

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

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BUSINESS MEETING

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MONDAY
JANUARY 14, 2013

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

PRESENT:

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
VADM MATTHEW L. NATHAN, MD, USN, DoD Co-
Chair

JUSTIN CONSTANTINE, JD, Member

RONALD DRACH, Member

TSGT ALEX T. EUDY, USAF & SOCOM, Member

CAPT CONSTANCE J. EVANS, USN, Member

LTCOL SEAN P.K. KEANE, USMC,
Member

KAREN T. MALEBRANCHE, RN, MSN, CNS, Member

MG RICHARD P. MUSTION, USA, Member

STEVEN J. PHILLIPS, MD, Member

DAVID REHBEIN, MS, Member

MG RICHARD A. STONE, MD, USAR, Member

ALSO PRESENT:

AMBER BAKEMAN, Research Staff

JOHN BOTTON, Operations Staff

LaKIA BROCKENBERRY, Operations Staff

BARCLAY P. BUTLER, PhD, Director, DoD/VA
Interagency Program Office

DENISE F. DAILEY, PMP, Executive Director

THOMAS J. DEGRABA, MD, Deputy Director,
NICoE

COL DONALD GAGLIANO, MD, MHA, Executive
Director, Vision Center of Excellence

JOHN HEGGESTAD, Operations Staff

JESSICA JAGGER, PhD, MSW, Research Staff

CAPT. SARA M. KASS, MD, Deputy Commander,
NICoE

JAMES P. KELLY, MD, FAAN, Director, NICoE

CAPT ROBERT KOFFMAN, NICoE

MARY LAWRENCE, MD, MPH, Deputy Director,
Vision Center of Excellence

SUZANNE LEDERER, PhD, Research Staff

STEPHEN LU, Operations Staff

MATT McDONOUGH, Research Staff

DAVID McKELVIN, Operations Staff

HEATHER MOORE, Operations Staff

BILLIE J. RANDOLPH, PhD, PT, OCS, Deputy
Director, Extremity Trauma and
Amputation Center of Excellence

ANNE SOBOTA, Operations Staff

JIM WOOD, Operations Staff

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

2 8:09 a.m.

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

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

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

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

1 him over here from the airport.

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

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

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

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

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

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

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

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

22 It gave me a very good look at

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

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

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

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

21 I was at a Tank recently. The
22 Tank is where the Joint Chiefs of Staff meet.

1 And we were talking about wounded warrior
2 paradigms. And some of the problems that
3 exist in supporting wounded warriors, not only
4 strategically and through a national
5 referendum. But tactically on the family to
6 family issues.

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

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

20 And just one quick story that I
21 would tell elected leaders, and senior
22 military personnel, and representatives who

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

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

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

16 And now, five years later, the
17 families say, or ten years later the families
18 will say, well, the good news is that 20
19 people have walked into the room every day and
20 handed me their business card. Each agency got
21 this and this and this. And if my husband's
22 big toe hurts, call this person. And if the

1 pay for the meals doesn't arrive, call this
2 person. We don't know who to call. There's
3 too many people. We feel we're overwhelmed.

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

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

20 We are going into our eleventh
21 year of war. A wounded warrior that is
22 affected today, in my experience, is in even

1 more dire straits, because they've been
2 exhausted for years.

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

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

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

19 The military health system is
20 reorganizing in a way that's unparalleled in
21 the last 50 to 100 years. There's going to be
22 a creation of a Defense Health Agency.

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

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

15 There's going to be the creation
16 of what's called Enhanced Multi-Service
17 Markets, which will affect places like
18 Portsmouth, Brooke Army Hospital, or the San
19 Antonio Medical Centers, San Diego, Madigan,
20 our major medical centers.

21 Many of our main casualty
22 receiving and treatment facilities will now be

1 under Market Service Managements, which again
2 will be under service purview, but have a more
3 collective approach to them. So we're really
4 sort of standing the whole place on its ear.

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

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

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

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

1 the Department of Defense and the VA.

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

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

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

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

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

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

15 And this, my actually last little
16 sea story. But I tell it everywhere I go,
17 about the spirit of wounded warriors. We had
18 a Marine at Bethesda about three years ago.
19 He had come in, he had lost one leg below the
20 knee, and would eventually go on to lose one
21 hand.

22 He had arrived -- As you know,

1 the big change in this conflict compared to
2 previous wars, Viet Nam, World War I, II,
3 Korea, Viet Nam, where the average medevac
4 time in those facilities from the theater to
5 the states was 45 to 60 days, before somebody
6 seriously injured would get back to the
7 states.

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

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

22 The little boy looked at him and

1 said, "Daddy, are we still going to Disney
2 World this summer?" And this was in the fall.
3 He was supposed to come back in about the
4 spring. And he came back early because he was
5 wounded.

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

11 I said, "Look, you're going." I
12 said, "Not only that," I said, "You'll be able
13 to get around. And you'll be able to ride
14 every ride. I know it. I've seen it. That's
15 how it works." And so everybody was very
16 happy.

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

1 rides before I got hurt."

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

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

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

21 MEMBER REHBEIN: Thank you for
22 allowing me to be the guinea pig. My name's

1 Dave Rehbein. I've served on the task force
2 since its inception. And have been very
3 pleased to do so, and very encouraged by the
4 progress that is being made on a number of our
5 recommendations.

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

11 The other half of my career was my
12 avocation through the American Legion serving
13 veterans, not only those coming out of the
14 military, but those that have been out of the
15 military for a number of years. To include
16 eventually being elected National Commander of
17 the American Legion in 2008.

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

1 background.

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

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

11 Past two years, probably three
12 years now, worked with the wounded warriors
13 over at Walter Reed. And I tell you, that was
14 a eye-opening experience.

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

19 And I think, just being a member
20 of the task force and knowing the history of
21 knowing how our families and our warriors want
22 to be integrated back into society. But just

1 meet a lot of obstacles out there. I think
2 this is the right group to make those
3 obstacles go away.

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

11 MEMBER PHILLIPS: I'm Steve
12 Phillips. I've been a member of the task
13 force since its inception. And I'm honored
14 and pleased to be here. The makeup of the
15 task force is incredible.

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

20 I'm a physician. I practice
21 cardiac surgery. I lived in Iowa for 30
22 years. I now work at the National Institute

1 of Health, National Library of Medicine. I
2 run a division over there. This is official
3 duty for me. And so I take it very seriously.

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

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

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

21 I've been on the task force since
22 inception. And my full time job here on the

1 task force is taking care of Captain Evans,
2 keeping her in line.

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

8 Was wounded in 2009 serving with
9 Marine Special Operations. And just
10 redeployed, actually last year, after return
11 to duty in a non medical case management role
12 for our forces at Bagram. So trying to
13 provide a different perspective.

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

22 So with that, I've had three years

1 of experience dealing as a liaison with our
2 families from all services. I've been blessed
3 to have that joint knowledge of seeing all
4 these policies and procedures, how each one is
5 written differently.

6 And so it's nice to be able to
7 walk in and have that joint perspective. I'm
8 very blessed in that manner. But I look
9 forward to being able to provide that. And to
10 be that voice for our junior enlisted force
11 that's out there. I'm just very fortunate to
12 be here. Thank you.

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

20 Like Alex, I have an understanding
21 of the wounded warrior mentality, because I
22 was shot in Iraq in 2006. And as you heard,

1 still in the reserves. I am in the IDES
2 process now facing, experiencing a lot of
3 challenges that we've heard about from other
4 wounded warriors and their families who have
5 spoken. So the program still needs a lot of
6 work.

7 And I've been here since the
8 inception as well, and have been very happy to
9 be a part of this. I think we're doing a lot
10 of good work. As we all know, even if we do
11 the work here, there's so much that needs to
12 be implemented at the lower levels, that I
13 hope we can really make and effect some change
14 in that department.

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

20 And really, before that in his
21 deployment to Afghanistan in 2001, he really
22 started having issues with post-traumatic

1 stress. But Iraq sort of sealed that deal.

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

8 And I found out, you know, how
9 many times he actually lost consciousness and
10 was obviously concussed, and hadn't -- it's
11 pretty shocking. Yes, he definitely had a
12 TBI. It took him forever to deal with that.

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

19 He was fortunate, and began a job
20 again within five days of his retirement. So
21 I've seen how the rehab works. And it has
22 worked fairly well for him. Although we may

1 not stay on that path.

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

8 I'm happy to be here. I am amazed
9 at the talent and intellect, and experience of
10 this task force. When I first arrived, I was
11 sure that somebody would fire me immediately
12 if I opened my mouth.

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

20 We're good. Normally during this
21 time we discuss site visits. And we have had
22 some. But I think instead we need to review

1 the recommendations, especially since we have
2 some new members here. And the response, Tab
3 B in your briefing books.

4 We'll wait until tomorrow to do
5 the site visit review, after the public forum.
6 So if we can go to Tab B and look at the
7 recommendations and responses. We have
8 received responses to last year's
9 recommendations. And those are in Tab B.

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

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

19 And I'm going to start back here
20 right behind you, sir, ma'am, with our
21 research staff. And I'm going to let them
22 introduce themselves. And we'll just start at

1 the left and go down the line there.

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

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

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

19 DR. LEDERER: Hi. Dr. Suzanne
20 Lederer, Deputy Director of the research team.
21 And I'm specializing in the reserve component
22 issues as well as transition outcomes, and

1 whatever else is necessary.

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

7 I've worked with Defense Centers
8 of Excellence and I just returned back from
9 Minnesota. Out there I was serving with
10 Americorps, and worked at the Veterans
11 Treatment Corps out there, and just accepted
12 a position at Walter Reed as a recovery care
13 coordinator.

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

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

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

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

5 MS. BROCKENBERRY: Hi, I'm LaKia
6 Brockenberry. I'm the executive assistant.
7 I am proud to say that I have been with the
8 task force since its inception back in 2010.

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

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

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

20 MR. LU: Hi. My name is Stephen
21 Lu. I'm essentially the resident techie here.
22 And I'm the web developer, I coordinate

1 outreach, and I also manage the social media.

2 MR. HEGGESTAD: Good morning. I'm
3 John Heggstad. I'm the budget analyst of the
4 task force. I deal with supplies and any
5 other little thing that comes up around the
6 office. I get the grunt work sometimes.
7 Don't mind doing that. I appreciate what we
8 can do for the task force to support it.

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

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

19 And I'd like to remind everyone
20 that according to our Congressional charter,
21 at 90 days DoD has a requirement to respond to
22 Congress with, using the legislative language,

1 "with an evaluation of the task force's
2 recommendations."

3 At 180 days they, DoD, has a
4 requirement to submit to Congress the
5 implementation plan. So we were fortunate
6 enough, like I said, last Thursday to get a
7 copy. These have gone to Congress.

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

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

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

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

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

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

19 MS. DAILEY: The services will be
20 coming to the table in February to walk
21 through the recommendations that deal
22 specifically with the services. Now an actual

1 response, we do not formulate and craft an
2 actual response to the DoD evaluation plan or
3 implementation plan to Congress.

4 MEMBER EVANS: Okay. It should
5 have been a concur with a time line of when
6 the other two would be -- and we did recommend
7 when the report came to the facilities, we
8 recommended a concurrence on through all the
9 DoDI, but just a time line of when all of them
10 would be published.

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

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

21 Now I do believe they're talking
22 about the 3 March, 180 day implementation plan

1 to Congress. The other highlighted guidance
2 that Air Force recommended be published, the
3 AFI was published on the 21st of June.

4 CO-CHAIR CROCKETT-JONES: The
5 office that's responsible for writing those
6 DoDIs, is that the policy office that we have
7 been briefed from before?

8 MS. DAILEY: Correct.

9 CO-CHAIR CROCKETT-JONES: Are they
10 --

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

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

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

1 coming to talk to us tomorrow afternoon.

2 So on number 2. we explained in
3 our findings and our recommendations that
4 there is still confusion about the roles of
5 the RCCs, the federal care coordinators. The
6 Department of Defense has initiated a task
7 force that is going to address this.

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

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

22 MEMBER KEANE: Ma'am?

1 MS. DAILEY: Yes.

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

4 MS. DAILEY: Oh, okay. No, I did
5 not. I appreciate you bringing that to my
6 attention. Good. Am I on track there? You
7 are anticipating a product or being able to
8 influence, publish, bring to table your
9 recommendations in the March time frame? I
10 don't want to put my members on the spot here.
11 I've asked, and will ask for a formal briefing
12 from this --

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

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

22 But again, this particular

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

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

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

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

21 It's one thing for us to publish
22 something that says, you will not cut the blue

1 wire, you will only cut the red wire. How do
2 we go out in the field and find out that they
3 are only cutting the blue wire? So that would
4 be something we would want to hear back as
5 well, is how they're going to measure their
6 effectiveness.

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

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

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

1 responses.

2 So "they" is DoD/Warrior Care
3 Policy. They said they would be providing
4 further guidance and would be providing
5 guidance to the field.

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

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

21 But the vision here was a plan in
22 which they would have a way to bring the VA

1 rehabilitation capabilities, and the DoD
2 capabilities together for a long term
3 preservation of the capabilities that have
4 been developed over the last ten years. DoD
5 concurred with this. However, they didn't
6 provide any other information other than a
7 concur.

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

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

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

1 Number 5.

2 Number 6 was about Twenty-Nine
3 Palms. We've made two visits out to Twenty-
4 Nine Palms. Lots of good things happened
5 between the first one and the second one.

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

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

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

1 Some of the specifics included
2 including more transition assistance. And
3 they have, since then, put a transition
4 coordinator in, a VR&E representative there,
5 just as a example. And in the February
6 meeting there the Marine Corps will also talk
7 to us about this recommendation.

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

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

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

22 When you, anything we do with

1 TRICARE, ladies and gentlemen, you have to
2 anticipate it may even take legislative
3 actions to change. Because much of the
4 TRICARE care for our service members is
5 embedded in law.

6 All right. Next slide, yes.

7 Excuse me. This was our recommendation about
8 ensuring that 100 percent of your behavioral
9 health providers are receiving care, are
10 receiving the proper training and evidenced
11 based treatment. And are able to provide that
12 evidence based treatment to service members.

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

20 So you have a concur on this.

21 However, DoD has some concerns. And they kind
22 of spread your answer out a little bit to talk

1 about further evaluation.

2 But your intent here was to ensure
3 your primary providers have been trained in
4 evidence based training. And that your
5 primary care providers and you primary care
6 clinics are able to identify PTSD
7 symptomology, and refer it into behavioral
8 health.

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

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

1 But the culture of a metric, as
2 Admiral Nathan talked about for evaluating
3 success of these programs is what you have
4 been advocating.

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

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

17 This gets at the heart of trying
18 to find a collaborative approach that can be
19 measured across the spectrum. Right now
20 you're not able to do that. Because the way
21 they treat patients in San Antonio is somewhat
22 different than the way they treat patients in

1 Washington, DC, which is different than the
2 way they treat patients at UCLA or in Madigan.

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

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

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

1 And I think that's going to be one
2 of the things we're going to, I think we
3 should throw our weight into, is to force the
4 services to really come together on what best
5 practices are and clinical practice guidelines
6 are across the spectrum.

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

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

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

1 And so DCoE is a think tank that
2 assimilates these centers of excellence, and
3 comes out with policies on what they should be
4 doing. But there was always a missing step
5 there to get DCoE to the execution phase. How
6 does DCoE then execute these?

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

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

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

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

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

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

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

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

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

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

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

19 Number 11, ladies and gentlemen,
20 we're talking about getting access to whatever
21 document this is, the CRP. And the concern
22 was with the CRP, the document used by the

1 recovery care coordinator.

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

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

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

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

22 Number 12, ladies and gentlemen,

1 is a pretty complex recommendation that you
2 were very interested in getting on the books.
3 And it was basically a more forward definition
4 of the second category, Category 2.

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

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

18 Let's say their PTSD hadn't
19 manifested until the third or fourth month,
20 and they were then put on Title X orders, and
21 put under the care of a nurse case manager,
22 and assigned to a military treatment facility.

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

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

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

19 And your number 13, ladies and
20 gentlemen, you are -- The vision here was to
21 extend the RCC training to all non medical
22 care providers. You felt strongly that it was

1 a good baseline for all your service members.

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

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

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

14 MS. DAILEY: Yes.

15 MEMBER PHILLIPS: That was a hotly
16 discussed issue. And we reviewed it
17 repeatedly. And my question is, will we be
18 able to hear from them in a timely fashion as
19 to their rationale for maintaining the present
20 system?

21 MS. DAILEY: Yes, sir. We're
22 going to put them on the March agenda. So we

1 will have an opportunity. That is when the
2 implementation plan is due to Congress.

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

8 MEMBER REHBEIN: Before we go on,
9 Denise.

10 MS. DAILEY: Yes.

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

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

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

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

13 And there's still a significant
14 amount of information a family members require
15 that are not HIPAA related. And you, in this
16 recommendation, urged DoD to move down the
17 road of providing that information, instead of
18 allowing HIPAA to be an obstacle to family
19 members receiving information that they
20 needed.

21 And DoD concurred with this one.
22 And they stated, in the implementation plan

1 they will address DoD card holders and DoD non
2 card holders information requirements.

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

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

16 And you identified that this is
17 point where you think family members should be
18 getting a briefing on changes to entitlements
19 that they may incur upon leaving the military.
20 And you identified in this place that service
21 families should be getting briefings on their
22 further or possible changes to their current

1 entitlements.

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

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

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

18 Number 18, ladies and gentlemen,
19 was designed to address reserve component
20 currently serving in a WTU. In a WTU, not a
21 community based warrior transition, but in a
22 WTU, or at the MEDHOLDS. It is the Navy

1 MEDHOLD East and MEDHOLD West, or any reserve
2 component members currently separated from
3 their family members.

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

11 MEDHOLDS also make a choice about
12 leaving and being in MEDHOLD East or MEDHOLD
13 West, and their families staying at their
14 original location. So these are tough family
15 decisions.

16 And your recommendation here
17 addresses trying to keep these families
18 together. Give them more opportunity to be
19 together. Better conditions to be together
20 during these separations.

21 You got a, there was a non concur
22 on re-naming the national resource director,

1 recommendation number 19. They are going to
2 continue to market it, and are not convinced
3 that a new name will be helpful in that area.

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

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

15 A more structured relationship
16 between your non medical care management teams
17 and these family centers, family service
18 centers. For example, possibly first, top of
19 the line, first of the line services, someone
20 in the family center trained, possibly RCC
21 trained.

22 So that when someone comes into

1 the family service center one person in there
2 has had RCC training. They get that family,
3 and that service member get front of the line
4 services from them.

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

13 Now in the Army we know that you
14 have the SFACs. And there's a significant
15 amount of talent in an SFAC. It's not,
16 doesn't need to be replicated in every
17 service, an SFAC in every service. But the
18 recommendation is there be a repository of
19 care for the wounded, ill and injured in your
20 service family centers.

21 The Air Force has a very good
22 model for this. They in fact co-locate with

1 their airmen and family service centers.
2 They've trained individuals. And the airmen
3 and family service centers have a checklist of
4 things when a wounded warrior comes in that
5 they are required to cover.

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

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

17 Twenty-one is very similar to
18 recommendation 12. It goes to your reserve
19 component getting centralized case management.
20 Instead of having to navigate, if they're
21 still in their communities, and if they're not
22 in a WTU, getting case management, medical

1 case management to the reserve component.

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

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

16 Again, these are both DoD concurs.
17 And I don't have any visibility from the
18 reserve component on this concur, what does
19 this concur mean to them? And how would they
20 implement the concur?

21 And 23 was a very specific
22 recommendation. We just, you wanted to see

1 that the reserve component leaving the WTUs is
2 pretty much an Army recommendation is out
3 processing. We're talking about post DD214,
4 leaving the military.

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

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

16 And in their response they're
17 talking about transition assistance program
18 eligibility, which was published on November
19 21st. So this is a concur. But Jess, did we
20 look over that publication on the 21st?

21 Does it address? It doesn't
22 address non-federal -- Yes, sorry. It does

1 not address non-federal internship
2 opportunities. This addresses the updating of
3 the transition assistance program.

4 So the response to us was a
5 directive type memorandum, published on the
6 21st of November about transition assistance.
7 The incorporation of the VOW Act, covers this
8 NDAA.

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

14 Twenty-five is a VR&E
15 recommendation, which is to ensure that the
16 legislation that expanded VR&E is carried out.
17 In fact, we actually saw this at Colorado.
18 VR&E has a very good stronghold in the
19 Colorado, Fort Carson area.

20 Everyone who goes through IDES
21 gets a VR&E briefing. So we see it being
22 implemented. DoD concurs on this one. And we

1 are seeing it in the field. It had been
2 established for a year out in Colorado. But
3 when we were at Walter Reed they just got
4 someone hired on 1 October. So the
5 implementation of this recommendation is in
6 various stages.

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

13 And so your recommendation 26 went
14 to updating transition assistance program to
15 incorporate the VOW to Hire Heroes Act. And
16 there is a lot of activity on this. They did
17 publish a directive type memorandum, not a
18 Department of Defense instruction. They did
19 publish that on the 21st.

20 And again, recommendation 24,
21 they're saying that that directive type
22 memorandum covers the non federal internship

1 piece. But again, we're going to have to
2 circle back around on the non federal
3 internship piece.

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

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

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

22 The co-chairs of the JEC would be

1 both the Deputy Secretaries of the VA and the
2 Deputy Secretaries of the Department of
3 Defense. Now currently the JEC is co-chaired
4 by the Deputy Secretary of the VA and the
5 Undersecretary of Defense for Personnel and
6 Readiness. That's written into law.

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

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

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

1 the resources in the IDES process.

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

10 DoD gave us a relatively long
11 answer on this. There are a number of
12 initiatives right now ongoing to package this
13 IDES paperwork in one location, accessible to
14 everyone, to transmit it electronically. They
15 have a number of initiatives, pilot projects
16 going on to do that.

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

21 Number 30 was your recommendation
22 to ensure that their IDES survey is used to

1 improve the system. You have in this
2 recommendation several points that you make to
3 say, once you get a result in this area,
4 satisfaction for example, turn that around and
5 change your system to improve those results.

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

11 And they concurred with that. And
12 they outlined several areas that they are
13 going to be doing that. And we'll track that
14 one. I don't have my IDES subject matter
15 expert here today. But we will turn the
16 results around as they change that survey.
17 And we can talk to you about how that's being
18 done.

19 Thirty-one. Terminal leave should
20 not be utilized in the IDES time line. You
21 got a non concur on this one. And they're
22 really trying to measure all the points. And

1 how long it takes not only the DoD, but the
2 VA, to get through this complete IDES process.

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

9 We recommended in 32 have a joint
10 board for the, modeled after the Physical
11 Disability Board of Review. This
12 recommendation is also in legislation. So
13 concurrent with our recommendation they have
14 a review process going on to look at the
15 feasibility of doing this.

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

22 So they are looking at their PEBLO

1 and PEBLO satisfaction rates. So there was --
2 So they gave us some language on what they're
3 doing here. Again, this was also requested by
4 the staffing study. So WCP is doing a
5 staffing study on PEBLOs.

6 Thirty-four was the MEB contact,
7 100 percent MEB contact. And you had a
8 partially concur on this, yes. DoD's
9 commitment here is to make sure that the
10 services have all the information they need,
11 make sure that the services know that the MEB
12 outreach is outlined in their DoDI for IDES.

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

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

1 VA.

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

9 Now this is kind of a lesson in
10 how we want to frame our recommendations here.
11 The intent and the discussion was about
12 incorporating the VA into leadership training,
13 basically. Your initial, your interim and
14 your senior leadership training.

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

20 And the partially concur here, the
21 partially concur does not address your
22 recommendation or part of the recommendation

1 that says, the earlier the integration into
2 the lexicon of a service member's knowledge,
3 that the VA occurs, the better.

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

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

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

17 And so this kind of checked the
18 block here that they are complying, or they've
19 started the process of integration for service
20 members, by ensuring they have a log on to
21 VA's accounts, and they can access eBenefits
22 as soon as they come in the military. They're

1 doing this sign training and getting into the
2 VA benefits piece when they're at their basic
3 training.

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

11 All 35, ladies and gentlemen, and
12 their current status. Again, this was DoD's
13 evaluation of the task force recommendations.
14 The 90 day, as legislated, evaluation. At 180
15 days there is an implementation plan due to
16 Congress. I am going to give you all a break.
17 Our first briefer will be here at 9:45 a.m.
18 Questions? Sir.

19 CO-CHAIR NATHAN: Briefly, because
20 I want to get to the break. But if you could
21 help me understand what the sense of the task
22 force was in terms of a common operating

1 resource for recovering warriors?

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

9 If you call the air lines,
10 regardless of what your issue is, you've lost
11 your luggage, you need a refund, you're not
12 sure your flight's going to work. You dial
13 one number and they get you there. You go on
14 a web page and you'll eventually get there.

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

22 Why don't we have a 1-800

1 recovering warrior number that somebody can
2 call? And they may be referred back to a
3 local person. But they'll be told who in
4 their locality has the information they need,
5 or a policy.

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

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

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

1 this way.

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

9 So far, the research staff can
10 correct me if I'm wrong, we've had zero
11 service members or family members who have
12 ever heard of the National Resource Directory,
13 or know what it does when they're told about
14 it.

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

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

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

8 Year two evolved somewhat based on
9 recommendations. You can see them, the 2011
10 recommendations. Some best practices that
11 were identified in an attempt to bring things
12 together. It still is an extraordinarily
13 difficult program across all services to
14 negotiate their way through.

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

22 If this was as easy as a 1-800

1 process of, here's where you are in this
2 system, here's where you need to go, it would
3 be welcome. It would be welcome to families.

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

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

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

22 But where the task force settles

1 on accepting from DoD that there are
2 significant inherent service culture
3 differences among the way recovering warriors
4 are percolated through the system.

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

10 The Marine Corps' basic philosophy
11 is the medical personnel can have my wounded
12 warrior for as short as is humanly possible.
13 And then I want them back into their, either
14 back to their unit or out of the Corps.
15 Because I, the Marine Corps, want to maintain
16 integrity over them.

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

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

8 But have we come down that point?
9 Saying, we respect the service cultures. But
10 they allow too much transformity in the
11 system. This is why we have differences in
12 the IDES rates right now. This is why the
13 different services have different approaches
14 to the IDES.

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

21 And where is the forcing function
22 to make that happen? As opposed to just

1 standing back and saying, well every service
2 has its own thing. And it sort of saw its own
3 level. So I don't expect to solve that now.
4 I'm trying to just educate myself, and see
5 where the task force has sort of settled on
6 that.

7 GENERAL STONE: So we have
8 identified best practices. Those are often
9 expensive practices. And there was
10 substantial debate in 2011, before the report
11 of whether those models were in fact
12 sustainable.

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

21 So as you look at best practices
22 as separate from the recommendations, I think

1 you'll find identification of areas that are
2 potentially able to unify. And one of the
3 things we might want to look at this year is
4 how we would unify those best practices, and
5 recommend across the DoD.

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

10 (Whereupon, the above-entitled
11 matter went off the record at 9:40 a.m. and
12 resumed at 9:48 a.m.)

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

17 CO-CHAIR CROCKETT-JONES: Okay.
18 We would like to welcome Lieutenant Colonel
19 Mark Packer, the Executive Director of the
20 Hearing Center of Excellence, which serves to
21 improve the health and quality of life of
22 service members and veterans, through the

1 prevention, medical treatment and research of
2 hearing loss.

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

9 LT COL PACKER: Thank you, ma'am.
10 It's a pleasure and privilege to be here to
11 present to you all today. I appreciate the
12 opportunity. As you see in the overview
13 slide, our plan is to introduce, and the
14 purpose the Hearing Center of Excellence.

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

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

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

6 And so to see this kind of effort
7 revolving around our wounded is a, very
8 impressive, not only to me, as a Director for
9 the Hearing Center, but also to our colleagues
10 who are trying to look at the reintegration of
11 troops with auditory injury, which happens to
12 be an invisible injury and sometimes easily
13 overlooked.

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

20 And then talk about the research
21 productivity and dissemination as discussed,
22 with the consideration for policies and

1 changes. And I feel that we are well on track
2 to hit the full operating capability mark by
3 the end of the calendar year.

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

7 Prior to the injury, hearing is an
8 extremely important sense. And hearing as a
9 sensor, is valuable and important for the
10 ability to hear and communicate.

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

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

22 Over the course of the decade we

1 have a million cases of tinnitus, and 800,000
2 cases of hearing loss. So the Congressional
3 mandate to look at this injury is well
4 warranted.

5 We do have capability to prevent. We
6 have education and training in place. There
7 are hearing protective devices that are
8 functional and tactical. Communication
9 devices that help integrate the communication
10 aspect into the prevention.

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

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

1 Moving on, just briefly remind you
2 that Executive mandates, so the Center of
3 Excellence for Hearing was established in
4 2009. The Secretary of Defense required the
5 development of a center to look at the scope
6 of injuries that we're seeing.

7 It was delegated to the lead
8 component of the Air Force. And the basis of
9 the hearing center is that, it is to be a
10 collaborative center with involvement of the
11 VA, with academia, industry and international
12 partners.

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

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

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

7 So a hearing health improvement
8 network or a practice based research network,
9 that will incorporate the clinical and
10 research interests, to develop the background
11 and foundation to provide for these injuries.

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

17 The organizational chart flows
18 down from joint councils and committees,
19 through the Senior Military Medical Advisory
20 Council, through the Air Force Surgeon General
21 as the lead component. And our Air Force's
22 Medical Operations Agency has incorporated the

1 Hearing Center of Excellence as a new
2 directorate.

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

8 So this is just a visual graphic
9 of what we feel a full operating capability
10 would look like for our network. We have
11 currently medical centers, and research labs
12 that do outstanding work. And they have
13 influence within their own spheres.

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

20 As you can see at the top left, in
21 the green and yellow, we feel that at full
22 operating capability we will have reliable,

1 valid flow of data. The aim is the Auditory
2 Injury Module of the Joint Theater Trauma
3 Registry.

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

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

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

22 The auditory research program

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

6 So basically we feel that the at
7 full operating capability the DoD and the VA,
8 auditory sciences and departments, will be in
9 full communication and be able to track a
10 continuous movement of patients.

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

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

22 And the injuries compound each

1 other and there are unique syndromes that
2 develop based on these injury patterns. And
3 we feel that, that's important to work
4 together strongly with the other Centers of
5 Excellence to develop that understanding,
6 characterize these injury patterns.

7 So we feel that the attributes of
8 full operating capability include the active
9 registry system. Includes a bi-directional
10 data sharing agreement, standardization of the
11 hearing systems and acquisitions.

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

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

22 The hearing center is becoming the

1 one voice that you see in the third, or the
2 fourth bullet. I think that we are being
3 called on consistently by Health Affairs and
4 by the services to answer questions related to
5 auditory injury and hearing loss.

6 And I think that collaboratively
7 within the Department of Defense and strongly
8 with the VA, we have a group of advocates and
9 subject matter experts that can answer the
10 mail.

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

17 The DoD HCE Prevention plan is
18 ready to launch this quarter. We are working
19 strong. We're pleased to have Colonel Retired
20 Kathy Gates in the audience, who is back on
21 board and helping us to develop this program.
22 She's been instrumental in the Army to develop

1 readiness programs and to help with this
2 process.

3 And we're excited about the
4 prevention campaign, which not only will look
5 at modifying behavior of individuals, but also
6 cover the breath of the institutions and to
7 develop the policies, and plans, and
8 procedures, and processes that will maintain
9 hearing protection as a priority.

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

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

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

5 It really does go hand-in-hand
6 with mission performance. We're not out there
7 on an island. We're out there as teams and we
8 need to be able to communicate effectively.

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

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

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

22 And the ones with hearing intact

1 get more paint on others and less paint on
2 them. The ones with hearing loss, you get the
3 opposite.

4 So we're looking at cataloging,
5 and characterizing hearing critical tasks, and
6 developing sound catalogs that will help us to
7 develop speech and noise parameters that will
8 go with an audiogram, to develop the coupling
9 of the performance and the hearing ability.

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

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

20 The Registry Development is on
21 course and where as to this point, we've had
22 transitional leverage teams working to develop

1 registry strategies.

2 Now I have a dedicated team of
3 experts with a military systems backgrounds
4 that are looking at a multi pronged, parallel
5 tracked approach.

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

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

18 And the research coordinators are
19 spread out around the region to help
20 facilitate and encourage the conduct of
21 research, by over seeing and developing the
22 administrative processes that will allow

1 clinicians to get into the research game.

2 Continuing on with staffing, the
3 services have agreed to place a military, a
4 senior military audiologist within the
5 headquarters.

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

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

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

1 So moving on, to update on the
2 goals and objectives. We'll go through these
3 through our directorates, starting with
4 Prevention and Surveillance.

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

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

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

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

21 The Fitness for Duty standards has
22 been identified and clarified. And we are

1 working to develop the studies that will
2 identify the speech and noise tests that will
3 act as that performance couple.

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

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

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

21 I'm going -- Clinical Practice
22 Guidelines is an iterative thing. We've

1 completed work with the Defense Center of
2 Excellence for Psych Health and TBI, in
3 relation to dizzy patients. And we have a CPG
4 roadmap that further outlines the needs and
5 the gaps in our clinical care.

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

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

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

20 MEMBER STONE: If I could ask a
21 question?

22 LT COL PACKER: Yes.

1 MEMBER STONE: What is the form
2 that you use to promote the clinical practice
3 guidelines across the services and what
4 compels the services to accept those CPGs?

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

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

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

20 MEMBER STONE: And so it would be
21 up to the services then to go to your web site
22 and either accept the clinical practice

1 guideline or not?

2 LT COL PACKER: Yes, and in
3 addition to that, we have a Joint Defense and
4 Veteran Ideology Conference that is held
5 annually. And for example some of these
6 developments we have presented to the clinical
7 end users, to develop their understanding.

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

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

17 MEMBER STONE: So this, you exist
18 separate from the services. You have a
19 memorandum of understanding that allows
20 management from the Air Force as the lead
21 agent, or the executive agent. You have
22 subject matter experts, but the promotion of

1 these areas of excellence, is by consensus,
2 not by DoDI?

3 LT COL PACKER: Correct.

4 MEMBER STONE: Okay.

5 LT COL PACKER: Correct.

6 MEMBER STONE: Thank you.

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

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

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

21 So for the VA part of the clinical
22 practice guidelines, is this not brought back

1 to the Health Executive Council as an outcome
2 or one of your products from this?

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

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

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

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

22 They foster consensus, they foster

1 some really good research. Sometimes it's
2 duplicative of other research going on within
3 the services. That's a problem.

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

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

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

20 MEMBER STONE: So here is an area
21 of massive disability long term. Post, during
22 and post service, that is crying out for

1 preventive measures. And I think one of the
2 things we need to get a hold of is, how do we
3 take these recommendations and do a forcing
4 function?

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

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

16 LT COL PACKER: I agree with you
17 and not taken as criticism, but construction
18 and I think those are good points. That is
19 our goal, is to place prevention first and to
20 develop the strategies that will change
21 behaviors.

22 And to educate leadership and

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

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

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

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

18 LT COL PACKER: Well that's a good
19 discussion and I can backup to a more general
20 picture. I think that the Hearing Center of
21 Excellence from our perspective.

22 We were stood up without

1 necessarily the mission or the authority to
2 overtake any hearing conservation programs, to
3 run any medical treatment facilities, or to
4 engage in the research programmatic
5 discussions.

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

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

17 Been involved in touting the need
18 for an exit audiogram, which is now
19 established across the DoD. So I think that
20 we are being looked at, as the voice for
21 Hearing and Audition. And we're trying to
22 respond in our capacity.

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

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

15 And so, these are extremely good
16 points. We need to have the proper touch
17 points to really institute these as
18 instructions, duty instructions, that will
19 make a difference now and forever. Any other
20 comments or --

21 CO-CHAIR NATHAN: Part of the
22 genesis of this, as you all know. Congress

1 got very concerned that there was these, this
2 myriad of injuries and impacts, auditory,
3 visual, that the military was not keeping step
4 with advances in the academic and civilian
5 sector.

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

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

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

1 this is the new standard.

2 So we really need to be looking
3 for mechanisms, and again this may be where
4 the DHA comes in. At least where the new
5 Health Affairs as it finds it's equilibrium,
6 comes in.

7 These probably -- what is your up
8 link to that Health Affairs, to TMA, to the
9 policy branch of the military and medical
10 service? What is your up link to them, to get
11 them to create this as policy?

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

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

22 But at this point, we've probably

1 been preparing the ship for a battle, so to
2 speak. We've been developing the organization
3 and the networks that we hope to put into play
4 to work some of these lines.

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

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

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

22 And again I think it's great. I

1 think the glass is half full. The services
2 are doing something. They're putting people
3 like yourself and others in the collaborative
4 forum.

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

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

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

21 You can lead a horse to water, but
22 making him wear the hearing aid is a whole

1 different thing. So I think we need to get
2 Health Affairs in here to tell us, you know,
3 what their vision is for transmission of COE
4 policy.

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

7 CO-CHAIR NATHAN: Let me just say
8 one thing first of all. I'm always impressed
9 when an Air Force guy uses a Navy thing of
10 preparing a ship for battle. We're going to
11 hear this in all the Centers of Excellence,
12 and we've heard it before.

13 And I think one of the
14 opportunities we have here is to prepare
15 recommendations that really sort of drive the
16 system. This is an, and look we in the Army
17 have eight of these executive agencies that we
18 lead.

19 And certainly we get a lot better
20 understanding of what recommendations and
21 direction are coming out. But it still isn't
22 connected in any driving force to develop in

1 DoD policy, DoD directives.

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

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

11 LT COL PACKER: Points well taken.
12 And thank you for that. Point in case is that
13 we have for years tried to discuss developing
14 hearing as a readiness program, and to develop
15 standardization of acquiring basic, basic,
16 trainee, accession audiograms, that will help
17 the VA.

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

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

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

11 So those types of things are easy
12 to identify and to sell within the medical
13 community without policy changes. And some of
14 those continuing programs under clinical care
15 and rehab will continue.

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

22 And by having all services order

1 hearing aids and implants through the common
2 source of the Denver Acquisition and Logistics
3 Center of the VA, will save money. And
4 provide the accountability and the access for
5 members with hearing loss to these aids in a
6 timely manner, that is unprecedented.

7 And this is another issue that has
8 kind of taken a couple of years to get
9 through. The Defense Logistic Agency has had
10 trouble looking at the, allowing the thought
11 of using the VA systems. There's a policy
12 that disallows us from using VA acquisitions.
13 We need to get a waiver. It's an annual
14 waiver event.

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

22 I'm going to move on in the

1 interest of time unless you have questions
2 about the Global Outreach. I think that part
3 of our outreach strategies have been
4 implemented through the web and social media.
5 And developing the partners with the VA and
6 industry.

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

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

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

21 Working in parallel to that, we're
22 undertaking the DIACAP process to create the

1 digital data and standard resources across the
2 DoD.

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

9 The Research Agenda, we have
10 developed an auditory research working group
11 based after the AHRQ recommendation for
12 practice based research networking. Invited
13 the clinicians into the research worlds.

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

19 The network has, and I think in
20 the following slides we'll see the
21 productivity of the research network to date.
22 We've found that the research world has been

1 fairly siloed in it's application.

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

8 And so we'll address the research
9 here. One thing to point out, the formal
10 approval of a single IRB has turned green for
11 us. We're excited that we're able to do multi
12 site projects now and to speed up the process
13 of research by utilizing multiple sources to
14 look at the same question.

15 So the Joint Strategic Plan in
16 progress --

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

21 LT COL PACKER: We do not have
22 research funding, and so our work in the

1 research world has been to integrate the
2 clinicians and the labs with the research
3 worlds.

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

8 Going through the Joint Strategic
9 plan, the next couple of slides just show
10 these are basically organizational. And I
11 think we're on the way to completing the
12 setup, with the final one pending.

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

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

1 way.

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

8 Again the parallel tracks are,
9 working with Vision Center of Excellence to
10 develop the infrastructure for the Federated
11 Registry, as well as looking at in-roads with
12 the Health Services Data Warehouse for
13 clinical management. Collaborating with the
14 VA's Hearing Loss Repository in Denver, to
15 share this data.

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

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

7 And through discussions with
8 Health Affairs, and through the Health
9 Executive Council, we've had the interactions
10 to be able to develop the in-roads.

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

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

19 Joint collaborative research
20 requires IRB approval from every engaged
21 research facility, which sometimes slows down
22 the process to receiving IRB approval over the

1 course of sometimes, two years or more.

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

6 In the hearing world, sudden
7 hearing losses or central auditory processing
8 disorders, or some refractory forms of
9 tinnitus, cannot receive subjects for studies
10 at a single site, in a meaningful time.

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

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

22 The Research Productivity and

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

4 We've been working to develop the
5 organization and the network. We have the
6 research coordinators to provide the
7 administration across the system. We brought
8 the clinicians together with the research
9 teams.

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

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

21 So where as we don't have RDT&E
22 budget or funds, we are having some success

1 working together with the VA, working with the
2 different services, working with academic
3 partners to develop productivity with this
4 administrative backbone.

5 We at the same time, have
6 developed sub-work streams out of the Auditory
7 Research Working Group. To try to standardize
8 outcomes measures. The Pharmaceutical
9 Intervention for Hearing Loss, and the
10 Auditory Fitness for Duty Work Groups are an
11 example of that.

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

18 And so if we can up front, at
19 least get the teams that are doing the
20 research to agree on standard practices, to
21 develop the outcomes measures in a coordinated
22 effort, then I think that we'll be able to

1 compare those studies against each other.
2 Where as now, they are somewhat meaningless.

3 The Auditory Fitness for Duty
4 Group, we talked quite a bit about. Along the
5 same lines, I think that we have worked with
6 the other Centers of Excellence to try to
7 develop the understanding of these multi
8 sensory syndromes.

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

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

22 The goal is to again, standardize

1 outcomes. Enhance clinical involvement that
2 will point to translational focus. Facilitate
3 administration and collaboration through the
4 research network that is setup. And then to
5 build the bench to institute the research mind
6 set into the residency programs and fellowship
7 programs of the DoD.

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

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

19 We look at performance. We look
20 at prevention. We look at acute care. And we
21 look at rehabilitation separately. We, the
22 research programs are broken up into military

1 operations, into combat casualty care, chronic
2 rehabilitative medicine.

3 We have funding agencies within
4 each of the services. Within the VA, through
5 NIH, and so our effort is not necessarily to
6 fund and sponsor research, but to facilitate
7 it. And to do this, I know that this is a
8 busy slide, but this how we are set up.

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

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

19 The portfolio management, we just
20 contracted a research coordinator to develop
21 a comprehensive portfolio, a comprehensive
22 understanding of all that's going on in the

1 hearing imbalance world.

2 To work with these different RADs,
3 the research activity directorates, to help
4 them understand what the gaps are, so that
5 they can prioritize that into their programs.
6 And then the centralized IRB solution down
7 here.

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

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

19 They can turn that back over to
20 our clinical teams to put those back into the
21 clinics, so we have a true bench to bedside
22 establishment. Does that answer your question

1 a little bit, sir?

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

5 LT COL PACKER: Yes, sir.

6 MEMBER STONE: And was determined
7 by in the Congressional NDAA that established
8 you, and provided ongoing funding. Right?

9 LT COL PACKER: Correct.

10 MEMBER STONE: It gives you, your
11 personnel.

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

17 LT COL PACKER: Correct.

18 MS. DAILEY: Okay. All right.

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

22 MEMBER STONE: Okay. So it is up

1 to your experts to hope, using Admiral
2 Nathan's word and yours, to hope that you can
3 convince those people with funding dollars in
4 the individual services to support you?

5 LT COL PACKER: Yes. It is. Now
6 we have models that show success with this
7 type of strategy. In the VA, we're working
8 with the -- looks like you have a question for
9 me -- you want to --

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

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

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

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

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

19 We have theories but that doesn't
20 translate well into science. You need to have
21 science to write a good proposal that will be
22 picked up for funding. Without that

1 fundamental knowledge, I don't think that we
2 will make a lot of progress.

3 One of the thoughts that we've
4 been discussing. We've, part of this network
5 development is that fundamental knowledge
6 building, through a higher order animal model.
7 We don't have a great animal model tinnitus,
8 is, as subjective experience. We don't have
9 an objective means of identifying that
10 clinically.

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

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

1 Is your funding at all fenced for
2 Wounded Warrior care? Or linked directly to
3 it, for ***GWAD10:44:39 or OCO? Is any of
4 your funding, because I believe it comes
5 through the services? It probably comes
6 through the Army's executive agent, and I
7 don't know if it's being fenced. And why is
8 that tactical?

9 LT COL PACKER: It's not.

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

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

22 LT COL PACKER: We're hoping to

1 establish that, and so back to the research
2 productivity, you see we're just still, we've
3 had a couple of projects that have
4 materialized.

5 And through this Grant Development
6 Administration Network, that's what we hope to
7 leverage money through, grantsmanship, but
8 it's just at the start.

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

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

21 That money's going to dry up. And
22 so the closest wolf to the sled right now in

1 the DoD, MHS, is research dollars. That's the
2 closest, that's the lowest hanging fruit.

3 Because as NIH, or another
4 department of the Army, or the Navy, or the
5 Coast Guard has given us grant money, to study
6 these things, and hire personnel, and do
7 research, that may well dry up. And so
8 research may die on the vine.

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

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

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

21 MEMBER PHILLIPS: Let me just ask
22 a simple question from my understanding. So

1 I'm assuming that all the COEs are
2 operational. None of them are funded with
3 research money or, so that's an area that we
4 should address?

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

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

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

17 One, was to help define and
18 identify the problems, the work that needed to
19 be done. But then the second function was
20 once that work was done, once progress was
21 made, they were expected to be people of
22 influence, and in influential places that

1 could help get, very much help get that
2 progress implemented.

3 Even where you talk about the
4 Fitness for Duty here, are your Advisory
5 Boards configured that same way? Or do they
6 have that kind of responsibility that they can
7 help get that implemented even though there
8 may not be specific regulations?

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

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

20 LT COL PACKER: It's a constant
21 battle. I think that one of the other issues
22 that we have, is we work through medical

1 lines. And to, which then have to, the
2 priorities that we elevate through medical
3 lines, have to be prioritized against the line
4 requirements.

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

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

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

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

3 MS. DAILEY: Very quickly.

4 LT COL PACKER: So in summary, I
5 think that considerations for policy changes
6 that create rapid processes, standardize
7 procedures, and policies across the DoDs.

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

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

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

1 members.

2 And we need to be able to make
3 them war ready, by looking at their hearing
4 status, that improves efficiencies across the
5 board.

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

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

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

22 So for us to be able to be an

1 implant center, so that we can treat veterans
2 closer to home, is not happening. We're
3 looking at that, but these generalized MOUs
4 for dual use would be helpful.

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

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

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

21 And then with the single IRB
22 that's developed, we'll still need to develop

1 these IRB agreements for institutional review
2 for a second level assurance at regional sites
3 where we want to do these multi site studies.

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

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

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

21 CO-CHAIR CROCKETT-JONES: Thank
22 you Lieutenant Colonel Packer. We'll take a

1 break until 11, not quite 15 minutes.

2 MS. DAILEY: 11 o'clock, please
3 members if I can get you back.

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

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

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

17 As a joint venture between the
18 Department of Defense and the Department of
19 Veteran Affairs the VCE advocates the
20 development of prevention, medical treatment
21 and research of visual system disorders to
22 improve the health and quality of life for

1 service members and veterans alike.

2 Colonel Gagliano and Dr. Lawrence
3 will be updating the task force on their
4 status since February of 2012 and discussing
5 research activities over the past fiscal year.
6 You can find their brief and there updates in
7 Tab D of your binder.

8 Don, go ahead.

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

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

22 We'd like to begin with a video,

1 we created this video for a congressional
2 briefing that we presented on September 26th
3 on the Hill. And it was designed to provide
4 an informal opportunity to see the integration
5 of the different stakeholders that we have
6 engaged in the work that we're doing. I think
7 it's an important point.

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

14 VIDEO

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

22 It was right when I picked up the

1 handline to tell my battalion commander to
2 make the call that I was about to move and
3 that's when an 82 millimeter mortar round
4 landed five feet over my right shoulder.
5 Instantly I saw a flash and a loud blast of
6 the mortar round.

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

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

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

22 FEMALE PARTICIPANT: We can't

1 replace the eye yet at all. There are
2 numerous endeavors but as to repairing you to
3 be functional again exactly the way you were
4 unfortunately we are not at that point.

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

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

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

20 People who have lost vision don't
21 know how to deal with that and it's important
22 to have a center, a place, where they can feel

1 there's hope. Where someone will be there to
2 take care of them. To help them figure out
3 how to regain their lives. And to bring back
4 as much of the joy that they felt before they
5 were injured to their lives.

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

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

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

20 MALE PARTICIPANT: In my opinion
21 the Veterans Administration visual
22 rehabilitation programs are the best in the

1 world. There are inpatient facilities that
2 have an incredible staff. And really an
3 incredible track record of rehabilitating the
4 service men and women to the fullest extent
5 that that individual serviceman or woman would
6 like.

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

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

18 We're not just looking at how can
19 we make you able to walk across the street to
20 how do you move forward to getting a degree
21 and taking on challenges of with new
22 communication tools that will allow people to

1 truly live a fully functional life.

2 In order to better understand what
3 we're doing on the battlefield we have to know
4 what's happening to individuals when they
5 leave the service or they're transferred to
6 the care of the Department of Veterans
7 Affairs.

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

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

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

20 MALE PARTICIPANT: What they're
21 doing in terms of developing a system that can
22 follow patients, can follow problems, can

1 follow events over many many years, analyze a
2 complex data set and give you very clear
3 answers to very important questions is truly
4 profound.

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

11 We really can make a difference in
12 peoples lives. We really can find new ways of
13 restoring vision and new ways of saving
14 vision.

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

20 MALE PARTICIPANT: Most of the
21 soldiers I've taken care of, and I've been at
22 Walter Reed since the beginning of the war and

1 taken care of hundreds if not thousands of
2 injured service men and women, is that they're
3 attitude is really actually incredible.

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

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

11 VIDEO ENDS

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

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

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

1 presentation and the slides.

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

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

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

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

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

1 mission areas.

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

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

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

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

1 If you look to the chart on the
2 right it describes in detail some of the areas
3 of eye injury and the numbers associated with
4 them.

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

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

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

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

1 Most of our injuries are in their
2 early 20s, they are expected to live for many
3 decades and we will need to care for them the
4 best way possible.

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

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

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

19 And the other, the brain trauma,
20 the TBI associated vision dysfunction
21 including the optic nerves. The visual
22 processing areas of the brain, cranial nerves

1 and would include visual field losses too.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 The VCE has led the way for the
22 inclusion of Fox shields into the individual

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

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

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

19 The picture on the bottom right,
20 you see a soldier being bandaged and you see
21 the bandage being put around the patient's
22 left eye. And if you look at you say,

1 probably no Fox shield, but interestingly the
2 patient has on glasses and I know it's a small
3 picture.

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

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

15 CO-CHAIR NATHAN: Dr. Lawrence?

16 DR. LAWRENCE: Yes.

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

20 DR. LAWRENCE: Retired Colonel
21 Robert Mazzoli really was working that through
22 his contacts, although he's an Army Colonel.

1 CO-CHAIR NATHAN: Prophet Without
2 Honor.

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

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

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

19 COL GAGLIANO: If I may answer
20 that question. We identified this as an issue
21 in working with the joint theater trauma
22 registry team. We have a CPG that is used,

1 it's one of the 33 CPGs with the JTS, used to
2 be the JTS not the Joint Trauma System.

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

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

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

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

1 place.

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

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

14 We were able to get both of those
15 modified through the CoTCCC accepting that as
16 one of their initiatives. They then pushed
17 for the Defense Medical Material, DMMA, I
18 think it is, or the logistics group to
19 identify this as a need.

20 Working with the combat developers
21 of each of the services. Then that's why
22 we're still finalizing it with the Army. In

1 getting that identified as a requirement for
2 the IFAK.

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

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

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

14 COL GAGLIANO: I don't know that I
15 can answer that. I'll probably answer by
16 saying we started working with Jim down at the
17 director of combat developments earlier than
18 any other service.

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

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

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

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

18 Not bad people, good passionate
19 people, just systems issues that need to be
20 overcome. And we want to help you mow down,
21 that's why we're critically interested in how
22 when you find good science and you change the

1 game in eye care and injury prevention and
2 treatment, how that gets transmitted rapidly
3 to the services.

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

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

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

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

16 MEMBER STONE: Would you like to
17 go to that now?

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

20 CO-CHAIR NATHAN: The crux of what
21 we want from you is how we can translate what
22 you discover, what you find, what you

1 determine as best practice into the best care
2 for the recovering warrior in the acute or
3 convalescent stages.

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

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

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

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

22 We work through consensus at the

1 moment and we build consensus predominantly
2 with organizations at that are empowered. I
3 don't believe we are empowered at the moment
4 to makes change or act as change agents.

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

14 There is no authority to enact
15 that at the moment. I hate using the word
16 authority because everybody gets shied away
17 from that. So we wrote down here enabling, us
18 to act as agents of change.

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

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

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

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

15 Rather than simply a relationship
16 based because of the respect that we all hold
17 the two of you, and your teams, a relationship
18 based process. How should this look in the
19 future as DoD redesigns it's defense health
20 program?

21 CO-CHAIR NATHAN: I'll answer that
22 for you. I think really we need to, as we

1 embark on the new organization and General
2 Stone, where health affairs is going to
3 reinvent itself under policy with the DHA
4 under execution. What's lacking?

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

9 And you're still waiting to get
10 over some of the bureaucratic hurtles of the
11 Army, which will undoubtedly get there too.
12 But that's the good will mechanism.

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

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

1 services.

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

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

15 But we don't have a codified
16 system that allows you to, if I said to you
17 who are you going to call to this put into the
18 services tomorrow.

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

1 COL GAGLIANO: That's exactly
2 right, sir.

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

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

15 But one of the things, and I think
16 this group is going to get a report at some
17 point on the interagency care coordination
18 council.

19 One of the things that group has
20 been charged with is for the three services in
21 VA to come up with a single overarching policy
22 and try to figure out how to get a DoDI and a

1 VA directive in one. And that's got about 30
2 days.

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

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

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

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

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

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

14 DR. LAWRENCE: Should I move on?
15 Thank you. Sort of on the same topic, on the
16 TBI associated vision dysfunction, we're
17 developing consistent based clinical
18 recommendations.

19 We're putting together SMEs,
20 Subject Matter Experts from VA, DoD and
21 private sector and academia. And again these
22 clinical recommendations have the same

1 approval difficulties. It's the same approval
2 environment.

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

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

12 And we're also working with
13 Harvard Medical School to develop an ocular
14 trauma mannequin. It also reduces the need
15 for the use of live animals in surgery
16 laboratories, so that is another advantage of
17 moving ahead on those initiatives.

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

1 forces.

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

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

12 In terms of TBI associated vision
13 dysfunction the vision care services
14 coordination services initiative is something
15 that we do to help facilitate appropriate
16 referrals for anybody with an eye or vision
17 injury across the DoD, VA and private sector.

18 Most of our work of course is VA
19 and DoD and the DoD does not do blind rehab so
20 patients do need to be transferred over across
21 the departments to the Department of Veterans
22 Affairs for blind rehabilitation and then

1 back. These are active duty service members.

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

6 In terms of quality of life, the
7 vision care services coordination really does
8 link service members and veterans to diverse
9 vision services throughout the military health
10 service, VA and other federal and civilian
11 agencies.

12 We have established several
13 stakeholder work groups to assess technology
14 camps for service members and veterans.

15 And we have produced two critical
16 updates, published in Federal Practitioner
17 which is a circulation of about 35,000, goes
18 to all federal providers. Some of the issues
19 facing people with visual impairment as a
20 result of their service.

21 The pictures, the picture on the
22 left is a picture of U.S. Navy Lieutenant Brad

1 Snyder. He was the U.S. paralympic team
2 winner of two gold medals in London in
3 September of 2012. And one silver medal.

4 Interestingly he won his gold
5 medal, the 400 meter freestyle on the one year
6 anniversary of the IED injury that blinded
7 him.

8 We have coordinated his care
9 across the system and he is a really wonderful
10 success story for getting back his life after
11 a blinding injury.

12 The picture on the right is of a
13 veteran working at the American Lake Rehab
14 Center near Madigan in Tacoma, Washington.
15 You'll see he's got a baseball cap on, this is
16 very typical of TBI patients.

17 They're very light sensitive,
18 sensitive to glare. And they often walk
19 around with baseball caps and of course he's
20 got good glasses that are perfect for the
21 distance he is away from the computer which is
22 quite close.

1 The computer screen is enlarged,
2 you can see how big the letters are. And you
3 can see there's a reverse black/white color
4 inversion on the computer terminal there. And
5 that's very typical of TBI patients because
6 the white screen causes a lot of glare.

7 We've worked with consensus panel
8 development for practice recommendations for
9 the care of these TBI-associated visual
10 dysfunction patients and we're establishing a
11 critical clinical research priorities.

12 In terms of our research program
13 which we have titled the Vision Research
14 Program, VRP, our goal is to foster innovative
15 and relevant research based on several focus
16 areas. Vision dysfunction after concussion
17 injury, TBI, protection against environmental
18 hazards. Modulating the ocular response to
19 injury. Total robotics and simulation.
20 Modulating ocular response to disease. Ocular
21 and visual restoration, and refractive surgery
22 and education and training.

1 The VRP is a requirement space
2 program, it includes 42 research grants in 17
3 states and two foreign countries including UK
4 and Israel.

5 We've divided a lot of the
6 research programs into two slides here so the
7 next two slides. The treatment of traumatic
8 visual injury and visual restoration.

9 In terms of traumatic visual
10 injury there's a current portfolio of 17
11 active projects with an amount of a little
12 over \$22 million.

13 Projects include designing ocular
14 membrane patches and adhesives for primary
15 management of ocular trauma and bio-compatible
16 membranes to guide ocular reconstruction.

17 Our performance highlights, there
18 have been 21 presentations, 14 publications
19 and two patent applications from some of this
20 research.

21 And the top right is looking at a
22 wound healing of the cornea using contact

1 lenses. This is in an animal model and the
2 bottom, if you can see, there's a corneal scar
3 here centrally which might be typical, you'd
4 see with shrapnel. And looking at some wound
5 healing capabilities for corneal injury.

6 In terms of vision restoration,
7 current portfolio is 14 active projects, \$18.6
8 million. Projects including assessing
9 regenerative capability of bandage lenses
10 which self-adhere to the surface of the eye.
11 And you can see the contact lenses above in
12 the two top pictures.

13 And sensory substitution
14 strategies for enabling the perception of
15 visual information. The bottom two pictures
16 are pictures about the brain port. I don't
17 know whether any of you have heard of that.

18 We often call it the lollipop.
19 And what happens is a little camera is in the
20 glasses and a processor converts the vision
21 image into impulses that are sent through an
22 electrode array to a device that is put in on

1 the patient's tongue.

2 The sensory stimulation to the
3 tongue is eventually converted, after six to
4 eight weeks of training into a visual stimulus
5 and on PET scans and occipital cortex which is
6 the part of the brain that accepts visual
7 impulses light up. And this is obviously in
8 connection to the tongue.

9 It's pretty amazing technology.
10 There are a lot of other vision restoration
11 projects out there.

12 The registry after all these
13 interesting clinical projects that I've talked
14 to you about, the vision registry might seem
15 a bit bland.

16 But this is, as Dr. David Park,
17 the American Academy of Ophthalmology said,
18 and Dr. Ron Hopping from the America
19 Optometric Association, stated in the video
20 this probably the most important thing for
21 developing longitudinal outcome analyses of
22 our vision-injured servicemembers and

1 veterans.

2 And will support prevention,
3 mitigation, treatment and rehabilitation of
4 the injuries and disorders of the visual
5 system.

6 In the interest of time I think I
7 won't spend too much time on this except to
8 say that our timeline -- we had a pilot effort
9 was approved in September of 2010.

10 And now as of last month we have
11 the vision registry pilot has been classified
12 as an ACAT IV program. That time frame is 15
13 months and it usually takes four to five years
14 for an IT program to reach that status.

15 We've been working really, really
16 hard and we have made some great achievements
17 on the vision registry so that we can really
18 have some good data analytics to move ahead
19 with the care of our service members and
20 veterans.

21 CO-CHAIR NATHAN: Dr. Lawrence,
22 what is your mechanism for, and maybe you're

1 getting to it in the next slide. But for
2 networking with sister centers of excellence
3 eye institutes, world-class places in Boston,
4 Palo Alto, Durham, Zurich, that are doing
5 avant-garde, new cutting edge things.

6 How do you stay abreast of that
7 and how do they work with you?

8 DR. LAWRENCE: Well, a lot of it's
9 personal communications. We have our ear to
10 the rail. And we have good collaborative
11 relationships with academia.

12 CO-CHAIR NATHAN: So the NICoE
13 this afternoon will tell the folks that what
14 they do is they have funding, some of it
15 governmental, some of it private partner,
16 where they host conferences. And they invite
17 the leading researches and authors from
18 various TBI, PTS centers of excellence
19 throughout the world in private and academic
20 sectors, to come and share what's new in a
21 symposium.

22 And they sort of leverage

1 patriotism to get these folks to come and talk
2 about what's late and great. Do you have
3 funding lines for that? Are you able to host
4 conferences or bring people in or host
5 symposia?

6 DR. LAWRENCE: Most of our funding
7 in that arena has come actually from the VA.
8 And our first few years, we hosted to big
9 symposia on visual dysfunction related to TBI.

10 And that was in fiscal year 2009.
11 And then in fiscal year 2010 we hosted another
12 dual sensory, so hearing and vision loss that
13 last one was in San Antonio. And we had
14 academia, very much what you're talking about.

15 Of course in this environment with
16 travel and conferences and post the GSA
17 debacle, there have been very severe
18 restrictions and cutbacks.

19 In August of 2011 we were able to
20 do a very small conference looking at certain
21 aspects of visual, it was really not a
22 conference; it was a working group.

1 To get together SMEs from across
2 private sector, academia, VA and DoD together
3 to talk about technology gaps and sports
4 adaptation and driving and some of the other
5 issues that are facing our service members and
6 veterans.

7 And then in fiscal year 2012 we
8 did not have any funding to have any of those
9 kind of activities. We continue to work on
10 those working groups. Leveraging other
11 technology with VTCs and conference calls and
12 emails.

13 So we're really trying to move
14 ahead despite the current environment we're
15 working in.

16 CO-CHAIR NATHAN: Thank you. And
17 I appreciate your passion on that. The
18 concern is that there's somebody right now
19 doing something in a lab or a research center
20 or a university that's a better mousetrap, and
21 we don't know about it.

22 DR. LAWRENCE: The biggest eye

1 research meeting in the world and with
2 researchers from truly global eye research, is
3 the ARVO meeting, the Association for Research
4 in Vision and Ophthalmology, and that is the
5 largest eye and vision research meeting in the
6 world.

7 We have been able to attend that
8 and Colonel Gagliano has given a big well
9 attended talk at that about some of our DoD
10 initiatives encouraging some of the best and
11 brightest minds in the world to focus on some
12 of the issues that we, the Department of
13 Defense and Department of Veterans Affairs
14 really want to focus on.

15 It's I think at 6:00 a.m. and many
16 researchers don't get up at that time often
17 but it's packed. Standing room only the last
18 two years.

19 And so I think that we've really
20 made big efforts, I've been in academics and
21 Colonel Gagliano has run several of the big
22 research institutes across the DoD. So we're

1 very well connected, thank goodness, in that
2 arena.

3 Okay. Staffing and strategic
4 communications. Our staffing is virtually the
5 same between February 2012 when we had the
6 honor of coming here before you last year and
7 now, 14.6.

8 In terms of strategic
9 communications, VCE website was transitioned
10 to the consolidated health.mil website. And
11 we have several updates that are planned for
12 this summer for health professionals only
13 link. And to synchronize all vision-related
14 messages across the enterprise.

15 Tools to develop external
16 partnerships in that may be leveraging the
17 health professionals only link. And to reach
18 all of our stakeholders.

19 We want to be 508-compliant and we
20 want to be actually put a plus there because
21 we want to be better than just compliant.

22 We want to really have people who

1 are visual impairment use our website and tell
2 us what can make our website easier for
3 someone with visual impairment to navigate.

4 We are building a suite of VCE
5 communication materials, including an annual
6 report that we'll have out in the next couple
7 of months. A strategic communications plan
8 and an update to the VCE strategic plan
9 planned to come out this summer.

10 In terms of regional locations,
11 we've had presence here in the national
12 capitol region since fiscal year '09.
13 Currently we have two offices, one in Crystal
14 City, just down the road here with proximity
15 to the National Center for Telehealth &
16 Technology or T2.

17 And then another office up in
18 Bethesda at the Walter Reed National Military
19 Medical Center that just opened in the spring
20 of 2012.

21 And of course that has wonderful
22 proximity to the National Intrepid Center of

1 Excellence, or NICOE. Uniform Service
2 University of Health Sciences and NIH,
3 National Institutes of Health.

4 We have a small office that two
5 people share at Tacoma Madigan Army Medical
6 Center that has proximity to the American Lake
7 VA Blind Rehab Center and the VA Puget Sound
8 Health Care system.

9 And we are hoping to open a
10 presence in San Antonio at the San Antonio
11 Military Medical Center. And that would have
12 some co-located or at least proximity to the
13 Hearing Center of Excellence at the Extremity
14 and Amputation Center of Excellence, the
15 surgical research and the center for the
16 intrepid.

17 MEMBER STONE: Dr. Lawrence.

18 DR. LAWRENCE: Yes.

19 MEMBER STONE: You discussed the
20 fact that the Department of Defense does not
21 do blind rehabilitation. As the Department of
22 Defense develops additional traumatic brain

1 injury centers, additional centers of
2 excellence around its system, how should we
3 view the relationship to visual rehabilitation
4 for the traumatic brain injured across our
5 system?

6 DR. LAWRENCE: Vision
7 rehabilitation for the TBI patients is
8 different than the more traditional vision
9 rehabilitation, blind rehabilitation, we call
10 it in the VA.

11 The visual dysfunction, often a
12 TBI patient will see 20/20 on an eye chart and
13 yet they can't read. They are very much
14 bothered by bright lights in a work
15 environment.

16 Bright lights driving, so if
17 they're living in a northern climate and
18 they're trying to get home from work at 4
19 o'clock in the afternoon and headlights are on
20 they may not be able to drive. Many of them
21 have difficulty with tracking and
22 microstrabismus.

1 And so the visual dysfunctions
2 associated with traumatic brain injury are
3 very different than the typical vision loss we
4 see with eye injuries. And both the VA and
5 the Department of Defense are grappling with
6 this.

7 And we are working on clinical
8 recommendations for the first ever, clinical
9 recommendations for vision dysfunction related
10 to TBI.

11 MEMBER STONE: So you're the
12 experts then that do visual rehabilitation as
13 part of traumatic brain injury then exist
14 within the Department of Defense or solely
15 within the VA?

16 DR. LAWRENCE: I don't know how to
17 answer that. It's not really my decision but
18 I think that would make sense.

19 MEMBER STONE: We've made a
20 decision that you appear comfortable with that
21 blind rehabilitation is solely done within the
22 Veterans Administration health care system.

1 Should we, as we develop the
2 additional traumatic brain injury centers,
3 partner with the VA or should we develop
4 additional capacity for brain injury
5 rehabilitation?

6 COL GAGLIANO: Sir, I think the
7 former is the correct solution. Because it
8 keeps the capability in alignment with the
9 long term outcome. And I'm not a big fan
10 personally of long term rehabilitation
11 embedded in the DoD.

12 As a matter of fact VA's
13 rehabilitation capability was started in 1947
14 when the Army ophthalmologists and at the
15 rehabilitation center forced the function of
16 starting that first blind rehabilitation
17 center.

18 And that has grown as a
19 capability. It was because there wasn't
20 really a good system for sustaining it. And
21 I don't think we need to relearn that lesson.

22 But I do believe that there is the

1 opportunity to actively embed VA capability as
2 we have done at Walter Reed. When I first
3 took this job one of the first questions asked
4 of me on the Hill was, why do blinded service
5 members get better care when they're in the VA
6 system than they are in the DoD system.

7 And the point they were trying to
8 get at was vision rehabilitation starts fairly
9 early in the polytrauma centers but it doesn't
10 start fairly early in our, like, CFI or MATSI
11 centers.

12 So we brought in that capability
13 to the MATSI at Walter Reed so that the
14 initial phases of blind rehabilitation can
15 occur while people were rehabilitating from
16 their amputation or extremity injuries.

17 I think there's a good model,
18 there's still some work to do, because the DoD
19 does not recognize blind rehabilitation as a
20 specialty.

21 They can't document on their own
22 in the health record. They have to go through

1 an occupational therapist or another care
2 provider.

3 And there are some occupational
4 therapists who are very good at vision
5 rehabilitation occupational therapy, as well
6 as physical therapists. It's a new growing
7 sub-specialty.

8 But having this blind
9 rehabilitation capability embedded in the VA
10 and integrating it is another chance for us to
11 capitalize on the capabilities of both
12 systems.

13 CO-CHAIR NATHAN: So we've got to
14 wrap up pretty soon. But what I hear General
15 Stone asking and I hear you saying is, you do
16 not believe there is unmet need in the DoD
17 care system for blind rehabilitation.

18 COL GAGLIANO: I do not. But
19 maybe you need to shift some resources at
20 times as we evolve the system. But I don't
21 believe that it will result in an unmet need.

22 CO-CHAIR NATHAN: So any unmet

1 need that you perceive should be migrated as
2 a joint process with VA?

3 COL GAGLIANO: Yes, sir.

4 CO-CHAIR NATHAN: Got it, okay,
5 thank you.

6 DR. LAWRENCE: I think we feel
7 that way because there's also economies of
8 scale. Why have two systems?

9 Next slide is our stakeholder
10 engagement.

11 MS. DAILEY: I'm going to need you
12 to wrap. So maybe we can --

13 DR. LAWRENCE: Why don't we move,
14 I just wanted to say here that service members
15 and veterans are the center of everything we
16 do. And that is our absolute focus.

17 The next slide just speaks to our
18 collaborative efforts for these injuries from
19 the last decade of conflicts. And I'll move
20 to Slide 17 and I'll let Colonel Gagliano --

21 Thank you very much for the
22 opportunity to be here this morning and here's

1 Colonel Gagliano to talk about the last slide.

2 COL GAGLIANO: Thank you, Mary.

3 So we've talked a bit about this slide. The
4 number two issue is really about what gives
5 the ability for the centers of excellence, I'm
6 not speaking just about the Vision Center of
7 Excellence. I think all of us have the same
8 struggle to act as change agents across the
9 system.

10 The first bullet addresses what I
11 think has been the real strength of the VCE
12 and that is the integration of VA and DoD.
13 Not just in language or in title but in
14 action.

15 Dr. Lawrence is an ophthalmologist
16 in the VA and at the moment about half of our
17 staff is from the VA. And we fully integrate
18 expertise to a common goal of the Vision
19 Center of Excellence.

20 The last one talks about something
21 that Dr. Packer was referring to in trying to
22 facilitate opportunities for education for

1 research, in particular clinical research and
2 the centralized IRB process that he's
3 described that we fully endorse and hope to
4 actually cap piggyback on the work that he's
5 done with that.

6 Because you cannot move from the
7 research program that Dr. Lawrence described
8 to an actual implementation without some means
9 of working through the acquisition and market
10 approval process for these great devices,
11 great therapeutics that we have evolving from
12 our research program.

13 We have to be full participants in
14 that case. And you're not going to be able to
15 do that without some means of conducting
16 multi-center clinical trials. That's part of
17 our big initiative in the next couple of years
18 to evolve that.

19 I just want to make one more
20 point. We talked about vision as a program
21 for readiness. Right now the refractive
22 surgery program is, I think, the only surgical

1 intervention that is performed on service
2 members to enhance their readiness.

3 Vision readiness is a critical
4 component of battlefield readiness. And those
5 of you who have had refractive surgery can
6 clearly testify to that.

7 We stay actively engaged with that
8 program and the results of what they're
9 working on. And that's one of our key areas
10 of research that we are working at.

11 With that, I'll conclude and open
12 for any questions if we have time.

13 CO-CHAIR NATHAN: Thank you very
14 much. The research you're doing with the
15 being able to put sensors on the tongue and
16 have them eventually communicate to the
17 occipital lobes that translate into visual
18 sensation is amazing.

19 And what I've learned from that is
20 if I stick my tongue out at somebody now I can
21 tell them I'm just trying to see them better.

22 COL GAGLIANO: I know I'm out of

1 time but you know I was in London with an
2 exchange with the Blinded Veterans
3 Association. I do want to acknowledge Mr.
4 Michael O'Rourke, who's in the audience
5 representing the BVA.

6 They have been a very strong
7 associate partner, a stakeholder. It's one
8 that we're lucky to have a VSO that is really
9 dedicated to vision. And they have helped us
10 a lot in so many ways.

11 But we made an exchange visit with
12 blinded veterans of the UK and the blinded
13 veterans of the U.S. and I was asked to
14 accompany them.

15 And we had a visit to Moorfield
16 Eye Hospital, one of the leading hospitals in
17 the world. And the Air Force, UK Air Force
18 ophthalmologist in the audience asked if we
19 were going to fund the concluding part of that
20 project.

21 It was almost passing through the
22 FDA final approval. And they were stranded,

1 they were not able to move it forward and the
2 answer is yes. It was one of our selected
3 research projects to continue to push.

4 Because it is really the only
5 current method for vision restoration other
6 than implant. Other than surgical methods.
7 There's wonderful opportunity in the future
8 that's happening. But they were looking for
9 us to help fund that.

10 So they in the UK and the company
11 brain port could actually bring this to final
12 FDA approval. That's the impact that we've
13 been able to have with our research program.

14 MS. DAILEY: Thank you, Colonel
15 Gagliano, thank you, Dr. Lawrence. I hope to
16 see you again next year with more good
17 information.

18 Ladies and gentlemen, we are at
19 lunch right now. I know some of you have
20 phone calls you need to make. Need some
21 privacy so I'd like to ask everyone to move
22 either to the lunch room, my staff will take

1 the members down to the lunch room.

2 And I would like the rest of the
3 room cleared out, please. And we will see you
4 back here at one o'clock. And Dr. Billie
5 Randolph will be here to talk to us.

6 (Whereupon, the above-entitled
7 matter went off the record at 12:07 p.m. and
8 resumed at 1:01 p.m.)

9 MS. DAILEY: So ladies and
10 gentlemen, we have, we'll be starting here in
11 just a minute with Dr. Randolph. But what I
12 would like to do right now as we wait on
13 Admiral Nathan, is I would like to do
14 introductions for those individuals who were
15 not here this morning.

16 So I would like to go around the
17 table. And we'll start with Mr. Drach. And
18 if you would introduce yourself and we'll put
19 you on the record for us, if you please. And
20 a little more detail like this morning, Tech
21 Sergeant Eudy doesn't know you. Major General
22 Mustion doesn't know you, so a little more

1 detail than, I'm Mr. Drach.

2 MEMBER DRACH: Thank you. My name
3 is Ron Drach. I'm one of the non-DoD Members
4 and I'm retired from the Department of Labor
5 a couple of years ago. And I'm doing my own
6 consulting and am very, very pleased to be
7 here. I'm sorry I missed this morning.

8 CO-CHAIR CROCKETT-JONES: No, I
9 think you have to include he's also the
10 repository of a lot of information on not only
11 Department of Labor activities, but other
12 vocational rehab opportunities. And he's a
13 gold mine. So don't let him get away with
14 that little introduction.

15 MEMBER MUSTION: I'm Major General
16 Rick Mustion. I'm currently the commanding
17 general of the Army's Human Resources Command
18 down at Fort Knox, Kentucky. And I apologize
19 for being late, but I got stalled by the
20 weather a little bit last night and again this
21 morning.

22 In a prior life I was the Director

1 of Military Personnel Management for the Army
2 and the Pentagon where Rich Stone and I were
3 battle buddies. In going back, I served as
4 the CG of the Army's Physical Disability
5 Agency in a prior life.

6 And then Denise and I crossed
7 paths when I was Dr. Chu's military assistant
8 a number of years ago when he was the
9 Undersecretary for Personnel Readiness when I
10 saw the first chart about the cost of the
11 defense health program and how it was going to
12 bankrupt the Department of Defense. And so
13 that's kind of my background.

14 MS. DAILEY: Major General Stone,
15 you weren't here this morning. We didn't have
16 a chance to introduce you.

17 MEMBER STONE: I'm Rich Stone.
18 I'm the Army's Deputy Surgeon General. I'm a
19 Reserve guy by commission. Been back on
20 active duty now for three years, in this
21 billet for the last two and a half years. And
22 physician by training and although I have not

1 gotten much chance to practice for the last
2 number of years.

3 MEMBER MALEBRANCHE: I'm Karen
4 Malebranche and I was with the Army for 30
5 years. I've been now with the VA for ten.
6 I'm the Director for Interagency Health
7 Affairs and been on the task force like this
8 now going on my second year.

9 And happy to be here. I apologize
10 also for being late. And I'm going to
11 apologize in advance that I seem to be playing
12 tag team with Captain Evans here, so.

13 CO-CHAIR CROCKETT-JONES: Okay.
14 We're going to hear from Dr. Barclay Butler,
15 the Director of Interagency Program Office.
16 The IPO focus is, no. Where are we? It's not
17 mine, is it? He's here. I don't, I'm like
18 missing a page or something. Here we go,
19 extremity trauma. That's yours.

20 MALE PARTICIPANT: Just in time.

21 CO-CHAIR CROCKETT-JONES: Yes, you
22 saved me.

1 CO-CHAIR NATHAN: Dr. Randolph.

2 DR. RANDOLPH: Yes, sir.

3 CO-CHAIR NATHAN: Welcome. Thank
4 you for coming back to update us. As
5 everybody here knows, there are two major
6 signature injuries that affect our wounded
7 warriors.

8 Extremity injury with amputation
9 and loss of function. And that's become very
10 prevalent as a result of better body armor and
11 as a result of much better on-scene
12 stabilization of life threatening injuries so
13 people are surviving with loss of extremities
14 that never have before. And the other is the
15 traumatic brain injury part and parcel of post
16 traumatic stress as well. The quote-unquote
17 invisible wounds of war.

18 So today we welcome Dr. Randolph
19 who's the Deputy Director of the Extremity
20 Trauma and Amputation Center of Excellence.
21 The EACE is a joint effort between the
22 Department of Defense and the Department of

1 Veterans Affairs to promote excellence in care
2 and research related to traumatic extremity
3 injuries and amputations.

4 Dr. Randolph is going to provide
5 us an update on the status since February of
6 2012, and discuss research activities over the
7 past fiscal year. You can find her updates in
8 Tab B of your binder. Dr. Randolph, thank you
9 very much for being here today.

10 DR. RANDOLPH: Thank you, Admiral
11 Nathan, Ms. Crockett-Jones and other
12 distinguished members of the Recovery Warrior
13 Task Force. It's certainly a pleasure for me
14 to be here this afternoon and to be able to
15 update you on the work that's being done in
16 the Extremity Trauma and Amputation Center of
17 Excellence.

18 Because my DoD counterparts are
19 located in San Antonio, Texas, and were unable
20 to be here, I have asked that we try to dial
21 them in. We just did a sound check. They can
22 hear you and can assist with any questions

1 that I might not be able to answer. Mr.
2 Shero, did you want to make a comment?

3 MR. SHERO: Thank you, Dr.
4 Randolph. And I just wanted to express my
5 gratitude to the Recovering Warrior Task Force
6 and you ladies and gentlemen for your interest
7 in the Extremity Trauma and Amputation Center
8 of Excellence and again to thank Dr. Randolph
9 for providing this briefing this afternoon.
10 Over.

11 DR. RANDOLPH: All right. Thank
12 you. This afternoon's agenda is up here. We
13 believe that we've covered all of the
14 information that you've requested for this
15 briefing. But if something is not clear or
16 you don't feel that we have covered it
17 sufficiently, please don't hesitate to ask.

18 Like I said, we're trying this
19 with Mr. Shero and hopefully if necessary he
20 will be able to answer any questions that I
21 can't. As Admiral Nathan said, we've had a
22 number of major limb amputations since this

1 conflict, these conflicts have begun. As of
2 January the 2nd, there were 1,581 individuals
3 who have suffered major limb amputation.

4 The chart before you shows a
5 breakdown of these patients that have been
6 treated within the three individual advance
7 rehabilitation centers. Some of the patients,
8 as you can see if you add up the numbers at
9 the bottom, have been treated at more than one
10 of the centers, meaning initially starting
11 perhaps at Walter Reed in Bethesda, then being
12 transferred to San Diego.

13 There are currently 257 of these
14 amputees that are receiving care in one of the
15 three centers right now. And nearly 1,200 of
16 them have already transitioned into the VA and
17 are receiving care in the VA. So we think
18 that's a very positive thing and we are
19 working very closely together to ensure this
20 continuum of care.

21 Two hundred and seventy five of
22 these amputees or roughly 17 percent have

1 suffered a major, I mean upper limb, major
2 amputation. And of the number the 1,581, 491
3 of them are multiple amputees of which 44 have
4 sustained triple amputation and five have lost
5 all four limbs.

6 This map shows the DoD and VA
7 amputation care sites. We have the Military
8 Advanced Training Center in Bethesda. The
9 Center for the Intrepid in San Antonio and the
10 Comprehensive Combat and Complex Casualty Care
11 in San Diego. The stars are not showing up
12 on, I hope they are on your maps. Okay.
13 They're coming in, sorry.

14 We also have the seven VA regional
15 amputation centers, including the
16 Servicemember Transitional Advanced
17 Rehabilitation Program, the, go back to the
18 pointer here, the STAR program in Richmond
19 that is directed by the VA Amputation System
20 of Care, Medical Director, Dr. Webster.

21 The priority for the patients in
22 the STAR program in Richmond for the VA are

1 the service members that have sustained
2 amputation along with another injury, such as
3 traumatic brain injury. There they receive
4 not only ongoing medical rehabilitation, but
5 vocational rehabilitation as well and a work
6 program. So we're very proud of that program.
7 Focus again is trying to get these service
8 members ready for reintegration into the
9 community and into the work force. In addition
10 to the seven regional amputation centers,
11 there are 14 VA polytrauma amputation network
12 sites. These are located in the, identified
13 by the yellow stars. I'm sorry, the blue
14 stars.

15 And we have three additional sites
16 that are proposed and have been tentatively
17 approved for funding this year. They are San
18 Antonio, San Diego and Salt Lake City. The VA
19 has identified the additional funding for
20 these sites to bring them to the polytrauma
21 amputation network site status because of the
22 increased need in the community for the

1 transitioning service members and the Salt
2 Lake City site because of the osseointegration
3 trials that are set to begin this year.

4 We envision the Extremity Trauma
5 and Amputation Center of Excellence as the
6 nation's premier source of information for the
7 mitigation, treatment, rehabilitation and
8 research for service members and veterans with
9 traumatic extremity injury. And we accomplish
10 this by implementing a comprehensive strategy
11 and plan for conducting clinically relevant
12 research fostering collaboration across a
13 broad spectrum of national and international
14 entities.

15 Our lines of focus, our lines of
16 effort are focused on research and
17 surveillance; clinical care which encompasses
18 treatment, rehabilitation and mitigation;
19 global outreach informations, informatics and
20 information technology as well as leadership.

21 CO-CHAIR CROCKETT-JONES: Can I
22 ask you a quick question? Do you all consider

1 your urogenital loss to be part of your, under
2 your umbrella?

3 DR. RANDOLPH: I'm sorry, ma'am.
4 What was the first part?

5 CO-CHAIR CROCKETT-JONES: Do you
6 all consider urogenital losses to be under
7 your umbrella?

8 DR. RANDOLPH: No, we do not.

9 CO-CHAIR CROCKETT-JONES: Okay.

10 CO-CHAIR NATHAN: I think that's a
11 great point too because I'm sure most of the
12 members of the task force are aware and the
13 stats vary, but now with the dismantled
14 mission in Afghanistan, the fact that most
15 people are losing their limbs as a result of
16 direct impact from the ground as opposed to in
17 vehicles.

18 And it's more common now to have
19 multiple amputations than it is to have a
20 single amputation from previous parts of the
21 conflict. About 15 to 20 percent of the
22 people who sustain these severe amputations,

1 usually bi-lateral lower extremity
2 amputations, about one-fifth also experience
3 a completely debilitating genital, urinary,
4 either loss of function or loss of anatomy.

5 And so there's been a great effort
6 by the urology groups working with the trauma
7 surgeons to try to figure out preventative
8 measures and then restorative measures.

9 DR. RANDOLPH: I agree. It is a
10 good point. I made a note here I need to
11 check to see how we can, you know, if there is
12 a way to collaborate with urology to enhance
13 that, so.

14 MEMBER STONE: So the Army about a
15 year and half ago completed a complex battle
16 injury task force work. And you're welcome to
17 share that report.

18 DR. RANDOLPH: Okay. Thank you
19 very much. Have to be coordinated up here to
20 do this. All right. The next slide just
21 depicts our operational authority documents.
22 The Duncan Hunter National Defense

1 Authorization Act in FY 09, authorized the
2 establishment of the Joint Center of
3 Excellence.

4 The Army was designated an Army
5 medical department, the lead component for the
6 EACE in 2009. The decision was made in 2011
7 to locate the EACE executive office in San
8 Antonio. We submitted a concept of operations
9 and that was approved in January of 2012.

10 Mr. Shero was appointed as the
11 director of the EACE in January of 2012. And
12 once the VA approved the four staff members to
13 support the EACE in early 2012, I was
14 appointed as the director the end of July.

15 This slide is just showing the
16 EACE governance and reporting chain going up
17 both the VA and then the Department of Defense
18 with the governance in the middle. This is
19 the current defense health program level of
20 funding that's been secured through the POM
21 process. As you can see it's fairly
22 consistent across the years.

1 This is our EACE organizational
2 chart showing the executive office, which I
3 said was in San Antonio, but is not depicted.
4 My office is in Crystal City and I've actually
5 been co-located with the Vision Center of
6 Excellence, which we do a lot of collaboration
7 between the Centers of Excellence. And we
8 felt it was important to have a member of our
9 team in the DC area.

10 So I am located in Crystal City.
11 We have the Clinical Care or the EACE
12 executive office, let me go back, there are
13 six DoD positions in there, two VA, myself and
14 an administrative assistant. We have the four
15 divisions. The Clinical Care which will have
16 a DoD and VA deputy director for the Clinical
17 Care.

18 We have the Clinical Informatics
19 and Technology. We will have two personnel in
20 that division. The Global Outreach and we
21 will have two personnel. And finally we have
22 the Research and Surveillance division which

1 you can see we will have researchers in the
2 three advanced rehabilitation centers. So
3 clinical researchers embedded in those three
4 advanced rehab centers in Bethesda, San
5 Antonio and San Diego.

6 This division is by far our
7 largest division. And it's not only because
8 we're congressionally mandated to conduct
9 research, but because we truly believe that
10 our practices need to be evidence-based. We
11 have currently about half of the positions
12 filled.

13 We're working through some of the
14 HR issues including establishing an MOA with
15 Fort Irwin to facilitate the hiring at C5. We
16 actually did get good news on Friday in that
17 we were approved to fill that position there.
18 So we have someone actually in the facility
19 research director position at San Diego.

20 Many of these positions, it
21 doesn't reflect here, are at different stages
22 of the hiring process. Some of them we're

1 negotiating pay right now. Others are
2 interviewing. Jobs have been announced. So
3 we are closer then this slide depicts to
4 filling many of these positions.

5 Within the Research and
6 Surveillance there are four focus areas. We
7 feel that there is a need first to define and
8 document the problem. We want to look at
9 basic sciences research. We also want to look
10 at laboratory based applied science, advanced
11 technologies what works, what doesn't work,
12 short and long-term functional outcomes
13 assessments.

14 And then we want to monitor both
15 the short-term and the long-term health and
16 wellness of our patients. And this we know
17 requires close collaboration between DoD and
18 VA because as you heard earlier, 1,200 of
19 these have already transitioned to the VA for
20 their care.

21 You asked about our research,
22 productivity. Certainly our priority has been

1 to embed these clinical researchers, get them
2 hired and put them in the three advanced
3 rehabilitation sites.

4 Once we've done that or we're
5 doing that, we're focusing on the act of study
6 progress. We want to make sure that they're
7 leading to scientific presentations and peer-
8 reviewed publications. And we use these as
9 our productivity metrics.

10 In FY 12 there were 22 abstracts
11 presented as either platform or poster at two
12 local, 17 national and three international
13 scientific conferences. And there were 31
14 peer-reviewed publications. And so we're very
15 proud of the fact that this has increased
16 significantly since FY 11 and especially with
17 as many vacancies as we have.

18 We have 72 studies currently
19 ranging from proposal to manuscript submission
20 right now. These are some of our partners
21 that we are actively engaged with to produce
22 this research. They are human performance

1 labs at each of those centers already. We're
2 certainly working with them. The US Army
3 Medical Research and Materiel Command, the VA
4 and the Joint Center of Excellence for
5 Battlefield Health and Trauma Research in San
6 Antonio.

7 You asked about the tool box and
8 the functional outcomes. We are working
9 diligently with patients and clinicians across
10 the three centers as well as the VA. What are
11 the clinical questions that we need to
12 address? And then to identify normative data,
13 reliability and validity of these outcome
14 measures.

15 We have made a lot of progress in
16 identifying what are the areas that we want to
17 focus on. Our clinical efforts and the
18 ongoing studies and the ones that have already
19 been accomplished are helping us to validate
20 these results for an active duty service
21 member population.

22 Studies have been distributed

1 across the three centers to make sure that we
2 are able to validate the research data that's
3 collected. And to date we've developed a
4 summary of outcome measures most used, those
5 that are frequently used, those that have been
6 validated and those in the validation process.

7 And this publication is pending
8 the return of the primary author who is in
9 Afghanistan that was deployed as she was doing
10 this. So as soon as Colonel Ann comes back we
11 will get that publication out.

12 What are the other things that we
13 have been doing to try to enhance the care and
14 the collaboration between DoD and VA? There
15 was an effort between the Providence VA and an
16 investigator at CFI which validated a
17 community reintegration measurement tool
18 within the population of military patients.

19 This was actually published this
20 year. This hasn't, this has not been done
21 before in the population military patients.
22 DoD and VA also developed a collaboration

1 guidebook for health care research. We will
2 be updating that annually to ensure that we're
3 capturing all of the information that will
4 help researchers on both VA and DoD to
5 collaborate on research efforts.

6 We did, we completed a laboratory-
7 based study between three VA sites and DoD,
8 the DoD site, the Center for the Intrepid on
9 the DEKA arm. Many of you may be familiar
10 with the revolutionizing prosthetics and what
11 DARPA has funded to develop upper extremity
12 prosthesis.

13 In fact, we had one on 60 Minutes
14 a couple of weeks ago where they were showing
15 the computer brain phase. Well one of these
16 arms is the DEKA arm. And we've now optimized
17 that arm through the laboratory studies and we
18 are now going into, as of late FY 11, we, I'm
19 sorry, FY 12, we have started the take home
20 study. And CFI is also participating with two
21 of the VA sites to do the take home study.

22 So the information that we will

1 get out of this take home study will lead to
2 a final version of this arm and hopefully will
3 improve the options for our upper extremity
4 amputees. Again, it's about 17 percent of the
5 amputees have suffered upper extremity
6 amputation. Many of our upper extremity
7 amputees still wear a body powered prosthesis.
8 Some use the Mio-Electric prosthesis.

9 And many of them frankly have
10 already abandoned their prosthesis. And a lot
11 of that is their dissatisfaction with the
12 technology. And so we're very, very hopeful
13 that this will and we've gotten great response
14 from the people who have worn it.

15 They absolutely loved it. So
16 hopefully we will be able to work out all of
17 the final elements that are needed bring this
18 arm to market and to get it on our veterans
19 and service members.

20 The DoD and VA, a couple of years
21 ago, actually produced the clinical practice
22 guideline for lower extremity amputation. We

1 will be putting a group together to relook
2 that because as you know we've amassed an
3 inordinate amount of information in the ten
4 years that we have had folks being injured and
5 improvements in the rehab and the technology.

6 So we will be putting together a
7 group to look at that and to make sure that is
8 being updated. But we're very, very excited
9 because we together went before the evidence-
10 based practice group we asked for an upper
11 extremity clinical practice guideline for
12 upper extremity amputation. And we were
13 approved.

14 And so we felt that this was very
15 much needed. We knew that we were competing
16 against things like urinary tract infections
17 and upper respiratory infections. But we were
18 successful. We have had a group of champions
19 that have been meeting weekly. We have
20 developed our questions that the contractors
21 will be searching.

22 We've put together a group of

1 subject matter experts and we will be having
2 an actual face-to-face meeting the end of
3 July. And we're hoping that within, you know,
4 a year or two, 15 months we will have this
5 published. So very, very exciting. We went
6 back --

7 MEMBER STONE: Dr. Randolph, if I
8 could interrupt you for a second?

9 DR. RANDOLPH: Sure, Mr. Stone.

10 MEMBER STONE: We're very
11 appreciative in the extraordinary advances in
12 the acute rehabilitation of these service
13 members. I wonder if you can provide some
14 insight as to what the lifetime needs of these
15 individuals will be? Based on previous
16 advances in prosthesis, what can we expect 15,
17 20, 30 years down the road for the needs for
18 these service members?

19 DR. RANDOLPH: You can expect that
20 the cost of technology is going to increase.
21 And we were asked to put together in the VA
22 some numbers looking at what would the costs

1 be. And for an upper extremity somewhere
2 around \$1 million to \$2 million over their
3 lifetime just for their prosthesis alone.

4 We know that they are three to
5 five times more likely or have more medical
6 conditions that require care. So we have, and
7 in looking at that we have assigned amputation
8 care coordinators in the VA to help manage
9 this group of patients in terms of
10 coordinating with primary care because they
11 really do have a lot of other medical problems
12 that bring them in.

13 We, you know, things like
14 transportation needs and home modifications.
15 And they're living longer and it's going to
16 require us to look at how we can one, prevent
17 a lot of the things that we have seen in the
18 past such as the weight fluctuations,
19 inactivity, reintegration.

20 And we've had several reports from
21 the OIG and the VA that have looked at, you
22 know, what are their current needs and how

1 satisfied are they with their care? And you
2 know, the OIG made some recommendations in
3 terms of primary care and making sure that
4 we're very integrated with them between our
5 amputation system of care and primary care to
6 take care of them.

7 The database, the clinical
8 informatics and technology, the database, the
9 amputee database that is the Legacy System.
10 We are currently working to improve this
11 system. And the current architecture until
12 which time we can bridge to the registry. At
13 the same time that we're working to improve
14 our database, our Legacy architecture, we are
15 working with the Force Health Protection and
16 Readiness division to develop the EACE
17 registry.

18 While the back end is the
19 enterprise system and I'm sure you've heard
20 about this in the previous two talks it's
21 populated from data feeds from various
22 sources. Each of the centers of excellence is

1 responsible for their front-end architecture.
2 And we are currently working on that right
3 now. We are developing our functional
4 requirements. Once these are developed then
5 we turn it over and they develop the technical
6 requirements and the acquisition process.

7 As far as our website we do, have
8 been approved for our presence on the
9 health.mil website. We believe that, and we
10 anticipate that we will have a strong web
11 presence by the end of this fiscal year.

12 So as we stated previously, our
13 concept of operations was approved by the
14 Center of Excellence Oversight Board in
15 January of 2012. We have developed an Army
16 Manpower Concept Plan. It is currently being
17 staffed in the Army Medical Command prior to
18 submission to the Army.

19 We have hired VA and DoD staff.
20 It's ongoing. It is our priority. Fourteen
21 of the 41 requirements have been hired. Our
22 initial operating capacity, capability of 50

1 percent has not yet been attained, but we are
2 close. Our budget of \$5.5 million a year is
3 in the POM and out year funding has been
4 requested.

5 The executive office again has
6 been, it's already now co-located with the
7 Army Medical Command headquarters. And we
8 believe that we are meeting all requirements
9 of the NDAA FY 09 Act.

10 What is the way ahead for the
11 EACE? Certainly we want to enhance the
12 collaboration. And so looking at things like
13 joint policy recommendations as new technology
14 is introduced, how do we bring that in to the
15 facilities? Do we just go out and buy the new
16 technology or do we identify centers where we
17 can best look at this technology, the benefits
18 before purchasing it across the board?

19 As for new and evolving research
20 collaboration, we have not had a joint DoD,
21 VA, IRB in the past. And so what we would
22 like to do for the research is to propose

1 having a joint DoD, VA. Therefore, we could
2 do research across, if we have one research
3 study and we want to look at it in multiple VA
4 facilities as well as DoD, we, I have been
5 talking with the head of research for VA.

6 We have been talking with Medical
7 Research and Materiel Command. We think this
8 is possible and we are trying to move ahead
9 with setting up some recommendations for how
10 that would occur. I think that would really
11 facilitate looking at the patient across the
12 continuum of care as you said, General Stone.

13 We want to make sure that we are
14 able to follow them and then to be able to
15 make more accurate projections about what
16 their needs are. We certainly want to focus
17 on integrating our staff in these treatment
18 centers. We want to leverage technology such
19 as the movie technology, video
20 teleconferencing, telerehabilitation,
21 telemedicine to enhance our communication and
22 collaboration.

1 One of the things we're looking at
2 right now is establishing the video
3 teleconferencing between the staff at the
4 advanced rehabilitation centers and the VA to
5 which the service member is transitioning.
6 Having that kind of face-to-face meeting
7 before they get there with their physicians,
8 with the staff that's going to be taking care
9 of them. And so hopefully we can get some of
10 these processes in place.

11 The hand and face transplantation
12 we're assisting in the development. Both Mr.
13 Shero and I have been part of the DoD, VA
14 group looking at this. We want to make sure
15 that we foster staff and patient education and
16 then certainly improve the access to
17 transplant services when appropriate.

18 These are all still considered
19 research protocols for DoD and VA both. But
20 we certainly want to make sure that our staff
21 have the education and the knowledge to be
22 able to talk to our patients that may require

1 these services or may desire these services.
2 And so hopefully whatever we can do to improve
3 that is certainly our goal.

4 Access to care. We want to
5 facilitate DoD, VA sharing opportunities. And
6 some of you may be aware that we have the
7 joint incentive funds. We've used those. We
8 established an agreement between the DC VA and
9 Walter Reed where we shared staff. And that
10 was very successful.

11 We are also looking at other
12 collaboration certainly between the San
13 Antonio VA Medical Center and CFI. The San
14 Diego VA we were out earlier in December, Mr.
15 Shero and myself along with VA and DoD
16 representatives, looking at those facilities
17 and how we can facilitate getting these
18 patients cared for most effectively.

19 We certainly want to explore
20 options for retaining those clinical and
21 research expertise. I think that's an ongoing
22 dilemma for all of us. How do we retain this

1 as the conflicts slow or we bring out troops,
2 what do we do in the future? And I think
3 that's foremost for both VA and DoD because we
4 certainly, we have amassed like I said, a
5 tremendous amount of information. We want to
6 make sure that we were able to retain that.

7 We want to increase our external
8 partnerships with civilian organizations and
9 academic institutions. How do we, you know,
10 who are the people that we want to partner
11 with? And how do we, you know, ensure that
12 the gaps that we've identified we're best
13 addressing with the most appropriate people.
14 And that's very important again.

15 And certainly, expedite
16 publication of research findings to inform
17 clinical practice. And one of the things with
18 publications, peer-reviewed publications, I
19 mean we do the poster and the platform
20 presentations. But the publications take a
21 little bit longer, as you know.

22 So one of the things that our

1 research that we're doing to try to facilitate
2 getting this information out sooner is, you
3 know, looking at the studies that are ongoing.
4 If we have some, you know, with the findings
5 and ensuring that on our calls with the DoD
6 and VA staffs that we are putting those
7 findings out there, that we're talking about
8 them, we're discussing them and we're
9 improving our clinical care by doing that.

10 The other thing is we hold, we're
11 holding our first call, or our first DoD, VA
12 kind of grand rounds call this week. We, our
13 plan is to hold these monthly. It's another
14 way to get the research findings out there and
15 things that are clinically relevant for both
16 DoD and VA across the nation.

17 And again, it says throughout the
18 world. That's where our global outreach comes
19 into play. And we definitely want to share
20 our findings with our partners. With that I
21 thank you, Admiral Nathan, Mrs. Crockett-
22 Jones, this task force members and between

1 myself and Mr. Shero or Mr. Mundy, who's our
2 chief of staff, we'll try to answer any
3 questions.

4 CO-CHAIR NATHAN: Dr. Randolph,
5 I'd like to ask you, what is going to be sort
6 of the final concept of operations for taking
7 care of these service members who are going to
8 have the high tech prosthetic devices but be
9 located in their final discharge locations
10 into the non-centric VA system?

11 I recognize 1,500, most of these
12 service members with amputations have been
13 concentrated in the Southern California area.
14 And even that has its problems because the VA
15 appropriately built its amputee reservoir in
16 West LA where the population with diabetes and
17 peripheral vascular disease was and now most
18 of the amputees that need these sophisticated
19 services are residents in San Diego.

20 And I compliment the VA because
21 they're hiring people in San Diego to partner
22 along there. But is the plan going to be to

1 mobilize these folks when they live somewhere
2 in maybe central Iowa or in upstate New York
3 to a center of excellence or is it going to
4 try to bring up the sophisticated ambience of
5 prosthetic care in that local VA?

6 DR. RANDOLPH: The plan is to, you
7 know, bring up that local VA. And the other
8 thing that I have to say is that the VA has
9 over 600 contracted vendors by which we use to
10 provide the technology in addition. So while
11 the VA has 157 facilities not all of them
12 actually even have an O&P service.

13 And so we've done a lot of
14 training, equipment has been purchased. I
15 know that I've been with the VA for four and
16 a half years now. There's been a tremendous
17 effort ongoing and I think that will continue.
18 You're seeing that with the three new
19 polytrauma centers being proposed.

20 That means additional dollars are
21 going in there to have dedicated resources to
22 be able to provide that. So, yes, you know,

1 any technology that is commercially available
2 they're going to have access to that.

3 I would say that as someone who's
4 cared for amputees most of my life and we have
5 some amputees here in the group, the whole
6 idea of trying to mobilize that patient and
7 take them to where that technology is, you
8 know, becomes, you know, a burden after a
9 while in that, you know, they need to develop
10 a local connection where they can get their
11 prosthesis fixed very quickly.

12 If they have problems, they start
13 to get breakdown, you know, they have a
14 problem with their socket, they need to get
15 seen right away. And so the VA is really
16 working to do that. So in addition to those
17 14 polytrauma amputation network sites, we
18 have dozens of more what we call amputation
19 care teams.

20 These are people that are trained
21 throughout the VA facilities in working with
22 their local O&P providers that are contracted

1 with the VA. We will be able to continue to
2 provide that care. I am part of a group that
3 is right now looking at, we put out a request
4 for information.

5 We're looking at putting out a, we
6 will be putting out a proposal to have the
7 entire O&P in the VA assessed. And that will
8 be done this year looking to see where we need
9 to increase resources, et cetera. So more to
10 follow on that. Right now that's still in
11 the, I'm still part of the team and we're
12 still drafting that final statement of work
13 for that contract.

14 CO-CHAIR NATHAN: Thank you.

15 DR. RANDOLPH: Yes. Any other
16 questions?

17 MEMBER EVANS: Just a quick
18 question on, so if you look at Walter Reed and
19 look at, since I'm Navy and I know San Diego's
20 length of stay and when I was assigned to
21 Walter Reed there's a difference in how long
22 the amputees of the length of stay or recovery

1 at Walter Reed and San Diego. Same type of
2 injury, so maybe a bilateral Walter Reed,
3 bilateral San Diego. But the San Diego member
4 seems to go back and reintegrate into the
5 community a little bit faster than Walter
6 Reed.

7 So it would be nice to have a
8 standardized across all three of your
9 facilities and to include the VA so when we
10 talk to the families at the deck plate level
11 we can say your average, unless, you know,
12 bearing variance or complications, but your
13 average length of stay should be, you know,
14 for a bilateral about 12, 16 months.

15 So that way the families have an
16 expectation at the beginning, we're trying to
17 do this catch up towards the end. And it just
18 creates a lot of confusion at the deck plate
19 at the treatment facility.

20 DR. RANDOLPH: I will take that.
21 But that is noted and we have looked at that
22 and will continue to try to track the patients

1 and their length of stay. Some of these
2 patients may have started at Walter Reed. So
3 that was like one of the things when I first
4 looked at some of the numbers.

5 I'm like okay so this was a lot
6 shorter out in San Diego, but not realizing
7 that they'd been treated at Walter Reed
8 initially for six months of their rehab and
9 then they get to San Diego, they only have,
10 you know, three more months. And so, you
11 know, having been there at Walter Reed during
12 the early days of the conflicts and seeing the
13 amputees come, you know, I think we've learned
14 a lot.

15 We are much, in a much better
16 place by far than we were then. And I think
17 looking at the number of days is going to be,
18 you know, a metric that we really need to
19 assess how, you know, effective our rehab
20 strategies are.

21 And, you know, what are the
22 differences? Why does this work better? Is

1 it how we introduce the prosthetic technology?
2 Do we start with body powered and then go to,
3 you know, like Mio-Electric for the upper
4 extremity or do we start with Mio-Electric and
5 then teach them the body?

6 Things with the upper extremity do
7 we teach hand transfer, you know, dominance?
8 You know, if they lose their dominant upper
9 extremity do we teach, you know, transfer of
10 that because we spend time doing that or do we
11 just put the prosthesis on them and have them
12 use that as their dominant hand?

13 That's what we're hoping some of
14 this upper extremity clinical practice
15 guideline will help us sort through and to do
16 that. And with the lower extremity, you know,
17 we start all the time do we start them in the
18 C-legs or do we start them on a mechanical
19 knee? Do we, you know, put them into the X2's
20 or do we go back to the C-legs?

21 And I think that having these
22 clinical researchers embedded in these

1 facilities will really help us kind of sort
2 through some of that so that we can finally
3 start to put out recommendations. And then
4 we're comparing apples to apples and not
5 apples to oranges in terms of stays.

6 But I do think, you know, I
7 remember being there and running the rehab
8 there at Walter Reed. And the patients well
9 how long is my son going to be here or how
10 long is my husband going to be there? You
11 know, you can't just keep saying it all
12 depends on him or her, you know.

13 I think, that there's plenty of,
14 that we can do and hopefully as we bring these
15 people on and we start to expand a little bit
16 in the EACE, you know, hopefully we'll work
17 with folks just like you and to try to say
18 where are the other needs? We're looking at
19 the clinical gaps right now, the research
20 gaps.

21 But what are the other things that
22 we should look at. And I'll make a note as

1 soon as I finish speaking.

2 MS. DAILEY: I'm sorry, sir. Can
3 I get one alibi? Your question number six,
4 you did cover it. And in one of the slides.
5 Can I get you to go over question number six
6 again? I'm not sure --

7 DR. RANDOLPH: I'm not sure I have
8 the questions right here.

9 MS. DAILEY: Sorry, the functional
10 outcome assessment toolbox.

11 DR. RANDOLPH: The functional
12 outcome assessment tool box. So, yes. So we
13 have identified what are the measures that are
14 most currently used, I mean the functional
15 outcomes.

16 What are the ones most frequently
17 used? Which are the ones that are sometimes
18 used? And then which were the ones that have
19 been validated? And which are the ones that
20 need the validation?

21 We're putting that, it's been put
22 together in a report. Again, unfortunately,

1 the person writing the report was deployed to
2 Afghanistan. I was not on board when, but we
3 will get that as soon as possible.

4 But the bigger thing is we have
5 that information and we've already distributed
6 out and that's part of those 72 ongoing
7 studies, what are the things that still need
8 validation. And those have been distributed
9 across the three centers.

10 And those are the studies that are
11 underway. So, yes, we are continuing to do
12 that. This tool box will then form kind of
13 the basis for our templated notes and then our
14 registry because we all want to be capturing
15 the same information.

16 What are the functional outcomes
17 that we think are important? Then we want to
18 be able to pull that information from the
19 patient's record so that we will be able to
20 look at over time how effective our rehab and
21 treatment strategies have been.

22 MS. DAILEY: Thank you.

1 CO-CHAIR NATHAN: Actually one
2 more alibi, now thinking about it. One of the
3 problems that you talk to trauma surgeons
4 about it and trauma orthopedists is making the
5 decision for limb salvage, visa amputation.
6 This becomes a critical issue for some, not
7 many.

8 But some of our wounded warriors
9 who try to hold on to their limb for as long
10 as possible, they end up in hind sight
11 probably going the wrong direction because
12 they become narcotic dependent, inactive, they
13 gain weight, they become depressed and they
14 end up in a downward spiral.

15 And so we've seen sort of a seed
16 change over the last several years where
17 orthopedists are getting to be more in tune
18 with this and trying to be more aggressive in
19 getting somebody who probably has no hope of
20 recovering their leg into that.

21 Do you have any comments in that
22 regard? Do you see that as a central theme

1 that this task force needs to be worried about
2 at all or is this being handled very well
3 within the orthopedic trauma and amputation
4 community?

5 DR. RANDOLPH: You know, I don't
6 know that I'm qualified to comment on that.
7 I do know that, you know, I work very closely
8 with my orthopedic counterparts, limb salvage
9 certainly high on their list. They want to be
10 able to save those. And Colonel Vickie down
11 at San Antonio and many other fine surgeons
12 whether at Bethesda or C5 are certainly
13 working to do this too.

14 I know that there are ongoing
15 efforts. I'm not sure that, you know, again
16 there was a recent, there's been recent
17 articles and media coverage of the IDEO brace
18 as one example. So we are working to develop
19 new technology, new orthotic technology that
20 will allow us to control those rotational
21 movements, maybe have less pain, let them be
22 more active because you know, as you know, I

1 spent 29 years in the Army too.

2 We're very active, we like to be
3 going and there's nothing like an injury that
4 makes you, even if you didn't run before, want
5 to run again. And so it's important that we
6 try to work with them and get them as active
7 as possible just with the endorphin release
8 and pain control there. So I think that work
9 is being done.

10 I know that I have sat on some
11 committees looking at the research proposals.
12 I know that it is receiving funding. We're
13 definitely looking at, you know, how can we
14 replace nerve? How can we replace muscle and
15 certainly bone? So I think that the funding
16 is there and I think but probably the best --

17 MEMBER STONE: Would you quantify
18 this population who have, and first of all
19 please, is there an agreed upon definition --

20 DR. RANDOLPH: No, there is not a
21 --

22 MEMBER STONE: -- of late

1 amputation after attempts at limb salvage? If
2 there's not, could you tell us about the size
3 of this population?

4 DR. RANDOLPH: I think I will
5 probably have to take that one for record
6 unless, Mr. Shero, you want to talk about, do
7 you have an idea the size of the population?
8 I think the first thing is there's not an
9 agreed upon definition and you know, for what
10 constitutes limb salvage. John or Jim, are
11 you there?

12 CO-CHAIR NATHAN: I think it's an
13 art right now, to some extent. I think it's
14 the partnership between the patient, the
15 warrior and the orthopedist. The orthopedist
16 saying maybe in time you'll know when it's
17 time to sort of fold and let us take the limb
18 so that you can get on with getting mobility
19 again and exercising again.

20 I think we've done a better job in
21 the medical genre, both in the military and
22 outside, of educating orthopedists in, to not

1 necessarily hope against hope that somebody is
2 eventually going retain them because we're
3 seeing that people then end up with downward
4 spirals in their life if we wait too long.
5 But it's a great question, Rich.

6 I think some of our most emotional
7 patients have been those that have been very
8 active, have undergone horrendous limb damage
9 to the extremity and the family is just beside
10 themselves, and you used to deal with these
11 folks, Connie, beside themselves because the
12 individual's laying in bed requiring constant
13 pain medication, won't exercise, getting
14 depressed, but yet doesn't want to lose the
15 limb.

16 And so I think we're getting the
17 psychosocial, we're getting better at this
18 psychosocially. But I think it's still a
19 tough problem.

20 MEMBER STONE: You bring up or at
21 least you touched upon the use of artificial
22 mechanical exoskeletons. Is there anything

1 that you'd like to give the committee on that
2 either verbally or in follow-up?

3 DR. RANDOLPH: You know, I'll
4 provide it in follow-up. But with the IDEO
5 and other exoskeletons that are, you know,
6 coming to market as well, I do know that the
7 one study that was published on the IDEO there
8 was about 50 percent of the group that wore
9 the IDEO that were considered limb salvage
10 that were contemplating amputation prior to
11 the study. And they actually elected not.

12 So, you know, in my mind if we can
13 just save one then that's a success. And I
14 think that we just need to keep exploring
15 other options whether it's the rehabilitation,
16 it's the technology, unweighting them, you
17 know, better narcotics control definitely, but
18 certainly pain management. And then
19 reintegrating them.

20 I know that we've worked very hard
21 to get like the adaptive sports equipment
22 through. And DoD is now providing that. VA

1 provides that as well. We try to get them
2 enrolled in these different programs where
3 they are, you know, more active and I think
4 we'll continue to try to see that. And those
5 are not just for the amputees but for the
6 extremity trauma as well.

7 CO-CHAIR NATHAN: Thank you very
8 much, Dr. Randolph. It may behoove us at some
9 point in the future to have, if you've not had
10 already, a brief from the AFIRM Coalition
11 Group, which is the armed forces coalition for
12 regenerative medicine. And this is centers of
13 excellence including Wake Forest and others
14 that are getting together --

15 DR. RANDOLPH: UCLA.

16 CO-CHAIR NATHAN: UCLA, getting
17 together and looking for ways to regenerate
18 tissue, including transplantation. But that
19 would dove tail nicely onto what you've told
20 us today. Thank you.

21 DR. RANDOLPH: Right. And for the
22 record I will take back the exoskeletons and

1 provide more information to the group on that.

2 MS. DAILEY: Good.

3 DR. RANDOLPH: All right. Thank
4 you, sir.

5 MS. DAILEY: Thank you very much.
6 Do we have our ten minutes still in our time
7 frame?

8 CO-CHAIR CROCKETT-JONES: We do
9 have a break right now.

10 MS. DAILEY: Ten minute break
11 then, thank you.

12 (Whereupon, the above-entitled
13 matter went off the record at 1:57 p.m. and
14 resumed at 2:15 p.m.)

15 CO-CHAIR NATHAN: Okay, I think we
16 have a quorum. I'm going to, after Dr.
17 Butler's presentation, I need to go across the
18 road to the Pentagon to brief the four stars
19 on the transition, the MHS transition. But
20 let me just say and I'll be back here bright
21 eyed and bushy tailed in the morning. I don't
22 know if that's encouraging or discouraging to

1 you.

2 But I've certainly appreciated
3 this conversation and it's everything I
4 thought it would be, Madam Co-Chairman, which
5 is an amazing eclectic group of corporate
6 expertise from various sectors coming together
7 talking about some big rock issues in
8 recovering warrior care. And so it's been
9 very educational for me. And once again I
10 want to thank you for the opportunity to serve
11 on this task force.

12 Without further ado, we'll welcome
13 outside of James Brown the hardest working man
14 in show business, Dr. Barclay Butler who has
15 really a big task which is to herd all the
16 cats and dogs basically in informatics and
17 electronic health records which is where we
18 need to be in the Department of Defense. And
19 the good news is we've made some real headway.

20 But anybody is anybody in health
21 care these days is all in and invested in
22 trying to get to an integrated electronic

1 medical record. We need it, if for no other
2 reason, just to increase the continuity of
3 care between our various system in the VA and
4 the DoD and then ideally into the private
5 sector as our patients migrate in and out of
6 there.

7 And Dr. Butler was brought on to
8 basically try to make sense out of the Rosetta
9 Stone and put an IPO together and do just
10 that. He is the director of that interagency
11 program office. He brings focus to full
12 interoperability between the Department of
13 Defense and the VA regarding the development
14 and implementation of an electronic health
15 record, an integrated EHR with systems
16 capabilities and initiatives.

17 Dr. Butler will provide us an
18 update on the status of that since Mr.
19 Wennergren's February 2012, briefing. And
20 he'll discuss the program activities over the
21 past fiscal years. You can find Dr. Butler's
22 update in Tab F. So Barclay, without further

1 ado, the floor is yours.

2 DR. BUTLER: Thank you very much,
3 sir. Sure appreciate it. And thank you so
4 much for the invitation to come and to be able
5 to brief you on the Interagency Program
6 Office, the IPO, and where we are on the
7 integrated electronic health record, the iEHR.

8 And I understand that this is
9 actually one of the task force legislative
10 mandates to assess how are we doing in the IPO
11 and how are we doing in bringing the iEHR to
12 both the DoD and the VA? And that will be the
13 purpose of my briefing today, is to give you
14 that update and then by all means interrupt me
15 at any time to drill in to ask any questions
16 that you might have.

17 I'd be very happy to address those
18 at any time through the talk. The primary
19 objective then will be to update you on our
20 deliverables, our accomplishments and
21 challenges over the last year to provide you
22 a status on our initial operating capability

1 the IOC.

2 That initial operating capability
3 is what we call our iEHR platform. And we
4 used the term platform because it is that
5 initial capability, those capabilities that
6 come out of our first and second increments,
7 that become the platform where additional
8 applications can they be put on top of it.

9 The platform really constitutes
10 all of those capabilities that include
11 infrastructure, security, our electronic
12 service bus, our service oriented
13 architecture, all of those things that we need
14 to get in place plus some initial clinical
15 capabilities that proves the end to end
16 deployment and architecture of the iEHR.

17 From that the following
18 increments, three through six bring additional
19 clinical capabilities over time. I will give
20 you an update on the overall iEHR and VLER
21 Health. And I emphasize the health side of
22 VLER in that this program has program

1 management responsibilities over the VLER
2 health side of it, not the VLER benefits side.

3 That really is the mission of the
4 entire VA. And our job is to connect the iEHR
5 data into the private sector so I can pull
6 data back. And I'll describe that a little
7 bit more and describe to you the relationship
8 between VLER Health and the IEHR.

9 I'll give you an update on our, as
10 I mentioned, our capability sets number one
11 and two and then provide you a listing of some
12 of the challenges that we have and some help
13 that you may be able to provide. The
14 secretaries met on December 6th and then again
15 on the 10th of January.

16 And I'll tell you I couldn't ask
17 for a more interested secretarial support from
18 both the VA and the DoD, just tremendous
19 support. I get to meet with them on a
20 quarterly basis and they're tremendously
21 interested in how we're doing. I'll tell you
22 to have almost a program management review at

1 the secretary level is quite unusual and I
2 really appreciate the interest that they've
3 got.

4 They did charge us to meet or beat
5 our schedule. And I have some decisions that
6 are coming out of the 10th of January
7 discussion with them that we can talk about
8 near the end of our presentation today.

9 What I'll do is I'll talk about
10 all the things we had accomplished through
11 this last year and then address any changes to
12 that near the end. I will say that this is a,
13 the scope of the iEHR covers about 20 million
14 beneficiaries, over 211 hospitals between the
15 DoD and the VA and over 350 thousand care
16 providers across both enterprises.

17 Let me address the three missions
18 that we've got. We've got the integrated
19 electronic health record, the iEHR, where our
20 job is to modernize both the Legacy EHR's,
21 electronic health record capabilities in both
22 departments using a common health record. The

1 goal is to get that common health record
2 across both departments.

3 It's really the same patient
4 database, right. It's the same patient, when
5 the service member raises their hand and
6 becomes inducted clear through the time where
7 they receive final benefits. We will replace
8 the DoD's CHCS and AHLTA systems. The CHCS is
9 their order entry system and the AHLTA is
10 really their clinical note.

11 And we will replace components of
12 the vista system. And I don't say we're
13 replacing all of the Vista system and that is
14 because the Vista is really a system of
15 systems.

16 It has over 300 different
17 components and lots of business applications
18 within the Vista system itself. We will be
19 though replacing the electronic health record
20 components of the Vista system and then
21 connect up the new iEHR into the rest of their
22 business systems.

1 On the virtual lifetime electronic
2 health record, VLER Health, this is that White
3 House initiative for the exchange of data
4 between DoD, VA, other federal agencies like
5 Social Security for example and private
6 providers all based on national standards. We
7 will be exchanging and are exchanging health
8 benefits, administrative information as well
9 as personnel records and military records.

10 And to date we've got four joint
11 sites. I'll show you those a little bit later
12 in the briefing as well as the VA has gone
13 ahead and continued the deployment and has not
14 12, but now 14 locations where they're
15 operating.

16 MEMBER KEANE: Sir, I have a quick
17 question.

18 DR. BUTLER: Yes.

19 MEMBER KEANE: I work at the VA
20 and since Ms. Malebranche isn't here, I'm
21 going to ping the VA. They're not very
22 information sharing for veterans. They love

1 our information that we have on Marines, but
2 they're hesitant to provide information on
3 veterans. Is this going to be a two-way
4 street of information sharing?

5 DR. BUTLER: Yes, it is. And
6 I'll, the way VLER Health works is it becomes
7 the communication link, the communication
8 channel to the private sector. And there are
9 two ways to get that data in and out of the
10 private sector.

11 If you're a doc office, in a doc
12 office, a couple of docs working together, in
13 that case we use the direct system. The
14 direct system is essentially secure e-mail
15 between the hospital and the docs offices. So
16 the consult goes out, the doc's now authorized
17 to treat and then the secure e-mail comes back
18 and that then becomes part of the overall
19 patient record.

20 When you have facility to facility
21 discussions, so for example the patient up at
22 Fort Drum needs to go to Syracuse, for

1 example, then it is a query and retrieve.
2 We're going to send a patient request for a
3 consult to the facility. The facility sends
4 back they've got availability. They then
5 treat the patient and then the data comes back
6 into the iEHR.

7 So there's two ways facilities and
8 direct. And, yes, the goal there, as you know
9 about 60 percent of the DoD patients are
10 treated out in the managed care support
11 contractors. And about 70 percent of the VA
12 are treated outside of the VA.

13 Now not all of that is fee for
14 service, as I'm sure you know. But that's a
15 lot of patient record data that we're losing.
16 And the goal here is to have that complete
17 continuity of care record so that we can have
18 access and actually improve quality of care
19 because they have that overall record.

20 So the answer is, yes. The goal
21 is to improve that continuity of care record
22 to improve our overall quality of care.

1 I do have a third mission though
2 and that's that lead, oversee and manage,
3 manage those things that are related to the
4 iEHR. And I know you probably talked about
5 some registries in your last briefing. Well
6 this is where data for those registries likely
7 resides already in the iEHR on Legacy systems.

8 And because the iEHR will have
9 that overall continuity of care record, when
10 we're looking at providing care for specialty
11 populations then that data then comes out of
12 the iEHR into those registries. They then do
13 their treatments, develop their treatment
14 protocols. Then their treatment protocols
15 likely can come back into the iEHR.

16 So we have an oversight role, not
17 an execution role, but an oversight role on
18 how do you exchange data? How can we get
19 protocols back into the iEHR for improving
20 quality of care? One of those missions, one
21 of those oversight missions is the James A.
22 Lovell Federal Health Care Center.

1 This is where we engaged in
2 October 1st of 2010, to combine both the North
3 Chicago Veterans Affairs Medical Center and
4 the Naval Health Clinic of Great Lakes merged
5 into the Captain James A. Lovell Federal
6 Health Care Center. And I will talk a little
7 bit more about that. I understand you're
8 headed out to visit them shortly. And I'll
9 give you some perspectives on what role the
10 IPO has in the JAL FHCC.

11 Let me spend the next couple of
12 slides, tons of text here identifying the
13 accomplishments that we have made. I'll just
14 hit a couple of them on each slide. But if
15 there's something in there you want to talk
16 more about, please interrupt me and I'll go
17 ahead and drill down into that.

18 So the first one is where are we
19 and what have we accomplished in the iEHR
20 proper, the integrated electronic health
21 record? And probably the most important thing
22 is we defined that program base line. That

1 means we've got our requirements, our
2 architecture and tremendously important our
3 design now and we've got a life cycle cost
4 estimate.

5 We just finished an initial design
6 review where we had over 300 participants
7 across both the DoD and VA. And we addressed
8 over a three day window, the designs of our
9 infrastructure, our security, our master
10 patient index, our pharmacy, laboratory,
11 immunization, our electronic service bus are
12 still in efforts.

13 And that's all based on the
14 requirement sets that we've got from our
15 clinicians. A number of years ago as a
16 medical CIO, we were combining the composite
17 health care system in the national capital
18 area. And I can't tell you how hard it was
19 back then to get the clinicians to agree to a
20 common set of business practices.

21 I can remember taking radiologists
22 and putting them in a room and taking away all

1 their food and water in order for them to come
2 to an agreement. Well, I will tell you I
3 can't tell you how pleased I am that in a
4 joint way across the services and in a
5 combined way across the departments, how well
6 the clinicians are working to develop these
7 common business practices.

8 And I'll use one example where in
9 pharmacy we now have 38 different business
10 flows that are agreed upon by the clinicians
11 across both departments in the services that
12 then will allow us then to go out and compete
13 that effort with our vendor community.

14 We do have single sign-on and
15 context management that's being deployed. And
16 I know this sounds very technology focused.
17 But it really is focused toward that
18 clinician. Single sign-on allows that
19 clinician to sign on once in the morning and
20 then use their common access card or their PIV
21 card and move from station to station to
22 station.

1 And their session then translates
2 with them instead of spending, believe it or
3 not, between six and ten minutes getting a
4 sign-on event accomplished which is time away
5 from the patient, they plug in their CAC or
6 PIV and about 10 to 20 seconds later their
7 session is up. And that returns a
8 considerable amount of time to that
9 patient/provider interaction.

10 Context management is really a
11 patient safety issue. So as the doc moves
12 from room to room to room, they saw a patient
13 Debbie in the first room and patient Mike in
14 the second room and Pete in the third. When
15 they change the name and when they're with
16 Pete to Pete, all of the applications all
17 immediately change to Pete's applications.

18 So they're not by accident looking
19 at some other patient's data while they're
20 trying to treat the latest patient. Very
21 important, context management to our patient
22 safety. We've got that now configured and

1 we're starting to deploy that. I'll show you
2 a picture a little bit later on, on how that
3 deployment's going.

4 We do have requirements for our
5 lab pharmacy identity management access
6 control and our presentation layer
7 capabilities. We have our development test
8 center, our DTC, up and operating. I know
9 that sounds like it's really early in the
10 cycle.

11 We have initial operating
12 capability coming in around the September of
13 2014 time frame. But I promise you this is
14 the time where you want to have your test
15 centers up and operating bringing in your
16 Legacy systems, bringing in your net new
17 capabilities.

18 And the key thing is having this
19 identified data in data sets that are large
20 enough so you can actually exercise and test
21 your systems. So many systems come near the
22 time to deploy and they're not properly

1 tested.

2 And that adds an unusual length of
3 time to the overall deployment. So I'm
4 pleased to see that our development test
5 center and our development test environments,
6 including DoD and VA systems around the
7 country, all link together in a virtual way so
8 that we've got an initial operating capability
9 test center.

10 We do have our data management
11 strategy and our road map developed. This is
12 our common information or operability
13 framework. It's all about the data, right.
14 If I can have mapped, normalized data across
15 both departments, that's how you accomplish
16 this single continuity of care record. That's
17 how you get an iEHR.

18 That is continuing to be
19 developed. We've got the initial pieces of
20 that completed and we're now doing some data
21 mapping, normalizing the data on a VA site in
22 Salt Lake City. This then takes the VA unique

1 data and maps it into the common information
2 of operability framework, which is also what
3 the DoD is using.

4 The DoD has accomplished this
5 mapping over the last number of years. I
6 think it took three to maybe four years to get
7 that accomplished. And that's done for them.
8 We're now engaging that in the VA side first
9 testing at Salt Lake City and then to our
10 initial operating sites in Hampton Roads area
11 and in the San Antonio area.

12 We did complete our systems
13 engineering plan. For the engineers in the
14 audience that is the road map, this is how you
15 get things done. That's the common operating
16 framework for a program management shop. And
17 then I'm actually quite pleased to see that
18 the technical specification package, along
19 with our architecture documents are not only
20 complete, but they are up on the web.

21 This is a little bit unusual in a
22 program management on the government side in

1 that everything that we finally get a
2 signature on we put out to industry.
3 Industry's got more information now then they
4 have ever had. And what this really does, it
5 allows us to further leverage the thinking and
6 the work of industry.

7 I'm not surprising them at all by
8 coming out with a request for a proposal and
9 asking them to respond to a tremendously large
10 effort over a three, four week period. I'm
11 giving them months to think about it and then
12 my RFI's and RFP's come out, give them a
13 couple of cracks at that apple.

14 Continuing along on our iEHR, I do
15 have my Service Oriented Architecture Master
16 Catalogue completed. These are those common
17 services that we will use for example for
18 patient identity management, that all
19 applications will use. So it's write once,
20 use many.

21 Our portal framework assessment is
22 completed. We did pick an open source vendor

1 for our portal framework. This is where the
2 clinicians have a common view of the data
3 across both departments. Yet it is
4 configurable for a particular speciality care
5 for example.

6 So we will build the starting
7 screens for each of the specialities. But
8 then with, allow the docs and nurses and admin
9 folks to configure those to their specific
10 business cases.

11 We have engaged DISA in creating
12 our medical community of interest, our network
13 and security capabilities here. This is a
14 huge lesson learned coming out of North
15 Chicago. In fact, this is something that
16 you'll still see in North Chicago.

17 North Chicago has three network
18 domains. It's got the military health system
19 domain, the Navy domain and the VA domain.
20 And I'll tell you it's very difficult to get
21 medical data flowing across all of those
22 domains, across all their firewalls and from

1 doc to doc, from a Navy doc to a VA doc. It
2 becomes problematic.

3 The lesson learned was don't do it
4 that way. Have a single medical enclave so
5 that any doc in any department can communicate
6 straight with another doc in another
7 department. Again, it's that common patient
8 data that we've got. And that's what we
9 wanted to exchange.

10 I mentioned our Health Data
11 Dictionary Mapping contract award. We award
12 this to an SDVSOB. And that is nearing its
13 first deliverable out of Salt Lake City. And
14 this is where we're taking VA data and
15 normalizing it to our common information
16 interoperability framework.

17 On the VLER Health side, we are
18 working with the Office of the National
19 Coordinator and to help them define their
20 HealthWay, their eat health exchange
21 interoperability specs of the, the DoD and VA
22 have been working quite a lot with those

1 organizations in order to help define what
2 those specs are and build their gateways.

3 And now we're continuing that
4 effort. If you are familiar with the concept
5 of the nationwide health information exchange,
6 that has now evolved to become the eHealth
7 exchange. So just do that mapping in your own
8 minds and where you see eHealth exchange think
9 of the Legacy NwHIN.

10 We are working with different
11 health information exchanges around the
12 country. I'll show you a list of those and
13 assisting them in adopting the eHealth
14 exchange efforts both on the direct and on the
15 exchange sides so we can exchange data with
16 the, with those organizations.

17 The Joint Executive Committee, the
18 JEC, gave us a go decision to go ahead and
19 deploy VLER Health. And they said that we
20 have to do this in such a way that we maximize
21 our return on investment, our ROI.

22 In order to do that we've created

1 some models to identify what communities do we
2 see out of both the DoD and VA where we're
3 having a lot of our patient population go out
4 into the private sector for care, number one.
5 Number two, where are all those communities
6 and do they have mature health information
7 exchange networks? As you know, there are
8 some out there that are quite mature,
9 MedVirginia for example is one of them. And
10 others that they just don't exist.

11 Third are the care providers in
12 the private sector ready for this? Have they
13 signed their data use agreements? And if all
14 those line up then that becomes an area where
15 we will invest our energies and efforts to
16 assist in that exchange, help those
17 populations in those communities come up in
18 the VLER Health area.

19 On the James A. Lovell Federal
20 Health Care Center, we have a number of
21 accomplishments where the IPO was responsible
22 for the IT, the Health IT portion of that

1 overall effort. We've got a common graphical
2 user interface called the Janus deployment.
3 That's out in James A. Lovell.

4 We have orders portability that we
5 have in common between the two and consults.
6 We have been exchanging lab data, pharmacy
7 data and radiology data. We have enhanced our
8 Single Patient Registration. This is where,
9 this is the only facility where we have this,
10 where we have joint registration across both
11 departments. Something that we will need a
12 little bit later on and our folks are working
13 to have that joint registration across both
14 departments.

15 To share with you what James A.
16 Lovell accomplished, they kept both Legacy
17 systems, both the DoD systems and the VA
18 systems operating. And their goal was then to
19 exchange data between them and provide
20 seamless care. And they have been able to
21 accomplish this and are continuing to ramp up
22 on additional areas of exchange in the normal

1 business flow in providing care to patients.

2 Then on the Clinical Information
3 Requirements Division, this is where we have
4 been able to begin our assessments of
5 measuring how well the IPO is doing in terms
6 of our initial operating capability in a
7 clinical effectiveness study. We've got
8 clinical requirements now submitted for our
9 clinical physician order entry, our CPOE and
10 our clinical decision support, our CDS.

11 What's important about CDS is it's
12 not just the drug allergy interaction,
13 certainly very important, but, which we
14 consider to be kind of low level systems kind
15 of checks. But it is bringing the clinician
16 information as the clinician's going through
17 their SOAP note as they are treating the
18 patient.

19 What kind of information can I
20 bring them based on the information that
21 they're already seeing? And in fact Admiral
22 Nathan mentions some friends of his were,

1 they've got an iEHR that shows who in the
2 institution is highly skilled in this area
3 that you are now treating this patient on. So
4 you have an immediate source, a name and a
5 phone number to call. What is a relevant, the
6 most relevant, recent literature that's out
7 there? These are the kinds of capabilities
8 that we want to bring our docs.

9 We do have deployment management
10 templates coming out of the CIRD. The number
11 one reason that EHR's have trouble in
12 deployment is they don't manage the change
13 management part of it. We found that you
14 can't come too early.

15 If you come a year ahead they said
16 yes, yes, but when is it really coming. If
17 you come too late in the cycle you catch them
18 by surprise. So it's about at that six month
19 window where you start engagement and then it
20 becomes, at about the 90-day window, where you
21 bring in training, initial training and then
22 refresher training. And then over the

1 shoulder during deployment. A pretty nice
2 deployment plan for each of our facilities.

3 We have an issue out at JAL FHCC
4 having to do with our two pharmacy systems.
5 And this is where we don't have the good drug
6 allergy checks that flow in a timely manner
7 between the systems. They do flow, but a
8 patient can go from one clinic to the next and
9 the data may not catch up to them.

10 So you could have the first
11 provider treat in one way, the second provider
12 treat and not be aware what the first provider
13 had prescribed to them. So we are working
14 with the JAL FHCC. We've got a solution that
15 we have identified and we're starting to work
16 that solution. And I think that over the next
17 couple of months we'll be able to provide that
18 solution to North Chicago.

19 Our Technical Division, this is
20 our infrastructure group, again we released
21 that technical spec package out into industry.
22 They know exactly what our specs are in terms

1 of our infrastructure. We've released an RFI
2 to have them comment back to us. And we've
3 got those comments.

4 I mentioned that Health Data
5 Dictionary Mapping and our, we defined what we
6 meant from the technical perspective on our
7 technical feasibility for our initial
8 operating capability. This is kind of the
9 nuts and bolts, the core of the infrastructure
10 that we're building for the iEHR.

11 What are our concerns? I'm going
12 to address most of these, if you don't mind.
13 And I need your help on a lot of them. We do
14 have unique department business operations and
15 program execution. And let me address both of
16 those.

17 First, on the clinical side and
18 you'll see this out at James A. Lovell, and
19 I'll use pharmacy, I'll continue to discuss
20 pharmacy, you've got policies on the DoD side
21 and policies on the VA side that just don't
22 line up with each other. Admiral Nathan knows

1 more about this then I do that's for sure.

2 And it has to do with for example
3 a pharmacy tech in one department is
4 authorized to dispense but on the other
5 department they're not authorized to dispense.
6 So how do you manage this in a joint
7 environment where you've got both pharmacies
8 and pharmacy techs all working together? I
9 think that we need to look at these
10 capabilities, these policies across both
11 departments.

12 And we're seeing, we're actually
13 seeing these for the first time up at James A.
14 Lovell. And I think you'll be interested to
15 see the progress that they've made on a number
16 of them, but some that we still need to make.

17 We do need to normalize data
18 across both departments and that's in that
19 Health Data Dictionary Mapping that we're
20 using. I think we have a model to get that
21 accomplished and we have a model that I think
22 we can accelerate that in a dynamic mapping.

1 Once we finish it in Salt Lake
2 City we're going to test this more, dynamic
3 mapping and bring that up to James A. Lovell.
4 And I think that will go a long ways to
5 assisting them in their pharmacy issues with
6 drug allergy interactions.

7 We've got to have a sufficient
8 requirements baseline. That means those
9 things that, it's not only the shall
10 statements, but it is the use cases, those
11 scenario driven, descriptive capabilities that
12 are required in order to complete our clinical
13 business cases. And those are then
14 accentuated by user stories which are a lower
15 level, more shall-statement focused.

16 We need information assurance and
17 accreditation, as you know, is different among
18 the departments. We really need that single
19 information assurance policy and accreditation
20 procedures so that when one department
21 accredits the system it's accepted by, not
22 just across the services, but across both

1 departments.

2 Contracting policies are different
3 and they are different in the world of agile
4 development. Agile development is a process
5 that we're using in the IPO that allows us to
6 lock in the cost and schedule, but we actually
7 vary our requirements.

8 And if you think about that, that
9 makes our contracting officers a little bit
10 nervous when you vary requirements. But what
11 we're saying is that given a cost and schedule
12 we can have requirements that corrode over
13 time that are no longer applicable and the
14 clinical business process owner can pull out
15 that requirement and enter in new requirements
16 to support this very short time of innovation
17 that we find in medicine.

18 We do have a cost sharing
19 memorandum of agreement and we need to
20 implement that every step of the way when we
21 hit a new effort, a new engagement, a new
22 aspect of that cost sharing, we've got to

1 hammer out all those responsibilities between
2 the two departments. Along with that would go
3 a shared fund.

4 I think we need a shared fund, a
5 joint incentive fund, like fund, where both
6 departments put their dollars into a single
7 pot and then the IPO is responsible for
8 executing that mission coming out of that
9 single pot. Right now I've got five
10 appropriations across both departments. And
11 if you can imagine trying to report on all the
12 different aspects of those five
13 appropriations, it becomes untenable.

14 It's too difficult to report those
15 up in both departments, when both departments
16 have very different requirements for
17 reporting. So I think I can give you a better
18 total cost of ownership coming out of a joint
19 shared fund.

20 We do have restrictions coming out
21 of the National Defense Authorization Act of
22 2008, that says the DoD can't expend funds in

1 a covered department unless that department
2 will certify that they will do their cost
3 accounting according to DoD measures. Well,
4 you know DoD measures are pretty thick.

5 And other departments are not
6 willing, the VA included, to certify that they
7 will follow all of not only the FAR but the
8 DFAR. And that restricts me from using
9 vehicles, contracting vehicles using DoD
10 dollars and contracting vehicles on the VA
11 side that would be quite appropriate to use
12 for the IPO, iEHR mission.

13 This would be solved if the DoD
14 would waive the requirement. And they have
15 gotten along as far as they can in that
16 waiving process. I think it's become harder
17 and harder as we go on. Or it would work well
18 if the VA would certify.

19 Thirdly, it would work well with
20 that joint incentive fund, that shared fund.
21 I think that's the real answer is that shared
22 fund that explicitly removes the NDAA

1 certification requirements. Continuing
2 resolutions, as you know those are always an
3 interesting effect on programs along with
4 potential sequestration.

5 So what will we accomplish by 2017
6 and why will it take between now and 2017 to
7 get this done? The question I get from
8 Congress and other senior stakeholders is why
9 does it take five years to get this done? And
10 let me share with you about seven or eight
11 reasons here.

12 First, is it's a tremendously
13 complex undertaking. It is a joint
14 departmental effort. Unique requirements
15 across both departments. We've got clinical
16 engagement here. Each of our capabilities,
17 I'll show you a capability chart in a minute,
18 each of those capabilities is like a program
19 in itself.

20 So it's like I'm managing six
21 different programs here. Each of those
22 programs have 30 plus projects within them.

1 It gives you an idea of the complexity of the
2 scope. I can't rip and replace, all right.
3 Unlike a bank, for example, that buys another
4 bank they go in and rip out the old system,
5 they bring in the new system, they transfer
6 all the accounts, you're done.

7 I can't do that in the health care
8 sector. I've got to be able to take my net
9 new clinical capabilities and run them through
10 my Legacy systems in order for those business
11 processes, those checks and balances to
12 continue to work. That adds cost and risk.
13 I do need those common standard business
14 practices that we're getting to. But I'm
15 telling you it's tough to get there. It's
16 lots of clinicians spending time, lots of hard
17 time to get that accomplished.

18 Large scope, I told you 18 million
19 patients, 440 thousand care providers, 211
20 hospitals, 229 data centers. If you think
21 about that 229 data centers that we will
22 consolidate down into nine data centers with

1 about 34 virtualization sites that are closer
2 to the facilities.

3 Significant downsizing and I think
4 significant cuts in costs here as well as
5 increases in reliability. Because I'm doing
6 that downsizing in the data centers that means
7 I'm essentially replacing the infrastructure
8 across the board in both departments. Now I'm
9 going to ride the same physical network, but
10 I'm changing the logical networks.

11 I've got to operate in mobile. I
12 mean who would accept an iEHR today that
13 wasn't mobile. But additionally has to be
14 deployed and operate in remote and in
15 disconnected environments. Those are the two
16 pieces that are very unique as you know better
17 than anybody the operations, in the area of
18 operations.

19 Single medical network, I talked
20 to you about that. And that was the big
21 lesson learned coming out of James A. Lovell
22 Federal Health Care Center. We are working

1 with DISA to get that accomplished. I'll have
2 initial operating capabilities by October of
3 '13. And then that sets me up for adding my
4 applications and my infrastructure on top of
5 the single medical network by the time I
6 finish my iEHR platform in 2014.

7 This is what that initial
8 operating capability, that iEHR platform looks
9 like. On the right hand side you see here
10 this our Hampton Roads area. And these are
11 the capabilities I'll be bringing to it,
12 single sign-on, VLER Health, my mapping
13 strategy, my test centers, my presentation
14 layer, my service-oriented architecture and my
15 enterprise service bus, identity management
16 and then three clinical capabilities, lab,
17 immunization and pharmacy.

18 And I'll do that both in Hampton
19 Roads and in San Antonio, both of the separate
20 regional sites and I'll bring capabilities to
21 fix the pharmacy up in the James A. Lovell.
22 So it becomes two years, two sites, two

1 clinical capabilities and fixing our Chicago
2 pharmacy.

3 This is what the iEHR looks like.
4 This is the overall program where in this
5 column, this is what I've got right now today.
6 I've got, you know, two separate systems,
7 unique business practices among both
8 departments. I've got ad hoc mapping. I've
9 got multiple data centers. And that's the
10 condition that you see. Two separate systems
11 operating across both departments.

12 My initial operating capabilities
13 is in the center column where I'm focusing in
14 on the direct care. Bring in that single
15 common graphical user interface. But now
16 we've got common business practices, common
17 data centers, a common infrastructure and a
18 common operating picture.

19 The final operating capability
20 covers the rest of them, the rest of the
21 capabilities, my payers, providers. Again, my
22 single interface system cutting across all of

1 my capabilities, those 54 joint capabilities.
2 I'll show you in just a sec. Assistance
3 capabilities, those 54 joint ones, a single
4 sign-on, context management, graphical user
5 interface.

6 My increment two is my
7 presentation layer with lab, immunization,
8 pharmacy, clinical decisions support, order
9 services, clinical documentation and all the
10 infrastructure to support it. Increment one
11 and two becomes my iEHR platform of which I
12 build applications on top of that.

13 Five year effort to get FOC.
14 Eighteen million patients, 22 medical centers
15 and as I mentioned 211 different hospitals.
16 And here's those stats for you, on the right
17 hand column here.

18 Who we serve? You know it's the
19 service members, veterans and their families.
20 You know better than I who we serve. What do
21 we do? It's those three missions, iEHR, VLER
22 Health and anything that oversees, lead and

1 manage that is related to the iEHR.

2 And why do we do it? This is this
3 bottom line here. How do I improve this value
4 proposition? And that value proposition is
5 how do I increase quality care for every
6 dollar expended? And that's the measure of
7 success for each one of these efforts that we
8 undergo, each one of these capabilities.

9 This is the history. How did the
10 departments get to where they were right now?
11 And I know you can't read this. But let me
12 just show you up here. Here's the composite
13 health care system that it took eight years to
14 get done. And here's AHLTA that took six
15 years. That's about 14 years across both of
16 them.

17 I don't have a similar break in
18 Vista, but Vista took about 14 years to get
19 where it is now. And we're being asked now to
20 create, as of October 27th, that single
21 integrated electronic health record and we're
22 being asked to do it in a five-year window.

1 Well that's, this is like version one. This
2 is version 2.0, in six years they want version
3 3.0 in five years. And I think we can get
4 that accomplished.

5 So what's our overall approach?

6 Our overall approach is to take a Best of
7 Breed solution and line that up with not only
8 open source and government off the shelf
9 systems, but also commercial systems looking
10 for what is that system that is the most
11 mature and most effective in the clinical
12 environment.

13 Where the pros are certainly this
14 open source capability, where we look to the
15 open source in order to pull in mature, open
16 source software and I'll give you one example,
17 in the medical imaging space there is a
18 company out there called Mirth. And Mirth
19 provides all of these image manipulation
20 routines. That is believe it or not, an open
21 source product. And all of the large vendors
22 use it. We will certainly be using an open

1 source solution in our imaging side.

2 The cons are, is the governance
3 side. Governance becomes highly complex. You
4 have to have both departments deciding not
5 only on the clinical capability that you will
6 go forward with, but then manage that across
7 both business processes.

8 Contrast that to a Best of Suite
9 solution where the clear benefit is speed of
10 implementation bringing an amount of clinical
11 capabilities to bear right away. The cons are
12 these top two, which are the hardest ones, is
13 that it gives us vendor lock.

14 That means I'm stuck with a
15 particular vendor and will have to effectively
16 do another rip and replace, if this were the
17 philosophy, in about ten to 15 years. And
18 data lock. Unless I can extract the data, if
19 I can extract the data, I won't have this data
20 lock.

21 Data lock means that I'm using the
22 vendor's data model and I really don't have

1 access to that data. And this is all about
2 the exchange of data. I've got to have access
3 to the data model.

4 So unless the Best of Suite
5 solution provides us relief in terms of these
6 two up here, vendor lock and data lock, I'd be
7 hard pressed to select that. But I would tell
8 you that we are looking at this as a potential
9 solution. The secretaries have very recently,
10 on the 10th of January, asked us to look at
11 this.

12 This is our iEHR platform. I will
13 show you on the top side this is our first
14 increment and this is our increment number two
15 joining around the fall of '13, the fall of
16 this year. This is our single sign-on and
17 context management that we're deploying out
18 now in San Antonio, Portsmouth, Tripler,
19 Landstuhl and this is the ability for that,
20 really to return time to the patient provider
21 interface.

22 Increment two is primarily focused

1 in on infrastructure ending up with these
2 three clinical capabilities, lab, immunization
3 and pharmacy along with computerized physician
4 order entry, clinical documentation and
5 clinical decision support in our initial
6 operating capability in September of '14.

7 On the development side I had
8 mentioned that both departments have their own
9 program management schema. And we have
10 decided that we actually would combine these
11 into a single schema that the IPO uses. On
12 the top half here I've got the DoD's business
13 capabilities life cycle, the DoD BCL, which is
14 a DoD 5000 like process, but it provides us
15 with the ability to add in agile development.

16 Agile development allows a very
17 cyclic, incremental type of development where
18 as I mentioned allows us to pull out
19 requirements that are no longer valid and
20 bring in new requirements during the
21 development cycle. This is very high level
22 program focus. As you can imagine the DoD is

1 very focused in on the overall program
2 management capabilities.

3 The VA has a system called the,
4 called PMAS, Program Management and
5 Accountability System. This is a very project
6 focused oriented management schema and we will
7 use for each of our projects within a
8 capability, we'll manage those under PMAS. So
9 PMAS is the project management piece and BCL
10 is the overall program management piece.

11 Each of our increments will be
12 managed at the high level of BCL. Each of the
13 capabilities within an increment will be
14 managed under PMAS. And let me show you those
15 increments. So for example on increment two
16 we've got access, control, and identity
17 management. That's identifying who is who.
18 Each of these will be managed under the PMAS
19 system as they all will.

20 Here's our portal framework.
21 Here's our order services documentation. This
22 will be managed overall under the BCL, the

1 DoD's BCL. What's difficult about this
2 schedule is if you look at what we're doing
3 say between 2014 and 2015 in this window here,
4 as other windows, I'm likely working on 30
5 plus capabilities at any one time. And that's
6 where the complexity in this schedule lies.

7 It's a fairly compressed schedule.
8 I mean if you were to ask me, it's because
9 I've got overlap. In increment two, I'm
10 finishing up the development of these
11 capabilities and then I'll get my full
12 deployment decision and then continue to
13 deploy those. Meanwhile I'm building, I'm in
14 the middle of building increment three and I'm
15 starting planning and execution development of
16 increment four.

17 So you see a lot of activities
18 across any number of increments. And there's
19 where the complexity lies. And the complexity
20 lies in the compression of the schedule. The
21 only way you can possibly do this is by an
22 agile approach, not a waterfall approach. And

1 that's our primary mitigation is using agile
2 development processes.

3 So why can't I just take an
4 application and just get it out there in front
5 of the clinicians? Well, here's why. We have
6 an N tier, it turns out to be a five tier
7 architecture where I start with my common
8 information or operability framework. And I
9 have to have some of this up and operating in
10 order to roll it through my data centers. And
11 I've got nine data centers.

12 I need a couple of those operating
13 from ILC in order to have the data centers
14 operating I need my common services broker, my
15 enterprise service bus and my service oriented
16 architecture. And then I can put on
17 laboratory, immunization or pharmacy on top of
18 that and light it all up with a common
19 graphical user interface.

20 I could say for example do
21 document management right now and get it
22 deployed. But what would I put it on top of?

1 I need this infrastructure, this whole
2 infrastructure and pieces of it in order to
3 deploy this out to the ILC sites.

4 So how do we affect that value
5 proposition? It's by improving those patient
6 safety and clinical outcomes. That's where
7 we're focused in every one of these. Reducing
8 waste from unnecessary tests, diagnostic
9 accuracy improvements, treatment guidelines,
10 build protocols, treatment protocols within
11 the iEHR system.

12 I think there's pretty good data
13 out there that tells us that it takes upwards
14 of 14 years for a clinical protocol to be
15 adopted. If we put them within the work flow
16 they get adopted much more quickly.

17 Public health and assessment using
18 our data warehousing systems, admin costs and
19 continue to improve efficiencies. Our current
20 state two independent systems leading to this
21 future state where I've got DoD and VA shared
22 data and single applications across both

1 departments including clinical decision
2 support and a single graphical user interface.

3 So how about VLER Health. We've
4 talked a little bit about that already. And
5 as I mentioned the JEC gave us that go
6 decision. I won't repeat this, but they said
7 go ahead and deploy this. And I talked about
8 the return on investment that they've asked me
9 to look at in order to pick the sites.

10 The services in the VA are working
11 together on those models so they can pick
12 those sites where we have not only a number of
13 patients going out in the private sector, but
14 as I mentioned those mature health information
15 exchanges and providers and institutions that
16 have accepted the data use agreements coming
17 out of the Office of the National Coordinator.

18 This is what VLER has accomplished
19 to date. Out in San Diego, they have this
20 C32. C32 is a reporting structure that is
21 common and accepted, common standard for
22 reporting including drug allergy

1 sensitivities, medications, person
2 identification. And that's been deployed out
3 in San Diego, Navy Med out in San Diego, as
4 well as Kaiser Permanente.

5 And you can see these are our four
6 pilot sites, our joint pilot sites. And what
7 we have accomplished in September of 2010,
8 November, March of 2011 and September of 2011.
9 And we will continue this deployment now with
10 the JEC's decision to deploy nationwide.

11 This picture shows you the three
12 TRICARE regions along with where we currently
13 have VLER Health deployed where this orange
14 color talks about both DoD, VA and private
15 sector exchanges, here and here. And VA
16 private sector exchanges in the red. And VA
17 private sectors with direct, that means down
18 to single doc offices in the blue.

19 This picture shows you our private
20 sector production sites by name and location,
21 just exactly where we are and where in this
22 blue is our three way exchanges, DoD, VA, and

1 the private sector. And the red is where VA
2 is communicating with the private sector in a
3 two-way exchange.

4 These are the sites where we've
5 got those eight two-way pilots, actually
6 that's increased now where I've got 14 total
7 between VA medical centers and the private
8 sector facilities. And here are the locations
9 where VLER Health is operating.

10 This is the architecture that we
11 use for VLER Health. We are using the NwHIN,
12 the eHealth exchange that is operated by the
13 Department of Health and Human Services. DoD
14 and VA were instrumental in helping this
15 overall design.

16 This is where we have Department
17 of Defense through its gateways as well as the
18 VA through its gateways running through this
19 NwHIN cloud where these private sector
20 providers have agreed to operate by the data
21 use agreements and they've built their own
22 gateways to connect into DoD and VA systems.

1 So the DoD would say what patient
2 do you have? Do you have, you know, Jimmy
3 Jones? And the private sector says I've got
4 him. And the DoD would then say, well what
5 data do you have? They would respond I've got
6 this data. And then the provider would say
7 well of that list of data you got I only want
8 this set here. And then that would be
9 exchanged with the VA or DoD providers.

10 At James A. Lovell Federal Health
11 Care Center, as I mentioned this is that one
12 of a kind facility. Both departments got
13 together to operate this single hospital. Our
14 role at the Interagency Program Office was to
15 provide joint information technology, health
16 information technology solutions to combine
17 and safely interface both the DoD and VA
18 systems. And it is serving both active duty
19 members, veterans, and their beneficiaries.

20 It was established in October of
21 2010, 146 thousand beneficiaries, 400 hospital
22 beds, 150 of which are acute care. Nine

1 hundred outpatient visits annually. More than
2 2,900 employees.

3 So in December of 2010, is when we
4 completed the infrastructure data center,
5 built the single patient registration, as I
6 mentioned, to have that patient reg across
7 both departments. And we created that single
8 sign and context management first out at James
9 A. Lovell, which is now being deployed across
10 the DoD.

11 Later on in 2011, single order
12 entry for orders portability for radiology and
13 our single graphical user interface which was
14 then modeled here and is further being
15 deployed now from a, through a secretarial
16 decision out to the polytrauma sites. Later
17 in 2011, our single order entry for laboratory
18 and then continuing with order entry with
19 consults management.

20 And with that let me open it to
21 your questions.

22 CO-CHAIR NATHAN: Barclay, I'd

1 like to ask you, you know, your, the roll out
2 of this or the continued evolution of an iEHR
3 which is I believe, most of us believe
4 critical to solvent care between the two
5 systems, is dependent on getting out of a CR
6 which we're in for the foreseeable future and
7 somehow finding our way out of a sequestered
8 budget that would take some of these
9 evolutionary ways of doing future business.
10 This doesn't preclude what, if we stop doing
11 this today, it doesn't preclude us from doing
12 business as usual.

13 We just know that business as
14 usual is not as optimal as an integrative
15 health record with the VA and a virtual
16 connection to the private sector to not see
17 each other's health records but to be able to
18 transfer data about the patient back and
19 forth. Your comments on that.

20 DR. BUTLER: Yes, sir. Coming out
21 of the secretary's meeting on the 10th of
22 January they are acutely aware of the issues

1 that you just raised. And so what they have
2 done is they've asked the IPO to look at
3 different ways that we can accelerate the
4 interoperability, that common data sharing
5 even among the Legacy systems as they exist
6 right now.

7 So even in the event of a
8 sequestration and significant cuts in the DoD
9 that would have an impact on our ability to
10 execute, we are focusing in on the
11 interoperability of data which then allows our
12 docs and nurse providers to see that common
13 data across both departments.

14 So first and foremost, accelerate
15 the exchange of data among Legacy systems so
16 we potentially avoid the situation that you
17 addressed. The second issue is, they asked us
18 to look how could we significantly cut costs
19 of our integrated electronic health record.
20 Now when the IPO was rechartered in October of
21 2011, along with that came a number of
22 secretarial decisions.

1 For example, we will use Best of
2 Breed. We will use service oriented
3 architecture. We will have an enterprise
4 service bus. We will have a common
5 information or operability framework. We'll
6 have abstracted data and abstracted
7 application programming interfaces.

8 All that led to, the only way, the
9 industry cannot respond to that. Industry has
10 nothing like that. So that led to a Best of
11 Breeds solution. We have to build it. If we
12 can relax some of those, not all of them
13 certainly, but some of them, then I can go to
14 a Best of Suite solution and dramatically
15 increase the amount of clinical capabilities
16 I can bring to the clinicians early on, number
17 one.

18 And I can likely deploy it at a
19 significantly reduced cost because industry
20 already has it out there. Now the danger
21 there, as I mentioned, is that vendor lock and
22 that data lock. If I can extract the

1 application in the single layer then I've
2 broken the vendor lock. What that allows me
3 to do is in ten years I could pull that vendor
4 out and bring in another Best of Suite.

5 I can break the data lock by
6 extracting the data as well. We haven't yet
7 made those decisions. We have to assess what
8 industry can do here. But I'm optimistic that
9 we'll be able to provide this capability and
10 I think significantly reduce our initial
11 projected costs of a full Best of Breed
12 solution going to a hybrid solution where we
13 have a clinical core that is tightly
14 integrated along with Best of Breed
15 applications on the outside. Still becomes a
16 platform where applications can be brought in.

17 CO-CHAIR NATHAN: So to segue on
18 that, so thank you. You've shown some
19 mechanisms as to how we might be able to
20 proceed in the face of these physical
21 challenges. Let's say we roll the tape
22 forward, we get there.

1 We're talking about a new
2 integrated health system about where the DoD
3 and the VA has to compromise and come
4 together, forfeiting some of their existing
5 infrastructure with AHLTA and with Vista.
6 It's sort of reminiscent of the chicken and
7 the pig walking down the road and they're
8 deciding what to have for breakfast and the
9 chicken says why don't we have ham and eggs?
10 It looks like the DoD's given the ham and the
11 VA's given the eggs. Do you foresee, are you
12 optimistic that we can really undo the wieldy
13 monster known as AHLTA?

14 DR. BUTLER: Yes, I do as a matter
15 of fact. And in fact I think that the easier
16 paradigm is turning off CHCS and AHLTA because
17 the DoD has been very careful to define those
18 boundaries. CHCS is what it is. You can
19 count the number of capabilities it has.

20 And they are all identifiable and
21 their interfaces are identifiable. Similarly
22 for CHCS. That leaves me then with that

1 common data, the clinical data repository that
2 I can interface in this architecture. So I
3 actually think it's easier for the DoD to
4 effectively do a rip and replace if I shorten
5 that time frame.

6 Industry now deploys an EHR at a
7 hospital, maybe their a second or third or
8 fourth site in about three month window.
9 Their first site takes about a year. Once
10 they get those practices down they can really
11 rapidly deploy it. I think we can bring that
12 to the DoD in a similar fashion.

13 The VA though is a different
14 animal, there you go. And where their Vista
15 system is a conglomerate of applications that
16 are layered and layered and layered, it I
17 hesitate to even say it's a platform. And I
18 say that because for example, when they bring
19 in a commercial off the shelf application and
20 I'll use laboratory it's taken a number of
21 years to get that interfaced and operational.

22 If it takes a number of years as

1 contrasted to a number of months, I hesitate
2 to call it a platform ready to be interfaced
3 with practiced Best of Breed solutions that
4 are out there. So I think the VA will
5 actually have a harder time and it's our job
6 in the IPO to help them through that to leave
7 that, to identify where those interfaces are
8 and to bring in that new core if in fact the
9 VA decides that they will go forward with a
10 new core iEHR.

11 CO-CHAIR NATHAN: Thank you.

12 Other questions.

13 MEMBER PHILLIPS: I was going to
14 say this is a daunting task at least. And if
15 you can accomplish 50 percent of what you
16 presented, I think you should be, you know,
17 congratulated. These huge Legacy systems,
18 what are you going to do with AHLTA? I mean
19 you mentioned you're going to replace AHLTA
20 which, great. But what are you going to
21 replace it with?

22 DR. BUTLER: Yes, we were, we

1 actually replace, remember the DoD's got, has
2 a combination of two systems that present the
3 overall integrated electronic health record,
4 the current one, the Legacy one. It's the
5 CHCS system, which is their order entry system
6 and it's the AHLTA which is the clinical
7 documentation system, right.

8 And the two communicate. I will
9 keep the data. And I will replace both of
10 those capabilities with the net new integrated
11 electronic health record. I will replace
12 order entry. I will replace lab, pharmacy,
13 radiology, et cetera all the way down the
14 list.

15 Master patient index, records
16 tracking, managed care support, all of that
17 will get replaced including the clinical note,
18 including the inpatient systems and the
19 speciality systems as well. And every time I
20 replace one of those systems I'll flip the
21 switch on the Legacy system and say not that
22 one anymore, but the net new.

1 And if we can get those deployed
2 in hospital number three, four, five in the
3 time frames that industry has proven that they
4 can, then I think we have a very rapid
5 deployment across the DoD system. But the
6 data remains, right.

7 I will federate the data, which
8 means that I will point back to Legacy data so
9 when the clinician says I need to see Jimmy
10 Jones data from three years ago because that's
11 relevant to how I'm treating them today, then
12 that data's available and displays on the net
13 new system.

14 MEMBER PHILLIPS: A lot of
15 information, I mean, for many reasons is
16 scanned in.

17 DR. BUTLER: Yes.

18 MEMBER PHILLIPS: How, do you have
19 a plan to deal with that? I mean how are you
20 going to make that interactive?

21 DR. BUTLER: Yes, there's a
22 considerable amount of data that's still in

1 paper. And that's especially important to the
2 VA when you look at benefit's adjudication.
3 Before 1974, we still have a number of folks
4 that are 100 percent paper record.

5 We do have to capture that data.
6 I believe that the answer is intelligent
7 scanning to get that captured. There are
8 systems that are out there that can scan at
9 incredibly high rates and recognize documents,
10 categorize documents and get those compiled
11 for later use.

12 You can do, with this intelligent
13 scanning, you can look for fields and turn it
14 into computable data. It's a harder task, but
15 I think one that should be undertaken.

16 MEMBER REHBEIN: We're working, in
17 my other life out at Iowa State, we're working
18 with a company that is able to take the old
19 electronic publications and actually do some
20 data searches on them, syntax sensitive, so
21 that we can extract some data out of them that
22 ordinarily an individual would have to sit

1 down and read through them and try to
2 understand that.

3 There's some real, there's some
4 real advances going on out there. There are
5 some things out there that are very, they're
6 hard for me to understand, frankly, because
7 now their not only moving from our language
8 into the pictographic languages and attempting
9 to do the same thing. So there is some real
10 capability out there.

11 CO-CHAIR NATHAN: Anything else?
12 I would only add if you can accomplish at
13 least 50 percent of this you shouldn't just be
14 congratulated, you should be knighted. So
15 thank you again.

16 DR. BUTLER: Thank you, sir. And
17 thank for your attention today. I certainly
18 appreciate it.

19 CO-CHAIR CROCKETT-JONES: We have
20 a 15 minute break and then we'll be back.

21 (Whereupon, the above-entitled
22 matter went off the record at 3:21 p.m. and

1 resumed at 3:33 p.m.)

2 CO-CHAIR CROCKETT JONES: Okay,
3 now we welcome Doctor James Kelly, Director of
4 the National Intrepid Center of Excellence,
5 Captain Sarah Kass, the Deputy Commander,
6 Captain Robert Koffman, the Deputy Director of
7 Clinical Operations. But I see four people.

8 CAPTAIN KASS: Yes, ma'am, we also
9 have Doctor Tom DeGraba, who joined us today.
10 He's our deputy director.

11 CO-CHAIR CROCKETT JONES: Thank
12 you. Established in 2010, NICoE is a
13 Department of Defense institution, dedicated
14 to providing cutting edge services for service
15 members and their families dealing with the
16 complex interactions of mild TBI and
17 psychological health conditions.

18 We have information under Tab G in
19 our binders for this presentation. And I'm
20 going to turn it over to you all.

21 CAPTAIN KASS: Thank you, ma'am.
22 Good afternoon everyone. I brought together

1 the experts on our team here from the NICoE to
2 speak with you today.

3 I believe we have about an hour.
4 And we wanted to make sure that we addressed
5 the ten questions that you provided to us. So
6 we have crafted our presentation to
7 specifically address those issues.

8 Many people have had the
9 opportunity to come to the NICoE up to this
10 point, or have some familiarity with it. For
11 those who don't, if you have questions that
12 aren't addressed in this, by all means let us
13 know and we'll provide some additional general
14 information.

15 But in the interest of time, and
16 leaving plenty of time for question and
17 answer, we'll go ahead and just get started
18 straight into the presentation.

19 As you know, like I said, we were
20 given ten questions in the agenda. We have
21 provided you a slightly reordered series for
22 those questions, and that's just to limit the

1 number of times we switch from presenter to
2 presenter.

3 So with that said, I'll introduce
4 Doctor Jim Kelly. Dr. Kelly has been the
5 director of the NICoE since its inception.
6 And so I'll let him start off our presentation
7 to you today.

8 DR. KELLY: Thanks, Captain Kass,
9 good afternoon, everyone. If we could turn to
10 that slide right there, Slide 2, our overview
11 and mission.

12 The vision of the National
13 Intrepid Center of Excellence is to, as you
14 see there, to be the nation's institute for
15 TBI and psychological health conditions
16 dedicated to advancing science, enhancing
17 understanding, and maximizing health, and
18 relieving suffering.

19 The mission is to serve as,
20 specifically, an institute, and I'll go into
21 the difference between that and a clinic,
22 dedicated to understanding complex comorbid

1 traumatic brain injury and psychological
2 health conditions by providing a comprehensive
3 and holistic care with focused research, and
4 exporting the knowledge that benefits a
5 service member's families and society.

6 So the mission really is broken
7 out into three parts, research, training, and
8 education. And the clinical care that we
9 provide in the building itself, many of you
10 this is actually a free-standing two-story
11 structure at Walter Reed Bethesda.

12 We actually are aligned under the
13 Walter Reed Bethesda Hospital. We had
14 previously, as many of you will recall, been
15 a part of Defense Centers of Excellence as we
16 grew up in response to the NDAA of '08.

17 So without reading to you in
18 detail each of the different pieces, what I
19 really want to emphasize is the research
20 mission, our research institute function, is
21 the major thrust of the NICOE, as we call it,
22 Institute at the present time.

1 We were intended, all along, to do
2 a deep dive into the diagnostic work-up of the
3 patients, and innovate in terms of treatment,
4 and then get those lessons learned out to the
5 MHS, and as you're aware now, through NICOE
6 satellites, which are being built in two
7 locations.

8 Those had been part of the plan,
9 structurally, organizationally, from the very
10 beginning.

11 And so what we do as an institute
12 is looking at the pathophysiology of that
13 comorbid state. Again the individuals that
14 we're looking at have had a traumatic brain
15 injury, and have psychological health
16 conditions in that same person.

17 This is different than just an
18 isolated traumatic brain injury, or somebody
19 without that neurological state who has PTSD.

20 But again, a huge part of the
21 population who come back from the war zones,
22 which was as we developed the concept of

1 operations and developed the mission and
2 vision, it was in order to hit that population
3 specifically that had the comorbid
4 neuropsychiatric condition.

5 If I may go to the next slide.

6 The overview of our mission is consistent with
7 NICOE's five year strategic plan.

8 Two imperatives for the
9 organization, being advance the understanding
10 of that comorbid TBI and psychological health
11 disease state in order to improve diagnosis
12 and treatment, and then also to influence
13 improvements in the quality of care through
14 partnerships across the MHS, the VA, and the
15 civilian sector.

16 Next slide. The answer to how
17 effective is NICOE and how do we know, in
18 terms of the clinical piece, we actually
19 follow six clinical evaluations that you see
20 listed there.

21 And those are done on day one, and
22 in the last couple of days before the

1 individuals leave after their four week
2 treatment program with us.

3 Those are well established
4 previously validated scales that are filled
5 out by the patient, sometimes in collaboration
6 with a family member.

7 Satisfaction with life scale
8 Neurobehavioral Symptom Inventory, a
9 sleepiness scale called Epworth, a specific
10 PTSD check list, the Dizziness Handicap
11 Inventory, the Headache Symptom Inventory, if
12 you will, the impact test, each of these have
13 demonstrated qualitative improvement in the
14 four week stay with us.

15 And the very next slide shows
16 statistically how that breaks out. So as
17 you'll see in the first column there, we have
18 the outcome measures listed again.

19 The second is the number of
20 subjects in the program that have gone
21 through, in this case, the four week program.

22 I should point out that when we

1 started two years ago, as we were pointing out
2 at the beginning, we were a two week program.
3 That gradually grew to a three week program,
4 and then ultimately a four week program as we
5 learned that we could actually accomplish more
6 if the patients were to stay with us just a
7 little bit longer.

8 And we also found that they were
9 more likely to share with us details of
10 information and so forth that they otherwise
11 felt reluctant to do so if they were just
12 going to be there for a short span of time and
13 then leave.

14 So we actually felt we could
15 expand the project to four weeks. And it's
16 this group then that had gone through that
17 four week project that we are currently, the
18 program as it exists.

19 So you see the greatest number is
20 182 that have filled out the headache
21 inventory, 181 for the other satisfaction with
22 life and Epworth Sleepiness Scale.

1 The low numbers of the dizziness
2 scale, and the Neurobehavioral Symptom
3 Inventory for headaches in specific, are lower
4 because not every patient has all of those
5 complaints. And so the check list, if you
6 will, or scale, isn't pertinent under those
7 circumstances.

8 And as you can see, at the far
9 right, statistically significant improvements
10 along each of those measured outcomes, those
11 standardized measures.

12 Next slide. We also look
13 specifically at the satisfaction scales that
14 the patients fill out. And the bar
15 underneath, the overall table that you see
16 there, indicates an overall patient
17 satisfaction score of 95 percent, indicating
18 that they agree, or strongly agree, that this
19 has been a positive experience for them.

20 And the positives in general, in
21 terms of the written comments that we hear
22 back from the patients include they enjoy the

1 team approach.

2 And I should point out, as you'll
3 hear shortly, the team is entirely co-located
4 in the building. All of the members are in
5 one location, which is not always the case
6 throughout the MHS.

7 And then the team takes time to
8 listen to me, and that they care. We hear
9 that theme very often, that there's an
10 empathic engagement between our staff members
11 and the patients and family members that they
12 may not always experience elsewhere.

13 And I think that's facilitated
14 again by the co-location and the easy access
15 that we have to the patients under the
16 circumstances of the building itself.

17 The negatives, the feedback we get
18 is that the program, even at four weeks, for
19 many seems that they need it to be longer, or
20 they would like it to longer.

21 And they're concerned that when
22 they leave they're going to back to care that

1 has not been changed, and will be similar to
2 what they experienced before they came to
3 NICOE, so that it would be care as usual, if
4 you will. Yes?

5 CO-CHAIR CROCKETT JONES: I'm just
6 trying to understand something. So of the
7 folks who have done the tests, the clinical
8 tests, your max number on those is 182. But
9 in responses on the effectiveness, am I right
10 in seeing the number 13,000, or 17,000 as
11 total responses?

12 DR. KELLY: Those are actually if
13 you add up the responses in that particular
14 survey.

15 CO-CHAIR CROCKETT JONES: So --

16 CAPTAIN KASS: The survey had
17 multiple questions.

18 CO-CHAIR CROCKETT JONES: Okay.
19 I see. So what I'm trying to, I guess,
20 understand is what is the total number of
21 patients that is reflected by this survey, or
22 by that testing.

1 DR. KELLY: These are different,
2 as you can imagine, so it's not exactly the
3 same number. We actually have many more
4 patients that have come through, 378 patients
5 have actually come through NICOE.

6 But by the time we were actually
7 able to gather the data, and in various time
8 frames after the four week program was put
9 together, these are the actual numbers that we
10 have in each of these different kinds of
11 inventories.

12 The n over at the far right of
13 that column actually reflects more accurately
14 what is the number that responded.

15 CO-CHAIR CROCKETT JONES: Thank
16 you. Go ahead, Mr. Drach.

17 MR. DRACH: Could you explain a
18 little bit -- I know the negatives, your last
19 comment, concern that they will return to care
20 as usual. I'm reading that to say that the
21 care as usual is substandard compared to what
22 they were getting.

1 DR. KELLY: Well, I think we'd
2 look at it a little bit differently. I think
3 what they're seeing is the care is standard,
4 where they are.

5 And this is a very innovative and
6 intensive program. It's truly an intensive
7 care model of a holistic, interdisciplinary
8 team specifically aimed at that comorbid
9 state. And until we get farther along with
10 NICOE satellites and other influence
11 throughout the MHS, it simply doesn't exist.

12 And so while they're receiving, in
13 many ways, what is standard of care in other
14 locations, what we're doing is innovative,
15 more intensive, actually more engaged on a
16 day-to-day basis.

17 Just as a for instance, over the
18 four weeks they have on average 104 hours of
19 interactions with our providers. If you were
20 to add that up, try to do that in the MHS, it
21 would typically take a year and a half or two
22 years to get that 104 hours with people, the

1 specialists that we have.

2 MR. DRACH: Got it, thank you.

3 But given the fact that there's a 95 percent
4 satisfaction rate, and based on what you just
5 said what, if any, potential is there of
6 making this permanent.

7 DR. KELLY: We readily realize at
8 the present time that this is probably a
9 pretty expensive, and not the easiest kind of
10 model to pull off.

11 In fact, we aren't fully staffed
12 even at this point, and having been open for
13 two years for seeing patients already. So
14 it's hard to get the right personnel on board.

15 It's a difficult model to do in a
16 location, unless you can dedicate the space to
17 it. And the satellites, hopefully, will help
18 us do that, because there will be that forcing
19 function, if you will, of everybody being in
20 one location and under one roof.

21 But the truth of the matter is,
22 sir, that even in the private sector, where

1 I've spent my previous years, there is no such
2 model. Nobody has this.

3 This is an opportunity that the
4 Defense Department has to innovate, and to
5 apply the principles that we've all learned
6 through our careers in the private sector, in
7 the VA, and in the DoD, in a way that has
8 lifted some of the restrictions and the
9 obstacles.

10 And I think, under the
11 circumstances, it's very effective because it
12 doesn't have a lot of the systematic snags,
13 and problems, and delays, and so forth, that
14 others live with.

15 I certainly lived with it in the
16 private sector. And this is a magical thing,
17 to me, frankly. There's nothing like this
18 that I've ever been able to put together in
19 some pretty top tier academic centers that
20 I've worked in. There's nothing like this.

21 MEMBER REHBEIN: The people that
22 have gone through the program, have you

1 contacted any of them, say six months after
2 they've left the program to see what kind of
3 permanent effects your program had?

4 Did they really go back to care as
5 usual, or did the effects of going through
6 your program stay with them and improve their
7 lives?

8 DR. KELLY: Much like the rest of
9 the MHS, and perhaps you've asked that
10 question of others as well, there's difficulty
11 in tracking individuals because of the
12 continuous sense of being mobile, and changes
13 of how you access people, and so forth. So
14 we're just now getting to where we have a more
15 systematic way of doing that.

16 It has largely been an
17 idiosyncratic and a small group of people
18 we've been able to track, and have been
19 contacting our clinicians that you'll hear
20 from as to their interest in maintaining
21 contact, and asking questions, and seeing how
22 it is they can influence and advocate for

1 themselves, which is a big piece of what we
2 ask them and teach them how to do.

3 So that once they've gotten the
4 skill sets that we help build with them over
5 the four weeks, and the information about what
6 has worked and what has not worked for them
7 individually, they then are asked to influence
8 the system outside.

9 And we hear about that either from
10 their practitioners, and sometimes I do that
11 when I'm elsewhere in the country, or they
12 contact our practitioners for more advice and
13 tell us how they're doing.

14 We have a database that's being
15 built and gathering that information right now
16 in the recovery care coordinator fashion
17 that's partnering with Defense and Veterans'
18 Brain Injury Center.

19 But we're aligning the data sets so
20 that what questions and outcome measures
21 they're using are the same as ours, so that we
22 can actually make sure that we're comparing

1 apples to apples when we look at our program
2 versus other programs, and so forth.

3 So it's a long answer to your
4 question about what ought to be a simple
5 explanation. Except we don't have a better
6 way yet of tracking those individuals.

7 We are building it in so that at 1
8 month, 3 months, 6 months, 9 months, 12
9 months, and so forth, we will be able to
10 access those individuals.

11 And to some extent, we're doing
12 that now. But it's a fairly small and start-
13 up part of our operations at the present time.

14 The next slide. And again, how
15 effective is NICOE in terms of education, and
16 how do we know? Again, I had mentioned that
17 part of what we do is education for wellness,
18 and skill building, and self-management
19 education modules for the patients and
20 families.

21 Captain Koffman can speak in more
22 detail in a minute to what those entail, and

1 answer questions about that. But 40 hours is
2 really quite a lot for individuals over a four
3 week span of time.

4 And the patients, we hear later,
5 very much appreciate understanding better what
6 the nature of the problems are that they've
7 had and they're facing, and what solutions
8 there may be.

9 In collaboration with this very
10 important initiative of our First Lady and
11 Doctor Jill Biden joining forces, as you may
12 have heard, that initiative was actually
13 partly rolled out right at NICoE on our
14 Bethesda campus, engaging the educational
15 systems in medicine, nursing, other allied
16 health programs to raise their hands to be
17 able to use the clinical approaches and
18 educational modules that are useful in the DoD
19 and VA, and make them applicable and
20 disseminated throughout the private sector
21 education system for healthcare providers.

22 So the joining forces model, if you

1 will, is to engage the private sector with
2 what is the military and veterans initiative
3 around TBI and psych health. That was a very
4 big piece of what it is we played a role in.

5 And then I have, and other have,
6 helped with a train the trainers, several
7 modules of TBI and psych health education for
8 the area health education centers.

9 These are Federally funded through
10 DHHS, that actually are in 46 states, and
11 serve as an infrastructure for health
12 education throughout the United States.

13 And so they already exist, teaching
14 continuing education to healthcare providers.
15 We're simply out there giving them the content
16 that they need in order to do so.

17 NICOE itself has hosted 123
18 conferences, or training seminars, over the
19 two years that you know we've been open, two
20 of which are notable.

21 The CDC concussion definition
22 working group is an ongoing project, which

1 will end next year, where the DoD, the VA, and
2 private sector entities in the academic world
3 are coming up with one uniform definition of
4 concussion, or mild traumatic brain injury
5 that can then lead to a coding that everybody
6 will be using, so that we can track what it is
7 that's happening in each segment, the DoD, the
8 VA, and civilian sector, in terms of
9 concussion, which doesn't happen right now.
10 It's a very important project.

11 And then we had the MIT-NIH
12 conference with some truly brilliant people,
13 two of whom were Nobel laureates, in the
14 building, talking about not only
15 neurodegenerative disease, which had been an
16 every two year project on an international
17 basis.

18 But they asked to come to NICoE to
19 bring the military research specialists in
20 regenerative medicine, and traumatic brain
21 injury as the model, into their thinking, so
22 that they were looking at the synapse of the

1 nerve cell, and how it is that actually can
2 regrow and make additional connections after
3 a trauma, after something has happened
4 adversely to the brain.

5 And so they were bringing their
6 science into the DoD thinking. And we were
7 influencing them on an international level as
8 well. It was just spectacular.

9 And then the other project is out
10 of the University of New Mexico. And Captain
11 Koffman can elaborate on this as well, the
12 project ECHO, the Extension for Community
13 Healthcare Outcomes.

14 And we've been asked, and quite
15 willingly participate in the DoD looking at
16 how to use teleeducation, teleconsultation,
17 emanating from our very robust capabilities at
18 the NICoE out to other locations throughout
19 the DoD.

20 We've already done two and have
21 additional ECHO projects planned to
22 disseminate. And again, we have more

1 information later if you'd like to hear about
2 that.

3 Next slide, please. In terms of
4 research, how effective are we? Again,
5 answering that question, we have 15 IRB
6 approved or pending research protocols at the
7 present time.

8 We've listed a few of them there
9 that I can certainly answer questions, or
10 Doctor DeGraba could answer questions about,
11 if anybody has specific questions about what
12 these projects really entail.

13 But then down below, in the little
14 table you see that we have several in
15 development, or in stages of data collection,
16 and so forth.

17 We have nine peer reviewed
18 publications in this span of time that we've
19 been open, and 39 poster or podium
20 presentations at national meetings. Next
21 slide.

22 CAPTAIN KASS: So as the military

1 leader of the group, I get to speak to the
2 challenges and the frustrations that we face.
3 And I think they're probably fairly consistent
4 with some of the ones we hear from the other
5 Centers of Excellence.

6 When the COEs were initially
7 established and staffed, there was a lot of,
8 for lack of a better phrase, beg, borrowing
9 and stealing to get staff onboard to help get
10 the initial mission accomplished.

11 And that works to a point. But
12 once you start to have those staff transition
13 onto their next job, if you don't have an
14 authorized manning document, it becomes much
15 harder when you don't have the same political
16 clout to refill those positions.

17 So two years into this endeavor, we
18 are now facing many of our military staff
19 PSCing. We still don't have a manning
20 document.

21 And so that is one of the critical
22 challenges that we face. Just in this year,

1 we've had two key Army personnel PCS, and
2 anticipate some additional losses in this
3 coming summer.

4 So we're working with our
5 leadership to push forward the idea of a
6 manning document. But that's certainly
7 something that's critical to future mission
8 success.

9 MEMBER EVANS: So, Captain Kass, is
10 that under JTF CapMed, that's responsible for
11 the manning document?

12 CAPTAIN KASS: Yes, ma'am. Right
13 now Walter Reed Bethesda falls under JTF
14 CapMed, so we'll work with them to get that
15 manning document established.

16 In addition to that, I would say
17 two other things in the same category as
18 staffing. One is our civilian hiring process.
19 I don't think I'm saying anything new when I
20 say it's challenging and cumbersome.

21 And when you're trying to recruit
22 top tier individuals to come be a part of your

1 Center of Excellence, the delays that we faced
2 with the civilian hiring process continued to
3 hamstring us to some degree as well.

4 And one of the most notable pieces
5 of that, honestly, has been the security
6 clearance process. We nowadays can have
7 people stuck in the security clearance process
8 for six months.

9 And you can't proceed to hire
10 somebody new, because the offer has been made.
11 And so you wait six months for that process to
12 be cleared. And that presents significant
13 challenges.

14 In addition to that, as Doctor
15 Kelly has mentioned, we're setting up the
16 NICOE network. So the NICOE Institute in
17 Bethesda, and the nine satellites that have
18 been proffered by the Intrepid Fallen Heroes
19 Fund that will be built over the next few
20 years, we've now taken on a new mission
21 requirement to serve as the oversight and
22 liaison for establishing that network. And

1 those are additional manpower requirements
2 that will need to be addressed.

3 Our second major hurdle that we
4 face has to do with research, specifically
5 research funding and then IRB. I know fairly
6 quickly I'll dismiss the IRB piece of this.

7 I know other centers have looked at
8 single IRBs for the work that they're doing,
9 because they're doing multi-site research.
10 And we're in the process of establishing the
11 same setup with a single IRB to serve as the
12 source for human subject protection for all
13 the research that will happen across this
14 NICoE network.

15 And we're receiving support from
16 JTF and Walter Reed to establish that. We'll
17 also continue to explore MRMC, which I know
18 some of the other Centers of Excellence have
19 done.

20 But the funding is a more
21 significant challenge for us. Again, I think
22 at the initial establishment of the NICoE, the

1 thought was in order to really function as an
2 effective Center of Excellence, it needed to
3 have approximately, many have estimated, \$20
4 million a year for the research to really do
5 the cutting edge research that needs to be
6 done.

7 But there is no dedicated research
8 funding for the NICoE or the NICoE network.
9 And so we face a situation of competing for
10 grants, like other people, which is fine.

11 But then we face the challenge of
12 not having the infrastructure to support
13 execution of those grant dollars when we
14 receive them.

15 Again, we continue to work with
16 Walter Reed Bethesda and JTF to fix some of
17 those processes, but the situation remains
18 that we, at times, will receive grant dollars
19 and then not be able to fully execute them,
20 because of some of the bureaucratic challenges
21 you face trying to get dollars executed in our
22 system.

1 So those are the primary ones, the
2 dedicated funding, and then once you have
3 funding, moving it.

4 And the last one, I think Doctor
5 Kelly also alluded to, which has to do with
6 the traditional measures of productivity that
7 we have in our healthcare system, look at
8 relative value units and how productive are
9 you.

10 But when you're setting up a new
11 model of care that includes an
12 interdisciplinary approach to care, with very,
13 very timely access to the next appointment
14 that you need, the business rules of our
15 current system don't support that.

16 I've been in meetings where people
17 suggested that we just book all of our
18 appointments through the traditional IRMAC
19 system that we have at Walter Reed Bethesda.

20 We reschedule our patients on a
21 daily basis, based on how they did the day
22 before. Our nurses will meet with them at the

1 end of the day and say what worked for you,
2 what did not work for you. How do we have to
3 shift things so that tomorrow we can address
4 the challenges that you're still facing?

5 And that requires a flexibility and
6 agility that the traditional system just does
7 not support.

8 Additionally, the standard measures
9 of relative value units really aren't the
10 measure of productivity here. So as we set up
11 the NICOE network, and we looked to build
12 these satellites, we really need to push for
13 relief from the traditional RVU measures of
14 productivity, and look at measures of quality
15 and outcome, and patient experience.

16 Did this meet your needs? And are
17 you doing better today than you were two
18 months ago, two weeks ago, as a measure of
19 success.

20 In addition to that, we do believe
21 that we are a value add and a value commodity
22 in the MHS. Because if you look again at

1 those 18 months of trying to get appointments,
2 if you're not getting better, that is not
3 efficient use of the healthcare system.

4 Instead, if we can front load
5 appointments, get people into a very intensive
6 program, even if it's more expensive up front,
7 we believe there's an opportunity to look at
8 do we gain improvements in care that reduce
9 costs in the long run.

10 So as some of the discussion about
11 the outcome measures, besides looking at how
12 patients are doing in their clinical measures
13 at the six months, one year, and two year
14 mark, we also want to look at decreased use of
15 the ER, and decreased unplanned access to
16 care, as measures of success of the program.
17 Yes, sir?

18 MR. DRACH: Do you have any idea
19 what the average time post entry of your
20 patients?

21 CAPTAIN KASS: I'll let Captain
22 Koffman answer that, because I think he's got

1 better numbers. I'll tell you it's very wide,
2 from a couple of months to 18 years, I think.

3 CAPTAIN KOFFMAN: Indeed, there is
4 really no modal delay in terms of between
5 injury and presentation at the NICoE, because
6 there are so many forms of head injury.

7 So typically if it is blast
8 related, it is during the more recent years of
9 war.

10 But many individuals have has head
11 injuries through their training combatives,
12 through high speed assault craft. So because
13 the modal presentation of head injury is so
14 broad, we see people with very chronic
15 traumatic brain injuries, sir.

16 MR. DRACH: So am I hearing
17 correctly that some of your patients are pre-
18 9/11?

19 CAPTAIN KASS: Yes, sir.

20 MR. DRACH: Thank you.

21 CAPTAIN KASS: The next question we
22 were asked to address was our clinical staff.

1 And so what I've presented is part of our
2 standard brief of what is our clinical team,
3 and who makes up our clinical group.

4 And so you see here, again, the
5 patient is at the center, the patient and
6 their family. But they are supported by a
7 nurse, and then all of the different providers
8 that you see on the outside of that ring.

9 The structure is set up to have
10 three inner-disciplinary teams of core
11 providers. Those core providers are the
12 internist, the neurologist, psychiatrist,
13 family therapist, and neuropsychologist.

14 And then the other providers would
15 support all of the teams. So we have a robust
16 interdisciplinary team making up a number of
17 different folks.

18 If we look at our staffing then on
19 the next slide, you asked specifically for
20 clinical staffing. But I wanted to present
21 the whole picture again, as an institute.
22 Really it's about having all of these folks

1 onboard.

2 Currently we're staffed at about 72
3 percent of our projected manning. We have put
4 a lot of emphasis towards the clinical
5 staffing initially, so we're approximately 83
6 percent manned in the clinical realm. But
7 directorates like education have taken the hit
8 and are not nearly staffed where we'd like
9 them to be.

10 At this point in time, the biggest
11 impact of that is on burn-out of the clinical
12 staff. We have a lot of our clinical staff
13 working extremely hard.

14 And the patient population, in and
15 of itself, can present challenges to work with
16 on a daily basis, And then asking them to do
17 it, and make up for the positions that aren't
18 filled, certainly adds to their wear and tear.

19 But I think it's also had a impact
20 on our ability to fully execute in the
21 research and education directorates in the way
22 that we would like.

1 And then, as I said, the satellite
2 oversight will only add to the requirements
3 that we have here.

4 Next we're going to move on to
5 referral patterns. And at this point I'll
6 turn it over to Captain Koffman for pretty
7 much the duration of the slides that we have
8 here.

9 And the rest of us will help and
10 answer questions. Captain Koffman serves as
11 our department chief for clinical operations,
12 and so is in the weeds on a day-to-day basis
13 with clinical.

14 CAPTAIN KOFFMAN: Thank you, ma'am.
15 You can see that we've had about 378 patients
16 referred to the NICoE. By our concept of
17 operations, individuals must have experienced
18 a comorbid brain injury, in other words a
19 typically mild or moderate TBI, most of them
20 are mild TBIs, with some form of a
21 psychological health condition.

22 And additionally, the individual

1 must be DEERS eligible, either active duty or
2 under orders to come to our facility.

3 We've had somewhat of a
4 disproportionate number of individuals coming,
5 largely from the Marine Corps, and this is
6 typically from Camp Lejeune.

7 And then from the Army we've had a
8 disproportionate number of individuals coming
9 from the CBWTU. Similarly, from the Navy, of
10 those 77 sailors, the vast majority have been
11 SF Seals from Virginia Beach or Dam Neck.

12 And so the story here really is
13 success begets success. And for the
14 facilities that we're getting folks from,
15 they're actually sending quite a large number
16 of individuals.

17 We have about a six to eight week
18 wait for our month long program. We onboard
19 five new patients a week. And as Captain Kass
20 mentioned, this is a very accelerated and
21 intensive program. Next slide please.

22 MS. DAILEY: I'm ahead of you.

1 Real quick, you sourced it by location, any
2 idea within those locations how they're being
3 identified?

4 Are they being identified in the
5 WTUs, obviously community based warrior
6 transition unit, obviously case management
7 teams are then referring them to you, I
8 assume.

9 CAPTAIN KASS: I think we addressed
10 that in this slide.

11 MS. DAILEY: Oh, I'm sorry.

12 CAPTAIN KASS: We'll try to get to
13 that.

14 CAPTAIN KOFFMAN: We've tried to
15 make it very easy for primary care providers
16 to refer to the NICoE. We actually have a
17 very simple referral package on the Web,
18 accessibly through DCoE, which was initially
19 our primary Web contact, or now through JTF
20 CapMed.

21 But essentially the primary care
22 manager fills out a one page referral. And

1 our triage body, our white team, looks at the
2 merits of that particular referral.

3 And if the individual meets
4 criteria, again, the presence of a traumatic
5 brain injury with some form of a psychological
6 health condition that is not responding to the
7 current level of care, then they would
8 quality.

9 And in fact, the vast majority of
10 individuals we've seen have met those
11 criteria. If the individual doesn't meet the
12 criteria, or if it seems like there's other
13 opportunities for our white team to work with
14 the home station in terms of potential
15 opportunities for intervention, either prior
16 to the individuals coming.

17 Or perhaps that's all that's
18 required is our white team is capable of
19 making recommendations to the referring
20 facility, or provider. And you can see of 13
21 patients, you can see typically our referrals
22 do come from primary care providers.

1 CAPTAIN KASS: I wanted to try to
2 answer Ms. Dailey's question. Because again,
3 as we looked at specifically what you asked
4 about your interest in understanding if
5 patients come as identified from PDHRA, or
6 from their command, or family members, the
7 challenge for us in that regard is that all of
8 our referrals come from the MTF.

9 So these people have already been
10 referred into the healthcare system. We did
11 pull the records trying to go through the
12 records to see if we could get back to the
13 original source of referral. And
14 unfortunately it was very difficult to define
15 that in the medical record.

16 So I appreciate the interest of
17 what you're trying to look at. Unfortunately,
18 I'm not sure we're the best organization to
19 answer that question, because we're, again,
20 that tertiary care center that's getting the
21 referral from the primary care site, the
22 primary site of medical care.

1 MS. DAILEY: No, I appreciate you
2 taking it down one more layer there. And we
3 ask this question usually at site level. And
4 we were at Fort Carson just last week, and
5 they're experiencing a similar kind of
6 challenges on who and how they got the
7 referral. So thank you, I appreciate the dig.

8 CAPTAIN KOFFMAN: Next slide. In
9 terms of non-completion, non-completion
10 through our four week program is essentially
11 not a problem.

12 We've only had a couple of
13 individuals who have had to return, because of
14 legal issues. And we try and screen folks
15 carefully to make sure that they'll be able to
16 continue their four weeks while they're with
17 us.

18 Those that have left, and
19 importantly those that do, we really have a
20 very elaborate discharge process where we
21 liaise with the home station.

22 And this is where the hand-off, to

1 include an incredibly comprehensive discharge
2 summary, is important. And again, this helps
3 us set the stage for follow-up data
4 collection.

5 Next slide, please. Doctor Kelly
6 mentioned our interdisciplinary care. The
7 opportunity that we have at the NICoE is
8 really to extend this model -- which is a very
9 front-loaded model of care early on, at least
10 early on in the presentation of the individual
11 -- to our facility, and share these best
12 practices with ECHO.

13 As mentioned, ECHO is Extending
14 Community Health Outcomes. And ECHO is the
15 teleconsultative, telecollaborative service
16 that we are developing with our NICoE
17 satellites.

18 And indeed, we ultimately see many
19 MTFs being able to dial in to this ECHO
20 network and be able to discuss best practice
21 amongst the comorbid TBI psychological health
22 sufferer.

1 We've started Project ECHO. We've
2 had two successful collaborative efforts with
3 two of our earliest NICOE satellites. And
4 this is really going to be a best practice, we
5 hope. It has been very successful at the
6 University of New Mexico, where the
7 availability of specialty care is similarly
8 fragmented.

9 CAPTAIN KASS: I think, again, to
10 add to that, I think in University of New
11 Mexico the model for this was Hepatitis C.
12 And it's a very algorithmic approach to a very
13 well defined condition. So it really was just
14 about getting people connected to the
15 consultation from a specialist.

16 But I think where this is different
17 for us is this is not nearly as crisp and
18 clean as Hepatitis C, as far as the diagnosis.
19 And then the treatment is much more complex,
20 and much less algorithmic.

21 So when we get to the idea of how
22 do you translate what you're learning at

1 NICoE, and infiltrate the rest of the
2 healthcare system, I think this is a key
3 initiative in that regard.

4 Because I think this is where you
5 start to talk about less so giving people
6 access to expert consultation. It's about
7 discussing best practices and then having
8 those people then carry that on in their daily
9 practice.

10 And so the more we're able to have
11 as ECHO, the intent of that is a reverberation
12 of what happens. That's why it's sort of the
13 name ECHO was craftily created into the name.

14 The goal would be that NICoE
15 Institute in Bethesda would host a case-based
16 conference where we talk about best practices
17 with the satellite locations.

18 And then those satellite locations
19 then have a similar teleeducation conference
20 with the primary care community that they
21 serve. And so that's the goal of that effort.

22 MEMBER EVANS: Right. So two of

1 our recommendations, and one of them for the
2 FY '12, and I believe you've seen the set for
3 primary care and the behavior health
4 providers, that they're trained.

5 And how are we tracking that
6 they've received the training for post
7 traumatic stress disorder. And then to carry
8 that even a little farther, how are we looking
9 at evidence base and ensuring that they're
10 trained on the evidence based.

11 We're going back looking at
12 records, or going back looking at the past,
13 the care, and how we're spreading that out
14 there to the field.

15 So I think we were talking about
16 this this morning. How do we monitor the
17 training of those in the primary care and
18 behavior health, as well as how we assure that
19 they are looking or using evidence base in
20 their practice.

21 CAPTAIN KASS: I think it's a big
22 challenge. That's the answer. It is complex.

1 I think others may have recommendations of how
2 we do that.

3 I think as we think about Project
4 ECHO and where we exist, some of those things
5 is we're looking at where there aren't
6 clinical practice guidelines, and where the
7 evidence is just now being developed.

8 That's where, when you talk about
9 it, and we'll talk about this a little bit
10 more in a couple of slides, when you look at
11 the confluence of TBI and psychological
12 healthcare together, there isn't a CPG right
13 now for that piece.

14 And so Project ECHO, and the
15 recommendations that we will have, are at that
16 cutting edge, at the innovative level.

17 But as those things become standard
18 of care I think the key, and especially as we
19 start to look at the satellite locations and
20 how we export how they do things, you have to
21 have the audit process.

22 Where you go back in and say, okay,

1 if we say you have to have an
2 interdisciplinary team, how do we audit are
3 they doing interdisciplinary care? Are they
4 doing what we say in a concept of care? And
5 unfortunately, the only way really is to go
6 back and have somebody take a look externally.

7 CAPTAIN KOFFMAN: ECHO model is a
8 little different from telemedicine in the
9 sense that we don't assume the care of the
10 patient at that teleconference.

11 This truly is a collaborative and
12 instructive model where the case is discussed
13 without patient identification. And so it
14 really is something that a lot of individuals
15 can dial in and learn from. And we're really
16 excited about it.

17 MS. DAILEY: And real quick, I just
18 want to highlight for the members of the task
19 force, we've had four Centers of Excellence
20 come in and talk to us today. And we'll have
21 a fifth tomorrow with psychological health and
22 TBI.

1 And as noted by our general
2 officers and the questions they were asking
3 earlier today, every one of them seems to have
4 a different way to disseminate their cutting
5 edge efforts, and disseminating the
6 information and the research that they are
7 developing.

8 And NICOE has presented another one
9 to us. And they've packaged it and call it
10 ECHO. But this of the fourth way we've seen
11 the dissemination of these cutting edge
12 practices coming out from the Centers of
13 Excellence.

14 CAPTAIN KOFFMAN: Even though
15 there's not a CoE specific for chronic pain,
16 our pain service on the Walter Reed campus
17 uses the ECHO model very effectively to
18 collaborate and discuss best practice with
19 pain management.

20 And we're going to talk a little
21 bit about best practice versus evidence based,
22 because this is really where colleagues can

1 really sort of help colleagues understand what
2 emerging best practices are. Next slide
3 please.

4 MEMBER PHILLIPS: I was, excuse me,
5 I was saving this for the end. But since Ms.
6 Dailey brought it up, and this is not really
7 a question directed specifically at you, but
8 we did hear from four different centers today.

9 And I've heard some common issues,
10 or common themes from all of you. One being
11 staffing, manning document, two, a mechanism
12 to deploy best practices, dedicated research
13 funds, seeking a single IRB, and there may be
14 some others that I left out.

15 And what I wanted just to bring up,
16 so I wouldn't forget it, because I have gray
17 hair, is it better for you all to talk from a
18 common voice, rather than for each Center of
19 Excellence going after its own results? Is
20 that possible? Is that something that we
21 should be talking about?

22 I apologize for interrupting the

1 train of your discussion, but I'm just
2 wondering. And perhaps we could hear from
3 some of the others later. Is that possible,
4 so that you can achieve some of these common
5 goals?

6 CAPTAIN KOFFMAN: Sir, to some
7 extent that is being done, just so you know.
8 So one of the efforts is a neurosensory
9 consortium idea, if you will, of the very
10 organizations you've been mentioning,
11 including some that you've heard from.

12 So there would be one integrated
13 approach with collaboration and a common data
14 set, and common data elements, and all that
15 sort of thing.

16 So it's fairly early because a lot
17 of these are just now maturing. And, as you
18 know, we're only two years old. But that's
19 where we're headed, and largely that's the
20 case, the limits then being the human
21 experience of what the organ systems are that
22 are involved.

1 So if somebody's working on
2 peripheral vascular disease, or amputation,
3 it's unlikely to fall within all the other
4 aspects of what it is that we may be engaged
5 in.

6 So there are intrinsic limits to
7 that approach working. On the other hand,
8 where they can work, that exact idea is what
9 people are already spending some time doing.

10 MEMBER PHILLIPS: Good. No, I
11 certainly understand that. Knowing there'll
12 be a bureaucracy, you don't want to be five
13 years down the road in a competitive situation
14 with other CoEs.

15 CAPTAIN KOFFMAN: And I should
16 mention there is already a CoE oversight board
17 that has been stood up, that you may know,
18 that's looking specifically at efficiencies,
19 and overlaps, and redundancies, and those
20 sorts of things, and asking very tough
21 questions as well, to answer your question.

22 MEMBER KEANE: I have a quick

1 question. What is your current patient
2 population?

3 CAPTAIN KOFFMAN: What is our
4 current patient census? We have 20 patients
5 a month. Right now we have a little bit of a
6 lull from the holidays, that individuals are
7 coming back from the holiday recess. And
8 we'll be at our steady state, 20 patients a
9 month.

10 MEMBER KEANE: The 20 patients a
11 month and 44 clinicians, if you take out the
12 ten percent that are researchers, 40
13 clinicians, so two clinicians for each
14 patient?

15 CAPTAIN KOFFMAN: It is a very
16 intensive program. And actually some patients
17 will have more than two clinicians, depending
18 on what their needs are.

19 And thank you, I'm going to
20 actually talk about the sequenced care in the
21 next slide, and our model, which really does
22 front-load a lot of the intervention early on.

1 Virtually everyone who comes to us
2 is suffering. They're suffering from chronic
3 TBI with any number of psychological health
4 conditions, typically PTSD.

5 But PTSD is perhaps one of the most
6 comorbid psychological health conditions
7 itself. So folks come to us. They're very
8 complicated, they're suffering, and they hurt.

9 And because of the TBI, almost all
10 of them have headaches. Pain is legion, in
11 fact nobody comes to us without chronic pain,
12 as well as some type of sleep disturbance, or
13 sleep disorder.

14 What we do, and this is why we
15 stack those treatments early on, is that we
16 sequence care in such a way that we can sort
17 of control a lot of the symptoms, and manage
18 the individual without necessarily chasing
19 diagnoses.

20 We stabilize the individual, we
21 make the individual comfortable, and that
22 enables us to proceed with psych testing,

1 neuropsychological testing, which typically is
2 more valid than having individuals come in who
3 aren't sleeping, who are on multiple
4 medications, polypharmacy, who have severe
5 pain.

6 So our front-loaded approach, and
7 we can't say this for certain but this is what
8 we're studying, is in terms of the chronicity
9 of this very uniquely comorbid population,
10 this is the way to manage individuals who've
11 been suffering.

12 And keep in mind that we're a
13 tertiary referral center. We don't take
14 individuals who just bumped their head last
15 week and are having mild concussive symptoms.

16 These are individuals, and it's a
17 somewhat pejorative characterization, it's not
18 mine, but post concussive syndrome is also
19 called the miserable minority.

20 Because those five or ten percent
21 of individuals who go on to develop symptoms,
22 every sphere, every aspect of their life is

1 affected. And they're suffering in so many
2 different ways.

3 So we really, we front-load this
4 intervention in truly a patient and family
5 centered approach. And about 20 to 25 percent
6 of our patients bring their families for at
7 least part of our care. And this is also
8 critical, because the families are suffering
9 as a unit.

10 And where there are no families
11 we've had individuals bring parents, or
12 siblings, or even support systems. And we
13 realize that the chronicity of this condition
14 does not exist in a vacuum.

15 So it's very front-loaded, it's
16 very holistic, it is very patient centered.
17 And it's not an efficient model when you're
18 teaching an individual how to overcome their
19 own disability.

20 The only treatment really
21 available for TBI is education. And again,
22 you cannot educate somebody if they're not

1 sleeping, if they're hurting, if every day
2 they wake up and they don't want to learn what
3 they need to learn in terms of lesson plans.

4 And so empowerment, and education,
5 and self-advocacy is key, particularly when
6 somebody becomes disaffected as all of our
7 patients have.

8 So is this evidence based? And on
9 the next slide, this is really the conundrum
10 that we face. You can see the overlap between
11 PTSD, TBI, and pain. I'm sorry?

12 CO-CHAIR CROCKETT JONES: Before
13 we get there, I know that this has occurred as
14 a concern among some of the task force
15 members. We go to installations and conduct
16 focus groups. And the comorbidity, and the
17 parallel treatment for PTS and TBI, we see
18 this everywhere we go.

19 I think some of us are concerned
20 that your environment is so specialized that,
21 you just said something that made me think,
22 that is almost the actual concern we have.

1 And that is since so much of the
2 treatment is really about education, and about
3 creating new habits, the big numbers that we
4 see of these folks out there in the field they
5 are not going to have the environment that you
6 create.

7 And so a best practice, do you see
8 what I'm saying? I think that to some degree
9 we're a little concerned that the best
10 practices that you generate don't translate to
11 the various installations, which don't even
12 have some of the folks that you have available
13 for your patients.

14 CAPTAIN KOFFMAN: So I think part
15 of the answer, ma'am, would be if you look at
16 a relatively isolated traumatic brain injury,
17 without all the other, especially what we see,
18 war related psychological stress related
19 conditions.

20 Those have better, well accepted,
21 and now in many cases long standing treatment
22 approaches that ultimately engage the patient

1 in an education as well, but also symptomatic
2 relief with headache and sleep disturbance,
3 and so forth.

4 Not everybody needs all of what we
5 have. That's part of what we're about, is
6 that tertiary care comorbid intensive project.

7 CO-CHAIR CROCKETT JONES: Yes. I
8 hear what you're saying. I'm not sure you
9 understood my concern. We see a lot of people
10 who probably need your care. We see a lot of
11 people.

12 And my concern is that I'm not
13 sure how we're getting those people into good
14 treatment. I'm wondering what you all do to
15 look at the patient population that's out
16 there in all these MTFs, and all these various
17 installations, to see how many people really
18 do actually fall under what would meet the
19 need for your care.

20 But they're never, never going to
21 get, they're never going to hear about it.
22 This is a serious concern and a dissonance.

1 Because when we go around, some of the things
2 that we ask folks is do you know what's
3 available right where you are. And they don't
4 know. And so --

5 CAPTAIN KOFFMAN: That's part --

6 CO-CHAIR CROCKETT JONES: -- do
7 you see what I'm saying --

8 CAPTAIN KOFFMAN: I do, and I
9 think --

10 CO-CHAIR CROCKETT JONES: -- my
11 concern is that I'm not sure. I'm very
12 concerned.

13 CAPTAIN KOFFMAN: We grew up as an
14 organization to meet that need. And again,
15 this is an institute model. It's not a clinic
16 with a high flow through.

17 It's intended to create evidence,
18 to the extent we can scientifically, and at
19 least get lessons learned, which this
20 interdisciplinary intensive model seems to be
21 the first lesson learned, networks out to
22 other organizations and influence them.

1 So we're trying, as you can
2 imagine, to get traction in that fashion.
3 Because we can appreciate the fact that we're
4 often not helping the very individuals who are
5 out there, and going back and forth between
6 programs that often don't talk to each other,
7 are on different parts of the base, and on,
8 and on, and on, or even competing for
9 resources, and personnel, and so forth.

10 We know that. And so we are
11 trying in what way we can to see, as best we
12 can, what is the nature of the problem. What
13 works, and how is it that under those
14 circumstances we can roll that information out
15 to the rest of the MHS and convince them to
16 start doing it our way.

17 We don't really, unfortunately,
18 have the authority to make it happen. If you
19 can make that happen for us, that would be
20 great. But you get it, you understand --

21 MEMBER EVANS: Right. And that
22 goes back to the recommendation that we made.

1 We really want NICOE, or someone, to have the
2 authority, or the ability, to train the
3 primary care providers, behavior health
4 providers, out there at the deck, in the
5 little bases that we have out there, on what
6 is the best treatment. We need to have one
7 organization taking the lead on making sure
8 that the providers --

9 CAPTAIN KASS: Yes, ma'am.

10 MEMBER EVANS: -- set standards.

11 CAPTAIN KASS: I think we hear
12 exactly what your concerns are. And we share
13 some of those concerns.

14 As we look at two different
15 issues, because we look at the demand that is
16 out there. As we were asked to help look at
17 standing up NICOE satellites in these nine
18 locations, what we hear from many people is
19 there isn't the demand. Why are we doing
20 this?

21 I would argue there is plenty of
22 demand. We are going to be in if you build it

1 they will come mode, without a doubt. Because
2 it is out there.

3 And I think as we look too, one of
4 the questions we asked trying to demonstrate
5 that was going back to the other organizations
6 that do have some responsibility for tracking
7 this patient population, and trying to partner
8 with DCO and DVBIC to understand not just what
9 are the numbers of TBIs.

10 But how do we tease through the
11 numbers of how many patients, what is the TBI
12 population, what is the PTSD population, and
13 where do they overlap?

14 I would completely, wholeheartedly
15 agree with you that we don't have that system
16 solved for tracking who those patients are.
17 And there are needs.

18 And the first step is getting
19 these practices out to those satellite
20 locations. But that's a building.

21 And one of the mantras that I've
22 often talked about with this is we have to

1 remove luck and location. If a service member
2 has a problem, remove luck and location.

3 Get them into the system that they
4 need to get the care that they need, no matter
5 where they're accessing it, and so whether
6 it's the NICoE satellites, or other MTFs that
7 don't have a nice pretty building.

8 And the building matters, but it
9 doesn't matter as much as the system in which
10 we're approaching the patients, having time
11 and an agile system to spend time with
12 patients, instead of caring more about
13 productivity.

14 If we can reach out and say for
15 that defined population this is the system of
16 care, I think it will make a very big
17 difference.

18 To your point, Captain Evans,
19 oftentimes you will hear from all the Centers
20 of Excellence, we have three missions,
21 research, education, and clinical care. And
22 then the next one will come in and say we have

1 research, education, and clinical care.

2 And we argue with each other a
3 little bit sometimes of where those boundaries
4 are, and where they exist.

5 And I would completely agree with
6 you that we need to say you've got the rose on
7 your chest, okay, you're it. You are the
8 group to do this. And we want to do whatever
9 our part is in that.

10 We would argue, for the most part,
11 that what we're focusing on is the comorbid
12 TBI and psychological health. And I think
13 that other organizations may have a robust
14 infrastructure for the education part for TBI,
15 and for psychological health.

16 And what we ought to be doing is
17 helping to feed content to them so that they
18 can then go out and execute.

19 But as you saw, my education
20 director, and I have one person right now, so
21 I don't know that we're robustly resourced to
22 do the education. But we absolutely have a

1 responsibility for feeding content to the
2 people who will be doing the education.

3 MEMBER REHBEIN: So let me circle
4 back to the referral patterns for a moment.
5 Because you talked about specific places where
6 you're getting a disproportionate part of your
7 population from.

8 Is that because there really are
9 more in those locations, or is that because
10 the providers there are more in tune with
11 recognizing, in their population, who could
12 use your services.

13 And that brings us back to the
14 recommendation we were making on training, if
15 that second one is the case.

16 DR. KELLY: Well, we can't really
17 say for sure without the number counting
18 system in place that there are more of them at
19 any given location.

20 What we are learning is that
21 certain high risk individuals, or not
22 individuals but individuals in groups that

1 have an op tempo that is so great, and/or
2 multiple high risk activities that they engage
3 in continuously, much like special forces and
4 special ops groups do, those individuals are
5 the ones who are now raising their hands,
6 having been through or having colleagues come
7 through.

8 And we're hearing from them
9 virtually everybody could benefit from coming
10 to NICoE. They all look around at each other
11 and say, holy smokes, you've got the same
12 experience I had. You have to go to this
13 place and help figure it out.

14 And then there's a flip side of
15 that. The providers may be more in tune with
16 that very population and the needs of that
17 population.

18 But there's something else that we
19 struggle with a bit, and I'll share, is that
20 the people that are the elite forces tend to
21 understand what we do and benefit from it
22 pretty quickly.

1 They're more engaged in
2 mindfulness, self engagements, and self
3 advocacy, and all of the kinds of things that
4 we do. And they pick it up very quickly.
5 Because that's the way they are. They're
6 built like that.

7 But what we struggle with is the
8 logical extension of that thinking, of the
9 referrals, if we just go in that direction,
10 then we become only the elite forces place.

11 And I, for one, really don't want
12 that to happen. I appreciate the fact that we
13 are understood by them best, and that they
14 seem to benefit, and we have these wonderful
15 relationships.

16 But we can't, I think, we can't
17 afford to just be perceived as the ivory tower
18 where, again, back to the luck and location
19 thing, where you've got a special in, and you
20 get to go there.

21 The satellites will help, I think,
22 largely in solving that particular

1 predicament. But in trying to answer your
2 question, I think that it's all of the things
3 you mentioned all wrapped up. Bob, you may
4 have something else.

5 CAPTAIN KOFFMAN: Sure. If I may,
6 next slide, I want to sort of wrap up the idea
7 of evidence based treatment. I think that's
8 what many of you are really concerned about in
9 terms of how do we provide care.

10 I will tell you that our secret
11 ingredients, if you will, of providing care,
12 it's not so much what we do. But it's how we
13 do it.

14 And the ingredients really are, I
15 mentioned education, but it is empowerment and
16 it is advocacy, your self advocacy.

17 It's not so much a passive system
18 in terms of having a patient, seeing them, and
19 saying here, take this. But it's actually
20 working with the individual so that sufferer
21 is able to navigate a very tiresome system.

22 And keep in mind that individuals

1 with TBI are already very resource overloaded.
2 And so try and set them up for success as they
3 leave.

4 If I may, just to address this
5 idea of best practice when it comes to
6 comorbidity, I had the opportunity to work on
7 the DoD/VA Clinical Practice Guideline Blue
8 Ribbon Panel for PTSD. So I know what is
9 evidence based treatment.

10 The problem is that there are five
11 different guidelines, one for PTSD, one for
12 traumatic brain injury, one for substance
13 abuse, one for major depression or depressive
14 disorders, and another one for anxiety
15 disorders.

16 There is not one guideline that
17 handles the intersection, or the confluence of
18 all of these. And that's really going to be
19 NICOE's job, is to come up with a guideline.

20 This is not a small number. By
21 Doctor Lu's study at the VA, individuals who
22 have had a lot of trauma in that middle

1 section is 42 percent of the population.

2 So it's a little disingenuous for
3 us to say what's evidence-based for TBI or
4 PTS. But an individual with all of these is
5 an entirely different animal.

6 And that's really what our charter
7 is, is to understand this one brain concept.
8 And it's vexing because the brain is certainly
9 the most complicated organ in the body.

10 But we do realize that there is a
11 mandate to come up with a best practice when
12 it comes to this complicated comorbidity.

13 DR. DEGRABA: To also answer the
14 question, we recognized back in 2003 or 2004
15 that there were a number of patients who did
16 well, who had the diagnosis of PTSD and the
17 diagnosis of TBI,

18 But there were many more who, even
19 with the best care being given and being in
20 the right place at the right time, in the
21 Washington D.C. area with the National
22 Regional Medical Center and Walter Reed having

1 lots of resources, these patients weren't
2 getting better with the conventional therapies
3 that were available to them, particularly on
4 an outpatient basis.

5 And so it was becoming clear that
6 comorbid state wasn't just an overlap of two
7 diseases, but in fact, they were synergistic
8 in their effect.

9 And so the things that we were
10 seeing told us that there were changes in the
11 brain, or suggested that there were changes in
12 the brain that told us we didn't understand
13 the full pathology of what was going on.

14 And so one of the advantages that
15 we haven't talked about much here today, but
16 I just wanted to bring to your attention, one
17 of the advantages of the model that we're
18 trying to build is, first and foremost, a
19 proof of concept.

20 Can those patients who have that
21 comorbid state, and not only who are not
22 getting better, but many of them are actually

1 continuing to deteriorate, can we change the
2 trajectory of their recover with a high
3 intensity model that we've created.

4 And the short answer is that we
5 have. And some of the early data that Dr.
6 Kelly has shown you demonstrates that even
7 within a four week period those patients who
8 are deteriorating start to recover.

9 And of course our effort, and our
10 goal in the future, is to identify those and
11 the things that are necessary to maintain that
12 sustainability of recovery.

13 But equally important is, because
14 we were able to have a high definition
15 evaluation of this complex patient population
16 at one time, we're able to be able to begin to
17 develop an understanding of the patterns of
18 the disease state, and be able to do the
19 research to be able to tell us, hopefully
20 early on, who those patients are and which
21 therapies are working.

22 And so some of the research that

1 is being engaged now is being directed at not
2 only looking at the patterns of the disease,
3 but now starting to put a biological construct
4 to it.

5 In other words, anatomical changes
6 on MR, physiological changes on EEG and sleep
7 studies, and biochemical markers that may be
8 able to tell us who's responding to therapy.

9 So that's another advantage of the
10 NICOE product that we hope to also add into
11 the productivity equation of something that
12 then, again, can be exported out to our
13 colleagues in the MHS.

14 CAPTAIN KOFFMAN: The last slide
15 addresses the issue that four weeks is really
16 not enough time to really definitively provide
17 any of these evidence-based treatments.

18 And so what we do is we identify
19 modalities that an individual most likely will
20 be able to respond to when he or she goes back
21 to their home station, and make those
22 recommendations in our very extensive

1 discharge recommendations in summary. That
2 concludes --

3 CAPTAIN KASS: And I think --

4 CAPTAIN KOFFMAN: Oh, I'm sorry.

5 CAPTAIN KASS: Just real quick to
6 emphasize. I'm a family physician, I'm not a
7 behavioral house specialist, but I learn a lot
8 from these guys.

9 And my understanding is that the
10 completion of evidence-based treatment for
11 PTSD is not super high. And part of that is
12 because of the hard work that it is to do
13 that.

14 And part of our goal, also, is to
15 look at what can we do to get people prepared
16 and empower them to actually engage in that,
17 and then complete PTSD evidence-based
18 treatment.

19 So I think another metric that we
20 can look at that is if the standard for
21 completion of evidence-based treatment across
22 the industry is 40 percent, are we able to get

1 people into a position where they're ready to
2 engage when they go back home, and bring that
3 completion rate higher than that.

4 So that's something we need to
5 look at. Because I think that is part of what
6 you guys do, Bob.

7 CAPTAIN KOFFMAN: And I think
8 that's important to realize. You say how many
9 individuals are practicing evidence-based
10 treatment. We could probably get to a number,
11 but how many patients are responding to
12 evidence-based treatment is an entirely
13 different question.

14 As Captain Kass was mentioning,
15 for prolonged exposure the gold standard for
16 PTSD, the drop out rate is as high as 40
17 percent, because it's a very provocative, very
18 difficult, intensive treatment. And we
19 realize that at the NICOE.

20 And so if we can provide stress
21 inoculation, and other self-regulatory
22 techniques to increase the likelihood of being

1 able successfully receive treatment, then
2 we've done the patient a great service.

3 CO-CHAIR CROCKETT JONES: Is there
4 any equivalent agency or program being
5 developed at the VA for a holistic approach?

6 CAPTAIN KOFFMAN: Not at the
7 present time. The Tampa VA, as one of the
8 polytrauma centers, has an inpatient project
9 that's looking at mild TBI with some
10 comorbidity. But truly their model, and their
11 staffing pattern, and their processes are
12 really quite different.

13 MR. DRACH: If the four week time
14 period is not adequate, what would be your
15 ideal time frame for treatment?

16 CAPTAIN KOFFMAN: Somebody else
17 try to answer that, because I have no idea.

18 CAPTAIN KASS: It's one of those
19 things we struggle with. And I know the
20 gentleman asked us about our staffing. We're
21 seeing 200 patients right now a year. We
22 could see patients longer, and then see 120.

1 And I don't think from a public health
2 perspective that's the right answer.

3 What we need to do is create the
4 system of care where we can provide
5 recommendations for post-NICoE care, and be
6 assured that those post-NICoE recommendations
7 are executed, and then get the the next group
8 in. It's sort of a Mayo Clinic approach to an
9 evaluation.

10 If we spend our whole time
11 providing the care, Captain Koffman will see
12 quite a few less patients.

13 And again, my understanding is
14 that the right time for care, again, just
15 because you say there's ten sessions for
16 prolonged exposure, you can't just do those in
17 ten days. There's just got to be time in
18 there. And so it can be months for somebody
19 to have that time.

20 MR. DRACH: You may have covered
21 this, and I may have missed it. Are you using
22 virtual reality therapy at all?

1 DR. KELLY: We have a research
2 project that uses that at the present time.
3 But that's not quite ready for prime time in
4 terms of a clinical intervention at the
5 present time.

6 We're very hopeful that it will
7 be, and there are also neuroimaging correlates
8 to that, that the organizers at University of
9 Southern California that we're partnering with
10 have already shown and published our benefits.

11 You can actually see the
12 diminished metabolic demand of the amygdala in
13 the brain with a model that they're using.
14 And that's our partner in this research
15 project that we're engaged in at the present
16 time. But again, it's truly a research, and
17 not clinical intervention at the present time.

18 MEMBER PHILLIPS: Along those
19 lines, are you finding any biomarkers, changes
20 in cortisol levels, or even PET identification
21 changes there?

22 DR. KELLY: Tom will go into some

1 detail on that. But the answer is we're
2 looking at it. Not anybody has it
3 specifically, except in maybe a couple of
4 early studies. But we are directly engaged in
5 that project, and one of them in particular
6 that Tom's engaged in.

7 DR. DEGRABA: Yes, and that is one
8 of the keys that we hope to be able to start
9 to unlock. If you have the concept of
10 patients coming in, in a perturbed state, in
11 a state that is not well, we talk about
12 getting to wellness.

13 The question is what is wellness,
14 and how do you measure that. Many times we
15 use the scales to tell us that the patients
16 are doing better. Our goal is to look at some
17 changes in the physiological parameters as
18 well as some biomarkers.

19 We're partnering right now with a
20 group at Harvard, Herb Benson's group at
21 Harvard, to take a look at epigenetics.

22 And a protocol that we're

1 currently writing for IRB approval is to look
2 at the changes in genes with the utilization
3 of wellness approach, mindfulness based and
4 wellness approaches in our patients with post
5 traumatic stress, to be able to identify those
6 pathophysiological functions and those
7 biochemical functions that are changed by the
8 utilization of these therapies.

9 And this is the type of
10 methodology that we anticipate using at the
11 NICOE to be able to tell us more about what is
12 those things that we think are directed
13 towards wellness.

14 Some of the early data that has
15 been found by their group has demonstrated
16 changes using these mindfulness techniques in
17 PTSD in inflammatory mediators, and
18 inflammatory markers, as well as increase in
19 mitochondrial respiratory chain activity, so
20 actual increase in energy.

21 So when people say they use
22 meditation to improve their energy, this may

1 actually be that biological construct. And we
2 want to measure that in our patients so we can
3 have a better understanding of biologically
4 what we're doing for the patients as we
5 utilize these techniques.

6 MEMBER PHILLIPS: The research
7 indicators seem to be that's a direction to go
8 into. Unfortunately, I wish we had a genetic
9 profile on everybody just coming in before, so
10 we can create some standards, just like we
11 know blood pressure, and cholesterol levels.
12 We're getting there. It's getting cheaper to
13 do the genome.

14 DR. KELLY: And the longitudinal
15 projects that are up and running are, in some
16 ways, banking blood and so forth, so that you
17 can actually, potentially down the road, do
18 that very thing. But we're not quite at that
19 stage of the science yet.

20 DR. DEGRABA: The other thing we
21 want to engage in, and we are engaged in, that
22 will hopefully move the field along faster, is

1 to partner with other agencies.

2 There's an initiative called
3 FITBIR, the Federal Interagency Traumatic
4 Brain Injury Research Working Group, who have
5 been working since December of 2009 to create
6 a national TBI psychological health database.

7 I sit on the steering committee
8 for that body. And our interest is to
9 collaborate with our colleagues at NIH, VA,
10 and CDC, along with the DoD, to develop that
11 database. We have the first version of that
12 database. It currently is available right
13 now.

14 Our goal is to try to create a
15 data dictionary, so that when people do
16 research in TBI across the country it doesn't
17 matter whether it's DoD, whether it's academic
18 partners, that the same language and the same
19 types of tests, or a sufficient number of
20 tests, are used so that data can be put into
21 the database so that we can start capturing
22 data.

1 As you know, looking at genetic
2 data requires large numbers. And any one
3 group would have a hard time filling that
4 need.

5 But collectively, if we have the
6 correct model to be able to capture that data,
7 then we can make those advances. And we're
8 dedicated in part of that effort to try to get
9 that project launched now.

10 MEMBER EUDY: In regards to MTBI,
11 as you've mentioned in your brief, I'm asking
12 specifically for pre-NICoE. We had mentioned
13 this at Fort Carson talking about the
14 concussive care recovery centers.

15 And as the NICoE is seen as the
16 knowledge base for further treatment down the
17 road, have the services come to you, or do you
18 go to the services helping them to standardize
19 the care received at those concussive recovery
20 care centers?

21 Because I know, across OEF for
22 instance, at each location those quantitative

1 reasons for holding someone can be different
2 at one location to another, based service-
3 specific. While one may be managed by a PT,
4 another may be managed by an TO, or
5 neuropsych, whatever have you.

6 But I'm just wondering NICOE's
7 involvement in that phase, since we're getting
8 closer and closer to battlefield level of
9 identification of MTBI, but treatment options
10 as well.

11 DR. KELLY: Each of us here on the
12 panel has been involved in helping with the
13 determination of what those approaches should
14 be, both in OEF and CONUS locations.

15 And so we're partnering with the
16 very organizations that you're talking about.
17 Fort Carson is one of them that I know best,
18 because I'm on the faculty at the University
19 of Colorado right up the road. And so I've
20 engaged with them even before I took this job
21 four years ago.

22 The truth of the matter is

1 everybody, just like you're saying, has a
2 little different wrinkle.

3 And except for the fact that we
4 are building these uniform data sets in order
5 to suggest that there are specific approaches
6 to diagnosis, and categorizations of diagnosis
7 that should be looked at uniformly, and then
8 we can measure the interventions that are
9 useful under those circumstances, without that
10 being the basic common denominator we're not
11 going to get anywhere.

12 And so the NICoE influence has
13 been engaged with us as individuals with the
14 thinking across the MHS with the documents
15 that you're aware of, and with the very
16 organizations.

17 The problem is, even within the
18 MHS, there isn't one uniform way of doing all
19 of that, as you're pointing out.

20 And what we're trying to do is
21 suggest that this intensive model for the
22 individuals with that comorbid state that

1 we're still going to figure out, as best we
2 can, is really the approach that ought to be
3 rolled out in some other locations. And the
4 satellites will help us do that.

5 MS. DAILEY: And Tech Sergeant
6 Eudy, that's also a good question for the DCoE
7 for psychological health and TBI. They
8 probably have a better grounding on what
9 they're doing to standardize that. And I
10 think it's more in their lane too.

11 MEMBER EUDY: Yes, I just wanted
12 to bring it up in reference to NICOE and
13 everything, as far as knowledge resources and
14 oversight of --

15 MS. DAILEY: But hold on to that
16 too. Because you'll get a good answer from
17 the PH and TBI guys tomorrow.

18 CAPTAIN KOFFMAN: When you do
19 speak with DCoE, one area of very interesting
20 and perhaps fruitful discussion is the utility
21 of various CAM modalities, complimentary and
22 alternative medicine, or now just all

1 complimentary medicine, in terms of everything
2 from sleep, to pain, to wellness in recovery
3 for this population.

4 I know the various concussion
5 recovery centers downrange utilize different
6 CAM modalities. Everyone has their own idea
7 as to what works within the CAM world. So I
8 think that would be an interesting discussion
9 to have with DCoE.

10 MEMBER EVANS: And Sara, I have to
11 tell you the reason that we're trying to get
12 NICOE to take the lead on a lot of this is
13 because we hear from the patient how
14 successful you and your staff are in treating
15 PTSD, mild TBI, and how they have really,
16 really, they do go back out and tell their
17 friends.

18 And so it's by word of mouth, that
19 they know your success. So we've had patients
20 at Walter Reed Campus that complain that they
21 couldn't get into NICOE, as you well know.

22 And so I think you have a really

1 successful program. I think what the
2 Recovering Warrior Task Force wants to do is
3 try to get you more patients over there.

4 And then ensure how do we get the
5 satellites to be, how do we get the patients
6 to that type of care so that we can see more
7 of a success rate with treating. But it's a
8 wonderful program.

9 CAPTAIN KASS: Yes, thank you. I
10 think that what's interesting is I've been in
11 this job about a year and a half.

12 And one of the first things that I
13 felt was really important for us to do to
14 succeed, in again this influence in
15 improvements on the quality of care, is to
16 create partnerships across MHS to make sure
17 that we're seen as a part of that Military
18 Health System team.

19 Because unfortunately, success
20 sometimes can put you at odds with other
21 people. Because a lot of people want to wait
22 until there's a lot of evidence of what's

1 working before they start to institute
2 changes.

3 And I don't completely disagree
4 with that. But it takes an awful long time
5 sometimes to collect as much evidence as
6 people want to change.

7 And so as we partner with, for
8 instance, even the satellite locations,
9 honestly there's sometimes a little bit of
10 resistance. We think we've got this, why do
11 we have to do it your way.

12 And I think one of the challenges
13 that we face is that -- I have great
14 clinicians who work at the NICoE, there's no
15 doubt about it, and the equipment is cool --
16 but really, I think, one of the most important
17 differences is that we get to work under a
18 different health system.

19 We get to not be stuck in 15
20 minute appointments, and a scheduling system
21 that doesn't allow that really agile, timely
22 access to care.

1 And so where we're able to say
2 look to do it the way NICoE's doing it, or how
3 can we export these things, we can't just ask
4 them to do what we're doing without giving
5 them all of the other support that we've been
6 given to do what we do.

7 Because these are caring,
8 compassionate providers all across MHS. But
9 they're being hit with a 15 minute
10 appointment, and get them through, and get him
11 through.

12 And that's just not for the
13 complex patient. That's not going to work.
14 The old system isn't going to work. So it's
15 really about a system change, is what we need
16 to look at to really affect a change, I think.

17 MEMBER REHBEIN: I'm going to go
18 back to my question about how you get most of
19 your --

20 CAPTAIN KASS: Patients?

21 MEMBER REHBEIN: -- patients, for
22 lack of a better word. Because what I'm

1 hearing here now, frankly, disappoints me as
2 far as the health care system is concerned.

3 Because what I hear a number of
4 people saying is that it is the people
5 suffering that are passing the word amongst
6 themselves, and recruiting each other.

7 And then having, maybe I'm going
8 to use too strong a word here, but then having
9 to almost force their way past their local
10 provider to get to you.

11 DR. KELLY: Sir, in fairness, it
12 isn't quite like that. Because they don't get
13 to us unless there is a primary care provider
14 that makes the connection for us.

15 MEMBER REHBEIN: But the most
16 effective way, I think, to do this, would be
17 for that local provider to be looking for
18 people to come into your program.

19 And it sounds like the people are
20 having to go to the provider to try to
21 convince the provider to get them into your
22 program.

1 DR. KELLY: We're still fairly
2 young, and you can imagine that the awareness
3 of who we are and what we can do is seeping
4 through and getting out there.

5 And there are places where the
6 primary care provider is, in fact, doing that,
7 just as you're saying.

8 But the other piece of it is that
9 they're also handling so many other kinds of
10 things that it's really not entirely, the
11 system isn't just built properly for that to
12 work right under the circumstances.

13 I don't have a good answer for how
14 it ought to be. But it's going to have to be
15 a combination of people saying, look, I've got
16 a problem here, breaking through stigma and
17 being able to say, yes, you know what, I need
18 that. I now know I need that, and actually
19 then influencing or convincing, as you say,
20 the system to get them the care that they
21 need.

22 Now one of the things, speaking to

1 the earlier very forward in theater approach
2 to this that Generals Corelli and Amos years
3 ago advocated, was that if we think you had a
4 TBI, something happened in theater, you're
5 going to get evaluated right here and now.

6 And they look do those of us
7 who've been doing it in the sports community
8 for years and said we want it that way. We
9 want it done like you guys do it standing on
10 the sidelines.

11 And so what happens there is it's
12 not even the clinicians, or the patients
13 raising their hands. It's a commander, it's
14 a buddy, it's a whoever, that says you are
15 going to get evaluated, because it says so,
16 right here.

17 This is the expectation in what
18 had been the DTM, and is now a DoDI for the
19 concussion management in theater.

20 That's better than we have in the
21 civilian sector anywhere, including the NFL,
22 which is, as you can imagine, kind of

1 squeamish about this whole idea about whether
2 they take the quarterback out or not, and lose
3 the game.

4 So I think that in many ways the
5 DoD, with its implementation of the kinds of
6 forward thinking, and forward in life, all the
7 way into the war zone, approach to this is
8 extraordinarily positive.

9 I've been involved to some extent,
10 and Bob's been there twice or three times,
11 I've been there once, in looking at how this
12 works and building the programs and the
13 systems around that.

14 It's something that I think if we
15 can take that and pull it into the CONUS
16 locations, and have that kind of thinking
17 infiltrate how we do it here, then we'll get
18 where you're talking about.

19 And in fact, just so you know
20 about this, tomorrow you're going to see DCoE.
21 And they are building a CONUS project that
22 will have an equivalent, if you will.

1 My understanding is that it'll be
2 equivalent to that in theater approach to how
3 do you manage concussion when you think it may
4 have happened, think it may have happened.
5 Get that person the evaluation they need.

6 MEMBER REHBEIN: If you want the
7 poster child for that you'll talk to Dale
8 Earnhardt Jr. He voluntarily took himself out
9 of the race car to get tested, and wound up
10 not driving.

11 MS. DAILEY: And ladies and
12 gentlemen, we do need to wrap. We've added 30
13 minutes to this and let the questions flow.
14 But please wrap if you've got one more
15 question.

16 CO-CHAIR CROCKETT JONES: Thank
17 you very much. I know you obviously see we
18 have a lot of interest here. And so thank you
19 very much for coming and talking to us.

20 DR. KELLY: Thank you all for your
21 interest and attention, and for staying late
22 with us in support. Yes, it's wonderful.

1 Thank you.

2 CO-CHAIR CROCKETT JONES: And I
3 think, do we have any business left for the
4 day, or we'll be back tomorrow morning?

5 MS. DAILEY: We'll be back
6 tomorrow morning, ladies and gentlemen, at 8
7 o'clock. And we'll start with public forum.
8 And following that will be a review of our
9 installation visit. So see you all here
10 tomorrow morning, thank you.

11 (Whereupon, the above-entitled
12 matter was concluded at 5:00 p.m.)

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This is to certify that the foregoing transcript

In the matter of: Recovering Wounded, Ill and Injured
Members of the Armed Forces

Before: US DOD

Date: 01-14-13

Place: Arlington, VA

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