, what pay and benefits are going to look like, what VA has to offer for the family, and so there is a lot of knowledge being delivered early in the process. And they concur, although I think across the

board without an implementation plan, we don't really know what it would look like, but we don't see a lot of improvement in this area. The best of what we're looking at, it's still difficult to get family members into these IDES briefings, and we do have some observations for you guys, that re-crafting that, this here into maybe another recommendation or a recommendation which says to follow along with this one.

Point of contact in 15. We get a concur on this, and we think this was being addressed in the IC3. Dr. ~~Geiss~~ Guice and the teams working in the IC3 are trying to pull together the process, ensure that information is passed, that the milestones are being checked, and that warm hand-offs are being accomplished. So for now we are looking to see the IC3 accomplish this task with lead coordinators, that is a recurrent terminology. It's in a pilot at this stage. They're anticipating some report back on the soundness of that in the fall.

Number 14 continues along the lines

of families and family caregivers. We have a concur on this. I don't see being foreseeing a lot of improvement in this area, but still, we do still hear a lot of -- we don't want to talk to the family member, we'd like to talk to the service member, we'd like to talk to the service member first, and each area of interest, each interest group, whether it be the leadership, small group leadership, squad leaders and section leaders, they've got to take up approaching the family members, nurse case managers, they feel a little more comfortable, so they'll talk about it a little bit more with us. Leadership talks about how they outreach to families. Family coordinators in each one of the battalions, their outreach to families, so we have a lot of people out there who can have contact with the family members, but we're not seeing a lot of improvement that they are actually the ones delivering the messages.

CO-CHAIR CROCKETT-JONES: I just want to point out that this, we, the issue that

we mostly see is not including, it's that because some services have designated cadre as RCCs. Where we see RCCs, the outreach requirement is getting really better, and where RCCs also see the jobs as giving the cadre, we see much less outreach, and we see the service to service discrepancy that goes beyond the recommendation and continues.

MS. DAILEY: Thank you, ma'am. Yes, we definitely like to see that family members are getting the necessary information from support groups, and education on PTSD, TBI - those would be indicators to us that there is an ability to outreach to families, not necessarily having to do with the health concerns of the servicemember, but more the health and needs of the family.

Number 13, you all kind of gathered around the RCC training program as a great baseline for training and maintaining this pool of knowledge about these services. So in recommendation 13, you talk about how valuable

this RCC training is, and exporting it to as many of the possible individuals who come into contact with wounded warriors and their families, and Recovering Warriors and their families, as possible. So you've generally taken the stance in recommendation 13 that the RCC training is a good baseline, it's got good information, and that population of individuals touching a Recovering Warrior and their families need to be trained, and need to participate in the RCC program.

We have a partially concur on that. Not all the services send individuals to the RCC training, so they have various populations that they do. But your intent here in this recommendation is that it be very broad reaching, for as many people as they can support in the class, and the content is that valuable to anyone touching a Recovering Warrior to know.

All right. Redefining recommendation - redefining category 2. Has a non-concur on this, although, for example, the

Air Force embraced it wholeheartedly. The areas that we recommended that the category 2 be extended to, and for example one of them was individuals in IDES with a PTSD diagnosis, they should have an RCC or they should receive some sort of non-medical case management and/or medical case management. So our recommendations that encompassed individuals in IDES with a PTSD diagnosis, reserve component individuals returned to active duty because of an emerging issue, individuals that were - individuals that were on reserve component - reserve component individuals on active duty orders for more than six months be included in Category 2. You wanted to expand the category 2 to encompass those individuals to get them non-medical case management, to get them case management if necessary. Basically all the things that category 2 entails, overarchingly. Reserve Component is an overarching -- capturing almost 85% of people who are in IDES were not a WTU, were not in a wounded warrior battalion, were not

being followed by AFW2, or Navy Safe Harbor. But we all had some concerns about those individuals in the IDES program who are there with PTSD, and we had some concerns about your reserve component being returned to active duty or staying on active duty more than six months, because of emerging issues, and you wanted to ensure they had the same entitlements for category 2 that other individuals who might have the WTUs, the Wounded Warrior regiment, or Navy Safe Harbor or AFW2, receive. So we didn't have something like this in the Air Force. We had some concerns across the board with providing the manning and the support for those individuals across the other services and components.

Number 11. So number 11, although we recognize the good work of the RCC in managing the CRP. Now this is the document which is an online document, belonging to the Warrior Care Policy office, but it wasn't built to be interactive. It wasn't built so that a family

member could go into the RSCP and - excuse me, could go into the CRP and say "Well, these ought to be in my goals; I'd like to put them in here." And what we're also finding, as a really interactive document between the RCC and a family, this is mostly in Air Force, Navy, and Marine Corps. It was not really an interactive document between the RCC and the family members, or the RCC and the service members. We did urge, we did in this recommendation urge the services to utilize this product, the CRP, to more actively engage, more copies, more copies, more opportunities to update, better advertising. We were at Navy Safe Harbor, and they said "We definitely use CRP everyday. Now, whether my family members know that's what's happening or not, we don't know." And we do our recommendations and market this product.

It is also their opportunity to influence their goals, to understand where they are in the process. So 11 talks about better marketing utilization and a better investment by

the family members and the service members in the CRP. And that's a training, that's a cultural thing that moves along, and you all caught that it needs to be better promulgated down at the RCC and the family of service member level.

Number 10. In number 10 you basically said to the Department of Defense, you got too loud there. You got the CRP, which is the DoD document, and you have the CTP, which is the Army document, and you really need to come up with one. They think that's being addressed by the IC-3. They believe it's the intent of the IC-3 to have one document. We'll have to see what product they come up with, but number 10 was a vote to say "one document for all the services".

Number 9 had to do with PTSD and treatment for PTSD. You become increasingly concerned about evidence-based treatments. I think we've got a good baseline for the training on that, we've got good laydowns as servicemember that the medical community is being trained in the evidence-based treatments.

Not a problem.

Where are we going from there? Are they being delivered? Are they being delivered with fidelity? Who's doing the follow-up? How are you following up? What are your procedures for measuring outputs? This is your recommendation number 9. And we had some observations this year about removing that recommendation along with it. So, number 9, you are very invested in evidence-based treatments being delivered, being delivered with fidelity, and measuring outcomes. We have a concur on that. We just don't think that it's at a state where you would stop following it, you continue that out in the field, how are you measuring the outcomes for your evidence-based PTSD treatment.

Number 8 was your recommendation on 100% training for all behavioral health providers in the evidence-based trainings. Services gave us very good laydowns on this in the February briefing and every time we went out

to the installations. So I think they -- we could say with some certainty that the training is out there, that there is good delivery of the training, there's good mechanisms for delivery of the training. The full-on steps in the clinics, how that training's being delivered, the outcomes, how you're measuring it is where you were a little bit, in number 9 last year, and you have some observations on the beginning of this. We'll try and take it to another line.

Number 7, we have the extension of TAMP benefits for one year versus six months, and the response from the DoD is that they're continuing to look at that.

We have at number 6, we were out in Twentynine Palms again in 2012, we continued to see needs out there for beyond medical case management, for example, that are transition opportunities for Service Members out there. We did get a commitment from the Marine Corps to work for the VR&E individual out there. Haven't seen that happen yet, to the best of my

knowledge. They've been keeping me updated on this; that one they haven't updated me on. But you wanted to continue your interest in the Twentynine Palms area.

CO-CHAIR CROCKETT-JONES: The system tracked that one was hired, accepted the job but then declined. So -

MS. DAILEY: VR&E?

CO-CHAIR CROCKETT-JONES: Yes.

MS. DAILEY: Okay. Good, good deal with that. So number 5 is the overarching recommendation in that you're trying to ensure there's a continuing knowledge base on warrior care policy. I think there was some concern that these policy offices go away when the war ends, and we wanted to kind of put your flag in the ground that you believe these policy offices need to be - remain in the, under the personnel or at least in personnel readiness where it was not an issue for us but that it not go away, and that recognitions and actually recommendation to Congress. Congress would put legislation,

permanently put it in place.

But any time we asked Congress to do something, review's not - does not turn out to be some of their favorite recommendations, when we ask Congress to do something, they really can't do it. They have assured us, though, with that non-concur, that the Warrior Care Policy Office is, is an embedded piece of the policy making of the Under Secretary of Personnel and Readiness, and that it will continue to do those functions.

Number 4 was also an overarching recommendation. You continued - and we had recommendations in 2011 - you continued to see the need to bring some of these major facilities together to deliver services in a comprehensive manner which allows for the smooth transition from the DoD to the VA. There are a number of good locations out there. If you would like to see the DoD start to actively plan for that transition of knowledge, or the smooth transition of the wounded into the VA facilities.

This is about maintaining the knowledge base; this recommendation is about maintaining the knowledge base as we draw down. And we got a concur. We'd like to see how they envision that recommendation. And you also have this here, some observations that you did see the model up at Chicago, and that maybe could be replicated at other locations, so this one might have another iteration this year with recommendations.

This number 3 is a follow-up to number - to 11, to a recommendation in 2011 about how do we want to address the needs of the IDES population, pretty much the IDES population, who are not in WTUs and are not in the warrior regiment, who are staying in their units. How are they - how are their needs going to be addressed? Their needs are different from the needs of a unit. And to document those expectations for managing them in a block in a letter, a leadership letter, a letter that talks about the population that was - continue to provide

leadership for, who may not actually be doing their job in their unit. Who are still continuing to contribute. How do we work and address in their own units? And because most of your IDES population is still in the units throughout all the services, a letter that talks about expectation for managing that population is what number 3 addresses, and it kind of follows up on our 2011 recommendation.

Number 2, follow-up also on 2011, has continued to define roles for these individuals, and assist Service Members in understanding what each player does, and each family member understand what each person does so that we aren't - our service members aren't continuing to be concerned about who's on first and where they're getting their service from, who's helpful on that. We continue to try and urge DoD to clarify these rules. We do think that the IC-3 will be addressing this as part of the mandate for the IC3 to try and address this, the rules, the hand-offs, the responsibilities at

each stage.

And then at number 1 you have three to publish policies that you absolutely felt had to be put on the ground very quickly, completed. DoD has done those, we've considered number 1 finished, and we are - again, we've kind of aligned end of year observations. Further policies that we might want to emphasize this year also, but we consider number 1 as met.

Okay. Just refreshers before we start the day. Our observations. Questions? Concerns? All right. We have until 9:45, 9:30's the break. We start at 9:45 with the IPO, excuse me, we start at 9:45 with the Centers of Excellence. We'll have 45 minutes to discuss where we might want to go, and what your observations are with the Centers of Excellence. I did make a commitment that I will give you some time, your observations are in the script, ladies and gentlemen, and they are numbered. So if you want to spend some time prioritizing those observations on what order you'd like to discuss

them with the group, I'm going to give you that time now, and we will start up again at 9:45.

I'm also happy that you coalesce in small groups, to get work done. Yes, and then we'd be off the mic. It won't change anything, you just kind of prioritize those observations that are moved from the document called "Preliminary Observations" and put them in the script. So all that information is in the script.

And I got you in groups, so you can move those and talk to each other, and see which ones want to talk first, and with noted, please keep in mind that Tech Sergeant Eudy might have an interest in something like vocational rehabilitation, and so we all have to be flexible about how you address them.

Okay. Break? And then come back and for my audience out there, we will be back here and talking at 9:45. We'll be back on the mics at 9:45.

(Whereupon, the above-entitled matter went off the record at 9:09 a.m. and

resumed at 9:40 a.m.)

MS. DAILEY: Ladies and gentlemen, we're going to be starting. We have some preliminary comments we're going to want to make. Our two co-chairs have been putting their heads together about how they want to look at this upcoming year, and they're going to kind of give you that overview, and I think that'll help with your context as you go through your discussion. All the information is here, ladies and gentlemen. It's really about how we're going to organize it. And so I'm going to turn it over to the co-chairs at this time for that discussion.

CO-CHAIR NATHAN: So Suzanne and I were talking, and she had, I think, some very cogent ideas about how we can get the best bang for the buck out of our - can you hear me? Can you hear me?

(Laughter)

CO-CHAIR NATHAN: So the best bang for the considerable time and effort that you all

spent, not the least of which is significant funds for both these meetings and the travel. So Suzanne and I will explain what the particulars are, but in concept it's come up with fewer recommendations this year that have more heft to them. In general, there will be some that we come up with that are overarching recommendations for the systems, bases, could be policies, could be approach to systems. And then some recommendations which are specific to certain areas or certain regions or commands or services that specifically target taking advantage of what all of us have seen and learned through our travels to make a difference in particular areas. The key being here to try to make concise, limited number of recommendations from the Task Force to send the message "Out of all the things we could be considering, this, these recommendations, are the ones that have our fullest attention, and that we expect the Department of Defense to give their fullest attention to." Anything further?

CO-CHAIR CROCKETT-JONES: Yeah, I was saying that I see it as basically there's - I want to thread both needles. I want us to be able to present some very overarching imperatives. I think that those of us who've done a lot of the traveling have seen sort of common denominator issues that are broad, and we tried in our first year to hit some of those broader terms, and I don't think we were understood very well. I think in our second year we tried to individualize those ideas down, and I'd like to try and combine both of those efforts and say "Let's have a few, up to maybe five, recommendations that are broad and big that address the powerful issues that we're frustrated with, and then from our individual groups, some of the more specifics that are persistent or fixable and maybe have a group of smaller, like a service-level or an installation level, in things that we saw that really need to be fixed, and more specifics, but limit those as follow-up recommendations. So that would put us

at about 15. That gives each of our focus areas two to three, and at par for overarching. If those overarching don't measure up to par, we can modify this next bit but that's sort of what I'd like to give us a little bit of some of the specifics so that we, where we know to change these in a very specific way. But I want us to address some of the overarching issues, and so I'm happy to hear feedback on people's responses of the two kinds of recommendations.

CO-CHAIR NATHAN: Just for the tactical implications of it, over the next two days, the groups will be considering two categories of recommendations. Each group will have their pet rocks that are overarching policy and/or system recommendations, and each group will be then looking at the data we've collated over the last year in traveling. And/or service briefs to us that are specific to a service, or specific to a region or command or a location being lost, or a WTB or a WWR that you have met. And then we will wrap and staff those tomorrow,

and the group will hone down, accepting no more than 5 general policy recommendations, and no more than 10 specific, meaning we have no more than 15 total recommendations coming out for the report. So questions, issues, comments, concerns?

MEMBER STONE: I welcome this approach. I talked about it last year. I think the value of the organization should be a broad policy, related issues now at the newest level with the current recommendations. I think the impact of the Task Force is really the experience that you've accumulated over these years, where you've taken really more knowledge across the system than just about any other task, and helped translate it into a policy statement. By the same token, I would recommend that for next year, you take a look out your window across the delivery systems outside the DoD and VA, and what best practices might look like, and how do we end our stalemate within the broader community, like I said, as well as broader policies regarding

disability in the civilian community.

CO-CHAIR NATHAN: I think that's a great point, General Stone, is to widen our aperture, perhaps now that we've become - I'm using the royal we here, because I'm the new kid on the block - we've become fairly well-versed and facile with the internal processes, and how they work and don't work, within DoD and VA and the federal healthcare system. What I hear you saying is we should widen the aperture, start looking at best practices and other systems of compensation, disability treatment, disability care in the civilian sector, which doesn't quite - doesn't translate completely across, but certainly when we look at the electronic medical record system for health care, and you look at compensation systems and the way various large organizations determine those. Other questions, concerns?

MEMBER PHILLIPS: I just want to emphasize on what General Stone had mentioned. Administratively, we have three different

health care systems. We have DoD, we have VA, and civilian system. Functionally, we are really integrated. Roughly 50% of the active-duty are contracted out to the civilian system. Approximately 20% of the VA as well. Of all the folks eligible for the VA, only about 20% utilize the VA full time, and correct me if those numbers are wrong. And so, as we said, I really think we need to look at our recommendations based on those three systems. I mean, if there was some way that we could have one electronic health system, record system, for all three, it would just solve so many issues. I don't want to take time, but I just wanted to emphasize that.

MEMBER DRACH: I don't have any objection to what you're rolling out. My concern, though, is are we sending a message that a lot of the other issues that we've talked about or we've heard about are not important? Is there some way that we could have a I don't know what it is, an appendix or something that addresses sort of the other issues and kind of phrases it

in such a way that these are issues that the Task Force is concerned about, that don't rise to the level of recommendations at this time? I would be really reluctant to have a report going forward that doesn't somehow at least identify and talk about some of the other issues.

CO-CHAIR CROCKETT-JONES: Well I would think - when I look at some of the issues that we've been talking about, and think about some of the things we've seen in the installations, I find that frequently a specific issue is related to a broader policy problem, a void. When you look at how many of last year's recommendations involved the IDES process as a whole, and we addressed it by trying to fix the various components. PEBLO ratios. Legal availability. Checklists for proper inclusion of information. Time of this - this is really an archive system that isn't improving, and isn't actually working. And we looked at all the small parts, but I think we need to consider making a recommendation that's more to the point, and if

there are specific concerns within that broader thing, I'm sure that that can be written into the supporting evidence for the recommendation. And I don't think that that's lost. I think that that just reinforces a big recommendation.

MEMBER MALEBRANCHE: Suzanne, I tend to agree, and I think the other area that we saw that was the IC3 where they were doing follow-up, because one of the challenges of that is to do an overarching policy. We'll cover lots of these issues, but then also, I understand that Mr. Drach is saying that we can take one of these past issues and to see it sitting to do at the overarching policy, is it or is it not being covered, and that might be one of the things that we do when we go through and look that you did it. Is it doing the things that we wanted it to do, or was supposed to do? But I understand what you're saying too. If you have fewer focus on it, you can use one of these little examples to see if it's working.

CO-CHAIR NATHAN: I think it's

important that we document all the issues that come before us that we feel, at least that the majority of us feel are worthy of attention to the government. What we want to do is send a message that these are the things that we believe are non-negotiable. And so we do it with fewer recommendations. As opposed to sort of a world-hunger group of recommendations. Which of these 30 to 40 to 50 recommendations do we caveat our message, our deliverable, with saying "Of all the things we could have chosen, here are these few things which we think you have to move on." Making people uncomfortable, in that if they don't do this, as General Stone said, you now have a collective, corporate insight of not only a diverse group that has created the Task Force, but the months and years of collective insight of the process overarching. So we just want to get - if we said to each one of you, if you were king or queen for the day, what would you change, if you had your magic wand, about the Recovering Warrior system, each one of you has

something that would be your top priority. Each one of you has something that you're passionate. I have mine, which would be my number one thing. It may not be shared by all of you, but if we can rack and stack those, and get those down to a very manageable number, if we deliver those to congress, deliver this to the Department, if we can go in with this saying "There are literally hundreds, if not thousands, of things that we would like to see fixed, but these are the important things that you had better take seriously, because we crystallized it, we distilled these down from our year of research and in our prior years of insights. So that's sort of the mechanism. Deliver more punch with each one. It's sort of a - I liken it to, a leader comes in and says "I'm the new leader and here are my 15 priorities for the organization" and everybody immediately rolls their eyes. Whereas if the leader comes in and says "Here are the three things we're going to do under my tenure", everybody sort of says "I'd better do those,

because it's pretty easy to check my homework on those three. So that's sort of where we're at.

MEMBER STONE: Sir, I think one of the questions you approach is whether we are facilitated or inhibited by the current edition of our recommendations into the various subgroups that we have. Does that really get at the very board concepts that are laid out for us, or should that be fit in with them in order to allow us to get to a much broader conversation?

MEMBER PHILLIPS: I would agree. There's so much overlap between these. I really can't support the idea of limited recommendations, and we try not to - at least, on the front page, categorize them. I think it would be a lot easier for people to understand these recommendations.

MEMBER REHBEIN: If I may, Suzanne? Earlier I went through all of the observations and identified some that I thought had a common standardization theme. I agree with what Steve was saying, and I was looking in the agenda

trying to determine a time we would talk about it. Those kinds of thing that move from one combined areas, right, how we would not have them as separate discussions, we would want to combine this section. But I want to expand on that a little bit further. After conversation with Suzanne, I was focusing on the differences in the way services do things, and thinking about standardization there. And I realize now that maybe that's not the best way to think about that. Maybe what we need to concentrate on is to make sure that the outcomes are equivalent, regardless of what the uniform is, regardless of how the service is delivered, as long as the outcome is the same, as long as the satisfaction of going through the process is equivalent, regardless of the branch of service, as long as the information that the service member feels they need is being delivered regardless fo the branch of service, I think that's where the standardization comes in. Now, I think that's a more valuable thing for us to focus on than the

way things are delivered, the outcome and satisfaction.

CO-CHAIR CROCKETT-JONES: I think that we've seen a certain frustrating response when we've called for standardization of policy and process. This we have not seen, we have not seen a refined standardization at that level, and I think that the reasons that we were aiming for that in our prior recommendations was because we wanted outcomes. And I think that we have tried, we have been clear, but I think that regardless of how it's done, it is absolutely necessary to say the outcomes must be the same. If standardization of policy and programs and the process to get to that outcome isn't possible - and it certainly seems like that is not going to happen - then we need to make it clear that the DoD becomes responsible for the outcomes to meet a standard. We just talked about the RCC, when Denise was talking about it, it struck me. The RCC role - we can't get them to agree on who is the RCC or if the RCC is separate, but we can

say that the outcome, the product of the RCC must meet a standard, and DoD is responsible. So I think we do need to, you know, be clear about these overarching things that we all can come to an agreement on about how we want to say this and what is the most important. I think that it can be hard to create, to get clear on our language. I think that the subgroups have purpose. I think that if the subgroups generate a couple of things that are then priorities, that we can as a group come to the overarching issues more easily. So I don't refer out the subgroups completely, but I do want us to have time to figure out what the big bangs are, as topics.

CO-CHAIR NATHAN: So I have - the one advantage of reading everything from the start of the Task Force, which I've done, is I've watched how the Task Force has matured, and I've watched how the recommendations have been received. And it's pretty clear that you can't fight city hall on some of these things. You're just not going to realistically, as much as we

yell louder and louder, about the services standardizing their processes, that's not going to happen in many cases. There's no outlets. And what we can do, and this is getting more into the discussion that we're having over the next two days, but we can, out of them, get traction with Congress and the program as to at least they have metrics. For example, with the IDES, where the services do it somewhat differently, but they have the same metric they have to hit. Within a hundred days of the MEB, they have to hit the 295 days until the process. That's common across the services, and the report is generated that compares all the services and how they're doing on their IDES thing, now we drill down even further on each service and say "Why don't you be more like Jimmy or Jane, in the way you do it?" But I think this is a good discussion, because we're now realizing, we're looking back in the retrospectoscope on what recommendations that were given and which ones we can make muscle movements with, we're now going to lose that

insight into making recommendations in the future that we think can move the ball from A to B and yet hasn't overwhelmed them. So, again, I think our deliverable - and I defer to all of you on your collective insight and how you are best to do this, but our deliverables, by tomorrow afternoon, to have no more than 5 sweeping policy recommendations, and 10 recommendations that go deeper than policy and into either service-specific or region-specific improvements that we can make. And some of these sweeping policies will come from some of the specific areas where we went, and in one of the recommendations to have people who have warriors get advice and review from legal staff after the NARSUM came out of some of the specific travels you made, where you looked at the Task Force and you looked at the focus groups, and this was just a solid home run. And you said "Boy, everybody could do that!" And that's where we need to be. And I'll defer to your collective judgement as to how you want to utilize the subgroups to tee

up any of the specifics of those, and then you get back together and rack and stack them, or look at in the subgroups anything and everything that strikes your fancy, and you're still responsible for bringing back your group's recommendations, and you can then rack and stack. Any comments on this?

MS. DAILEY: I think we're on a very good course here. I have all the data. I need to know where your heads are. That's really what will help me. And we slowly sent out your preliminary observations. We kind of had a cross-cutting set of your preliminary observations. So believe it or not, you already did amass a lot of cross-cutting, overarching observations. But I need your thoughts, in the public record, and I need my researchers to hear it, and I think you're going to quickly, even though we compartmentalized this, you'll be able to say "Well, so we're talking about percentage of absolute from the oversight board right now." That's cross-cutting. So I think your

cross-cutting ones, or overarching ones, are going to be evident. It might not - you don't think we can spend the time saying "It's a lot of this, this is an overarching one and these two will be the detailed recommendations." I think that out of the discussion we will be able to coalesce around an overarching interest and your specific ideas. And if we can get that on the table as part of the discussion, my research staff will be able to pick it out and kind of a wrap-up, and each one of these time periods, at the end of each one of these time periods, kind of wrap it and say "Yeah, that one is going to be in the top five, and it might even be six and seven, and you would all eliminate next in July." So we might, in this time period, get six or seven overarching and then you all say "Nah, we want 2 and 4" at the next grouping. We might have 10 or 12 detailed recommendations, and you all eliminate them in July, basically. So I think we're on a very good track. I'm very happy with your cross-cutting, overarching, that'll leave

the discussion on the public record, I need my researchers to hear it, and we wrap at the end, each one of these discussions, and we say "Yeah, that's going to go across several concept areas, and these are the detailed." I believe it's very doable in the format we have now. It's going to be a good discussion, an open discussion by the time.

MEMBER PHILLIPS: Just one quick comment. I just don't want to abandon the standards of improvement. At least, as someone, I think previously mentioned, a recommendation to develop tools or some way to translate the different terminology so that the people who are using this, the boots on the ground, understand the differences.

MS. DAILEY: I am - I share with you the standard piece will resonate with DoD. They know, the warrior policy offices, and helping theirs are trying to go to one format. But they also realize that for them to develop IT systems, they've got to define a program, they've got to

define terms for that program, hand-offs, transitions. And so a recommendation of standardizing language, standardizing processes, standardizing transition points, that resonate with the Department of Defense, and it would help them build the IT systems case, that we talked about earlier, the case management systems that they need at the right place in the process. The transition plans will all then be able to be common across the services. And I think the standardization recommendation would definitely resonate, and we're all going to get traction on the DoD IT systems, once those processes have been defined.

CO-CHAIR CROCKETT-JONES: Okay, well, if we're ready, if you all are ready and comfortable, let's move on to discussing the Centers of Excellence. Are we ready to do that? Okay. During our January and April business meetings we gathered the log on three or four of our Centers of Excellence. Although we had a specific recommendation in our 2011 annual

report, we did not see a need to provide the recommendation in our last report. As this time period falls under restoring wellness and function, we can schedule input from Dr. Phillips, Lieutenant Colonel Keane, and Tech Sergeant Eudy. If you'd like to comment?

MEMBER PHILLIPS: Basically, we agree with one, two, and three. We thought that perhaps you could combine these into two recommendations, one being that we recommend dedicated funding for Centers of Excellence, I don't know how we combine that into two, and two being that Centers of Excellence have common standards, one voice. Subcategories related to this being standard ways of collecting, employing, and translating research into practice, standards, evidence based practices, training contractors and those involved in evidence-based practice, in evidence-based medicine, and political guidelines that cover both the VA and DoD. I guess we need to wordsmith it a little bit, but -

CO-CHAIR NATHAN: One of the growing concerns has been that the Centers of Excellence, one, are sort of threaded together in a command-and-control environment, who will take best advantage of their good work. Let's use the objection, I'm going to sort of ask Dr. Lockett, who's here, if he could come in, talk a little about, from your perspective, Warren, as clinical, chief medical officer, who brokered some of these issues with Centers of Excellence in science and medicine that they create and the recommendations that create the best practices via hearing, vision, TBI, and your perspective on how to win over, how well or not we're doing in translating the research and their collation of ideas into practice.

DR. LOCKETT: I'll be happy to answer any questions. I think what happens is the Centers of Excellence generate certain findings that inform the clinical practice guidelines. The concern, and I'm not sure how to address this, is that there are - what happens with the

Centers of Excellence guidelines, they overlap significantly with the civilian community where there are a lot of competing entities that also want to develop clinical practice guidelines. So there are unique needs of the service members, but for example, if you have a clinical practice guideline on those kind of treatments, evaluation and treatment of post-traumatic stress. How would that be different for a patient that might have post-traumatic stress as a result of a military experience, as opposed to post-traumatic stress from some type of civilian experience? It's a little difficult. I think that what we need to do is make sure that there's not an overlap of function with what the civilian community is doing in terms of developing clinical practice guidelines. The other concern I have is that clinical practice guidelines themselves need to be vetted by an individual body that does not have a vested interest. You know, I'm an internist, like Matt, and they wanted to redesign or redefine the definition of

what hypertension was. Or what glucose intolerance was. Because there are certain components of industry that would serve to benefit by having a redefinition of what the process is. So one of the things that is unique about VA and the DoD clinical practice guidelines, because they're primarily driven by federal agencies, we can remove those kinds of industry endpoints. But I think there's a real question here as to making sure that we're not duplicating what is going on in the civilian sector in terms of the development of practice guidelines. I'm not sure if I'm answering the question exactly.

CO-CHAIR NATHAN: I think what you heard is trying to avoid contradictory -

DR. LOCKETT: Practice guidelines?

CO-CHAIR NATHAN: Well, duplicate, duplicative. Conflicted, right, conflicted or maybe the federal medical practitioner is given one set of guidelines for patient care from our system, and at the same time there is a parallel,

perhaps alternate pair of guidelines coming out of civilian centers, so reconciliation of those, though based on the main question, Warren ,is if we believe that the Centers of Excellence are important, and they are fairly resource-intensive, in both funds and personnel that are assigned to them, if they indeed do come up with innovative ways of taking care of Recovering Warriors and generally, ideally, warrior-specific type of injuries, the visual Center of Excellence was created to look for new and innovative ways, be it from our own services or be it form the civilian services, to treat eye injuries. And eye illness as a sequela of warrior activity. And we came up with something: how do we then get it into practice? What is the mechanism that is going to get that translational either research they have done or observations they have made, and now, tactically, get it as far as clinical practice guidelines into the various -

DR. LOCKETT: Okay, so once the

clinical practice guidelines are disseminated, they are sent to the services for dissemination, because the services have individual responsibly for ensuring those clinical practice guidelines are followed or executed. But to be honest, I don't think that's where the problem is. I think where we've been hampered in the Centers of Excellence for clinical practice guidelines is using or having the metrics of effectiveness and knowing what works. I mean, the research is just one aspect. The research tells us or informs us, but then there's the execution phase. If you have a research study for which findings can be suggested that a certain type of translational medicine should be applied, then we need to see where that translational medicine is being done. Is it working? So I think the disappointment - and I don't know if that's too strong a word - that I've had with some of the Centers of Excellence, is because in an effort to promulgate clinical practice guidelines, first we can't decide on

what the focus should be on what those clinical practice guidelines should be. And so I think one of the things that I've been urging the Centers of Excellence to do is to step back and look at measures of effectiveness of what we're doing out there. I'll cite an example. We currently have an ordination of policy that says "Behavioral-" - and this is for the Centers of Excellence of behavioral health - that behavioral health practitioners will use instruments that tell us whether they are being effective in the treatment of the most common behavioral health disorders that we see: anxiety, depression, substance misuse. Now, as an endocrinologist - and I was explaining this to Ms. Dailey earlier - as an endocrinologist, you can tell whether a patient in my endocrine clinic is getting better, because we're following their blood sugar or we're following their glycosylated hemoglobin. We haven't been able to do that with our behavioral medicine patients. So we have issued a policy to help

compare this level that we've asked the services confirm its importance: that when a patient comes into the clinic, they're given a validated tool to assess what their level of anxiety, depression, or substance misuse is, and we track them over time. Having implemented this kind of tool, we can then look and determine which clinics are making the patient better, and which ones are not, and then, on the basis of that, the clinical practice guidelines can be employed. So I think that the problem that we see in the deployment of clinical practice guidelines has been this kind of angst as to how we're value-added from what is already out there in terms of clinical practice guidelines in the civilian community. We've also done this with a recent assessment of all of our behavioral health problems in the DoD. Where we looked at the programs, not just traditional clinical programs, but those that were funded with special dollars to improve behavioral health, and we then racked and stacked. Two hundred

programs. All those kinds of findings will help inform the Center of Excellence as to what works and what doesn't work. So I think the real focus here is not on how that gets out, I think we're struggling to make sure that we have appropriate clinical practice guidelines that are value-added.

MEMBER REHBEIN: I agree with what you're saying, Doctor. Having spent my life in research, these projects are designed, too often, too often, the question is "This is what we as scientists have developed. Can you use it?" As opposed to the customer saying "This is what we need. Can you help us fulfill this need?" It's the second question that's really the important one. The customer has to be very deeply involved in designing these things in order to make sure that when the product comes out, that it's going to be useful to the customer, that's it's going to be of value. Research folks, and I fall victim to this as much as anybody else, we tend to wander off down those side alleys of things that are

very interesting to us, but may not have any practical value for the next ten years. We need to make sure that we have our Centers of Excellence keeping their eye on the ball, that they are really providing the kinds of tools and clinical practice guidelines that are of use to our folks right now.

DR. LOCKETT: So I'll cite a specific example. There are currently two conflicting guidelines on the use of anti-depressants for mild to moderate depression. In the US, it's recommended that anti-depressants be equally considered as other types of psychotherapy. If you look at the British health system, where's it recognized that antidepressants are no better than placebo for mild to moderate depression, you don't see that recommendation. So what we need to do is not come up with the third DoD clinical practice guidelines. At this point, we need to look at our patient population and figure out whether these antidepressants are working or not, and then promulgate the appropriate

clinical practice guideline. So I'm a little concerned that there's a focus on promulgating these clinical practice guidelines, when I still think the reality - and I'm sorry to admit this, three or four years after the development of these Centers of Excellence - that we're still identifying what best practices are.

MEMBER STONE: If I may, Warren, I appreciate your comments. Centers of Excellence, I think, exist for three reasons. One is to inform care and you can talk in here how they assimilate information from various sources to inform care for the Service Members. The second is to identify gaps, through bringing collective knowledge together, identify gaps that then informs future research, and even though it may be a small area that researchers develop, it still has value or opens up several more opportunities. I think the broader question that you opened with in your opening comments, in the area, does the current structure of the Centers of Excellence, reporting through an

oversight board, facilitate the rapid accomplishment of the three tasks that I identified? Now, if you disagree with the three tasks that I've identified for the Centers of Excellence, okay, but I think the broader policy question, going back to our opening discussion was: these great ideas that gives us Centers of Excellence, is it appropriately tied into our delivery and research system, so that it works well? And I submit to you that the policy recommendation should be that the current structure of the oversight board fails to recognize the rapid assimilation of knowledge that we want, and that therefore our recommendation and outcome should identify the fact that we do not believe that the oversight board is the right model with which to handle this in accomplishing the mission, and then secondly, what do we think that should work with? And that's a whole broader discussion.

DR. LOCKETT: Yeah, I'm not sure I would agree with that statement, with all

respect, because I asked for examples, where there was something that should have been rapidly disseminated.

MEMBER STONE: I think you've just done that. I think in your statement you've just done that. You've showed us even in behavioral heath there is an irreconcilable difference in clinical practice guidelines. Tell me, Warren, how you reconcile that, and how you do that in a rapid manner, if one of the conclusions is the fact that irreconcilable difference that you identified in behavioral health, has been covered for you.

DR. LOCKETT: Because I think it was the Centers of Excellence oversight board that send that guidance to the Centers of Excellence that this needed to be done.

CO-CHAIR CROCKETT-JONES: Perhaps perception of the Centers of Excellence or their role has never quite been on target. But let me just say this: this is my concern when it comes to the Centers of Excellence. The complex mix

that has been involved can lead to very specific problems within our combat forces, and they required innovation and adaptation in order to address these problems, PTSD being one. And the Centers of Excellence were focused on the very specific things. But I fail to see a leadership that has moved forward at any pace different than what has been happening in the civilian force in some of these areas. Some areas, like when we went to Landstuhl, and then looked at the way traumatic injury care has evolved over time, with great leadership to say "This must happen. We need better outcomes." And to see the change that has happened. The changes that have happened in amputee care. The changes that have happened in orthopedics and physical therapy all have happened. The amazing changes have happened at rapid rates, because they were pushed, and have leadership dedicated to that push and change to get better outcomes. I'm not seeing that in behavioral health, and I don't see the Centers of Excellence being a force of

leadership that challenges what is out there in the civilian world. They seem more passive, and that is just my perception, but if that is my perception, and I'm more informed than the average taxpayer, the average servicemember, the average spouse of a service member by virtue of the briefings and in some cases, if that's the impression I'm getting, that's the impression that's out there. That there is no leadership when it comes to behavioral health that is saying "This is unacceptable. What we are seeing is~~n~~ unacceptable, and change must happen to improve the delivery of services for care." And I'm not sure where, in the Centers of Excellence, that gap happens, that says in some areas, the Center of Excellence functions great as a leadership and driving force. In some areas it doesn't. The NICoE is great, it's putting out a pilot program, and the centers are going out, it seems innovative and driving. But I'm not sure that's across the board with all the Centers of Excellence, and I haven't heard much from those

involved in the Centers of Excellence to say where the gap is in other places. So I think what we're saying is we would -

(Simultaneous speaking)

MEMBER EVANS: So I think we would like to see from the CoEs, selected, we don't want all of the in-between. We want CoE policy, CPG, in order to reach, there are members out there. So whenever it's needed to remove the in-between, I think this Task Force is going to go there, what do we do to get all that removes so that we can see policy for our service members and their families benefitting. So I think that's where our frustration would be with what we have before us, and so you could tell us how to make that better -

CO-CHAIR NATHAN: So I think I'll have you just sum it up, because we have to move to the next topic here in a few minutes. And this is good food for thought that we will formulate recommendations around. I'll give you your last thoughts. But what you're hearing is, number

one, if the CoEs were to disappear tomorrow, would that create a significant void in the way we're practicing health care and/or restorative care for warriors, and number two, they are expensive, and if you go to the CoEs, and you talk to the individuals who staff them, they are passionate, very bright, very innovative people, and how does that, if they come up with something - one tactical example, if you'll recall, from the Visual Center of Excellence, was when we had the Dr. DeLeon in front of us, and he talked about they had determined there was a new way to use an eye shield for ocular injuries, and it was completely new, antithetical from the way they had done it in the past with pressure bandages on the eye, now you use an eye shield to remove all ocular pressure on an eye injury while transporting a patient. And we asked "Are all the services doing it?" And he said "Everybody except the Army." And we said "Well, you're the Army! Why isn't the Army doing this?" And he said "Well, I happen to know a few

guys in the Air Force and the Navy who run ophthalmology logistics, and they put the eye shield in, so they changed it around the way." He's still working through the Army bureaucracy. So when we asked "Well, who do you have higher up than you who can make this happen across the services? And ideally it shouldn't be the President of the United States, it should be somebody lower than that." And he said "I don't know."

Now, that is just a tactical example, and that's a significant clinical example, it's not horrible harm, but those are the kinds of things to worry about. Now, one more question I have, is there a report that is generated by either health affairs or somebody else at the end of the year that we can put on a desk that says "This is the annual report of the Centers of Excellence, and what they have done this year, and what their recommendations are for the way ahead." Something that can be a tangible example of the fruits of their labor and

recommendations they have that put the department on the record for what needs to be done according to the Centers of Excellence. Because if they don't have that, they should just let it go away.

DR. LOCKETT: So the annual - so each of the services do have to have, or each of the Centers of Excellence do have to present such an annual report with their accomplishments that justify their raison d'etre. And Rich, maybe you and I are in agreement, but I don't think the issue - remember, the Centers of Excellence oversight board just makes recommendations. The true authority lies in the executive agency. So this has happened on a repetitive basis, where the center of oversight board has made a recommendation, but we are dependent upon the executive agent, which is one of the service, to get that done, because that Center of Excellence first response to the oversight board is "We don't work for the oversight board, we work for the executive agent."

MEMBER STONE: Which is exactly why the executive agent should progress with that, but if the structure is effective in that relationship, it makes the subsequent one repetitive.

CO-CHAIR NATHAN: Thank you all, very much, and now we have to talk about climate change in the arctic. Your addition to the conversation was very germane, so, thank you. Any last comments before we go, before we move on.

MEMBER MALEBRANCHE: Yes, on one of our site visits, and I think we refer to it, but on one of our site visits we asked the group of professionals about the Centers of Excellence, and what they had contributed, and they said "Well, the Beacon did really good research" but the contribution to them, in a large area, was nothing that they could really put their fingers on. We asked that a lot in the installations, and we got a very similar response from place to place. Every now and then we would find someone

who was able to connect some experience with a drawing.

MS. DAILEY: So as to that, ladies and gentlemen, we do feel you are to talk about internet communication, we would like to see what you would put in your recommendation that has to do with a different structure, a better way of delivering your findings and recommendations more efficiently. So it would be along those lines. It wouldn't be along the lines of research from them, it wouldn't be along the lines of clinical practice guidelines, it would be more along the lines of a better structure to deliver their practices, their findings, and research more quickly.

CO-CHAIR NATHAN: We're missing, I think, the common denominator of command and control to distribute best practices. For Dr. Lockett and all who disagree, is that each Center of Excellence is currently under the aegis of an executive agency, which is a service, and so they always have to hear something, here's something

they come back to vision, which the navy is the oversight for Vision, and if the Navy doesn't see fit to push this hard and to get it done, or even kind of do it, if I stand up and yell and say "You can do this!" I have no command and control over the Army medical system or the Air Force medical system to implement this. And so finally the executive agent should be the ad-con support for these Centers of Excellence, but the forwardness leaves the rest higher than the services at a common denominator to get these things put into traction. The services have the right to advise, consent, and disagree with what's been put out, but once it's been decided it should not be up to the individual service to make the other services all go along with a standardized either mental health practice or legal practice or varying practice.

MS. DAILEY: Ok. The background history, the Surgeon General's group, it was their recommendation in the 2010, 2009 period to align their CoEs under service, to align their

funding for their services, and in our 2011 report, we endorsed that recommendation by the council of surgeon generals, and Dr. Green was adamant in that decision. But we now are looking at - we're not backing up on that recommendation in 2011, which was to leave aligned under the services, but to ensure there was a better way of delivering their recommendations and their research and their findings to the field. Quicker and more efficiently.

CO-CHAIR NATHAN: Exactly. What happened in the past was the services liked to pick on everybody else and say they can't execute them. So give it one of use, we're in the execution business, and we'll execute it. So the good news was that we get the centers or excellence that are under our wings. We get the going. We get them funded, we make sure they get to work on time, the water runs, the lights are on, and we prompt them. But we don't have a good way of then distributing their best practices across the DoD. And so we need a better mousetrap

for that.

MS. DAILEY: Very good, research team, any questions? We're good? Okay, thank you.

CO-CHAIR NATHAN: Now we're going to move on to a review of transition outcomes and DoD/VA overall coordination. Last year we provided recommendation which you saw before, 4, 25 and 27, and that relates to these subject areas. You can look under tab B to refresh your memory for those, but these subjects fall under Enablement of the Future. At this time Ms. Malebranche and Mr. Rehbein will frame our discussion. And General Stone. Now we're just going to name the recommendations by the numbers. Guy goes to, he's a friend, he has a friend who's a monk and he goes to dinner with him, and he says "Listen, we don't usually invite outsiders, but we try to keep conversation to a minimum." He goes to dinner, and while he's at dinner, one of the monks says "Number 4." And he nods. A little later one of the monks says

"Number 17". And he nods. And he asks his friend who's a monk, he said "What's going on?" He says, "You know we've told the same jokes over and over again so many times, just to save time we numbered them, and we just say the number." And a little while later, his friend decides he wants to be in this order, accepted by the monks. He says "Number 8!" Nobody laughs. "Number 6!" Nobody laughs. He turns to his friend and says "What's wrong?" He goes "Look, it's not the joke, it's the way you told it." So when I say recommendation 4, 5, and 27, you'll know exactly what I mean.

MEMBER REHBEIN: I think I just lost the vote. I didn't even know there was going to be a vote, and suddenly there was one. These all fall under what happens long-term. Because number one, there, deals with that problem of the hand-off between the DoD and VA, and we see that in a lot of places. I'm not sure how to - and I'll turn this over to the rest of the team, to - I'm not sure how to develop a recommendation out of

this - I'd like to see - is there someone who's doing it well? And I don't know if we found someone that's really doing it well. But before we get onto that one recommendation, because these really all tie together and talk about handoffs and long-term meetings and how people are going to be treated for the rest of their lives, let me bring them all together and jump to number three for another minute to. Discussion amongst us this morning. We think number 3 is worded too strongly. While Chicago, while Lovell, is doing a lot of good things and identifying a lot issues that need to be addressed, they do not have it right yet. It's not a model we think should really be replicated as it is everywhere, that maybe we need to wait a little longer at let them work out some fo the other issues before we recommend that model. We applaud the concept. We think it's a good concept. But it's not ready to push out into a lot of other places yet. So there is those two. And then number two, of course, again, locations

deserve the most needs. This in number two touches on some of the things we talked about with Centers of Excellence. How do you - how do we - advances in prosthetics, there's lots of things happening out there in the civilian community. How do we makes sure we get state-of-the-art to the people that really need it? How do we get people to where services are being delivered? So this really wraps up into one recommendation, but I'm going to come back it, and there was some, I saw some interest over here when I asked the question "Is there somebody who's really doing it right in that handoff from DoD to VA and keeping contact with that service member doesn't feel like they've dropped off the cliff.

MEMBER MALEBRANCHE: And this slide where we were talking earlier, it was a little bit of inside info I guess, but some of us on this team are also on the Interagency Care Coordination Group, and one of the things that that group has been doing, and we're also in the

midst of a pilot and Captain Evans has been working as lead coordinator pilot on this whole issue of transitions. And I think that also the way it's back that we were talking about earlier, it's the outcomes, it's not necessarily who. It's the RCC, the FRC, but at different points in time it's necessary for a different person to be the point of contact for that family, and that Recovering Warrior. And so that handoff, which hasn't been done well, is one of the things that this group is doing a policy for, and looking at all the services and VA's policies, to include the DoDI, and VA handbook. And so what they tell them to do and what's going coordination now for all the services and VA is this one mission, one plan, one intent that our secretaries have said we need to do. So that's a coordination, the lead coordination. A coordinator pilot is also in progress. Just as Marsha Poller was a pilot, and it's not near the end of that either, and we know that probably, if we start to do recommendations employing delivery, we haven't even made it to

the results, and just on the preliminary results and things that we've heard from the Institute of Medicine, from Marsha Poller folks themself, there are issues now related to the even the electronic health record. Should have had it in place before the summer; it would have made things a lot easier. There are so many of these pieces that, similar to what Mr. Rehbein has just said that we need to look at this again, broader, and I think allow some of these pilots to take place before we start acting halfway through, and look at outcomes and metrics more, so the same sort of thing, I think.

MEMBER STONE: I think the first recommendation is about transition points of care. I think we do have a pretty good model in our current centers. So we do a pretty good job, telephonically, and using various methods to transfer care of very acute patients. Where we get in trouble in our decision points where acuity is bound and we're on an ambulatory basis, and it's more the long-term needs, and therefore

I think we've got a real struggle on a policy basis in order to do that, came back effectively at lower levels of acuity. As far as unification and long-term amputee needs, we looked at the rapid advances in the DoD, even at the Pentagon. So that the functions that have been created is a pretty raw challenge that I think we need to address to make sure that the replacement parts - expertise, stuff, is available, and when you deal with those, even the ideal project right now is part of our exoskeleton, service members on it, and transition and how you add the active duty, and what happens when travel people getting TDY funds to get people down on something that's trying to get through that. But it's that type of corporation, some sort of overarching body ought to be put in place to move to a more effective GI relationship with a lot of the - the third one would be the Lovell center. Lots of us would work with the Lovell center, but I don't think we can replicate this it would probably be the end of an era, should follow in the

facilities, and that, you know, even service bases all have their own facilities and that they would act independently share together on an efficiency basis, but the lessons learned are as positive as they are negative.

MEMBER MALEBRANCHE: I think would be a - sort of sad; I think there would be a third model of something that comes out from this, or a variation of that, or facilities. I do think a piece of that would be a policy. Wherever we're going to build just as they were doing in Chicago, it's important to look at the time where that might be possible, depending on what's there. And I guess another thing, just to touch a little bit on this amputation piece. When the services have a lot of research and ability to do things, and are not necessarily patents, and the VA doesn't necessarily have that ability, or that same stack, and all these different things, we have to look at that too. How do we make it equitable across so when they do transition, they can transition, and it's still able to

covered? I mean, for the patient it doesn't matter. It's just covering. And so I think if we look at policy and that sort of guidance, that keeps us above those to look and focus on, again, the sort of simple but definite improved effects on day to day, and we should be counting some of the stuff behind the scenes. That's the difficult stuff to do and deals a lot more with what they need to worry about, which is getting back to what they need to do.

CO-CHAIR CROCKETT-JONES: I would say that some of the takeaways from Lovell is less about coordination and tradition, is the importance of leadership at a forces location, it's a different approach. People were much more of a single mindset. If this thing had a successful, been successful at making that a single joint forces site in a way that we did not see at any of the other joint forces sites that we went to, which all seemed about puzzle pieces together clearly making a bigger picture, whereas they have achieved something, but I

agree that they did not give us necessarily give a model for the VA/DoD.

CO-CHAIR NATHAN: Remember that the business statement of the Lovell cCenter was to basically reduce costs and resources by creating a joint building that would house a VA and DoD personnel and allow them to leverage each others' capabilities to take care of their patient population. So if only they recruit a civilian leader, and they were able to obviate the naval hospital, no longer in use, and now when a recruit is hospitalized, they're hospitalized in the VA of Chicago, which is primarily staffed by the inpatient center by VA personnel. They can both see common patients, each other, can see on an outpatient basis, so that was really more of an economization of sharing and removing redundancies and working together. The one long pole in the tent that still remains at the Lovell center is the electronic health record. They've worked on some work-arounds, but they have yet to create a

single electronic health record that allows them to to talk to each other. So if you were to say "Boy, this is a great thing, let's put it everywhere" you still have the long pole in the tent between the VA and the DoD, which is the health record. And that has engendered a tremendous amount of passion from many sides on what the ultimate answer should be, and there is the "tastes great", and there's the "less filling" side. The "tastes great" side says "Let's throw lots of money in to force them, Alta and Vista, two respective records, to talk to each other." The "less filling" side says "No, let's abandon these two in favor of a commercial electronic health record, be it Epic of be it somebody else that's cheaper and easier to use." That's beyond the scope of our discussion right now. But I look at this - so the Lovell center was not designed to coalesce for Recovering Warrior care. Ideally it could, as a warrior goes in there, but it was designed to be more of a joint facility for primary care and for acute

care. Whereas, an example being Southern California. So the VA Amputation Center of Excellence is located in Los Angeles California. Why is that? That's where all of - the majority of the veterans were who need prosthetic health, because the majority of those veterans were older veterans, who had amputations due to vascular disease and diabetes and occasional trauma. But the Recovering Warriors were all amputees reside in the San Diego area, and the San Diego VA was not at all prepared to take care of the prosthetic requirements of the patients coming out of the San Diego C5 facility, with the new acuity to enrich the sort of space-age prosthetics. And this is the problem we got in Anderson. Veterans in the VA that sit somewhere in a small area of Ohio, and a wounded warrior who was last seen in Walter Reed-Bethesda coming with their rocket science prosthetics, and saying "I think this needs a tune-up, the VA in Ohio says "I can't help you, we're going to have to mail you back to Walter Reed to get this done,"

and it's prohibitively expensive to assist the VA in all facilities come up to speed with prosthetists who can take care of these advanced systems. So I think the intent of this group of recommendations comes from how long do we allocate to do the transition, one of them being some of the best practices we say with the VA inserting personnel into the DoD system, so when the individuals are going through IDES they were in their downtime, they were already getting their VA intake physicals done, and getting leg up in the system. And so when they handed off to the VA, they were already somewhat well-versed in the program. And that's what we saw in some of these recommendations. And that's the sort of thing I hear us talking about. But I just wanted to maybe talk about the Lovell health care center and what it's designed to do, and what it wasn't designed to do, and I agree with the sentiment of the group which is that it's not yet ready for prime time across the spectrum.

MEMBER REHBEIN: And it may never be

ready exactly as it's being accomplished at Lovell. General Stone made the comment earlier that that model is replicated in other areas, it's shared services that are important to it. And it may be that Los Angeles has a different set of shared services that are necessary than Lovell has. So it may never be a cookie-cutter approach. As far as - and we'll get into the electronic health record later, but I want to make a comment here because the comment has been made, the observation has been made, not in this Task Force but outside, that Lovell should have waited till it has electronic records. And that may be true. But Lovell being in place has increased the pressure to get that electronic health record. And if we waited with Lovell until electronic health records were in place, we may never get Lovell. Without that kind of pressure, I don't know that the electronic health record would be making that kind of progress.

MEMBER STONE: This is really about wounded warrior treatment. I said in my earlier

comments we seem to do a pretty good job at borderlines and health/healing. Going forward, so the DoD hands off to the VA. Effectively from the VA coming back to the DoD. Probably not. Probably not. Whereas in some of the areas it seems to me that the density of people could work on some of the appliances that we're talking about could be involved in very specify areas, for some period of time they are able to catch up. So I think probably to these, what I'd like this meeting, is a broad policy discussion of how we build back and forth in an effective manner, continuing to blur the lines between DoD and VA for the very specify needs of our service members.

MEMBER EVANS: Denise I think one of the things that kind of gets to the ground, we see in our group, when we talk about education and transition. That kind of hits the point, so Congress says "you need to have a comprehensive plans for Recovering Warriors and family members," and that's the tool that was supposed

to decrease the gaps between DoD and VA. So FRCs were to see the comprehensive plan on the DoD's side. This is a core process, and the process is honed by service. So we need a really strong statement to enforce what the DoD and VA group is trying to do. One IT system that follows that comprehensive plan. Currently we have four different systems following four different plans, owned by each of the services. And so the has to transfer folks from DoD or VA back to DoD, it's very cumbering. And I think in order to get back, to decrease all carrier, we have to go back to that standardization, which we can back up and say "Standardize that comprehensive plan. The handoff starts from DoD and enters that warrior in all the systems. And we are able to see that comprehensive plan both DoD and here. And communication starts early, but that lead coordinator, that one person identify, and in both systems would hand that point off. And so that's where you have a lot of gaps as they move through, not inpatient but outpatient that

removes that.

MS. DAILEY: We do have recommendations for one comprehensive plan. We made that last year. Recommendation 4.

CO-CHAIR CROCKETT-JONES: I have a question about 150. The question is for the emerging Defense Health Agency and it's set, you know, in a broadness, increase interaction with the VA, is that you see that as a potential outcome, or is that not just going to follow on the scene, sort of the overarching health agency. Do you think that won't actually help this interaction, because we are no longer the service, the individual service to VA? It's easy to get along the way it should, but structurally, it's designed to do so. And the second question I have, and I'd like to give you time to mull over it. Is there concerns among the Task Force about what should go forward on the electronic health record. You described a case very much filling. Is there a consensus on the Task Force about one or the other of those camps? So you all think

about that.

CO-CHAIR NATHAN: The Defense Health Agency, in my view, if you all worked to help facilitate the deduction of elements across services. It will have the ability to find efficiencies, to enhance a number of things that related to removing barriers across the three more important services. There is little system in place in the initial resolve that will result in further integration with other agencies. It stands to reason that once you reach full operating capacity and full operating capacity that as the Defense Health Program is operating in a uniform manner, it will put pressure on other agencies that interact with DoD to respond. So we'll be two independent services operating separately. So I think there's hope for them in the future.

CO-CHAIR NATHAN: That's a winner. That's a great answer. The DHA itself is going to take a lead time before it reaches a level of quality, and we probably need to be moving on

faster with the VA, because people are depending on help from the DHA any time soon, or VA, for certain persons' admission to the VA. So I really think that this is the category that we have to address, the electronic health record. We know the Commander in Chief, that's all that he said-

CO-CHAIR CROCKETT-JONES: We have another category for electronic health record. I just wanted to get a survey.

CO-CHAIR NATHAN: As we already said, we have three separate systems. As we said, I want one EHR, at least a virtual EHR, across the country. Everybody needs agreement with that. At some point in the discussion today, we have to come down on where ee want to be, if we want to be, on record for EHR. I think it's easy for us to simply say "EHR is a good thing." Common EHR is a good thing. We'll have to decide at the time where we want to go beyond that.

MEMBER PHILLIPS: Suzanne I had one other question. It's sort of tongue-in-cheek. Would the transition college exist if the DoD and

the VA would want it. Is there something that we could - seriously, though, is there something that we could do to recommend that component? I mean, it clearly falls to us. Is there some way to take a lesson from that - and create new things? That made some sort of component or some element that just eliminates the VA's role, and the DoD roles. Eliminate that boy's own - somehow - function.

MEMBER REHBEIN: As I think about it, why the acuity people do well ,and why nobody else does, I keep coming back to the DoD and VA folks all being there at the bedside at the same time, and so there is no distinct point at which it stops being DoD and becomes VA. Whereas with many of our folks, there is a very distinct point, because the DoD folks say "Here's the name of the OIF/OEF coordinator, at the VA hospital, for you to contact." And they're never all three in the same place, with the DoD, VA and the Recovering Warrior. They're looking at one another, talking to each other, at the same time.

So while it may be a warm handoff, it's certainly not a seamless transition. And if anything we could do in a recommendation that would - I'm reminded back to what the Doctor was saying about Centers of Excellence, because it's an information process there. And it's much more - it's an equally informal process here. If we could somehow specify that when those transitions happen, DoD and VA and the Recovering Warrior all have to be - not necessarily in the same place, but talking to each other at the same time, particularly at connection between DoD and VA. The worst places we've seen is where the DoD folks or the National Guard or the Reserve Component folks don't even know exactly who the OIF/OEF coordinators are. Alls they know is the name, the guard, go contact.

MEMBER MALEBRANCHE: One of the things - and I agree we do the best, I think, with systems down there, most acute. But I also think that's a function of the people and the

professions of those on the ground. And you talk to people who are taking care of patients, both VA and DoD, they're talking care of somebody that they both respect and honor. It wasn't about a lot of things initially. And even VA to VA, DoD to DoD, on both sides, there are issues. So it is that communication piece that is just so critical. And a lot of it now, we've established really, really sound relationships. We've taken VA to Landstuhl to show them where things started, so that's the whole issue of medevacs, how that works. They've constantly been seen together so that they meet each other, even if it's over the airwaves, you know that your social worker is going to be on the VA and when the DoD people come down. So it's good now because the communications, and I don't disagree with you at all. I think somebody was saying "King or queen for a day, what would you want?" One, a system. I mean, that would be a great thing. I do think that there are some issues over the different missions. I'm not saying that it is impossible.

We could do that. I mean, it's going to take some time, because even now there is some concern about whose priority, when you have all these different patients, how's the priority if the resources are scarce? Right now I think the DoD is very well-resourced to do this, and we have been, and I mean as far as the people on the ground, and I think things are changing, but I do think we have the ability to, because the communication piece, if we don't get that right, it doesn't matter. Working with the civilian sector - we have got to get that communication piece right. Whether it's the phone, the VTC, or electronic health record, it has been with a lot of growing pains through the years.

MEMBER EVANS: So we have to remember too, inpatient medical medicine, we talk to medical, so we own that process. Outpatient is the transition. It's more services on that process. Maureen's presented on set - do we really want transition care? And we said "Yes." So those non-COMs, so we provide case managers

to provide transition care, it becomes non-medical service responsibility. Although Army is a little - it complicates case management actively engaged in the process. Other services divide into non - so there's a huge difference, and when we do transition care and handoff communication, and witness this day in, day out at Walter Reed. We used to see physician to physician, nurse to nurse, inpatient to inpatient, case manager to case manager, even RCC to RCC. When we transitioned to outpatient, that's a different process. So that where we have a lot of our warriors and where we need to really work at the outpatient side of care.

MEMBER MALEBRANCHE: That actually relates back to what you said earlier, and that's when you start bringing in the community, because there's so much to do when you've got the transition, where are they going to be, are they going to be on active duty or somewhere that's not military, that doesn't have military on it? That piece is real critical, I know. And the

command structure, how they fit in, they were asking about that as well. So I think you're right, you're bringing in a third entity right there.

CO-CHAIR NATHAN: Right. The inherent mission of the DoD in this case, the DoD medical system, is basically to support he warfighter. By design, we create a medical system that maintains a repository of personnel, who simply - we put together hospitals in the DoD system, not because we're trying to take care of people who live in the area, but to keep to currency and competency up of our practitioners so that they can deploy in a time of war or a time of catastrophe, and what started off as a mission, where you became, if you were discharged from the service, then the VA would be the one who would pick up your care and be in support of the veteran. And then we start blurring the lines as we started becoming overwhelmed with casualties of limb loss, limb damage, and post-traumatic stress, and we

started taking more a liberal take in care of the DoD system of these patients, while the VA sort of ramped up. And then VA ramped up in a way that was unprecedented, with the polytrauma centers, and so if you were - had devastating injuries that were going to require long-term rehabilitative care, you were basically completely disabled from those, or mostly disabled from those, the VA stepped up and took those patients, and we're going to try to see some next year of these polytrauma areas that have seen a marvelous continuum of care that the VA provides for those patients. But in between, if you have chronic medical issues which go beyond just a simple form of medical condition, but one that continues to affect your quality of life, yet you don't need the heavy investment, that rehabilitative pulmonary, ventilator, or neurological care that a polytrauma center offers, now - as you were alluding to, Captain - you're serving the veterans now. And our task is: how do we deal with, how can we better improve

those hand-offs, and as you said, Ms. Malebranche, so many of our people now go back to communities where neither the DoD or VA footprint is available, or if it is, it's not - it doesn't have large capacity. We must rely, now, on having a civilian population, and their population take care of them. And if you don't have a medical record that you can take back and forth between the civilian sector, you're in real trouble. And this is one of the complaints we've had. So this is - I think that there are separate issues here, and we blur the lines ourselves, and you said, Rich, one of our jobs here is to figure out how we can better blur the lines. It really is. But one of our challenges is, the lines got blurred in the DoD missions. Because the DoD likes to say "You know what? We shouldn't be in the rehab business. Once you've demonstrated yourself to be chronically, emotionally wounded you need to be leaving our system for another one. It's just the sheer numbers and the acuity that I think overwhelm the

system. So everybody tried to pitch in. And now we've got - we don't have crisp demarcation over here.

CO-CHAIR CROCKETT-JONES: I just want to say that there is a component, and that would be TRICARE outreach, that adds a component to all of this when it comes to the practical, with the servicemember who is in various sort of states of transition. You know, the IDES processing more fully in having benefits, VA is working on a TRICARE scenario. Increasing TRICARE division in VA, because if we're saying it's mitigating some of that, of course we want to on the ground experience at those VAs, because we don't - it's not a- I will say that TRICARE acceptance and TRICARE rules and regulations, the coverage is open and it is transitioned as well. A person who goes to all those and is in that very gray area, either they are distant from certain provisions of medical provision that they could still get back from a military facility; they're distant from the VA, and what

is working, the available models that I know of, but also that is covered by TRICARE globally. This is a very complicated area. I know people who, you know, basically their TRICARE says "you must go back to the military facility" and it might be 70, 80 miles away. So we've got a lot of strings on the people who are in this gray area, and the better we can do at moving that forward, I'm just not sure how cogent the recommendations are going to be crafted out of this situation.

CO-CHAIR NATHAN: So I think all of us need to be thinking in terms of - it can be more recommendations, and if there are we should put our minds to a cogent recommendation, from what we've seen, from what we've experience over the last year, pivoting into this conversation, what would make the difference. But again, framing the question -- tell me if I'm wrong, but framing the question on this particular topic, is how we better create tangible recommendations to move on, they can be general or specific, to

create better transition for the non-devastatingly-injured veteran leaving the DoD, going into the VA. Some of the specifics that we've seen here, number two, is how we deal with the long-term needs of the young veteran, the under 25 or under 30 year old who has significant limb issues, prosthetics. How are we going to adapt to them, because they are moving out, and they're in areas that are not near either an NDF or VA. Looking at how to choose to build on anything that's been done at some of the places where's there's overlap, in DoD and VA already, such as the Lovell healthcare center or polytrauma units. And then back to number 1, which we discussed, is there a cogent recommendation, either general or specific that has to do with trying to get VA into the process further, as the person who's going to transition to the VA for outpatient care, and/or, should DoD be pulled a little longer, as they go in through the VA system, and not let go, because there are mechanisms that are not let go until we feel

there's been a complete handoff in the VA system, so that the patient is not left in the lurch. And the only reason they'd be left in the lurch is not because the VA wants them there; the VA is passionate to embrace these folks, and is just as frustrated as we are when our folks come to the VA system without a record that they can easily see what happened in their track.

MEMBER EVANS: I think here your first option was allow them to transition for the the earlier we get service members informed and sort of the right personnel in the VA -- I think that's the way that you would hear our service members, you would hear from them. That's what they want. They want to be the roadblocker.

CO-CHAIR CROCKETT-JONES: I have a question. Would opening the OR or a reporting office the same way you view our need - was made earlier with that and through this?

MEMBER MALEBRANCHE: I don't know, and I think that's all things we can look at. There's a couple of things that are on some

cases. Some that want to be with those too, and aren't frightened to say, you think are going to be able to take that on active duty, because now we have soldiers on active duty that might have been back there. So we do have some of those expectations that we have to do it. A lot of the recommendations that we have made last year I wasn't totally embarrassed about, informing leadership of what to say to, to your veterans, and what to know, and what you can possibly expect, but I think we're doing better as far as the medical side, at how's the expectations. We do have some of the overlap with our liaison programs we have amenities, certain MTFs you can a fair number. However, I think they tend to be more getting the appointments on the other side. I'm not so sure how much they do internally, maybe some of those drug sort of offices. The other thing we have is we have a fair number of DoD folks in our polytrauma centers, again, they do a good job on the acute side, and each of the services has to go there, sometimes more than we

have patients. So maybe that model, or that piece, are making a grey area, maybe a little federal-type office. I think we're trying to get there, maybe a little bit slow, with the center agency care coordination, and this lead coordinator concept, because there is this handoff, and I'm not so sure about code for that, which is maybe what we need to look at.

MEMBER EVANS: And also, GAO asked us to go over it.

CO-CHAIR NATHAN: One of the things that there's going to be a significant change in the service would be the Transition Assistance Program. It's going to become much more robust. This is the advantage of the service is because it's going to be expensive, takes people away from their service, they're out of a job, but someone who's more familiar with the nuts and bolts of it than I am, but it basically is a - it's a mandatory, several-day program for everybody in the service who is leaving the service to be given all the information in a

classroom setting about life after the service. So that would include the VA benefits, that would include your retirement, that will include how you make appointments, that will include resume design, all these things that the White House and all of use are very interested in trying to so often the landing of someone leaving military service. So that's coming down the road. And we're trying to figure out how we can both find the money to execute and the time, but it's not available to me, it's going to happen. So that will help, I think, in some cases, get the average servicemember more up to speed. And that's a gift that keeps on giving, because once several Service Members sort of understands the formula, they become kind of the seed lawyers that tell other Service Members "Here's what you have to do." I think everyone on active duty knows you want to develop sleep apnea, because they've talked to those individuals that have gone to the VA and have sleep apnea, and they've seen the disability percent that you get for

that. So I have people coming up to me who have never seen a VA, or a doctor, for that matter, and saying "Do you think I have sleep apnea?" So I think that it will - that'll help. I think that's one program that will help. Again, it's going to be cumbersome to execute, but it will happen. Karen, any thoughts from your perceptive on - anything you know we should be doing across the board to maximize or increase the robustness of the VA liaison into DoD sooner rather than later?

MEMBER MALEBRANCHE: One of the things again that this group again is looking at with the FRC therapy - they're limited. 26 of them , I think is the max. But they're trying this. They feel like they've got to Southern command and at a command level tried to get some of that, expertise, if you will, on both sides, so they got both training, and maybe having that level of oversight. And they're clinical, whereas the RCCs are not. And I thought too, why put them all together in one office, but I have

to tell you, it's not expensive, because the offices are not so sure if they're ready for that, and they don't want to be causing issues. And one thing this group has not talked about, and I hesitate but I think we have to rip off this - the whole issue about care and the impact on some of this on the veteran himself and their families, because the VA still in terms of the readjustment counseling, we take care of families in coordination with Veterans but not necessarily with family. And if there's going to be those decisions made, I guess, families generally would follow the person - the way, in most cases, you might want to think about how that care, how that would go and the impact on the families. Still had a huge impact. And we haven't gotten into that sort of thing as a Task Force. Because we've been going up to the current state of things. I think there's some significance in things there too. But I do like the idea of having some joint offices and facilities in both the VA and DoD. What are you

doing to do about the outpatient piece? Because that's what we find when we're walking through. We don't walk through in the middle of a critical step. We walk through in another part that ends up being critical to something else.

MS. DAILEY: Okay ladies. So, I see a lot of - let a few of the transitions. So are we okay to try and craft the recommendation on a little QA piece? Is that some - got some resonance here. Good. We'll go on that. General Stone, you actually talked about the blurred lines going back and forth between DoD and VA and VA back to DoD, which is - and that in particular has a little bit to do with the amputee population being - ending up being more resident with us until technology and transition. We have several of the amputee issues here as a research team, we didn't look at amputees as a group, and so three thousand, pretty much, right now across the nation. So we want to go there with you. We are a little limited in information.

MEMBER STONE: So I would ask you to

look at on a much broader basis, the invisible wounds of this war have created a long-term process that both Suzanne and Admiral Nathan have discussed. In treatment of chronic head injuries, in complications of head injuries, and therefore the continued blurring of who has responsibility includes the fact that we can keep people with some complications and head injuries indefinitely, and remember that 85,000 post head injuries a year occur in garrison, and so we need to continue to operate with some degree of capability in chronically injured on that. But what Suzanne brought up that I had not thought of was that the presence of an AR, TRICARE, puts a third piece of blurring to this, and that is that some of the care will go outside our direct care system, and when I say our direct care system, I include both VA and DoD. So how we come to this I don't think should be limited to simply the complications. It should recognize that like all wars previous, we have struggled with what are the lines between our care delivery

systems, because of the prevalence of TRICARE.

MS. DAILEY: Okay, so we are planning to come together around the transition piece. Low acuity, long-term, and it's being efficiently managed through the DoD system, so bringing liaison offices maybe to guide the IDES process so like we did with the VR&E, OEF/OIF, program management offices possibly already in the system, so I do see a lot of interest in the transition piece being directed at the low-acuity areas and trying to start it all a little bit earlier. Overarching -- this is kind of an overarching piece here, ladies and gentleman. We put this in the overarching area of interest. Okay.

MEMBER PHILLIPS: Can I make - I'd like to make a comment about the reimbursement. Something I've been thinking about for a while, and I hope I can formulate it in an understandable way. We have three components. We have DoD care which is free - I mean, it's government money. We have VA care, which is

again, government money. And then for the civilian population, over 65 of whatever, you have medicare. And we should know that roughly 50% of the DoD's contracted out to max location, line of services, and that requires a certain amount of paperwork and approval. 40% of the VA-eligible veterans in the VA, others use the private sector, probably because most of the medicare eligible, some locations offer it. Now, again, I don't know if this is even applicable, but to save some of the angst, the paperwork, and all the differences between the three, if we could identify this group, Recovering Warriors, and just make them eligible for medicare, I don't know how to do that, I don't even know - maybe, this is still an idea. But then, you do away with all the, perhaps, paperwork and activities and costs for a period of time. And they simply can just be taken care of. Again, I may not be stating this as clearly as I should - but all the money's in the same pot, and it's all government money, that is, medicare or TRICARE or VA. Just think

about it.

CO-CHAIR CROCKETT-JONES: Well I think that would certainly eliminate huge - wrap this whole thing up in long lines, but.

(Off-mic comments)

CO-CHAIR CROCKETT-JONES: I don't know if you want to move ahead for lunch, or should I - yeah?

MS. DAILEY: I do have you scheduled to 11:05. We can pick up at lunch, or we can start lunch - I think earlier. Maybe an hour for lunch. We'll start at 12:30.

CO-CHAIR NATHAN: I'm all for consensus.

CO-CHAIR CROCKETT-JONES: We could always have the lunch first. Reconvene at 12:32.

(Laughter)

CO-CHAIR NATHAN: And a half. I was thinking if we had slack time, we ought to push grouping to the left so we can get out earlier, or if we get passed on, we have the entire end of the day to deal with issues, so --

CO-CHAIR CROCKETT-JONES: 12:15.

CO-CHAIR NATHAN: So we'll reassemble at 12:15.

CO-CHAIR CROCKETT-JONES: Thank you, we appreciate it.

(Whereupon, the above-entitled matter went off the record at 11:15 a.m. and resumed at 12:22 p.m.)

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

(12:22 p.m.)

CO-CHAIR CROCKETT-JONES: Welcome back. We're now going to review medical cases management, which falls under Restoring Into Society. Our last annual report we provided recommendations 10, 11, 12, 14, 15, 16, 17, 18, 19, that relate to this topic area. Most of these recommendations focused on providing more coherent information services to families regarding non-medical case management. So I'm going to turn this over to Captain Evans to start us off, and Command Sergeant Major DeJong when he sits down.

MEMBER EVANS: So, to the Task Force, I would ask you to look at recommendation 10. And in 10 we say "one comprehensive plan, and that comprehensive plan should be standardized." I think 1 though 12, 13, 16, when you're talking about education of the warriors and their families, it truly starts with the comprehensive plan. If we have both the families and the

warriors involved with that plan early, to include inpatient side, as they transition to the outpatient, and as they transition to either VA, DoD, and that plan follows that member to the VA back to the DoD. The education that's encompassed in that plan, I believe, would capture all of this.

And it goes back to another recommendation of training, when we talked about RCC, FRC, case managers, everyone having that same type of training, and that training should be centered around the comprehensive plan. So my recommendation for all of this, even looking at, when we talk about Safe Harbor in number 6, again it involves a plan. How do we educate? Who educates? How do we hand off? Who are we handing off to? And is it following that member through the continuum of care?

That's what my recommendation - that's a congressional law, that they have a comprehensive plan, and I would also challenge you that I think medical - me being medical -

should have more oversight of that plan.

CO-CHAIR CROCKETT-JONES: Well, I think - here's the issue with more medical. The issue with families getting the information they need for their benefits bumps into HIPAA, so we have to make sure that they get the non-HIPAA information that they need regarding the servicemember, and their personalized information regarding their benefits and programs that are available to them.

I think that there has been improvement. I think that when I compare what I have seen at the first installation visit I ever made, to this past year, this installation visit - families are better informed, somewhat, but what is most noticeable is that there is a priority to inform families, now exists within the DoD. I mean, it was non-existent at the first installation visits we went on that first year. When asked about informing families, the concept was rejected. Now there seems to be at least a mission to inform families.

Getting the information to the person who needs it seems to be difficult. There's a lot of different things being tried. I know that it's hard to know what to recommend because so many different potential methods are being tried, some with more success than others. This is more an area almost of best practices than it is of recommendations.

So, on that general topic of non-medical case management, I think this is one of those where what we want to see are outcomes that are standardized, that are measured the same way and achieved to a certain level. I'm not sure that our recommendations to manage, micro-manage the various aspects of this within the services has met with any success, but I think that it - that what we want to see, the real outcome that we want to see when it comes to non-medical case management, is a parity of outcomes regardless of what service you're in.

I think that families - for instance, when we went to - Lejeune families

seemed better informed, better involved. When we went to - these are just a lot of different, we've seen a lot of different best practices, and I'm not sure that what we can do is recommend anything other than saying, "This needs to be measured in a different way."

MEMBER DeJONG: Well, again, along the same lines as the Centers of Excellence, every comprehensive plan across all the services is slightly different. Again, we're looking back the last two years, we've dug into the weeds pretty deep on some of these things. I think we need to be looking more at the outcome again than looking at the actual process itself.

MEMBER EVANS: I concur. And I think that's why we have NDA 2013 asking us for performance outcome. But what I can't concur with is that we have four different plans. We have four different - each of those plans are measuring different outcomes. We have four different services. But at the end, we're trying to transition that ~~servicemember~~service member

to home, to one location.

So, I think, in order to get us to where we want to see a medium, you know, somewhere in the medium, we have to standardize somewhere. We have four different IT systems with these recovery plans. Each service, they take their own recovery plan and say, "This is what I'm going to do with this plan," and then they decide how they're going to hand off their ~~servicemember~~service member. So I think that in order for us to get to where we want to have - where I see the IDES. IDES is just - they've taken this program and you see outcome metrics, you see comparison of services, you see - "I'm doing better than you, why aren't you here?" And it's at the leadership level.

Our care plan, our transition plan, it's not there yet. And so I think we need to get that level of oversight for our plan, and I think the plan needs to be one. We have too many different systems out there for our warriors, too many. And so when you talk, when you get to

the families and you talk about transition, what they want to hear is that I have one person to tell me how I'm going to transition through this long process and get to the final destination. Where am I going? Home. Or back to duty. Or back - so we need to standardize as much as possible, and this is one area that I see us, and we're already doing this, this is why I'm trying to get the Task Force, DoD/VA Task Force already trying to make this move towards one plan, one IT system.

CO-CHAIR CROCKETT-JONES: I think we also can look at the list that falls under this and see if any of these relate to some of the larger issues or if they merit inclusion in a more specific recommendation. And there is something I want to add to this list of 16 items. That is, a lot of the places that we went, TSGLI had as many negative issues as positive, that a lot of the non-medical case managers found that the TSGLI was opening doors for issues with family members, and that the TSGLI payment was

sort of causing Service Members to have skewed expectations and to sort of fall off a little bit of a cliff in their personal organization, thinking that that amount of money would just last forever.

And one of the ideas that we have had is to break down that - maybe TSGLI should be broken into annual payments over the course of four years so that it is not a lump sum that causes some of those - it's like instant financial planning. They still get the benefit, they still get the boost, they still get the needed funds, but they don't get it in a way that encourages negative issues, if you want to talk on that at all.

MEMBER KEANE: A few of the places that we visited, two of the places in particular, they said "you know you're getting close to where the wounded warriors are because you can see all the new cars." And instead of trying to instill the services to come up with some kind of way to mandate financial planning, as Ms.

Crockett-Jones mentioned, having this four-year $25,000 disbursement is instant financial planning. And of course, as with everything in the services, there's a waiver. So if you needed the hundred thousand dollars, you could petition to get that, by whatever means, but in the absence of requesting that waiver, we're suggesting having this four-year disbursement of the TSGLI.

MS. DAILEY: You know, ladies and gentlemen, I can get a TSGLI briefing and I can ask TSGLI briefing questions next year when we go out to the sites, I can gather more data on it; I'm flat-footed on this one right now. I don't even know if I've got any comments in my focus groups about TSGLI. I don't have one - I could search my focus group for TSGLI, I would not get one hit.

CO-CHAIR CROCKETT-JONES: We would be perfectly happy in researching this and having it go on board next year.

MS. DAILEY: Okay. Good, good.

CO-CHAIR NATHAN: So there are a number of specific points made here. And the Task Force has to decide if it wants to pick some of those up as specific recommendations. As you peruse the list there, of those 16 is there those that catch your eye, that you as members would think this deserves the light of day?

MEMBER REHBEIN: Sir, there's four of them that reference staffing problems. And if I see four observations that all tend to deal with the same subject, that tells me that there's some across-the-board problems there. I'm referring to number 6, number 7, number 9, and number 12. And so maybe we need a little more digging into that staffing. Are we adequately staffed? Are the services each following their own model and that's creating problems in areas? Is there best practices? Because many of these recommendations refer to one service. Now, I don't know if that's a service problem or a site problem. But all I see is the four recommendations that refer to staffing

problems, and so that, in my mind, rises to the level of we ought to think about - we ought to take a good look at it, we ought to talk about it.

MS. DAILEY: Let me pull 6 out of there, that's not really a staffing problem. Six is a policy issue on the part of Navy Safe Harbor to categorize the MEDHOLD guys as Category Ones.

MEMBER REHBEIN: Okay, that alternate reading - I could have misinterpreted that, certainly.

MS. DAILEY: Yeah, so - but 7, 9, and 12, and I would like to highlight also what Admiral Nathan said. This area, since we've done a lot of work in non-medical case management, might lend itself more to your specific type recommendations. They aren't going to be policies.

We did see, for example, at least at number 8, at least at Fort Lewis, they were capped against the hospital's authorization. So in quick math, if the hospital had 20 social

workers and they could only hire - easier numbers: they has 10 social workers and they were capped against 8, if they were capped at 80%, then the Warrior Transition Unit was capped at 80% also. Whereas there's other publications on the street where the Warrior Transition Units are not supposed to be capped at all. They are to man and be filled to the full table of authorizations.

So, if we're talking about some more specifics, localized recommendations, as you mentioned in your earlier organization discussion, this list here does lend itself to some of those more specific recommendations, which could be - which would be easily aligned against a specific location where they came out of.

MEMBER EVANS: Number 13. I believe we should somehow capture that data to come back to the Recovering Warrior Task Force. I'm not sure in a recommendation or a co-finding.

MS. DAILEY: And I can pull people in

for a briefing on that next year, if you don't want to make it a recommendation.

MEMBER EVANS: Okay.

MEMBER DeJONG: A little bit back to what you were talking about, Mr. Rehbein. Two of the three that you mentioned is a results of policies and getting reserve component staffing into those billets. I think you're going to see a change in that within the next coming years, based off the sequestration and the other things, and the less utilization of reserve component forces for certain positions.

We've addressed this over the last two years, specifically, on several - we've kind of reworded it different ways over the last two years already of trying to figure out how we can overcome some of these bureaucratic hurdles that are out there. But I think we're going to see that one pretty much mend itself in the near future. Correct me if I'm wrong, any of the two generals that know.

MEMBER MUSTION: No, you're right.

You're going to see a larger - or a fewer - a reduced presence in reserve component in WTU structures supporting the force.

MEMBER KEANE: That's not true for the Marine Corps, though. When we went to Manpower and asked, I guess about 18 months ago now, about getting more active-duty structure, Manpower's - and I agree, I think this is a smart thing - is having a majority of Wounded Warrior Regiment being reserve, so we can ebb and flow, so we can contract and expand. So the majority of the foreseeable future of Wounded Warrior Regiment's squad leaders will be reserve.

CO-CHAIR NATHAN: And you said "I agree," I think?

MEMBER KEANE: I definitely agree. I concur with that suggestion by Manpower to not make - what we were looking for was - I don't want to even say the right number, but it's a majority is reserve, and we were hoping to flip flop and have it being a majority of active duty structure. And I agree with Headquarters Marine

Corps Manpower saying "This gives us the flexibility to ebb and flow." You know, to ebb and flow, contract and expand.

CO-CHAIR NATHAN: And would those reservists be combat-experienced?

MEMBER KEANE: I don't have those numbers, sir. But that's a good question, though. Is that across the board, number 7, or is that in one location? That concern?

MS. DAILEY: That's a consistent finding that we have with the Marine units, when we talk with them about squad leaders. And last year we did make a - no, two years ago - I think it was the first year we recommended they review their ratios, and they came back to us officially, non-concurred, and said "We will not be flip-flopping our ratios." We have it here because it continues to be validated in our focus groups and it's validated in their own surveys. They have a high satisfaction rate with their squad leaders, but in their qualitative comments of their own surveys, are very similar to the

comments we get in the focus groups about "squad leaders haven't been where I've been, they don't understand my experience." And so, regardless, and remarkably, they have a high level of satisfaction. And I don't even want to say "remarkably." That sounds pejorative. Their own surveys document a high level of satisfaction with the squad leaders. But again, in their qualitative statements it is very similar to our focus group responses.

So we just - that topic, if you want to take it forward again, we can. If not, we have made this recommendation, or similar recommendation to this one, before.

CO-CHAIR NATHAN: I think it's worth exploring, because I think, from my visits and talking to people, both at my current job and as part of the Task Force, there's a high level of satisfaction with the desire of these folks to be helpful. They sense that they are eager to try to do a good job and make themselves available. What you hear is not - what you hear from the

Recovering Warrior is not "these are lousy folks who don't understand anything I've been through". What you hear is "they're really good folks and they're trying to do the best they can to help me, but they don't understand, they don't have the background, they don't have the perception that I have, that I'm dealing with. And I feel like they'd have more credibility, or I feel they would be better advocates for my situation, if they had more empathy for what I'd been through."

That's what I hear. So I think they're satisfied with the level of effort, and with the desire of their facilitators to make a difference. But they feel that they're sort of at a loss to understand some of their emotions.

CO-CHAIR CROCKETT-JONES: I just want to put in a caution here. We also hear folks saying "they expect me to behave like I'm still in a combat unit" as a converse commentary. We hear conflicting things. And while I know this is - we have heard this, that we need someone who

can empathize, who has been where I've been, we also hear "this person has an unreasonable expectation and cannot separate what he did when he was a combat commander and what he's asked to do now."

So I just want to throw that out as a caution in looking at this, that they might want the desire for someone who can empathize with things that they've been through, but they give us conflicting opinions on this topic.

And I want to ask a question about number 11. The CBWTUs having VTA access - I believe - am I wrong? I thought I heard somewhere that this was a policy that was already in the process of changing. Am I - no? It is changing?

MEMBER EVANS: Should be. Because I thought they wanted all of them to have CB - that was the last, that they will have access to the tracking, be able to track.

MS. DAILEY: Well, I know that's our recommendation. I know when we left the CBWTU in Arkansas, they didn't have it, and it may be -

I can check with Warrior Transition Policy office, but they have not come to me saying, "we're giving VTA to all the community-based warrior transition units."

MEMBER EVANS: We need to go back. So we just need to check to verify that that's not happening. Because warrior transition, the Warrior Care Policy said they are. So we just need to make sure.

MS. DAILEY: Okay. Did they say it to this meeting, or did they say it in another meeting.

MEMBER EVANS: No, no. Another meeting.

MS. DAILEY: Okay. So we have this recommendation in a couple places. VTA access for the warriors, and VTA access for the community-based warrior transition units.

CO-CHAIR CROCKETT-JONES: So if we can get verification on that status, that seems like a pretty obvious --

MS. DAILEY: I mean - how do you want

to handle those things? Do you want to go forward with these smaller recommendations even through we've got a verbal that they're going to do it anyway, or do you want to hold them to it if --

MEMBER EVANS: We need to verify and then hold them to it, if they said -

MS. DAILEY: Yeah, and I mean, the only place I can hold them to it is in a recommendation.

MEMBER EVANS: A recommendation. So would we be able to get verification before we end tomorrow?

MS. DAILEY: I'll shoot them an email right now.

MEMBER EVANS: Okay.

CO-CHAIR CROCKETT-JONES: Yeah, I would say it depends on the tenor of their response.

MS. DAILEY: In five minutes their tenor is going to be, you know not a prepared response.

CO-CHAIR CROCKETT-JONES: Yeah, and

I'd rather have a better response than the five minutes, but - if this is something that's already happened, I don't want to use one of a limited number of recommendations on something that is already in process. I mean, that's the way I feel.

MEMBER MALEBRANCHE: But you know things can change. If you want it to be solid, probably ought to put it in a recommendation. I mean, if it's an easy concur for them and they've done it, that's one thing, but things can change between now and the recommendation too. I think -- I don't know.

MEMBER EVANS: Denise, I think - I know we - I'm not sure if we come to a solid, a few recommendations from the 16, 17 items that we have here, but I tell you, the overarching issue that I see is education to our warriors and their families. I mean, we hear that over and over. You know, when it's done correctly it's good, but when it's not, it's really bad.

And so I think we need to somehow,

out of this 16, make sure that we address how we're going to fix, or what recommendations that we want DoD to - that we want to put before DoD to fix that education. You know, right now we have the National Resource Directory, which - I don't know if I want to say on the record or off the record, just not - it's a failure, in my eyes, because when we go out there to the field, we hear, over and over, "I don't know anything about that." So we have to really come up with a strong recommendation of how we're going to get our warriors and families educated to their care, services, and benefits.

MEMBER MUSTION: You mentioned a few moments ago the variation that exist between the four different comprehensive transition plans and the CRPs, and you're much more familiar, probably, than many of use with the eaches of those, so are there specific gaps and seams between those four? I don't dispute that there should be a baseline that's - I'd be leery to use the word "standardize" but if we believe that's

the baseline that should shape and guide everything as our soldiers or warriors go through the process as well as a baseline from forming the families, and there's probably a lot to be said about the consistency. And if it's our observation that, as we've looked at this during the past year, there are gaps at the seams, it would probably be useful if we highlighted that, and used that as a baseline to get at, also, that number 4 recommendation or highlight there about educating soldiers or warriors as well as the family members.

MEMBER EVANS: So I could tell you where we stand. Right now we have, what is it, 800-line, 22-page document that we've identified as far as services between DoD and VA. So they took the four different transition plans, cross-walked them, and came up with this 800-line, 22-page document. And so that document is now trying to be developed into one master comprehensive plan. You know, if I'm working case management, I'm not going to work with a

22-page, 800-line. That's going go somewhere. So it has to be something that's at the deck-plate that you can work, and at the same time still have time to interface with our warriors and families.

So there are gaps, but more seams. And I think what they've done with this 22-page, and I wish we could get that document in front of us, I think it's a - I know Denise is shaking, saying no - it's wonderful, because it's a great reference source to look, to say, "okay, have I talked about VBA and who's the point of contact for VBA". I think that's a great reference source, but to be a play-in or a document that we're going to utilize, it's not there.

So I tell you, in working with the families and listening to the families, and that was my job for about two years, when they have the right person to go to, whether it's a case manager or RCC and they get the information that they want, and it's in a transparent, seamless fashion, you can make some mistakes in

communication, but they love you. When you don't give them the information early, and they don't know who to go to, I tell you, that's when they get really upset. All they want is one person to turn to. That's all they want. And they want that person to be well-informed and to tell them where they need to go to get the rest of the information, the rest of the story.

And so that's why I keep preaching this. Who's the lead? Who's the one person? What document do you have to help you recall what information they need to be informed of early? And then what do we send over the VA to say, "VA, this is what you need to pick up and continue with?" And that's what we've seen to make the warriors and the families satisfied and pretty happy with that transition part, hand-off.

CO-CHAIR NATHAN: So different services have different vehicles for accomplishing that.

MEMBER EVANS: Correct.

CO-CHAIR NATHAN: Some rely heavily

on RCC/FCC type personnel, others on the SFACs, others on, if it's - sorry?

MEMBER EVANS: The cadre.

CO-CHAIR NATHAN: Cadre, the cadre. Navy Safe Harbor. Maybe blending that concern, which I agree is something that is a needed benefit, with our outcomes discussion we had earlier, is there some sort of coherent survey or metric that the services can provide that is standardized, that all Service Members or family members have to take. In other words, if I ask the Army, "how are you doing at taking care of your wounded warriors," the Army has some good survey criteria that are based on Army-specific questions to Army personnel. The Navy has theirs, the Air Force has theirs. Should we recommend - I'm just spitballing here, you won't hurt my feelings if you disagree - should we recommend a standardized set of survey questions, not unlike IDES, that are asked across the enterprise, and then looked at by the overarching DoD, whoever that is, we'd have to

decide or that would have to be worked out, so if the services are forced to - you know, Hawthorne effect on IDES is very good. When a service secretary gets that report, and sees how their own service is doing, and if it's doing better than other services or worse than other services, they become very animated in either direction.

And what we don't have - or if we have it, I'm not aware of it - is something that's similar across the spectrum for families that are - for warrior and family satisfaction of education or whatever. So if you asked the same question across - and you're going to get some push-back on the services on these, because the services are going to say, "well, there's a cultural bias on some of these questions." But if you asked the same question, and I'll be very generic here, and probably too fundamental - every family gets a question that comes from DoD, not from the service, that says, "how early in the process, within one week or within two weeks

or whatever, of your entrance into a wounded warrior program, be that whatever that is, how well did we do at educating you on your plan ahead?" Call it whatever you want, call it the CSF.

And then the service secretaries get that results, there'll be action taken. And the action taken won't be the same. It'll be service-specific action. The Navy will hit Navy Safe Harbor on the head, and the Army will hit the SVAC and the cadre on the head, and the Marines will hit the WWR on the head. And so do we need a standardized view for the Hawthorne effect of how families and wounded warriors perceive they're being educated on the system?

CO-CHAIR CROCKETT-JONES: I'm going to agree that we need some sort of way to get a standard view. But I think one of the things that occurs to me is that at our installation visits, we frequently find that the same people who have a sort of simmering dissatisfaction and who upon question are largely uninformed, when asked if

they're satisfied, will say yes. Because their expectations are so low. So I'm not sure - they have very low expectations. They think they've just got to get through this, and they've accept that they're going to be uninformed, and they just sort of accept it, and they're angry, but - so we - this would have to be a pretty carefully crafted tool, and I'm not sure the surveys necessarily get to some of the meat of the situation.

You know, I get that satisfaction surveys are important. But when you compare, sort of what satisfaction surveys has set up, expectations among leadership, and then we go into focus groups - I wonder at some of those disparities.

CO-CHAIR NATHAN: Well, I think your point's well-taken. I'm not as interested in the absolute answers as much as I am in the relative answers. In other words, I don't know that the tests would be scientifically, or statistically significant, other than just showing - it might

be bad questions and bad data, but it would be interesting to see if the bad questions and bad data have significant service differences. And so we've asked bad questions to everybody that don't really get at the heart of it, but yet the Army comes back very high, and the Navy comes back very low, then what is the Army doing that we need to learn from, or why the disparity?

And so I'm the first to agree with you. Because having been in the business, and having had to command and take care of large groups of wounded warriors and their families, there's a very - often there's a very vocal minority that captures a very powerful majority of people's sentiment. And we run around with a sledgehammer trying to put this one little problem out, when it's not really indicative of the entire process across that particular area.

But what we don't have - and so we do town halls, and we do meetings. But when we go, I've been impressed by the fact that when we go to a various area, some do it better than

others, but the service that's there does a pretty good job of trying to assess how good their doing the job, but they do that in a stovepipe compared to other services. So if we're trying to force standardization, as we said - and I'm very sensitive to what Dr. Phillips said, which is let's not get too far away from trying to push standardization - but if we're trying to force standardization, we can do it one of two ways. We can make a recommendation that says, "all Recovering Warriors and their families will be educated by the same vehicular mechanism upon arrival into the system." I don't know that that's going to go anywhere. I think the services are going to come back and go, "nope, you're asking us to fix something that isn't broken, so we're not doing it." Whereas if we said, "you've got your mechanisms. That's great. Go forth and multiply. But we want a common metric. We want a survey instrument that will measure the effectiveness of that, asking the same questions across the

spectrum."

The services will still push back and say there's some cultural bias there. And I would say there is cultural bias, and there shouldn't be. The questions should be the same whether you're in the Coast Guard, the Air Force, the Army, the Navy, the Marine Corps. At what point in the process did you feel that you were given insight into the overall plan? When you were given insight into the overall plan, were all your questions answered? Do you feel you understand the overall plan? Call it whatever you want.

And those may be bad questions. Those may not be great questions. But I'd be very interested to know if the Air Force people are up here, and the Navy people are down here. Because that would cause me to start digging.

CO-CHAIR CROCKETT-JONES: I get the point. It would engender a different view of innovation towards solving - towards parity.

MS. DAILEY: And we have data that we

collected form the service on their surveys, and they all briefed us. We did some work on that too, on what the outcomes were. So we have a lot of data here that we could craft a survey question around, correct, team? It's not - we didn't capture it here in non-medical case management. Did we put it anywhere in here?

(Off-mic comment)

MS. DAILEY: Number 16. Okay. And I don't have the table in any one of the tabs? Okay. So, yes, 16 was the intent to capture a survey question or a survey direction for our recommendations, Jess?

(Off-mic comment)

MS. DAILEY: Correct, 16 on non-medical case management. But, yes, we can craft recommendation on this and have data for the survey efforts of the services, and make recommendations they collaborate on several questions that would be uniform across the board in order to measure certain points in the process.

CO-CHAIR CROCKETT-JONES: I think that if we ask the service to collaborate, it'll take a very, very long time. I think it might be better to say that the DoD is responsible for measuring their effectiveness against one another and comparing them.

MS. DAILEY: Well, they do. They have that. Dr. Banniock briefed us on the DoD survey. And it's not used, pretty much. The ones that are used are the services' surveys. They are more used the closer that the service is to the survey. So for example, the Marine Corps does a survey, and they immediately turn and they own that survey, and they had the surveyors embedded in their organization, and they immediately kind of turned that survey around and used it to improve their programs. The farther away from the service that the survey is conducted, the less ownership they have of it. Which is one of the reasons why, probably, Dr. Banniock's survey, across all the services, is not well utilized. They can easily argue with Dr.

Bannick, and say, "well, that really doesn't apply to my program." So the closer you keep it to the service, the more likely they are to utilize it and own the results of it.

CO-CHAIR NATHAN: Again, you have to subscribe then to the philosophy that every service has the right to sort of determine how good or bad they will be to their own organization. Rather than - I'll give you a great example. Service treatment records for the VA, this is a recent - as you know, Karen, this has been front and center over the last few months. There's been a requirement to have every medical record that leaves either the MTFs, the NOSCs, the reserve centers, or the fleet, the operational platforms in the service, to have an accompanying letter that says, "this record is certified to be complete and ready for disability evaluation."

And the Air Force is at 100%. The Army is at 50%. The Navy is at 13%. I got a call, from the highest leadership level in the Navy,

saying, "fix this." I think they would have called anyway, but when they saw it on one piece of paper compared to the other services, it doesn't matter how many times we win the Army-Navy football game, it doesn't matter.

MEMBER STONE: Sir, when you get to 49%, would you call me?

(Laughter)

CO-CHAIR NATHAN: We get creamed. We get creamed. And so I'm telling you, I'm here to tell you as a card-carrying member, that when data goes up and it's compared across the services, and the service secretaries or the chiefs of staff, or whoever, MRNAs or whoever, can all see what the other services are doing, based - and the STR is a standardized metric. It is the same requirement for every record to the VA. The Navy doesn't have one form and the Army another. It's a standard thing.

So we're fixing it. And, I mean, it's front-burner. And so, again, this is why I say that I live in a world when I see action taken

when it's brokered across the top spectrum. I believe every service is genuinely interested in doing the absolute best for its warriors and its people. They truly are. But as many things go in these days of competing interests, some things have more importance to some services than others, depending on what the wolf at the sled is at the time. If you want this to be the wolf that jumps on your sled, then you have to make it a standardized format that everybody sees.

MEMBER MUSTION: I think - if my time is right, I think I have just about as many days on this Task Force as you, so I think we were both confirmed at about the same time. The thing that stood out, throughout all these discussion and all the unit visits and everything else, there are three things: education, information, and awareness. And this whole area here that we're talking about, I think, ties into that. How well we're educating, informing, and then providing awareness, where that's access to the VTA, ability to track cases, how we're informing them

with the CPT when they come into the program. And I think that's the biggest takeaway is, well, we've been at this for a number of years - our services have. We still have not broken the code of proving common information, common education, and common awareness to soldiers and family members, which would get at much of the angst that we've heard from the 173 service members and the 73 family members that we heard during the different sensing sessions or focus sessions that we've had this past year. And that's something that all the services have got to get after. And just as you said, implementing a tool that allows us to assess the effectiveness with which we're going that as an institution.

CO-CHAIR NATHAN: Well said.

MS. DAILEY: Okay, so in an overarching recommendation, which would be in number 3, we're seeing you call us around number 4, here on this page. Which is, we really want the services, you really want to hold the services accountable for re-engaging in the

delivery of these services. Renewed commitment to and a strategy for delivery of education and outreach to Recovering Warriors and to their family members.

CO-CHAIR NATHAN: So number 4 is a philosophical recommendation, which basically says there is an onus to engage and to renew a commitment more actively involved. So that's sort of a philosophy. That's what we expect you - that's what we expect you to do. A specific recommendation would be - and if it's Dr. Banniock's survey, I don't care - but you will craft a survey that is seen by senior leadership and DoD that metric service comparisons based on the standardized questions that were asked. I mean, for instance, I'd be very interested in a question - and I haven't see Dr. Banniock's survey, but I'd be very curious - and that's telling in itself, isn't it, that I haven't see his survey?

MS. DAILEY: You have seen it.

CO-CHAIR NATHAN: Not that I

recognize it as such.

MS. DAILEY: True.

CO-CHAIR NATHAN: I was asked one time if I'd ever seen a patient with that disease, and I said, "maybe, but I didn't recognize it."

So I think that if you had said, "please, at what time in your entrance into the Recovering Warrior program, from onset of injury or from arrival to tertiary medical care, did you receive counseling" on the ultimate plan, CSF or whatever, it would be very interesting to see if some service comes in at 3-5 days, another service comes in at 10-14 days, another service comes in "never have." That's sort of the philosophy we're going - so 4 is sort of the general "this is goodness." Sixteen is a little broad, because 16 is uniform measures of wounded warrior program effectiveness across DoD. That encompasses just how effective is the program as opposed to how well you are educated in the program. Other thoughts?

MEMBER MUSTION: Sir, isn't 16 implementing a measure that allows you to assess, effectively assess, is that what you said? I mean, if you were to rework number 4 to talk about the things that you mentioned, then number 16 becomes employing a tool that effectively allows you to assess that.

CO-CHAIR NATHAN: Yes, if 16 feeds back to 4, then absolutely.

MEMBER MUSTION: Sir, there's one other thing I would mention as part of this, and it's kind of highlighted, and we talked about it earlier in three or four other places, that services have got to make sure they continue to sustain their investments that they've made, whether that's resources and people, facilities and time. As we go to the future and we see diminishing resources, we have to continue to sustain the same level of investment, the same ratios that we have adopted in the past, and not put those at risk, as well as the same balance between active and reserve component. I think we

have to be careful, and the Army has to be very attentive to this in particular, that we don't go too far to the other end of the spectrum where we don't have the appropriate representation, reserve components, in many of our organizations, given that a proportion, about 50% of the forces still going to remain reserve component that we're dealing with. Over.

CO-CHAIR NATHAN: And as Ms. Dailey's group sort of distills that and crafts that into proposals for us to look at at this meeting and the next, what about some fo these more specific areas here that we see, that come from some of you? Do you want those to be in the roster, to be racked and stacked with your final ten specific ones? Specific ones would be, oh, USMC, you know, revisit the USMC, taking into account Ms. Crockett-Jones' great point, which is you have to be careful, because some people relate and enjoy combat-centric individuals leading them, others don't. Do you put in that Navy Safe Harbor should provide to all Recovering

Warriors? Those are some specific ones here. Do people have some of those they see?

CO-CHAIR CROCKETT-JONES: I can say we remained pretty concerned about the reserve component at MEDHOLD East and West and that this policy of keeping them there for extended times, but we had made recommendations regarding, that we had hoped would push that to some sort of improvement last year. I don't know that by the time that we were looking at those folks again that we had seen any changes, whether they've since happened.

As far as the leadership with combat experience, squad leadership with combat experience, I think that at one point we basically said that the selection process for being a squad leader in a transition unit had to be a careful - we emphasized the need for a leadership process, leadership to take hold and determine a command climate. We made that as a recommendation and we were aiming for that to be sort of in selection of everyone, that we wanted

people to feel that being squad leader in a transition unit was a career-enhancing move, and that this was a selection not to be given lightly. And so I don't know if we want to revisit the efforts that we've made anymore in these areas, but I would love to hear from others and how they feel about that.

MEMBER DeJONG: From what I've noticed, with a lot of the focus groups that we've attended, is you get personal opinions into it, and there's not a lot we as a Task Force can do about correcting personal opinions on likes and dislikes of cadre. We've spent a lot of time on it. I think the services have done a great job with the selection criteria and setting themselves up for success with the cadre that they have over the past three years, we've seen the cadre come leaps, so far, of being trained and being compassionate in their job, and some of the best NCOs that I've ever seen across the services. So, I think we've done what we can, and my personal opinion is that we can't

fix opinions. We can't fix opinions of individuals.

MEMBER KEANE: I don't know if we want to get into the business of telling Mother Marine Corps what people are good squad leaders. Just like the Sergeant Major said, people have their opinions. If ultimately the majority of the wounded, ill, and injured Marines are satisfied with the way the squad leaders are, maybe that's also another indicator.

The majority of the Marine Corps supports combats arms. I think it's 27% is combat arms. And do we want to define that? I was in Afghanistan, but I wasn't in combat, so I couldn't be a squad leader? I was in the infantry, but our unit didn't see combat. I was in the rear doing MP duties, does that mean I wasn't in combat? Do we want to get wrapped into all that? I wouldn't be surprised if this goes downrange and Marine Corps says non-concur. I don't know if it's worth putting forward.

CO-CHAIR NATHAN: I think those are

great points. I think that the focus groups I heard, most of the people weren't concerned about in combat, they were concerned about people who had deployed to the OR, who had had to live in that environment, and had to experience just basically being in theater. But again, I don't disagree with you. Are we trying to fix something here that isn't necessarily broken? And as the Command Sergeant Major said, there may be an individuals who is the perfect cadre leader, who is doing all the right things, and the individual, the warrior has no problem with all the right things, but just their opinion is they don't like all the right things being done for them by somebody who hasn't been in theater.

And so the question comes down to, as somebody who hasn't been in theater, are they unable or incapable of doing all the right things to lead the people, and the answer, what I'm hearing, is probably not. They are capable. They are capable of doing all the right things. So

that may not be one we want to take on. Any other specifics in here that you see that you think need the light of day?

MS. DAILEY: So, ladies and gentlemen, if you recognize any of these as ones that you gave me to work on and you haven't spoken up, I really need you to. But I'm happy to take them off. It's not a problem. I've been trying to honor the things that resonated with you, but if it doesn't resonate with you here, then I will take them off.

MEMBER EUDY: Ma'am, regarding number 12. I can see that almost spanning across to all the services, maintaining that continuity of care amongst non-medical care to provide that oversight, whether that's at a local facility due to the high rates of staff turnover, especially amongst physicians, regardless of service branch, both on the active and reserve component side, being able to keep orders and duration for longer than one year really benefits the whole as an end result. And I think

that that in itself fixes a lot of the problems that end up at the end, versus making a new squad leader, section leader, cadre member, on a recurring basis getting a more solid end result, a more predictable end result, because you have that long-term education and capability. So I agree with number 12. I would like to save it if it were given a perspective of a broad, you know for all the services component to address full-time staffing positions.

CO-CHAIR NATHAN: I think number 12 just came up because during the visit to Walter Reed-Bethesda, talking to the Air Force Recovering Warriors and some of the other warrior/staff liaisons, the Air Force was a little bit missing in action as far as continuity goes. But you could certainly extrapolate it. And the question is, do you think - I'm asking the rest of the Task Force here - should it leave the grounds of a specific service at a regional area, that's what it is. Whether this would make our top ten or not, I don't know, but in other

words, do you fire an arrow at the Air Force, at Walter Reed, and say "keep your guys and gals there for longer than 12 months," or do you expand that, as Technical Sergeant Eudy just said, and say it is our recommendation that any facility that has liaison personnel have continuity of care, or continuity of tour, for a minimum of - if you want to get that specific, 24 months or something like that.

MEMBER MUSTION: Are you just specifically talking about the LNOs, or are you talking about cadre of warrior transition units, and CBWTUs, and -

MEMBER EUDY: Across the board, as a very general summation of that. Whether that would be a PCSN, or even a PCA from local areas, because we see that a lot, addressing that specific Air Force instance where it's coming from Andrews, but we see that in the Army cases with the WTC with the parent command in that area, the standing division then donates, or gives up their soldiers in order to provide and

facilitate that. But yes, for longer durations than one year. Twenty-four months minimum.

MEMBER MUSTION: I could support something that says 24 months, but I think going to the other end of 3 or 4 years in those particular positions, I think the fair wear and tear on the individual might be putting it at the other end. It won't be treating those soldiers and airmen that are providing that support, but if you put it at the 24-month mark I think that's reasonable. And that gets at the turbulence and the transitions that you're highlighting.

MEMBER EUDY: In our discussion, sir, with cadre members, I'll just say cadre as a general term across all the services, two years seems to be ample time before we started going toward the three-year burnout period, and then they're mission-ineffective.

MEMBER DeJONG: I concur with that. And we've asked this question, we've breached this over the last couple of years. The magic number has always been 24 months, across

leadership, at all levels of all services, and above that you start getting some compassion fatigue and other things setting in. We reached this at Landstuhl with orders from the Navy. We've talked - and again, a lot of this ends up being reserve component coming on one-year orders and then having to be renewed.

MS. DAILEY: And first year recommendations, second year recommendations, continuity, minimizing turnover, minimizing transition, we've got a lot of those recommendations out there. And in fact we're starting to kind of check those off as completed, because there are new rules out there. About 720, sir? Is that what you called it?

They've just put the new rules about 720 in place. But we have done a lot of recommendation on continuing, minimizing transition, minimizing turnover.

But that still keeps cropping up in the liaison positions and the smaller utilization speciality boutique-type of person

they need to do some of these specific liaison functions. They are very good pickings for being a one year or less, or a ninety day tour, or a hundred and eight day tour. We can do a general - we can make this another overarching, minimize transition, minimize turnover in personnel. I really don't think it'll get back down to these liaison positions as a executable recommendation. If you really want specific positions filled longer, you're going to have to put that in your specific, site-specific type of actions to be taken.

CO-CHAIR NATHAN: Denise, I absolutely agree. I think if you made a general statement saying the Task Force recommends that there be continuity of care in positions that both guide, facilitate, and that's the spirit of our intent, I think all the services will come back with a very strong concur, exclamation point. And we'll check a year from now, and some of the services will still have 12-month wonders. So I think we need to - if it's going

to make it to the hit parade, it needs to say, you will have, including liaison officers or liaison personnel, you will have 20-month, we recommend 24-month minimum tour length, or 24-month tour length minimum.

And we can put a ceiling on it if we want, but I think our biggest concern is to allow them to leave at any time after 24 months based on service desires, but stay for a minimum of 24.

Other observations or insights into the other recommendations? There was one that came out of a couple of focus groups, where in my limited experience, and I haven't traveled as extensively as most of you, but there certainly seems to be somewhat of a disparity, and it may just be training level or years in, between the junior and the senior warriors, as we talked to them in the focus groups. The seniors tend to feel that they are doing pretty well. We often that that's because they've developed a little more self-sufficiency, have a little more resources, may have more financial resources

available to them, may have more vehicles available to them, whatever the reason is, they seem to be a more satisfied, content group, thinking that the system kind of works for them. Maybe they have more training, more education, they've had more experience in being able to figure out how to take care of their issues on their own and be their own advocates.

And then we talk to the more junior enlisted personnel, who feel they're often left swinging in the breeze, and especially their families. Is there anything we can - A) I would ask you, should we address that? Is it something that you think is enough of an issue that you think it need to warrant our attention? And B) if we do, what should our recommendation be, as opposed to just a generic "make sure you take care of the junior personnel as well as you're taking care of the senior personnel." Because all we'll get from that is "concur."

Gentlemen, anything on that?

MEMBER DeJONG: Sir, I concur with

your statement. I think it's hard to formulate into a recommendation, I think across - your statements I concur with is that I believe that the senior personnel have a little bit - they're more comfortable in their surroundings. The junior personnel, they feel a little less informed, but I think they feel less informed -- because we're talking to the cadre, they'll tell you that everybody's informed the same. I think that the senior personnel have a little bit more responsibility in taking on the information that they have, and I think that they also have less interaction with the cadre than what the juniors do, because they're kind of on their own. They set their own path. They've got the CTP out there and they know where they're going.

I think where we run into a lot of these, the junior enlisted, the junior soldiers altogether, whether it's a junior officer - they're in a strange transition point within their career to where maybe they saw a career on the horizon. They're young, they don't have a lot

of financial support, and now they're in position where they don't know where they're going. They don't know what the next step is, because they don't know if they're going to be able to continue on with their career, or if they're going to have to change roles altogether, whether they're going to transition out or they're going to stay in. I think age and maturity has a lot to so with, and how to formulate that into a recommendation, I'm not sure.

MEMBER PHILLIPS: Along those lines, in our discussion, previous discussions, we all agree that the junior personnel enlisted officers do not advocate for themselves as much and are not as well informed. And there's a lot written, a lot of policy written. But someone made a suggestion that perhaps we could suggest that very short summary documents related to specific issues be written up. I remember hearing that. And that seems like it might be helpful with bullet points or whatever, and then

they can follow up from there with a deeper document.

MEMBER DeJONG: And the last quick point, and it sort of encompasses this ins one of the last site visits that we went to, we had mentioned coming up with the handbook of acronyms, and we were talking to some of the cadre about encompassing all of this together, for both the families and service members. And one of the officers, not sure exactly what his position was, said "We could write anything down that you wanted this day and age, but unless it's in electronic format, the junior soldiers aren't going to pick it up and read it." So looking at trying to address that population and where we're at in technology, it may be something along the lines of more technologically encompassed type information flow to the younger generation that's out there, whereas the older generation will still pick things up and read it. So just trying to throw an idea out there.

CO-CHAIR CROCKETT-JONES: Yeah I

think this connects to a concern that I had the last - I guess it was in Alaska, we were walking through the - the equivalent of the SFAC, or was it an SFAC? It was an SFAC? There were several places where there were brochures available, like all in these slots, and I think about that. That's generally true also of every MTF I go into, the waiting room and the slots, and the - and I think that we are technologically behind in that most people have a phone now that if they had the scanner instead, that same information could be available for them to take with them on their phone, which they might be more likely to do than carry home a pamphlet. If they do carry home a pamphlet, where does the pamphlet go? I know paper comes into my house and disappears on a daily basis. And so I think this might be where we are getting a generational divide as well, is the method by which resources are disseminated might be more effective for someone who grew up with that method and is already comfortable with it, as opposed to a generational - we see

everywhere we go, it's true, junior enlisted seem to have less ability to hold onto information even if they're given it, and they do advocate less effectively for themselves. But maybe it is a tool/technology issue that is compounding this problem.

CO-CHAIR NATHAN: Yeah, that really resonates with me, what you two have said, because we're seeing so much more of our younger crowd, be it officer or enlisted, who really wants to do transactional medical work via applications. Apps. So that's something to think about. Do we recommend - and this would be a hard one to make a specific recommendation about - but do we recommend that - and if we're going to restrict ourselves to this particular subject, right now we're basically sort of on the engagement and education and outreach to Recovering Warriors as they assess through the program, but do we make the recommendation that the DoD should be committed to creating a digital equivalency of all the information that they

would provide via paper for education and understanding? And again, that's a pretty broad spectrum. It's world hunger. And I'm open to suggestions. But I really like the idea, because, as you said, if it's a brochure that the young soldier has to pick up and read, they're probably not going to do it. But if they have an app on their iPhone that when they're back at the barracks or wherever, they can sort of hit and scroll down through either their CSF, or through the various steps for getting disability. That may be something that would resonate within DoD if it came from us.

MEMBER EUDY: I think there's something that already exists with the Wounded Warrior Regiment, the app that they have and utilize for directing it to both the marine and to their family members. That's going to fall under tomorrow's discussion of the review to support family caregivers, that way both parties have a single go-to source. I think everyone else expressed this concern, though with not creating

something that's already been created. If not, now I have four different apps on my phone to meet my Recovering Warrior needs. It gets a little complicated. So if it's one specific, that makes things a lot easier. One updated resource.

CO-CHAIR NATHAN: Well and that dovetails with sort of the prevailing concern that we've had all along, which is either disparity or redundant or too many places to go get information. We know of certain websites, and OneSource, and places akin to that, but again, one of the chronic laments we hear from families "I'm so overwhelmed with so many different websites." We certainly hear that from the staffers in the Senate, who are relentless with beating up on us for not having a one-stop shopping website which can triage you to various pieces. We do, in a sense, but we don't advertise it as well, and we don't - a lot of our folks don't really utilize it. But again, and is this an issue. In other words, is this something - I'm not a junior enlisted Recovering Warrior, so I

don't know whether this exists or not. I'm assuming since you brought it up, Sergeant Major DeJong, that it doesn't exist. And what I hear you saying, Tech Sergeant Eudy, is "Great! Let's get electronic." But let's not have five apps for the Navy, five apps for the Army, five apps for the Air Force. And each one gives you a different webpage or a different set of information. Should the onus be on DoD to create a transcendent digital information system that can be hit from an iPad, an iPhone, an Android system?

MEMBER EUDY: And again, sir, that falls right under the standardization across the services. If everyone's directed toward the same resource regardless of if it's foreign policy, procedure update, then regardless of uniform, everyone is seeing the same exact processes.

CO-CHAIR CROCKETT-JONES: And I can say that if you walk through an airport, a mall, a grocery store, this service exists in the civilian world everywhere. Every movie poster

has a scan-thing, and you can get a trailer. Every advertisement in a grocery store has a scan-thing, you can get the little, the USDA vitamin and nutrition box. You can - this exists everywhere else, and the idea that I walk into the SFAC and there are a bunch of pamphlets that say "Family reintegration" or "Handling Anxiety" or "Children with Depression". All those, in the rest of the world, those would now be available to be scanned, and so I don't think it's necessarily a matter of reinventing resources, or I think that there is some simple access solutions, and you know, I think that the experts in the rest of the world should be brought to bear on bringing us, technologically, into the 21st century on this stuff.

MEMBER PHILLIPS: There are many ways of doing that. An example - my day job, I deal with information and communication. And I tell my staff to always think about how you're going to present it and communicate it, and we go by this sort of silly slogan: Just when I need

information, just in time. And you have the national resource guide and so forth. And our recommendation can be to focus on that, digitize it of course, for all the services, one app, and you can categorize it for what I need, when I need it, and so forth.

MEMBER DRACH: I agree with you conceptually, Admiral, that perhaps DoD should develop a single app. But in all due respect to the services, what are the services going to say? They're going to say - perhaps they're going to say - we don't like the DoD one, because it's not as good as what we can do for our members. We want to have our own. And they're going to continue down that lane, and you're going to end up with that many more. It also brought up - I was thinking earlier this morning, when we were talking a little bit about the NRD. The NRD doesn't have an app. Is that one reason why it's not being used, if it were an app? And as the Sergeant Major pointed out, I'm not going to pick up that pamphlet and carry it around with me, but

if I have it on an app, I have my phone with me 24/7. I hate to admit this, but the last thing I do at night is look at my email; the first thing I do in the morning is I look at my email. Used to be I smoked a cigarette. When I quit smoking cigarettes, I found a substitute for last thing and first thing. And I don't know whether they're going to use it or not. You start giving too many apps, then they're inundated. When Military OneSource started up, it was my understanding that part of the thinking was that military one source, and everybody's going to use Military OneSource as the go-to place for information. I don't know. Do we have any idea how many hits that the Wounded Warrior Regiment app gets? It's a very, very good site! Are other service members using it, just for general information? I don't know.

CO-CHAIR NATHAN: Now, it's - you bring up a great point, as to how realistic our expectation is that the services will bite on this. They'll bite on anything they're told to

bite on by DoD, if at the departmental level, so that can happen. Again, I temper it with the - you're in my generation. This is somewhat of an academic discussion. But to the younger kids coming up. And I've learned this the hard way, providing medical care. I can't get them to call me back for an appointment, but if I text them, I get them to text me back within five seconds. If I want my daughter to come downstairs for dinner, I text her. And if she doesn't come, I text her in all caps, and then she texts back in all caps, "Okay". So I think it's hard for you and I to appreciate sometimes, just how dialed in these young folks are. And if we can make it available to them, or to their families - I don't think it'll give us 100% penetration, but I wonder if it won't really increase the ambient awareness if these programs are. So that's step one, which is to make it at least electronically available to them. And step two is, and this is where Technical Sergeant Eudy came in, how much do we allow individual service electronic

information advice, saying this is our one shot to get the young soldier, young sailor, or the young marine's family and the Recovering Warrior, this is our one shot to push out electronic information to them on an application. Should we do it in unison and use this as an opportunity to create one system that they understand? I don't know.

MEMBER DeJONG: I don't know what the right answer is, either, sir, but I think if instead of mandating the actual product you could put some restrictions into it, or not even so much restrictions isn't the right word. Have some content that has to be in there. A link to the National Resource Directory. We know we've had problems with that over the last - how many years of people just not knowing what we're talking about? Again, I think, like Mr. Drach was saying, it all depends on how it's presented. I don't think it's ever going to go away. It's there. It's just not being used to the extent that it could be. So instead of DoD making the

product, it would be DoD looking at it and advising what goes into the product, and if the services want to put some fluff in there to make it their own, they can make it their own.

CO-CHAIR CROCKETT-JONES: Well, I think that when I, when I, one of the things that I thought about when I've seen those pamphlets, is I'm pretty sure the DoD is the one printing up those pamphlets. They look the same whether you see them in the Navy clinic waiting room or in the SFAC, they all look like the same pamphlet. They all use the same font. They have to be all DoD, right? You all know what I mean. With the little balloony-head characters? You've seen them all. And I'm pretty sure the DoD is the one producing those pamphlets. They're either orange or blue. They're very bright and easy to see, and it seems to me those - if the DoD is the one printing them, they're already digitized. Cause you don't get mass printing jobs done any more, unless the product is already in digits. And so this is not a big step. But it

is very much about currency.

MEMBER REHBEIN: You know, and we can talk electronic, but it's more than just electronic. If you go to CNBC, you'll discover that one industry that's really beginning to explore what their future is, is the PC industry. Dell, and IBM, and HP, because everyone's working tablets and phones. And I've even found myself now, I'll go two or three days without setting down with a laptop. And so even though National Resource Directory may have a good website, it doesn't come across a tablet or a PC very well. Or a phone very well. So maybe be we need to make a recommendation that it's not about getting it out there electronically, it's about getting it out there onto the platforms that these young soldiers are using. Maybe we do need to make the recommendation about an app. Rather than just making an electronic recommendation.

CO-CHAIR NATHAN: All good discussion. Denise, do you have what you need from that?

MS. DAILEY: Yes sir. Actually, kind of came together a little bit in the end here. So would you kind of coalesce around asking, recommending the DoD pick some specific critical information topics that need to be digitized for the mobile platform delivery? And you let them pick, DoD pick the topics, basically. And then the services would have the requirement to develop the app for a mobile platform.

CO-CHAIR NATHAN: I think you have to walk before you run, and our expectation is that they start creating disseminated information of their choosing that they believe to be foundational and important regardless of what service you're in, to be available on a mobile application platform.

MS. DAILEY: Okay, and when we say "They" we're talking about -

CO-CHAIR NATHAN: DoD.

MS. DAILEY: Okay. So DoD would tell the services to pick their topics and start making them available on the mobile platforms.

CO-CHAIR NATHAN: Yes.

CO-CHAIR CROCKETT-JONES: And DoD might have some of their own topics. I mean, DoD should pick the topics that is important at that - no? I saw a face.

MEMBER MALEBRANCHE: No, no, I'm just thinking. Because I think VA should be part of this, and actually I think there's a group with VA/DoD doing mobile apps, and I know the PTSD app, which we went out, and we talked to groups, they didn't know about. That was phenomenal. They're pretty excited about it. So I guess as you do this, to consider VA in that. Same thing with Military OneSource. I agree with Mr. Drach. When they talked about Military OneSource, and it was first legislated, it was to get a 1-800 call number, because there were thousands out there. They put it under the umbrella of DoD. But each of the services had a point person in there, as did VA. So again, it's one umbrella to go to one source, but when you say one source, and you're saying DoD, please include VA, because,

remember, we're on both sides of the DD214 now.

CO-CHAIR CROCKETT-JONES: Absolutely.

MEMBER PHILLIPS: Well said. This may be a little too specific, but when you do tell someone to develop an app, somehow we have to include maintenance and updating, so that you don't have to go back and say "Oh, we have to update this and go through a new regulation and so forth.

MS. DAILEY: Okay so we really want it - as we talk about overarching gotta-dos, we really want to push and make the recommendation that the Department of Defense is leaning forward aggressively in the mobile application field for the delivery of this information. That it is one of their top priorities for delivering this information.

CO-CHAIR NATHAN: Exactly.

MS. DAILEY: Okay.

CO-CHAIR NATHAN: And in the words of Ms. Crockett-Jones, it needs to have some of

those balloony-head pamphlets.

MS. DAILEY: Good. And so you really want to kind of drive them to the mobile platform in the recommendation. Okay.

CO-CHAIR NATHAN: Okay, so I think we - this is a wrap for this section. Anybody have anything they can't live without on this section? All right. We'll take a break. And we'll get back together in 15 minutes.

(Whereupon, the above-entitled matter went off the record at 1:48 p.m. and resumed at 2:03 p.m.)

CO-CHAIR NATHAN: Okay, I think we have a quorum. We're now going to move on to reviewing the medical care case management. And this is where we provided recommendations 1 and 2 for the previous 2012 annual report. The recommendations were focused on standardizing and defining Recovering Warrior care. The topic area falls under the Restoring Wellness and Function. And Dr. Phillips, Lieutenant Colonel Keane, and Technical Sergeant Eudy will help

facilitate our discussion on that, and the rest of us can chime in as they frame this.

MEMBER PHILLIPS: Both my comrades thought it would be better for a civilian to do this, so -

(Laughter)

CO-CHAIR NATHAN: They both bailed on you, in other words.

MEMBER PHILLIPS: Number one, medical case care managers should have areas of specialization or expertise. I think we all agree that I'm not sure where that came from. I am - we don't agree that they should have specialization or expertise unless chosen to. What we had discussed was that they should have definition of duties, and have a basic level of expertise and then they can go on from there.

MEMBER EUDY: Regarding Number 3, that should be pushed I feel, as a recommendation. Because the high rate of turnaround that we saw of those that were either pushed to some type of community-based care,

whether that be guard of reserve, regardless of service branch, having to go back to higher care facilities in order to receive care, we were basically cycling individuals through the system, pushing them out to the community level, in some cases before they were ready, or what we had deemed was ready would then reveal later medical conditions. And that in itself would solve the issue that we run into of the MRDP continuation of orders processes that we have discussed.

MEMBER KEANE: I had a quick point of clarification for number two. Am I correct to assume that the - when we're talking about the Marine Corps Recovering Warriors, that includes those Marines that aren't assigned to Wounded Warrior Regiment Battalion East - ah, Battalion West?

CO-CHAIR CROCKETT-JONES: Yeah because it was all of the nurse case managers and that was something that stood out in a local place that I confirmed that they were not - the

policy is not to have them make appointments, that this was just not a localized issue. But that is the Navy policy, was for those folks not to make appointments, and their Recovering Warriors felt it. They could not exactly tell us what their nurse case managers did for them, and they struggled to make appointments. And this was really contrasted with other services. This is an area where I think we do need to make sure - this is an area where I think we have good evidence that there is a disparate outcome for folks, and the ability to get appointments in a timely manner, if they have a nurse case manager making them or helping them, versus not. Go ahead, jump in.

MEMBER EVANS: I wonder if I should excuse myself? So the policy - the case managers at Camp Pendleton, they do make appointments, matter of fact they were the ones who showed me Outlook, and how they communicate with the member through Outlook, text message. The policy is that we try to encourage members as much as

possible to be independent and making their own appointments. When there's cognitive or reasons, then yes, the case managers they have to intervene. So there's no standard policy automatically, when someone's assigned to the Marine Corps barracks there at Camp Pendleton or Kraus, that we automatically start making appointments. An assessment is made. And once that assessment is made, and determined that that member does not have that ability, then the case managers are to intervene and make those appointments for the members. So Camp Pendleton, as soon as the Task Force left I jumped on a plane to see what was going on there, and again, I think the problem is that case managers are in a hospital, not located directly with the warriors in the hope and care center. And so I think engagement is the number one concern where I can see the warriors - they have to walk over to the hospital to see their case manager. And I think moving, doing some movement of case managers to put them where the warriors are, having the

warrior to articulate clearly, or the case manager intervening early as to appointments are not being made in a timely manner, or there are issues with appointments, I think that's where we need to look at. We had a long conversation with the case managers about that process. They clearly make appointments! They showed me the process of how they communicate. But again, the warriors have to go over to the hospital, or they're texting back and forth through Outlook. So they were very surprised. And there's no, we do not say they cannot make it, that's not a Navy medicine policy, that case managers are not to make appointments. Their policy is to assess each of the members in their -

CO-CHAIR CROCKETT-JONES: That's not what they told us.

MEMBER EVANS: Okay.

CO-CHAIR CROCKETT-JONES: They told us flat out they don't make appointments unless the service member has an issue getting an appointment, and the service members said that

having one issue getting an appointment would not get them help from a case manager. If they had been delayed by quite a long time, their case manager might step in. So their service members are getting a different experience. And even the lead nurse case manager who briefed us there said that their policy was not, that they did not, unless specifically asked by a service member, to intervene.

MEMBER EVANS: That's not a Navy medicine policy.

MEMBER STONE: Okay so I wonder if we could just bring this up to a larger level of policy: the role of case managers as integrators, facilitators, and continuity. The difficulty we have is that service members are all over the place. Some are way out remote in community-based systems, some are co-located to small institutions, some are co-located to institutions with broad sets of services. It is the case manager who is the integrator and facilitator, not just the person who makes

appointments. It is the person that knows that service member's medical care system the best. So therefore the broad policy discussion should be every service member deserves an effective case manager who, regardless of where they are in the system, no matter where they are - you just had a whole discussion for an hour on apps - is connected to their case manager who knows them well, has picked them up at some point in care when they could be co-located, but then continues their care no matter where they are. Now, we recognize in chronic disease management, one of the biggest problems is that people run out of prescriptions. If you go to Kaiser Permanente, Kaiser Permanente handles chronic cardiac management, not with nurse case managers, but with pharmacists, because people, 65-70% of the time, quit taking their medicines when they run out of a prescription. And they go through some period of time, they're not on their medicine, and then they get some sort of side effect. What you have a chance to really discuss

here is what should be the role for the enterprise in case management. I would ask that we avoid this discussion of does Navy do something at this site, and does Lovell do something at this site. Let's really define the fact that this should be geographically independent, so that when we have a service member in North Dakota, they get the same level of case management as does the person on the Walter Reed campus. Now, I'm especially appreciative of number 7 in this list that says Walter Reed's a great place, but the other 6, I think, could stand to be completely reworked to capture these other thoughts, if the rest of the group feels that they have validity.

MEMBER EVANS: I appreciate that thought process, by the appointment, because I can concur, and I think I have some backup in the audience out there, that we don't just want our case managers as appointment makers. We want them to be the integrator, the person that service member to be able to go to. Not - I

understand one specific area or two specific area, but I don't - I want the overall broad recommendation to heighten case management to be that service -

CO-CHAIR CROCKETT-JONES: I think that's fine, to say "this has to be a good quality of care in their case management." I would challenge the idea, though, that for the everyday life of a service member that's got sometimes a dozen appointments a week, when they're in the WTUs, it's the frequency of their appointments that keeps them in the WTU sometimes. That scheduling that, and keeping those straight, and getting them on time, and not lapsing in their behavioral health appointments, and not having these limitations on this appointment, and then restarting a program because you couldn't make this one, and being in trouble because they didn't make this appointment because it was made overlapping with another - that that isn't. I would argue that if you're not making those appointments and knowing

that pressure for that service member, you're not going to be the person who knows their medical care best. You don't have an idea of what they're going through. And I think that these complex appointment schedules are sometimes - it's, this takes up the entire anxiety focus of a service member. So I agree the problem is really about having case management become very interconnected to what's going on with that service member. I'm just not sure that you can say appointments aren't a big factor for those folks who are still in a WTU.

MEMBER STONE: I think that speaks to number 6, which talks about the acute environment, which is really an acuity-based process, where the case manager in that case would have a very low volume of people, and would in essence become the NCO for that service member, saying "And here's where we're walking today."

CO-CHAIR NATHAN: So being sort of a product guy, what's the product from all this

then? What is the sound bite that we want to transmit in regard to medical and non-medical case management where we see a perceptible possibility for improvement, and is it centered on staffing, or does it center on roles or does it center on both?

CO-CHAIR CROCKETT-JONES: I think it's defining the roles. But I - you know, you can argue with me over it.

MEMBER PHILLIPS: I think it just - I think it goes more to the roles. Staffing would have to follow that. It's more functionality. I don't know if there's a checklist of the standard things that a Recovering Warrior has to go through, but I think we're looking at the gaps as opposed to what happens. They miss an appointment, they can't make an appointment, they have trouble. So I don't know exactly whether there's a checklist that the person in charge has to go through at the beginning of every week or every month. Number of appointments, rehab visits, on and on and on like

that, so that whoever is running that individual, those individuals, at least can go down that list and make sure that they cover everything, because the service member may not, and especially if the family or caregiver doesn't exist, or is remote or not involved, at least they can take that role over, perhaps like taking off an airplane. I mean, you go through these checklists beginning of the week with each individual, and say "Oh, we forgot to do this," or "I need to catch up on that." I know it was very board, but I was trying to stimulate some -

MEMBER MALEBRANCHE: Actually you did. Part of - one of the other groups, again, I don't want to keep putting all of this on this IC3, but part of this whole issue is they are doing checklists and the roles change over time and depending on the situation. So early on, your nurse case manager might be doing something daily or weekly, and that's the person, the go-to person, and within whatever time frame the

person starts to go through the process, it might be the RCC that's checking in and saying "Hey, you've got to go see the benefits person, you've got to go to the VR&E. And you're right, there are checklist things. It's probably part of that 22-page thing you were talking about, Captain Evans. But there is part of this, so I guess for the recommendation, this is something kind of in the works still, this one policy, but for the recommendation I think it is roles and it has to be a model that's adaptable to individuals. It can't be one size fits all. But checklists at different points, and it will vary from individual to individual. That's kind of a broad answer and a non-answer. I don't know, Connie, you might have.

MEMBER EVANS: So I work this every day with Navy medicine, and I tell, I think one of the things that's challenging with the case management - and probably not so much with the Army, but the Air Force and Navy medicine, we struggle with this, our training, so right now

we're trying to standardize across, saying, if there's a checklist, I want it at every command a checklist, documentation the same, coding the same, so that when you move from one command to another, it looks the same and may vary depending on where you are, the population that you serve. And so I say that at Camp Pendleton, I'd give you an example, so I - when I went there, I say, if a wounded warriors ratio is 1:20, why would you be at 1:26, and did you scream "I need more staff" and they said "No, we were comfortable with 1:26" And so that was a region policy that says "You will be 1:20". And so it goes back to the standardization. If we say 1:20, every command would be 1:20 when it comes to wounded warriors. And so I think training across what the case management program is probably where I know I'm trying to go more of the same, following Navy medicine policy, not the local command, but what we say in Navy medicine. And so when you came back and said "Well, they say they don't do appointments," that's not our policy. And so

that's why I was really surprised to come back. What we say, we'll assess the member, and if there's multiple appointments, multiple specialty involved, they should be coordinating that care. And so I think training, speaking the same language, looking at that across all - and I'm not sure if it should be just one service or across all services, are we - and I hope I'm not just rambling, but I know that's what I'm challenged with, in trying to standardize across one service all our policy and making sure that we are the same. And I'm not sure if that's happening, if that's a problem with other services.

CO-CHAIR NATHAN: So I'm still trying to find a deliverable out of all this.

MS. DAILEY: And may I ask real quickly where we drove this pretty much last year was we wanted them to put on the street the DoD policy, the overarching medical case management policy. So that's where you had this big overarching recommendation last year. Has it

been any help to you, to the community out there, that it helps? It did give you broad guidance for case management. It gave you acuity tables, not exact case management numbers, but acuity tables to measure case management levels against, there was a standard set of training in that that is required. Does that document need to be modified? Has it not been sufficient. We're talking about -

MEMBER EVANS: The medical management; the DoDI.

MS. DAILEY: Correct. The new DoDI.

MEMBER EVANS: The new DoDI. And so the key word is new, and so we're still trying to meet the intent of the instruction, so maybe next year this time we have a different conversation, but right now, it is a new DoDI, and so we are making sure that we are meeting that DoDI. And it is helpful, and the good part is that all services, all the case manager lead for the services, we all had input into that DoDI.

MEMBER MALEBRANCHE: I guess one of

the things the Admiral I think is looking for - we were talking about outcomes, and we've got the DoDI, but that doesn't tell you exactly how what we were trying to do, and even looking with VA working with DoD on this so we're all at close together here is to look at what's the outcome. I think we're always going to get the anecdotals. I mean, I was there with Suzanne when they said that. "What do you mean, she doesn't make appointments?" Well, they never asked. They never told her they had a problem. It was just 8 weeks, and they decided to let it go. I mean, you can't help that. But they didn't know, and nobody followed up with that. The outcomes, I guess, follow-up, and checking back. And checking back. And that has to be an assessment and a skill level. So I don't know for the metrics here if you have a DoDI, each of the services can implement however they want, VA's got their reg, they implement - one VA is one VA. But the outcome, I guess - and I don't know, I don't know how to state that. I'm not quite sure.

MEMBER DeJONG: We're struggling pretty hard to come up with something on this that we may just not get anything out of until we review it for the next year. The new DoDI's out. Let's just let it ride. Let's see how the outcome of that new DoDI is. Right now we're kind of all beating our heads against the table trying to come up with something that we could probably - right. We could probably leave this one lie.

CO-CHAIR CROCKETT-JONES: Can I ask the - about the suspense times for the IC3 to come up with role definitions?

MEMBER MALEBRANCHE: In the current draft that's being staffed through DoD and VA right now, there are definitions of the different, like the RCC and the case manager, and I don't know what it'll look like when we get it back. We've asked - I think it's within six months is what they've asked, because it's got to go through all the services and the VA. I can't remember - I don't know that the DoD did, I asked for it in 30 days and they laughed at me. It's

in - there are role definitions in there. Again, it's pretty broad, but it, again, it pulls this all together and finally gives definition. It took away categories. And I can bring a draft in so that we can take a look at it.

MEMBER EVANS: Because that would do - basically it would give us between the response to the DoDI and the process of redefining roles, it would give us something more concrete to measure for next year's recommendations.

MEMBER MALEBRANCHE: Yes. The other thing we'll have next year, hopefully, is because the lead coordination pilot, and how that role - because remember, even though they have roles, that armband of lead coordinator will pass from person to person and this pilot that is currently on, going on, I don't know what's the timeline for that. Is that also six months?

MEMBER EVANS: Dr. ~~Geiss~~ Guice just extended us for a couple more months, so that we could come back with data that she feels that she

can brief to the JEC. So a couple months we have.

MEMBER MALEBRANCHE: So the Sergeant Major might be right. You have to have - we've got a pilot in play, so with the recommendation out there you want to make sure that hopefully we learn something from it, and we can take advantage of that.

MEMBER PHILLIPS: I'm just a little uncomfortable. I don't have a solution. Part of the issue is that we don't have a level playing field. We have Recovering Warriors in very good environments that have tremendous support, like a major hospital like Walter Reed, and then we have others that are in community-based units that don't have the support, so no matter what we come up with, related to job description, roles or functionality and staffing, it's uneven. And I don't really know what the answer is unless you were able to cluster these folks in one main or central facility that could deal with it. Or there's some online service, some central service that could deal with

appointments and getting them transitioned and integrated through it. That's what I'm uncomfortable with. We're not starting with the same issues. And waiting till next year, I don't know if that's going to help. We'll be having the same conversation.

MEMBER MALEBRANCHE: I guess I'm thinking, though, patients at Walter Reed are at Walter Reed - it's again, like inpatient versus outpatient, and when can they go out? In a tiered system of care where you have like a system of care, they should be first at tertiary and then moving their way out. I don't know. Are we moving them out too early? I don't know. I mean, that could be something too. Because I'm thinking those at Walter Reed probably still need to be there. I don't know. I don't know the answer to that either. I'm pulling hard for you here, Admiral Nathan. I don't know if I can get an answer.

MEMBER EVANS: So I greatly appreciate the National Guard here, because I

concur with him. No recommendation should be made on this topic, because I only have to respond to it. So what I would recommend is that I think we need to - I don't think I had a chance to brief the Recovering Warrior Task Force on Navy medicine program, as case management I think you had that brief a couple years ago. So I think you need to hear what currently - because if I look at the recommendations, we're talking about, although Lovell is federal, they still, they were Navy medicine case managers prior to becoming the federal, and they still, we still provide guidance to them. And Camp Pendleton. So I would tell you, let's look at where we are. I think you have a small picture of what the true case management program looks like, so I will offer that to the committee, and again, I think maybe for FY '14 to go out and look at Pendleton again, and maybe one of the site visits, maybe not, or at least a couple of other programs that we have, or commands where we have a large number of Marine and Navy wounded, ill and injured. So

that's what I will offer.

MS. DAILEY: Okay, we - this is probably a good area, as we discussed earlier, for survey material. I mean, if we could suss out questions about case management and you could compare them across the services, or satisfaction levels with case management across the services, this would be a pretty - this would be a good point to be able to put in front of leadership. Correct, sir? You would want to know, because people generally understand what case management is, you'd be able to say "What's your level of satisfaction", a survey question about level of satisfaction with case management. Pretty high? Pretty low? And then probably be able to suss out whether one service or another service had high or low scores and why. And we did try and do that. I couldn't get the level of fidelity by service for case management. There isn't a metric out there. Now when we are briefed by the people writing the DoDI, they said they were going to insert

questions into Dr. Bannick's DoD-wide survey, and measure the effectiveness, or measure the status of medical case management from the publication of the DoDI. The recommendation - and I don't have anyone, I don't have any medical feedback from the Navy. All I have is the DoD survey, the Navy warrior policy, the Navy Safe Harbor didn't ask case management questions, and I don't think they, I don't think the Wounded Warrior Regiment asked questions about Navy medical case management. So maybe the recommendation is to go out and survey your programs? We just don't have visibility other than feedback from the focus groups which on the whole was - is not as favorable for the Navy case managers as it was for the Army case managers. We didn't look at Air Force case managers this year. So we just have anecdotal information. Don't know if there's a problem there or not.

CO-CHAIR NATHAN: So at this time the floor will entertain motions. The last motion I have on the floor was Captain Evans saying "No

recommendations from this area at this time, then I have the -

MEMBER DeJONG: I'm going to second the motion that's -

MEMBER STONE: Shows you how quickly the Army moves. We first and second all of our motions.

CO-CHAIR NATHAN: So you're sort of saying what the Chicago White Sox fans always say after the first game. "Wait till next year!"

MEMBER STONE: That would be the Cubs.

MEMBER KEANE:Admiral I have a couple questions, sir. I think I have a totally different perception of the way this question is being asked, number two, and I first want to, before I get into it, it may take ten minutes, is - I think early on we established the population we're talking about, number two, are those marines that aren't part of Wounded Warrior Regiment. Is that correct?

MS. DAILEY: I'm sorry if that's what

you heard me say. I apologize. These are the Wounded Warrior Regiment service members talking in a focus group to our members about their nurse case management.

MEMBER KEANE: What leads me to think that it is not is because they're excluded by squad leaders and RCCs from the CRP. That smells like those Marines who aren't part of the regiment.

MS. DAILEY: No, and in fact that was a bullet in the nurse case managers' briefing to us that they would like access to the RCP. That they don't have access to the RCP. That was their brief - that was the nurse case managers' briefing to us. The context was "We'd like to be more involved." That was the context of that. We would like to be more involved, which goes back to Captain Evans' observation that being at the hospital and not in their work environment also leaves them excluded.

MEMBER KEANE: I give back my ten minutes I was willing to waste.

MEMBER EVANS: I think we still agree. Let's come back next year. Revisit.

MEMBER MUSTION: Should - I found item number 3 here concerning, if that's a general observation, as you went around during visits that we may be pushing soldiers prematurely to CBWTUs, in turn generating additional challenges, additional problems. And I don't know if that's a consistent problem across the board, or if that was isolated to a particular area, or if anybody who contributed to that had additional thoughts on that one. Over.

CO-CHAIR CROCKETT-JONES: We saw it in more than one place. Where WTU staff basically said that they would get folks back. Because they were not thriving at the CBWTU. And so it was not isolated to a particular place or a region. This was not in overwhelming numbers, this was generally said to be, as I recall, onesies and twosies at various places, but persistent. Everywhere had trouble with when folks got to the

CBWTU, sometimes they were not ready, and sometimes what they needed was not available. So there is a concern that the process that transitions someone to a CBWTU - either it's not thorough, or it's not being implemented thoroughly. I wouldn't be able to say which of those two things is true.

MEMBER DeJONG: What I gathered from this, and dealing with these in my day job, is that some of the criteria serve for going into the CBWTU, one of them is PTSD as a disqualifier, severe PTSD as disqualifying. So I think my rationale and my opinion of this is that there was a lot of boxes being checked to get home. They got home and things got out of control, and then they had to go back. So I don't believe it's a system problem, I don't believe it's a screening problem, I believe it's just a soldier issue that wants to go home, and then things got out of control once they got there. Because the link to that, mainly when we see this, it's a PTSD-related. You very, very seldom would you

see anything orthopedic or any other injury type. Yes sir?

MEMBER REHBEIN: I had a soldier - the king-for-the-day question. I had a soldier tell me that he thought the CBWTU should be done away with. Further the conversation with him, that situation exactly. He had worked to get to a CBWTU before he was ready to be there. So what he really wished was that that temptation had been taken away from him. That would have been the only way that his situation could have been rectified. How much of that goes on, I don't know. This soldier was frank enough to talk about it. I would imagine if there's one frank enough to talk about it, there's quite a few others that are keeping it to themselves that have done the same thing.

MS. DAILEY: And so we had feedback on this one from both the top, I call it, the upward, the top of the river, and then the downward feed. So we talked at Fort Lewis, and I though the nurse case manager was very candid.

The amount of time they'll have a reserve soldier at Fort Lewis is filled with a lot of activity. Frankly, she was telling us, it's tough to get a lot done in the three or four months they will be at the Warrior Transition Unit at Fort Lewis before they send them downstream to the CBWTU. Now that leaves a lot of work for the CBWTU to accomplish prior to making decision about retainability, trying to get their care taken care of, trying to get them to a point where they can make a decision. But I thought it was an interesting discussion that she admitted there's a lot that has to be done, and it's tough to get it all done while they're still at the WTU. So the workload does get pushed down to the CBWTU. So that might be a staffing issue at the WTUs. And certainly down at the CBWTU, they've got to do a lot of work that they didn't anticipate when someone comes in their door. So we saw at Massachusetts two years ago. I can only hope it's better now that evidence-based treatments are much more promulgated, but they

complain that there have been no - at Fort Drum, there had been no evidence of any type of PTSD treatments delivered, and they were having to do that at their level. Now, maybe low - what they were doing with PTSD cases, I never figured out, but there wasn't a lot of evidence of these things being done upstream. So we are getting a good picture of the tempo and workload upstream, and the workload that then gets pushed downstream. So there is - could be some concerns here.

CO-CHAIR NATHAN: Other questions? Comments? Going once? Going twice. Okay. I think we're ahead of schedule.

CO-CHAIR CROCKETT-JONES: We are ahead of schedule. I would take a brief 15-minute break before the next.

MS. DAILEY: Let's do that.

(Whereupon, the above-entitled matter went off the record at 2:42 p.m. and resumed at 3:02 p.m.)

CO-CHAIR NATHAN: Let's go ahead and

get started.

MS. DAILEY: And sir, we do want to - we had some fresh ideas during the break. Nothing like a break. So Captain Evans would like to put a flag here in the ground for the development of two recommendations for the medical case management.

CO-CHAIR NATHAN: Nothing would please me more.

MEMBER EVANS: So I think one of the recommendations that I would like to recommend to the board is that we look at a joint training for case management across all services, and that we actually have joint outcome MOEs, measurements of effectiveness, across all services coming out of that. I think that way we will see a more unified, standardized type of case management program. So I'd like to put that proposal before the board.

CO-CHAIR NATHAN: Okay, so we have a nomination for joint training in medical case management, and joint measures of

effectiveness, to be brokered by who?

MEMBER EVANS: We currently have TMA that provides our joint.

CO-CHAIR NATHAN: Okay.

MS. DAILEY: We've got good data that would lend itself to the measures of effectiveness, MOEs, so that will be an easy one. And training will be - we'll figure out something with training.

CO-CHAIR NATHAN: Okay. Any -

MEMBER MALEBRANCHE: I think that's a wonderful idea, only because we just at VA gave the medical management folks that are doing this training for case managers, we just gave them like a hundred-page module for VA on this. For VBA, VHA, and NCA. So that does - it's concentrated similar, so they'll get all the same thing.

CO-CHAIR NATHAN: Okay. Sounds good. Thanks!

CO-CHAIR CROCKETT-JONES: Okay, our next topic area for review is PTSD and TBI

services, which falls under Restoring Wellness and Function. We provided recommendations 7, 8, 9, in last year's report, which focused on training for providers as well as assessing completion and lessons learned from audited treatment records. So if Dr. Phillips, Lieutenant Colonel Keane, and Tech Sergeant Eudy would like to take on starting this, moving us through this discussion, please? No?

MEMBER PHILLIPS: We looked at number 1, and we spent a while this morning discussing these issues under the Centers of Excellence. And one suggestion is that we can sort of roll this in to the Center of Excellence recommendation. Because again, if you read these, these are recommendations that I think should come for the Center of Excellence as opposed to directly from us. If there's no disagreement, that's what we have agreed upon. And number 2 sort of fits in that area as well. These are related to standards of treatment, standards of outcome, training across the board,

including the contractors which are the civilian providers.

CO-CHAIR NATHAN: So I think, clearly, the technical recommendations for how you measure effectiveness in treatment, how you train people, what the qualifications are or the characteristics are of people who are engaged in treating and/or caring for TBI and PTS needs to come from Centers of Excellence. Our challenge is going to be - this is my editorial comment, please welcome to differ with it - our challenge is - and from my perch, the biggest challenge I think we have in Recovering Warrior care, outside of the administrative, getting people on one sheet as far as their administrative requirements and logistical support goes, is standardizing emotional health and TBI therapies and outcomes. We currently have some amazing venues, but this probably highlights more than any other, both the advantage, the opportunity, then the challenges of the Defense Center of Excellence for TBI and PTSD, the DCoE.

Which was established to try to herd all the dogs and cat and find best practices and disseminate them, and so I'm just - I'm adding to this conversation in the sense that I still believe that the great challenge ahead of us in PTSD, TBI treatment is trying, is attempting to wrap up - and I know this, in large, in personal, because I am constantly dealing with the pressures, the legitimate pressures, to create more connectivity and more situational awareness and more coherency with the private academic sector and the military excellence, facilities of excellence. And so I think some of this standardization gets to not just determining what the best practice is, Dr. Phillips, but who's going to determine it, and how are you going to disseminate it? Because there are people at Fort Hood and Fort Campbell that are doing magnificent work that don't necessarily subscribe to the NICoE way of doing business. Because they believe - and they may be right, that they have their own sort of system, their

cell down there, that works for them. Why would they use NICoE? You then have UCLA and Pitt and RIC and these other facilities, that come in and say "You should be using our scientists in your world-class facilities, and teaming up with us, because we have better mousetraps. So I think one of our challenges, and this is a difficult one, this is not one that you can simply just write an order and make it happen -- quick sea-story just to break things up, I was an intern one time in the VA hospital in Augusta, Georgia, and a patient had come back and was very volatile and emotionally upset, and was discharging a firearm in the ward, so we were all huddled down at one end behind the nursing station, and he was shooting into the ceiling, but we were all huddled down, and the patient was clearly distraught, and the resident I worked for at the time grabbed his chart off the chart rack, wrote something in it, and handed it to the nurse, and what he wrote was "Take gun away from patient STAT." So it's difficult sometimes to just write

something and have it happen. But I just want to frame the discussion, that this is the challenge we live in in the services, and I don't know if you'd agree with me or not, Rich, but trying to figure out how to satisfy Congress, the DoD, and more importantly, the people who depend on us for the care to find the best practices and what's working, what's new, what's innovative, and somehow not building redundancies, ineffectiveness, and three different ways to try to treat something without evidence-based outcomes.

MEMBER PHILLIPS: And as an editorial, we're going to have a suite of different practices that people use depending on the stage and time that they're in their process. I mean, we can't even agree on how to treat the common cold. Let alone post-traumatic stress. But again, just to go back. I think these first few bullets really can fold into the Center of Excellence recommendation, and perhaps the specific recommendations on the different

1 therapies should come from them rather than from
2 us.
3 CO-CHAIR CROCKETT-JONES: I would
4 say that in looking on the third on the list,
5 number three, I think that there is, while there
6 is a huge disparity of, sort of, mission, as far
7 as assessing outcomes between military out there
8 and the civilian world, the idea that behavioral
9 health is run based on RBUs with this population
10 kind of disturbs me. Especially when I hear
11 briefings that seem to take a very - seem to
12 indicated that defining PTSD has taken a very
13 long time, that there is presentations that -
14 thousands of them, that outcome, when we ask
15 about outcome measurement, the first initial
16 answers we always get are "Well, we know we have
17 good outcome, because we use evidence-based
18 therapies" - which are not outcomes. And then
19 when we nug down on better outcome measurements,
20 and look - they say both direct and indirect
21 outcome measurements, they're all qualitative,
22 not quantitative. And the distinction between

direct and indirect seem pretty tremulous to some of us. It's an ephemeral line there. And I just want to find a way, I want to throw out to folks that this is almost why military behavioral health has to be more active and less passive in the system, because an RBU-based assessment of how clinic is working might be adequate for a for-profit clinic out in the civilian world. But we've got a pretty intense population that is suffering from the very slow innovation, slow plodding transition in this area. And I'm very concerned. I think Dr. Phillips has a valid point, that the standardization and getting the Centers of Excellence involved in driving the standardization of therapy is great, but I'm very concern about not moving to an outcome, finding good outcome measurements and using those as the way to assess the programs throughout the services.

MEMBER STONE: Okay, so RBUs is not the problem here. RBUs is an attempt to schedule

effectively and to reimburse based on the acuity of engagement, but nobody tells people that they can't engage with the patient for what a patient needs based on RBUs. On Lymph's, the medical care systems are for RBUs, where when I talk to people about productivity, they said "Well, my patients are sicker than everybody else's so I need more time with each patient. RBUs are an attempt to quantify that, and they're not the enemy here. Now, there is a lot of things happening in the area of PTSD and behavioral health. The Aarmy has implemented its behavioral health data portal in order to mine data more effectively on outcome. We know that 85% of our service members in the Aarmy go into combat and come back home and do well. They're different; they have incorporated their experienced in combat, but they do well reintegrating. We know that 15% don't, and of those 15% that don't, about 50% will get better. About half will get better. The other half, or 7.5%, will have chronic problems. Those number have been pretty stable since the Korean War.

The Behavioral Health Data Portal has been supported by embedding behavioral health. We have over 1000 providers now embedded in our formations, with the initial look being that there's dramatic reduction in hospitalization for various problems related to this, these disease processes. So when you look at these things, I'm troubled with number three, just because to reach the conclusion that RBUs do not support good patient care, well, I'm not sure how we came to that conclusion, so I would ask for it to be stricken.

CO-CHAIR NATHAN: Well, I think what happened there was that simply - and I think that Suzanne and maybe some others heard providers talk about they're required to produce RBUs, and the assumption was made that the providers are more worried about producing a number than they are about an outcome of a patient. And as long as they got their numbers, whether the patient really improved or not, and they got, quote/unquote, paid for it. But as you pointed

out, the RBUS is just simply a tool to measure what they do. Not necessarily to guide them in what they do.

MEMBER STONE: What we would really like to see happen is for us to develop some data that would help us skew that 50% recovery, 50% non-recovery, and give us some predictability in this whole area of work is just so immature. As it develops, I think it will get better.

CO-CHAIR NATHAN: So there are two - if I could segue into that, I think there are two watershed programs going on which really hold promise. One is the Army's Adult Behavioral Health portal. And the other is the COSC, Navy Marine Corps COSC program, out on the West Coast in Southern California. The psychological health pathways program. Those two programs, really, for the first time, feed back in real time to providers, what's working and what's not working in the confines fo the collective patient population. An example would be - and Rich, I'm more familiar with the PHP than I am

with the Adult Behavioral Health Portal, but when you are at Pendleton in San Diego and you're part of the Warrior Recovery Clinic in psychological health, when you come in you're given an iPad to the waiting room, and you are asked a series of questions about your emotional health. How are you sleeping, how are you doing this, and you're asked to check which medications you're on, and that all goes into a collective data file, which then in real time displays on any provider's screen what medications people are on and how they're doing. Not the individual, how are you doing yourself, but I may know when I see on patient, how that one patient's doing, and I may try something else through trial and error. But what if I were to see, in this emerging population of hundreds of warriors and their families, how well - and an example is, they determined that they were not treating sleep appropriately enough. That in their population, they just were missing the boat on sleep! They were treating depression,

they thought, and they were treating anxiety, they thought, but when they saw the cumulative reports of all the patients for that day, week, month, and six months, sleep was not being adequately addressed. And so they made a different tack and started recommending different medications to treat for depression that might actually help sleep as well. So that's real time feedback. I think that one of the recommendations that could come out of us, and again, I recognize - Rich and I may know a little more about this because this is our parent services that do this - but I was just out at COSC two day ago, and said "Where are we with trying to create one overarching program between the adult behavioral health portal for the Aarmy, and the Psychological Health Pathways of the Navy. And the answer I got was, what I thought was sort of the slow roll - this is my people telling me this, was sort of the slow-roll bureaucratic answer "Oh, we are huge fans of the Aarmy system, and we like pieces of it, but the

IMIT is too hard to overcome right now to merge the two things, but we certainly need to look into it." And so I left and I wrote a little note, saying "Okay, I need some foot to neck to make this happen." So we may want to - if you want to explore it more, to educate yourselves on it, we can do that, but I know you also have experience with it from your visits out to Southern California. That may be something that we want to push, is a more, again, to get this adopted sooner rather than later across our enterprise, this is fairly innovative. There is not - please correct me if I'm wrong, anybody, if you know, but I'm told by my experts, and again, they're parochial, there is nothing really analogous to this in the civilian sector. This is truly a military-unique enterprise coming out of a need from this tsunami, if you will, of deserving men and women who need help, sooner rather than later, in trying to change the paradigm that General Stone was talking about, which is - we're making heroic saves here and there, but as a

population, we haven't moved the paradigm much in changing those people who are resistant or recalcitrant to therapy compared to previous conflicts. We're just embracing them more. And this is finally giving us real-time data as to what may actually work for this population. So that may be one recommendation, is that sooner than later, the Army and the Navy forges collaboratively from the two systems, the system to be disseminated throughout the DoD in behavioral health patient feedback. Other items on here?

MEMBER DeJONG: With a note on that real quick sir, who's the driving force behind that?

CO-CHAIR NATHAN: So in the Navy, it's the Operational, it's the Center for Operational Stress Control, which is about 40 100-pound brains, PhD types, allocated in Southern California doing research and things like that, and then generating it with investment money for the southern California

Warrior Clinics. For the Army, it's coming out of the -

MEMBER STONE: Behavioral Health Task Force.

MEMBER DeJONG: So none of these efforts are coming from the Center of Excellence.

CO-CHAIR NATHAN: No, not that I'm aware of.

MEMBER DeJONG: Okay. I'm just going back to that, because that would seem something to me that they would probably want to be part of.

CO-CHAIR NATHAN: Well, I'm sure that -

(Simultaneous speaking)

MEMBER STONE: So could we go back to Admiral Nathan's comment? So if the Centers of Excellence went away -

(Laughter) MEMBER STONE: I'm trying to put it politely.

CO-CHAIR NATHAN: Now if the Center

of Excellence works the way I think they could work, they're not necessarily tasked with coming up with those ideas as much as they should be brokering them. In other words, so again, because a lot of money poured through the windows for the last ten years, down to Hood, to San Diego, to Pendleton, to Campbell, to Travis, to Walter Reed-Bethesda, everybody had their own start-up company! They didn't have to go out and seek venture capital. They had their money coming in. So everybody sort of built their programs. And if you put 40 PhDs, like you have at OSC down in San Diego, together, and give them enough money, they're going to come up with something that is probably pretty innovative. Now, as much as I like that program, I would have liked to have seen it be a proposal, like a start-up company gives to a venture capital corporation, which would have been the Defense Center of Excellence for this, and come to them and said "Listen, this is where we'd like to spend our money. Can we get your blessing? And

then they would have looked at it, and they would have said "You know what? The Army's already doing this. Why don't you dovetail with them, an instead of building your own system, why don't you go with them? And then if the Aarmy - which would be unheard of, for the Army to say "We're going to do it our way, and nobody's way at all", I would be shocked if that ever happened, but if the Army said that, then they could come back to us, or to the DCoE, and say "We're trying to do some innovative thing here, but the Army won't play." Or vice versa. The Army said "The Navy won't do anything" - because then the DcoE could be the parent that says "Don't make me stop this car." What's happened now is they've both had these good program shoot up, and they've both realized they've each got a great program, and now we should combine them, and they're both resistant, surprise surprise. So here's - we become, Sergeant Major, we become, sort of the ad hoc DCoE in this Task Force to tell them "Get together." Because it's for the goodness of

wounded warriors that you collaborate and find one system that we can then distribute across the enterprise.

MEMBER PHILLIPS: We should do that. Let me continue with a couple of the other areas in the behavioral health care. Things that we ran into, especially with the guard and reserve, where the service members are going outside the system for therapy, either to the VA if they're on active duty or to the community is the timely transfer of medical information back to the medical command, so that the command knows exactly what's going on, and can intervene if there are issues. Related to HIPAA, the suggestion was made that perhaps before they're seen, they sign a release, so that the appropriate information can go back to the command. I can elaborate on that if anybody has any questions related to that. The other issue perhaps related to the care and treatment is number 5, having more aggressive caregiver involvement in the whole system. Educational

management and so on and so forth. I know, we've discussed this repeatedly, related to the service member has to giver permission for a spouse to be involved, and in the transplant world we do it the opposite way. Instead of signing for permission, you can sign for refusal of permission. In Europe, you're a donor unless someone says no. You know, it's sort of a play on words, but if we could recommend that the caregiver be involved unless the servicemember says no. As opposed to the servicemember having to say yes. And the other area that perhaps the seven and a half - there's 50% of the 7.5% that become chronic problems is perhaps in the recruitment area, maybe there has to be a little better analysis and evaluation of past history, so maybe that might help. It's always patient selection related to outcome, so -

MEMBER PHILLIPS: Moving on, looking at number 6 - and I don't know how to, I don't want to get too narrowed down.

MS. DAILEY: Hold on, because I'm

backtracking. I just need to kind of review this a little bit. So timely transfer of data back to the command, statements fo release and HIPAA releases signed prior to leaving, right? Okay. Is this an overarching recommendation? We had talked about five or six overarching. Would this be a site specific recommendation? Okay. Just making sure I'm tuned in here. I'll add it. I'll add it.

MEMBER PHILLIPS: Only because of the issues associated with that.

MS. DAILEY: On psychological health? Okay. I can capture that in part of our findings. Is it a recommendation? And would it be - can I put it - where'd we see this at?

MEMBER PHILLIPS: It was in Iowa.

MS. DAILEY: Iowa?

MEMBER PHILLIPS: Suicide -

MS. DAILEY: Okay, so this would be a good - this would be a good recommendation for site specific. Okay. And then involvement of the spouse until the member says no; opting in

instead of opting out, which we have covered in previous recommendations. We have covered it in previous recommendations? So you all gotta give me some help here. We're adding. And I'm way beyond my list here, and I'm finding some redundancies with past, other actions. So I would like to include the Io1 in the unit-type activities.

MEMBER PHILLIPS: I know we discussed opting in versus opting out. I don't know if we made that into a - if we formalized that in any way.

CO-CHAIR CROCKETT-JONES: Not in behavioral health.

CO-CHAIR NATHAN: So just to summarize that again, the premise being for opting in/opting out is what?

MEMBER PHILLIPS: For behavioral health specifically, in order for a caregiver, spouse, a Mom or Dad, the Servicemember has to give permission related to HIPAA rules, and instead of asking for permission to allow

someone in, automatically have them allowed in unless the servicemember specifically denies it. It's a little play on words, but that seems-

CO-CHAIR NATHAN: And so my comment to that is: first of all, I think that's great. I think that all that you have do is go to one, you can go to almost any warrior recovery center and talk to the spouses, and they'll tell you that they feel disenfranchised. Now your problem, I think, though is, we might want to do a little legal research on this. Because I don't know that you're going to, without some sort of affirmative signal form the member, be allowed to give anyone else, including the spouse, entree to the medical history.

CO-CHAIR CROCKETT-JONES: In regards to this, in the same way, and I'm just, this just occurs to me now, in the same way that we say one of the criteria for going to a CBWTU is that you must have stable family situation, and that's assessed, it could be that in order to participate in one of the intensive outpatient

programs, you must have family involvement. It wouldn't even necessarily have to be HIPAA level, but just a family that was willing to participate in an education briefings or something like that, in order to draw family members in. I'm not sure. I think that it would be a good thing. I think that we have data that says families that involved improve outcomes. I think it is a justifiable recommendation to say that family participation could be tied to participation in long-term behavioral health outpatient programs. But this is a new idea, and, but I can see how it could be managed, in the same way that we set criteria, instead of saying whether it's opt-in or opt-out, it could be that some programs, we could recommend that intensive outpatient programs, a pilot be made to have criteria requiring family participation. I don't know if that would work, but I'm just throwing that out as an alternative to this consternation of legal over HIPAA.

MEMBER PHILLIPS: Well and the whole

spectrum of dropping out, missing appointments, the family is usually the one to blow the whistle and say "we're losing him or her." So somehow, as you say, getting them actively involved from the very beginning would be helpful.

MEMBER REHBEIN: I think maybe just letting the family know what the course of treatment is, how long it's expected to take. Having been on the receiving end of what some may call nagging from a spouse to finish some of my own heath treatments. I think that would reduce the dropout rate, if the family knew how long the treatment is supposed to take, and suddenly the warrior, halfway through, is no longer going. So I think there's some implications there back to number 4, and I don't know where - we have a recommendation about DoD examining the drop-out rate, that they're still studying the further implications of that recommendation. But I think having the family involved I don't have the data, but it just seems to me that the dropout rate would go down if the family was involved.

CO-CHAIR NATHAN: I think it's all goodness, I think we just need to find the correct verbiage to let it happen realistically. If you talk to the NiCOE people, they'll tell you there are two reasons they have overwhelming success with otherwise very difficult patients who have not succeeded in other places. Number one is they do the multidisciplinary comprehensive care all at once. The neurology, the alternative medication, the psychiatry, the substance abuse. And the second is family. They will not see you at NICoE without your family, if you have a family. And as you know, they fly the families back, and they put the families up, and when they meet the patient for the first time, and do the intake physicals, they do it with the family, and they explain to the family the whole protracted course, and often during the course of the two or three weeks, they bring the family back in, including kids, to talk about where they are and their therapeutic milestones. So there's no question that's a huge benefit. And

as Suzanne said, it could be done as simply as - if you're going to enter into this, whatever program that we're talking about, if you're going to enter this program you sign this and you say "I have fully expectation that my spouse or my family will be kept abreast of my progress, and my treatment course. And then it's done. And then the wife would have to - or the spouse, whoever, would have to opt out. But I think whatever we can do to frame it in a way that propagates that mechanism, because, A: we know it works, from our own scientific Centers of Excellence, and B: on the road, we've seen so many cases where the spouses have been so frustrated, feeling that they're just disenfranchised. And often - and I think you'll all agree with this - often they're blaming the providers, when in point of fact it's their spouse who's telling them they're not welcome.

MEMBER PHILLIPS: I think it's just analogous to transferring the information back to the command, is transferring the information

back to the caregiver, the helper.

CO-CHAIR CROCKETT-JONES: I think using the NICoE as a model to require some level of family involvement, I 'm sure there's a way to use similar language and call it criteria for participation, rather than worrying about HIPAA-level permissions.

MS. DAILEY: Okay, we got it. We've been tracking down that line for a while to include the spouse in the assessment of the service member before they go into these programs, to try and bring the spouse into these programs with the servicemember.

MEMBER DeJONG: And help me out here, we know it's large population, so we can't really specify a BAMC or a Walter Reed to deal with PTS or TBi. But we also know that there's places that really exacerbate the problem, and aren't staffed, aren't in a position of treating PTS or TBi. So do we look at something somewhere and how do we manage it to specify locations of specialty care for severe PTS or TBIs and get some of the

remote locations where there's not a lot of access to care, or environments that may make the problem worse. Do we look at that, or are we getting too narrow with that?

CO-CHAIR NATHAN: How would you frame that, you know, in a sound bite?

MEMBER DeJONG: We've got two locations now that have outstanding programs going, but I don't know what the patient load they can handle is. It's just - where do we look at, who can handle the patients, where the best care is, where the - I think it all kind of ties together into these innovations that are coming out along with providing a location to - that the individual can sign up and ask for treatment there, along with what we had just talked about with spouse, with family interaction, and we have some designated areas so we can deal with these cases instead of trying to spread it all over the footprint of all services.

CO-CHAIR NATHAN: Well, so we are, right, with the NICoE satellites? And there'll

be, I guess, seven of them or six of them. There's one in Belvoir now. There's one - the next one will be in Lejeune. Campbell, Hood, Pendleton, Carson. So slowly but surely I think we're sending out pods of what works or these TBI patients. And the NICoe satellite will hopefully educate more and it will be the gift that keeps on giving. I see your point. The challenge, of course, is - and again, I'm stating the obvious. The challenge is that the numbers are overwhelming. You can't process nearly the number of people who need the help, even with the satellites in full swing, so you rely on places that have no MTF, and you are now, you're a reservist, and/or you're discharged form the service as a veteran, and you're in an area where there's no VA proximal, or no hospital proximal, and then what are we doing for you in the community and how are we creating standard of care that transcends the military, federal, and civilian academic private sector. And that is a huge, that is probably the hugest challenge in

- it's not the individual who's declared themselves in extremis because they end up at the NICoE and Walter Reed-Bethesda. It's the individual who is simmering along, who is not doing well, who hasn't reached the threshold to trigger one of those medevacs and is living in Iowa, or living in Detroit, or living in Connecticut. How do they, how do we get them the proper care? That's what we wrestle with every day.

CO-CHAIR CROCKETT-JONES: Before we're done with this subject, I have a question, a TBI question. I can recall several places where we heard folks say that when they went in to the TBI clinics, they were told they didn't have a TBI, and there was some concerns raised that by the time - when they get to the VA, the VA says "Yeah, you do. And the disparity between the levels of diagnosis. And I don't know, because we don't really have VA, we can't really reach into the VA and find out how much of that is really happening, I wonder if anybody else has

concerns about that, just if anyone else who had done the installation visits remembers hearing those "I was pretty sure I had a TBI, I had these symptoms, I had these events, they say I don't have it; I'm struggling with PTSD and my treatment is not going well" I'm just wondering if anyone else heard any of this, or is it just something that - if I'm the only one who has this concern, I don't want to blow it up.

MS. DAILEY: In recommendation - not recommendation, in discussion point 9, we put a TBI recommendation on the table based on those very observations, ma'am. So the answer to your question is we do have focus group data, we have briefings, all which could validate a more extensive program in TBI. Documentation tracking for the TBI client. So I do think our evidence supports an observation that the TBI program needs to capture its best practices, put some policy in place, standardize procedures, and be able to move their patients down the road with more fidelity. And that would be the way we

would craft number 9. And we do have evidence to support that.

CO-CHAIR CROCKETT-JONES: I would hope that they have some way to track the folks who present with symptoms, come into their clinics with a complaint, just to get an idea of their numbers, to find out if one service or another or one clinic or another consistently has complaints that don't lead to a TBi diagnosis, that if their numbers are very different form one to another clinic, it would warrant closer looks for those folks.

MS. DAILEY: Well, in the absence of an overarching policy to gather that data, to measure that data, you won't know that. And so that's really what -

CO-CHAIR CROCKETT-JONES: We need to consider asking for that data to be gathered. Okay.

MS. DAILEY: That recommendation would first of all put the policy, recommend they put those policies in place, and they gather that

data, it's very similar to evidence-based outcomes for the PTSD, which in some arenas could be said to be a little farther along in the process, with the TBI still to catch up.

CO-CHAIR NATHAN: Well, one of the problems is there's a gradation between TBI and PTS. As we learn more and more about it, we recognize that there are more similarities than there are differences. Chemically and at the cellular level. One of the challenges, I think, Suzanne, is that you are going to run into a fair amount of people who are given a diagnosis in one arena, and they go somewhere else and the diagnosis is either rescinded or changed, and it breaks their confidence in the system. The NICoE often takes people who have either come from Beaufort or Pendleton, or Hood or whatever, and they change the diagnosis upon sufficient evaluation. Part of the problem is - and part of it's because they have some sophisticated equipment and top-flight people but part of it is because there's so much subjectivity in those

diagnoses. If you have diabetes, you have diabetes. There's the American Diabetes Association which says "Your blood sugar is this level, you have diabetes." If you have high blood pressure, you have high blood pressure. You can measure it all by instruments in labs. You can't do it with TBI and with PTS to the same extent. And so much of it's subjective. But I think we're on the right track by trying to make recommendations that create some sort of measurement of what the incidence of TBI is found, or PTS is found in their populations, and if it were abnormally low or abnormally high, you would then drill down on those populations, and you would say "Why" - equally adjusted for other factors - "why is this group so much lower than others, or so much higher? And I think that's fine.

MEMBER EVANS: It goes back to our CoEs, that this is one of the ones that they really should be providing research and policy down to the deck-plate on standardization for

TBI and looking at outcome measurements. So I think this really goes back to one of our CoEs, and how come we haven't seen something in place? In speaking to the TBI group that worked in the same CoE that I work in, day 7 when the servicemember enters the program, or when they have done a 5-day seven, you can see some standardization in the treatment modality, but it's day one through six each of the services are kind of treating or identifying - so it's not a standardization.

MS. DAILEY: I'm sorry, I thought it was the other way around. Day one to six in the battlefield, at the point of injury was well-defined by the DTM, and-

MEMBER EVANS: In the battlefield, correct.

MS. DAILEY: So once back here, in the clinic, the process loses some overarching guidance and policy. We do ask - we get a lot of products out of the DIDVIC. They can document extensive amount of research, they can document

extensive amount of training and products that get pushed out. We get good feedback about DIDVIC, quite frankly, when we're out in the field on TBI, but we don't get the same type of feedback from Service Members about the TBI programs at the installations.

MEMBER EVANS: When they come back to - right. So that's where we need to focus, I think. We'll consider day 1 through 6 then, standardized over in the theater, but once they get back here, we need standardization there. And so that's where we need the Centers of Excellence, DIDVIC or whoever owns that to come back to a more standardized program here, with outcome measurements.

MS. DAILEY: We talked about that earlier, we've kind of worked up something for that. So we're good on the TBI recommendation, if the Task Force wants one out there.

CO-CHAIR CROCKETT-JONES: Well, I think that we'd all like one to look at, at least

to put it on our list.

MS. DAILEY: So I got one and two. We talked a little bit about combining into recommendations, and you thought about tasking in the recommendation, task the DCoEs, to do that. That's a nuance. Whether it's a stand-alone recommendation or whether it's a tasking to the DCoEs to do it, we can work out. I got the part where we want to bring spouses in. I'm going to include under the - are we still on track, this morning, when you discussed with me several overarching and then smaller detailed ones? So if you're still on that concept, then I would put the IO1 collection of data under the Iowa site visit. We did talk with the National Guard with that, sir. There is now, they're working on a policy called - it required to inform. So when Service Members are at the VA, this was a VA issue, correct? You wanted them to feed back information? When they're at the VA and they demonstrate and exhibit behaviors that would be harm to themselves or someone else,

there is now, they're working on a law or legislation to require to inform. Which mean that it has to go back to the service, it has to go back to the command. What's what? Excuse me, duty to inform. So it's not just passing the records back or giving them the records, It's a little higher standard, actually. Or lower? It's a higher threshold to meet before they inform the command. So your issue is not even when they're the case of illness or stress, but if they've touched the VA, you want the records? So even if they've just touched the VA, you want the commands to have access to those records. Okay.

MEMBER PHILLIPS: Yeah perhaps specific to Iowa, the behavioral health access for the Guard and Reserve was the VA or the private sector, but they want that information back.

MS. DAILEY: Okay. Sir, you kind of prompted number 6 there. It had to do with our location in Alaska. Does that ring a bell for you about bringing in the uniformed provers in these

remote locations?

CO-CHAIR NATHAN: Yes, completely.

MS. DAILEY: Do you still want to go down that road?

CO-CHAIR NATHAN: Well the context, Denise, there, was if you recall, they were having a very difficult time hiring case managers, nurse case managers. Because they said Alaska's just a difficult place to recruit to. Makes sense to me. The question that was asked is "Why don't you make those uniformed positions, and shift your contracting to bigger cities, in Texas or wherever, where there's more of a population to draw from?" And the answer I got from the local chains of command was "We wish big services would do that. We don't control the mix." So that's why we said at the time "Note to self: in austere locations, in Diego Garcia, we don't have a civilian nurse. It's hard to hire a nurse that's willing to like without his or her family for two years on an island. At least a small island. Maybe they would in Hawaii, but the

island of Diego Garcia would be tough. So why not shift the contract people out of Anchorage to the big city and shift the uniform requirement up to Anchorage? And that would be true, I think, with most remote places. So I - I mean, I was hard over on the philosophy of that one. Whether or not we feel it should be a recommendation, but it might help the services. I came back, I talked to my two counterparts, and I said "Do you have a problem with this? And their answer was "Wasn't aware of it."

MS. DAILEY: And it kind of lends itself to a good overarching recommendation also. Or we could kind of bring it into site level, but I think there are more locations than Alaska that would benefit from that recommendation, that direction.

CO-CHAIR NATHAN: I think that, prior to the wounded warrior population, which has flowed over the last several years, you probably could get away with these remote locations having somewhat of a sparse contractor or

federal employee requirement, because there would be probably enough spouses that wanted employment and other things in those remote areas that you could do it. But now with the load that they have, you can't meet the demand signal with civilian hires. Not for the money - and they pay pretty good money, but they don't pay exorbitantly, so you're not going to meet the demand signal.

MS. DAILEY: And then I think the last one we haven't touched on was service, service, number 7.

MEMBER PHILLIPS: As far as we can tell, the response about service animals was very positive. I haven't heard anything negative from any of the focus groups or any of the Recovering Warriors that have service animals. Again, this - I've heard that there's some pushback from the command and various places related to service animals being in the barracks and being associated too closely on post. But that's just what I've heard. I don't know how

documented that is.

MEMBER STONE: Sir, the Secretary of the Army just signed off on a new service animal policy that we've worked on for quite a bit of time, trying to get the advocacy groups engaged. And we'd be happy to provide a copy of that to the Task Force.

MS. DAILEY: Sir, depending on how recent that was, that, I do think that's what our service members are concerned about. There are individuals who lost their service animals because of the constraints in that policy, but that's probably why it's bubbling up now, if it's a new policy.

MEMBER STONE: Well, I guess I don't know how to respond, then, Denise. We've worked on this for a long time, trying to get compliance. I'm quite sure that there's somebody that's not happy with it. There's - we've had great difficulty with where animals come from, the training of animals, as well as good order and discipline in some of our areas related to

the animals present, and so we have tried to be inclusive in the release of this policy, and so if the Task Force feels there's additional recommendations, that's fine, if there's something that's been seen that's inappropriate.

CO-CHAIR NATHAN: I don't know what the question is, so I can't really answer it. In other words, it sounds like your policy may be addressing the concern here. We'll have to see what it is. If it has to do with the specific pets that our wounded warrior has an animal, because this says "Including animal supporting service members with behavioral health issues". I'm assuming this means vetted service animals, or does it mean "I have a dog at home; if I could have my dog on campus here, it would improve my outlook". I don't know.

MEMBER KEANE: I believe it's those trained dogs that are bomb-sniffers who still have a life expectancy that they can serve another few years in the service, but that

service member who was injured served with that dog, and wants that dog taken out of service, he wants the dog with him.

CO-CHAIR NATHAN: Okay.

CO-CHAIR CROCKETT-JONES: There were multiple wrinkles to this, but it was mostly about what was a legitimate place to acquire, from whom to acquire a dog that could act as a service animal who was legitimately able to train them, could dogs that were already part of a service member's family be trained to become a service animal? I think that a lot of this is sort of bubbling up. People want to have their own dogs trained to be their service animals. There's a limit on the number of dogs, for instance, you can have in on-post housing. So if you already have your two pets, you can't acquire a third. There's a lot of wrinkles to this that folks just thought - the impression that we got at the installations where I heard this as a complaint, it was generally that this system, it seems to have such positive results, and it's

really hard to get over the barriers to be in that process. Now, I think some of the requests were - I'm not saying that everything we heard was reasonable. But it does seem to be an area where the complaint is that it's getting harder to get this involvement than easier.

CO-CHAIR NATHAN: I think it would be very interesting to see what your policy is, because that may answer some of the questions.

MS. DAILEY: We do have the policy. It was signed on the 29th of January. It was part of the research of the comments that came out of the focus group. There's a nuance here. Is the issue that bringing access, bringing service animals onto the installation? So what happens is that under some laws ,you're allowed to bring service animal on installations. The ADA laws allow -

(Off-mic comment)

MS. DAILEY: So we've done a lot of research. We've framed it up here in regard to access, the access of our service members'

certified animals to the installations, am I getting it? So sometimes that is restricted, which is where we framed this recommendation to try and eliminate that restriction. Am I on track here?

CO-CHAIR CROCKETT-JONES: Doesn't the same restriction issue apply to VA as well? So that service animals that were - even service animals who were accepted in WTUs are then no longer considered service animals once they get to the VA? Is there some other wrinkle that is a little beyond our reach on this as well?

DR. JAGGER: There's two different policies that apply when you start talking about VA: what the Aarmy has cited, and what others are citing, installations individually, is that VA policy regarding what service dog benefits they'll pay for, which is different than the federal policy that governs access to federal facilities. So the access to the installations is one issue. Whether Army or VA pays for service dog benefits is another issue. However, the

access issue has been linked to the VA benefit policy, and they're restricting access based on whether the dog was trained by an organization that was certified by a governing body, Assistance Dogs International.

CO-CHAIR NATHAN: This may be something, Denise, that we may want to explore on our next round - unless, have you had service animal organizations come and present to you and tell you what they provide, and also tell you from their experience, what their frustrations are and what they're not allowed to provide, and what gaps there are?

MS. DAILEY: No sir. We have not.

CO-CHAIR NATHAN: In the Army, we just signed a regulation. You can bring any dog on campus that answers to "Hoo-ah."

MS. DAILEY: Okay. Okay. I'm happy to do that. We can get the Aarmy to come, brief the policy. We can get the service organizations to also talk about it, that's good. Just bubbling up out of the services in the focus group

discussions, there is concern. And Service Members had demonstrated it for us, so it's incumbent upon us to put it on the table.

MEMBER STONE: This has been about a year and a half for us of incredibly emotional work on behalf of beneficiaries and the command teams. There's very few good answers to this one. Americans love animals. They have therapeutic benefit. We've tried to reach consensus, but it's been difficult. I would be - if this organization, if this Task Force makes additional recommendations, I'm sure we'd be happy to look at them for value, but we've had some very unfortunate incidents with injuries to family members when animals were not trained properly, especially with some small children. And so we're trying to be careful, but provide a safe and therapeutic environment.

MEMBER DRACH: Are we talking about service animals in a generic sense, or are we talking about, as I understand it, there's two sets of animals, one is a service animal, and the

other is a therapy animal, and they are different. Therapy animals are being used more for PTSD, and a service animal traditionally has been trained to help the individual do certain things. So do we want to differentiate between service, or do we want to just broadly define service animals as both?

MEMBER DeJONG: I'd like to gather a little bit more information on this. I think we're dealing with a very small population. And I also think some of what I remember from the focus groups was a lot of, again, personal issues, of "They won't let me keep Fluffy in the barracks", they didn't want to go through the process of getting an actual trained dog. I'd like to put a little bit more research into this before we put a whole lot of time into it.

CO-CHAIR NATHAN: Okay, any other points? Denise, any questions on your part from that last section?

MS. DAILEY: No, sir. I think we've coalesced around looking at quantitative

systems such as the ~~a~~Army and ~~n~~Navy system for measuring the behavioral health outcomes. We have family participation, bringing the family into the behavioral health early, up front, ensuring that they're part of it, feedback from the VA, timely transfer of data back. We have a TBI recommendation that we'll build that we've got, that you've looked at, or you have some data on it in the notes. And I have a yes on 6, which is yes on, I believe, that was the remote locations.

So we're really coming out of here with four recommendations. We had four from earlier today. So we're kind of up in the 5, 6, overarching, and I've only got like one or two for your smaller installation that I would roll into a small detailed installation type area.

CO-CHAIR NATHAN: All right, well.

MS. DAILEY: We're doing fine.

CO-CHAIR NATHAN: We'll revisit them. And we may decide to throttle back on the specifics and amp up on the generics, we'll see,

as time goes on. Do you want to just power through this last topic?

Anybody have a problem with just powering through this next topic, and the last one of the day, which I'm not sure how much it'll have to add to the discussion, because this already so front and center in the Department of Defense, and the Department of VA. But this a review, this has to do with the interagency program office, the IPO. This area falls under Enabling a Better Future.

In 2011, two years ago, there was a specific recommendation, but not last year. Ms. Malebranche and Mr. Rehbein were going to sort of frame this discussion for us, which centers itself around the Interagency Program Office and the Electronic Health Record.

MEMBER REHBEIN: And, sir, I need you to know that I have Ms. Malebranche's proxy, and she and I have voted General Stone to lead this discussion.

(Laughter.)

MEMBER STONE: Well, I for one am incredibly pleased with the Secretary of Defense's decision and endorse it wholeheartedly. Since he's the boss that empowers the committee, it seems to me that we should probably allow that to work its way through. And let me - in all seriousness, this has been a very difficult area to work our way through. And there's a couple of ways to think of it. VA and DoD can work off the same platform, or VA and DoD can have access to data that exists in the cloud, and we each reach into that data in our own manner, with our own software systems. And what the Secretary has authorized to go forward is DoD will reach out into the civilian community and take a look at what exists, and request some proposals of what exists based on some lessons that we learned in some of the previous work. Three of the anticipated proposals are versions of VISTA, which is the VA system. Some others are commercial off-the-shelf products. Coincident to that

decision, he also made a decision that we would enhance the interface between existing AHLTA and VISTA, using some GUI interface that I can't remember the name of the software system that we're rolling out that allows enhanced visibility in the interim while this thing gets fielded. I think we've got to let this whole thing to work its way out. He's given pretty direct testimony up on Capitol Hill. He agreed to think about it for 30 days. He directed the Department, and the Department's working its way through, and I think this is the one you just come back to next year and say "Look, it's moving." And there's probably been more movement in the last 30 days than there's been in a long time. Now, coincident, or following that, the VA has moved off in some of its own direction and has released some contracts recently that indicate it will move in its own direction and has made some decisions, but also has endorsed the interface network that will allow us to see each other more effectively. So my recommendation is

we set this one aside, watch to see what happens over the next few months, and just observe this one.

CO-CHAIR NATHAN: I don't think there's - we can't add to the gravitas of this. This has already got the attention of the White House. Both the Secretary of the VA and the Secretary of Defense have a regular drumbeat where they meet over this very issue. It came to a head about a month ago, where we were all waiting for the big decision to determine if our marching orders were to be "Listen, we don't care. Figure out how to make VISTA and AHLTA talk to each other. We're going to stay with those two systems, those two legacy systems, and you will figure out how to make them communicate. Or - and there was a memorandum signed by the three surgeon generals, saying, "Please open the aperture and as you consider that, consider looking at other off-the-shelf systems that are used in large civilian medical institutions which can communicate back and forth," and so the

Secretaries met, and came back, and said "We're willing to open the aperture and look at other options. Including VISTA permutations, including EPIC, including others." And they've set the gurus to do just that. I guess your point's well taken. If we could take pitchforks and torches and march saying "EHR. EHR." and we'd have trouble getting to the front of the line, because there's' so many people ahead of us with pitchforks and torches saying "EHR. EHR." So unless you all can think of something specific that you don't think has been considered that we've learned from our trips or from our briefs that would be novel to the conversation, I would agree that we, we sort of applaud or affirm the passion that we're seeing over this.

MEMBER REHBEIN: I think if the Task Force is going to take any position at all, it would be something similar to what you just said, sir, that we understand and we appreciate how high a priority an electronic health record is to the recovery of our wounded warriors, of our

Recovering Warriors. And how much it would help that recovery. And that we hope the high level of attention that's being placed on this progression now, that it will remain at that level. That we won't let distractions, because of, frankly, the amount of money that's going to be considered here by many of the commercial entities, that's going to be a big fight, and it potentially could lead to a lot of distractions that could lead to considerable delays.

CO-CHAIR NATHAN: Right and your point's very well taken. And it may be that the most appropriate thing for us to do is certainly not to tell them how to build whatever the next system is, or to recommend any permutation. But it may be either to simply either, as they say, a friend of the court, on our recommendation or as a finding to say, to validate the current thinking and to keep the inertia going, that you cannot have, in our opinion, based on what we've seen here and when we travel remotely, you cannot ultimately have a successful continuum of care

- the highest possible success in the continuum of care of a Recovering Warrior, from the time they are injured to the time they are released in a convalescent status or a rehabilitative status, or a citizen status requiring episodic care from either the civilian, the VA, or the DoD system, you cannot reach near-perfection with that without having a seamless electronic medical record that speaks between the federal health care systems and the private sector systems. And we just know that. And I recognize that's not going to happen in a year. But ultimately, I would love to think that the young boy or girl enlisting today, who gets injured five years from now, or ill five years form now, will have a semblance of a chance of being able to be seen at Kaiser, or Duke, or Palo Alto, or St. Mary's in Dubuque seamlessly, as easily as they could be seen at the VA in New York, in Florida or the Army hospital in Texas. That - we should not allow anybody to settle for anything less than that in the continuum of care for our

patients, for this population of patients. And they should get there first, ahead of everybody else.

MEMBER REHBEIN: And so even if we would be just one more voice in the crowd, I think we should add our voice to that crowd of how important we think this is.

MEMBER PHILLIPS: Absolutely agree. There was just one thing I wanted to mention, and I don't know whether the Task Force wants to jump in on this, and I have sent a separate note to Secretary Hagel, who I know casually. It's related to what expertise exists at the NIH. We have a whole 10-floor, story building of people that have really been working on electronic health records for their entire career. And my suggestion was just to include a free government group in the mix of these contractors. And I haven't heard back, but I see no downside to that, unless we want to just spend the money in the private community.

CO-CHAIR CROCKETT-JONES: I think

waiting until next year to have a definitive statement is fine, but that is our last year, and Congress did tell us to look at the Interagency Program Office. So I think we need to prepared to speak in support, perhaps. I think my only concern in the process as I've seen it was really off my radar until I participated in this Task Force, but it seems the direction has been wavering around quite a bit since I started. And the wavering - I'll use my nicer word - the wavering around concerns me because it involves delays and costs and so I would say "Yes, there are things that are waiting to come to fruition, and we can certainly wait, and we can certainly speak in positives, but I think that we need to be careful that we fulfill what Congress asked us to do, and be deliberative about this next year when we say - if we have to, to be emphatic in support. I know it's front and center, but I'm not sure it's - I would hope that we take this next year to consider deeply what it is we do want to say, in next year's recommendations.

MEMBER STONE: As you know, a virtual lifetime record was one of the president's priorities at the beginning of his first term. He has, through his emissaries, has re-emphasized to the Departments and to the Secretary of the VA and the Secretary of Defense, his personal interest in this. And I would say that if you want to add a voice to that, okay. But I'm not sure how we could re-orient anybody more than it's been done already, and including the movement of the monies that were being held within health affairs at the Department of Defense level have been moved to a different contracting area. There has been substantial reorientation under this Secretary of Defense to this project. And I think you just have to allow them to work their way through. Now, that doesn't mean that if you want to add another voice, okay. But you don't get much higher than the re-orientation that's been done in the last three months.

CO-CHAIR NATHAN: I think the

advantage to adding a voice from this crowd is the main challenge with this is, as you can all imagine, the dollar figures are going to be very impressive, for whatever the final solution is. So you can imagine the amount of private sector interest, the lobbying that's going in, and the congressional partisanship that's going to occur in some of these things to try to get their folks into the mix. Because we're talking billions and billions of dollars here. And so I think that anything we can do to allow the Secretary of both the VA and of Defense and the service secretaries to try to push through parochial interests that may be financially and/or profit-driven, which is what sort of got us here in the first place, by the way, just kind of right where we are, where we are, to push through that and say "We've got to get something sooner rather than later." Here, I've got a non-partisan group of passionate leaders from all sectors, and outlining the diversity of this Task Force that have said "You can't be

successful in the continuum of care, you can't be ultimately successful in the continuum of care for wounded, Recovering Warriors without this deliverable.

And that may just help sort of push it through. And gives the Secretary, who is politically appointed and gives the companies who have their own congressional advocates pause, gives our Secretary ammunition to get an altruistic solution cooking. So I agree with you. If we went up to any of those senior leaders right now and said "You've got to do this", they'd say "Where have you been? Get in line. We're way ahead of you. We're doing it." When they finally start to implement and start drawing on procurement, and acquisition, and proposals, and things like that, I think to have us there is just another card to play. Could be helpful.

MEMBER PHILLIPS: And especially if we don't say something, someone may come and say "Listen, you had this four-year Task Force that

didn't even address this. So I think we have to.

MS. DAILEY: And with that in mind, on Tab G, what we've done is just, in one document, capture the timeline since we've been, since they established the IPO office, which is no longer called the IPO office, But we've established a timeline, we've gathered the data that we've collected over the last few years in one location. Because it has been an area that has changed so much. It changed immediately, within 30 days of the briefing that Mr. Butler gave us in February. So we have a one-stop shop document on what has happened in IPO since its inception in 2009.

CO-CHAIR NATHAN: Very good. So, further discussion on this and/or any other subject we've covered today. Reclamas? Alibis? Going once, going twice, any administrative comments before we adjourn for today, Denise?

MS. DAILEY: Thank you all very much. I appreciate the time that you gave us today, and I'm very appreciative. So thank you for your hard

work.

CO-CHAIR NATHAN: Thank you. We'll see you all tomorrow morning at 0800.

(Whereupon, the above-entitled matter went off the record at 4:25 p.m.)