

DHB-101409

UNITED STATES DEPARTMENT OF DEFENSE
DEFENSE HEALTH BOARD

TRAUMATIC BRAIN INJURY FAMILY CAREGIVER PANEL

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- 5 MEG CAMPBELL-KOTLER
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- 9 COMMANDER EDMOND FEEKS
- 10 FREDERICK FLYNN
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- 1 PARTICIPANTS (CONT'D):
- 2 GLORIA STABLES
- 3 MAJOR MEGUMI VOGT

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MIKE WELSH

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P R O C E E D I N G S

(9:20 a.m.)

MS. MOESSNER: welcome, everybody. I think we'll go ahead and get started this morning. And I'll turn immediately to CDR Feeks to officially open our final meeting as a panel.

7 CDR. FEEKS: Thank you, Anne. As the
8 alternate designated federal officer for the
9 Defense Health Board, a Federal advisory committee
10 and a continuing independent scientific advisory
11 body to the secretary of Defense via the -- excuse
12 me -- the assistant secretary of Defense for
13 Health Affairs and the surgeons general of the
14 military departments, I hereby call this meeting
15 of the TBI Family Caregiver Panel, a subcommittee
16 of the Defense Health Board, to order.

17 MS. MOESSNER: Thank you. Apparently we
18 forgot to do that last time, so that was very
19 impressive. Thank you.

20 CDR. FEEKS: It's more impressive when I
21 have a gavel.

22 MS. MOESSNER: Yeah, you know, we had a

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1 gavel the first meeting, and actually I'm thrilled
2 that it's no longer with us. So, thank you very
3 much for formally opening the meeting.

4 I think you all have a packet with an
5 agenda. And the next order of business is just to
6 simply run through introductions. And then Kathy
7 Helmick from DVBIC apparently is on the premises
8 and she'll speak to us for a few minutes after our
9 introductions.

10 So, we have mics scattered throughout
11 the tables here. You might need to pass along or
12 lean or something. We do have a transcriptionist
13 recording in -- today's meeting, so she asked us
14 to try not to speak over each other too much and
15 to speak clearly as we're each taking our turn.

16 So, maybe I could ask Megumi to start
17 off on the left-hand side of the room, to just do
18 introductions?

19 MAJ. VOGT: I'm Major Megumi Vogt, and
20 I'm working at Defense Centers of Excellence for
21 Psychological Health and Traumatic Brain Injury
22 with Kathy Helmick at the TBI Clinical Standards

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1 of Care. And I'm a neurologist by training.

2 DR. FLYNN: I am Fred Flynn. I'm the
3 medical director of the Traumatic Brain Injury
4 Center at Madigan Army Medical Center, and the
5 chief of Neurobehavior there. I'm a neurologist
6 by trade, also.

7 COL. FORTUIN: I'm Colonel Nancy
8 Fortuin. And I, despite my outfit today, I have
9 not retired from the military. And I was
10 previously the managing -- or helping to oversee
11 the LOA 2, which was PH in traumatic brain
12 portfolio in OSD Health Affairs. But as of

13 August, I'm now the deputy surgeon at NORAD
14 NORTHCOM. So, big difference.

15 MS. SARMIENTO: I'm Kelly Sarmiento, a
16 health communication lead at the Division of
17 Injury Response at the CDC.

18 And I've been on leave, so this is my
19 first meeting in about nine months because I just
20 had a baby. So I've -- if you don't remember my
21 face, that's why I've been out, but.

22 CDR. MILLER: Commander Larry Miller.

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1 Used to be with the wounded warrior Regiment. And
2 about three months ago I transferred to Marine
3 Corps Central Command as the deputy four surgeon
4 for Marine Corps Central Command. And we're
5 working in-theater on TBI issues with Dr. Kelly.
6 Thank you.

7 MS. COLLINS: I'm Patricia Collins from
8 the Office of the Chief Medical Officer. I'm the
9 senior nurse in the office.

10 MS. PRIES: I'm Rose Mary Pries. I'm
11 the program manager for the Office of Veterans
12 Health Education and Information. And I'm a
13 health educator by background.

14 MS. MAXWELL: I'm Shannon Maxwell. I'm
15 the spouse of Lieutenant Colonel, Retired, Timothy

16 Maxwell, who sustained a penetrating brain injury.

17 SPEAKER: I'm knocking over things.

18 MS. ROCCHIO: I'm Carolyn Rocchio from
19 Florida. I'm representing the Brain Injury
20 Association of America. And I'm a family
21 caregiver.

22 MS. BIGGERS: I'm Liza Biggers. I was a

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1 caregiver for my brother, SPC Ethan Biggers, for
2 about a year. He had a severe traumatic brain
3 injury.

4 CDR. FEEKS: Hi. Commander Ed Feeks,
5 executive secretary of the Defense Health Board.

6 MS. MOESSNER: Good morning. Anne
7 Moessner. I am the TBI clinical nurse specialist
8 for the Mayo Clinic in Minnesota. And another
9 half of my job involves coordinating research
10 studies for the TBI Model System Program.

11 MS. HELMICK: Good Morning. My name is
12 Kathy Helmick and I'm the interim senior executive
13 director for Traumatic Brain Injury at the DCOE,
14 Defense Centers of Excellence. And I also dual
15 hat at the DVBIC as the deputy director for
16 Clinical and Educational Affairs.

17 MS. CAMPBELL-KOTLER: I'm Meg
18 Campbell-Kotler. I'm the manager of the Office of

19 Education for the Defense and Veterans Brain
20 Injury Center.

21 MS. KILADA: I'll just sneak up. I'm
22 Sandy Kilada. I'm the coordinator for the Family

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1 Caregiver Project for DVBIC.

2 MS. STABLES: I'm Gloria Stables. I'm a
3 partner with Catalyst Health Concepts. And we're
4 the writer-editors (inaudible) this wonderful
5 project.

6 MS. LLOYD-KOLKIN: And I'm Donna
7 Lloyd-Kolkin, the other half of Kellis Health
8 Concepts.

9 CDR. HEPPEL: I'm Jane Heppel, director
10 of the Federal Traumatic Brain Injury Program.

11 MS. BENEDICT: I'm Sharon Benedict. I'm
12 with the Office of Rehabilitation Services at VA
13 Central Office, and the national director for the
14 Assisted Living TBI Pilot.

15 MS. CHURCH: I'm Cheryl Lee Church. I'm
16 the independent living coordinator in the
17 Vocational Rehabilitation and Employment Service
18 in VA Central Office.

19 LCDR. HERBIG: I'm Lieutenant Commander
20 Herbig. I am a psych nurse practitioner and
21 professor at Uniformed Services University of the

22 Health Sciences.

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1 MS. COHOON: I'm Barbara Cohoon. I work
2 with the National Tri-Family Association. I
3 handle health care for our organization and look
4 (inaudible) the wounded as one of the (inaudible).

5 MR. DODSON: I'm Jon Dodson. I'm one of
6 your two severe (inaudible) survivors. Mine was
7 from Vietnam. I celebrated my 40th alive day on
8 the 18th of September, a couple of weeks ago. I
9 work as a full-time volunteer at Walter Reed, both
10 inpatient with the TBI families and patients,
11 coordinating, a lot of the times, with DVVIC.
12 Sometimes I don't, and they get upset. And also
13 working in 7 East over at National Naval Medical
14 Center in Bethesda. That's the TBI ward.

15 MS. MOESSNER: Thank you, everyone.
16 Vickie, do you want -- we have a public member
17 that's attending, as well, today.

18 MS. YUCHA: Hi. I'm Vickie Youcha from
19 BrainLine at WETA, Channel 26, in Arlington,
20 Virginia.

21 MS. MOESSNER: Thank you for attending.
22 Well, I think Commander Feeks actually has a

1 couple of administrative remarks.

2 CDR. FEEKS: Okay. Thank you, Anne.
3 Vickie, do you have a business card that you can
4 give to our transcriptionist, at your leisure?
5 Okay. well, first of all, I want to say thank you
6 all for being here. It's good to see you again.
7 It's been, what, 10 months since our last meeting,
8 and I was brand new in the job at the time.

9 I want to thank everybody who worked
10 hard to put this meeting together. First of all,
11 I want to thank everybody who prepared a
12 presentation to give.

13 I want to thank Meg Campbell-Kotler and
14 her team, Kenesha Groves and Dytrea Longon and
15 Sandy Kilada.

16 Let's see. If you have not already
17 signed the attendance roster on the table outside,
18 please do that, because we have to keep a public
19 record of who comes to the meeting.

20 Let's see, bathrooms: Out the door,
21 turn right, at the end of the hall on the left.
22 Men's and women's are right next to each other.

1 If you need telephone, fax, copying, or
2 messaging services, Dytrea or Kenesha outside at
3 the table can help you with that.

4 Since this session and the open parts of
5 it are being transcribed -- and our
6 transcriptionist this morning is Christine Allen,
7 sitting at the table by the door -- please make
8 sure that when you begin a statement, that you
9 state your name and that way she can accurately
10 attribute your remarks to you. If you know that
11 your name is easily misspelled, you can either
12 spell it the first time you introduce yourself or
13 you can give your name on a piece of paper to
14 Christine so that she'll get it right each time.

15 And that is all I have to say, Anne.

16 MS. MOESSNER: Thank you very much. We
17 will do our best to comply. Oh, this is Anne.

18 So, Kathy, it looks like you're up next
19 for some remarks on behalf of DVBIC.

20 MS. HELMICK: Thank you, Anne, very
21 much. And I don't want to steal Anne's thunder.
22 I know she's going to be giving an update in just

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1 a little bit from the big DHB meeting in Colorado
2 last month. But I do want to report that I've

3 never seen Greg Poland as speechless as he was
4 after Anne's presentation. He said three wows.
5 He said wow, wow, wow. And then he had some
6 positive remarks, obviously, and some questions.
7 But it was just fabulous.

8 And I'll leave it there, but it was
9 nice. I was in attendance at that meeting, and it
10 was absolutely a wonderful presentation that your
11 chairperson presented on behalf of this Panel,
12 this esteemed Panel. So, she did you well. She
13 did you right. That's for sure.

14 My comments today are actually in lieu
15 of Colonel Jafee being here with us. He is in
16 Afghanistan for about a week and a half, taking a
17 look at some of the theater assets for traumatic
18 injury, and was sent over on behalf of the Joint
19 Staff. A team of six folks are over there taking
20 a look at some current assets and some
21 possibilities for the future. So that's why you
22 get a female instead of a male today.

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1 But he sends you his best and, as
2 always, is very supportive and encouraging of the
3 work that's being done here. And has many times
4 alluded, in the numerous public venues he's had an
5 opportunity to speak in, the importance of this

6 work, and tries to highlight this ensuing product
7 that many are just chomping at the bit to get. So
8 please know that your work is well appreciated and
9 is -- and participatory -- majorly in an
10 anticipatory manner.

11 Meg asked me to just review a few things
12 that are hot topics, if you will, going on in the
13 TBI arena now. And so without going into a lot of
14 detail, I just want to mention a few of those
15 pieces, some of which I've intimately been able to
16 work with Major Vogt on, and live through this
17 exciting journey of really trying to address TBI
18 issues in wounded warriors and veterans.

19 A couple things we have in the queue
20 that are hot topics and garnering a lot of
21 interest both in Congress as well as within the
22 Department of Defense is the issue of cognitive

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1 rehabilitation. We just presented a cognitive
2 rehabilitation clinical guidance package to the
3 Clinical Proponency Steering Committee last month,
4 headed and chaired by Dr. Jack Smith.

5 And that package was approved
6 unanimously. And so what does that mean? It
7 means that we are going to be moving forward with
8 the places in the military health system that

9 already are -- have assets for cognitive
10 rehabilitation. We're going to standardize that,
11 the assessment and the management approaches. And
12 we're going to get some metrics so that we can see
13 if it's efficacious and see if we need to expand
14 the cog rehab component.

15 This is something, for those of you that
16 know Bob and Lee Woodruff well, has really been on
17 Lee's plate. She wrote an article in the front of
18 Parade magazine a couple months ago, with the
19 interest in both the reimbursement strategies
20 related to cognitive rehabilitation as well as
21 just the efficacy and making sure that this is
22 available for folks that come back with attention,

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1 memory, cognitive dysfunction, social pragmatics,
2 and executive functioning issues.

3 So that's been -- the work's there. We
4 had a consensus conference. There's not a lot of
5 literature to make it an evidence-based document,
6 but we did provide some basic guidance related to
7 the assessment and management treatment strategies
8 for cognitive rehabilitation.

9 So that's not going away. You're going
10 to see a lot of that in some upcoming
11 Congressional language. And we fully intend to

12 get that out in the field and make people
13 comfortable with strategies and have a better
14 handle on what's going on in the military health
15 system related to cog rehab.

16 Another area that we've done some
17 significant work on since we've last met is
18 driving assessments after brain injury. There was
19 a recent article, front page, by Erika Stearns'
20 group at University of Minnesota, I think she is,
21 looking at the driving behaviors of returning
22 deployers. And many of the driving behaviors that

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1 are lifesaving tactics in a theater of operation
2 are not necessarily lifesaving here when you get
3 back to the States and, in fact, can be
4 deleterious.

5 So we are working on some guidance
6 related to -- we know that there's some
7 (inaudible) driving behaviors in general from
8 deployers back to the States, but what we're
9 looking at is the role of traumatic -- incurring a
10 traumatic brain injury concussion and how some of
11 the cognitive and behavioral sequelae can affect
12 those driving behaviors coming back.

13 So that's another "hot topic," one that
14 I am proud to say I think we've been a little bit

15 more anticipatory on instead of reactive. We
16 don't have data saying that we're having a lot of
17 motor vehicle crashes related to traumatic brain
18 injury from deployers. But yet if you follow the
19 natural linear relationship here between mild
20 traumatic brain injury, the post-concussive
21 syndrome symptoms that we're seeing, and then
22 these -- this change in adaptation to behaviors,

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1 we know that that's in the queue. So driving
2 assessments after brain injury is another area
3 that we're doing some work with.

4 Post-deployment health assessment TBI
5 screening came about last year. May it actually
6 was; came out in January of '08, but wasn't really
7 fully implemented until May of '08. So we have
8 about a year and a half worth of information
9 looking at brain injury screening with the thought
10 of trying to detect brain injury as soon as
11 possible, ideally in theater or stateside through
12 emergency departments and primary care clinics.
13 But if that fails to happen, one of our safety
14 nets is trying to pickup on continuing symptoms at
15 the post-deployment arena.

16 So we've asked for some modifications to
17 the current TBI screening that we think may be

18 able to better fit that bill of trying to find
19 folks with continued symptoms after deployment.
20 So there is some circling policy memos and some
21 draft information related to some proposed changes
22 looking at post-deployment TBI screening.

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1 And then one of the big things that's
2 going on this last month is at the very highest
3 levels of government -- I'm sorry, in Department
4 of Defense, we've been asked to really
5 operationalize the mild traumatic brain injury
6 protocols for care that we have in theater. So
7 instead of making a service member come to seek
8 care because of self-reported symptoms, we are
9 looking at mandatory events, i.e., maybe an MRAP
10 got vehicular damage from a blast or, you know,
11 all of your personal protective equipment was
12 flown off of you during a blast. So the event
13 would trigger that somebody would take a look at
14 you as opposed to you saying, oh, I got a headache
15 and I think I need to go to medical.

16 So many of these initiatives -- or the
17 request, the urgency for this is to try to get
18 people seen and treated and recovering much
19 quicker than waiting for the symptoms to appear to
20 a degree that they're going to seek medical out.

21 So it's taking a little bit of the subjectivity
22 out of putting the pieces of the puzzle together

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1 and, rather, making it mandatory depending on the
2 inciting event to get people care.

3 Both the Marine Corps and the Army feel
4 as though we can do a much better job at early
5 detection and early treatment. And so that's what
6 this is all about: Operationalizing mild
7 traumatic brain injury protocols.

8 And, also, with a new force in mind,
9 which is the Afghan terrain, geography, weather,
10 and different conditions than we faced in Iraq.
11 So we need to make allocations for that related to
12 our air evacuation systems, our ground transports,
13 our convoys, and just the size of units.

14 So they've asked us to really roll up
15 our sleeves. We've never had this type of
16 involvement and attention, and it's the good, the
17 bad, the ugly. I mean, this is great to have the
18 opportunity in history to make sure that we're
19 detecting this very fast.

20 Talking on the battlefield, we also have
21 significant helmet sensor data that's now
22 beginning to emerge to inform us a little bit more

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1 of what blast is doing. So there's a very robust
2 research portfolio looking at helmet sensor
3 information, detecting incidences of blast, and
4 doing some corollaries to that.

5 We are -- finally, this is the last
6 thing. This is not a lecture. I just wanted to
7 mention some of the hot topics that are surfacing,
8 is looking at remote 24/7 access and trying to
9 leverage telemedicine, whether it's plain old
10 telephone systems to e-mail to video
11 teleconferencing to avatars to cell phones,
12 whatever the landscape may be, but trying to
13 leverage all this technology we have at our
14 fingertips to connect people with either specialty
15 services or experts in the field or, in some
16 cases, to avoid an unnecessary air evacuation or
17 convoy. So we're looking at telehealth, virtual
18 TBI clinics, et cetera, to serve rural areas as
19 well as to help connect specialty services with
20 the folks that need it.

21 A lot of the things I've mentioned are
22 really aimed at clinicians and trying to

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1 understand this problem more. That's why the work
2 done in this Panel is so important. It's not as
3 though we have many, many things in the queue that
4 are addressing the family dynamics and the family
5 journey.

6 And one of the parts that I thought was
7 so intriguing and was -- I really want to read it
8 when this is approved, hopefully, today -- is
9 finding meaning in caregiving. And I think that
10 that's going to be one of your big sell points, is
11 to be able to have caregivers really find meaning
12 in this as opposed to a task-oriented, this is
13 their new normal, and this is life. So I was
14 really intrigued and happy to see that piece as
15 well as the other fine work that's being done in
16 creating these curricula.

17 But as we march forward with looking at
18 our stakeholders, commanders, we've spent a lot of
19 time this last year really targeting command in
20 line, providers and clinicians, families and
21 patients. This is by far the top initiative we've
22 got going on related to TBI, and patients and

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1 families.

2 So, I applaud your work. I know it's
3 been as volunteers. It's been quite a commitment
4 of time and energy and travel, et cetera. So
5 thank you for what you're doing. And really
6 anticipate the dissemination strategies that are
7 going to be laid out before us. And then also,
8 hopefully, a unanimous vote for approval of the
9 curriculum. And look forward to the future as we
10 continue to go on this journey. Thank you.

11 Any questions? I don't know if I have
12 any.

13 SPEAKER: Sure, we have time.

14 MS. HELMICK: Fred?

15 DR. FLYNN: Yeah, Kathy. Yeah, two
16 questions. One, was there any update or mention
17 of Admiral Mullins' new concept to have three
18 concussions in your out?

19 MS. HELMICK: There has been. Funny you
20 ask, because we'll be calling you.

21 There has been a lot of interest in
22 cumulative concussion, and I actually probably

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1 should have put that on my hot topic list.

2 The unfortunate part is we are nil of
3 military data related to cumulative concussion.

4 So the very little literature that we have, we're
5 borrowing from the sports domain. Where we are
6 right now is, you know, there's some policy the
7 Marines have put out and an impending policy that
8 the Army plans to release looking at cumulative
9 concussion.

10 when we held a conference recently to
11 look at the operationalizing of MTBI protocols, we
12 tagged on a group to look at cumulative
13 concussion. And the major throughput from that
14 conference was instead of keeping them behind the
15 wire when three concussions, three documented
16 concussions, occur within the deployment cycle is
17 that we rather would recommend that an evaluation
18 be done, a clinical evaluation that involves
19 neuroimaging, neuropsychology testing or
20 psychology testing, a review and a workup of
21 symptoms, a neuro evaluation -- I think I already
22 said that -- functional testing, and the symptom

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1 workup. So five things all together. I don't
2 know if I listed all five, but five components of
3 a comprehensive evaluation that would take place
4 after that third concussion.

5 But unfortunately, we really are nil of
6 a lot of military-relevant data on repeat

7 exposure, cumulative concussion, and said sequelae
8 from the cumulative concussions. So we have a lot
9 of work to do in that arena.

10 Thus far, the Marine Corps, as they sent
11 that policy out, there's been very small numbers
12 that have been affected by this three strikes,
13 you're out, is what they're calling it. And
14 actually we're looking at changing the jargon to
15 three strikes and you're up, meaning you're
16 getting ready to go up and get your evaluation
17 done. And then the possibility of resetting after
18 three concussions if your evaluation is clean.

19 So we know we've got a lot of work to
20 do. Unfortunately, we don't have the data to
21 really help inform a lot of decision making that
22 needs to take place quickly. But we'll be calling

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1 you about some of that neuro and neuroimaging and
2 nueropsych testing so that we can give some basic
3 guidance on how that comprehensive evaluation can
4 take place.

5 DR. FLYNN: Kathy, the other question I
6 had refers to a trend that we had seen over the
7 last couple years of soldiers who have had a
8 concussive injury or mild traumatic brain injury
9 that once they got to Landstuhl, if their

10 immediate acute treatment protocol didn't seem to
11 be working and they were still symptomatic, once
12 they got to Landstuhl, it was automatically a
13 ticket home to CONUS. And many of these soldiers,
14 by the time that they got back and were seen by us
15 in our evaluations, the most disheartening thing
16 to them was that they were pulled out of their
17 units and left their units over there. Many of
18 their symptoms have actually returned to baseline
19 by this time.

20 And I received a, really, a wonderful
21 report for me to take a look at, by one of our
22 brigade surgeons over there in Iraq, who suggested

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1 a really intensive protocol for keeping many of
2 these soldiers with a mild concussive injury in
3 the FOB, maybe extending a little bit of their
4 time out of action to get them back to baseline,
5 and then have them there return with their units,
6 which really maintains a lot of the spirit in
7 corps.

8 Do you know if anything's happening at a
9 larger systematic level on that?

10 MS. HELMICK: There's a lot of
11 discussion about integrative care models lasting
12 up to 30 days in-theater to try to keep people

13 with their unit. Try to rehab, if you will, and
14 provide this integrative care approach, looking at
15 pain aspects, PH aspects, TBI, and keeping them
16 in-theater.

17 One of the cons to the cumulative
18 concussion workup that I mentioned may mean that
19 when you hit three, you're taken out of theater to
20 Landstuhl if our neuroimaging sequelae's going to
21 be that you have an MRI because we know we don't
22 have theater capability for that.

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1 So it's going to be important to --
2 knowing that that's a con, we want to keep people
3 in-theater as long as they can, and close to their
4 unit and mission focus. So that's always going to
5 be a significant balance. But I do understand
6 that there's conversations going on with CENTCOM
7 looking at centers that will try to keep folks
8 maybe up to 30 days in-theater, aggressively doing
9 rehabilitation strategies with the thought of not
10 going to a level four, but rather staying in CONUS
11 -- of staying OCONUS.

12 DR. FLYNN: Thank you.

13 SPEAKER: Me and Barbara.

14 MS. COHOON: Kathy, I'm Barbara Cohoon.
15 The NDAA had had a provision, and I haven't looked

16 at this yet, for cognitive rehab. Did that get
17 taken into -- did that come out at conference or
18 not, the cognitive rehab that was in the Senate
19 version? Did that come out in conference?

20 MS. HELMICK: I have seen some e-mails
21 as recently as over the weekend. And I don't know
22 where it is in the pipeline in terms of

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1 legislation. But it's still around, because I've
2 seen it as recently as Sunday when I was looking
3 at some randomized clinical trials looking at the
4 efficacy of cog rehab.

5 We're also awaiting a report that was
6 sanctioned by the Office of the Chief Medical
7 Office, out of Jack Smith's office, looking at
8 where we stand today in terms of the literature
9 support for cog rehab.

10 MS. COHOON: Is what the -- in the NDAA
11 --

12 SPEAKER: Yes.

13 MS. COHOON: -- there's supposed to be a
14 cover --

15 SPEAKER: Yes.

16 MS. COHOON: -- to cover the therapy.
17 And so the conference report came out. I haven't
18 seen the whole entire thing, that's why I was

19 asking, because I've been traveling.

20 You had mentioned about the driving
21 assessment. The VA briefed us (inaudible) that
22 they're seeing a huge increase in accidents with

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1 their veterans, OIF/OEF. And so basically they
2 have -- actually it's a car. And so what they're
3 -- they reached out to -- and again, I'm not a
4 NASCAR fan, but one of the big NASCAR gentlemen,
5 and he's done a commercial, but they are seeing a
6 big uptick in car accidents with this particular
7 population.

8 And again, the commercial is geared
9 towards veterans and the poster that's out is
10 geared towards veterans. And so when we were
11 briefed on this, I mentioned the fact that an
12 active duty service member might not necessarily
13 recognize themselves in this commercial because
14 they don't consider themselves veterans at this
15 point. They are seeing an uptick on that.

16 MS. HELMICK: I didn't know about that.
17 we had Dr. Liu, who's done a whole lot of work in
18 the driving simulator world and virtual realities
19 for treatment of driving rehabilitation, as part
20 of our working group earlier. July 28th is when
21 we met. So we asked for data, and I hadn't heard

22 that there was specific data showing spikes or

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1 increases.

2 So I'd be really interested to use -- I
3 mean, I don't think we really need a lot of
4 supporting data to move forward with this
5 initiative because I think it's a very linear
6 relationship. But if we have it, we might as well
7 use that as part of our case of why we need to get
8 some more structure into the evaluations that are
9 done.

10 MS. COHOON: That would be Dr. Cross.
11 He's the one that briefed us and what the VSOs
12 were concerned about was asking if it was more
13 having to do with suicide rather than the fact
14 that they were driving reckless. And they felt it
15 wasn't a suicide link.

16 MS. HELMICK: That it wasn't. Okay.

17 MS. COHOON: Right. And on the -- just
18 for some clarification on the three and out: It's
19 out of theater, not out of the military?

20 MS. HELMICK: Correct, it's -- actually,
21 the current policy that only Marine Corps has is
22 that you're out of the fight. You can stay

1 in-theater, but you're inside the wire; you have
2 no combat duty. So you're -- you know, it's a
3 desk job; you're doing some other non-exposure
4 activities.

5 And so what some of the recommendations
6 are is instead of staying inside the wire and
7 continuing in a limited capacity, but you're still
8 with your team, is to get a full eval at that
9 point and see where you stand, and maybe you can
10 be getting some treatment and be getting better.

11 So that hasn't been approved. That's
12 really in a pre-decisional state right now.

13 MS. COHOON: So they're finishing up
14 their whatever.

15 MS. HELMICK: Tour, right.

16 MS. COHOON: Okay.

17 MS. HELMICK: Yeah.

18 MS. COHOON: That's all I need to --

19 MS. HELMICK: Yes.

20 MS. COHOON: Oh, the National Defense
21 Authorization Act for the Fiscal Year 2010. They
22 were asking what NDAA stood for. So, I'm sorry.

1 SPEAKER: It's okay.

2 SPEAKER: Take one more.

3 CDR. HEPPEL: This is Jane Heppel. I
4 don't know if this is a hot topic. It was a hot
5 topic last year in San Diego at the DOD meeting I
6 attended. And at that time, Major Vogt was
7 briefing the audience on a hyperbaric oxygen study
8 that was beginning about then. I just wondered if
9 you might have any updates on that.

10 MS. HELMICK: Can do it. Enrollment
11 begins right after Thanksgiving. HBOT is moving
12 forward. The reason you may not have heard a lot,
13 we've had a little bit of transition. Colonel
14 Williams was heading this up at DCOE and he just
15 recently retired two weeks ago.

16 The HBOT is moving forward. There's a
17 PI on the study. There's places that have been
18 assigned as study sites. Fort Carson is the first
19 one that'll be standing up for that. And I
20 actually heard that -- your timing is great --
21 6:00 this morning the new PI facilitator said that
22 they're planning to do this right after

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1 Thanksgiving, in terms of first enrollment. I
2 don't know what the total N is, but it's moving

3 forward.

4 So, they're gauging, I think it -- 9 to
5 12 months for preliminary data analysis on if
6 there's a big hole, yes, no, in a major way. But
7 we're looking at about 9 to 12 months to start
8 having some preliminary information, the end of
9 2010.

10 MS. MOESSNER: (inaudible)

11 MS. HELMICK: It's for mild TBI. And I
12 don't -- but I don't know what the power analysis
13 showed for the N.

14 MS. COHOON: And where are they going to
15 holding that, Kathy? Do you know where the sites
16 are going to be?

17 MS. HELMICK: Pendleton, Carson, Wilford
18 Hall, Lejeune, and I -- there's one more. Do you
19 know?

20 MAJ. VOGT: (inaudible)

21 SPEAKER: I'm sorry?

22 MAJ. VOGT: I blanked on it --

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1 MS. HELMICK: Blanked on it.

2 MAJ. VOGT: -- I don't remember the
3 fifth one.

4 MS. HELMICK: Those are their proposed
5 sites. Okay. My time.

6 SPEAKER: She's said it's (inaudible).

7 MS. HELMICK: Yeah.

8 MS. MAXWELL: Shannon Maxwell. Just
9 with the changing policy and the possibility of
10 rehabbing in-theater, is there a way that as a
11 board we can recommend that there is some
12 education of the caregivers or the families during
13 family readiness or pre-deployment? Because I can
14 see a lot of misunderstandings, miscommunication
15 when a family finds out that their son or
16 daughter, husband has been wounded and isn't
17 coming home.

18 MS. HELMICK: Absolutely. That's a
19 great point. That's a wonderful point.

20 And I'm not sure. This has been a
21 little bit of a slower train in terms of getting
22 going. I can't tell you that for sure it's going

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1 to happen. But if we do go down that road, we
2 absolutely need to get family readiness and
3 centers involved so that -- you're right, that's
4 going to be a little out of the mainstream.

5 CDR. MILLER: And I'll be going with Dr.
6 Kelly in November into Afghanistan to look at
7 exactly that. And not only the family stuff, but
8 if we're going to do that, where are we going to

9 put it. And to go down to FOB Dwyer where they
10 are keeping those guys inside the wire and looking
11 in to that. We're going to be in FOB Dwyer.

12 MS. HELMICK: Thank you for your time
13 and engaging in some information. That's really
14 helpful.

15 MS. PRIES: (inaudible) one more,
16 please? Oh, Rose Mary Pries. I think another
17 important part about informing families is the
18 benefits to the service member. It's not just,
19 you know, they've been injured and they're not
20 coming home, but what may be the benefits to the
21 service member of staying inside the wire for a
22 time. And so it's not -- so there's a positive,

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1 you know, part of this.

2 Thank you.

3 MS. MOESSNER: All right. Thank you.
4 Thank you, Kathy, for your update. You're a
5 wealth of knowledge, as always.

6 So, Commander Feeks, administrative
7 update from the Defense Health Board.

8 CDR. FEEKS: This is Commander Feeks. I
9 may be speaking prematurely, but just to give you
10 a general picture of what happens next when the
11 curriculum is accepted in its final form by this

12 Panel. It then goes in front of the core of the
13 Defense Health Board where it is deliberated in an
14 open forum and then a vote is taken as to whether
15 or not the curriculum will be accepted in that
16 form.

17 And I can't speak for the Board, but I
18 think the impression that Anne Moessner just
19 shared with us at the beginning -- maybe it was
20 Sandy who said it -- that she's never heard Greg
21 Poland say wow three times in a row before.

22 So I think everyone is very impressed

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1 with what this Panel has produced. That doesn't
2 mean that I can guarantee that they'll accept what
3 you've done, but I'd be very surprised if they
4 don't say wow all over again.

5 We're making preparations to send each
6 member of the core of the Defense Health Board the
7 packet that you all received, complete with the
8 backpack and the cool binder and all that good
9 stuff. And it really is a very impressive packet,
10 as I'm sure you all agree. So we'll go ahead and
11 send those to the core board and they'll have
12 plenty of time to look it over and handle it in
13 preparation for the November 12/13th meeting of
14 the Defense Health Board here in Washington.

15 So that's all I really wanted to say.
16 And so I hope everyone's thankful that I kept my
17 remarks short.

18 MS. MOESSNER: We are, indeed. So, Meg
19 and Sandy, do you want to break now? I mean,
20 right now it's scheduled for a break. Or I can
21 certainly give the DHB update.

22 MS. CAMPBELL-KOTLER: Go ahead.

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1 MS. MOESSNER: Should I do that? And
2 then we can break afterwards? Okay.

3 So I did attend the last full Defense
4 Health Board meeting in Colorado Springs in
5 August. And I thought we would just let you know
6 what I reported on and some of the comments that
7 we got from the members of the Defense Health
8 Board.

9 So I worked, as usual, with the DVBIC
10 staff on developing a presentation and making sure
11 that we were covering what needed to be covered.

12 So in general for these presentations we
13 remind the Defense Health Board about the
14 Authorization Act that created this Panel. I
15 reminded them about the role of the Panel, the
16 role of DVBIC as the agency that's been supporting
17 the Panel. We reminded them about the definitions

18 we had come up with in the early meetings of
19 Family Caregiver, the intended benefits of the
20 curriculum. I reviewed for them the four modules,
21 what were the -- what was each module to focus on
22 in general terms.

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1 I gave a fairly detailed update of the
2 January 2009 Panel meeting, our last time we were
3 face to face together, and informed them that we
4 shifted from four work groups centering on
5 different modules to four work groups that were
6 really looking at completing the project. And
7 that those work groups were a design and editing
8 team, a multimedia team, the qualitative process
9 review team, and then the dissemination team.

10 And then I proceeded to give updates
11 from each of those work groups. So, from the
12 design and editing update, we shared that the
13 content had been finalized. vignettes, you know,
14 offered information about the writers had been
15 working very hard to interview family caregivers
16 to work those vignettes into the curriculum; that
17 we had worked with the Henry Jackson Foundation on
18 graphics, layout, packaging, you know, backpacks.
19 All of that information was shared, that we had
20 completed the acknowledgements for the curriculum;

21 that there had been a consensus among Panel
22 members that we keep the reading level, the health

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1 literacy level, at about 8th grade; and also
2 discussed the workbook companion piece, that that
3 had been included in the curriculum.

4 And then, finally, shared that we had
5 printed 100 copies that would go out to the focus
6 groups. We just put up some on slides, graphics,
7 what does it look like, the outer binder, the
8 covers to each of the modules. I did bring one
9 copy with me. Luckily Sandy shipped that off to
10 me quickly before the meeting. So I brought a
11 copy that got about halfway around the room before
12 the meeting ended. So not everyone got to see it,
13 but at least half the Panel was able to -- or the
14 Board was able to see that.

15 I also commented on our work with CEMM,
16 and reminded the Defense Health Board what CEMM
17 was and what that relationship included. I gave a
18 multimedia update; showed pictures of the CEMM
19 website with our Family Caregiver button
20 highlighted, and that that's where the content
21 would be loaded over the course of time; talked
22 about the interactive nature of the CEMM website.

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1 Proceeded to then give a review about
2 the qualitative group and how that was going. And
3 just maybe two or three days prior to this meeting
4 we had at least the preliminary verbal report from
5 the Alan Newman Research Group. And so was able
6 to then talk away from the slides and give an
7 update on the focus group, which I think in a
8 little bit here -- I know you all received a
9 written report of the focus group outcomes, but I
10 think we'll go over that with you verbally.
11 Because, at least for me, certainly it was a nice
12 report to get right before going before the Board
13 because the focus group input was lively and
14 positive, and so I was able to portray that as
15 part of the presentation.

16 And reviewed a basic timeline and then
17 we talked just a bit about the dissemination
18 efforts. But I did make it clear to them that
19 that would be the focus of this meeting. A large
20 focus of this meeting is to talk about, okay, we
21 have a product that we think looks pretty good,
22 how are we going to get it out there and keep it

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1 up to date and so on and so forth? So that was
2 basically the presentation.

3 As far as their comments, yes, we did
4 get -- actually, it's funny. Dr. Greg Poland has
5 been part of the Defense Health Board for, I
6 think, decades, as best I can tell. And his son
7 and my son are friends; they go to the same high
8 school. Dr. Poland works at Mayo Clinic. I had
9 never met the gentleman until we went to -- I went
10 to my first Defense Health Board meeting. So we
11 live in this very small community, our children
12 are friends, and now I actually know him. So
13 that's been a nice side effect.

14 So he was very complimentary about the
15 curriculum, as was the Defense Health Board in
16 general. I will -- and several other people were
17 at that meeting, they did have some questions and
18 comments and some suggestions. But in general the
19 feedback was positive. And I was approached
20 afterwards by several people sort of reinforcing
21 that even more. So that was nice.

22 Basically some of the comments were to

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1 keep in mind social networking options for this
2 curriculum. We talked about CEMM. We talked
3 about brainline is actually fairly setup for
4 social networking. But they wanted us to keep
5 that in mind as we discuss dissemination efforts
6 today.

7 They also talked about that the way this
8 curriculum was developed, the process that it went
9 through may be one that they will consider
10 replicating for future educational curriculum.
11 H1N1 was brought up as an example. They liked how
12 this was setup and what the end product looked
13 like, at least at first glance. So, looks like it
14 may be a future model for other topic areas.

15 They did emphasize, in a couple
16 different ways and statements, the importance of
17 the marketing and the dissemination efforts. And
18 that they were eager for us to spend some time on
19 that this meeting. Again, they agreed pretty
20 unanimously that it would be a shame to have such
21 a fine product not get out as quickly as possible
22 and as widely as possible. So, some comments

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1 about that.

2 A couple of people in the room asked, if
3 I work in the VA or DOD system, can I prescribe

4 this? Is there a way for me as a provider to make
5 sure that everyone gets it? Can I write an order
6 for this curriculum? Can I mandate that it be
7 given out?

8 So, I took away from that that they
9 really do want this to get into everyone's hands
10 and are there, you know, creative ways we can make
11 sure that that happens. The vignettes were well
12 received.

13 They did talk a little bit about the
14 curriculum. There was a couple of folks with a
15 strong educator background, health educator
16 background, and they said it's a little text rich.
17 They asked us to consider pictures, graphics, you
18 know, whatever we could do to make sure that it's
19 pleasing to the reader, easy to navigate, and so
20 forth.

21 And that is feedback that we, you know,
22 DVBIC took back to the writers. And, you know,

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1 we'll talk about some of those updates when we get
2 to the curriculum approval discussion -- or review
3 and approval discussion.

4 They did think if a family caregiver was
5 going to get through this curriculum, could there
6 be some sort of acknowledgement, whether it's a

7 simple certificate. And I don't think anyone on
8 the Board wanted there to be a competency, sort
9 of, level certificate, but some sort of
10 acknowledgement. And we'll talk about what the
11 decision was regarding that, as well.

12 There was support that we get to the key
13 people that will be handing out this curriculum
14 and get their buy- in, get them excited about
15 them, have them know what it is. So that they are
16 eager to give it out. They're eager to follow up
17 with families they give it out to. That they have
18 a bit of knowledge themselves about the curriculum
19 before they're expected to hand it out. So that
20 we find those key people and get to them and
21 prepare them.

22 we had a specific offer from -- and I'm

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1 sorry, Commander Feeks, I know I asked you his
2 name and I probably forgot it after I asked you.
3 But there was a doctor from the Tampa VA, the
4 James Haley Center, and he sits on the Defense
5 Health Board, and he --

6 SPEAKER: Dr. Scott.

7 MS. MOESSNER: It wasn't Dr. Scott.

8 SPEAKER: No.

9 MS. MOESSNER: No. Well, we'll see if

10 we can't --

11 SPEAKER: (inaudible) Florida.

12 MS. MOESSNER: Maybe we can dig -- yeah,
13 he's actually -- he's in Florida, but I don't know
14 that he's staff --

15 MS. CAMPBELL-KOTLER: (inaudible) South
16 Florida.

17 MS. MOESSNER: Right.

18 MS. CAMPBELL-KOTLER: And he probably
19 does a co-appointment at the VA. He's a --

20 MS. MOESSNER: I think he does.

21 MS. CAMPBELL-KOTLER: -- health
22 educator. He's improved public health there, I

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1 think.

2 MS. MOESSNER: He had some insightful
3 remarks. And he actually had an offer. So as
4 soon as we figure out his name, but he spoke on
5 behalf -- he felt very confident that he was
6 speaking on behalf of the entire team at the Tampa
7 VA. And he said you know, we see -- in his words
8 -- massive numbers of folks with mild traumatic
9 brain injury and more involved TBI. And we would
10 actually offer our facility up as an evaluation
11 site for continuing to figure out how do you get
12 this out? what's working; what's not working? He

13 said I would really like to offer up our center,
14 which seemed like something we would like to say
15 yes to, but maybe we can talk about that, too, as
16 we put together some recommendations for the
17 evaluation process, you know, that needs to be put
18 together, so.

19 CDR. FEEKS: Anne?

20 MS. MOESSNER: Please.

21 CDR. FEEKS: This is Commander Feeks. I
22 think you're referring to Dr. Thomas Mason.

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1 MS. MOESSNER: I am, indeed.

2 CDR. FEEKS: Okay, good.

3 MS. MOESSNER: Dr. Thomas Mason. I'm
4 going to write that down this time. Yeah.

5 And some of the staff that work with Dr.
6 Mason at the Tampa VA also have a long history
7 with the model systems, and so I actually know
8 many of the staff there. And I was approached at
9 a model system meeting about that as well. So
10 they seem to be a site that is offering themselves
11 up, which seemed, again, something that we should
12 discuss a little further.

13 Let's see. Posting, linking, websites.
14 You know, making sure this gets out there and is
15 accessible to everybody in every creative venue we

16 could possibly come up with. I know at the first
17 meeting, and we tried to go back and dig that out,
18 we spent quite a bit of time generating an
19 enormous list of websites where this curriculum
20 may be posted. So they indicated that that would
21 be a good thing to continue to refine and build.

22 Someone asked if there was a way -- I

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1 don't know the electronical medical system records
2 between the VA and DOD. But somebody asked is
3 there a way that there could be an electronic
4 checklist started that would follow the person
5 along so that you know who gave it out on what
6 date, and then who does follow-up and reinforces
7 the education of the entire package or even module
8 by module? So we'll put that out for the
9 discussion later this afternoon.

10 And I think those were the basic
11 comments from the Defense Health Board.

12 I am, as Commander Feeks mentioned,
13 going to present our final report to DHB at the
14 next meeting. And so that date, I did hear from
15 your staff that I am going to be on -- or we are
16 going to -- we, let's say we are going to be on
17 for a 45-minute presentation on the morning of
18 November 12th. So anybody who lives in the

19 region, the meeting is at -- it's in Fairfax in --
20 CDR. FEEKS: It's at the -- this is
21 Commander Feeks. It's at the Fair Lakes Hyatt.
22 MS. MOESSNER: At the Fair Lakes Hyatt.

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1 So, all I know is it'll be 45 minutes and it'll be
2 the morning of the first day of the meeting, which
3 is November 12. So I certainly am happy on behalf
4 of the Panel to get up and, you know, do a little
5 dog-and-pony show. But certainly for fielding
6 questions, which there may be questions about,
7 again, dissemination and evaluation and upkeep and
8 so forth, would love anyone else to be there to
9 answer some of those questions. So if anyone's in
10 the area and is able to make it, that would be
11 wonderful.

12 MS. HELMICK: Anne, can I just --

13 MS. MOESSNER: Sure.

14 MS. HELMICK: This is Kathy Helmick.

15 Two take-home messages that -- you described it
16 really well, and we had a lot of positive
17 feedback. But the sustainment piece was a crucial
18 part of the conversation. Everybody glowed over
19 the product and the process and everything. There
20 was grave concern that something good would get
21 out there and give it one year and then everybody

22 would say what was that? What is going on? So

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1 sustainment.

2 And I know you're going to talk about
3 that today. But that was very much ripe on
4 everybody's mind.

5 And then the other piece they asked
6 about was how many providers had been part of
7 this. Did the Services know that this was being
8 formulated and put together? So there was concern
9 about provider buy-in at the Service level to
10 ensure, as Anne mentioned about the prescribing of
11 said curricula during -- in the context of a
12 medical encounter.

13 So as you talk about dissemination, some
14 of that -- and this may -- you've already -- I may
15 be repeating myself because you've gone there, but
16 how to link with the Services. And we're kind of
17 at letter W at this point, you know. It's almost
18 done. How do we try to make sure that there is
19 some visibility, buy-in, adaptation, commitment to
20 actually deploy this product in the settings in
21 which family caregivers are part of their
22 clientele?

1 Those were the two things I just wanted
2 to mention.

3 MS. MOESSNER: Thank you. Questions
4 from anybody? Yes, Barbara?

5 MS. COHOON: I see more of our issue
6 going to be to find those that are already out,
7 you know, in our communities, as far as the
8 outreach there. You know, like the Shannon
9 Maxwells where, you know, you're husband's now
10 retired; things have settled down. They still are
11 going to need the book. That's where I see the
12 hardest piece as far as getting it way out there
13 so they're aware that it exists.

14 But they have a strong network and
15 communicate on a regular basis. Those that when
16 they were injured further -- I mean, closer to
17 when we started at war. So maybe the networking
18 there.

19 And Shannon, I'm sure, can give us a big
20 help with that.

21 MS. HELMICK: So you're thinking that
22 there'll be a retrospective dissemination

1 approach, i.e., people that have had TBI before
2 the launch of this product. And then a
3 prospective dissemination approach to make sure
4 that it's inculcated to the MTFs in facilities in
5 an acute period.

6 MS. COHOON: Yeah, because I -- looking
7 at the -- great product, by the way. I was so
8 excited when I saw the tree. And it's just
9 exciting.

10 No, because there's -- all these pieces
11 in here are relevant no matter when the injury
12 occurred. I mean, you could be, you know, eight
13 years out and still there's pieces in here that
14 you're going to find that are relevant. So, yes.

15 And not only through the DOD, but as Jon
16 was mentioning, we're obviously going to have to
17 make sure that the VA's very well aware of this
18 particular piece, which we have many folks on the
19 Panel to help with that.

20 MS. MOESSNER: Yeah, I will. A few of
21 us have been part of a small dissemination work
22 group and we've had a few conference calls over

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1 the last several weeks. And so a little later
2 today that's what we'll focus on. And actually

3 Shannon, in all of her wisdom, with a marketing
4 background and being a family caregiver, an
5 experienced family caregiver, we did put down some
6 tentative plans for exactly as you mentioned. So,
7 excellent idea about retrospective and
8 prospective.

9 So we will be happy to review at least
10 our preliminary thoughts and looking for ample
11 feedback from everyone today.

12 Yes, Jonathan.

13 MR. DODSON: Anne, to leverage off of
14 that, are we planning on distributing this to, at
15 least initially, the four polytrauma centers?

16 MS. MOESSNER: Yes, sir.

17 MR. DODSON: Thank you.

18 MS. HELMICK: I mean, I think this is
19 where you're going to have to get your
20 dissemination plan to senior DOD leadership,
21 senior VA leadership, Service leadership to
22 include the deputy directors of each of the

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1 Services. But to make sure that you've got that.
2 And there's platforms for that through Health
3 Affairs. For the VA, I don't know. But I assume
4 the VA folks through Central Office and VACO are
5 going to be able to navigate that one.

6 But I think that having large, senior
7 level platforms to start with is probably the best
8 route as opposed to the smaller platforms and
9 building up, if you will. And then on top of that
10 whatever Congressional platform may be necessary,
11 which of course is Commander Feeks' lane.

12 MR. DODSON: To add to that, have we
13 briefed General Shinseki on this? Ric Shinseki?

14 MS. BENEDICT: No, they're aware.

15 MR. DODSON: But Ric himself?

16 SPEAKER: Shinseki --

17 MR. DODSON: Ric Shinseki shows up in
18 the MATC over at Walter Reed, walking around.
19 He's the secretary of Veterans Affairs --

20 SPEAKER: Right.

21 MR. DODSON: -- former Army four-star.
22 But I've seen him over there several times. I

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1 worked for him in three different jobs.

2 MS. HELMICK: This is all part of your
3 Master Senior Leadership Plan in all your
4 stakeholders: DOD, VA, Congress, Services. And
5 getting top, and then moving down. But making
6 sure that they have visibility and somehow, you
7 know, not after the fact. You know, not this is
8 your product, now let me make sure I kind of --

9 MR. DODSON: Rest assured Ric knows
10 about our Panel because I told him.

11 MS. MOESSNER: Yeah. Thank you.

12 MR. DODSON: I'm going to give him
13 Anne's name and address.

14 MS. MOESSNER: Yeah. Fabulous. Sharon.

15 MS. BENEDICT: I can tell you that the
16 chief consultant for Rehab Services is briefing
17 the secretary tomorrow.

18 MS. MOESSNER: Okay.

19 MS. BENEDICT: Has a three-hour
20 briefing. And this is on polytrauma and lots of
21 TBI-related issues. And I think this is part of
22 the presentation.

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1 MS. MOESSNER: Oh, wonderful. Thank
2 you. Rose Mary.

3 MS. PRIES: A couple of things. First,
4 and we may talk about this later, but I didn't
5 know if we'd breaking into small groups and I kind
6 of wanted to throw this out for the whole Panel is
7 I notice that there's going to be, like, a
8 certificate in the back that you put your name in.
9 well, I'm not opposed to that, but I think there's
10 a much nicer way to do it, if it's possible. And
11 I don't know if we might have subsequent contact

12 with caregivers, that when they complete the, you
13 know, the curriculum, they let us know, and then
14 we send them a very nice, printed certificate and
15 a letter in gratitude for the support that they're
16 giving to their veteran or service member.

17 And I guess it has sort of another
18 purpose also. We could certainly use it, and this
19 was Sandy's idea, as an evaluation. But we might
20 also be able to use that post- curriculum contact
21 to do a needs assessment. Because we had
22 previously identified that we knew that this was

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1 kind of a jumping off point in that families may
2 have other needs that we just hadn't had an
3 opportunity to consider yet. But having those
4 data, you know, from caregivers who had used the
5 curriculum might give us a leg up.

6 So I'm certainly not attempting to
7 create more work for DVBIC or for anybody else,
8 but I think, you know, we know these people's
9 needs are not going to stop here with the
10 curriculum, and by what process could we use to
11 continue to address them.

12 So, anyway. And another, second point
13 is that I totally agree with the need for senior
14 level buy-in, but I guess working in the VA for as

15 long as I have, I think there's another strategy.
16 And that's to really impact the front-line
17 caregivers as well. So you not only get senior
18 level buy-in, but you get folks out in the field
19 in the front lines clamoring for whatever it is.
20 And I think we have a number of mechanisms, at
21 least through VA, where we can let those
22 front-line folks know about this and really

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1 increase their interest. So certainly it's an
2 adjunct to what Kathy described. So -- that was
3 Rose Mary Pries. Sorry.

4 MS. MOESSNER: Thank you. Yeah, please,
5 Kelly.

6 MS. SARMIENTO: This is Kelly Sarmiento.
7 I can give you the spelling of that.

8 I just wanted to ask, we've done similar
9 types of things in some of our materials through
10 CDC, and one was actually in a kit for physicians.
11 And we did a feedback card. And we don't ask
12 survey questions; it's just an open ended, you
13 know, tell us what you think about the materials.

14 And then that'll, you know, that way you
15 don't go through the OMB process and those sorts
16 of things.

17 And that was really informative and very

18 helpful in terms of building off the initiative
19 and creating new materials, and helps with
20 sustainability. And one thing we did to get
21 people to fill it out was to give a checkbox to
22 order more. And so they could tell us to order

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1 more.
2 And then the certificate idea would be
3 another way, you know: Checkbox, I want to order
4 two more, I want my certificate, and here's what I
5 think about it.
6 MS. MOESSNER: Great.
7 MS. PRIES: Could I just clarify? I
8 meant with certificates for caregivers. Because I
9 thought that was the --
10 SPEAKER: Yes.
11 MS. PRIES: So I may be --
12 MS. SARMIENTO: No, that's right, same
13 thing.
14 MS. PRIES: Did I -- okay.
15 MS. MOESSNER: That's right.
16 MS. PRIES: Yeah. It would just be a
17 very nice personal way to --
18 MS. MOESSNER: Yeah, we were trying.
19 MS. PRIES: -- to follow up.
20 MS. MOESSNER: You know, there were a

21 few of us who don't have much background in this
22 part of the process trying to drum up some ideas.

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1 so we are delighted to hear any ideas today.
2 Please.

3 MS. CAMPBELL-KOTLER: This is Meg
4 Kotler. I just want to say, Kelly, if you can
5 provide us with a copy of that feedback card.

6 MS. SARMIENTO: Oh, sure.

7 MS. CAMPBELL-KOTLER: we'd love to see
8 it --

9 MS. SARMIENTO: Yeah.

10 MS. CAMPBELL-KOTLER: -- and see what we
11 can do. Thanks.

12 MS. SARMIENTO: Yeah.

13 MS. MOESSNER: Great. Yeah, Shannon.

14 MS. MAXWELL: Can I just recommend a
15 slight change in the agenda?

16 MS. MOESSNER: Sure.

17 MS. MAXWELL: That might help in this
18 process, too, if instead of doing the breakout
19 groups prior to the presentation of the Foundation
20 --

21 MS. MOESSNER: Do the --

22 MS. MAXWELL: -- do the presentation

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1 first and then --

2 MS. MOESSNER: Yeah, and we actually
3 spoke -- Sandy and Meg and I spoke this morning a
4 little bit. And everyone is -- feel free to be
5 honest today. But we didn't know how many people
6 had actually had time to read through the
7 marketing plan. So one of the thoughts we had, at
8 the beginning of lunch hour was just to, rather
9 than even do groups or an overall presentation,
10 was to give you all time to sit and read if you
11 haven't had time to read the marketing plan.
12 It's, you know, it's, I don't know, 15 pages
13 maybe. So if people want some time for that, we
14 can tweak the agenda such that we could do that,
15 give you time to read, gather your thoughts. We
16 could do a group presentation and then we can
17 breakout as needed from there, if that sounds
18 reasonable.

19 Yes, Barbara.

20 MS. COHOON: Do we -- is there money set
21 aside as far as for printing these and then
22 disseminating these?

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1 MS. MOESSNER: Okay, I defer all money
2 questions to Meg. The question was is there money
3 to print and all of that?

4 MS. COHOON: And to mail these and --

5 MS. CAMPBELL-KOTLER: I'm trying to plan
6 for some funds for that. I think that, you know,
7 5,000, at least to begin with. But I'm sure the
8 numbers are going to be greater. And I hope that
9 Health Affairs, which will be the ultimate arbiter
10 of where this curriculum actually goes, will be
11 helpful in terms of helping us with wherever the
12 Panel decides the executive agency should remain,
13 you know. If the Panel decides it should be
14 DVBIC, wonderful, we're happy to do that. But,
15 you know, if the Panel makes another choice,
16 that's also something to consider.

17 But we are planning -- I certainly am
18 planning to be in our budget for next year to be
19 able to distribute this.

20 MS. HELMICK: And I think since it's not
21 a copyrighted product, you may want to look at
22 that strategy as a buy-in strategy for the

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1 Services, for the VA, and for the Department of
2 Defense. Is if they -- because it's not
3 copyrighted and you can disseminate however,
4 perhaps that's a cost incurred by the Services,
5 that you have somebody that is sending that out
6 and producing it and -- I mean, that's just a
7 brainstorm idea, but I just think that it's very
8 key to ensure that the Services have buy-in to
9 this, that they're well familiar with it, or it
10 won't get out to that grassroots level to the
11 ultimate -- your ultimate stakeholders here.

12 So that's just one thought, when you
13 start thinking about funding, is how to maybe
14 disburse that.

15 MS. KILADA: This is Sandy Kilada. I
16 just wanted to say, my only concern about that is
17 just we should keep in mind version control.
18 Because as this is being updated, both the written
19 piece and then also the CEMM, the electronic
20 version, to have -- somebody needs to have some
21 sort of control over what version we're
22 distributing to whom. So, just something to keep

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1 in mind.

2 MS. MOESSNER: Yeah, and it looks like
3 our discussion at the very end of today or if it

4 rolls over into tomorrow morning is, you know,
5 centers around upkeep, maintenance, that sort of
6 thing. So, besides dissemination and marketing,
7 how do you keep this updated and how do you track,
8 what kind of metrics do we want to put into place.
9 So we'll definitely include that in discussions
10 today and tomorrow as well.

11 Okay. Well, how about a 15- to
12 20-minute break? It is about -- it's 10:20. So,
13 you know, about 20 to 11:00 we can regroup. And
14 then we'll -- I think we'll just keep on with the
15 dissemination discussion.

16 (Recess)

17 MS. MOESSNER: Okay, I'm going to get us
18 started again here this morning and we're going to
19 be spending some time -- we have about an hour
20 assigned, but we'll see how fast we can get
21 through this -- to talk about the curriculum, the
22 content, and actually put it to a vote because one

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1 of the missions of this particular meeting was to
2 officially approve the content.

3 I thought I might -- I asked Sandy and
4 Meg if they would be willing to lead us through a
5 couple of things. I don't know if you all had
6 time again to read the official report on the

7 feedback from the focus groups, but in case you
8 didn't or if you wouldn't mind listening in anyway
9 about some of the verbal discussions that we had
10 with the individuals who ran the focus groups
11 because I think it may kick off this discussion a
12 little bit by sharing with you what the actual end
13 user group thought about the curriculum.

14 And then we will also talk a little bit
15 about the forwards -- the introductions that were
16 written because I failed to mention that at the
17 DHB meeting, that was brought up as well. This is
18 a very nice product. Make sure that you put a
19 welcome letter in there and make sure you put in
20 some bit of instruction about this manual. This
21 is why it was designed, this is how we envision
22 you using it, so we did spend some time on that so

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1 we can talk about that for a few minutes as well,
2 and then I know you all received a list of master
3 changes. So we just wanted to put up the
4 curriculum and we'll talk about that master change
5 list and make sure everyone understands what those
6 basic changes were to the curriculum.

7 So I think I'll turn it over to Sand --
8 to Meg.

9 MS. CAMPBELL-KOTLER: Okay, thank you.

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Sand-Meg, like sandbox.
Okay, thank you very much. I just was going to just talk about the focus group process and the findings from the focus group and I -- for those of you who haven't had a chance to read the full report, I think that we can all feel very gratified by the overwhelmingly positive response that the caregivers had to this curriculum.
I think uniformly they were pleased and visibly excited about the curriculum and I think that's just a very gratifying report back to all of us about how valuable, I think, the work that we've done together on this has been.

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The focus groups were conducted between July 27th and August 21st. We had six groups and one was conducted by a teleconference because we had a number of scheduling changes that occurred. We had hoped to have the focus groups all done by early August and of course there's always sliding in the timeline, and so folks that had originally volunteered weren't able to participate, but were so eager to give us their input that we did a telephone conference focus group with about three people.
we had a total of 23 people participate

13 which was not as great as we would have liked, but
14 we had the majority were spouses. We did have an
15 in-law who was a primary caregiver who was a male.
16 So at least we had that perspective. And we had a
17 range of lengths of time in caregiving, which I
18 think we can all feel good about in terms of folks
19 that -- 6 were caregivers up to a year and we had
20 three that were greater than 4 years, and one of
21 the findings was that even those who had been
22 caregivers 10 years found something in this

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1 curriculum that they did not know about, primarily
2 in the systems area. But it's gratifying to know
3 that we're putting all the information in one
4 place where people who have been in this business
5 for quite a long time are finding resources and
6 information that they weren't familiar with.

7 You can see that the sites we selected
8 were the Tampa VA, Walter Reed Army Medical
9 Center, the Fort Bragg Medical Center in San
10 Diego, and then the telephone group. And of
11 course these sites were selected by the
12 qualitative process review group in a
13 teleconference that was held in June or July of
14 last year.

15 So some of the specific recommendations

16 -- the groups lasted for an hour and a half to two
17 hours and the caregivers really felt that the
18 curriculum provided information that was
19 comprehensive and useful to caregivers across a
20 wide range of experience. They found the
21 curriculum to be accessible and easy to use and
22 easy to understand and I think this is very

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1 telling in that these family caregivers simply
2 receive the curriculum in the mail and were asked
3 to -- were given one module to review in detail
4 and asked to look over the entire curriculum and
5 the fact that they found it fairly easy to use and
6 understandable I think was a good sign. And I
7 know that, you know, a recommendation
8 dissemination is to be sure that we have people
9 who are educated about the curriculum discussing
10 it with family caregivers. But it is, I think, a
11 document that people can pick up and learn from if
12 necessary, if we're not able to achieve the
13 optimal distribution system. It's a very user
14 friendly, I think, and intuitively understandable
15 module curriculum.

16 Some of the recommendations that we took
17 from the family caregivers and have incorporated
18 as changes, which Sandy and our writers will

19 discuss later, have to do with perhaps the
20 emotional tone of the curriculum being a tad too
21 optimistic. There was a lot of concern about the
22 term "recovery" with family caregivers, I think

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1 primarily from the polytrauma site feeling that
2 recovery was not recovery to where the person had
3 been prior to the TBI, it was not going to be the
4 outcome for their family member, and so we decided
5 to strike "recovery" from the title of the manual.
6 They also were concerned about the brightness and
7 cheeriness and so one of the recommendations was
8 perhaps to tone down the brightness of the cover
9 and I'll let Sandy and the others talk about the
10 solution to that.

11 while they found the guide easy to
12 navigate, they also suggested that there be tabs
13 on the different modules so that it's easy to tell
14 where one begins and where one ends. And I can
15 understand just receiving this and not recognizing
16 that there are four or five modules within this
17 loose leaf book could be overwhelming and the tabs
18 will enable people to refer to the section of the
19 curriculum that they need to refer to more
20 quickly.

21 Interestingly, they found that the

22 coated and slick paper was not conducive to

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1 writing and so we actually are -- maybe, if it's
2 possible to say -- downgrading the quality of the
3 paper so that it's not as slick and, therefore,
4 you can write in pen and pencil and have those
5 comments remain. So, that was an interesting
6 finding I would not have thought of without the
7 focus group.

8 I think just to comment, I think that
9 the focus group process was invaluable to really
10 having a curriculum that was going to meet the
11 needs of the family caregivers, and I'm so glad
12 that the Panel recommended so strongly that it be
13 done. We -- based on some caregiver confusion
14 about the use of forms and on the use of the
15 journal entries, we have made changes as they
16 recommended and have introduced a whole new
17 introductory section or module which will help
18 people understand how to use the curriculum and
19 how to use the journal questions, how to use the
20 forms.

21 They loved the caregiver companion and
22 felt that that lent a lot of credibility to the

1 curriculum. Because the development of that
2 companion said to the caregivers that we really
3 did understand what they were facing and that we
4 were providing them with a real comprehensive tool
5 for keeping track of all the information and
6 people that they were coming in contact with. So
7 that was an excellent recommendation from the
8 Panel.

9 They felt that the guide should be given
10 in total. I know that one of the concerns that we
11 had as a Panel was that this was an awful lot of
12 information to give to a person at one time, but
13 the caregivers felt that we should give it at one
14 time and that families would take the information
15 in that they needed at the time and they would
16 have it as a reference. And people move through
17 the system so quickly or not quickly or radically
18 and that we wanted to be sure that everyone had
19 the full curriculum, that if we gave out the
20 caregiver companion in Module 1, initially, there
21 is a possibility that they might not get 2, 3, and
22 4, so we're going to just give the whole

1 curriculum. We have the opportunity.
2 We were asked to consider adding
3 information addressing the minimally conscious
4 state and we have added to Module 1 a little more
5 information about that aspect. We looked at the
6 emotional tone and writing. All of you were privy
7 to the excruciating decision about the title of
8 the caregiver. And I think that we came through
9 with, I think, something that we can all live with
10 at least, which is "Traumatic Brain Injury: A
11 Guide for Caregivers of Service Members and
12 Veterans." So, it speaks to the target
13 population. We call it a guide. We did lose the
14 term "journey" and we lost the term "recovery,"
15 but I think, in essence, I hope that our family
16 caregivers on the Panel are in agreement that the
17 title meets the need and says what it is. So,
18 that was very hard to do that kind of work by
19 committee.
20 They did like the idea that the guide
21 would be both on hard copy and online and they had
22 some very interesting -- it would promote

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1 communication with family members. They could
2 refer distant family members from afar to the
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3 website. They also felt with the guide that it
4 provided a very -- it provided a context for
5 discussing TBI with their children, with their
6 loved one who had sustained the TBI, that it
7 really was a teaching tool within the family as
8 well as for the caregiver, and I thought that was
9 a very interesting insight. We had been, at least
10 in my thinking, I hadn't really looked at it that
11 way. It's a way to help others and the family
12 understand what's going on in a way in which the
13 individual doesn't have to keep repeating the
14 story and repeating the information to family
15 member after family member, can refer them to the
16 website, can give them sections of the module to
17 read. And so, in a way, that alleviates a burden
18 on the caregiver just in terms of explaining
19 what's going on.

20 Let's see, they did suggest that we
21 provide a protocol for giving the guide to new
22 caregivers and, of course, that's what we'll be

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1 discussing in the dissemination phase of our
2 discussion, to give the guide as early in the
3 caregiving process as possible. They also felt
4 this would be a good tool for mentoring new
5 caregivers. So as we look at the dissemination

6 phase, one of the things I want us to talk about
7 is the role of family caregivers in dissemination,
8 in educating. I think that they should be -- as
9 many who would like to be, should be part of this
10 process of dissemination.

11 And they also felt it would provide an
12 orientation on TBI to non-specialist medical and
13 health care staff. So this is a professional
14 education teaching tool as well.

15 We talked about minimally conscious.
16 There were a few people -- I mean, the majority of
17 folks really felt very positively about this.
18 There were one or two who felt it was too much
19 information, that we should condense the page
20 layout, too much white space, but, you know, in
21 any kind of a focus group you're going to have a
22 bell curve and we have the outliers, and I think

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1 that we've tried to be responsive to that in terms
2 of making the curriculum more understandable.
3 We're adding graphics, adding pictures, taking out
4 charts that were not meaningful, and responding to
5 that concern without totally rewriting the
6 curriculum at this point since the majority of the
7 members found that to be -- found it to be a very
8 good guide.

9 One of the other changes that we made
10 based on caregiver input was on the caregiver
11 companion, to make that a loose leaf binder rather
12 than a bound module because there are forms,
13 because there is the capturing of medication and
14 other kinds of forms that will need to be copied
15 and then inserted so that you have a continuous
16 record of what's going on with the -- with your
17 loved one. And I think that made the caregiver
18 companion more user-friendly and more
19 understandable.

20 They liked all of the bullet -- they
21 liked the bullet points, they liked the charts and
22 tables, and most people felt that the pages,

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1 because they were not densely organized, that it
2 was more readable.

3 Interestingly, they liked the advocacy
4 tone of the curriculum and they were, I guess,
5 appreciative and somewhat surprised that the guide
6 did take that kind of tone. Some, of course,
7 wanted it to be even more aggressive, but it was a
8 document that I think families felt was not a
9 government document, that this was something for
10 them and that we weren't necessarily keeping to a
11 party line, so to speak.

12 They did suggest, in terms of the
13 military ranks, that we reverse the order of the
14 display of the ranks so that the lower ranks came
15 first because it showed respect for the injured
16 service members and veterans who were on the
17 frontlines and so the group has taken that into
18 account and has made that change -- pardon me?

19 SPEAKER: (inaudible) made that request
20 or was it several?

21 MS. CAMPBELL-KOTLER: I think it was
22 several.

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1 MR. DODSON: Okay, John Dodson working
2 at Walter Reed in Bethesda. Our organization is
3 working with 306 type people, seriously wounded.
4 This war is awful. It's catching everybody. It's
5 not like my war where captains were the highest
6 person on the battlefield.

7 MS. CAMPBELL-KOTLER: Yeah, yeah. So --
8 well, that's perhaps something to talk about then
9 in the next phase when we talk about the
10 curriculum and the insignia and the ranks and it's
11 really just a different way of ordering, it's a
12 unique way of ordering. And I don't think it says
13 one thing or another about who's been effected by
14 TBI.

15 MR. WELSH: It's interesting that
16 several people made that comment. You know, a
17 family member, a spouse or somebody, you know,
18 through their eyes, may see it different than I do
19 or maybe John sees it.

20 MR. DODSON: I was a captain.

21 MR. WELSH: It's an interesting point.

22 MS. CAMPBELL-KOTLER: Yeah. The

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1 caregivers really liked the quotes and
2 particularly the new caregivers commented that the
3 quotes provided emotional support, a sense that
4 the caregiver was not alone, and provided hope,
5 which is certainly one of the most important
6 things we want to provide.

7 There were a few who responded
8 negatively to the quotes taking up too much space
9 and making the guide longer, and some thought
10 there were too many and I think we have reduced
11 the number of quotes and maybe to positive --
12 portrayed caregiving too positively. And I think
13 the writers have looked at that issue and we've
14 made some reduction in the number of quotes and
15 kept the ones we thought were most pertinent.

16 The caregivers were a little confused
17 about the journal pages and journal questions.

18 They were concerned about writing very personal
19 information in the curriculum that other family
20 members would see and so a modification has been
21 made in that regard as well.

22 So I think that the changes group

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1 probably will talk about and we'll talk about, I
2 think, the changes that were made in response to
3 the family caregiver focus groups. And so I won't
4 take up anymore time, just to say that I think
5 this was a very beneficial process. The focus
6 group leader felt that it was very rare that we
7 would have such a unanimously positive response,
8 that his experience has been that materials are
9 written too densely. They felt that the literacy
10 level was just right, written at the right
11 literacy level, so we did a lot of things right in
12 this curriculum guide that I think the
13 recommendations were really more around the
14 margins than the sense that the curriculum was not
15 going to meet the needs that we know are out
16 there.

17 So, any questions about the focus group?

18 MS. MOESSNER: I know when I was on the
19 call with the gentleman who ran the focus groups,
20 a couple of the individuals who reviewed the

21 curriculum for us said are you kidding me? Like
22 all I ever received when, you know, I started this

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1 journey was a pile of xerox copies that you
2 couldn't even read anymore, you know. This is
3 quite the booklet to be receiving at this point in
4 time compared to what they had been exposed to so
5 far.

6 I remember him also saying in particular
7 this companion, which was modeled after something
8 that already exists with --

9 MS. CAMPBELL-KOTLER: Military One
10 Source.

11 MS. MOESSNER: -- Military One Source,
12 that they -- a couple people had actually told the
13 facilitator that's a home run in their book, you
14 know, something portable. And I think Liza, I
15 know you had been one of the proponents of having
16 some place to keep track of information because it
17 does get so overwhelming. And, again, they told
18 the facilitator home run, loved the companion
19 guide.

20 MS. KILADA: And just to add to that, he
21 also had mentioned that if -- he said if you did
22 no edits to it, you could send it out just as it

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1 is right now. That's the sense he got from the
2 group. So, of course, we did make edits, but that
3 was --

4 MS. MOESSNER: I was just asking Sandy
5 to remind me about how we acknowledged the focus
6 group members and they were acknowledged formally.
7 So just so you're reassured that they were thanked
8 for their time and acknowledged for their
9 contributions.

10 Yes, Barbara?

11 MS. COHOON: One of the things that we
12 talked about we were unable to go on to was it
13 Pennsylvania, as far as to do the focus groups,
14 because one of the participants had mentioned that
15 they really thought this was a great education
16 tool as far as her other family members and
17 providers. And because we didn't have the
18 civilian sector looked at, one of the things we
19 talked about was this also would be a great tool
20 for teaching the civilian sector about our
21 culture, our service members, and what caregivers
22 are going through, so we're looking for that

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1 feedback. But when that didn't happen, that was a
2 discussion we had when we were briefed on the
3 focus group findings.

4 MS. MOESSNER: Other comments? Okay. I
5 think then I'm going to turn it over to Sandy, who
6 will talk a little bit about some of the changes
7 and also the writers as well. If you have
8 comments, please interject.

9 MS. KILADA: Thank you. Some of the
10 things -- I'll repeat what Meg said, but I'm just
11 going to run through, I know you have the master
12 list of changes, but just sort of the highlights.

13 One thing we thought would be important
14 and we kind of caught it at the last minute was to
15 put the URL and the version number on the actual
16 physical curriculum so we can track the versions,
17 but also let people know, every module on the
18 front has the -- actually, at the end of the table
19 of contents has the URL to the same website.

20 MS. CAMPBELL-KOTLER: It's also on the
21 back cover.

22 MS. KILADA: It's also on the back

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1 cover. And then, of course, we changed the title,
2 as you know, and the papers from slick to
3 non-slick. And then the writers went through all
4 of the websites throughout the entire module to
5 make sure that they were active and accurate and
6 many of them were not. So many of them had to be
7 changed and updated, so that was a lot of hard
8 work. And we also had an intern who went through
9 the entire module to check all the contact
10 information -- phone numbers, addresses -- to make
11 sure that those were still accurate. But we do
12 have a caveat in there saying that the phone
13 numbers and the URLs are current as of the date
14 that this is published, so -- because those things
15 change all the time as we found out.

16 And then the biggest thing, we added an
17 introductory section. If you look through the
18 version you have, there were lots of things that
19 were repeated, the list -- the advisory panel list
20 of the advisory panel, the rabbi's poem, I
21 believe, there are several quotes, things that
22 just kept showing up in each module because we

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1 were concerned -- we didn't know about
2 dissemination and we didn't know if they would
3 have each piece by itself and wanted to make sure

4 that that was included in every piece. So -- but
5 we got the feedback from the focus groups that
6 said it was just too much repetitiveness and then
7 they didn't see the table of contents, that wasn't
8 the first thing they saw when they opened a
9 module, which was really kind of disorienting, I
10 guess.

11 So, we removed all the information and
12 put it in a new piece, which is the introductory
13 piece. And that has the preface Colonel Jafee
14 wrote, a welcome letter, and on behalf of the
15 Panel also wrote a sort of a welcome. We put the
16 "How to Use the Guide," what's in this guide, how
17 to use it, we put the poems in, and then the
18 certificate we thought would go into this portion
19 of the curriculum, so that's something that we
20 still have to talk about.

21 MS. LLOYD-KOLKIN: It was companion.

22 MS. KILADA: Right. That's yesterday's

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1 decision. So, but I guess we should discuss -- I
2 mean, it may not go anywhere at this point -- and
3 then overall, for the modules to help with
4 navigating, the front cover of each module will
5 actually have a tab on it so that they can easily
6 find the modules. Most people didn't notice that

7 they were different colors for each module and
8 when it was pointed out to them by the focus group
9 leader said, oh, well, if I had noticed that, that
10 would have been much easier. So to make that more
11 obvious we're putting tabs on.

12 And then we reduced the number of
13 quotes. And the quotes that were in the
14 curriculum themselves were also sort of -- we took
15 the relevant pieces and left those in there to cut
16 down on the quotes a little bit. And we added
17 pictures because the Defense Health Board had
18 asked for more pictures, so the caregivers gave us
19 their consent to put their pictures in there,
20 which was wonderful. So I guess they're not as
21 anonymous as -- originally they were going to be a
22 little bit more anonymous, so that's gone, but we

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1 still have only their first name and the last name
2 -- just the initial of their last name.

3 And then in the caregiver's companion,
4 as Meg mentioned, instead of it being bound the
5 way it is, we put it in a three-ring binder. That
6 should be easy to carry around. We also put
7 instructions in there saying that the forms, the
8 medication forms and the other tables that are in
9 the provider list, things of that sort, can be

10 photocopied. And then we figured it would be
11 easier for them to insert it, just put three holes
12 in it, and then they can just keep adding to this.

13 we also added -- they had requested more
14 cardholders, so we have a couple more sheets of
15 that in there. We also made sure the forms were
16 front-to-back the same because that was a bit of a
17 design error where we had medications on one side
18 and then some other list on the other side, so
19 they couldn't pull it out. So we made sure that
20 those were back-to-back.

21 The military terms were reversed. We
22 added insignia so that there were, you know,

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1 visuals there. And then we also added
2 black-and-white line drawings of the brain so that
3 they could take this document with them to their
4 neurologist or their physician and then they
5 could, you know, explain this is where the injury
6 was and, therefore, these are the consequences
7 cognitively and physically. And then a bunch of
8 changes to the glossary, just some minor things,
9 and then we added to Module 1 the minimally
10 conscious state. We expanded that section a
11 little bit. And then we also, because of the tone
12 and them saying that the tone was too positive, it

13 was hard to go through the entire document and
14 change the tone; and also the comments, all of
15 these comments that came up were generally one or
16 two people.

17 I mean, these were very minor and so we
18 didn't want to go through and, you know, you would
19 risk then making it too depressing, so there's
20 that balance. And so what we did was just add
21 some lines in there about, you know, the
22 curriculum sort of assumes that everybody's going

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1 to come home and everybody's going to be fine, you
2 know, that sort of thing. We changed those kinds
3 of statements and we added statements that said,
4 you know, your loved one may not come home and, if
5 that's the case, then so on.

6 Is that accurate, would you say?

7 MS. MOESSNER: Yeah.

8 MS. KILADA: And then we incorporated
9 all of Sharon Benedict's changes to Appendix B.
10 Thank you for going through that. I'm not going
11 to go through those. You have those. It's a long
12 list, but that was extremely helpful as well as
13 Colonel Boyle's changes to Appendix -- I guess
14 that would be still Appendix B, not C.

15 Let's see, what else? And basically

16 that was it. So the major additions were that
17 introductory piece and then expanding the
18 caregiver's companion and making some tweaks to
19 the rest of the module, lots of changing
20 semicolons to periods and commas, and capitalizing
21 things, so lots of small edits of that sort, but
22 no major content changes.

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1 I just want to make sure I have
2 everything. Oh, we also expanded the table of
3 contents also to help with navigation, so it's a
4 little bit more detailed than it was, than it is
5 in the version that you have.

6 I think that's pretty much it. Any
7 questions or concerns? Yes?

8 DR. FLYNN: Just from a purely
9 neurological standpoint, on the Module 1
10 corrections, think about -- let me see, it's five
11 lines down where it says, page 33, sidebar
12 definition of PTA, meaning post-traumatic amnesia.
13 It says, "Change 'amnesia' means forgetting to
14 'amnesia' means confusion after a serious TBI."
15 In fact, that's incorrect. Amnesia, is, in fact,
16 forgetting and you can't test for true amnesia if
17 someone's in an acute confusional state. So, I
18 think if you wanted to put down there it's

19 frequent that there is a period of confusion after
20 a serious TBI or after awakening from a serious
21 TBI, that's fine, but post-traumatic amnesia is
22 not the same thing as confusion. That really is

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1 forgetting or the inability to lay down new
2 information.

3 MS. KILADA: So, should we leave it the
4 way it originally was?

5 DR. FLYNN: Well, there's a paragraph in
6 here that says, "Post-traumatic amnesia often goes
7 hand-in-hand with extreme confusion."
8 Neurologically you can't diagnose a true amnesia
9 if the patient's in a state of acute confusion.
10 So, acute confusion is very common after awakening
11 or regaining consciousness from a serious TBI, but
12 post-traumatic amnesia, to test for that, the
13 person has to be in an alert and awake state. And
14 what it is, it's the inability to lay down new
15 information.

16 MS. MOESSNER: Yeah, and I think, again,
17 just as a clinical provider who -- you know, a lot
18 of families, when they hear "amnesia" or see that
19 word, you know, presume it means amnesia like on
20 the movies and the soap operas, which is they will
21 forget their entire life, they don't know their

22 name, they can't recognize anything about their

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1 life and history. So I think one of the attempts,
2 in my recollection, was to distinguish, you know,
3 this early confusion and forgetting the event
4 perhaps as compared to forgetting one's whole
5 life, which is extremely, extremely rare, but
6 often portrayed in the media.

7 So, I don't know -- we do that verbally
8 a lot when we talk to families because they see
9 PTA and they say, amnesia, oh, no. They're not
10 going to forget their whole life and their name,
11 are they? well, you know, they're in an acute
12 confusional state right now, so they, you know,
13 might not even recognize their own hand at this
14 moment, but once that clears, then we can sort of
15 get a handle on --

16 DR. FLYNN: You know, another way would
17 be to break it down into layperson's language.

18 MS. MOESSNER: Yeah, that's what I was
19 thinking.

20 DR. FLYNN: Amnesia means that they may
21 not be able to recall some of the events prior to
22 the injury and after the injury they may have

1 difficulty remembering things from day-to-day --
2 MS. MOESSNER: Right.
3 DR. FLYNN: -- but rarely will they have
4 difficulty with --
5 MS. MOESSNER: Remembering.
6 DR. FLYNN: -- remembering long-term
7 events from the past.
8 MS. MOESSNER: Maybe something like that
9 would do the trick.
10 MS. KILADA: We'd probably have to make
11 that change in the glossary, too, because there's
12 a post-traumatic amnesia definition in the
13 glossary that reflects the same error that you
14 were mentioning. Okay. Thank you.
15 MS. SARMIENTO: This is Kelly. And we
16 have language on that. I think it's "difficulty
17 remembering events prior to the injury or
18 immediately after." There's wording on that I can
19 show you guys.
20 MS. MOESSNER: That would be nice.
21 MS. SARMIENTO: Yeah, and we've tested
22 that one with --

1 MS. MOESSNER: Families -- okay, thank
2 you.

3 CDR. MILLER: Commander Miller. I sit
4 on the Purple Heart Board for the Marine Corps out
5 of Central Command, and what we're seeing right
6 now on these reports of the guys coming back, we
7 are seeing the diagnosis of concussion with
8 amnesia, so a lot of that's going to be in their
9 record. And the criteria to get a Purple Heart is
10 a Grade 3 concussion or a Grade 2 concussion with
11 amnesia. So, we're seeing -- the buzzwords are
12 going to be there in the documents coming back, so
13 families that read the documents may see that. So
14 a better explanation of amnesia is good.

15 MS. MOESSNER: Okay. Thank you.

16 MS. CAMPBELL-KOTLER: This is Meg. I
17 just wanted to ask Dr. Flynn what we should do
18 then to the reference to confusion that we have
19 there? Should we just eliminate it or --

20 DR. FLYNN: No, I think it's very
21 important to basically state that it's very
22 common, especially after a serious traumatic brain

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1 injury, to see a period of extreme confusion, you
2 know, after awakening from a coma. That's very,

3 very typical. And if anything at all, you may
4 want to even elaborate a little bit that it's
5 during this period of time that patients are often
6 highly agitated and highly combative as well. And
7 I think the important optimistic point would be to
8 say this is usually a transient period which will
9 pass.

10 MS. CAMPBELL-KOTLER: Should we
11 eliminate the third bullet there, which seems to
12 explain what post- traumatic amnesia is confusion
13 about where he or she is?

14 DR. FLYNN: No, because confusion about
15 where somebody is, is not post-traumatic amnesia.
16 Again, it's confusion.

17 MS. MOESSNER: Right.

18 MS. CAMPBELL-KOTLER: Right. So, we
19 should eliminate that bullet then because it's
20 under -- it's kind of explaining what
21 post-traumatic amnesia is?

22 DR. FLYNN: Well, I think to say that

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1 someone is confused about where they're at or
2 where they're located can be explained as part of
3 the post-coma awakening confusional state, but
4 that's a different paragraph than post-traumatic
5 amnesia.

6 MS. MOESSNER: Right, okay. We'll take
7 that out.

8 MS. CAMPBELL-KOTLER: Right. Shannon?

9 MS. MAXWELL: I was just wondering if
10 you could state it sort of in a -- just lost the
11 word -- continuum sort of thing that it can --
12 like in a confused state to the post- traumatic,
13 so continuum sort of --

14 MS. MOESSNER: Yeah, and certainly
15 disorientation, as you know, is another term
16 that's thrown around a lot and that's sort of part
17 of the confused state that many people are
18 disoriented. But, again, I would agree that it's
19 different than post-traumatic amnesia. And then,
20 right, it's this new memory, new learning -- it is
21 a little confusing.

22 DR. FLYNN: Yeah. One of the things,

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1 just as a point that Larry mentioned, too, that is
2 very difficult to piece out, even in patients who
3 have had a mild concussion or a mild traumatic
4 brain injury or a concussion, even as Grade 3
5 implies that there has been a loss of
6 consciousness, but, you know, when you lose
7 consciousness, there's no ability to lay down
8 memory. So there's oftentimes a difficulty in

9 interpreting did someone really lose consciousness
10 or did they have what's referred to as an
11 anterograde amnesia, or the inability to recall,
12 laying down new information right afterwards?

13 So, it can be very tedious, even for the
14 medical provider, to be able to piece out those
15 two issues. But you certainly don't have any
16 memories for the things that you've been
17 unconscious through.

18 MS. MOESSNER: Right. Carolyn.

19 MS. ROCCHIO: Carolyn Rocchio. I think
20 -- I mean, I totally agree with Fred that the
21 distinction between the PTA, the anterograde --
22 you know, the amnesia effect versus the confusion,

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1 particularly where there's a lot of temporal lobe
2 damage, that confusion is going to go on, well,
3 forever in some cases, where they have difficulty
4 determining when they're confused and when they're
5 not. So it's a very important point.

6 MS. MOESSNER: Other questions or
7 comments? Yes, please, Pam.

8 LCDR. HERBIG: Lieutenant Commander
9 Herbig. In Module 2, just as a provider
10 standpoint, we talk about the cognitive and
11 behavioral effects. Can we put in some really

12 strong language that if there are any changes in
13 their current functioning, cognitive, behavioral,
14 emotional, that you need to discuss this
15 immediately with your provider? I don't know
16 about the other providers in the house, but I know
17 I would like to know --

18 DR. FLYNN: Sure.

19 LCDR. HERBIG: -- changing.

20 MS. MOESSNER: Yeah.

21 LCDR. HERBIG: And then put it in front
22 of each section so that way it's very clearly

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1 delineated to let your health care provider know.

2 MS. MOESSNER: Good. Yes, Shannon?

3 MS. MAXWELL: One more suggestion on the
4 caregiver's companion. Can we include verbiage to
5 instruct them that they may want to use this as a
6 tool to keep pertinent information that could be
7 used for the future, for example, the PEB or the
8 Social Security Disability forms, medical
9 diagnoses, medications, the dates and place that
10 care was received? That was hard going back
11 through the Social Security Disability application
12 to find all that information again.

13 MS. MOESSNER: Okay, good. So a little
14 tip up front that you may want to hang on to this

15 information.

16 MS. MAXWELL: Yeah.

17 MS. MOESSNER: Good, thank you. Other
18 discussion? Yes?

19 MAJ. VOGT: Major Vogt. Going to Module
20 2, on page 4, there's a draft of the DOD system of
21 care and it's only -- it's almost all Army bases,
22 a couple of Navy, and there's Camp Lejeune, but

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1 there's no Air Force. And if we're looking for
2 buy-in from all the services and we want to do an
3 MTF picture, then we definitely want to broaden
4 that scope a little bit.

5 COL. FORTUIN: But do Air Force have
6 MTFs now or are they just clinics?

7 MAJ. VOGT: Yeah. Oh, yeah, yeah.

8 DR. FLYNN: Yes.

9 COL. FORTUIN: They're still considered
10 MTFs?

11 MS. CAMPBELL-KOTLER: Megumi, can you
12 help us with that?

13 MAJ. VOGT: Sure.

14 MS. CAMPBELL-KOTLER: It's also on page
15 89 because I had a similar comment.

16 MS. MOESSNER: Yes?

17 COL. FORTUIN: On page 2 of Module 2,
Page 92

18 middle of the page, and I hate to bring this up
19 now, but it says, "Emotional conditions like
20 post-traumatic stress disorder." And I'm not a
21 clinician, but my sense was is that a lot of
22 psychologists would probably not appreciate

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1 calling PTSD an emotional condition. I'm not sure
2 if it would be mental health condition or what the
3 correct terminology might be.

4 MS. MOESSNER: Sharon, any suggestions?

5 MS. BENEDICT: I certainly understand
6 why we said "emotional condition" because I think
7 a lot of times people freak out when they hear
8 "psychiatric" conditions or "psychological"
9 conditions.

10 MS. MOESSNER: Yeah, maybe that -- it's
11 hard to remember.

12 MS. BENEDICT: I think "emotional" is a
13 little bit softer and -- that's just mine --

14 COL. FORTUIN: And I'm fine with that.
15 It's just like the community I came with, they'd
16 pitch a little fit, but from a family perspective
17 that might be more palatable.

18 MS. BENEDICT: Yeah. And I don't have
19 that module because it's still at VA Central
20 office. I had them take a look at it, but do we

21 say anything about -- is there anything about
22 getting psychological care, psychiatric care? Or

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1 do those -- that condition is -- warrants further
2 investigation?

3 MS. MOESSNER: It's somewhere. I don't
4 know where it is.

5 COL. FORTUIN: It just says, "Emotional
6 conditions like PTSD and depression also make it
7 hard to tell if an effect is due to TBI." I mean,
8 it's not --

9 MS. STABLES: It goes on to say the
10 health care team is familiar with all these
11 conditions. They will develop a proper treatment
12 plan. They will teach you about how you can help.
13 We could include, you know --

14 MS. LLOYD-KOLKIN: I think there's
15 something further back.

16 COL. FORTUIN: I do, too. I think
17 there's more.

18 MS. STABLES: There's (inaudible) that
19 we ask them to seek psychological care, but it's
20 just not tied right there to psychological care.

21 MS. BENEDICT: Okay. I would rather say
22 "conditions" than "diagnoses." And, I mean, I

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1 just -- and not get too technical there.
2 SPEAKER: Okay.
3 SPEAKER: Just say "conditions" and
4 forget "emotional?"
5 MS. BENEDICT: No, I think you should
6 say emotional.
7 SPEAKER: Emotional, okay.
8 MS. CAMPBELL-KOTLER: (inaudible) the
9 8th grade literacy level to consider.
10 MS. BENEDICT: Right.
11 MS. CAMPBELL-KOTLER: You know, the
12 literacy level, so emotional I think works better.
13 MS. BENEDICT: Yeah, and I think the
14 word "diagnosis," there's -- it's too loaded. I
15 know a lot of times it isn't right, at least at
16 the time that they're looking at this. Enough
17 time hasn't elapsed for them sometimes to be able
18 to make a diagnoses, so I think "conditions" is
19 fine.
20 MS. MOESSNER: Good. Fred?
21 DR. FLYNN: Yeah, Fred Flynn. Meg, one
22 of the big issues among soldiers that we hear a

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1 lot, and I know that this is probably splitting
2 fine hairs, maybe opening up a can of worms, but
3 they look upon the chronic stress that they feel
4 in the field as a normal response to a very
5 abnormal situation. And as such, they take grave
6 offence at the term "PTSD" with it being labeled
7 as a disorder, that if you come back feeling a lot
8 of chronic stress that there's something wrong
9 with you.

10 Again, I don't mean to be getting into
11 the splitting of fine hairs between psychiatric
12 diagnoses as defined in DSM, but, at the same
13 time, I'm just wondering for this book, would it
14 be effective enough to say post-traumatic stress
15 and leave off the term "disorder" or is -- because
16 that encompasses a broader field and makes it seem
17 more reasonable that most folks probably come back
18 with some degree of stress.

19 MS. BENEDICT: Well, I think -- you
20 know, they're familiar with PTSD, the term PTSD,
21 but maybe what we could add is for acute chronic
22 stress, you know, under conditions, whatever that

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1 said, PTSD, depression or acute chronic stress.

2 MAJ. VOGT: I do know that, like, this
3 issue has come up a little bit with our
4 operationalizing, the mild TBI protocols and
5 stuff, and you know, trying to use acute stress
6 reaction versus PTS. And after Admiral Mullen
7 sort of made his PTS comment instead of PTSD, that
8 language has kind of taken off. And so even if
9 we've talked about acute stress reaction, when
10 we've briefed to them, we've had to use the PTS
11 instead of acute stress reaction.

12 MS. BENEDICT: Okay. Okay. I mean, I
13 don't have a problem taking out the "disorder"
14 part because I think a lot of times it's
15 misdiagnosed --

16 MAJ. VOGT: Right.

17 MS. BENEDICT: -- or combat-related
18 stress or whatever will make them feel better, I
19 think, about --

20 MS. MOESSNER: Yes.

21 MS. COHOON: Senior leadership
22 (inaudible) post- traumatic stress. When Admiral

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1 Mullen recently spoke at a wounded conference he
2 was very specific and only said post- traumatic
3 stress. And so if that's the movement and the

4 direction they're going into, but also, too, this
5 is for veterans, too, so what's VA adopting?

6 MS. BENEDICT: Well, I think VA is still
7 with PTSD because likely at that stage, you know,
8 post-separation from service, you know, enough
9 time has elapsed where the disorder could be
10 diagnosed, so.

11 MS. COHOON: But that's been the
12 movement is to drop the "D."

13 MS. BENEDICT: Yeah. But I think it's
14 not fair to those who actually have the "D" to
15 drop the "D." You know? I don't know.

16 MR. DODSON: John Dodson. Psychologist,
17 also. From my psychological (inaudible) the
18 DSM-IV TR, we have to stick with that for the
19 disability stuff. They call that PTSD until the
20 American Psychiatric Association changes that.

21 Meanwhile, back at the ranch, within the
22 military and the veteran community at Walter Reed

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1 and Bethesda, we're using PTS, post-traumatic
2 stress, so that we don't label the military
3 service member as disordered. It has a different
4 -- disorder has a different meaning for clinical
5 people like myself and the various psychiatrists
6 and people in the room than it does for the

7 layperson.

8 MS. KILADA: This is Sandy Kilada. I
9 just have a question. If it's not labeled a
10 disorder, will that make them less likely to seek
11 treatment for it, though?

12 MR. DODSON: It depends on their medical
13 treatment team, which includes mental health.

14 MS. BENEDICT: I mean, a lot of them
15 don't like that. I know at the PRCs, a lot of the
16 service members don't like the term PTSD. They
17 don't want that. They're okay with, you know,
18 chronic stress reaction, they're okay with
19 combat-related stress. That makes sense to them,
20 but they kind of balk at the disorder part of it.

21 MR. DODSON: At Walter Reed, again, John
22 Dodson, Walter Reed. It's difficult for NCOs,

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1 from about E-5 and above and officers, for me to
2 get them to go over to mental health -- now I've
3 forgotten the name of the hall -- but I change the
4 words around and say this will help you cope with
5 this and then they'll go over. And I have several
6 neuropsychologists over there that I just call up
7 and say this guy or this woman is coming over, be
8 careful about the labeling, and they do very well.

9 MS. CAMPBELL-KOTLER: I'd just like to

10 recommend maybe a compromise on this. It leads to
11 that introductory paragraph that we not bold it
12 and that we call it post- traumatic stress in that
13 particular location. On page --

14 MS. COHOON: Meg, where are you? Page
15 2?

16 MS. CAMPBELL-KOTLER: Page -- pardon me?

17 MS. STABLES: It's maybe because it's --
18 (inaudible) defined.

19 SPEAKER: Definition in the --

20 MS. STABLES: It's defined in the
21 margin.

22 MS. CAMPBELL-KOTLER: Ah, gotcha. Okay.

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1 MS. MOESSNER: It's bolded because
2 there's a definition in the sidebar.

3 MS. STABLES: Right.

4 SPEAKER: Yeah.

5 MS. MOESSNER: Module 2, page 2.

6 SPEAKER: well, why can't they put
7 post-traumatic stress, post-traumatic stress
8 disorder?

9 MS. MOESSNER: And just for my
10 knowledge, again, coming out of the civilian
11 world, very few to almost no individuals who have
12 -- that I see, who have a serious injury deal with

13 post-traumatic stress because, you know, they have
14 no memory of the accident in those early days and
15 everything awful that happened. But my
16 understanding is that soldiers, veterans, that
17 they have stress related to the combat experience,
18 not necessarily the injury, that this is even a
19 bigger -- so that does exist in this population.
20 It seems to be even a dicier issue when you get
21 into the people with milder type injuries, yes?
22 Because I know we have struggled with how do we

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1 just begin to discuss this complex issue in a
2 booklet we're trying to put together with mild
3 TBI? So that's even been more challenging than
4 trying to figure out, you know, what to say in
5 this particular curricula.

6 Shannon?

7 MS. MAXWELL: Removing the "D" might
8 also make it easier for the caregiver to talk to
9 their service member or veteran about it because
10 there are a lot of spousal fights that I'm aware
11 of about that issue.

12 MS. MOESSNER: Okay.

13 MS. MAXWELL: But when it's expressed as
14 post- traumatic stress or combat stress, it goes a
15 little easier.

16 MS. MOESSNER: Okay. Good point. Yes,
17 please, Barbara?

18 MS. COHOON: So it incorporates what the
19 VA is looking with the disorder and you're looking
20 long-term. And since we're looking at caregivers
21 across the spectrum in which they can receive
22 this, can we put -- because it's a listing of

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1 things -- can it be post-traumatic stress, post-
2 traumatic stress disorder, and depression? So
3 that, therefore, we're separating the two out,
4 that we're acknowledging the fact that there's a
5 post-traumatic stress and then some can actually,
6 you know --

7 MS. MOESSNER: Progress to be --

8 MS. COHOON: -- disorder, so that way
9 we're not -- because VA hasn't moved towards PTS
10 because, hopefully, by the time they get there,
11 you're seeing --

12 MS. BENEDICT: And at this point,
13 they're still service-connected for PTSD, so I
14 agree with Barbara.

15 MS. MOESSNER: Okay.

16 MS. BENEDICT: I'm fine with that. I
17 think that's fine.

18 MS. COHOON: Would that work for you,

19 Shannon?

20 MS. MOESSNER: I mean, is there a
21 general agreement that that would be a compromise?

22 MS. STABLES: Just on page 2 or

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1 throughout the whole guide? Because it comes up
2 often and throughout the guide, and so we'd have
3 to -- I mean, if -- this is sort of a
4 case-by-case. It works here, but it may not work
5 everywhere depending on how it's being used.

6 MS. COHOON: I'd refer to Shannon on
7 this since she's dealing with it on a daily basis
8 and what works best.

9 MS. MAXWELL: I would just take a look
10 again at the curricula, but I do like that listing
11 of each separately, that way you may not have
12 spouses and parents self- diagnosing.

13 MS. MOESSNER: Right.

14 MS. BENEDICT: And I think it's valid,
15 too. I think there are some folks that with time
16 are going to get over this and some folks that are
17 going to progress and actively meet the criteria
18 for, you know, diagnoses, but --

19 MS. MOESSNER: Good. Thank you.

20 MS. COHOON: When Major Vogt brought up
21 as far as the fact that there is some health care

22 services, MTFs that are missing, we see there's a

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1 lot of Navy that's missing, there are two, but if
2 we put every single MTF that's available
3 throughout the United States, it would make this
4 very busy. And so if you look at how it was
5 structured for the VA, where you have the major
6 ones which are service members and veterans are
7 going to for care, and then it lists basically
8 that there are 17 polytrauma network sites and 81
9 polytrauma support clinics that may be going in
10 that particular round, so that what's here,
11 dotted, is where our service members are more
12 likely to go. And right now -- and John may have
13 a better feel for this than is for me, but you've
14 got Bethesda, Walter Reed, you have Brooke and you
15 have Madigan, you have Balboa, and I'm sure there
16 are others in which, in other words, would be your
17 -- not necessarily your first, you want to make
18 sure you have those, but our second line where
19 we're sending our service members to. And so
20 we're kind of capturing equally or universally
21 what you've done for VA and for DOD.

22 And then you also have as far as the

1 fact that DOD provides care through the TRICARE
2 and C Module 4. If we can maybe put the pages in
3 which that captures, because a lot of our service
4 members are trying to get them as close to home.

5 They are going out into the civilian
6 sector. They are using our contractors and so
7 instead of giving the whole Module 4 to look for,
8 where would those pieces be as far as for the
9 community basis? Because depending upon for TBI,
10 as you know, you might go to, what is it, Sheppard
11 in Atlanta? There's several ones that our
12 contractors --

13 MS. MOESSNER: RIC.

14 MS. COHOON: -- there are several ones
15 that our contractors are working with that would
16 be part of this.

17 MS. MOESSNER: Thank you. Makes sense.
18 Fred?

19 DR. FLYNN: Just to add to that map,
20 too, I don't think we should forget our number 49
21 and 50 states because, you know, Hawaii's got TBI.

22 MS. MOESSNER: Whoops!

1 DR. FLYNN: Alaska, I just returned from
2 there and there's Fort Wainwright and Fort
3 Richardson, but actually it's Elmendorf Air Force
4 Base that has the bigger TBI program, so I think
5 that that should be noted as well.

6 MS. MOESSNER: Another good catch.
7 Thank you.

8 COL. FORTUIN: So, I guess, Meg, trying
9 to find that map, what do we want to capture in
10 this? I mean -- because when I first looked at it
11 I thought it was for primarily we were sending
12 people with TBI or -- you know, the certified
13 hospitals and clinics and so on, so that's a great
14 point is, what do we want to show here, because if
15 you put every MTF and clinic --

16 MS. MOESSNER: No, no.

17 MAJ. VOGT: We have a different map that
18 has by service what areas have a TBI program.

19 MS. CAMPBELL-KOTLER: That would be --

20 MS. MOESSNER: That sounds like a
21 winner.

22 MAJ. VOGT: You know, again, there are a

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1 lot of service members and veterans who are not
2 near those areas either so, it really -- and that
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3 doesn't mean that the other bases like Write-Pat
4 or Travis that don't have a bona fide TBI program.
5 They have the specialty care to take care of these
6 patients, so, do you want to look at --

7 MS. CAMPBELL-KOTLER: We have to clarify
8 that this is -- or that we have certified TBI
9 programs or distinct TBI programs to --

10 MS. MOESSNER: Right. Can you tweak the
11 preface a little bit? Mike?

12 MR. WELSH: Mike Welsh. If we add to
13 that certified or something in that context, some
14 of the spouses might go like, you know, why is my
15 husband going to the place that's not certified?

16 MAJ. VOGT: Right, and actually the Army
17 is the only one that has a certification
18 validation process; both the Navy and the Air
19 Force do not.

20 SPEAKER: Use the word "specialize."

21 MAJ. VOGT: I think then it still
22 doesn't answer, you know, why am I going to Travis

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1 or Wright-Pat that has great specialty care, but
2 doesn't have a program?

3 MS. CAMPBELL-KOTLER: We could change
4 this to DVBIC sites.

5 MAJ. VOGT: I mean, I'm open to all,
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6 just before I start really searching the net --

7 MS. MOESSNER: Yeah, to try and figure
8 that out.

9 MS. CAMPBELL-KOTLER: We could just show
10 the DVBIC system of care here. No?

11 SPEAKER: Obama's trying to kill it.

12 MR. WELSH: By year 2011, a lot of these
13 military treatment facilities are going to do
14 another big realignment and another shift.

15 MAJ. VOGT: We could very easily go and
16 say these are the larger hospitals within a
17 service and that would bring down so you would not
18 see places like Fort Riley and, you know, you may
19 only see the larger centers, but that would be one
20 approach so you sort of capture it.

21 MS. MOESSNER: Maybe we could add a
22 sentence into the intro to the map just

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1 explaining, you know, that there is some
2 flexibility that may occur to this, but, again,
3 right now, these are the major sites, and even
4 though they might not be close to your home, talk
5 to your team sort of thing.

6 MAJ. VOGT: There are other sites that
7 have -- provide great care, some smaller sites as
8 well, but that these are just a list -- a map of

9 the largest centers.
10 MS. MOESSNER: Right.
11 MS. CAMPBELL-KOTLER: Major medical
12 centers or major larger --
13 COL. FORTUIN: And on a very minor
14 point, but on page 89 where you list them again,
15 for Madigan Army Medical Center I put the state as
16 well as with Walter Reed Army Medical Center, put
17 the state or the district of the (inaudible).
18 MS. MOESSNER: You caught that already?
19 Okay, thank you.
20 MR. WELSH: Maybe we should do that in
21 one of our breakout groups today. It's a big
22 issue.

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1 MS. COHOON: When I had mentioned
2 before, how you've laid out the VA, you've
3 actually given kind of numbers and so if we did
4 kind of the same there, how many MTFs are we
5 looking at, how many clinics, just as far as
6 numbers, and then I'm sure there's a website that
7 basically has where all the different are located,
8 so just that, the way that we've laid out the
9 information for the VA is similar to how it's laid
10 out for DOD so that you can cross-reference back.
11 I mean, for someone who doesn't understand the

12 military system whatsoever, we're looking at the
13 fact that DOD and VA is the same. So, therefore,
14 how it's structured under VA I should probably
15 look at something that's similarly structured
16 under DOD. That's not necessarily the case, but
17 as far as putting down the numbers so they realize
18 that there are clinics available, there are other
19 levels of MTFs that are available, we're just not
20 putting them all on this particular map.

21 MS. CAMPBELL-KOTLER: I think we're
22 going to need some help with that. Our writers

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1 are saying that they looked for that kind of
2 information and couldn't find it.

3 LCDR. HERBIG: It's not on TRICARE?

4 MAJ. VOGT: There is a list of MTFs --
5 there's an MTF locator, but it's not a map and
6 it's got every single --

7 MS. COHOON: You have to plug in your
8 ZIP code and they will find it for you. Yeah.

9 MS. MOESSNER: Okay. Well, it does
10 sound like maybe a few of us will need to sit with
11 the writers and DVBC staff to try to hammer
12 through this section.

13 Yes, Rosemary?

14 MS. PRIES: This is totally off current
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15 topic, but I just thought I'd bring it up now.
16 You have the list of military ranks on the inside
17 of front cover and you have a continued list on
18 the inside of back cover.

19 MS. LLOYD-KOLKIN: That's all changed.

20 MS. PRIES: That's all changed? Okay,
21 good.

22 MS. MOESSNER: Yeah, that's an older

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1 version.

2 MS. STABLES: It's now in the companion.

3 MS. PRIES: Okay, good. But it's all
4 together, it's not split? Thank you.

5 SPEAKER: It's all together and it's in
6 reverse order.

7 MS. PRIES: Okay, thank you.

8 MS. MOESSNER: Good. Thank you. Yes?

9 MS. COHOON: I know we're going to talk
10 about how (inaudible) information that's in here
11 stays up to date, but the National Defense
12 Authorization Act for Fiscal Year 2010 has come
13 out of conference and there are some -- or at
14 least there was some caregiver pieces that were
15 put into language, both House and Senate, to make
16 sure that -- and again, I apologize, I've been
17 traveling so I haven't read verbatim as far as

18 what's in there. So if there's any caregiver
19 pieces that actually came out of there, that
20 that's included in this particular version since
21 we've got time before it's going to go to the
22 Defense Health Board.

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1 MS. KILADA: I just want to say we don't
2 have that much time because the Defense Health
3 Board meets on the 12th and they need to have a
4 copy of the curriculum two weeks before that and
5 it takes three weeks to get it printed, and so if
6 you work back we're actually kind of already
7 behind.

8 MS. COHOON: So the printing piece that
9 they're going to get is going to be the final
10 version then, Sandy?

11 MS. KILADA: Yes.

12 MS. COHOON: All right. Because there
13 was a compensation piece that was in the House
14 section and also the Senate section, it was just
15 depending upon how far it would be extended. And
16 what they were proposing was that if the service
17 member decided that they wanted to go through the
18 disability evaluation system in a quick fashion,
19 they could then qualify for what's called aid and
20 attendance. It'd be \$1,800 a month. And

21 basically it's considered caregiver compensation
22 although it would go to the service member, but

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1 the service member -- again, how the language was
2 written, I don't know what came out -- was that
3 the service member had to step forward and say I'm
4 going to go through a rapid DES piece on this in
5 order to qualify.

6 MS. CAMPBELL-KOTLER: But we don't know
7 what the final bill is going to look like.

8 MS. COHOON: No, no, it's out. The
9 House already voted on it. And Deb, where is it
10 with the Senate?

11 MS. FUNK: The Senate was expected to
12 take it up this week, but I don't know whether
13 they've --

14 MS. CAMPBELL-KOTLER: Are they the same
15 bills or the Senate version is different?

16 MS. COHOON: No, no, it came out of
17 conference and so the House voted on the --

18 MS. CAMPBELL-KOTLER: Oh, it's out of
19 conference, I see.

20 MS. COHOON: And they can't make any
21 changes to it.

22 MS. CAMPBELL-KOTLER: Right, okay.

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1 MS. MOESSNER: well, and I think you're
2 right. we'll talk at the end of today or tomorrow
3 about maintenance of the curriculum and keeping it
4 updated. And so we will be proposing that it be
5 updated on some regular basis so that maybe these
6 issues can get into the queue and that whoever is
7 on record as updating this keeps an eye on those
8 sorts of issues and gets that information in
9 there.

10 MS. CAMPBELL-KOTLER: Could someone get
11 that to us by Thursday afternoon, Friday morning
12 at the latest? Otherwise we can't -- some
13 language?

14 COL. FORTUIN: Until it's DOD
15 regulation, it won't be implemented. It could be
16 a year or more.

17 MS. MOESSNER: Right, so maybe we should
18 try to catch it on that first update.

19 SPEAKER: Just leave it out.

20 SPEAKER: We'll catch it on the --

21 COL. FORTUIN: (inaudible) thinking is
22 the next revision, those sorts of things. They're

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1 very important, but then you're going to raise
2 people's hopes that they're going to have it and
3 it's not been implemented yet.

4 MS. CAMPBELL-KOTLER: Good point. Thank
5 you.

6 MS. MAXWELL: That's something you could
7 include on the online forum.

8 MS. MOESSNER: Right.

9 MS. MAXWELL: You know, this is coming.

10 MS. MOESSNER: Right, a little notice.
11 Other discussion?

12 COL. FORTUIN: How were the glossary
13 terms decided upon? Because as I was going
14 through it, I would periodically go back to the
15 glossary to look something up and it wasn't there.
16 And, you know, as an example, the PNSs the PSCTs,
17 and so on. So I wasn't sure if you had a criteria
18 for what would go into the glossary or not.

19 MS. MOESSNER: So it sounds like it was
20 a list pulled from DVBIC.

21 MS. CAMPBELL-KOTLER: So if there are
22 some things missing that we need to include in

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1 that, let us know right now.
2 COL. FORTUIN: Okay.
3 MS. BENEDICT: (inaudible) system of
4 care acronyms, I noticed that too, so, you know,
5 PRC, polytrauma rehabilitation center; PNS,
6 polytrauma network site. I can give you a list.
7 MS. LLOYD-KOLKIN: Are you suggesting
8 putting those in the glossary, in the caregiver's
9 companion? Is that what we're -- is the proposal
10 on the table?
11 COL. FORTUIN: As I was reading -- I
12 think it would be helpful, yes. But you could end
13 up with a glossary that's, you know, six pages
14 long, but I don't know if that's necessarily bad
15 or not.
16 MS. BENEDICT: Well, the only thing --
17 SPEAKER: It's a question of, is there
18 enough time to get it done between now and Friday.
19 MS. STABLES: The polytrauma -- the PSCT
20 is written out in the text.
21 MS. BENEDICT: In the text it is.
22 You're right, though, it isn't in the --

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1 MS. STABLES: Do you want it also -- if
2 it's in the text do you think we also need it?
3 Because we have a medical glossary. We'd have to

4 create another glossary for these kinds of terms.

5 MS. BENEDICT: Or the only thing -- the
6 other thing you might do in addition to VA is to
7 put polytrauma system of care, put PSC, polytrauma
8 system of care. I don't know if we're putting
9 pages behind those.

10 MS. LLOYD-KOLKIN: well, there's also
11 the list of military terms. Do they appear in
12 there anywhere? I mean, that's more the set of
13 acronyms and they're not here now, but that might
14 be an easier place to add things like that.

15 MS. MOESSNER: Yeah, Rose Mary, has a
16 health educator comment.

17 MS. PRIES: Yeah, a comment about
18 glossaries. Glossaries are all well and good for
19 people who had relatively high health literacy.
20 People who do not have high health literacy are --
21 almost never go to glossaries. So that's why it's
22 critically important that if we're going to use

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1 terms or acronyms, that it is spelled out in the
2 context of the narrative, where it belongs,
3 because they're very -- they just don't go to
4 glossaries.

5 MS. MOESSNER: Okay.

6 MS. BENEDICT: And actually, I'm kind of

7 okay with not putting all those acronyms in there.
8 I understand what you're saying, Nancy, but it is
9 spelled out in the text and after a while it just
10 gets confusing and you're not sure what you're
11 supposed to be looking for, so.

12 MS. MOESSNER: Okay.

13 COL. FORTUIN: Okay. I went to the
14 glossary.

15 MS. BENEDICT: well --

16 COL. FORTUIN: I guess I fit the --

17 MS. MOESSNER: Yeah, that's right. Yes,
18 Pat?

19 MS. COLLINS: And then once it's online
20 it's (inaudible) a list.

21 SPEAKER: Yeah, exactly.

22 MS. MOESSNER: Good point. Good. Other

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1 discussion? So, as for proceeding to a vote,
2 understanding there's a little work that may need
3 to be done on the map section in particular, I
4 mean, are we okay with a formal vote understanding
5 that still needs to happen? Or how -- what are
6 people thinking? I mean, I personally would be
7 comfortable with that knowing that that's still --
8 and believe me, all changes need to be
9 incorporated by Thursday or Friday of this week

10 because it's off to print, so, you know, we would
11 make these done quickly, efficiently. Are people
12 okay with that, Fred?

13 DR. FLYNN: Fred Flynn. I just had one
14 other question and Sandy's very familiar with
15 this. On one of the diagrams we were trying to
16 get the accurate location of the anatomical area
17 stated and I think we're still working on that.

18 MS. KILADA: Actually, Major Vogt just
19 pointed out exactly where that is and I'm taking
20 that right over to graphics.

21 DR. FLYNN: Okay.

22 MS. MOESSNER: What part did you lose?

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1 DR. FLYNN: Well, it was supposed to be
2 an inner ventricular hemorrhage that was actually
3 in the parietal cortex. We tried to move that.

4 MS. MOESSNER: Trying to find those
5 ventricles, huh? Gotcha. Okay, thank you.

6 All right. Well, if people seem to be
7 okay with proceeding to a vote from the Panel to
8 approve the curriculum, I would look for a motion
9 to do so.

10 MS. MAXWELL: I move.

11 MS. MOESSNER: Okay, so Shannon looks
12 like a motion. A second?

13 COL. FORTUIN: I second.

14 MS. MOESSNER: Okay, second. Any
15 further discussion at this point in time?

16 Okay. All those that are in favor of
17 approving the curriculum with a little bit of work
18 as to be done per prior discussion that's well
19 documented, please signify by raising your hand.

20 Okay. Any nays, please signify by
21 raising your hand.

22 Any abstentions? If not, then we will

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1 consider the curriculum approved. Thank you very
2 much. Okay. I believe that we're back on time
3 for lunch. The agenda, again, did leave an hour
4 to an hour and a half to have a working lunch, but
5 if people would like to spend some time visiting,
6 relaxing for a few minutes, enjoying your food,
7 that would be perfectly acceptable, also time to
8 read the marketing plan since that just kind of
9 was e-mailed out fairly recently. You can have
10 some time to read.

11 Do you want to reconvene in an hour?
12 Does that give people enough time to have some
13 food and also read through the marketing plan?
14 Should we reconvene about 1 o'clock? And then we
15 can have some overview discussions.

DHB-101409

16 Shannon and I will lead you through the
17 marketing plan verbally and let you know our
18 thinking and then we can decide if we want to
19 break off into small work groups or what have you.
20 And then do you -- if you need help with a map
21 decision, do you want a few people to sit with you
22 at lunch to help with that or at the end of the

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1 day? Maybe at lunch?
2 So if anyone has a particular interest
3 in helping with this map business with some visual
4 and also verbiage, we'll have you sit on the
5 corner over to the right here.
6 MS. CAMPBELL-KOTLER: Do I see Megumi
7 working on it right now?
8 MAJ. VOGT: I went to the TRICARE side
9 and what I did was I narrowed it down to hospital
10 and medical --
11 (whereupon, at 11:58 a.m., a
12 luncheon recess was taken.)
13
14
15
16
17
18

22 How is this going to get out? How are you going

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1 to maintain it? That perhaps one of the things we
2 may consider doing is developing an Executive
3 Summary of the marketing and maintenance plans so
4 that when I present to the DHB, I can present
5 something that's brief and makes sense to them and
6 is, you know, short and to the point. And so
7 maybe as we go through, if anything jumps out at
8 folks about, yes, this is definitely something
9 that we should highlight in an Executive Summary,
10 you could point that out to us. We'll take some
11 notes about that.

12 Otherwise, we'll let Shannon take it
13 away.

14 MS. MAXWELL: Okay. As part of the
15 marketing and dissemination plan we took a look at
16 the market trend analysis, which, hopefully, you
17 all have read through a little bit, but really
18 refocusing again on the caregiver remembering that
19 this curriculum is going to the caregiver, not to
20 the traumatic brain injury patient. So we wanted
21 to really focus on their -- the caregiver's
22 demographics and trends, their associated

1 behaviors and access points that we may have to
2 the caregiver during this journey to recovery.

3 Also we, in that initial paragraph,
4 really refocused whoever's reading this on the
5 fact that this curriculum is viable and useful if
6 presented with personalized introduction and
7 education. So that became part of the
8 dissemination and marketing plan as well. And
9 then that note is there based on the survey as
10 well that backed up that thought.

11 I'm not going to go really through too
12 much of the demographics. They're fairly
13 self-explanatory. We do obviously have a lot of
14 young TBI patients, so we have parent caregivers
15 to consider, young spouses to consider and as well
16 as some more experienced spouses, and then
17 siblings and stepparents and grandparents. The
18 curriculum as a whole has really been written to
19 that broad spectrum. So now just looking at where
20 the access points are, too.

21 And we looked at this as, again, the
22 access points, but also to the severity of TBI.

1 So when you look through the recovery patterns and
2 the caregiver access points, we broke it down by
3 sort of the phases of recovery. Their MEDIVACed
4 to CONUS. In CONUS most of them will -- the
5 severe and moderate, we'll focus on them for right
6 now -- are going to hit the military treatment
7 facilities, the major military treatment
8 facilities like Walter Reed, Bethesda, Brooke Army
9 Medical Center. And at this point, federal
10 recovery coordinators and recovery care
11 coordinators are today more rapidly engaging the
12 caregiver. You also have the DOD liaisons, both
13 Army, Marine Corps, Navy, engaging the caregiver
14 immediately.

15 Length of stay at that military
16 treatment facility can vary on average one to two
17 weeks with longer stays based on stabilization and
18 condition. And the caregiver is really at this
19 phase learning more about what is TBI, what does
20 it mean to us.

21 Moving into the acute inpatient
22 rehabilitative treatment then, we look at the 4 VA

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1 polytrauma centers and the 17 VA polytrauma
2 network sites. At this point there's a greater
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3 understanding of the effects of TBI. They're
4 really getting into more of the extent of the
5 physical and cognitive deficits as they rehab.
6 And their main point of contact here is going to
7 be a case manager, but there's also going to
8 continue to be follow-through from the FRC and the
9 RCCs.

10 That contact then follows through with
11 the outpatient phase. This is the phase that we
12 have a greater possibility of losing some of our
13 access points because they are spread now all over
14 the nation. They may not be quite as in contact
15 with the DOD and VA representatives, but the FRCs
16 and RCCs still provide a consistent contact point
17 for most of the severe and moderate TBI's
18 caregivers.

19 Here in the outpatient phase they're
20 looking at the realities of the effects of TBI,
21 what this means in transitioning and the caregiver
22 is now becoming more of a self-advocate and an

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1 advocate for the service member rather than
2 relying on more of the patient and case management
3 teams.

4 There is an important phase in that
5 outpatient area that we need to look at, too, with

6 the disability evaluation system and the PEB.
7 This is a crunch point for families. It's a
8 source of financial stress. It's a place where
9 decisions made then effect the outcome of their
10 benefits. So, having knowledge of the portion in
11 our curriculum about the DES and PEB program then
12 is very important prior to that point.

13 I have a little paragraph in here that
14 there is -- just pointing out that there are some
15 TBI treatment programs being established in
16 Landstuhl, now also need to consider not only the
17 CONUS aspect, but looking at a global aspect of
18 dissemination.

19 So, summarizing that, throughout each of
20 these phases, the FRC and the RCC truly provide
21 the most consistent access points for the
22 caregivers.

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1 we also took a look at caregiver
2 socialization and support. Throughout the phases,
3 caregivers find support in friends and family as
4 well as the case managers and other wounded
5 families, that peer-to-peer and word of mouth
6 sharing are really given quite a lot of
7 credibility. So, looking at those points where
8 that word of mouth and peer-to-peer access

9 happens, the Fisher Houses, the Malogne House
10 Family Service Centers, some of the waiting rooms,
11 Caring Bridge, some of the social sites like
12 Facebook, those become important.

13 Okay, connectivity. As service members
14 transition home, then, and particularly as they're
15 transferring out of service or transitioning out
16 of service, connectivity with the caregiver and
17 DOD begins to decrease. There are implements
18 being put into place by some of the service
19 branches to enhance that connectivity. The Marine
20 Corps wounded warrior call centers, one, they're
21 calling out to all their wounded patients. The
22 Army has some similar call centers through their

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1 AW2 and WTUs.

2 The Marine Corps really -- the Marine
3 Corps is the one service that actually calls all
4 of their wounded. Army and AW2 and WTUs are
5 really tracking more of the 30 percent or higher.
6 So missing out with those mild/moderate TBIs
7 somewhat through the Army and correct me if I'm
8 wrong.

9 Other areas of connectivity for the
10 caregiver they come in some of the paperwork that
11 they're experiencing and covering for the patient,
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12 their LES, their retirement account statements, VA
13 statements of benefits, TRICARE EOBs. So these
14 are also some good potential connectivity points
15 where we could access the caregiver.

16 Again, because the FRC and RCCs are
17 charged with following a TBI patient into the
18 transition and into civilian life, they provide a
19 continuous flow of access.

20 The Alan Newman Research Survey, just
21 with what they reported with regards to the
22 curriculum and dissemination is, again, focusing

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1 on the presentation in person. There was
2 agreement that a phased instruction that would
3 incorporate differences in learning styles was
4 needed. And then the recommendation that all four
5 modules be presented to the caregivers at the same
6 time so that there was no missing of a module
7 because of odd transition or missing of a stage.

8 So, our biggest market access barriers
9 then became access to caregivers of TBI service
10 members who used medical providers outside the DOD
11 and VA system of care, and those caregivers of
12 mild TBIs who are particularly harder to reach due
13 to the fact that TBI may have not been diagnosed
14 early, may have been diagnosed later, they may not

15 have been -- the caregiver may not have been
16 identified right away.

17 Okay, and I think that's it. So when we
18 looked at all that data, we tried to come up with
19 a market entry strategy that would form a
20 foundation for a recommendation. The objective,
21 then, to place in the hands of caregivers and
22 support the educated use of Traumatic Brain

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1 Injury: A Guide for Caregivers of Service Members
2 and Veterans throughout the Continental United
3 States and OCONUS. The curriculum is to be
4 distributed at appropriate intervals in the
5 recovery process in a manner that supports and not
6 overwhelm the caregiver.

7 The committee came up with several
8 goals. We have a couple of quantitative goals,
9 but mostly these are qualitative due to the nature
10 of just access to the caregiver. The first one --
11 do you want to go through these in detail, the
12 goals?

13 MS. MOESSNER: I think so.

14 MS. MAXWELL: Okay. The first goal,
15 place the curriculum in the hands of 98 percent of
16 the TBI caregivers of patients with moderate to
17 severe injuries who have been assigned an FRC or

18 RCC and are currently in or just entering the
19 system of care. Dissemination must be
20 personalized, gradual, and education-based
21 beginning July 1, 2010. This goal, this high
22 percentage rate was based on the fact that we, at

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1 this point, because they are currently in the
2 system, we have access to them. There should be
3 no reason that we can't get the curriculum to them
4 other than maybe they turn it down, which I can't
5 imagine somebody would. And we also have the fact
6 that they are assigned an FRC or RCC.

7 The dissemination date was based on the
8 curriculum release.

9 MS. COHOON: Shannon?

10 MS. MAXWELL: Yes.

11 MS. COHOON: What we're discovering is
12 that not all services are assigning these
13 individuals federal recovery coordinators.
14 They've decided that until the FRCs get full up
15 and running and they feel secure enough that
16 they're doing their job well enough, the services
17 aren't even telling anyone they qualify. The AW2,
18 when they had their summit, they never mentioned
19 FRCs, never talked about FRCs nor told them that
20 they even qualified for an FRC. We all agree that

21 they're supposed to have FRCs, but they're not.
22 And when we had our wounded Camp, there were 17

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1 families that were there and only 1 had even heard
2 of an FRC and all of them qualified for an FRC.

3 MS. MAXWELL: Some of the
4 recommendations, particularly with regards to the
5 FRC and RCC, are going to be based on buy-in.
6 We've talked to Dr. Geiss with the FRCs and
7 there's some discussions being had with heads of
8 the RCCs, too, to get that buy-in and to establish
9 a procedure where they will formulate a
10 standardized approach. So, hopefully, that won't
11 be left up to the service; that will be a mandated
12 FRC function to engage those traumatic brain
13 injury patients.

14 MS. COHOON: Right, but if the FRC
15 doesn't know that they exist, then they don't know
16 that they exist and the services aren't telling
17 them that they exist. I had this conversation
18 with Karen when it was finally validated at our
19 wounded, so I fully agree with you that the FRC is
20 the place as far as to go, and we're bringing up
21 now the fact that the services are not telling the
22 individuals that they qualify for FRCs.

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1 MS. MAXWELL: Is that something then we
2 can place as a recommendation that that's
3 mandated, that the services inform the FRCs
4 regardless of their personal discretion?

5 COL. FORTUIN: That speaks directly to
6 the proponency for this product anyway. It's got
7 to land -- we were talking earlier -- it's got to
8 land somewhere and not knowing where it's going to
9 land makes that sort of direction difficult to do
10 at this point. So I think that that is absolutely
11 a priority that we're going to get -- we need a
12 decision on.

13 MS. MAXWELL: Okay. Our second goal is
14 to reach and inform the caregivers of TBI
15 patients, wounded or injured post 9-11, who are in
16 later phases of recovery and/or beyond the
17 military treatment facility and VA care center
18 services about the existence of the curriculum and
19 provide information on how to obtain a copy. So,
20 again, we're looking at those caregivers who are
21 now beyond our immediate reach; they're in the
22 outpatient phase or they're accessing civilian

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1 care centers. The committee felt that it would be
2 beneficial to narrow the population down to
3 wounded or injured post 9-11 just not to overwhelm
4 the system at this point.

5 Goal number 3, deliver the curriculum
6 with education to 88 percent of those caregivers
7 of TBI patients in later phases of recovery and/or
8 beyond military treatment facility and VA care
9 center services who were reached and informed. So
10 when we make those contacts with caregivers that
11 88 percent of those contacted will receive this
12 curriculum.

13 MR. WELSH: May I ask you a question?

14 MS. MAXWELL: Sure.

15 MR. WELSH: Mike Welsh. I don't really
16 need to know why, but when Anne presents this, she
17 might have to explain how you came up with the 88
18 percent.

19 MS. MAXWELL: The committee looked at
20 the percentages and we went back and forth on
21 several percentages. We want a commitment to the
22 goal, so the higher percentage was there because

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1 of the commitment to the goal. The reduction in
2 percentage is really due to caregiver desire.
3 There are going to be some caregivers that may not
4 want this curriculum.

5 Does that help? Okay. Item 4, goal 4,
6 conduct an annual assessment of the effectiveness,
7 usefulness of the curriculum for the purpose of
8 modifying and updating their curriculum as needed.
9 Educate and inform providers/advocates across the
10 TBI care continuum about the availability and
11 purpose of the curriculum as well as how to obtain
12 a copy. This speaks to medical providers, case
13 managers, et cetera.

14 And we could -- do we want to add into
15 this goal the service -- the higher branches?

16 MS. MOESSNER: Yeah, maybe. Yeah, maybe
17 so.

18 MS. MAXWELL: Okay. And the last goal,
19 investigate a data collection mechanism for
20 tracking the distribution of the curriculum and
21 gathering matrix.

22 So, those are the basic goals.

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1 MS. MOESSNER: Yeah, please. We have a
2 few questions.

3 MAJ. VOGT: Thanks so much for doing

4 this (inaudible). It's just an amazing piece of
5 work. It's really impressive, so I know
6 (inaudible).

7 I was going to say, first of all, thanks
8 so much for doing this because I know -- it's an
9 amazing piece of work and I know it must have
10 taken a long time. So, the one thing I may
11 suggest is that we may want a goal that's specific
12 to National Guard Reserve. I know that we say
13 that the barriers are the people accessing care
14 outside of the DOD and the VA, but I think having
15 some sort of metric that looks specifically at
16 that population may be important.

17 MS. MOESSNER: Good idea. Thank you.
18 Yeah, Larry?

19 CDR. MILLER: Yes. Shannon, that was
20 great. I have a couple of questions. First, are
21 we doing this in a different language as well? Is
22 this going to be in another language?

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1 MS. CAMPBELL-KOTLER: Could be a goal.

2 CDR. MILLER: It's a goal for the
3 future?

4 MS. MAXWELL: Yes.

5 CDR. MILLER: Okay. I know in the
6 Marine Corps we have a lot of families that are

7 Hispanic and I know that they would also like to
8 benefit from this, so we need to consider that.

9 MS. MOESSNER: Good.

10 CDR. MILLER: I take this from a
11 military standpoint as well and if you're going to
12 be disseminating this out into the field, we have
13 to get the service chiefs' buy-ins, so there has
14 to be a clear plan for starting with the -- maybe
15 even as high as the secretaries of the Navy and
16 the Army and the Air Force and pushing something
17 out to them.

18 And I know, Anne, I talked to you
19 earlier about maybe coming up with a three or four
20 slide presentation that we could take to the
21 service chiefs. You're also going to then have to
22 get the surgeons generals in this so that you can

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1 -- they will allow you to disseminate this all the
2 way down into the MTFs, so that it can go out and
3 be utilized and you can put up brochures and
4 things like that. I think that has the kind of --
5 from top down information. And then I know that
6 the Marine Corps has a general officers meeting a
7 couple times a year, and I was asked by the
8 wounded warrior Regimen, Colonel Boyle, to go to
9 one of those meetings with him to answer questions

10 about TBI.

11 Because there are a lot of general
12 officers' wives that go with them to those
13 meetings and areas like that. Four or five slides
14 or three slides presentation to the general
15 officers of each of the services during their
16 meetings might be also a good way to consider
17 disseminating it because if we're going to push
18 this out and not involve from the top down,
19 there's liable to be some friction and that would
20 include -- I think somebody had said that they
21 were going to brief the VA secretary as well. So,
22 you know, the top down approach I think absolutely

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1 has to happen in the military.

2 MS. MAXWELL: I'll add that as a
3 separate goal, education and buy-in.

4 MS. MOESSNER: Yup, that sounds good.
5 Thank you.

6 MS. COLLINS: Pat Collins. I would add
7 to Commander Miller's list. Each service has a
8 service secretary, but they also have an active
9 duty chief of staff or they're called -- they're
10 different -- the chief of Naval operations, so
11 there's a military chain and also the civilian
12 chain. The undersecretary for Personnel and

13 Readiness, we don't have a political appointee
14 yet, but certainly because of their role as the
15 personnel component of DOD, they should be
16 briefed. I would hope we'd have a press
17 conference at DOD, probably with Ellen Embrey and
18 Colonel Sutton -- I mean, General Sutton.

19 The SMMAC is the Senior Medical Military
20 Advisory Committee that has all the surgeons
21 general and some of the other heads in DOD. They
22 should be aware. And Military One Source is not

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1 on the list, but they're often used for
2 information and referral. They would be a good
3 place.

4 And another possibility is the American
5 Hospital Association. I know that they
6 disseminated information on patient- and
7 family-centered care, and there's something like
8 over 5,000 hospitals in this country and that
9 might be another potential place to make them
10 aware of this.

11 MS. MAXWELL: Okay.

12 MS. MOESSNER: Good, excellent. Thank
13 you. Yes, please?

14 MS. SARMIENTO: My comment's kind of
15 built off of those. I also had questions about it

16 sounds like there's a date for release, if there's
17 an actual launch date, if there's going to be a
18 press release, whether it's going to be a
19 multiagency release and how it's going to be -- in
20 terms of a lot -- if there's going to be an
21 activity or press conference, telebriefing, those
22 type of activities, given that clearances and

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1 talking points, and all those sorts of things,
2 take a while to clear if it's a multi-federal
3 agency issue.

4 And then obviously, I'm not as familiar
5 -- well, I'm not very familiar at all with the
6 military system with that. But dealing with CDC
7 and HHS, I know that those are different things
8 you have to plan for in the future.

9 I have a few comments in terms of the
10 goals, I didn't know -- for the delivery of the
11 curriculum to outside the system, I can see the 98
12 percent initially that that would -- because of,
13 as you mentioned, you have that direct contact
14 while they're in the system, and I could
15 definitely see how you would lower the percentage
16 for once they're outside that system. would it be
17 good to include maybe a phased percentage, like,
18 after the first year of the launch we hope to have

19 60 percent of people with this material? And then
20 as word of mouth, if that's one of the strategies,
21 to then up it to say, by 2 years out, we hope to
22 have 88 percent, to give you some benchmarks

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1 perhaps?
2 MS. MOESSNER: That sounds great.
3 MS. MAXWELL: We've done that with -- we
4 actually do it by quarters sometimes and then we
5 have to track and I have lots of comments, but I
6 can do it offline as well -- in terms of tracking
7 systems. We do that all the time, web metrics.
8 Oh, gosh, there's so many different metrics you
9 can collect. So, I'll talk with you offline, but
10 other -- in the promotion strategies I thought it
11 would be helpful, there's a topic on messaging and
12 I didn't really see any messages, and I was
13 wondering if any messages were tested on how it's
14 going to be promoted. I know that because of the
15 title issues that came up, that potentially would
16 be nice to say how your -- the promotional
17 materials, those sorts of things, are listing out
18 the messages and breaking it up by audience such
19 as this is how we would talk to the caregiver
20 about it or talk to the physician or whether --
21 it's each of the important contacts within the

22 military system. It sounds like there's going to

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1 be lots of different people that need to be
2 briefed and told about it and they're all going to
3 get different information and systems, so the
4 caregiver's going to hear a different message than
5 the --

6 COL. FORTUIN: RCCs.

7 MS. MAXWELL: RCCs. Sorry, grew up in a
8 military family, but I'm not very versed in the
9 acronyms.

10 And so that -- I thought that would be
11 helpful in terms of messaging to actually write
12 out sample messages if possible to test them in
13 certain ways and then break them up by audiences
14 and same thing with the organizations. I think it
15 would be important to break that up by audience as
16 well because what you'd be doing with
17 dissemination -- American Hospital Association we
18 work with a lot, CDC, AMA, American College of
19 Emergency Physicians, family physicians, and we
20 have contacts at all those organizations. I'm
21 happy to help make connections there and include
22 in our physician materials. And we already link

1 and provide links to the Defense (inaudible) Brain
2 Injury Center, but I can add stuff to our website
3 so you can add CDC to the list as well, but if
4 you're having a gatekeeper approach and then your
5 target audience, breaking it down by primary,
6 secondary audiences and gatekeepers for your
7 messages as well as your organizations -- sorry if
8 I'm --

9 MS. MOESSNER: No, this is excellent.
10 Keep going.

11 MS. SARMIENTO: Also, what I find
12 helpful when coming up with promotion
13 dissemination plans is a list of materials, so you
14 have listed PSAs and print stories. I would
15 expand that to -- and as flyers -- web page text,
16 promotional announcements, posters, pocket cards.
17 I mean, that doesn't mean you have to develop all
18 of that. I know there's a very limited print
19 budget and marketing plan, so it would be coming
20 up with strategies that would be cost-effective
21 and most appropriate. And those are things it
22 sounds like you tested in your focus groups, so

1 that's -- that would be good feedback. But really
2 pushing people to an online approach and given the
3 print budget limitations and printing only 5,000
4 is -- to reach these goals you may end up with
5 more needs and requests than you have to supply.
6 So one thought would be to break up each module
7 and have a one-page factsheet that would be very
8 -- if possible, keep it to one page front and
9 back. I know that strategy is very, very
10 difficult, and to have that just as a PDF online
11 and printing factsheets is very inexpensive. You
12 can -- gosh, you can get thousands of them. And
13 so that was just one thought and I had a few
14 others regarding that, but -- and then working
15 with the trade magazines. I saw a little bit of
16 mention of that, but really -- like USAA does a
17 bunch of stuff like that. I know I can get them.
18 And then the trade magazines, I know through the
19 veterans and the active duty.

20 And then one other thought I had, so,
21 doing pitch calls to them before the launch, you
22 know, working with a press release, and then

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1 post-launch and sustainability, the sustainability
2 issues following up with them. And the other
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3 thought I had is doing op-eds or sample articles
4 or getting -- I mean, if -- those in areas where
5 there's large military populations, for example,
6 San Diego, San Diego Union Tribune, or the local
7 Oceanside paper, newsletters, because of the
8 military population, it's huge; Camp Pendleton
9 where I grew up. Or -- and other areas even in
10 this D.C. area doing the op-ed stuff or getting
11 some of your experts from all the agencies,
12 whether it's VA or DOD, to do interviews with
13 them.

14 And that will, hopefully, reach out to
15 those people that are outside the system that are
16 obviously still tied to some form of the military.

17 I think I've talked long enough.

18 MS. MOESSNER: I think that was worth
19 three "wows." Excellent. Your expertise will be
20 very valued in the work group we have because a
21 couple of us are medical people and we have -- you
22 know, we're way out of our zone of expertise or

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1 comfort or anything, and Shannon actually has a
2 marketing background so she's been very helpful
3 pulling together this wonderful plan. We wouldn't
4 have gotten this far without her help, so we would
5 love your expertise. Fabulous.

6 MS. COLLINS: May I?

7 MS. MOESSNER: Yes.

8 MS. COLLINS: This is for Rose Mary
9 because she had to leave for a conference call.
10 Her office coordinates the Health Education
11 Coordinators at each VA medical center and they
12 could blitz them with curricula -- curriculum
13 information. They will be able to ensure that the
14 curriculum is distributed to caregivers of mild or
15 moderate TBI who are no longer in the VA
16 polytrauma centers, but being followed in other VA
17 care venues.

18 MS. MOESSNER: Good. So we'll talk to
19 her a little bit more about that, too. Thank you.

20 Yes, please?

21 COL. FORTUIN: This is a question for
22 Commander Feeks, actually. Has there been any

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1 talk -- I know I keep harping on this, but the
2 proponency for this, is Ms. Embrey prepared to
3 take this on at Health Affairs or is it the Senior
4 Oversight Committee who -- I mean, who -- I know
5 we're going to talk, hopefully, later, but this is
6 just so key as to who will own this, who will do
7 the policy for it, and who will do the palming,
8 the programming to fund it, and so on and so on.

9 CDR. FEEKS: This is Ed Feeks. I do not
10 know the answer to your question, and Meg and I
11 have been talking about this today that I would
12 imagine that this program would reside somewhere
13 in DCOE. I would guess that it would probably
14 live at DVBIC.

15 As for appropriations of monies,
16 initially you are aware that there was a big pot
17 of TBI and psychological health money. It was
18 two-year money. I'm an idiot when it comes to
19 money, so I don't know what that means, but it
20 means that it doesn't go away when the fiscal year
21 ends, so.

22 COL. FORTUIN: All of that money has now

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1 been baselined, so if it wasn't in the baseline,
2 and this was not --

3 CDR. FEEKS: Okay.

4 COL. FORTUIN: You know, it's gone now.

5 CDR. FEEKS: Are you saying that the TBI
6 PH money is gone now?

7 COL. FORTUIN: No, the PH TBI money went
8 into the POM, but that was all determined a year
9 ago. So this was, you know, the two-year money
10 that you got of the supplemental has now been used
11 up.

12 CDR. FEEKS: Okay, so it's gone.
13 COL. FORTUIN: So the question is -- but
14 that does bring up the proponency is it's got --
15 someone has got to own this and it's more, you
16 know, it's a policy issue as well. Because within
17 DOD this will have to be implemented in some sort
18 of a policy, which is health affairs, but it also
19 has to cross over to the VA, which is why the
20 senior oversight committee would be a good place.
21 And Dr. Geiss could certainly help with that, or
22 the HEC or the JEC, the Joint Executive Council,

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1 or the Health Executive Council also bridges both
2 DOD and VA, but they're two different policy
3 entities and two different money entities.
4 So, I mean, it's killing me not to be
5 able to work on it. But Ms. Embrey might hold the
6 key, so if someone could talk with her and find
7 out what her thoughts are on it.
8 CDR. FEEKS: Okay. I'll take that for
9 action.
10 MS. COHOON: I said earlier in the
11 meeting (inaudible) mentioned all base papers, you
12 know, have a newspaper as far as putting out
13 information. Obviously all the MTFs and the VAs
14 have their own websites as far as information.

15 And I know that, because our organization is part
16 of a military coalition, any time that information
17 is being put out, they also have published
18 journals are asking for the information to go out
19 at least two months in advance so it makes their
20 current publication. So, when you're looking at
21 roll out, just take that into consideration.

22 Now, there are all sorts of ways in

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1 which to educate the coalition. There's a monthly
2 meeting that we all go to through TMA, it could
3 roll out that way. There's another one as far as
4 it's mixture between veterans service
5 organizations and military service organizations
6 that has to do with health and readiness. They're
7 monthly as well as rolling it out there, and
8 that's Dr. Kilpatrick runs that. And then the VA
9 has one quarterly that all the veterans service
10 organizations go to and it's usually
11 health-related, not necessarily benefit, and that
12 would be another way to roll it out. But again, I
13 know that those that have published material are
14 always stating the fact they need at least a
15 two-month window --

16 MS. MOESSNER: Two months.

17 MS. COHOON: -- in order to make sure it
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18 rolls out on time.

19 MS. MOESSNER: Okay.

20 MS. COHOON: And then obviously the
21 TRICARE website and then all three of the TRICARE
22 contractors along with the U.S. Family Health Plan

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1 which works with TRICARE, as far as making sure
2 that they're aware of this being rolled out and
3 they can send it out to the beneficiaries. They
4 kind of put together a factsheet and send some
5 things out. So, again, publication as far as
6 getting some lead time to them so that
7 everything's kind of rolling out at the same time.

8 And I believe at Defense Center of
9 Excellence, been using Booz Allen, has been doing
10 kind of your marketing for Real warrior campaign.
11 They might be able to provide some insight as far
12 as what they've been running into, as far as lead
13 time, and some contact points on disseminating
14 information and getting the word out.

15 MS. MOESSNER: Thank you.

16 MS. CAMPBELL-KOTLER: May I?

17 MS. MOESSNER: Please.

18 MS. CAMPBELL-KOTLER: This is Meg. One
19 of my concerns as I'm listening to the discussion
20 is that the population for this caregiver guide is

21 fairly targeted: TBI family caregivers, primarily
22 moderate and severe, although in the mild category

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1 it would be individuals that are -- really have
2 post-concussive syndrome, and this is a product
3 that I think everybody would want. If we hear --
4 if someone learns about it, they will want it, and
5 I am concerned that we get this in the hands of
6 the right people. I would not want to be turning
7 down requests for the curriculum based on whether,
8 you know, it's appropriate or inappropriate. So I
9 would like us to kind of focus our marketing
10 specifically on where we're going to get to the
11 families that are in this situation. There's a
12 very broad caregiving community and this is a
13 reference that in many ways is applicable across
14 the board.

15 So, I just want us to kind of keep that
16 in mind as we're talking because it's a very
17 targeted group and I would just hate to get
18 flooded with requests for a product that really
19 needs to be saved for a particular population.

20 MS. COHOON: Like I said earlier, the
21 hard part is going to be those that are already
22 out into the communities --

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1 MS. MOESSNER: Right.

2 MS. COHOON: -- as far as that
3 particular outreach. I think, you know, the way
4 that you've got it structure, you know, your
5 population that you can really get your hands on
6 are the ones that are currently still capturing
7 the system at the polytrauma centers or at our
8 main MTFs and have an FRC.

9 MS. MOESSNER: Right.

10 MS. COHOON: It's the ones that
11 basically qualify for this, who have not been
12 given an FRC, who are back home, but still need
13 the curriculum, how do we get the word out to them
14 that it exists.

15 MS. MOESSNER: Right.

16 MS. COHOON: And these avenues in which
17 Kelly was talking about are ways in which they may
18 hear about it --

19 MS. MOESSNER: Right.

20 MS. COHOON: -- and they reach back.
21 But how many people you send this to is, without a
22 budget, is concerning.

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1 MS. MOESSNER: Right.

2 MS. CAMPBELL-KOTLER: And I guess we
3 just have to have a very targeted message about
4 for whom the curriculum is for, at least
5 initially.

6 MS. SARMIENTO: I think one way to
7 address that or solve that would be you could
8 restrict the hard copies that you give away maybe
9 to your initial -- the 98 percent target audience
10 you have, as your primary audience. But in terms
11 of web distribution, because it's going to be
12 online, I don't think you should limit that at all
13 and I think that should be your main push in
14 dissemination anyway because while you can deliver
15 hard copies to each of the medical facilities, I
16 mean, I don't know who's going to be running your
17 mail outs and that sort of thing, but likely
18 that's a very time-consuming thing that you don't
19 want to run anyway. And so really your push
20 should just be the website and pick a very easy
21 URL, whether it's just DVbic.org or whatever you
22 decide or whoever is in charge of it, if you can

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1 get like TBI.gov or something like that, or
2 TBicaregiver.gov. But I think really you
3 shouldn't try to limit it; it's just be strategic
4 about what you're pushing out. And so really hard
5 push the website because everything's online.
6 People really want electronic resources now
7 anyway.

8 we really limit our print distribution
9 anyway now, and so any postering, you hand out
10 flyers, it should really just push the URL, not
11 the hard copy materials, because I deal with
12 printing all the time. You do not want to run
13 into an issue of having to reprint this
14 constantly. First of all, it's harder to update.
15 If there's an error that you find and -- or
16 there's a problem, you have to throw it all out
17 and reprint. And there's mailing costs, there's
18 -- just, it becomes cumbersome. And so push
19 people to download the materials, whether it's
20 just a factsheet version or the whole guide, print
21 them out themselves or show them how. You know,
22 people could buy these binders and create it

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1 themselves. Obviously that's not ideal, but with
2 the print budget that you're looking at and the
3 audience that you have, I don't know how much

4 options there are unless there's good fallout
5 money, which, you know, keep your fingers crossed.
6 And I know I've been talking a lot, but
7 in terms of social networking sites, we've been
8 doing a lot with that, so if you guys have any
9 questions I'm happy to help with that. There's a
10 new federal agency guidance on use of social
11 networking sites. They're becoming a lot more
12 open on that, especially -- well, at least HHS is.
13 we've been very successful with Facebook and
14 Twitter and YouTube. We have -- CDC has a whole
15 bunch of channels for H1N1. We've done quite a
16 bit of that. I've done it for our own division,
17 trauma care issues, so developing your own
18 Facebook sites and, you know, so if you wanted to
19 go in that direction as well. And that's easy to
20 link from your electronic resources and developing
21 web banners and buttons, instead of having all the
22 content spread out on multiple sites, I would

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1 recommend having a web banner button small content
2 and link everybody to the same website because
3 that's going to help you track your hits, track
4 your downloads, track your web metrics, and then
5 it's less confusing for a promotion. And so
6 instead of, you know, the Air Force sending people

7 to their website, have -- or the Army sending them
8 to their website, everybody to the same place.

9 And then, electronic medical records, we
10 actually are, in March, going to launch. There's
11 new MTBI guidelines for physicians in emergency
12 departments on diagnosis and then patient
13 discharge instructions. And that CDC did with the
14 American College of Emergency Physicians and it's
15 focused on mild TBI. But we just had meetings two
16 weeks ago with vendors that deal with the medical
17 records, the EMR systems as well as the patient
18 discharge systems. Unfortunately, they're not all
19 one in the same all the time, and so I'd be happy
20 -- what we're going to do is work with them, get
21 our new guidelines and patient information sheets
22 into those systems. And I'd be happy to talk with

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1 them as well and follow up to see if we could have
2 an extra link added for, you know,
3 military-related or caregiver information. It
4 would have to be limited to one page. It's very
5 -- they're not formatted very nice. I don't know
6 how many of you have seen patient instructions
7 printed out. It's just very -- text documents, no
8 graphics, but we could provide -- what we're doing
9 is keeping the text very simple and then linking

10 them out to websites for later, and I'd be happy
11 to add content on this topic area as well.

12 And limited funding, as well, I know,
13 but it's possible to do a follow-up evaluation on
14 knowledge added to behavior changes after using
15 the curriculum.

16 Great. Now, again, I'll take another --

17 MS. MOESSNER: Pause for just a minute.

18 Yeah?

19 MS. CAMPBELL-KOTLER: I'm so glad to
20 have you with us.

21 MS. MOESSNER: Yes.

22 MS. SARMIENTO: This is the fun part.

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1 MS. CAMPBELL-KOTLER: I just wanted to
2 mention that we do have the website already. It's
3 www.TraumaticBrainInjuryAtoZ.

4 MS. MOESSNER: A to Z, like A to Z.

5 MS. CAMPBELL-KOTLER: Dot org.

6 MS. MOESSNER: AtoZ.org. Mike?

7 MR. WELSH: Who is hosting that website?

8 MS. CAMPBELL-KOTLER: CEMM.

9 MR. WELSH: Okay.

10 MS. MOESSNER: And Colonel Mauffray is
11 here tomorrow morning to give an update, so we'll
12 have him to visit with tomorrow. Do you want to

13 keep marching through the -- we all -- the
14 discussions, you know, have been going off in many
15 directions, which is absolutely fine. Maybe we'll
16 keep -- we'll let Shannon continue to go through
17 some of our preliminary thoughts about channels of
18 distribution, timing of handing the curriculum
19 out. We do need to get into the issue of getting
20 this into the hands of the people that give it out
21 and how do you train or alert the FRCs and so
22 forth, so that's another issue we need to tackle

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1 as well.
2 MS. MAXWELL: Okay. When we looked at
3 channels of distribution, again, we're focusing on
4 -- more on the moderate to severe, but we're
5 looking at a multipronged approach to the
6 distribution of the curriculum based on stage of
7 recovery and the severity of injury. It was,
8 throughout this plan, that the comments made
9 through the Panel about not overly controlling
10 distribution. We're taking it into consideration,
11 but the committee also felt that there had to be a
12 certain level of control in order to control the
13 additions, the modifications, and accurate
14 dissemination with the education-based model
15 instead of just handing this out willy-nilly to

16 anybody and confusing people.
17 So, within the dissemination plan, we
18 worked in sort of built-in education timelines for
19 the modules, again taking into consideration that
20 the caregivers really wanted this curriculum all
21 at once so they didn't miss any part, but the
22 personalized education piece would be done in more

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1 of a phased setting.
2 So, in distribution method one, we're
3 looking at targeting TBI caregivers in the system
4 of care, either currently in or just entering. If
5 the point of contact is the military treatment
6 facility, upon arrival, their first contact are
7 the DOD liaisons. So if we can have a one-page
8 flyer info sheet with a call to action about the
9 traumatic care -- sorry, traumatic brain injury
10 curriculum, that would be a good initial piece,
11 something that they may look for and start asking
12 people about, particularly ask their FRCs or RCCs.
13 Anne, do you want to go through --
14 MS. MOESSNER: Yeah, a couple of us were
15 trying to come up with a way to not impose
16 timeframes, rigid timeframes on when this
17 information should be given out. I mean, thinking
18 about the average length of stay in some

19 facilities, understanding that, you know, the
20 average is -- there are a lot of people on either
21 ends of an average, but thinking in broad terms
22 about family readiness to receive something. And

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1 so, I'd be interested, too, in some of the family
2 caregivers around the table, if you can think back
3 to when it might have been helpful or too soon or
4 too late to receive something like this. But just
5 as a first pass, we wondered about as people are
6 first connecting with their recovery coordinator
7 or care coordinator, you know, that we put a range
8 in from day one to a couple weeks after they make
9 that first contact.

10 would that be a reasonable amount of
11 time for them to receive the entire binder with
12 some specific verbal focus on Module 1, presuming
13 that that would be what they want to hear the most
14 about, what's a coma, what's that tube, you know,
15 medicines, complications, pneumonia, you know,
16 some of those early sort of topics? So again,
17 that was sort of our first best guess that within
18 a couple of weeks, you know, would that be a
19 reasonable amount of time to at least introduce
20 the concept of this so people have transitioned,
21 you know, they've gotten through those first

22 couple of days? So I would be interested in your

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1 comments about that.

2 For Module 2, thinking that the person
3 may be out of a military treatment facility and
4 moved into a VA PRC or, you know, not quite sure,
5 because I assume some people would still be in
6 military treatment facilities, but keeping that in
7 mind, you know, within a week to 30 days, so maybe
8 some time in the first month, maybe there's some
9 effort to begin to review Module 2, which talks a
10 little bit more about lingering residuals, sort of
11 early and late in the cognitive, physical,
12 behavioral, emotional domains.

13 And Modules 3 and 4, of course, speak
14 more to later issues, again, in our minds anyway,
15 about some of the system issues and understanding,
16 also just about the caregiving journey. And so,
17 again, we just try to put in some basic verbiage
18 in here that Modules 3 and 4, maybe as you get
19 closer to dismissal from your facility, within a
20 month or several weeks of dismissal, that really
21 somebody spends some time reviewing Modules 3 and
22 4 with you. So, very interested in your thoughts

1 about some of this timing.

2 Again, always deferring and trying to
3 put some language in here that people need to use
4 their clinical judgment on when is the time, but
5 thinking that if there was some timeframe on here
6 that may build in some accountability or at least
7 some reference for the FRCs and care coordinators.
8 So, I mean, that's sort of what we were thinking,
9 but, again, we're throwing this out for
10 discussion.

11 Sandy, do you have --

12 MS. KILADA: Yup, this is Sandy. And we
13 had a few comments from the focus groups of
14 caregivers, the ones that had been caregivers for
15 a longer period of time, looking specially at
16 Module 4 and saying, you know, this is really
17 important stuff and suggesting that that should
18 actually be introduced early. So maybe Module 1
19 because it is appropriate early on, but also
20 Module 4 because all of these things sort of come
21 into play --

22 MS. MOESSNER: Okay.

1 MS. KILADA: So the system comes into
2 play. So, it might be a good one to introduce
3 early on even though it is a bit overwhelming, but
4 --

5 MS. MOESSNER: But at least introduced
6 as a reference guide.

7 MS. KILADA: Exactly.

8 MS. MOESSNER: We're not expecting you
9 to read this, but as people are talking to you
10 about these things --

11 MS. BIGGERS: Yeah, I think you should
12 add in the first, like week or so, Module 1. But
13 after that, everything because, I mean -- but
14 introduced as like a guide. You don't have to
15 read it all, but there's -- I mean, these aren't
16 about the PEB and stuff. I mean, you need that.
17 I mean, they're going to be -- if they're severe
18 injuries, they're going to be in the polytrauma
19 centers for months.

20 MS. MOESSNER: Right.

21 MS. BIGGERS: So, you need the advocacy
22 part then, too. So, it's, you know, I think it's

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1 all pertinent up front.

2 MS. MOESSNER: Okay.
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3 MS. BIGGERS: So, maybe like in the
4 first couple weeks or something.

5 MS. MOESSNER: Okay. Other comments?

6 MS. COHOON: This is Barbara. I have a
7 question. Are we looking at -- are we discussing
8 as far as they're going to be giving it like one
9 module at one point, one module at another? Or
10 are we talking about giving it to them all at once
11 and then educating them on the modules at
12 different points? I'm trying to get some --

13 MS. MOESSNER: Choice B. Yes.

14 MS. COHOON: -- on where you guys are
15 with that.

16 MS. MOESSNER: Yeah, so we were thinking
17 about -- yeah, it would be handed out by a person,
18 you know, early on in this experience. But then,
19 you know, the focus group clearly told us it would
20 be nice to have somebody verbally review this, you
21 know, not just hand -- do one single point of hand
22 off and then never to be covered in any way,

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1 shape, or form. So I guess this discussion was
2 meant more towards verbal review, that somebody's
3 actually checking off, yes, we sat down and went
4 through this.

5 MS. COHOON: So, you're going to give
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6 them all four?

7 MS. MOESSNER: We are going to keep it
8 together as a unit, but sort of different areas of
9 focus and when do you want to focus on each of
10 these, sort of broad topic areas.

11 Yes?

12 CDR. MILLER: Commander Miller. Can you
13 make this maybe a broad -- because in taking care
14 of these families, you know, they come to you and
15 they say, hey, I need to start learning some more
16 about what's going on. It sounds like this is
17 going to, you know, carry on a long time. The
18 families usually approach you and so when do you
19 want this -- that's what I usually say. It's time
20 to get out some more information.

21 MS. MAXWELL: The roadmap basically just
22 provides that, a map. So if the family is not

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1 engaging in asking for their curriculum, there is
2 a mechanism so that the FRC and the RCC are
3 engaging the caregiver. But certainly based on
4 the -- in that first meeting, day 1 to day 14,
5 where they're delivering the entire curriculum,
6 the caregiver companion guide, they're going in
7 detail with the caregiver companion guide in
8 Module 1, but they're briefly introducing them to

9 the other modules so they're aware of them,
10 allaying any concerns about being overwhelmed by
11 this massive amount, and letting them know at
12 phases either when they're ready to receive it or
13 at, you know, predesigned times, that they will
14 get education on those other modules as well.

15 MS. CAMPBELL-KOTLER: I just want, if I
16 could, just ask a question about, what about
17 utilizing the TBI care units within the key
18 military facilities like Walter Reed, Bethesda
19 Naval, Brooke Army, where people are going
20 primarily directly from the front, where we
21 actually have the curricula on the floor for
22 providers to -- whether it's the nurse or

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1 physician to actually give to the family? What
2 about that model? Just throw it out for
3 discussion.

4 LCDR. HERBIG: Good luck keeping it
5 there.

6 MS. CAMPBELL-KOTLER: Okay.

7 LCDR. HERBIG: I mean, seriously, you
8 have all these different providers that say, oh,
9 this is really nice and unless you have it -- I'm
10 sorry. Unless it's chained down, maybe I'm wrong
11 about that, it's going to walk away. I mean,

12 seriously.

13 MS. CAMPBELL-KOTLER: Thank you.

14 MS. BURKE: I'm Teresa Burke. I'm a
15 headquarters regional care coordinator for DVBIC
16 and with working with families directly now with
17 TBIs, you have to remember that this is a
18 complementary piece as well. We have all the
19 other programs that are going to be giving
20 individual presentations on some of the things
21 that are in this curriculum so they will be -- the
22 families are inundated a lot of the times,

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1 overwhelmed with materials and programs, so don't
2 forget that piece as well. This is complementary
3 to those other programs. So, this is a kind of a
4 guideline piece that they've put together so that
5 we can also, you know, like add to what other
6 programs come directly when the TBI has occurred
7 in a family. It's complementary.

8 MAJ. VOGT: I really feel like it's the
9 nurses in these units that know the patients and
10 know the families as well as to when is the right
11 time to deliver it. So, I don't know if there's a
12 way to -- I know the ICUs always have packed rooms
13 and there's never a spare room, especially to put
14 so much material, but having some way where they

15 have access to the stash and there's a place where
16 they can -- you know, they do their daily nursing
17 notes, say, okay, it's been given or it's been
18 reviewed. But I know the case managers, too, are
19 an important link, but I feel like it's the
20 nurses, you know, 24/7 that are there with the
21 families, so --

22 MS. BURKE: Megumi, there's also a way

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1 to add it into the ALTA system as well where you
2 can actually state on a form that they have been
3 given this as a part of their curriculum or part
4 of the medical record, so it would go with them
5 throughout the time of being in the military or
6 outside with the VA.

7 In addition to that, the nurses
8 sometimes are so busy with all the testing and all
9 the other kind of pieces, but the case managers
10 within the hospital, the medical setting, are a
11 good resource as well as the FRCs. But the FRCs
12 are really there to do the -- and the RCCs are
13 really there to do the family systems piece and
14 the care coordination throughout a long period of
15 time. I think when the nurses get so busy with
16 the actual medical piece, that is sometimes good
17 for the social work department to kind of come in,

18 all of the RCCs and the FRCs, to provide some of
19 that care coordination along with that plan. The
20 plans I'm now seeing in ALTA that are being
21 written by the FRCs and RCCs, they are there now
22 and I'm seeing those on a regular basis. So that

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1 piece has already been bought-in by the FRCs and
2 the RCCs and that's kind of a neat piece. So if
3 this were to be added to that, I think it'd be
4 nice.

5 MS. MAXWELL: This is Shannon again. I
6 think the caregivers on this end of the table
7 shaking their head no that the nurses are not
8 really the ones that we're looking to for that
9 information, they're not -- the same nurse is not
10 always on duty consistently to give that
11 education.

12 MS. MOESSNER: And I presume, you know,
13 that we would want to alert the nursing -- you
14 know, these key nursing personnel that this
15 exists. I presume, especially early on, the
16 questions will come out on Module 1, again, you
17 know, what are these medical conditions, what's
18 that tube, how do people tend to awaken from a
19 coma, you know. I assume these are questions they
20 could handle verbally, but, you know, that they

21 should know that this curriculum is now being
22 given out and it exists and they should have some

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1 exposure to it. Yes? No?

2 MS. ROCCHIO: This is Carolyn. In
3 disseminating information that we published over
4 many, many years in Florida Brain Injury, we found
5 you have to have a point person, an identified
6 targeted person within the organization, either a
7 case manager, the famous service coordinator,
8 someone who has the responsibility for knowing it
9 exists and for developing internally that
10 dissemination plan. That's the only way we got
11 our stuff widely utilized.

12 MS. MOESSNER: Thank you.

13 MS. KILADA: This is Sandy again.
14 Gloria just reminded me, let's not also forget
15 about the caregiver companion and adding it to --
16 when you think it should be introduced.

17 MS. MOESSNER: Right.

18 MS. MAXWELL: The first.

19 MS. MOESSNER: The first, it should be,
20 when you give the whole package, that is
21 specifically gone through, like, this is a way for
22 you to track information and -- yeah.

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1 MS. MAXWELL: So, the first meeting is
2 two-pronged education -- well, three-pronged
3 education. It's the caregiver companion guide,
4 Module 1, both of those in-depth, and then an
5 overview of the other three modules.
6 MS. MOESSNER: The rest of it. Okay.
7 MS. MAXWELL: Okay. And we looked at if
8 they put --
9 MS. MOESSNER: One more question.
10 MS. MAXWELL: I'm sorry.
11 DR. FLYNN: I just had a quick comment.
12 Fred Flynn. Quick comment. I was just thumbing
13 through Module 4 and I came across page 122 where
14 they have all the VA state offices listed, that
15 list stops with Vermont. There's nothing on
16 Virginia, Washington, West Virginia, or Wisconsin,
17 so.
18 MS. BURKE: Those states don't exist.
19 DR. FLYNN: Yeah, excuse me --
20 MS. MOESSNER: Yeah, Washington -- yes,
21 please, Cheryl.
22 MS. CHURCH: I have a question about the

1 -- when the information is given out, are we going
2 to develop something that's standardized that we
3 want them to say about the modules? Because
4 otherwise, you're going to get all kinds of --
5 from 5 minutes to 45 minutes.

6 MS. MOESSNER: That's actually on our
7 list of things to review is how do we train the
8 people that are handing this out. How do we
9 access them? We don't have a large budget to
10 educate those individuals, but what will be the
11 creative ideas we can come up with at this meeting
12 to get to those people and talk about just that
13 thing. Do you develop a script? You know, what
14 key points do they need to hit, so on and so
15 forth. Plus we also want to get them excited and
16 get buy-in from the people handing it out, so we
17 do need to figure that out during this meeting as
18 well.

19 MS. MAXWELL: This is Shannon. One of
20 the recommendations that we'll cover later is to
21 create an instructional DVD similar to what's been
22 done for the TAP classes so that, you know, I took

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1 the TAP class by DVD. It was a very good
2 instructional. So, if that's developed, maybe
3 that could be the training mechanism that's a
4 consistent point for the trainers as well.

5 MS. BURKE: There's also training for
6 the AW2 groups, the new docs that come into all
7 the facilities, the treatment facilities, there's
8 all sorts of training that this can be added into
9 as part of training the trainers for the
10 caregivers and it's -- at each different kind of
11 group, they do have training sessions that are
12 required during -- prior to them starting like at
13 the hospital or starting as an FRC or an RCC, so
14 they can be trained in those venues.

15 MS. MOESSNER: Just for my information,
16 can you educate me about a typical -- is there a
17 typical FRC, RCC background? Are they nurses or
18 social workers or -- I mean, do most of them come
19 with a significant amount of TBI experience?
20 They're fairly new to this as an injury topic
21 area? Or do you have a sense of that?

22 MS. BURKE: Well, that's part of the

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1 personnel piece, but I think the RCCs are all
2 licensed social workers or have a LPC or along
3 that line at a master's level. I think the FRCs

4 are not. I think there's a variety for FRCs --
5 Megumi, correct me if I'm wrong -- I think that
6 the FRCs may have a variety of education
7 backgrounds; they can be nurses. In our program
8 you can be a nurse, you can be a social worker,
9 you can be a rehabilitative counselor, and so
10 there's a variety. It's just like specialties for
11 docs and nurses. You may be a neuropsych, you
12 know, or you may be a neurology doctor or you may
13 be a foot doctor, you know, and that's kind of how
14 it is in social work as well as in a counselor
15 positions. And that makes a difference when
16 handing a curriculum out like this is how do you
17 train all that variety?

18 MS. COHOON: Anne, that's where the
19 education piece, I think, is important, but you're
20 going to get into more of what you're looking at
21 to educate because they're not going to be able to
22 answer a lot of the questions that are detailed in

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1 here. You want to steer them to the professional.

2 MS. MOESSNER: Right.

3 MS. COHOON: This is more of your,
4 what's actually in each module and where you can
5 go to maybe for certain types of information --

6 MS. MOESSNER: As opposed --

7 MS. BURKE: Right, and that's where that
8 complementary piece comes in, is the referral
9 process and your social workers and your RCCs and
10 FRCs can do that referral piece.

11 Okay. I don't know anything about this
12 program, like a TSGLI, we'll send you to the
13 military group that does that, but I know where to
14 -- I have that number and I know where to direct
15 you.

16 MS. COHOON: Here's some information
17 that you can read up ahead of time.

18 MS. BURKE: Right.

19 MS. COHOON: And also to the advocate
20 piece as far as working with your FRC or your RCC
21 as all part of the advocacy piece, too, but, you
22 know, they're -- some -- most of the FRCs do have

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1 a medical background --

2 MS. BURKE: Right.

3 MS. COHOON: -- but not to the point
4 where they could, you know, get into detail about
5 the chemical changes across some walls regarding
6 TBI.

7 MS. BURKE: Exactly. It is a variety.
8 It really is a variety out there. And that's --
9 the other part is some of the -- the military

10 programs like AW2 and the Marine's wounded warrior
11 Regimen -- it used to be Marines for Life -- those
12 programs, a lot of times they're just retired
13 military staff that have come back in and are
14 helping to help, so there's a lot of different
15 variety in how they hire in those positions.

16 MAJ. VOGT: One other one, Meg, and I
17 don't know -- is potentially working with Army
18 OTSG. I know their web modules, their web-based
19 modules, they're going to be mandating it for all
20 -- anyone in the Army. And it goes through, like,
21 you know, they've got different module levels,
22 like one for all line, anybody active duty has to

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1 take it, but then it steps up to, you know, anyone
2 in the hospital, then, you know, higher provider
3 levels, and then it goes all the way up until
4 they've got like a 101, 201, 301, and 401. And so
5 it'd be working with Army OTSG to get that updated
6 and get a curriculum portion in there. I know
7 they've worked hard to make the web-based modules
8 at DOD sort of a tri-service feel and the hope, I
9 thought, was to get it over to DVBIC and get the
10 Army logo off of it, so.

11 MS. CAMPBELL-KOTLER: Right, right.
12 That's an interesting idea to go for the technical

13 assistance for doing the DVD. So I'll follow up
14 with Lynne Lowe on that and we -- I think the
15 long-range plan was to have those modules based on
16 MHS Learn, and that was also where I would like to
17 see this DVD placed, on MHS Learn, so it becomes
18 something that new staff can go to and get
19 oriented.

20 MS. BURKE: And training is always a
21 moving target. We always have -- and the
22 military, as you well know, once we have our

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1 people transition so often that that's -- you have
2 to continually train that with the FRC, the RCCs,
3 the case managers, the care coordinators, or
4 whatever they are out there. And the program
5 providers, all of them have to be retrained and
6 retrained, because there's such an influx of
7 coming and going because as soon as you have a
8 little bit of information in this area, you kind
9 of move to a different position in the
10 organizations as well. So it's kind of, you know,
11 valuable to have the military jargon and to be
12 able to train the families of the caregivers and
13 to have access, so it's a real moving target for
14 training.

15 MS. COLLINS: I just wanted to

16 underscore the script part that Anne mentioned.
17 I've been taking change acceleration process
18 training from GE Healthcare and they talk about
19 the 30-second elevator speech. So if we can keep
20 it simple so that we don't freak out the people on
21 the front line and keep it simple so that we have
22 a shared mental model about what we're doing, that

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1 would be real helpful.
2 MS. PRIES: Rose Mary Pries. I don't
3 know if this got discussed before, but in my role
4 as coordinating all the patient education
5 coordinators at every VA medical center, one of
6 the things that I was thinking about doing --
7 because I think those people could be excellent
8 conduits for this curriculum, to folks like in our
9 primary care settings, to those people who are not
10 severe or moderate, but still experience mild TBI
11 -- what I would consider doing is to develop a
12 very brief PowerPoint for those folks to use at,
13 you know, primary care staff meetings, to
14 introduce that level of staff to the curriculum
15 and tell them how they can get their hands on it.
16 Because I think that would be another really
17 important audience, you know, clinical audience to
18 let know that the curriculum is available. What I

19 like about PowerPoints, too, versus DVDs is if
20 things change, it's real easy to update.

21 So, you know, if I were doing that
22 myself, I would certainly run it by, you know, the

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1 folks at DVBIC to make sure that I haven't
2 misconstrued anything or spoken out of school, but
3 to be able to use that with my constituency.

4 MS. BURKE: And I know for sure that
5 DVBIC does go out and train on a regular basis
6 with our PowerPoints about the DVBIC program and
7 the RCC program, so -- and it is a PowerPoint with
8 the slides and we do update that every time we go
9 out because something usually has changed.

10 MS. PRIES: Exactly, we know that. But
11 I thought this would be a really excellent way to
12 reach folks in our front lines who could be
13 wonderful conduits for getting the curriculum out
14 to other clinicians at their medical centers.

15 MS. MOESSNER: Well, we have our work
16 cut out for us, don't we, or somebody does? Oh,
17 that's right, we're done as of tomorrow.

18 Shannon, do you want to try to go a
19 little further?

20 MS. MAXWELL: All right. The next
21 distribution option -- well, B -- looks at the

22 point of contact being the VA polytrauma center.

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1 So these patients have bypassed the military
2 treatment facility, either we didn't reach them in
3 time with the curriculum or for whatever reason
4 they entered the VA polytrauma center before
5 getting the curriculum.

6 This really follows a similar
7 distribution plan and education plan as what you
8 saw in a military treatment facility. In the
9 first phase the introduction of the entire
10 curriculum, the detailed education on Module 1 and
11 the caregiver's guide, the timeline is a little
12 shorter because I think they're in a higher level
13 to receive it.

14 Anne, you --

15 MS. MOESSNER: Right. Mm-hmm.

16 MS. MAXWELL: Right? Okay. There was a
17 question by the committee that's highlighted there
18 whether or not there's any central documentation
19 that can be accessed to determine whether or not
20 the curriculum was received by the military
21 treatment facility. I think there's going to have
22 to be some good coordination between the FRC and

1 the case manager at the VA facility.

2 But if those patients are entering the
3 VA without being in the military treatment
4 facility, I don't know how they're going to find
5 that out.

6 MS. BURKE: Well, that case management
7 plan goes with them from the military treatment
8 facility and is a lifetime plan, and so it is
9 written to carry that service member that's
10 injured all the way through for life.

11 MS. MAXWELL: Okay. So if a person
12 shows up without one, then they assume it's not --

13 MS. BURKE: Right. It could very easily
14 be documented there.

15 MS. MOESSNER: Okay.

16 MS. MAXWELL: Okay. Okay, and then
17 again, in that first meeting, there's a mechanism
18 for the case manager to also confirm with the
19 caregiver whether or not they have received the
20 information. If so, they can clarify any
21 information in those modules. If not, then to
22 proceed with a distribution and education plan.

1 we did leave in here that the FRC and RCCs would
2 remain responsible for tracking the receipt of the
3 modules, following up with the case manager to
4 obtain feedback, caregiver feedback.

5 Okay. Number two, distribution method B
6 targeting TBI caregivers of patients in later
7 phases of recovery or beyond the military
8 treatment facility and VA care center services.
9 Again, this is our stumbling block. This is where
10 we're having less access and really need a device
11 to get it to people. We talked about the
12 recommendation of creating -- because these
13 caregivers are now outside the curriculum, it may
14 not be possible to get the curriculum to somebody
15 in person because the geographic separation, that
16 we create a phased instructional DVD or rely on
17 the online curriculum to supplement the printed
18 documents so that the caregiver is still feeling
19 like they have support possibly -- we didn't talk
20 about this, but possibly a call-in line where they
21 can ask questions about it as well. And this plan
22 would also meet the needs, hopefully, of the

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1 National Guardsmen and reservists. And we really
2 looked to DVVIC, and their RCCs as this point
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3 having knowledge of TBI patients in the area that
4 FRCs and RCCs may not have been assigned to, but
5 that DVBIC then provides this central
6 dissemination again, they have the knowledge, they
7 could provide that phone line, that contact and
8 support for mailed curriculum.

9 And then if it's determined that the FRC
10 or RCC needed -- should have been engaged or
11 needed to have been engaged, then possibly DVBIC
12 can refer that back to FRCs, RCCs to continue that
13 relationship and continue that training.

14 Inventory, we looked really at a central
15 storage and dissemination of curriculum, again to
16 enhance the accuracy of the documents for
17 revisions, quality control. On that, our
18 suggestion is to be held at DVBIC with secondary
19 inventory then from DVBIC, from that master plan
20 to the VA and the DOD to distribute to the FRCs,
21 RCCs and VA case managers as necessary.

22 In training, I think probably we need to

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1 put a line in here that it's training to the
2 curriculum, not to the medical --

3 MS. MOESSNER: Yup.

4 MS. MAXWELL: That was something I just
5 assumed. But our suggestion is that DVBIC would

6 develop and conduct basically a turnkey training
7 program. They would train the trainers for the VA
8 and DOD, and then the VA and DOD would then be
9 responsible for training their FRCs, RCCs, TBI
10 case managers and front line people.

11 And then we also mentioned MHS Learn
12 could be used as an online training module. OTSG
13 was mentioned, the PowerPoints, which I think are
14 all good additions.

15 Okay, promotion strategy. Just a basic
16 message that we threw out there: Caregivers are
17 an important and critical part of the care team
18 and are not alone through the journey of recovery.
19 Therefore, Traumatic Brain Injury: A Guide for
20 Caregivers of Service Members and Veterans,
21 support the caregiver throughout the journey. We
22 would need to develop an approved and standardized

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1 message about that curriculum, again, targeted to
2 the different audiences.

3 There's a list of electronic media which
4 we could continue to add to. We certainly were
5 interested in Facebook and the social networks. I
6 did have a conversation with America Supports You
7 and they're willing to support the dissemination
8 of the promotion of this piece as well through

9 PSAs, any of their stories, their newspaper
10 outlets, the Pentagon channel, the radio, so we do
11 have buy-in there.

12 In print media we looked at flyers to be
13 inserted about the curriculum in LES, the retired
14 account statements, VA statements of benefit,
15 TRICARE EOBs, Social Security paperwork. We also
16 looked at seeking the assistance of AARP since we
17 have a lot of the caregivers who are over 50 to
18 dissemination PSAs. Again, this is the low-budget
19 marketing plan.

20 Navy Marine Corps Times and all the
21 other suggestions that were listed would be great.

22 MS. ROCCHIO: Shannon, I just have one

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1 comment. If you distribute to the Brain Injury
2 Association of America, it subsequently goes out
3 to all the state associations, so you wouldn't
4 have to contact them individually. That goes
5 through their network.

6 MS. MAXWELL: Okay. That standardized
7 message, the recommendation for having a banner or
8 a button then, that seems like a good, consistent
9 --

10 MS. MOESSNER: I think so.

11 MS. PRIES: Shannon --
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12 MS. MAXWELL: Yes.

13 MS. PRIES: I'm sorry, Rose Mary Pries.
14 We have a veteran's health education portal that's
15 called "My Healthy Vet," and I think it will be
16 really important to link the electronic version of
17 the curriculum to that health education portal for
18 all veterans. And I would love to be able to
19 offer them the same kind of button for My Healthy
20 Vet so folks could really easily zero in on the
21 curriculum. So, if you could sort of keep that as
22 a specific note of another button location.

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1 MS. MAXWELL: Okay.

2 MS. PRIES: Thank you.

3 MAJ. VOGT: This is Major Vogt. DCOE
4 does have, through their clearinghouse, outreach
5 advocacy --

6 MS. COHOON: Shannon.

7 MS. MAXWELL: Yes.

8 MS. COHOON: Barbara. As far as doing
9 outreach and being able to locate folks, sometimes
10 what the TRICARE contractors can do is they can
11 run where there's been certain claims for certain,
12 what do you call it, ICD-9 codes. And so,
13 therefore, they'd be able to find who was maybe
14 still receiving services or had received them in

15 the past that would qualify for these particular
16 -- they also have case managers to -- each of the
17 contractors do. And once they get out into the
18 community, so there'd be a point of contact in
19 order to be able to find these folks.

20 MS. MAXWELL: Okay. I know we had part
21 of the demographics; a TRICARE case manager for
22 active duty service members was one that I really

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1 relied on. But I know that once they stop being
2 active duty, then it switches over to a general --
3 another population of TRICARE and --

4 MS. COHOON: Actually, Humana still will
5 keep you if you're a veteran.

6 MS. MAXWELL: Okay.

7 MS. COHOON: The other two don't, but
8 we've got two new contractors coming up. And we
9 shouldn't say that they don't. It's just that
10 they (inaudible) keep them while they're active
11 duty. But they'll still have all that information
12 that's going on. And most of them are severe, so
13 they'd qualify for the FRC and also their
14 services, case manager piece, too.

15 MS. MAXWELL: Okay.

16 SPEAKER: (inaudible) non-active duty
17 Reserve and Guard --

18 REPORTER: Can you get closer to the
19 mic, please?

20 SPEAKER: -- (inaudible) --

21 SPEAKER: She needs you --

22 SPEAKER: The mic.

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1 SPEAKER: She can't hear.

2 SPEAKER: You're right in between two.

3 COL. FORTUIN: Sure. Sorry. Nancy
4 Fortuin. For those non-active duty Reserve and
5 Guard members, the Military Medical Support Office
6 under TRICARE is the best -- they've got case
7 managers as well. And they do equivalent work to
8 the (inaudible) the contractors.

9 MS. MAXWELL: Okay. All right. Point
10 of contact. We looked at posters. Again, with
11 just a quick standardized message and a call to
12 action: ask your FRC, RCC military liaison; or in
13 the VA, ask your case manager; or have a phone
14 number, call this number. And location of those
15 posters. Again, those points where the caregivers
16 are having that face-to-face contact, the
17 peer-to-peer and word of mouth access points:
18 waiting rooms, Fisher House, Mologne House, the
19 lodges, the TBI wings, pharmacies, and the VA
20 polytrauma centers, the rehab floors, cafeterias,

21 travel and benefits offices.

22 MS. BENEDICT: I would say mental

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1 health, too.

2 MS. MAXWELL: Mental health, too. Okay.

3 MS. PRIES: And I don't know if this --
4 sorry, Rose Mary Pries. I don't know if this
5 would work, but almost every VA medical center has
6 a Patient Education Resource Center, so, you know,
7 to ensure that those folks stay in the loop and
8 have access to where they can direct families.
9 Because a lot of times they'll just go to the
10 Resource Center and say, can you give me any
11 information about X?

12 SPEAKER: Mm-hmm.

13 MS. MAXWELL: Okay. We also suggested
14 Social Security offices. As they're filing Social
15 Security Disability claims, that might be a good
16 point of contact to reach caregivers.

17 And then the TAP and DTAP classes, the
18 SEPs and Retirement offices, particularly for the
19 severe and moderate TBIs, where those caregivers
20 are conducting some of those rigorous duties for
21 the service member.

22 what?

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1 MS. BIGGERS: Chaplains' offices.
2 MS. MAXWELL: Chaplains' offices? Liza
3 suggested chaplains' offices, as well.
4 MS. BENEDICT: You know, I just noticed
5 just at Richmond last week that they've mounted
6 flat screens all over the facility now.
7 SPEAKER: Oh, we could run electronic --
8 MS. BENEDICT: And they're just running
9 a loop of things. So we might want to consider
10 that for any of the facilities, actually. That's
11 a good way; people pay attention.
12 SPEAKER: Yeah.
13 MS. MAXWELL: Yeah. So we'll put that
14 under electronic media, flat screen. Just
15 probably a one slide?
16 MS. BENEDICT: Yeah, I think so. With a
17 contact number or something.
18 SPEAKER: Yeah.
19 LCDR. HERBIG: Lieutenant Commander
20 Herbig. Did you get that? I don't have a mic.
21 I think we talked --
22 SPEAKER: (inaudible)

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1 LCDR. HERBIG: Are we all right?
2 SPEAKER: You need to be closer.
3 LCDR. HERBIG: I do?
4 SPEAKER: Yes, please.
5 LCDR. HERBIG: I have a big mouth. I
6 can't get closer.
7 SPEAKER: It doesn't come closer.
8 SPEAKER: How about this one? Yeah.
9 LCDR. HERBIG: I think we talked about
10 this, but did you talk about VFW and American
11 Legion as far as dissemination?
12 SPEAKER: The VSOs. All the VSOs.
13 SPEAKER: Vet centers.
14 LCDR. HERBIG: Vet centers and all that
15 stuff?
16 SPEAKER: For electronic, but we didn't
17 (inaudible).
18 MS. MAXWELL: I think they're listed
19 under the electronic media. But certainly for a
20 point of contact --
21 LCDR. HERBIG: Okay.
22 MS. MAXWELL: -- we could do that, too.

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1 MS. COHOON: In the publications, too,
2 Shannon.
3 MS. MAXWELL: Okay. That would be under
4 print.
5 SPEAKER: Yes.
6 MS. MAXWELL: We didn't get into a lot
7 of pubs. I was really relying on ASY to help with
8 some of the pubs because of the limited marketing
9 budget. But if we can ask for the world, we'll
10 ask for the world.
11 MS. COHOON: If you let them know,
12 they'll put it in their published material
13 themselves.
14 SPEAKER: Yeah.
15 MS. MAXWELL: Okay.
16 MS. COHOON: That's, you know, kind of
17 the press that Kelly was talking about. And then
18 they'll put stuff in their own published materials
19 that'll come out of their own pockets, not out of
20 here.
21 But just, as I mentioned, they always
22 talk about the lead time that -- whatever date you

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1 wanted it to come out, back it up at least two
2 months, so that their information's coming out in
3 their published journals the same time that you're

4 wanting this all to come out.
5 MS. MAXWELL: All right.
6 SPEAKER: We have another question down
7 there.
8 MR. WELSH: (inaudible). Does DVBC
9 have --
10 SPEAKER: Can you pull the microphone --
11 MR. WELSH: -- public affairs officer, a
12 press information officer, media relations?
13 SPEAKER: (inaudible)
14 MS. CAMPBELL-KOTLER: No, we do not.
15 MR. WELSH: I think you said no.
16 MS. CAMPBELL-KOTLER: I did.
17 SPEAKER: How about DCOE?
18 MR. WELSH: All right. We don't know
19 where this is going as far as a reporting agency,
20 but I recommend that one of the things that we
21 recommend is that we designate a public affairs
22 officer to staff this thing and follow it to the

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1 day it dies or else this is going to become
2 another one of those things that just collects
3 dust somewhere in Washington, D.C. You've got to
4 have somebody that's going to be designated with
5 that duty to track it and take the actions.
6 COL. FORTUIN: That's why this policy is

7 so important --
8 SPEAKER: That's right.
9 COL. FORTUIN: -- (inaudible) designate
10 all those responsibilities. whoever owns the
11 policy on this --
12 SPEAKER: Right.
13 COL. FORTUIN: -- (inaudible) report.
14 SPEAKER: Right.
15 SPEAKER: That's right.
16 MAJ. VOGT: And DCOE does have a
17 STRATCOM Directorate that can work to support, you
18 know, either DVBIC or, obviously, DCOE. So, you
19 know, so there's that corner.
20 The other thing is I'm still pretty
21 worried about the Guard and Reserve. And one
22 option would be that -- I don't know what else,

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1 but maybe, like, the Yellow Ribbon conferences,
2 the -- I think you said the -- what was the other
3 one?
4 COL. FORTUIN: The NGAUS and Reserve
5 Officers Association. The National Guard
6 Association and Reserve Officers Association.
7 MAJ. VOGT: The National Guard
8 Association and the Reserve Officers Association
9 have, I guess, annual conferences, too. But I

10 don't know if there are any --

11 COL. FORTUIN: And they have
12 publications.

13 MAJ. VOGT: And publications.

14 COL. FORTUIN: And web pages.

15 MAJ. VOGT: And web pages, so. I don't
16 know if there are other ways to specifically
17 target those people, too.

18 MR. WELSH: They could go on forever.
19 You go to the AUSA Conference, the Marine land
20 warrior thing, whatever it was called, two weeks
21 ago. I mean, it's -- if you have a designated
22 public affairs team or officer, then they could

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1 attend these functions and, you know, get the
2 space, get the booth, roll out the material, get
3 the puppets out, set the whole thing up.

4 MS. BURKE: Speaking of puppets, I was
5 actually the service delivery manager when
6 Military OneSource rolled out their Sesame Street
7 Live or Sesame Street videos and DVDs, and it is
8 quite an undertaking. And you have to have the
9 buy-in and you have to have a strategic plan for
10 it. We used to have to put in staff to man the
11 phones. We had to have a distribution outlet
12 place. But -- and also the web builder for that,

13 to make sure it got on the website.

14 So it's quite an undertaking. We used
15 to start several months in advance just for the
16 rollout date, and staff that. So it's kind of an
17 overwhelming kind of piece. But you do have to --
18 I agree, you do have to have somebody that's in
19 charge of that.

20 MS. PRIES: Okay. Let me just say,
21 Shannon, if you also get me a copy of anything you
22 want to see in print or posted on websites, I can

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1 make sure that it gets published in every VA
2 medical center's local veterans newsletter or on
3 their website. So that would be another -- so
4 just, if you shoot that to me, I can get it out.

5 MS. MAXWELL: So we're going to put you
6 down as part of the --

7 MS. MOESSNER: Yeah, I think you have,
8 you know, self-selected yourselves right onto the
9 work group.

10 SPEAKER: Sorry.

11 MS. SARMIENTO: I can totally relate to
12 having very limited marketing budgets. So one way
13 to get legs for your -- when you're doing press is
14 to -- you'll have your official press release
15 coming out of whatever the lead agency is, and

16 then getting an -- or -- but making it a joint
17 press release. And, yeah, I totally agree you
18 need to time out your long-lead media, which would
19 be the magazines and print articles, and then your
20 shorter timeline. So you need to develop the
21 press leads well in advance because you're going
22 to need to submit an embargoed copy of that

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1 release and the -- you know, through your media
2 relations department. That's very common
3 practice, so it's just something to do. Also,
4 pitch calls to long-lead and short-lead media.
5 But to get more legs for your press, you
6 know, you'll do the -- you can do a national
7 release. But then you can have the Brain Injury
8 Association affiliates do state and local press
9 releases and -- or a Swiss cheese news release.
10 And I don't know what that stands for, but that's
11 just a common word they use. And basically it's a
12 template, a news release that has the same
13 messages. And you would obviously take off the
14 agency logos, and then that organization can pick
15 up that press release, modify it to their needs.
16 But it'll have the key messages and send the link,
17 and then you can give them a place to add in
18 quotes. With a federal agency, you likely have to

19 pull out all the quotes from your experts that you
20 put in the official press release, but you can
21 leave a place to say insert quote and that sort of
22 thing.

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1 And that's a pretty nice way to get the
2 state and local stuff, where you get a lot of pick
3 up and it's free, so.

4 MS. MOESSNER: It's free.

5 MS. MAXWELL: All right. Okay. The
6 last mode of publicity we talked about were
7 conferences. A national conference to launch and
8 inform DOD, VA care providers, wounded warrior
9 units, case managers, FRCs, RCCs. This national
10 conference, similar to MOAA, we can try and tap
11 into their conference or any of the other
12 organizations that are having these
13 multidimensional provider conferences.

14 I'm sorry, go ahead.

15 MS. FUNK: AMSUS.

16 MS. MAXWELL: AMSUS.

17 SPEAKER: (inaudible)

18 MS. MAXWELL: Military Surgeons
19 Association.

20 SPEAKER: AMSUS.

21 MS. COHOON: The annually. That'll be

22 in January. I mean, that'd be the first --

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1 Nancy's shaking her head.
2 I'm not sure if it's --
3 SPEAKER: (inaudible) the annual. Just
4 drop the annual part.
5 MS. COHOON: Okay. Anyway, the MHS
6 Conference would --
7 SPEAKER: Yeah, you might want to have a
8 booth, like at AMSUS, the Association of Military
9 Surgeons of the United States, and the MHS
10 Conference.
11 SPEAKER: And the AMSUS Conference is
12 coming up. Was it December, right? It's in St.
13 Louis --
14 SPEAKER: November.
15 SPEAKER: It's a week after Veterans
16 Day.
17 SPEAKER: It's too soon.
18 MS. CAMPBELL-KOTLER: (inaudible) will
19 be too soon. We won't have the approval of the
20 DHB heads, so.
21 MS. BENEDICT: There's also the National
22 (inaudible) PRC conference, Polytrauma Conference

1 in January. So I don't know if that's too soon.
2 SPEAKER: So that might --
3 MS. BENEDICT: I don't know if that's --
4 I think it's still on the docket.
5 MS. MOESSNER: Do you know where it is?
6 MS. BENEDICT: I don't even know if they
7 gave us the money for it.
8 SPEAKER: Yeah.
9 MS. BENEDICT: No, I don't.
10 MS. SARMIENTO: I would recommend --
11 sorry, I keep forgetting to say my name, Kelly
12 Sarmiento. Instead of tying to a conference a
13 launch, it depends on your audience. Obviously if
14 you're doing the launch to target your -- whether
15 it's the gatekeeper audience, the system people
16 that will be -- the trainer audience, the
17 conference obviously would be a good place. If
18 you're targeting your caregiver as your primary
19 audience, the conference is not generally an
20 effective way to get that message out because
21 they're going to be in attendance and not even
22 know the conference exists, most likely.

1 So what we find most effective, and most
2 effective in getting media to pick up, and
3 probably just because it's CDC and we're big on
4 statistics, but we actually don't do press
5 releases just on we have a new educational
6 material. It's actually a very competitive
7 process to do press releases. I don't know how
8 DOD is, but if you do a press release just saying
9 we have a new booklet available or a new
10 curriculum, you're not going to get a press
11 release.

12 So in terms of timing, probably, if
13 there's new data that's coming out, whether it's
14 released to, you know, there's new numbers on
15 returning veterans -- or returning military; if
16 there's new numbers on stats related to
17 caregivers; if there's any papers coming out,
18 whether it's journal, whether it's a report; if
19 you have high-level people, sometimes you can get
20 a press release out without this, you know, that
21 just talks about the curriculum because they want
22 to hear from, like, the secretary level-type

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1 person. Like if the CDC director wants to say it,
2 the media generally picks up on it. But if it's
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3 coming out from CDC Injury Center and we're saying
4 we have a new report, the media's not going to pay
5 attention. They're bombarded with things, so you
6 have to come up with an important hook on that.
7 And it's usually from a federal agency. You need
8 some sort of statistics or reporter, a finding.

9 So I would recommend moving away from
10 the conference idea unless you're doing two types
11 of launches. You can do a soft launch to your
12 trainers. If you want to do a, like, hey, this is
13 coming out. You know, you're going to get trained
14 on this. Be aware that we're going to have a
15 final launch date going out to caregivers, so you
16 get a heads up on it. And then do the more
17 formal, official launch with your primary,
18 assuming that the primary audience for the whole
19 promotion is going to be the caregiver. And I
20 don't know if that's decided on officially, but
21 I'm guessing that would be it.

22 MS. MAXWELL: I think when you

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1 (inaudible) to work in here the -- and just
2 separate some of these promotional pieces by
3 target audience. Because we did talk about those,
4 you know, tagging on to some of the national
5 conferences. And many conferences are video or

6 PMEs. Really just to get the general message out
7 that this curriculum now is in existence.

8 But also looked at caregiver
9 conferences, national or regional, to -- and,
10 again, based on funding, to train peer-to-peer
11 leads because that word of mouth is so important.
12 There are a lot of TBI caregivers in the community
13 that really are leaders for other caregivers.
14 They relate to them. They talk to, you know, big
15 groups. I know wounded warrior Project does a TBI
16 Caregiver Summit annually or biannually.

17 So tapping into some of those
18 conferences will get our direct target audience,
19 to really give them the education and sort of
20 train them to train other families to look for
21 this curriculum, ask their people about the
22 curriculum, know that it's out there.

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1 SPEAKER: Shannon, what's a PME?

2 MS. MAXWELL: A PME is a military
3 education --

4 SPEAKER: Yeah, it's military training.

5 SPEAKER: Professional Military
6 Education.

7 MS. MAXWELL: Sorry, that's a jargon
8 term.

9 SPEAKER: Jargon.
10 MS. MAXWELL: Professional Military
11 Education?
12 SPEAKER: Yeah.
13 MS. MAXWELL: Is that what it's called?
14 SPEAKER: Yeah.
15 MS. MAXWELL: All right. Okay. Market
16 metrics. I think this is probably the largest
17 need, but really the most difficult area to
18 pinpoint because we don't yet have all the buy-in
19 and the systems in place. But there were
20 recommendations for tasking DOD and the Service
21 Branch outreach centers with calling TBI families
22 to ask if they have received the curriculum, if

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1 they know about the curriculum, just some informal
2 surveying-type reporting.
3 The FRCs and RCCs who are sort of the
4 lynchpins in this dissemination and education plan
5 to provide reports on monthly or whatever the
6 committee decides, based on usefulness,
7 effectiveness, gaps in curriculum, and basically
8 to report what they're hearing from the caregivers
9 that they're talking with. So that those useful
10 pieces of information can then go back to DVVIC
11 for the modification and update of the material.

12 There was a suggestion to include a
13 tear-out or a pre-stamped postcard in the
14 curriculum to obtain consumer feedback, an online
15 survey as part of the online curriculum; the
16 caregiver conferences, if that is a feasible
17 avenue. Again, we have, almost like a focus
18 group, we have direct access then to develop some
19 metrics there.

20 we talked about having notes in the
21 electronic medical health records so that we can
22 track whether the curriculum is received, at what

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1 points in time those are received. And then there
2 would need to be a periodic survey of those
3 records to disclose that information.

4 And the possibility of a checkbox in the
5 Retirement Checklist before the service members
6 are separated.

7 I'm going to turn it over (inaudible).

8 MS. CAMPBELL-KOTLER: We were debating
9 about whether we should have small group
10 discussion on any part of the dissemination plan.
11 And based on the specificity of some of the
12 recommendations, I'm wondering if we should think
13 about having some small group discussion: One
14 based on metrics; one that would be focused on the

15 print material, online resources, the promotion
16 strategy, taking some of these headings; the
17 market entry strategy. I guess that would be
18 three work groups, if there's a need to flush more
19 of this information out.

20 I'd like to leave here today with as
21 much detail as possible on what you're thinking is
22 on some of these areas that we've had a lot of

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1 discussion on, and that I've taken a lot of notes
2 on. But just a thought.

3 MS. MAXWELL: Meg, on that promotion
4 strategy, so you want to split that into two
5 groups: One for promotion to the caregivers and
6 one to promotion to the general population?

7 MS. CAMPBELL-KOTLER: Good idea.

8 MS. MAXWELL: Trainers --

9 MS. CAMPBELL-KOTLER: Or to the
10 providers or to the gatekeepers. One promotion to
11 the gatekeepers and the other to the families.
12 would that --

13 MS. MAXWELL: Yeah. That makes sense.

14 DR. FLYNN: One area point of contact --
15 Fred Flynn. One area point of contact within
16 large combat arms populations is that the -- I
17 know out at Madigan it's -- or out of Fort Lewis

18 it's this way, probably at other forts, too. But
19 for each brigade, they have family resource
20 groups, or what they call FRGs, that are located
21 at -- they have them at the company level, at the
22 battalion level, and at the brigade level. And

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1 they do an incredible job of disseminating all
2 types of information regarding their loved ones
3 who are either deployed or getting ready to deploy
4 or whatever. And they are a fantastic resource
5 for other family members within their group. Many
6 of these groups are as closely knit as their
7 spouses are within the active duty unit.

8 I think this would be a good target
9 audience, even though specifically traumatic brain
10 injury may not apply to some of the people in the
11 group. But the ability to get information out to
12 other family members and other spouses is second
13 to none with these groups because they are so
14 close knit.

15 The other thing, too, and Megumi and I
16 were talking about this, is that some of the very
17 special, more insular groups, like we have a
18 Ranger Battalion and we also have a First Special
19 Forces group, it's very, very difficult to get a
20 lot of these soldiers in after deployment because

21 of, you know, fears of losing their position in a
22 very elite force. But, you know, going through

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1 the spouses and having this at the tight knit
2 family resource group level, where the spouses are
3 all in the same boat, as well. This may help to
4 promote getting some of these soldiers in to see
5 us.

6 So I, you know, again, I don't know
7 whether anyone is familiar with some of the other
8 Combat Arms post, and whether they have groups
9 like this, but I can get more information for you
10 from Fort Lewis, if you'd like.

11 MS. CAMPBELL-KOTLER: Dr. Flynn, is
12 there any kind of central coordinating body of
13 these family resource groups?

14 DR. FLYNN: Yes, there is. There's two,
15 actually. There's one that's the General Family
16 Resource Group Association at Fort Lewis. It's
17 actually out of ICOR, which is the command for all
18 the brigades out there.

19 And the other one, which is more
20 health-based, is -- we have what we call a FAMF
21 Program, or Family Advocacy Military Family
22 Program, for those who have health care needs, and

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1 TBI is among those.

2 MAJ. VOGT: I think there's also another
3 -- I can't remember the name of the group, but it
4 was -- Jim Lorraine used to be the guy that ran
5 it. But there's a group that's almost like a
6 family advocacy for all of Special Ops, I thought.
7 I think --

8 MS. BURKE: Isn't that that USCJ? I've
9 actually had it on a slide for -- with the Care
10 Coordination (inaudible). And they do, they have
11 their own -- they will address care, they have a
12 care coordination program for wounded.

13 MAJ. VOGT: Right. So I don't know if
14 going through there, since it's sort of different.
15 I don't know enough about the Special Ops.

16 MS. BURKE: Yeah, it's Special Ops.
17 It's a Special Ops, specifically for wounded
18 Special Ops.

19 SPEAKER: Yes, please.

20 MS. COHOON: This is Barbara. Again,
21 depending upon what sort of information we're
22 getting out, we talked before that as far as just

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1 letting people know that the product exists,
2 there's a lot of different avenues and which we've
3 kind of touched on. But all the services have
4 these family support groups. The Navy uses
5 ombudsmen. The Air Force uses key spouses. And
6 the Army uses the Federal -- what do they call it,
7 the FRGs. And each one has a central command in
8 which the education piece goes out.

9 The ombudsman actually is here; it's in
10 D.C. It's through CNIC, and any sort of
11 information you want to get out, there's 1,600 of
12 them. They can certainly get the information out
13 to all the spouses.

14 But again, you're not wanting them to
15 have the whole entire curriculum; you're just
16 wanting them to know that the curriculum exists on
17 that particular realm. And also, too, if an
18 injury does occur, then they know that it exists
19 and then they can let the person know that this is
20 where you can go as far as to get that.

21 But all the services have that, just
22 like all the services have their own injured.

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1 And Coast Guard now is using Safe Harbor
2 as far as for their injured. So everything that
3 has to do with Safe Harbor will be taking care of
4 the Coast Guard and the Coast Guard families. And
5 Coast Guard families also use the ombudsmen.

6 MS. MOESSNER: Well, I wonder if I could
7 propose a break. Because I don't know about
8 everyone else, but a lot of information exchanged.
9 I'm not sure, you know, what's the best way to
10 spend the rest of our time today because we
11 haven't talked too much about Panel
12 recommendations for evaluation. This has been a
13 lot on distribution, dissemination. You know,
14 what are those evaluative loops you put in there,
15 as well.

16 SPEAKER: Sustainment and --

17 MS. MOESSNER: And the, you know, the --
18 right, who's going to house this and the
19 sustainability. So we have other big topics to
20 discuss.

21 But maybe we could have a break, and
22 maybe we could brainstorm a little bit on this end

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1 of the table during the break about how else we
2 might spend the rest of today. And we do have
3 some sort of flexible time built into tomorrow, as

4 well.

5 So why don't we break for 20 minutes or
6 so?

7 (Recess)

8 MS. MOESSNER: All right. Where to go
9 from here. So I had a couple of conversations
10 with folks from DVVIC and a couple of other
11 individuals in the room, trying to think -- it's
12 already 3-something, 3:25.

13 We were only scheduled to go till 4:30
14 today, I think.

15 MS. CAMPBELL-KOTLER: Five.

16 MS. MOESSNER: Oh, 5:00. Well, there
17 you go. I am lopping a half-hour off already. I
18 don't know about you all, but I lose focus by
19 mid-afternoon. It just gets to be hard when
20 you're not used to sitting all day.

21 So I think rather than break out into
22 small groups to get more information from

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1 everybody around the table about how else and what
2 else, I think we have actually gobs of information
3 about, you know -- I mean, there have been really
4 brilliant ideas shared today with who to get this
5 to and how to do it, and so on and so forth.

6 So I think what I may recommend is that

7 it does seem like Kelly has very valuable
8 knowledge to share. Shannon obviously does, Rose
9 Mary. That maybe sometime today, tomorrow if --
10 everybody's still in town through tomorrow
11 afternoon, is that right?

12 The agenda tomorrow is pretty flexible.
13 so maybe a few of us could meet and think about a
14 process whereby we could tweak the plan here, and
15 also develop a plan for writing up an Executive
16 Summary that we can present to the DHB. Maybe a
17 small work group wouldn't mind working on that
18 kind of off to the side so that we're not taking
19 any more of the large group time to do that. And
20 then that can -- I don't know if the full Panel
21 wants to see the entire plan again? Or would like
22 to at least see the Executive Summary before it

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1 gets presented to the DHB? Any thoughts about
2 that?

3 Again, we've got about a month before
4 the DHB meeting.

5 Yes, Mike.

6 MR. WELSH: We're at a point where we
7 got to let this go and, you know, give this to
8 DVBIC to finish up. And we got the 95 percent
9 solution done. I'm comfortable with going back to

10 their office with recommendations from this Panel
11 and letting them -- let them do the final task.
12 So it, you know, it gets pushed out on time.

13 MS. MOESSNER: Well, good. I'm going to
14 take that as a recommendation from Mike that --
15 because actually I was going to lead into a
16 discussion about -- which I think maybe we will
17 spend the rest of the time, however long it takes
18 this afternoon, about we really do need to make a
19 recommendation as a Panel as to who should house,
20 you know, where should this curriculum be housed,
21 in what federal agency.

22 That's the type of recommendation we

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1 need to take forward to DHB. And ultimately it
2 will be their responsibility to figure out that,
3 as well as assign somebody to carry out all these
4 wonderful things that have been suggested.

5 So I would open the floor, right, to
6 comments or discussion about, again -- and Mike
7 sounds like his vote would be with DVBIC -- to
8 house, sustain, disseminate, distribute the
9 curriculum, maintain it, keep it up, and all of
10 that.

11 But other comments, please.

12 DR. FLYNN: Well, yeah. I mean, I think

13 DVBIC's a real good idea because it is the Defense
14 and Veterans Traumatic Brain Injury Center. And
15 that's what we're all about in putting this
16 package together. It's also now under the Defense
17 Center of Excellence, which I think is a good
18 central location for this.

19 Now, I, you know, I don't know whether
20 this Panel has the right to just vote and then
21 take it back and say to General Sutton, oh, by the
22 way, we decided this is in your lap --

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1 MS. MOESSNER: Yeah, that you should
2 have this.

3 DR. FLYNN: Yeah, yeah.

4 MS. MOESSNER: Yeah.

5 DR. FLYNN: I think she probably has the
6 last say on this, but --

7 MS. MOESSNER: Sure, sure.

8 DR. FLYNN: But that would, I mean, that
9 would be my vote to --

10 MS. MOESSNER: Just that we come up with
11 a --

12 DR. FLYNN: -- to put it there --

13 MS. MOESSNER: -- a general
14 recommendation?

15 DR. FLYNN: Yeah.

16 MS. MOESSNER: Please, I'm sure you have
17 some insights for us, Colonel.

18 COL. FORTUIN: Yeah. This is Nancy
19 Fortuin. There are two things. The policy has to
20 -- the policy can't be at either DCOE or DVBIC.

21 MS. MOESSNER: Mm-hmm.

22 COL. FORTUIN: So I would recommend, I

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1 think, that the policy be at OSD. And it's really
2 easy for me to say this because I don't work there
3 anymore, but.

4 MS. MOESSNER: Right, right.

5 COL. FORTUIN: At OSD Health Affairs.
6 Now, I would recommend that the responsibility be
7 at DVBIC.

8 MS. MOESSNER: Okay.

9 COL. FORTUIN: The execution be at
10 DVBIC. And hence for most of those
11 responsibilities I think should be there because I
12 -- correct me if I'm wrong, but the VA, I know
13 talking to Dave Chandler, he's usually very
14 comfortable with DVBIC doing these sorts of things
15 --

16 MS. MOESSNER: Okay.

17 COL. FORTUIN: -- in conjunction with
18 the VA. So I think the VA would be okay with

19 that.

20 Now, the other thing that I don't want
21 to discount, though, is the -- either the Senior
22 Oversight Committee, the wounded, ill, and injured

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1 Senior Oversight Committee, or the Joint Executive
2 Council, which is over both the VA -- or, you
3 know, a group between the VA and DOD, as well.

4 But I think the easiest and cleanest,
5 given that this was tasked originally by Congress
6 to DOD, not -- I don't believe it was tasked to
7 the VA; hence it ended up under the Defense Health
8 Board.

9 CDR. FEEKS: Commander Feeks. Just to
10 clarify. You're correct that the task of
11 producing the curriculum was given to the
12 secretary of Defense.

13 COL. FORTUIN: Okay.

14 CDR. FEEKS: But the same law tasks both
15 secretaries to report to Congress a year after the
16 curriculum comes out.

17 COL. FORTUIN: Okay. All right. So
18 then you might want to take it to the SOC,
19 probably the SOC, since it's more aimed at
20 wounded, ill, and injured as opposed to the JEC or
21 the -- yeah, the JEC.

22

DHB-101409
MS. MOESSNER: Okay.

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1 COL. FORTUIN: With the recommendation.
2 Because ultimately it will be them who makes the
3 decision. The DHB will only recommend to --
4 MS. MOESSNER: Right. Okay.
5 COL. FORTUIN: -- Miss Embrey.
6 MS. MOESSNER: Okay.
7 MS. CAMPBELL-KOTLER: What is the
8 function of the Senior Organizing Committee? Are
9 they an operational body?
10 COL. FORTUIN: No, no.
11 MS. CAMPBELL-KOTLER: No.
12 COL. FORTUIN: They are very much a
13 policy body. And that the SOC, the Senior
14 Oversight Committee --
15 SPEAKER: Oversight.
16 COL. FORTUIN: -- Wounded, Ill, and
17 Injured Senior Oversight Committee was legislated
18 back in '07, I believe, and then it was redone
19 last year. So they are still in place and they
20 are co-led by the deputy secretary of Defense and
21 the deputy secretary of the VA. And then they
22 have various leaders from both organizations,

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1 makes up the Committee itself. And they meet --
2 they had been meeting at least monthly. I don't
3 know how frequently they are currently meeting.
4 But I would -- and Miss Embrey sits --
5 the assistant secretary of Defense Health Affairs
6 sits on the SOC. She is one of the members.
7 MS. MOESSNER: Okay.
8 COL. FORTUIN: So she could get this,
9 you know, I would recommend brief -- getting this
10 on the agenda --
11 MS. MOESSNER: Yeah. So --
12 COL. FORTUIN: -- of the SOC.
13 MS. MOESSNER: Yeah. So just for my
14 knowledge, and logistically speaking -- sorry for
15 being sort of dense about this -- so do you
16 envision a Panel person along with a DVBIC person
17 presenting? You know, getting on the agenda for
18 the SOC meeting? Or do we present to the DHB and
19 then they bring it forward, or?
20 COL. FORTUIN: You're a --
21 MS. MOESSNER: Maybe you can help me --
22 COL. FORTUIN: Yeah, I think --

1 MS. MOESSNER: -- figure that out.
2 COL. FORTUIN: Again, I think Miss
3 Embrey would have to make those decisions.
4 MS. MOESSNER: Okay.
5 COL. FORTUIN: I have some ideas, but I
6 think she would --
7 MS. MOESSNER: Okay.
8 COL. FORTUIN: -- need to ultimately --
9 MS. MOESSNER: Good questions to ask
10 her.
11 COL. FORTUIN: Yeah.
12 MS. MOESSNER: Okay.
13 COL. FORTUIN: Yeah.
14 MS. MOESSNER: Thank you. Okay.
15 COL. FORTUIN: Because another option
16 is, if it doesn't go to OSD Health Affairs, it
17 could go to undersecretary P&R. Because the RCCN
18 Program and all the family readiness stuff falls
19 under P&R, not under Health Affairs.
20 MS. MOESSNER: Okay.
21 COL. FORTUIN: So that's -- although,
22 you know, DCOE and DVBIC currently falls under

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1 TMA, which is part of Health Affairs, so.
2 MS. MOESSNER: Okay.
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3 COL. FORTUIN: I'm sorry, Personnel and
4 Readiness.
5 MS. MOESSNER: Okay.
6 MAJ. VOGT: (inaudible)
7 SPEAKER: Yeah.
8 COL. FORTUIN: Right, but they would
9 still -- they would be responsible for the policy.
10 And then they could task it down through Health
11 Affairs to DCOE, to DVBIC if --
12 MS. MOESSNER: Okay. So either way, it
13 could still trickle --
14 COL. FORTUIN: Either way it still --
15 MS. MOESSNER: -- down to DVBIC --
16 COL. FORTUIN: Yeah.
17 MS. MOESSNER: -- depending on what they
18 --
19 COL. FORTUIN: Absolutely.
20 MS. MOESSNER: -- decide.
21 COL. FORTUIN: Yeah.
22 MS. MOESSNER: But that would be the

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1 policy agency.
2 Okay. Thank you. I thought the human
3 brain was complicated, but.
4 COL. FORTUIN: Yeah, no, this is -- and
5 don't look for any line and block charts of the
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6 web because it's impossible to figure out OSD, let
7 me tell you. I've tried.

8 MS. MOESSNER: Thank you. Thank you for
9 your insights. I have a hunch we'll be back in
10 touch. Thank you.

11 Please, Rose Mary.

12 MS. PRIES: This is Sally Smith. I
13 don't want this question coming out under my name.

14 MS. MOESSNER: Oh, okay, Sally.

15 MS. PRIES: The top question that I --
16 forgive me, but I've got to get it out.

17 SPEAKER: Okay.

18 MS. PRIES: I have a great appreciation

19 --

20 REPORTER: Could you walk closer to the

21 --

22 MS. PRIES: Oh, I'm sorry. I'm sorry,

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1 (inaudible). I have a great appreciation for the
2 cost of doing initiatives like this. And I know
3 what it costs in terms of production money and I
4 know what it costs in terms of staff. Because
5 what we're talking about is a curriculum which
6 must be up to date, reviewed, maintained, et
7 cetera. And is DVBIC both staffed and resourced
8 to take on this work?

9 Because if they're not, we can --
10 forgive me, because I got to say this. If we --
11 if they're not, then we may be talking -- we may
12 have to scale down what we hope will happen.

13 MS. MOESSNER: Right.

14 MS. PRIES: Because I would like our
15 planning to be realistic.

16 COL. FORTUIN: And that's why the --
17 where this will be housed and who does the policy
18 is so critical. Because once the authority is
19 given, then they can program for it.

20 MS. PRIES: Okay.

21 COL. FORTUIN: And it may take a little
22 while to get enough money. But they can take it

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1 out of hide initially, and then program for it.

2 But that's why assigning it -- the
3 policy to the right organization and then --

4 SPEAKER: Is so --

5 COL. FORTUIN: -- the responsibilities
6 within that policy will provide the authority to
7 get the funds.

8 MS. MOESSNER: Okay.

9 MS. PRIES: Let me also, though, say
10 right after Nancy has said that, I am very well
11 aware of mandates that are unfunded. So, again,

12 it's just a dose of reality for me and I don't
13 want it to be an ugly dose of reality for the work
14 of the Panel.

15 MS. MOESSNER: Fred.

16 DR. FLYNN: Yeah. I'm sorry. Fred
17 Flynn. I just have a question regarding our
18 Panel. I know that it seems like this is the --
19 you know, this meeting's the end of our job and
20 everything. But if this is a dynamic process of
21 constantly upgrading, reassessing, reevaluating,
22 and all, is this panel then disbanded after this?

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1 Or do we stay in kind of an as-needed basis or
2 what?

3 Because I think that's going to
4 determine an awful lot about who has the final say
5 in all the modifications that were additions or
6 deletions or whatever that may go into this.

7 CDR. FEEKS: Funny you should mention
8 that. This is Commander Feeks, and I was just
9 communicating recently with the Washington
10 Headquarters Service Committee Management Office
11 that has cognizance over the Federal Advisory
12 committees in the DOD. And I can pull this up in
13 just a minute, but he used the figure of 60 days.

14 And I can't remember if it was 60 days

15 after the curriculum is delivered to the
16 secretary. That would be the most logical that he
17 would hook to, but it was something like that, and
18 the task force dissolves.

19 And then what I envision is that the
20 responsibility for external independent advice as
21 regards the curriculum would come from the TBI
22 Subcommittee of the Defense Health Board. And, in

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1 fact, that Subcommittee, along with our
2 Psychological Health Subcommittee, both have in
3 their mission statement to provide independent
4 external advice to the DCOE. So the relationship
5 already exists, if it does, indeed, come to rest
6 in DCOE.

7 DR. FLYNN: Okay.

8 MS. MOESSNER: Jonathan, please.

9 MR. DODSON: I'm Jon Dodson. The
10 question to Commander Feeks. Does this curriculum
11 have any wedges in the FY10-11 budget, in the
12 FY10-15 POM?

13 CDR. FEEKS: To be honest, I do not
14 know.

15 MR. DODSON: Because that goes straight
16 to Rose Mary's question. If we don't have some
17 wedge or some seed money in the FY10 budget that's

18 currently being passed -- that started the first
19 of October of 2009.

20 But, you know, we work in two-year
21 cycles: 10-11 went to the Hill; 13, 14, 15, the
22 out years. Next year we'll do -- the DOD, DVA

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1 will do a POM 10 through 15 update, which is in a
2 budget year 11 update, and then amend the 12, 13,
3 14, 15. Next POM cycle after this is the 12
4 through 17 POM.

5 If we don't have any money in there,
6 it's -- you know, what's the DHB going to do? I
7 mean, you know, are we going to --

8 CDR. FEEKS: well, remember now -- this
9 is Commander Feeks -- the curriculum is a product
10 of this Panel, and, therefore, of the DHB, as a
11 recommendation to the secretary of Defense. The
12 secretary of Defense was told by Congress to
13 develop a curriculum, to stand up a panel and
14 develop a curriculum. That's not really a direct
15 answer to the question, at all. It's just that
16 the DOD is aware that it had to produce this
17 curriculum and that it has to report to Congress a
18 year later on how it's going.

19 That doesn't -- again, that doesn't
20 answer the question as to whether anybody

21 remembered to put money against it.

22 COL. FORTUIN: I can also tell you that

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1 it was not POMed for. However, I, being
2 intimately familiar with the FY10 POM for the
3 whole PH and TBI Program, there is more than
4 adequate funds in the FY10 budget to fund any
5 priorities. And that's all it comes down to. And
6 I'm sure that this will be a priority, so.

7 MR. DODSON: Okay.

8 COL. FORTUIN: And then they'll be --
9 once the authority is put into DODD or DODI or
10 whatever, then it can be POMed for in the next
11 POM.

12 MR. DODSON: So essentially OSD will
13 reprogram 10 funds into this --

14 COL. FORTUIN: It won't need to -- there
15 will be no reprogramming action.

16 MR. DODSON: Then it will be --

17 COL. FORTUIN: It's just a budget
18 action.

19 MR. DODSON: Then it'll just be puts and
20 takes in the budget.

21 COL. FORTUIN: It's just taking it out
22 of hide then.

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1 MR. DODSON: Okay.
2 COL. FORTUIN: There's plenty of hide to
3 take it out of, so.
4 MR. DODSON: Okay. Thank you.
5 SPEAKER: Yeah. That's right, off the
6 record.
7 SPEAKER: Don't put that in the record.
8 REPORTER: I didn't catch the
9 (inaudible) anyway.
10 MS. MOESSNER: Oh, good.
11 SPEAKER: Oh, no, Nancy.
12 MS. MOESSNER: Good. Good. Other -- I
13 mean, other discussion about Panel support for
14 housing this in DCOE, DVBIC? I mean, I know that
15 DVBIC is sort of under the umbrella of DCOE, but I
16 personally don't, you know -- does DCOE mean
17 DVBIC? Are they separate?
18 Any further discussion about that?
19 Again, I don't -- if we specifically say DCOE, or
20 do you want to specifically say as a Panel that
21 this seems like a natural fit to DVBIC? Or we say
22 DCOE and they make a decision about where, then,

1 the curriculum is housed and maintained?

2 MR. DODSON: Without being an official
3 DVBIC spokesman, Loree Sutton has emphasized that
4 DVBIC is the operational element of DCOE.

5 MS. MOESSNER: Okay.

6 MR. DODSON: So DVBIC is part of DCOE.

7 MS. MOESSNER: Right. Right.

8 MR. DODSON: Just for general
9 information. So if you give it to General Sutton,
10 she can give it to DVBIC.

11 MS. MOESSNER: Be her decision, maybe.

12 MR. DODSON: Yeah.

13 MS. MOESSNER: Okay.

14 MAJ. VOGT: I would say, too, just --
15 and this is just a staffing issue, looking at, at
16 least for the short term (inaudible), that
17 there's, in terms of the TBI availability and the
18 manning and the staffing at DCOE versus DVBIC,
19 that it would be better at DVBIC.

20 MS. MOESSNER: Oh, okay. Thank you.

21 MAJ. VOGT: I mean, there, you know,
22 there -- we do, but we work very closely with

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1 Kathy Helmick --

2 MS. MOESSNER: Right.

3 MAJ. VOGT: -- in DCOE. And so there
4 are ways that we can support. But in terms of --
5 I would vote for DVBIC.

6 MS. MOESSNER: Okay. Barbara?

7 MS. COHOON: I think what we -- this is
8 Barbara. I think what we've been saying is that,
9 you know, we -- obviously there's a policy side
10 here that needs to take control.

11 MS. MOESSNER: Right.

12 MS. COHOON: And whoever that is, is not
13 really our decision as far as to make -- other
14 than the fact that a policy arm needs to be in
15 charge.

16 And then as far as where it needs to be
17 located, I think all of us would agree that
18 whoever ends up with it needs to be -- have the
19 expertise to be able to maintain it, whoever that
20 entity becomes, if it's DVBIC or it needs to be
21 under something.

22 And we also would agree that it needs to

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1 make sure that it's adequately funded in order to
2 be able to get out the product in the manner in
3 which it needs to get out to reach the population

4 it's intended to because the book's very large.
5 And as we talked about as far as publishing it, we
6 need to make sure that all of our caregivers, at
7 least, have access as far as to that.

8 But, so, I would say those three things
9 that we could talk on a little more broader scale.

10 MS. MOESSNER: Yeah, and we talked about
11 that a little bit at the break, too, that maybe
12 it's more some criteria that we would support.

13 MS. COHOON: And I think that, again,
14 going back to the focus groups, since I was part
15 of all of that. We had asked for some feedback on
16 what needed to be added that wasn't there before.
17 And majority of our injured aren't just TBI. And
18 so where does the curriculum go from here and what
19 do the caregivers really need? And there has been
20 some interest on the Hill as far as adding where
21 the curriculum would be for those with amputation
22 and burn and that sort of thing.

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1 So again, that we would recommend that
2 maybe this be looked at as far as now that we've
3 got the model, how do you expand this to
4 incorporate other injuries that would also help
5 the caregiver?

6 MS. MOESSNER: Thank you. Okay. Any

7 other discussion?

8 MR. DODSON: Anne?

9 MS. CAMPBELL-KOTLER: Who -- yes,
10 please.

11 MR. DODSON: I'm sorry.

12 MS. CAMPBELL-KOTLER: Oh, excuse me.
13 No, go ahead.

14 MR. DODSON: Just an add-on to my short
15 course on the POM budget cycle. The departments
16 are submitting their FY11 budget updates to --
17 through DOD comptroller to OMB mid- December,
18 mid-, late December is the normal date. I don't
19 know; have they changed that?

20 So in other words, they're working on it
21 right now. So any monies to this program that you
22 want FY11, which is one year from report back to

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1 Congress, DOD and DVA is working on it right now.

2 MS. MOESSNER: Okay. Thank you.

3 MR. WELSH: We're talking about a small
4 budget, in reality. In the scope of the entire
5 DOD budget, it shouldn't be hard to get this thing
6 resourced. It's just like Colonel Fortuin said,
7 we got to get somebody to own it, then they could
8 be the bill payer.

9 MR. DODSON: Just a heads up. Yeah.

10 MS. MOESSNER: Good. Meg?

11 MS. CAMPBELL-KOTLER: Colonel Fortuin,
12 who are the members of the Senior Oversight
13 Committee? What agencies sit on that group?

14 COL. FORTUIN: The co-chairs are the
15 deputy secretary of Defense and the deputy
16 secretary of the VA. The vice chiefs of staff of
17 all the services sit on it. Dr. Cussman from the
18 VA, is he still around or is he gone now?

19 SPEAKER: No, he's gone.

20 COL. FORTUIN: Well, whoever -- whatever
21 his position is, okay, and several other people in
22 the VA. The comptroller sits on it. The

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1 assistant secretary of Defense Health Affairs,
2 undersecretary of Defense for Personnel and
3 Readiness. I can't remember all the members now,
4 but it is a very, you know, very high-level
5 between DOD and VA.

6 MS. CAMPBELL-KOTLER: Mm-hmm. How --
7 what --

8 MS. COHOON: (inaudible), but it's not
9 permanent.

10 SPEAKER: Yeah, right.

11 MS. COHOON: Again, without seeing what
12 came out of the NGAA FY10. That was in there.

13 Don't know if it came out of conference that they
14 would have a stake in another year.

15 SPEAKER: That's what they got last year
16 in the NDA. I thought they got -- oh, no, they're
17 supposed to go back in August and recommend if
18 they would be expended. That's right.

19 SPEAKER: Exactly. So I don't know
20 what's in there.

21 SPEAKER: Yeah, I don't.

22 SPEAKER: They're not planning on

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1 expanding, but it's not a permanent body.

2 SPEAKER: Okay.

3 SPEAKER: (inaudible)

4 MS. COHOON: It's not a permanent body.

5 SPEAKER: Thank you.

6 MS. CAMPBELL-KOTLER: The question I
7 have is what does this -- would this body have a
8 capacity to help us reach Guard and Reserves?

9 COL. FORTUIN: Absolutely. Yeah.

10 MS. CAMPBELL-KOTLER: They'd -- okay.

11 Okay.

12 COL. FORTUIN: Yeah.

13 MS. CAMPBELL-KOTLER: Through what
14 channel?

15 COL. FORTUIN: Well, they make -- they

16 will make very high-level decisions and
17 priorities. Okay? So if you go in with the
18 brief, you have to have it very austere and very,
19 very, very pithy.

20 MS. CAMPBELL-KOTLER: Mm-hmm.

21 COL. FORTUIN: Like no details.

22 MS. CAMPBELL-KOTLER: Right, right,

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1 right. I understand --

2 COL. FORTUIN: And just go for decision.

3 And they're looking for decisions.

4 MS. CAMPBELL-KOTLER: Right.

5 COL. FORTUIN: So, you know, so an

6 appropriate decision is where does this land.

7 That would be a good decision for them to make.

8 And then they debate it.

9 MS. CAMPBELL-KOTLER: Okay.

10 COL. FORTUIN: But they've got the
11 assistant secretary of Defense for Reserve Affairs
12 attends it. He's -- I don't know that he's on the
13 SOC, but he frequently attends it.

14 MS. COHOON: They have a working group
15 that -- Meg, there's a working group that's
16 actually a staffed body that meets --

17 SPEAKER: Right.

18 MS. COHOON: -- and are there, you know,

19 five days a week.

20 MS. CAMPBELL-KOTLER: Oh, good.

21 MS. COHOON: And so that's the group
22 that she could reach out to and they could explain

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1 to you what you need to be doing and put together.
2 And they're broken up into line of action items as
3 far as the -- there's a DOD and VA counterpart.
4 And Miss Embrey sat on -- or still does -- the TBI
5 Psychology Health --

6 COL. FORTUIN: Right, she's --

7 MS. COHOON: -- line of action item.

8 COL. FORTUIN: -- the co-lead. And
9 Karen Geiss is on there, as well, which is why I
10 really think Karen is going to -- Dr. Geiss is
11 going to be an outstanding -- we need to make the
12 linkage with her.

13 MS. COHOON: Yes. Actually --

14 COL. FORTUIN: She sits on the OIPT,
15 which is the full-time working --

16 MS. COHOON: Right. That's the --

17 COL. FORTUIN: -- the staff --

18 MS. COHOON: -- that's the full-time
19 working group that's there.

20 But again, I think that we can -- as a
21 group we can recommend, but I think the Defense

22 Health Board will ultimately decide where they

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1 think that this should be housed policy wise, and
2 then as far as where it needs to go with the
3 experts to keep it updated.

4 SPEAKER: Mm-hmm. Okay.

5 MS. CAMPBELL-KOTLER: And just wanted to
6 let the group know that I, thanks to Shannon
7 Maxwell, I'm going to be speaking to -- with Dr.
8 Geiss and her federal care recovery coordinators
9 on November 4th at their meeting here in
10 Washington, just to give them a preliminary sense
11 of what's coming.

12 SPEAKER: Good. That's great.

13 MS. MOESSNER: Any other -- I mean, we
14 have a few other topic areas. We wanted a little
15 bit more discussion on metrics and, you know, what
16 you want in that area. But I think, maybe, we do
17 have ample time tomorrow, I think, to discuss
18 that. So I think I'm going defer that until
19 tomorrow, as well.

20 we'll talk about the Mild Module
21 tomorrow, as well, and what the plans are for
22 that, or what your ideas are for that.

1 And again, Colonel Mauffray will be here
2 tomorrow to talk about CEMM and the multimedia
3 approach to disseminating this curriculum.

4 But I think if everyone's -- I don't
5 suppose I'll hear any opposition to ending the
6 meeting a little bit early today and regrouping
7 tomorrow.

8 Fred?

9 DR. FLYNN: Anne, I just wanted to add
10 one thing. I noticed on your very nice letter
11 here as an introduction to everybody, the
12 signature block on your name leaves off all your
13 credentials and your area of expertise. And I
14 think that that would be important to include
15 because you are an expert in the area of TBI and I
16 think the family caregivers need to know that.

17 MS. MOESSNER: Thank you.

18 DR. FLYNN: Sure.

19 MS. MOESSNER: Yeah, well, that all sort
20 of happened quickly last week. You know, sign and
21 fax and send and, you know, write a letter quick.
22 And I will -- I'd like to publicly thank Caroline

1 and Mike, helped pen a letter on behalf of the
2 Panel. So hopefully, that was acceptable, just
3 welcoming the reader to the curriculum and hoping
4 what they get out of it, so.

5 But yeah, I'll have them work on that.
6 Thank you very much.

7 DR. FLYNN: Okay.

8 MS. CAMPBELL-KOTLER: (inaudible) the
9 certificate?

10 MS. MOESSNER: Oh, the certificate.
11 Yes. So I think, you know, there was some
12 recommendation earlier from people who have more
13 experience with certificates, that I think we will
14 weave into the, you know, make it better over the
15 course of time plan. But because it's already
16 woven into the Companion Guide, we may just start
17 with a tear away certificate and, you know, build
18 in something more personalized over time.

19 Is there any recommendation about who
20 should sign the certificate?

21 MS. COHOON: Anne, I have a question
22 about the certificate. There's been some movement

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1 as far as compensating caregivers and having them
2 certified.

3 SPEAKER: Right.

4 MS. MOESSNER: I've heard that.

5 MS. COHOON: And it's been a lot of the
6 language as far as on the Hill, both through the
7 Veterans Affairs Committee and out of the Armed
8 Services Committee.

9 So when you're talking about the
10 certificate, I don't want there to be some
11 confusion by staffers or others that because
12 you've got the certificate and you've gotten the
13 curriculum, this certifies you to be compensated
14 as a caregiver. And that's -- only thing I'm
15 bringing it. This is the first time I've heard
16 about the certification, but.

17 MS. MOESSNER: Yeah, yeah. And I think
18 there's been past discussion about that, that this
19 not certify a competency, but it certify
20 completion. You know, that the caregiver kind of
21 muddled their way through the guide.

22 Sandy?

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1 MS. KILADA: This Sandy. I just want to
2 say that this was a suggestion by the Defense
3 Health Board. So that's kind of where it came
4 from.

5 MS. COHOON: Okay, but --
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6 MS. MOESSNER: Right.

7 MS. COHOON: -- but again, as long as
8 the -- there's -- on the certificate maybe it
9 explains that it's for, you know, whatever, so
10 that people aren't looking at this --

11 MS. MOESSNER: Okay.

12 MS. COHOON: -- you were certified with
13 the curriculum and now this qualifies for
14 compensation.

15 MS. MOESSNER: Okay. So maybe we'll
16 think about the wording on the certificate.

17 MS. CAMPBELL-KOTLER: Do you think it
18 would be wise for us to just go back to the
19 Defense Health Board in our presentation and say
20 we considered your recommendation about a
21 certificate, and because of the complications with
22 regard to other actions, we don't think it's a

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1 wise move at this time?

2 MS. COHOON: No, I think that to
3 recognize them, that they went through this, and
4 that they were educated to what Shannon was
5 talking about, I think it's a wonderful thing for
6 them to have. I'm just saying that -- may be a
7 little careful -- is that it's not a certificate
8 for being a caregiver, and that you've been

9 through the curriculum that the -- it means --
10 anyway. But we're not tying that together.

11 MS. CAMPBELL-KOTLER: Okay.

12 MS. COHOON: But I think it's important
13 they be recognized.

14 SPEAKER: Okay.

15 MS. BENEDICT: I think we're going to
16 have to be pretty careful about this.

17 MS. MOESSNER: Yeah.

18 MS. BENEDICT: With the pending
19 legislation, I could see where there could be a
20 lot of misunderstanding. And where we would be
21 fielding calls about this and trying to -- I just
22 --

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1 MS. MOESSNER: You're right. I mean,
2 right now all it says is a Certificate of
3 Completion. This is to certify that so-and-so
4 completed the Traumatic Brain Injury:

5 A Guide for Caregivers of Service
6 Members and Veterans. And it doesn't --

7 SPEAKER: (inaudible) introduction.
8 Completed the introduction to.

9 SPEAKER: I think (inaudible).

10 MS. BIGGERS: What's the purpose of the
11 certificate?

12 SPEAKER: Right.
13 SPEAKER: To make the caregiver feel
14 like --
15 SPEAKER: I agree.
16 SPEAKER: -- they've accomplished
17 something, or?
18 MS. KILADA: The DHB's point of view was
19 to give them a sense of community, of belonging to
20 some special group. It was sort of -- it was for
21 support and --
22 MS. BIGGERS: You know what would work

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1 is, like, I mean, you're like the Gold Star Moms,
2 the Blue Star Moms. Why don't we just give them a
3 pin or something that they can wear and be proud
4 of as a caregiver, like, that comes with the
5 packet? Like that kind of identifies them so they
6 can feel good about that. And then so it's not --
7 there's no confusion there. I don't know; I just
8 had that thought.
9 SPEAKER: Yeah.
10 MS. BIGGERS: That seems to be the way
11 (inaudible).
12 MS. MOESSNER: Over here, please.
13 MS. CAMPBELL-KOTLER: I just -- could I
14 just comment?

15 SPEAKER: No, of course.
16 MS. CAMPBELL-KOTLER: Liza, we've got
17 the backpack with the tree on it, which can
18 provide some identification.
19 MS. BIGGERS: Yeah, well, I mean, not
20 that they -- just something --
21 SPEAKER: Yeah, something --
22 MS. CAMPBELL-KOTLER: Something more.

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1 Something --
2 MS. BIGGERS: Something to make them
3 feel --
4 SPEAKER: Yeah.
5 MS. BIGGERS: You know, because I think
6 that's what the certificate is aimed to do.
7 SPEAKER: Yeah.
8 SPEAKER: Right.
9 MS. BIGGERS: So, you know, that's
10 something along those lines. I don't know. It's
11 just --
12 MS. MOESSNER: Something to acknowledge
13 that they, you know, got through this large --
14 SPEAKER: Yeah.
15 MS. MOESSNER: -- large curriculum and
16 --
17 MS. PRIES: Right. And -- it's Rose
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18 Mary Pries. What you could say is "in
19 appreciation," something like those kind of words.
20 And perhaps what you could have made is I'm sure
21 all of us have seen those little round enameled
22 pins, you know, that they're often given away at

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1 conventions and things. But maybe to have one
2 with the, you know, the tree logo on it. And just
3 have a nice letter of appreciation and somehow
4 affix the pin to the letter.

5 MS. MOESSNER: What do people think
6 about that? Something more in that flavor as
7 opposed to a certificate?

8 MS. PRIES: Yeah, that sounds nice.

9 SPEAKER: I agree.

10 MS. PRIES: But, like, a little letter
11 or something just (inaudible).

12 SPEAKER: Right.

13 MS. BIGGERS: Which, by the way, the
14 backpack is awesome.

15 MS. MOESSNER: Oh, good. That was your
16 suggestion, so.

17 SPEAKER: Yeah.

18 MS. MOESSNER: And I don't know if
19 that's actually the final backpack? Or those are
20 being tweaked a little bit, or?

21 MS. KILADA: That is the --
22 MS. MOESSNER: Okay.

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1 MS. KILADA: This is Sandy. And that is
2 the final backpack, unless someone doesn't like
3 it.
4 MS. MOESSNER: Okay, good.
5 MS. BIGGERS: It's awesome.
6 MS. MOESSNER: Not too big, not too
7 small.
8 MS. BIGGERS: Perfect. I carried it all
9 around D.C. last night.
10 MS. MOESSNER: Nice. Very nice. Good.
11 Okay. Well, that actually sounds nice. Yeah,
12 maybe like, again, more of a letter format in
13 appreciation, and a pin of some kind, so.
14 Who should sign the letter? I guess we
15 still have that issue. Would you like -- I mean,
16 I would be happy to sign it on behalf of the
17 Panel. Does it make sense for someone from DOD or
18 from DVBC to sign such a letter? DHB? Any
19 thoughts about that, or?
20 SPEAKER: President Obama.
21 SPEAKER: (inaudible) secretaries.
22 SPEAKER: Yeah.

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1 SPEAKER: Secretaries.

2 CDR. FEEKS: This is Ed Feeks. I don't
3 think it should be the DHB. And the reason I
4 don't is because the DHB is an independent
5 external advisory body to the secretary. I think
6 that's getting out of their lane, sending letters
7 of appreciation --

8 MS. MOESSNER: Okay.

9 CDR. FEEKS: -- for that. For
10 completion of a curriculum, is outside their lane.

11 MS. MOESSNER: Okay.

12 MR. DODSON: How about a -- Jon Dodson,
13 how about a double signature using the proverbial
14 iron hand of the secretary of Defense and the
15 secretary of Veterans Affairs?

16 I mean, supposedly the President signed
17 my retirement papers. I doubt seriously that he
18 sat down at his desk and signed them.

19 MS. KILADA: This is Sandy. And I'm
20 sorry to be sort of fixated on this, but in terms
21 of timeline, this would not be ready for this
22 version -- or the version that's going to go to

1 the DHB. I mean, we're not going to be able to
2 get pins done and the letter that's signed by
3 someone in time to have this submitted.

4 So I don't know if we want to put
5 something temporary in there or just kind of save
6 the whole idea for a little bit later?

7 MR. WELSH: You'd have to staff
8 something like that to get the secretary to sign
9 it.

10 MS. MOESSNER: Right.

11 MR. WELSH: And you're right, that could
12 take some time. They'd want to know what they're
13 signing. Whoever their gatekeepers are --

14 MS. MOESSNER: Right.

15 MR. WELSH: -- would want to know from
16 the front to the back this book, what they're
17 going to put their name on.

18 MS. MOESSNER: So I guess it's either I
19 am happy to sign on behalf of the Panel, to at
20 least have something in there to start, or we
21 forgo it and try to get higher level folks to sign
22 and do it on round two.

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1 SPEAKER: Let's have Ellen Embrey sign
2 it --
3 MS. MOESSNER: Opinion?
4 SPEAKER: (inaudible) make the motion
5 that Anne signs --
6 MS. MOESSNER: Just sign on the behalf
7 of the Panel.
8 SPEAKER: Yeah.
9 MS. MOESSNER: So at least there's
10 something in place that could be tweaked over
11 time, as needed.
12 SPEAKER: Let's have all of us sign it.
13 We'll sign all around --
14 MS. MOESSNER: I think we'll turn it
15 into more of a letter. Yeah, just something
16 acknowledging.
17 Okay. I mean, I'm happy to do that on
18 behalf of the Panel. And that would probably be
19 easier in terms of logistics and time to just get
20 something put together quickly and by tomorrow.
21 Very good.
22 SPEAKER: well, I'd be happy to do that

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1 tomorrow, so.
2 MS. MOESSNER: All right. Sounds good.
3 Any other comments today? Otherwise, I think

4 we'll move to close today's meeting. As far as
5 tomorrow, do you --

6 MS. KILADA: I'm sorry.

7 MS. MOESSNER: Do you have a comment?
8 Yeah, please.

9 MS. KILADA: May I? Sandy, again. I
10 don't know how different this would be then from
11 the welcome letter that's already -- was already
12 written --

13 MS. MOESSNER: I know.

14 MS. KILADA: -- and put into it.
15 Because it is, in a sense, a letter of
16 appreciation.

17 MS. MOESSNER: So maybe we can talk
18 about that.

19 MS. KILADA: So I'm not sure if we can
20 make it distinct enough that it has some weight to
21 it or if what we have is enough --

22 MS. MOESSNER: Yeah, because right now I

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1 say, you know, good luck. And what would I say at
2 the end? way to go? You know, hi, me again.

3 SPEAKER: Yeah.

4 MS. MOESSNER: Right, right. So, well,
5 maybe we could talk about that and try to put
6 something together quickly for you to react

7 tomorrow.

8 MS. MAXWELL: What about the letter
9 signed by Carolyn and Liza as caregivers of the
10 Panel?

11 MS. MOESSNER: That'd be great.

12 SPEAKER: That would be great.

13 SPEAKER: Or --

14 CDR. FEEKS: Let me, please. This is Ed
15 Feeks. Can I understand it, are we talking about
16 a letter of appreciation given to someone who
17 completes this curriculum on an ongoing basis.

18 SPEAKER: I mean --

19 CDR. FEEKS: Now, say a year or two from
20 now, if somebody completes this curriculum, and
21 we're talking about who's going to sign that
22 letter of appreciation to that person, right?

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1 MS. MOESSNER: Well, and I think the
2 original idea, when it was a certificate idea -- I
3 guess we should think that through -- it was it's
4 embedded in the curriculum from the time they get
5 it. So they tear it out and there it is.

6 CDR. FEEKS: Oh, I see.

7 MS. MOESSNER: But if it's a letter,
8 right, would that be the same sort of a situation
9 or would it be these -- something mailed out to

10 them at a later point.

11 Please.

12 MS. PRIES: Pries. One of the things we
13 talked about was tear-off postcards, you know, so
14 we could get some evaluative data or something.
15 And if people send those into us with information
16 --

17 SPEAKER: We could send them --

18 MS. PRIES: -- we could then, in
19 appreciation for them sending us their, you know,
20 their feedback, we could then send them a letter
21 and say we really appreciate your using the
22 curriculum and we value your -- the feedback that

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1 you've given us. And as a token of our
2 appreciation for your use of the curriculum and
3 your, you know, your giving us some feedback, you
4 know, we are sending you this little pin or
5 whatever.

6 MS. MOESSNER: How does that sound?

7 MS. BENEDICT: I like that idea because
8 I think then we send it to the people who have
9 really taken the time and --

10 MS. PRIES: Yeah, exactly.

11 MS. BENEDICT: -- who had made a
12 meaningful --

DHB-101409

13 MS. PRIES: A little thank you.
14 MS. BENEDICT: -- contribution.
15 MS. PRIES: Exactly.
16 MS. BENEDICT: It just makes me nervous,
17 this certificate, letter signed. With all the
18 stuff going on, it just --
19 MS. MOESSNER: Okay.
20 MS. BENEDICT: I think it could be
21 misinterpreted very easily. And, in fact,
22 thinking about having the secretaries sign this

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1 when the secretaries are the ones that are going
2 to have to designate who are the primary
3 caregivers that receive compensation --
4 SPEAKER: Yeah.
5 MS. MOESSNER: Maybe that's too messy.
6 MS. BENEDICT: -- I think it opens up a
7 huge can of worms.
8 SPEAKER: Yeah.
9 SPEAKER: Yeah, exactly.
10 SPEAKER: Misleading.
11 MS. MOESSNER: Okay.
12 SPEAKER: Yeah.
13 MS. CAMPBELL-KOTLER: And one of the
14 things that is a problem is just because you
15 receive the curriculum doesn't make you the

16 primary caregiver to receive reimbursement.

17 MS. BENEDICT: Right.

18 MS. CAMPBELL-KOTLER: And that's a real
19 sticky wicket.

20 MS. BENEDICT: Right, right.

21 MS. MOESSNER: Yeah. Barbara?

22 MS. COHOON: I mean, I think when you go

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1 back to the Defense Health Board, since it was
2 their recommendation, that we had a conversation
3 and really felt that we couldn't come to consensus
4 on the certification for whatever reasons you want
5 to list that we've talked about here. And that
6 the other option was to do what you guys are
7 talking about now, and would that be acceptable
8 for them. And then if they feel that it
9 definitely needs to be a, you know, certificate or
10 whatever --

11 MS. MOESSNER: (inaudible) go from
12 there. Okay.

13 MS. COHOON: Yeah. So we're throwing
14 the ball back into their court since it was their
15 recommendation in the first place.

16 MS. MOESSNER: That sounds lovely.

17 MS. MAXWELL: Probably not the
18 appropriate thing to say, but as a caregiver, a

19 certificate, especially a self- certification,
20 really means nothing to me.

21 MS. MOESSNER: Yeah, well, I wondered
22 about that. You know, that came from the DHB, you

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1 know, as some sort of recognition. But as a
2 caregiver, would that have meant anything to you?
3 Not so much.

4 MS. ROCCHIO: I have a whole folder of
5 them.

6 MS. MOESSNER: Right.

7 SPEAKER: (inaudible)

8 MS. MOESSNER: Yeah, okay. Okay.

9 MS. ROCCHIO: I like Rose Mary's idea of
10 --

11 MS. MOESSNER: I think I'll recommend
12 that, if that's okay. I'll take that forward to
13 the DHB as part of the discussion there and just
14 say I know this came from you, but I like the
15 suggestion of -- so this is what we ended up with.
16 A way to get feedback, and then return a letter to
17 them.

18 MS. PRIES: Yeah, to second Shannon's
19 comment, I felt like signing your own certificate
20 was really tacky. I'm sorry.

21 SPEAKER: I do, too.

22 DHB-101409
MS. MOESSNER: Yeah. Yeah, good. Okay.

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1 CDR. FEEKS: This is Ed Feeks again. My
2 own opinion, for what's it worth, is that a letter
3 of appreciation that's sent to somebody in
4 response to an act in space and time should be
5 signed by somebody who's occupying the relevant
6 office in that space and time. So it would be,
7 maybe, the director of DVBIC --

8 SPEAKER: Yeah --

9 CDR. FEEKS: -- or something like that.

10 SPEAKER: Yeah.

11 MS. MOESSNER: That sounds good.

12 MS. KILADA: This is Sandy. So if we're
13 going to put a card in, is that just going to be a
14 recommendation to do that in the future? A
15 recommendation to DVBIC? Or do we need to come up
16 with whatever questions we want on that card as we
17 sit here, so that we can have this inserted
18 tomorrow.

19 It's tomorrow, again.

20 MS. SARMIENTO: I don't think you want
21 to put questions on the card because then you're
22 going to have OMB issues. What you can do is just

1 put let us know -- or any -- I forget the wording
2 we used. Something -- you actually don't even ask
3 a question. It's just, like, comments. Yeah.

4 Comments, colon, and then a space, and
5 then a place for them to reorder. And then if --
6 I guess if you're giving out a pin, you --
7 something like that.

8 But that's what we've done. But you
9 wouldn't want to ask any formal -- and ask for
10 their mailing address, you know, that sort of
11 thing.

12 MS. MOESSNER: Okay.

13 MS. SARMIENTO: So that'll make it
14 really simple. But I'll give you our sample one.

15 MS. MOESSNER: That'd be great. Okay.

16 MS. CAMPBELL-KOTLER: I don't think we
17 need to worry about having that card for the DHB
18 presentation.

19 MS. PRIES: On second thought, do we
20 have problems with personally identifiable
21 information collected? Is that an issue?

22 SPEAKER: What does that mean?

1 MS. MOESSNER: So if someone sends me a
2 card with their name and address on it, do you
3 mean?
4 MS. PRIES: Yeah. Yeah.
5 MS. CAMPBELL-KOTLER: We're not going to
6 ask -- oh, that's right.
7 MS. PRIES: Yeah, yeah. That's -- all
8 of a sudden it hit me like a bolt of lightning,
9 like, oh, dear --
10 MS. MOESSNER: Kelly, no?
11 SPEAKER: It's purely voluntary.
12 SPEAKER: Consent to use --
13 MS. SARMIENTO: It's not a survey. And
14 when you -- people place orders online, they're
15 giving us their mailing address and name.
16 SPEAKER: That's true.
17 MS. SARMIENTO: So if that's an issue,
18 then any distribution we do would be in that
19 category.
20 SPEAKER: It's voluntary.
21 MS. SARMIENTO: So it's really an order
22 -- I mean, you can call it an order card. And

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1 that's really what the main purpose is, is to get
2 for reordering materials, and then there happens
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3 to be a comments section. It's not mandatory to
4 fill that out.

5 MS. LLOYD-KOLKIN: I think I saw some
6 regulations that you can't keep the information
7 for more than 30 days, and then you need to
8 destroy it.

9 MS. SARMIENTO: Yeah. I mean, that
10 would be a warehouse question because we collect
11 the mailing address and contact info millions of
12 times a day to produce and distribute materials,
13 so.

14 MS. CAMPBELL-KOTLER: But we're not
15 going to be ordering. I mean, if a family
16 caregiver looks at this curriculum, they're not
17 going to be ordering more. I mean, there are only
18 going to be, like, one per family. So.

19 MS. SARMIENTO: Yeah, that would depend,
20 I guess, on your distribution. If you -- we
21 actually -- for the toolkit we actually -- it's
22 not to reorder the toolkits; to reorder a fact

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1 sheet or something like that. So it's -- so it
2 depends on if you have collateral materials. But,
3 yeah, that'd be up to you, I guess, so.

4 MS. MOESSNER: Okay.

5 MS. BENEDICT: You know, I kind of feel
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6 like, with regard to the DHB's recommendation, it
7 was a good recommendation, but in theory. But in
8 practice presents a whole bunch of --
9 MS. MOESSNER: Right.
10 MS. BENEDICT: -- potential issues.
11 MS. MOESSNER: Okay. And I --
12 MS. BENEDICT: Maybe we should just --
13 MS. MOESSNER: -- I'm fairly comfortable
14 --
15 MS. BENEDICT: Thanks --
16 MS. MOESSNER: Thanks, but no thanks.
17 MS. BENEDICT: But no thanks, yeah.
18 MS. MOESSNER: It's my last meeting, so
19 I'm happy to say whatever you'd like. So, okay.
20 SPEAKER: Yeah.
21 MS. MOESSNER: I think they'd be pretty
22 amenable to a discussion about that. So, okay.

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1 other comments?
2 COL. FORTUIN: Are we discarding Rose
3 Mary's idea then? Because I really like her idea.
4 MS. MOESSNER: Yeah.
5 SPEAKER: Maybe we --
6 MS. BENEDICT: well, you know, I would
7 like to ask Shannon and Liza. would it mean
8 something to you to get something back, or no?

9 SPEAKER: If you --
10 MS. BENEDICT: Not necessarily. Because
11 --
12 MS. BIGGERS: Well, I think that, you
13 know, if you're a caregiver -- I mean, I'd leave
14 my address on it so I could more information in
15 the future if I needed it. Like, I don't think
16 people are going to be like, oh, my gosh, am I
17 going to get cold calls now because I sent my info
18 to, you know. But if you --
19 MS. BENEDICT: No, but I mean, would it
20 mean something to get some --
21 MS. BIGGERS: Yeah, to get a letter
22 back?

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1 MS. BENEDICT: Or a letter or a pin or
2 some sense of recognition.
3 MS. BIGGERS: Yeah.
4 MS. BENEDICT: I mean.
5 MS. BIGGERS: I think, I mean, when I --
6 I just think of these pins because, you know,
7 like, charities give them out. And, you know, I
8 might get on the Blue Star Moms again, but, you
9 know, they -- it's this identity they have and
10 they're proud to wear it. You know. I have,
11 like, a Fisher House pin. I have all these pins,

12 an AW2 one. And I remember them giving them out
13 all the time and I just have a coat filled with
14 them.

15 But I think something to identify a
16 caregiver because they do put in a lot of work.
17 It might be something that would, you know --
18 maybe give them -- and it wouldn't mean the world
19 to me, but it'd be kind of cool, maybe.

20 SPEAKER: Yeah.

21 SPEAKER: It's like the coins.

22 MS. CAMPBELL-KOTLER: If I -- oh,

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1 Carolyn? Could I just respond to Liza?

2 But would a form letter be a good
3 response? It would have to be personalized to
4 some degree, in terms of whatever comment you
5 made. So that complicates the process quite a bit
6 for DVbic.

7 MS. BIGGERS: I think a letter -- I
8 mean, you have how many letters. But if you got
9 something like a pin or something that you could
10 wear, it might be a little more personal. And
11 then you wouldn't have to personalize letters all
12 the time.

13 SPEAKER: Right.

14 MS. BIGGERS: So.

15 MS. KILADA: This is Sandy. I was just
16 going to -- sort of a middle ground would be to
17 personalize it, to say dear
18 whoever-you-really-are, and then the form letter.
19 And then not necessarily address, you know, what
20 was on the card.

21 And then with a pin, it does need a
22 little bit of something else. But personalize to

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1 a certain extent, but not all the way.

2 MS. MOESSNER: Yeah, because if a pin
3 just showed up --

4 SPEAKER: Right.

5 MS. MOESSNER: -- you know, you would
6 need some sort of acknowledgment to go with the
7 pin.

8 SPEAKER: Jewelry just came in --

9 SPEAKER: Dear caregiver --

10 MS. MOESSNER: Right.

11 COL. FORTUIN: Not to burst any balloons
12 or anything, but with an autopen, you can't tell
13 if it was an autopen or an original signature, so
14 don't listen to that.

15 MS. MOESSNER: Yeah, right.

16 COL. FORTUIN: But if you put it on nice
17 paper --

18 MS. MOESSNER: Yeah.
19 COL. FORTUIN: -- it's a -- it would be
20 nice, I think. A pin and a little --
21 MS. MOESSNER: Yeah. Carolyn.
22 MS. ROCCHIO: This is Carolyn. I

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1 wouldn't want to overlook the value of the
2 opinions that we get back as far as future needs
3 assessment. And I know in Florida we do a lot of
4 tear-off cards. That's what keeps, you know --
5 use to keep us current with what are the needs out
6 there that we overlooked and as they change.

7 So I think something they could tear off
8 and how it's worded, that they may receive a
9 letter of appreciation or whatever, a pin or
10 whatever. I don't think that's as important as
11 trying to get -- you know, if you get 20 letters
12 back, you know, that represents, what, like, 100
13 responses. So I think the information gathering
14 part of this is the key piece of it.

15 MS. MOESSNER: Yeah.

16 MS. ROCCHIO: And as far as whether you
17 appreciate me or not, I don't really care. I know
18 I'm doing the best I can. But I think, you know,
19 a nice letter that would say, you know, we do
20 appreciate. We hope that you found it very

21 helpful.

22 Even if you do direct them to an onsite,

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1 like a survey Monkey or something, where they
2 could answer a number of questions, could be very,
3 very helpful as far as this is, you know, updated,
4 maintained, and sustained.

5 MS. MAXWELL: Just to add to that, too.
6 Throughout this curriculum, you have empowered the
7 caregiver to be an advocate. So by providing that
8 card and a survey mechanism, you're providing them
9 that avenue to be that advocate.

10 MS. MOESSNER: Yeah. well, and I think,
11 too, even in the focus groups, they found some
12 mistakes. I mean, they found just some simple
13 mistakes, definitions that needed to be corrected.
14 And, you know, this is a large curriculum. Those
15 could be lurking around in there. I mean, it
16 would be nice to have in a venue, even for simple
17 catches, as well.

18 well, right. Oh, excuse me, no
19 mistakes. But, you know, every time you read it
20 you find something. It's, like, oh, oops. You
21 know, today, you know, things that we just missed
22 in printing and layout and whatever.

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1 So, okay.

2 MS. KILADA: This is Sandy. And I think
3 the evaluative piece is essential. And I think we
4 all agree on that. I think it's just -- and this
5 might be a whole other discussion about how best
6 to get it, but I think we all agree that that's
7 the only way we're going to keep it updated.
8 That's the only way we're going to have version
9 two and three and four, so on --

10 MS. MOESSNER: Right.

11 MS. KILADA: -- is mainly feedback from
12 caregivers. And also, as the science changes and
13 what we know changes. But definitely the feedback
14 of the caregivers is key. So.

15 MS. SARMIENTO: Again, you can't even
16 direct them to a Survey Monkey, anything like
17 that, so --

18 SPEAKER: without --

19 MS. SARMIENTO: -- just to --
20 unfortunately. I know unless an outside agency
21 wants to take that on without our involvement,
22 even technical assistance. But anything done,

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1 even with technical assistance, we need to go
2 through OMB.

3 MS. MOESSNER: Okay.

4 MS. MAXWELL: This is Shannon. One more
5 thing. Can we put maybe a request on it: would
6 you like to participate in a caregiver conference
7 or -- that's part of the healing process for
8 peer-to-peer relations again. And then that would
9 provide us both with direct access to that
10 peer-to-peer team and trainers-to-trainer. You
11 can't do that --

12 MS. KILADA: Does that question then
13 require OMB, because it's a question?

14 MS. SARMIENTO: So you would just say
15 for -- can we just say for more resources,
16 including support group info, go to this website.
17 Is -- are you -- because if you're collecting the
18 data to then follow up, and I think that gets a
19 little bit fuzzy. I mean, we'd have to probably
20 confirm that, but it may be just rephrasing.

21 I think that's a really good point,
22 though, is referring them to more resources.

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1 Because if they say, okay, I want the Guide, but I
2 wanted to sit with other people that are going
3 through the same process. I think that's a really
4 nice point. So, whether it's directing them to
5 their state or, you know, Brain Injury Association
6 or whatever, which is in the Guide already. But,
7 yeah, because --

8 I know there's umbrella OMB related to
9 communications. And I know for HHS we can tap
10 into that. I don't know if DOD has a similar
11 process. It's just a -- it's a much shorter
12 process. But it's an umbrella. It's called
13 Health Message Testing System and it just got
14 approved last year, so you may want to look into
15 that.

16 And then, for me, I just did it and it
17 was -- actually, it only took a couple weeks,
18 which was amazing --

19 SPEAKER: Wow.

20 MS. SARMIENTO: -- (inaudible).

21 MS. MOESSNER: Okay. And other
22 comments? We can certainly carryover into

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1 tomorrow. So if you have some wonderful flash of
2 insight this evening about this issue or anything
3 else we've talked about today, we'll certainly

4 open up for a discussion tomorrow, as well.
5 otherwise, if it's okay, I think we'll
6 call today's meeting to a close.
7 Oh, I almost got the last word out.
8 Mike? I didn't quite make it.
9 MR. WELSH: Can you turn that mic this
10 way?
11 SPEAKER: Yes.
12 MR. WELSH: I don't know how many
13 meetings we've had now over the last two years,
14 but I don't think the Commander knows that it's
15 tradition that the representative from his office
16 always buys drinks for everybody at the end of the
17 meeting.
18 SPEAKER: Yeah.
19 MS. MOESSNER: Okay.
20 CDR. FEEKS: It's a shame that I don't
21 know that.
22 MS. MOESSNER: Yeah, actually, that's a

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1 good point. I think a few of us will be gathering
2 in the --
3 MR. DODSON: John Paul Jones started
4 that tradition.
5 MS. MOESSNER: Yeah, so if anybody is
6 interested in dinner or, you know, drinks or

7 whatever, I think a few of us are going to wander
8 out towards the lobby area for a little while
9 after the meeting, so please join us. We feel
10 like cause for celebration.

11 And everyone needs new parking tickets
12 from Kenesha, for those of you who have a car
13 today.

14 SPEAKER: (inaudible) for more than six
15 hours (inaudible) --

16 MS. MOESSNER: Okay. So if you drove
17 in, please see Kenesha out at the desk. Okay.

18 Okay, sounds good. Thank you.

19 (Whereupon, at 4:15 p.m., the
20 PROCEEDINGS were adjourned.)

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2 I, Carleton J. Anderson, III do hereby
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