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UNITED STATES DEPARTMENT OF DEFENSE

TASK FORCE ON MENTAL HEALTH

San Diego, California

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ANDERSON COURT REPORTING

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Alexandria, VA 22314

Phone (703) 519-7180 Fax (703) 519-7190

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- 1 PARTICIPANTS:
- 2 LTG KEVIN KILEY

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Surgeon General, U. S. Army - Falls Church, VA

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COL ANGELA PEREIRA, PH. D.
Department of Behavioral Health Dewitt Army
Community Hospital - Fort Belvoir, VA

COL DAVID ORMAN
Director of Residency Training in Psychiatry,
Tripler Army Medical Center, Oahu, HI

CAPT WARREN KLAM
Senior Medical Officer, Mental Health Director
Navy Psychiatry Specialty Leader, Staff
Child/Adolescent Psychiatrist - Naval Medical
Center, San Diego, CA

LT COL RICK CAMPISE, PH. D.
Chief, Air Force Deployment Behavioral Health
Program, Air Force Substance Abuse Prevention
Program, Air Force Medical Operations Agency
Office of the Surgeon General - Washington, DC

LCDR AARON WERBEL, PH. D.
Program Manager Suicide Prevention Program Manager
Headquarters, U. S. Marine Corps - Quantico, Va.

LT COL JONATHAN DOUGLAS
Headquarters Marine Corps Manpower and Reserve
Affairs Personal and Family Readiness Division

A. KATHRYN POWER, M Ed.
Director, Center for Mental Health Services
Substance Abuse & Mental Health Services
Administration, Health and Human Services

DEBRA FRYAR
Deputy Director of Government Relations Military
Family Association

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3

1 PARTICIPANTS (CONT' D):

2 RICHARD McCORMICK, PH. D.
3 Assistant Clinical Professor, Psychiatry Dean Case
Western Reserve School of Medicine

4 R. LAYTON McCURDY, M D.
5 Dean Emeritus, Medical University of South
6 Carolina, Past President of the American Board of
Psychiatry and Neurology, the American College of
Psychiatrists

7 SHELLEY MacDERMID, PH. D.
8 Professor of Child Development and Family Studies
and Director Military Family Research Institute,
Purdue University
9
10 THOMAS BURKE
Executive Secretary to the Task Force

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1 P R O C E E D I N G S
2 LTG KILEY: I don't have a gavel. Can
3 everyone hear me? Welcome all to the meeting of
4 the Congressional directed Task Force on Mental
5 Health. We have much to accomplish today as we
6 endeavor to have the information needed to deliver
7 the Task Force and report to the Secretary Defense
8 a continuing assessment of and recommendations to
9 improve facilitation of mental health services
10 provided to the men and women in the armed forces

11 and to their families.

12 Ms. Ellen Embrey, the designated federal
13 official of the task force's current federal
14 advisory committee, the Armed Forces Epidemiology
15 Board, had an unavoidable conflict and will not be
16 able to attend the meeting. In her absence, she
17 has appointed Colonel Jeffrey Davies, the Army
18 Surgeon General's Executive Officer, as the
19 alternate designated federal official.

20 Colonel Davies, would you please call
21 the meeting to order?

22 COL DAVIES: Thank you, General Kiley.

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1 As the acting designated federal official for the
2 Armed Forces Epidemiological Board, a federal
3 advisory committee of the Secretary of Defense,
4 which serves as a continuing scientific advisory
5 body to the Assistant Secretary of Defense for
6 Health Affairs, and the Surgeon General of the
7 military departments, I hereby call this meeting
8 of the congressionally directed Task Force on
9 Mental Health, a defense forward subcommittee to
10 order. General Kiley.

11 LTG KILEY: Thank you Colonel Davies.
12 Before we get started, I'd like to introduce
13 members of the task force, and provide a brief
14 explanation for why we're here and what we want to

15 accomplish. First, I'd like to introduce my task
16 force co-chair, Dr. Shelly MacDermid, and then I'm
17 going to ask the other members of the task force
18 to stand up and introduce themselves. And then
19 Dr. Burke has got some administrative comments.

20 DR. MacDERMID: I just want to welcome
21 you all and thank you for coming. We're looking
22 forward to learning as much here at San Diego as

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1 we have learned on other site visits. You'll find
2 that we are eager students. So I hope you'll take
3 the opportunity today to let us know your
4 thoughts. Thank you again for coming.

5 (Introductions)

6 GEN KILEY: Thank you all very much.
7 Dr. Burke, do you have some administrative
8 announcements?

9 DR. BURKE: Yes, sir, just very briefly.
10 I'm Dr. Tom Burke; I'm the executive secretary to
11 the task force. The restrooms are down the hall
12 on the right, and would you please sign in on the
13 sign in sheet outside the front door before you
14 leave. Thank you.

15 GEN KILEY: I think our intent this
16 morning is to have a presentation. I'll introduce
17 the speaker in just a minute, for one hour, until
18 about 9:45, at which time we'll break from this

19 open session for a closed session for the task
20 force. And then I think we re-open at 1:00 this
21 afternoon.

22 COL DAVIES: 11:00.

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1 GEN KILEY: Here in this room again.
2 Our intent of course is to go around the nation,
3 around the world, examining and asking members of
4 the general community, family members, medical
5 community, their perceptions, concerns that
6 programs, policies and procedures with regard to
7 mental health and mental health services. The
8 group has been doing an outstanding job at that.
9 And this visit the San Diego and Camp Pendleton
10 and Balboa is another example.

11 This morning we've asked Commander Mark
12 Russell to give us a presentation based on his
13 view from the military health care system
14 regarding mental health. I'm going to introduce
15 Mark now and work the computers, and ask him to
16 introduce himself and tell you a little of his
17 background. Thanks very much for being here. The
18 floor is yours.

19 CDR RUSSELL: General and task force
20 members, it's an extreme honor to be here today.
21 It's a little bit overwhelming. This is not my
22 typical day of work is to come up in front of this

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1 crowd and give this kind of presentation. My name
2 is Mark Russell, I'm a clinical psychologist.
3 I've been in the military for about 24 years. I
4 was enlisted in the Marine Corps 1979, and for 10
5 years I was working on jets. I broke more than I
6 fixed, so I decided to get a different job and got
7 into psychology and went and got my Ph.D. from
8 Pacific Graduate School of Psychology in Palo
9 Alto, and then came in the Navy. I did my
10 internship at a Navy hospital, Medical Center
11 Portsmouth, and ending up having a wonderful
12 career. My family has historically been in the
13 Marine Corps. My father's a retired Marine,
14 enlisted for 27 years. My brother's are in the
15 military. One is in Afghanistan right now. I
16 have a son who is a corpsman with the Marines in
17 Okinawa, and I have a son who's in the Pentagon,
18 who is an enlisted Marine. So being part of the
19 warrior class is part of my blood. Again, it's an
20 honor to be here. So we'll go right into the
21 presentation and try to leave room for questions.

22 The first slide just says, and I think

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1 everyone knows that wearing a uniform in the
2 military presents many occupational hazards.
3 Whether it's going to combat, or if it's accident
4 due to training, if it's humanitarian, or disaster
5 relief, peace keeping, typical things, motor
6 vehicle accidents that can happen to anybody. So
7 being exposed to traumatic stress is one of the
8 hazards that we have in uniform. And so given
9 that that's the case, the DoD military medicine is
10 in particularly in a unique position to really
11 advance the science of understanding the nature of
12 traumatic stress, the assessment, prevention and
13 treatment.

14 When I refer to a perfect storm is
15 partly why we're here today, is that what are some
16 of the issues that we're facing. And what we'll
17 realize, I think most of us, is that this isn't
18 anything new. This is something that recurs,
19 repeats itself throughout history. One, we have
20 an overwhelming demand, or a very high demand.
21 Second is that there is a lack of access to
22 quality mental health care. And then, thirdly, is

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1 that there's an undercurrent, and I say
2 indifference, it's really more that society has

3 indifference or sometimes intolerance towards
4 mental health and mental health illness, and so
5 there's a disparity. And these three things I
6 think constitute a perfect storm.

7 I'm going to go into this. These are
8 the experiences that everyone has seen. It was
9 presented in 2004 in what the folks who are
10 deployed what they're experiencing on a regular
11 basis.

12 These are table that shows the number of
13 deployments. We are now tracking people who are
14 in their fifth deployment, but on average you're
15 seeing folks with maybe two deployments underneath
16 their belt. So you have an intensity of combat
17 experience as far as number of exposures and you
18 have duration, both issues that we know that add
19 up to a higher rate of mental health problems
20 afterwards. OEF, Afghanistan, where my brother is
21 currently serving, we see there's an increase both
22 in wounded and killed in action, so that, again,

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1 should give us reason to expect the mental health
2 demand will only increase.

3 This is where I'm at in Iwakuni. I'm
4 the only psychologist in the Marine Corps air
5 station. Luckily about 6,000 people on the
6 pediatric psychologists, run the EDIS programs for

7 the Navy in Japan. So this is just active duty
8 and adult mental health care. And you can see
9 each time it's exploded as far as the prevalence.

10 And this is just more statistics as far
11 as on the base. It's not just what I'm seeing;
12 it's what the Marine Corps of family services are
13 seeing, MCCF, the alcohol treatment, domestic
14 violence, the things that have already been
15 reported.

16 This is what the VA is seeing. This is
17 kind of dated somewhat, but relatively out of the
18 600,000 folks who have gone, deployed, and
19 separated from the military about 200,000 or so
20 are seeking help through the VA. You can see the
21 primary reason is for musculoskeletal disorders,
22 mental health disorders about 32 percent, and

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1 ill-defined symptoms or aka psychosomatic illness
2 about 30 percent. So we have a large number of
3 people getting help coming back from the war for
4 mental health related issues.

5 In 2004, we published the VA/DoD
6 clinical practice guidelines for managing PTSD,
7 which are outstanding, to say the least. They
8 identify four psychotherapies that were strongly
9 recommended as evidence based. They had enough
10 research that say these are the four primary

11 treatments that should be offered to provide
12 quality care. As far as acute stress disorder,
13 the question is: Well, what is the treatment of
14 choice? Really, there is no treatment of choice.
15 We don't know enough about how to treat acute
16 stress disorder which is the immediate aftereffect
17 after someone's been exposed to traumatic stress
18 who hasn't resolved in a couple of days, they go
19 on and develop --

20 Percent of these folks go on to develop
21 PTSD. So we don't really have a treatment of
22 choice for that condition yet.

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1 These are the guidelines. And you can
2 see there are four on the significant benefit.
3 These are four of the most highly recommended
4 cognitive therapy, exposure, stress inoculation,
5 EMDR.

6 And the guidelines say very specifically
7 that psychotherapy should be provided for
8 practitioners who have been trained in these
9 particular treatment methods, which makes sense.
10 If you're going to provide a treatment you have to
11 have some training, maybe, supervision as well to
12 see that you can do that effectively. So I
13 conducted a survey when I got back from my
14 deployment. In 2003, I went to Fleet Hospital 8,

15 Bremerton. At that time we had a -- we weren't
16 really sure what our mission was. In fact it was
17 said to me that they weren't even sure why mental
18 health was even on the deployment. I knew that
19 mental health had to play a role, obviously, which
20 is why I was eager to be a part of the team. But
21 one of the concerning things is when we augmented
22 our staff of psychiatrists and with other mental

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1 health folks, most of them said they had no
2 training in how to actually treat and manage PTSD,
3 acute stress disorder, which of course are some of
4 the predictable outcomes of combat.

5 So I surveyed 133 mental health
6 providers in DoD across different disciplines,
7 psychiatry, social work, psychology, across the
8 services, and roughly 90 percent reported they had
9 not received treatment or training according to
10 one of those four highly recommended treatments.

11 I conducted that survey because I knew
12 that if I just went to my superiors and said,
13 "Look, we need to do training," that that wouldn't
14 probably cut it. Some people need to see data, so
15 that's why I did this survey and try to alert
16 folks that there is a problem with training in
17 order to meet the oncoming need that's going to be
18 demanded. So I went, and actually with a team a

19 folks in the VA, we did a grass-roots training
20 project where we did some EMDR trainings, myself
21 and Steve Silvers from the medical center in
22 Pennsylvania. And we went out and did some

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1 trainings to different regions, and we looked at
2 outcomes of those trainings.

3 So altogether we did a total of 10
4 trainings. We had 257 participants. And these
5 trainings were at -- the first one was at Fort
6 Lewis up in Washington State, then we had one in
7 Great Lakes, and NAS Brunswick, Maine, Navy
8 Hospital Bremerton, where I was home based at that
9 time. We had a second training at Fort Lewis, one
10 in San Diego, orchestrated here by Captain Klam.
11 And then we had Camp Pendleton, and Fort Hood,
12 Texas, a total of 257.

13 So we provided them this training. This
14 is EMDR, which is one of the four types of
15 evidence-based treatments recommended, and we
16 asked them to go back after they completed
17 treatment, do the chart reviews to send back some
18 information on the outcomes of these completed
19 treatments. So we got some -- this was obviously
20 a very biased sample, but we looked at a mean
21 number of sessions was about 4.3. There's 48 been
22 diagnosed with combat-related PTSD out of OIF,

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1 OEF. And the pretreatment SUDS is a zero to ten
2 scale, ten being the highest rate of anxiety. And
3 then we have VoC is their level of confidence at
4 the time, so it's on a one to seven scale. This
5 is pre-treatment and this is post. So you see the
6 SUDS went down and the confidence, more positive
7 cognitions went up with this very brief treatment.

8 This is an impact of events scale is a
9 PTSD survey and the BDI in these same 48 veterans,
10 and you have impact event scores, pre/post and
11 then you have Beck depression inventory pre/post.
12 So, again, wanted to present this information is
13 this is one way we can do this training to provide
14 people training. We take trainers, we go to the
15 regions, we did this training for VA, for DoD, for
16 civilian contractors. Everybody in that region
17 was able to come to this training and get this
18 training at a very reduced cost, saving hundreds
19 of thousands of dollars on TAD funds to provide
20 that training and it was very efficient.

21 Some other concerns that have come up in
22 my looking at this issue; one, is that we offer a

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1 lot of web-based alternatives, a lot of hotlines,
2 and these are the things that are outstanding and
3 are applaudable. What we don't know though is
4 what is the quality of that kind of information
5 that's being given out, what the quality of that
6 treatment that's being provided by these contract
7 services. If we don't have uniformed providers
8 who are adequately trained in mental health to do
9 that we have to make sure that the civilian people
10 we're contracting have that training. We don't
11 have a standardized way of assessment, so we have
12 a lot of false positives, people are being
13 diagnosed, and they really shouldn't be diagnosed
14 in a 30-minute visit or so. We have folks who are
15 getting false negatives. Again, people aren't
16 having the training, they don't have a
17 standardized right now in DoD, how we go about
18 assessing whether people really meet the criteria
19 for PTSD or acute stress. We have a problem with
20 monitoring in terms of what's been reported
21 already about the post- deployment health
22 assessments. We don't really monitor treatment

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1 progress. We don't know who is getting treatment,
2 are they getting better or not? With what

3 treatments? We don't really know that question.
4 So then we ought to be looking at it. We also, as
5 I mentioned, we don't have enough mental health
6 related training for mental health providers, but
7 also just in general. Primary care providers are
8 the primary point of contact in these
9 post-deployment assessments. The majority have
10 not been trained in how to do these
11 post-deployment health assessments. So when they
12 don't refer, as was reported in the GAO, reported
13 in May of 2006, the majority don't get referred,
14 partly, maybe, because they don't really know what
15 is the protocol and what they are looking for.
16 And troops themselves don't have a lot of training
17 as reported by the MHAT that was done in 2005 as
18 far as combat stress. The troops were asked and
19 they did need more training on that, as well. And
20 the lack of coordination and awareness within the
21 mental health community, I'll touch on that a
22 little bit later.

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1 Front line psychiatry. We have, I
2 think, been unprecedented in trying to prevent
3 PTSD and other chronic problems by forward
4 deployment of mental health. We have
5 unprecedented numbers -- I don't know the numbers,
6 but I just know there's a lot of people over

7 there. And what I do know is that also the
8 literature is not really clear though if this
9 really prevents PTSD or not. We don't know. One
10 of the things was, in my first slide is, have we
11 really seized the opportunity in terms of
12 researching that? Are we following up these folks
13 who are getting help on the front lines when they
14 come back, and we're seeing what types of
15 interventions work to prevent problems, which ones
16 didn't as far as the front line efficacy?

17 This is part of that of that MHAT survey
18 that was done in January '05, too. And they've
19 reported that regarding compassion fatigue or
20 burnout of the health care providers, the healers
21 themselves, roughly 33 percent of the behavioral
22 health personnel they surveyed reported high

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1 burnout. 27 percent had low motivation, 22
2 percent low morale, and 15 percent said their own
3 operational stress was inhibiting their ability to
4 provide quality care. These are the folks on the
5 front lines.

6 The reason why that is an issue is
7 because it's having a problem with attrition of
8 mental health providers. And this is where I
9 think we're running into the crisis. We have an
10 increased demand; we're having fewer people

11 available to provide services. And I used the
12 Navy psychology, because that's the only data I
13 know firsthand, is we have 135 billets, currently
14 we have 80 filled, which is about 59 percent. 12
15 of those, though, are in training and 68 are
16 actually deployable, 10 of those are on carriers.
17 So about 58 are going to be deploying to Iraq and
18 Afghanistan as well as provide garrison care back
19 home. Roughly five a month are retiring or
20 getting out after their first contract. So we're
21 losing people very quickly. And it was told to me
22 that the Navy's doing better than the other

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1 services in that area, I don't know who's better
2 or worse, I just think that we're all kind of
3 hurting right now. I think that's pretty evident
4 in terms of what we do at staffing.

5 Then lack of mental health parity. This
6 I say is the root of all evils. I think the
7 reason why we're repeating history is due to the
8 lack parity with mental health. This is just not
9 in the DoD, this is in society, this is in our
10 society, this is across culture, so this not
11 something unique to the DoD.

12 This is some evidence for mental health
13 disparity. We don't have regional treatment
14 centers other than what I've learned at Walter

15 Reed, which is certainly one of the premier
16 centers in San Diego. We've got great treatment
17 centers, but there's really not regional centers
18 are set up the same way we treat amputees and we
19 treat people who have severe burns in the DoD.
20 When people don't get better at the front lines,
21 they don't get better at the garrison care, there
22 ought to be some regional treatment centers where

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1 they do go get state of the art treatment,
2 evaluations and treatment before they're separated
3 from the service. We don't really have that type
4 of a program set up that I'm aware of.

5 Non-medical mental health providers.
6 Most psychotherapies provided by psychologists,
7 social workers, counselors, pastoral care,
8 chaplains, and psychiatrists as well, there's a
9 glass ceiling. I do not know of any flag-level
10 officers who were psychologists. I don't know of
11 any flag-level officers who were social workers.
12 There might be, I'm not aware of it. I know for
13 psychology there hasn't been that I'm aware of a
14 flag-level officer. It just seems to be a glass
15 ceiling in terms of career opportunities. There's
16 also disparity in evaluation and promotions. We
17 have MSEs the psychologist and social workers are
18 lumped with the MSEs and this means we have to

19 compete with administrators for promotions. And
20 we're losing a lot of good people, because they're
21 not getting promoted, or they get a bad fitness
22 report and they feel dejected and they're ready to

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1 get out. So we're losing good people because the
2 standard of how we evaluate psychologists and
3 social workers is different than how we evaluate
4 psychiatrists, who are part of the medical corps.
5 I think this is again part of the disparity. Also
6 in terms of incentives and compensation, the
7 mental health providers -- the maximum we can get
8 for psychologists and social workers, and
9 chaplains I believe don't get any bonus, is that
10 the specialty bonus about \$2,000 annually for 10
11 years or less. 5,000 total for ten years or more.
12 In the medical services since -- psychiatry, for
13 example, 15,000 annually is given. They have
14 special pay for just being a psychiatrist, for
15 being a dermatologist, family practice, pediatrics
16 are getting 12,000 a year. Then they have board
17 certified pay on top of that, if you get board
18 certified in those positions. For the
19 psychologists and social workers the only way
20 you're going to get those bonuses is if you are
21 board certified. Roughly about 11 percent get
22 board certified. So we have a lot of people who

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1 months ago mostly forward deployed are going to be
2 your psychologists, and social workers, and
3 psychiatrists as well. But the ones doing a lot
4 of psychotherapy aren't getting the kind of
5 incentives to stay in.

6 This was supposed to be one slide. Name
7 one medical innovation by DoD as far as research?
8 What have been some things? And the list is
9 impressive; plasma, use of the med evac
10 helicopters, blood transfusions, new band-aids.
11 We're saving 93 percent, I understand. Physically
12 wounded are coming back who survived these wounds.
13 This is unprecedented. This is something
14 outstanding, because we learn from the battlefield
15 lessons. But the next slide will ask the
16 question: What about mental health innovations?

17 What have we learned from military
18 medicine with regard to mental health? We've been
19 fighting wars as long as -- since 2000 B.C. as far
20 as the history of the world goes, what do we know
21 about the effects of warfare? We know it messes
22 up your psychology sometimes, your biology. What

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1 have we done to fix it? Nothing in military
2 medicine is really advanced. And PIES was
3 something that we do for the front line isn't a
4 treatment for PTSD. So what have we done to
5 actually research that? This is something I did
6 when I was in the fleet hospital. I saw four
7 people, two of which had acute stress disorder in
8 a fleet hospital setting using EMDR in a single
9 session, and these are the pre/post impact event
10 source. This was published in 2004 Military
11 Psychology. Since that time I know of no other
12 studies that have been published or being
13 conducted on how we treat an acute stress
14 disorder.

15 Again, this is the same slide, but I ask
16 why is there no follow-up? There's also a bias
17 about this idea about EMDR which I won't go into
18 here. And I'm not saying this is a panacea, this
19 is not going to cure the world, but we ought to
20 have all tools open, we ought to be researching
21 every possibility, but what might help people and
22 not eliminate one just because of academic bias.

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1 So this is my effort, as I say,
2 screaming in a storm. Since 2003, I've written 27

3 memoranda, point papers and data-driven reports,
4 like I've alluded to, with over 50 contacts. Did
5 the surveys, did the training with the VA actually
6 showing what the results are when you provide that
7 training and the efficacy of those treatments. So
8 I've been trying really hard to get this
9 information out so we can start fixing some of
10 these problems, and I think that's part why I'm
11 here.

12 So the question is carpe diem, did we
13 seize the moment? Are we going to look at the
14 recommendations from this task force we'd be
15 looking at symptom reduction? We're going to
16 treat the symptoms or are we actually going to go
17 for the cause? To me this is an opportunity. We
18 are in a crisis, it's going to get worse, but I do
19 think that we can do something now that's going to
20 mitigate it and also do some long-term fixes that
21 are going to advance and do good for the majority
22 in long term.

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1 So what I offer is that we do something
2 very bold, very creative, very outside the box,
3 and use this opportunity to actually fix something
4 long term and to right a wrong. And the DoD has a
5 history of doing this with racial integration,
6 with gender equality; now the task at hand is to

7 eliminate the stigma of mental health and the
8 disparity of mental health. And so this is what I
9 challenge us to do in DoD is to find ways that we
10 attack that (off mike). And one way to do that is
11 this new vision for DoD or unified medical
12 command, whatever it comes in, that we really need
13 to pull together and look at how we're going to do
14 some groundbreaking mental health and actually try
15 to fix the system of disparity. DoD is in a
16 position to become a world leader in the research
17 and advancing science of mental health and in
18 treating post traumatic stress. I challenge us to
19 make that a reality, to pick up that challenge,
20 become a premier leader to benefit not only the
21 DoD and people who serve, but also societies
22 outside who would benefit from that.

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1 This is the initiative to advance mental
2 health science and eliminate stigma. As you see
3 these are brain imaging scans that have been done.
4 These studies have been done for a few years now,
5 showing that PTSD is not a mental illness in the
6 sense that it's something that's kind of in the
7 gray box, or black box, it's actually in the
8 brain. You can see it lit up on these scans.
9 When you see pre/post, pre-treatment, post-
10 treatment, as well then we know that maybe we have

11 some way of demonstrating efficacy as a therapy.

12 This is the proposed vision for DoD
13 medicine. Since we're all frequently exposed to
14 occupational hazards of traumatic stress that we
15 become the leading experts in this area and that
16 -- well, anyway, I think I kind of restated that.
17 That we're going to attack stigma, we're going to
18 eliminate barriers of care by addressing the
19 leadership issues, and making sure that the stigma
20 of mental health is a priority.

21 Again, we're assessing to be a premier
22 leader. We're going to eliminate the false

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1 dichotomy of mental health and physical health,
2 because we know that the brain and the body are
3 connected, right? And that's what we're going to
4 be pursuing now is a period of enlightenment as
5 opposed to continuing in the dark ages.

6 We know the costs of delayed treatment
7 or no treatment is staggering. I mean, people go
8 in the VA, by the time they get to the VA a lot of
9 these folks can develop chronic problems. The
10 idea is to get it while they're in service, and
11 that the very few would have to get separated,
12 hopefully, from conditions like PTSD if we can
13 treat it effectively while they're on active duty.

14 So for leadership what I purport is that

15 a flag-level officer is appointed as head of this,
16 and the more stars the better. If we got someone
17 like General Kiley here, it would be outstanding;
18 I know he's got a lot of other jobs besides having
19 to deal with mental health. But we need somebody
20 who can really be an advocate for and
21 compassionate about fighting the stigma of mental
22 health. We have definite recommendations on this,

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1 but this really requires top down. This goes not
2 only from the military but from the civilian
3 leaders as well to really get out in front and say
4 we have a long- term history in this society as
5 well as others to destigmatize mental health and
6 we're going to fix that. I recommend that we
7 establish a separate corps; call it behavioral
8 health science corps, call it mental health corps,
9 probably the former, but have that as a separate.
10 We have medical corps, you have nurse corps, you
11 have chaplain corps. Rather than lump us all in
12 MSC, medical service corps, I think we ought to
13 include a special corps that is separate and give
14 it more esteem and more elevated status than what
15 currently exists.

16 This would also help equate mental
17 health care with physical care instead of us kind
18 of being in the lower echelon. I won't go into

19 that. We need instructions, obviously. We need
20 something -- if we're going to submit policies
21 like post-deployment health assessment, we say
22 we're going to do these; we need some way to

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1 follow up and hold people accountable when they're
2 not doing it. Fact is that we're not doing as
3 good a job as we could on post-deployment, and
4 we're talking health assessment and following the
5 guidelines. So we need some way to enforce that.
6 And the best way to avoid history repeating itself
7 is by, I think taking the steps to cure the
8 problem which is varied disparity.

9 As far as staffing fixes, I recommend we
10 take an immediate stop-loss in mental health
11 providers. I submitted my retirement, Captain
12 (off mike) over there got her retirement in; we
13 can't really afford to lose us right now. Right
14 now I'm the only DoD trainer in EMDR who's
15 certified to train. We need other people who are
16 trained, not only in EMDR, in cognitive and
17 exposure, any other new treatments. We start
18 losing people like we are, we're losing the brain
19 drain, we're losing the experience, it's going to
20 hurt us even more. So I would recommend a stop
21 loss goes in effect immediately. And I'll explain
22 it to my wife when I get back to Japan. I

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1 recommend for COs to do -- the MTFs to do a
2 survey. What is the mental health needs to meet
3 the current and future demands that are going on?
4 And when you look at staffing, make sure that
5 we're looking at standard of care. In
6 psychotherapy, if you're trying to provide
7 cognitive therapy according to guidelines, it's
8 like weekly therapy. 10 weeks, 12 weeks, and
9 there's no way in here -- and I'm a psychologist,
10 I'm a grunt, I'm in the field seeing patients.
11 You can't provide that therapy. You can't provide
12 weekly follow up. It's because the limit in staff
13 and increased demand. So we need to look at that.
14 We need to establish specialty pay for mental
15 health providers that would include chaplains as
16 well. But in addition to the board certified
17 incentive we need to provide other types of
18 incentives like the MPSP that's available in the
19 medical corps. And I would make it retrospective.
20 If you're going to do a stop loss, people's morale
21 is going to go down, and they're not going to be
22 happy about it, we also need to send a message

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1 that we'll revalue you. We want you to stay in,
2 and have incentives for these people that stay in,
3 and also recruitment bonuses to get people to come
4 in, because right now we can't recruit people,
5 qualified people, to come in. We're getting
6 people to come in, the quality is suspicious.
7 Some, we have some good folks, but in some cases I
8 could -- I won't go into examples, but we need to
9 do a better job of getting quality people and we
10 need to do it by offering incentives. That's
11 enough of that.

12 So we increase the numbers of
13 well-qualified staff. We need to survey mental
14 health providers about compassion fatigue. I see
15 the APA Division 18 website and everyone I talk to
16 feels pretty much the way I do. I'm one of those
17 who's in the compassion fatigue -- I'm a textbook
18 case, and I won't belabor that. But it's rampant;
19 we need to do something to help people. Why are
20 we getting so overworked and overloaded, and how
21 can we help that? And this needs to be addressed
22 I think immediately. And then we have to make

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1 sure that all DoD, DVA, civilian contractors all
2 receive adequate training and, again, that

3 regional model is one way I propose that we do
4 that.

5 Increase public awareness. And these
6 are according to the elements of the task force.
7 I see a lot of TV spots, a lot of different
8 issues, sitting in Iwakuni AFN, but maybe one I
9 see about PTSD, and usually it's a voice that you
10 hear. It's not a public figure. You know, it's
11 not a surgeon general, it's not a secretary of
12 defense type of person, it's some kind of a
13 reporter doing a spot. We need to get top leaders
14 visible and out front speaking about the issues of
15 mental health, and that we're going to treat this,
16 and we're going to treat this issue about stigma.
17 There needs to be a lot more frequent public
18 spotting of these types of ads. We need to
19 educate the public and the troops on the
20 neuroscience of mental health to eliminate the
21 stigma. If they know it's in the brain, they can
22 see pictures of brain imaging, and show that PTSD

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1 is in the brain and then maybe they won't think of
2 it as being so weak-willed and something that's
3 kind of a mental illness or a weakness. Again, I
4 don't have much time to go over all these, but
5 we'll go over it later.

6 This is the new paradigm. I know we

7 talk about public health paradigm, that's needed,
8 you know, public health approach (off mike)
9 absolutely. We also need to get neuroscience
10 involved with mental health, and get the myth, the
11 mysticalness out of it and look at it in more of a
12 scientific way.

13 We need a lot more training, of course,
14 on this issue of PTSD. We don't have any GMF
15 mandatory training. We do CBRNE with the
16 chemical, biological, nuclear -- everyone's done
17 that in active duty, right? How many of us have
18 completed mandatory on post-deployment health
19 assessments, or on treating PTSD? We don't have
20 it mandatory, we mandate it on the physical side
21 of it, we haven't done that the same on the mental
22 health side. And post-deployment health

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1 assessments is a big project. A great project
2 that was unprecedented, but we're not enforcing,
3 we're not really monitoring is respectively. We
4 need to get people trained on how to do that.

5 Looking at efficacy of these programs we
6 look at our front line policy. We're sending a
7 lot of people out, we're burning people out,
8 mental health providers; do we need as many people
9 there? Are they utilized as often as they can be?
10 What happens right now is when we pull people out

11 of the hospitals back in the states, or in Japan,
12 or overseas to the front lines, there's nobody
13 going back and replacing these people where
14 they're coming from. So when these people come
15 into those centers at CONUS or overseas to get
16 care, get treatment for the post-deployment,
17 there's nobody there to provide treatment or they
18 don't have access. They have to wait a month or
19 two months to get care. So our front-line policy
20 right now is we're robbing Peter to pay Paul, and
21 it's not working. We need to pay both Peter and
22 Paul. So I would just recommend really ramping up

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1 our mental health resources, ASAP. And we need to
2 mandate that health care providers get training on
3 post-deployment health assessments, on PTSD, on
4 ill-defined medical symptoms. Next to
5 musculoskeletal injuries, right, which is the
6 highest reason people go to the VA, mental health
7 is the second highest. And ill-defined medical
8 problems is the fourth highest. So we need to be
9 training on that, and everybody needs to have
10 that, from troops all the way to medical
11 professionals.

12 Same thing goes with the online,
13 hotline, civilian contractors. We need to make
14 sure they have some training so that we know what

15 the quality of feedback that they're giving our
16 troops is, and that it's just not deferred out
17 them. I recommend that we develop a certification
18 continuum in the DoD. Right now it's presumed if
19 you wear a uniform like I do, I'm an expert in
20 PTSD, combat PTSD. When I went through
21 internship, I had no training combat PTSD, the
22 majority of people don't. Now they started it,

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1 how to treat it. I'm not talking about PIES and
2 that kind of thing, I'm talking about how you
3 actually treat, assess, diagnose and treat acute
4 stress and PTSD. We don't get that training. We
5 ought to have it. Everybody who wears a uniform
6 ought to be an expert. It shouldn't be just the
7 members of the task force or someone like me
8 coming up who has some expertise, it should be
9 everybody. We should train for experts, and we
10 need a continuum of that training starting from
11 its infancy.

12 We need to develop standardized
13 assessments. Everyone's a little afraid of
14 saying, "Okay, we've got to use this tool versus
15 that tool." I just say we don't have time for
16 that. I could meet with two or three of you or
17 you could meet with yourself, you can probably
18 pick out a couple of assessment tools, and

19 surveys, some of the measures we're going to use,
20 and that's it. We're going to go with that. We
21 can refine it later on, but we need to have some
22 way of standardizing how we assess -- and it

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1 should be consistent with what the VA does so
2 there's a seamless transition. And one of the
3 things I'd recommend is that PTSD is not diagnosed
4 in one visit that you recommend at least two or
5 three visits and there's some documentation on
6 impairment. Again, we don't do that. We get very
7 mixed results on that.

8 I recommend that we do that regional
9 combat operational stress treatment centers.
10 That's referred -- if it's Walter Reed that you
11 get Navy, Marine Corps, Air Force, DoD, civilians
12 come in there. But we had to do more than Walter
13 Reed of San Diego; we need to have regionals to
14 have access. So I recommend that we develop
15 those, probably in concert with the VA. Use of
16 neuroimaging and other kinds of advanced sciences,
17 we need to really kind of up our use of those.
18 Establish a continuum of mental health care and
19 the public health I already mentioned. I think
20 that's enough. I'll go with that.

21 We need a central point of contact to
22 kind of help glue this together, and that's why I

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1 said we need a flag officer appointed, have a
2 separate corps for behavioral health sciences.
3 And the DHHC, I think it is, deployment health
4 centers has got a great website. We've got
5 website on a military one source, but there's no
6 glue to kind of keep it together. There's a
7 disconnect. So we need to be able to provide
8 information to everybody, make sure we're all on
9 the same page and that hasn't been done. And the
10 VA centers, the research is very unfriendly to
11 those of us in the field. When I was printing
12 together a proposal to do a follow on with the
13 research I've done, I'd do a 15-page application,
14 had to complete all these trainings, and I'm
15 seeing patients from morning to afternoon. I
16 don't have time to go through all those steps.
17 And I was even told that just to survey mental
18 health providers -- what treatments are you using?
19 Is it working? What is your level of
20 satisfaction? I had to get an IRB approval. It's
21 just so onerous; it's prohibitive, so the only
22 ones doing research are the research centers. And

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1 if you want to look at disparity, go and look at
2 the federal level of research, how much funds are
3 going to mental health, look at DoD military
4 medicine and research, how much is being spent and
5 done in mental health compared to physical health,
6 it's overwhelming disparity. And you look at
7 combat PTSD, combat acute stress disorder; you
8 know the amount of research that's been done is
9 very miniscule, when you look at the comparative,
10 so we need to really ramp that up.

11 This is some of the slides that studies
12 have been done with this EMDR and I think they're
13 doing some with cognitive therapy as well, I just
14 didn't have those resources, but pre/post changes
15 using brain scans, SPECT scans understand
16 functional changes in the brain pre/post with
17 successful treatment. Now, these are -- the study
18 I did are flawed because they're small samples and
19 so on, but this should already give us a way in to
20 kind of help us attack this problem in a more
21 serious way.

22 I already talked about research. I

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1 think we can go on. One of the things on that
2 slide was that when people come in the military,

3 recruits come in; we don't do a very good job of
4 screening them, we ask them questions. I
5 recommend that we do a comprehensive history of
6 their psycho-social, looking at all those
7 vulnerability factors that we all know about,
8 maybe do testing, and we track these people
9 throughout their career and when they separate.
10 We've got an ideal opportunity to do longitudinal
11 research of an unprecedented scope, and we're
12 missing this opportunity. Right now our
13 pre-deployment assessments ask one question: Have
14 you seen a mental health provider in the last
15 year? That's useless. We really need to know
16 something that's going to help us identify people
17 who are at high risk, provide combat, operational
18 resiliency training and basic training as a
19 continuum throughout the military career. This
20 ought to be part of GMT, ought to be part of basic
21 training.
22 OCONUS, the problem with families. I

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1 can tell you that families aren't getting a lot of
2 mental health services because most of us are
3 deployed or overstretched. We also have problems
4 with recruiting in the family service centers,
5 because they get a GS-11 pay and not many people
6 are willing to come, or the quality people aren't

7 willing to come uproot their lives for GS-
8 Pay, so I recommend we do 12 and try to
9 get quality providers, especially overseas. And
10 then we have to make sure these people get
11 adequate training.
12 Public awareness. I think we can skip
13 that. This is just more issues about how we
14 reduce the barriers of care, and I've already
15 touched on that.
16 The expectation here is that if you go
17 to combat, you go to operational stress; you
18 develop a condition, some type of mental health
19 condition that we're going to treat it. The
20 expectation is to return to duty, just like we
21 have with the front line. So very few people
22 ought to be separated and go right into the VA as

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1 has been the case. But we can't treat it, so what
2 we do is we separate them. The time for treating
3 is while they're in service where they have the
4 support available and they're wearing a uniform,
5 that's time we treat them. We've got to treat it
6 aggressively. We treat it at the front lines, if
7 that doesn't work you go to the garrison and
8 provide treatment at the local level, and if that
9 doesn't work they go to a regional center. And if
10 that doesn't work then you have a way of assessing

11 disability and they can get a seamless transition
12 to the VA. I think I'll skip that. I think we
13 covered that already.

14 Outreach to families. We've got great
15 resources, but again it's all -- they've got a lot
16 of internet resources, but there's not a glue to
17 keep it together. I recommend that we set up a
18 deployment health center at each base, and I think
19 this has already been talked about, and some have
20 it, where there's a central point of contact that
21 does all the post- deployment health screenings
22 and re-screenings. When families go in deployment

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1 -- before they go in deployment there's briefings
2 done, there's an individualized case manager that
3 sets up with the family that develops an
4 individualized family plan and support,
5 pre-deployment, during deployment, they follow up
6 -- that case manager follows up with the families,
7 plugs them into the resources. Post-deployment
8 they meet with the family and the service member
9 and they look at integration in providing these
10 services. We did that EDIS; we already have the
11 model for this program. If we do what we can do
12 with EDIS and do that with mental health and have
13 a service coordinator provided, and we do that
14 transition assistance from one agency to the

15 other, I think you'll provide a lot more
16 coordinated, comprehensive care. I also recommend
17 that the DoD align with the task force that
18 Commander Johnson is going to talk about, APA test
19 for some family mental health, that we have to
20 start connecting dots. Right now we have a lot of
21 dots that are disconnected.

22 Substance abuse is the same kind of

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1 issue. We have a lot of people who aren't getting
2 treatment. We don't have enough people qualified
3 to treat, not enough staff to provide treatment
4 because they're being pulled out and they're doing
5 different duties. So we need to have more
6 training in that area. Then the transition I've
7 already talked about and I won't go into that.

8 Long-term follow up; this is the same
9 thing. The idea is that we're going to track
10 people when they come in the military to the time
11 they die. So if they come in the military, we do
12 this assessment, we get a good idea of the
13 premorbid factors, what they're life is like, do
14 some testing, whatnot. We follow them up
15 throughout their career; we do all these
16 post-deployment reassessments that are being done.
17 They go to the VA, the VA keeps records, and we
18 have a way of documenting and tracking what the

19 progression is to a person's career, and also the
20 impact on the family members who are in that kind
21 of a system as well, because we're meeting with
22 the family too. Again, an unprecedented

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1 opportunity to actually get our arms around this
2 issue.

3 The collaboration piece, I think I've
4 already spoken to and I won't go into that
5 anymore. And resource sharing, I think we can
6 skip, I've covered that. I want to leave it open
7 for questions.

8 Commanders need mental health training.
9 There's a lot -- there are trainings available for
10 Navy, Army, commander leadership training on
11 management of PTSD, or management of combat
12 stress, but they're not mandatory. They ought to
13 be part of basic officer school, basic leadership
14 school for NCOs as well as officers. And it ought
15 to be, again, from basic training all the way
16 through the end of your career you ought to be
17 getting these refresher courses, and not wait
18 until you're in war, but this is part of our
19 peacetime plan as well, keeping ourselves
20 prepared. I already talked about the deployment
21 screening. I think I won't go into that.

22 Languages. I think that was another

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1 element. I don't know of any of these services
2 that have been translated into Spanish, but
3 certainly that seems to be something we could do
4 with Spanish and a couple other languages that we
5 see commonly.

6 And the idea is carpe diem. When I was
7 thinking of this in my room last night, I was
8 trying to think of a way to summarize what are
9 some of the problems. I can think of one way to
10 do it, and this is the three Ds, and no one has
11 probably ever heard of the three Ds, but it will
12 be a new vernacular to introduce.

13 The first D is that we have a
14 disconnect. There's a disconnect between
15 disciplines. Psychologists don't talk to
16 psychiatrists, psychiatrists don't talk to social
17 workers, and psychologists and social workers
18 don't talk. So within the disciplines we don't
19 talk. There's no coordination of training of
20 policy, very little, I should say. And then even
21 within the disciplines, I'm a psychologist, but I
22 don't have a lot of interaction and connection

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1 with my peers. So many of us are feeling isolated
2 and that can add to compassion fatigue. So we
3 need to connect the dots. And then there's not a
4 lot of talk across the services, the Army, Navy,
5 Air Force in terms of mental health providers.
6 We're all kind of disconnected. There's DoD and
7 the VA somewhat disconnected, we're working on
8 that. We've got a lot of disconnects. We've got
9 to connect the dots and streamline things so that
10 we're connected. I think that should help. The
11 second D -- let's see, the first was disconnect.

12 The second is diffusion. There's a
13 diffusion of responsibility, because you have so
14 many different agencies that are responsible for
15 different parts of the pie, there's no glue to
16 hold us all together. You have active duty mental
17 health and behavioral health, and then you have
18 the family service centers, you have the alcohol
19 treatment centers, you have the new parent support
20 programs, and all these other programs, all these
21 support programs, but there's no cohesion, there's
22 no coordination amongst them. So one of the

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1 recommendations I put in there was that we find a
2 way to connect these dots to eliminate the

3 diffusion. The other part of diffusion is when
4 you have problems like we're having; whose
5 responsibility is it to fix it? Navy can't fix
6 Army's staffing problems; Army can't fix Navy's
7 staffing problems. Army does a lot more training
8 in mental health than the Navy and the Air Force
9 do, but we can't -- they can't compel us to do
10 their training, it's already available, but we
11 don't do it. So each of the services are
12 developing their own policies by recreating the
13 wheel. Every base has a different post-
14 deployment program. We have different policies in
15 how we do our business and how we train people.
16 And if we could connect the dots, we'd probably
17 save a lot of money, for one, by having less
18 redundancy and by providing a greater sense of
19 community and continuity. So that's the second D.
20 The third D is the disparity. The
21 overriding cause, I think, of why we're having
22 problems here and why they had problems after the

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1 first gulf war and Vietnam, after World War II,
2 and after World War I is because there's a
3 disparity of mental health. We don't value mental
4 health as a society, in our culture, in the DoD,
5 yes. We don't value it, we don't value the
6 providers and it's evident by I think some of the

7 slides I presented here. So I think that if we're
8 going to start anywhere, we've got to address those
9 three Ds. We've got to eliminate the diffusion;
10 we need get a streamlined central coordinating
11 point of contact. And if we're going to do
12 unified medical command, I think mental health
13 ought to be the first priority. I wouldn't even
14 wait until we get that; we need to do something
15 even sooner.

16 Secondly, we need to fix the issues of
17 disparity and the disconnects and I think by doing
18 that, those three Ds, I think that we'll find not
19 only the short-term fixes, but also long-term
20 fixes. And I think that's all I have to talk
21 about right now.

22 GEN KILEY: Thank you, very much. We

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1 have time; do you have some time for some
2 questions from the task force?

3 CDR RUSSELL: Yes, sir. Absolutely.

4 COL PEREIRA: That was a wonderful
5 brief, very, very visionary. It makes me sad
6 because you've pointed out a lot of the problems
7 that we've been looking at as a task force, but it
8 also makes me hopeful that some of your
9 recommendations are some of the things that we've
10 been looking at, too. And hopefully we can be

11 part of the fix. So you've given us a lot to
12 think about.

13 I'm particularly interested, as somebody
14 who has done two combat deployments and has been a
15 provider in the field trying to provide some of
16 the services that you were talking about, that we
17 do lack training in that area. I'm wondering --
18 you've done a lot of work on doing that kind of
19 training. How do you envision it to actually be
20 implemented? What are some of your ideas about
21 how we would go about training all of our folks in
22 these different methods?

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1 CDR RUSSELL: That's a very good
2 question. This is where I came up with my partner
3 in crime at the VA, Steve Silver, in a joint
4 DoD/DVA effort to do the regional trainings. If
5 you just do by MTF by MTF, you're picking a
6 low-hanging fruit, and that's what's going on now.
7 There is training occurring, there's trainings
8 that I've done, there's trainings that the VA's
9 doing, there's other trainings that people are
10 doing, so I know trainings are being done. But
11 how do you ensure everyone gets it, and how do you
12 make sure this is systemic and that we're just not
13 doing a band-aid fix. We get people training,
14 and then all the new people that come in and when

15 the war stops we don't have it part of our
16 organizational structure that we're doing
17 training. We keep training records. We have GMF
18 that's required, we have things that are required
19 and it's tracked very closely. I know CBRNE was
20 tracked very closely with a hit list every week.
21 Who didn't complete their training? I think it's
22 going to take -- that's why I say a flag-level

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1 officer ought to be in charge of this, because it
2 takes that kind of power to say we need to do this
3 and we need to track it. It could be done in
4 records, keeping in track of a service record or a
5 training record, sort of, who has that training,
6 who hasn't. How I would do it is I would do a
7 regional model. I would go to a regions. When
8 you go to regions like what we did here with Fort
9 Lewis, you train everybody in that region. So you
10 get the DoD, you get the VA, you get the civilian
11 contractors, the TRICARE providers, you provide
12 that treatment. If you've got people like me in
13 the VA it doesn't cost you money, because we don't
14 get a stipend or honorarium. So I would do it
15 that way.

16 As far as in Iraq, you could send me and
17 Steve over there tomorrow, I would be thrilled to
18 go and provide that kind of training to the people

19 in the front lines if it would be of help, and to
20 more importantly than just do the training, we get
21 to monitor the outcome. What is the benefits of
22 that training? And that kind of -- that's why I

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1 did that follow on field research where we asked
2 for people to submit outcomes. We don't want just
3 to see the good outcomes; we want to see all the
4 outcomes. Is it working or not? Are you
5 satisfied with it? Are people getting better or
6 not? We've got to eliminate this IRB kind of
7 issue, because it's not experimental. We're
8 providing treatment which is according to standard
9 of care. All we're doing is we're trying to
10 document the efficacy of that treatment, we're not
11 withholding treatment. So we've got a way to
12 provide that training, we've already got a model,
13 and I think you get a lot more numbers, you get a
14 lot more bang for your buck by doing it on a
15 regional basis as opposed to any way. It has to
16 be tracked by -- again, if we have a separate
17 corps, or if we task the respective specialty
18 leaders to make sure their people have gotten that
19 training, we need to do it. I would recommend
20 that people get trained on at least one if not two
21 of these -- or the four best treatments available.
22 I think EMDR ought to be one, that's just my own

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1 personal bias, but I think it's briefer and I
2 think it works well with our population. But
3 cognitive therapy would be the other, exposure
4 therapy is fine. We just need to have a couple
5 more tools underneath our belt. Right now people
6 don't have a lot underneath their belt and they
7 have to kind of recreate it, they have to read the
8 book while they're in theater. So I would just do
9 that, and I would do that ASAP. I said I'm ready,
10 task force wants to send me away, I'm ready to do
11 whatever trainings are available, and I'm sure I
12 can speak the same for all of my VA colleagues.
13 Does that kind of answer that?

14 COL PEREIRA: It does. It sounds like
15 you're thinking it should become part of our
16 standard military training.

17 CDR RUSSELL: Absolutely.

18 COL PEREIRA: And that possibly we need
19 to establish some kind of course that may be an
20 add-on course to officer basic training or -- I'm
21 not sure what you call that, but our initial
22 training, or possibly -- but somewhere early in

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1 the career where you have a block of time, maybe a
2 month, where you can get trained on all of the
3 different methods of treatment. I think that's a
4 good idea.

5 CDR RUSSELL: I think it's a great idea.
6 Now, what I had recommended in the past is that we
7 do that in the internship and residencies. Again,
8 it was kind of astonishing when I look back and I
9 realize I didn't get anything on combat stress in
10 my residency. I think that's changed since back
11 in that time, but that ought to be the accession
12 point, everyone gets that training and then you
13 have refresher training. It's got to be more than
14 computerized modules, Power Point, or you get a --
15 what we do at the CMDR training, I think other
16 types of commander training, we actually get
17 people to practice it so you get some clinical
18 supervision when you're trying to practice it.
19 You're practicing with other people, but at least
20 you're going through the mechanics and you
21 actually can work out some of the bugs as opposed
22 to just having it all here. Then when you've got

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1 a patient in front of you that's actually is
2 freaking out or they're really distressed, how do

3 you put your academic without the experience. So
4 we try to provide some experience, I think, some
5 supervision. That's why an accession point would
6 be ideal for that. I wouldn't rest on that alone.
7 And the regional treatment centers that I envision
8 would be practicing state of the art treatment,
9 but they would also be doing the research that's
10 being done to help develop new tools, because the
11 tools we've got are 1980 technology. This is old
12 stuff and it's effective, but it's not nearly
13 effective as we would like it to be, then we train
14 people on our new tools.

15 MS. FRYAR: I thought your presentation
16 was very refreshing and quite compelling,
17 particularly because you took the time to
18 articulate the fact that there should be a public
19 health approach in mental health care. The fact
20 that you articulated that these are brain diseases
21 and people do not understand that they are brain
22 diseases, and that we should be treating them as

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1 we do physical illnesses. And the fact that you
2 made mental health leadership so important,
3 because oftentimes leadership training itself does
4 not talk about the emotional and behavioral life
5 of the people that you are supposed to lead. And
6 I thought that was very compelling. Because of

7 its nature of being compelling, I'm curious about
8 as you've stepped out into the storm, what's been
9 the reaction from the audiences that you've given
10 this presentation to? And are people resonating
11 thematically with what you're presenting? And are
12 you really building a sense of urgency as --
13 clearly this task force is resonating with what
14 you've said, but what has been the reaction of
15 other audiences that you've presented to?

16 CDR RUSSELL: Thank you, ma'am. I
17 haven't really presented this to an audience. I
18 had that one lecture I did in Yukuska which got in
19 Stars and Stripes, and how I ended up being here,
20 I think. When I talk to individuals and I went to
21 the Washington State Psychological Association
22 before I came here and talked a little bit about

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1 that, what's going on with what was reported in
2 the Stars and Stripes, is overwhelmingly what you
3 just said. Anyone who is a mental health
4 provider, anyone who is a healer, it doesn't have
5 to be mental health, it should resonate, it's
6 right. It's the right thing to do, and it's been
7 neglected for too long. We've discriminated
8 against people with mental illness too long,
9 there's been disparity. And what we're unhappy
10 about is the state of the science. We say

11 psychotherapy doesn't work. Well, it doesn't work
12 because we don't put the research into it to find
13 out what really does work. And the things that do
14 work, we do show evidence, there's institutional,
15 academic bias that says, well, we can't do that
16 because it doesn't fit my paradigm, my zeitgeist
17 of what is cause or how we treat conditions like
18 PTSD. So overwhelmingly, I have never heard in
19 all those 27-some-odd point papers and
20 memorandums, people get tired of reading, I know
21 because I never learned the art of brevity, but no
22 one's ever come back and said that was BS that was

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1 way off the mark that was wrong. Now there
2 obviously can be disagreements on subtle points,
3 but the overall message of disparity, and the
4 disconnection, and the diffusion, I think
5 resonates very well. That's been the feedback.

6 DR. McCORMICK: First of all let me say
7 I certainly resonate with your idea that people
8 should be trained in the evidence-based practices.
9 All those evidence-based practices are designed
10 and are well delivered in an outpatient format.
11 In fact, in the VA the paradigm is really moving
12 away from regional centers with residential
13 treatment that sucks up a lot of resources to
14 small interdisciplinary teams that can do those

15 evidence-based practices. So why would you
16 recommend regional centers rather than teams, and
17 you get a lot more teams out there a lot more
18 places, when the evidence really is that all of
19 these approaches do not require residential care?

20 CDR RUSSELL: That's a great question.
21 Again, many in here are going to have a lot more
22 experience, obviously, than I do, because I've not

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1 worked in a regional center. The reason I thought
2 that the regional model is because right now
3 starting where we're at, we just don't have the
4 state of the art facilities that can do that
5 treatment to train those teams. Not only that the
6 research and the training that comes out of those
7 regional centers too is invaluable. We need
8 somebody to connect these dots, and so that idea
9 of regional centers is that the interns and
10 residents would train in those centers without
11 some exposures on that, and until we get everybody
12 in uniform to become an expert, so then having
13 those individual teams is not hard, because when
14 you come in you've got the training, you have the
15 expertise, both in terms of knowledge base and
16 experiential, then we won't need to have regional
17 centers. But I think that's where we're starting
18 at now is that we just don't have that. Not every

19 place, not every local place is going to have MRI
20 or SPECHT scan capabilities, some of the
21 neuroimaging that's very costly so those would be
22 things I would do in terms of more of a regional

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1 center. I think when you let somebody go out of
2 the service and you say they have a disability and
3 they're going to go into the VA, would be on
4 disability the rest of their life, which the
5 majority of them do, that they ought to have --
6 make sure we give them a state of the art
7 assessment. A lot of people are concerned about
8 malingering and false positives and if we get the
9 science down to where we can understand where we
10 see on a reliable basis and use neuroimaging as a
11 way of assessing PTSD, I think it also would give
12 some people kind of a better feeling as far as
13 when we do say somebody has a disability and they
14 need to go in to be separated from the services,
15 we know what that level of disability is, and we
16 know more that they're getting the kinds of
17 benefits that they deserve and not wasted. So
18 that was just kind of my short answer, but I love
19 the idea of having it local once we have that
20 expertise, but we're starting from ground zero
21 right now.

22 DR. MacDERMID: You expressed concern

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1 about the quality of care provided by people who
2 are out in the network and the web-based folks.
3 Could you talk a little bit about the mechanisms
4 you use and the evidence you have about monitoring
5 quality of care provided by uniform providers? In
6 other words, if we were going to try to do
7 something about these other folks, what should we
8 be doing and how does it compare?

9 CDR RUSSELL: That's a great question.
10 That, again, is something that's going to need to
11 be looked at. I don't have the ready answer for
12 that. How do we monitor quality care in the
13 military? As I said, right now, most of our
14 providers are not experts in treating PTSD. The
15 majority of them haven't even seen the guidelines,
16 haven't read the guidelines. These are great
17 guidelines, everybody -- I think they ought to be
18 mandatory reading, many of them haven't even seen
19 it. That's what we have to start with is the
20 training. And how do you monitor it? One would
21 be looking at outcomes, kind of what we did here
22 with the regional training, we gave people

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1 training, but we look for outcomes. And what we
2 did is have that as part of peer review, when they
3 do the chart reviews they could look at those
4 outcomes. So if you have, instead of individual
5 providers doing that, you had that as a system so
6 it's part of our peer review, which we do do on a
7 monthly or quarterly basis; that we're looking at
8 the outcomes not just looking at JCHA0, check the
9 box, do you have -- did you check for pain? Did
10 you have barriers to care? That kind of stuff,
11 objectively look at what the responses in progress
12 of treatment is.

13 DR. MacDERMID: So what you're saying is
14 we don't really have evidence in hand to tell us
15 that care provided by uniformed providers is
16 significantly better than care provided by
17 civilian providers?

18 CDR RUSSELL: No, not at all. Not at
19 all. I don't think there's any advantage being in
20 the military as compared -- in fact, being in the
21 military, right now I've got a gunny waiting for
22 me in Iwakuni, he was part of the 9/11 attack at

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1 the Pentagon, he was picking up body parts. He's
2 got severe PTSD. This is a gunny in the Marine

3 Corps, they're not going to come very lightly to
4 you, and I can't see him. I can't see him once a
5 week. I can't even do EMDR with him once a week
6 the demand is just too high. So what's the
7 quality of care he's getting? And I do have the
8 training. I can provide it if I had the
9 opportunity I could give him that training; I
10 think I could help him. It's very frustrating,
11 it's part of what feeds into my compassion fatigue
12 is not being able to provide that treatment. So
13 the problem is that we don't know what the quality
14 of care is, we're not monitoring it. We need to
15 monitor when people get diagnosed with a
16 post-deployment condition, we've got to monitor
17 who those people are that they've got a
18 standardized assessment so we have some sense of
19 reliability or validity of that diagnosis as a way
20 of tracking their treatment over time. Are they
21 getting better or not? If they're not getting
22 better, are we shifting gears, are we trying a

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1 different approach? We ought to try everything we
2 can before they get separated and we give them
3 that disability paycheck.

4 DR. McCURDY: I too would like to thank
5 you for a very instructive presentation and I
6 admire and thank you for your passion about this

7 as well. Is the electronic medical record, the
8 new military and electronic medical record, could
9 that not facilitate the assessment of treatment
10 performance, performance measures outcome to a
11 little lesser degree, but performance measures
12 within the military. I know less about that than
13 I do in the VA where it has, in fact, contributed
14 significantly to progress following along
15 treatment approaches.

16 CDR RUSSELL: Yes, sir. I'll probably
17 step in it a little by going into that. But I do
18 think the two systems ought to mirror up. You're
19 looking at you want a seamless transition yet I
20 have the same systems working. And my experience
21 with the DoD system has got some benefits, but
22 from what I hear, the VA system seems to be a

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1 little more what we need especially with regard to
2 mental health. I'm not a computer expert, but I
3 think with AHLTA II, the new DoD electronic
4 database, it can probably be jerry-rigged somehow
5 where we could do post-deployment assessments and
6 have that integrated. Right now you have a
7 separate database for post- deployment health
8 assessments. You probably know that, right?
9 They're not connected through CHCS, although you
10 could get some data out of CHCS or AHLTA, they're

11 disconnected, one of the disconnects. And they're
12 disconnected with the VA and the DoD as well. I
13 would like to see what you all have in the VA so
14 that when they do separate in the coming year of
15 service, you have all the assessments already done
16 in the same way we do our assessments, the same
17 you all do your assessments, and there's no doubt
18 that these people had this diagnosis, this is what
19 has been tried and now we need to you help provide
20 follow on care. So I would hope we can develop a
21 system to track it. We really need to track who
22 comes back from war. What is their condition like

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1 over time? And are they getting better or not?
2 And that needs to be tracked. And, again, I think
3 if we do that from public health model, do that
4 from this neuroscience model, we'll get people to
5 come in and we can start to actually get
6 groundbreaking data that has never been ever
7 looked at before. We have a great opportunity; I
8 just hope we seize it.

9 DR. KING: Good morning. My name is
10 Clay King; I'm the chief of social work at the VA
11 in San Diego. I'm also the seamless transition
12 coordinator. We've had a social worker placed at
13 the hospital at Pendleton and Balboa for the last
14 year or so doing the military treatment liaison

15 function. A couple of questions.

16 First of all, VA does have the resources
17 to provide training to DoD for PTSD treatment that
18 is evidence based, including exposure therapy, or
19 EMDHR, or CBT, or DBT, or whatever T's you want.

20 Second of all, I think the electronic
21 record, for us, is a real barrier. We get
22 patients who have been seen and treated in DoD,

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1 but we get very sparse information because of the
2 lack of the electronic record.

3 Third of all, which I think is really
4 the most important, our goals are very different.
5 The goal, I was told by a military psychiatrist,
6 is to patch up the service person and send them
7 back to Iraq. Your goal is to help them integrate
8 into society.

9 CDR RUSSELL: You mean the VA's goal?

10 DR. KING: Yes. So we're dealing on two
11 different levels.

12 CDR RUSSELL: Yes, sir. I think that's
13 -- we need to change that goal to the extent, yes,
14 we do, we have to fight wars and we have to be
15 involved with the readiness, and that's why we
16 have mental health in DoD. We also, the research
17 shows that people have worse outcomes when they're
18 separated from the support systems. And I think

19 when you put away that uniform and now you're a
20 civilian and you've already been separated with
21 this diagnosis and you've got this label put on
22 you, start getting a paycheck, it really puts a

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1 barrier for you all to treat him, right? The
2 whole issue about secondary gain and that kind of
3 thing. So I think all efforts need to be made and
4 really kind of ramping up, VA ought to come
5 forward and they ought to come in the front lines
6 of the DoD, I guess if you would. I mean, we
7 really need to make sure we get treatment before
8 they get separated, and then separation and the VA
9 ought to be the last.

10 GEN KILEY: Couple comments first I
11 would take on in the issue of ALTHA and VISTA (off
12 mic) you literally recommend that (off mic)
13 wouldn't be like a seamless transition (off mike).
14 There are some fundamental differences between the
15 two systems both the departments are pretty
16 heavily invested in those systems, and there are
17 requirements when it's DoD that aren't going to
18 (off mike) the VA in terms of worldwide (off mike)
19 credibility, et cetera. So we're working our way
20 through that (off mike) I concur. That is an
21 issue that I think goes to the VA and the DoD
22 statement (off mike). I'm not sure I concur or

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1 agree with the characterization military
2 psychiatrist that's not (off mike) there's a lot
3 going on in military psychiatry (off mike)
4 incentives (off mike) to the VA. So due the
5 hurdle that the VA is totally committed to this
6 and I think that's great. I think that's great
7 synergy this year (off mike). Before I thank you
8 for an outstanding presentation, I have a couple
9 questions. Are you familiar with Chuck (off mike)
10 work with respect to (off mike) implement mental
11 health training (off mike)

12 CDR RUSSELL: Yes, sir. I'm not
13 familiar with (off mike) training. I know they
14 have a lot of modules (off mike) website (off
15 mike) ones who are really enlightened the ones who
16 want to know more they can get that training (off
17 mic) and until they have that training
18 post-deployment (off mike) disconnect.

19 GEN KILEY: My last comment, and then we
20 do need to break here, I at first blush it strikes
21 me that a continuous medical record that tracks
22 Kevin Kiley through his whole career so that we

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1 can see how Kevin does as an intern and then how
2 he does as the surgeon general, compare and
3 contrast all that; that strikes me as, on the
4 face, very valuable. And then I started to think,
5 do I really want a database out there that's
6 tracking me for 10, 20, 30 years when we have a
7 struggle having soldiers, sailors, airmen and
8 marines come forward and say I'm having a problem
9 and I need to talk to somebody because of the
10 stigma. And you had one slide that kind of ran by
11 that. I'd be interested in your thoughts on how
12 we're going to destigmatize this thing. And
13 frankly I'd vote yes if we could go to the
14 American people or the world population and say
15 let's just destigmatize that with a snap of the
16 finger, but you know as well as I do that this
17 stuff is much more complex and in some case
18 ingrained. So how do we balance the normal
19 tension between commanders and medical providers
20 in getting the soldiers and marines who need help
21 without creating such hoopla, if I can use that
22 term, that it almost reinforces potential stigma

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1 inside the force at the staff sergeant level and
2 at the platoon leader level. Do you have any

3 experience or thoughts with that, Mark?
4 CDR RUSSELL: Yes, sir. That's a big
5 one to take on. Thank you, sir. I guess from my
6 experience -- well, you look at the study done by
7 ^HODs and if the barriers of care, which is more
8 or less is a repeat what you saw in the Vietnam
9 readjustment study. I mean, it was more extensive
10 and it was done in the current time, but the
11 Vietnam study looked at barriers of care too and
12 they found the same thing. A lot of it has to do
13 with leadership. You look at what they're more
14 stigmatized -- what are they afraid of? They're
15 afraid of the leadership reaction. How's this
16 going to affect their career? And what the
17 leaders are going to think of them. That's why I
18 think it needs to be a top down and they'd be at
19 the highest level and we need to get out in front
20 of the mental health issue. I think part of that
21 is that public health model, but also the
22 neuroscience model. I think once troops know that

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1 this isn't something that they're mentally ill or
2 weak at, you can actually see it on an image, like
3 an MRI like you would see a broken bone on an
4 x-ray, but if you can see that there's something
5 going on in the brain, that that might help people
6 come forward. It needs to be an aggressive public

7 awareness campaign, top down. It needs to be
8 steady; it needs to part of training from
9 accession throughout one's career as far as the
10 training on mental health to help destigmatize
11 this. The leadership training, every level --and
12 that needs to be part of it. This ought to be a
13 leadership issue. If people aren't getting the
14 help because they're afraid, that's a failure of
15 leadership in my opinion. If we're charged to
16 take care of our troops and we're not reinforcing
17 the message that this is part of taking care of
18 yourself if you had a sprained ankle you would go
19 to medical. Well, if you've got depression or
20 you've got PTSD then you go to medical. So there
21 needs to be -- I think people are really concerned
22 about their career and the impact of coming

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1 forward would have on their career. I think we
2 need to look at how we're going to protect people
3 who do get help.

4 One thought, maybe, just off the top of
5 my head would be we have protections for people
6 who are sexually harassed, people who are
7 discriminated against because of ethnicity or race
8 or religion and we have a way of resolving those
9 grievances. We may need to put that protection in
10 for mental health if they are people who are

11 getting discriminated against because they sought
12 help. I'm just throwing it out there, that's just
13 a thought on the spontaneity it's probably got a
14 lot of bugs in it, but it has to be that kind of
15 out in front, this is what we're going to do. I
16 think by elevating mental health as a priority in
17 the DoD by the top leaders, and not just a one
18 time spot, but a continual drum roll, I think
19 eventually you'll get to that point where people
20 aren't going to have a problem with those records.
21 And this is just part of what we do. We keep
22 physical health records, extensive physical

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1 records from accession to separation; well, we
2 ought to include the same for mental health, too.

3 GEN KILEY: Commander, you're a credit
4 to your profession and to your corps and your
5 service, and thanks very much for coming out here
6 and doing this presentation. I'm going to turn
7 the floor over to Colonel Davies now.

8 COL DAVIES: Sir, at this time, we're
9 going to close the open session and we will go
10 into a closed executive session and we'll
11 reconvene here at 11:00.

12 GEN KILEY: Thank you, all.

13 (Recess taken)

14 COL DAVIES: As the alternate designated

15 federal official; this is an open session of the
16 task force.

17 DR. MacDERMID: Thank you all, again.
18 Welcome back. Our next session is with LCDR
19 Shannon Johnson, and she doesn't have slides so
20 you're not going to get Power Pointed to death.
21 She's going to share her ideas with us. She may
22 follow up with things she can send because she's

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1 in the middle of a PCS, so her things are probably
2 not in a place where she is. She is prepared and
3 eager to have questions, although she also does
4 have prepared remarks. So make notes of your
5 questions and we'll try to allow lots of time at
6 the end for them. Thank you very, much.

7 LCDR JOHNSON: Thank you for this
8 opportunity. I'll just tell you a little bit
9 about my background, because then you can kind of
10 decide what areas you want to ask questions about.

11 I started off in the Navy more on the
12 operational side. I spent three years on an
13 aircraft carrier, and I think that's one thing
14 we're doing a good job of is our operational
15 billets for our psychologists and other mental
16 health professionals. I think we need to out
17 there with our deployed troops and sailors. After
18 my deployment experience, I did a post-doc in

19 child psych, and then spent the last few years
20 over in Japan in charge of the EDIS program, which
21 I'm assuming you're all familiar with by now. I
22 have a lot of thoughts and input about our

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1 services for families overseas. I think the
2 reason I'm here today is because -- and I'll tell
3 you how I got to this point, but I'm currently
4 chairing the task force that's been established by
5 APA to look very similarly at the issues you're
6 looking at. So as a result of that I've had to
7 get smart on all these issues very quickly. So
8 that's kind of my background. Also I've gotten to
9 work with Commander Russell for the last few
10 years, well, actually this last year in Japan. I
11 think he and I have come at this issue from very
12 different paths, but I think we've arrived at the
13 same kind of conclusion; and that is that what we
14 really need is a very coherent, well coordinated
15 approach, tri-service approach, to our mental
16 health services in DoD. Having a flag-level
17 person to oversee and be accountable for our
18 services to families and active duty members, I
19 think would go a long way to getting us to where
20 we need to be.

21 Let me tell you how I got to the place
22 with APA. Over in Japan I arrived to find a

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1 program that had not been well monitored, and was
2 not performing the way it needed to be, and we had
3 a lot of families and children that were going
4 without critical services over in Japan. I just
5 had broader concerns about mental health services
6 overseas. I'm sure you've all -- I know you've
7 been to Korea, I don't know -- I think you've been
8 to Okinawa, but there is no TRICARE overseas. So
9 what we have on our bases is it. With all the
10 operations we have going on now and all the
11 service members being deployed, the mental health
12 service members being deployed, there are critical
13 shortages.

14 Also, I don't know if you've heard about
15 the issues with getting fleet and families
16 services well staffed overseas. It's a chronic
17 problem. We had eight-week waiting lists for
18 people to get in and to get one session with the
19 social worker, and then not being able to get
20 follow-up for eight more weeks. So the situation
21 was rather -- to me it was seeming desperate, and
22 to the families I was trying to work with, was

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1 seeming a bit desperate. Somehow I got connected
2 with Mrs. Roughead, whose husband is the commander
3 of the Pacific fleet. She and I started a lot of
4 projects together and working with the admirals
5 wives throughout the Pacific fleet and here in
6 the San Diego area as well. So one of the things
7 that I did several conferences with the admiral's
8 wives and I was really pushing the -- well, one of
9 the things I was trying to do is work on that
10 stigma issue that we talked about earlier, and
11 really encouraging them to get out and mentor the
12 CO's and XO's wives about how to really work with
13 the spouses and destigmatize coming forward and
14 getting help for your families. I think we have a
15 long way to go to do that. People won't speak up
16 when there aren't good services available for
17 mental health. They'll complain if the
18 commissaries aren't well stocked and if they don't
19 like what's at the NEX, but they aren't going to
20 come forward and say, "I can't get help for my
21 family, and we're desperate." It's kind of this
22 quiet problem that people don't talk about. That

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1 was one of the barriers I was trying to overcome
2 in my work with the admiral's wives.

3 The other issue is I'm a realist, and I
4 know we're at war and our resources are really
5 low, and we're all over stressed. I've long
6 believed that we need to do better at mobilizing
7 the civilian community to support us and to help
8 us. So in trying to rally them to get out there
9 and be creative and get the community involved in
10 supporting our military families, I kind of said,
11 I'll tell you what I'll do, I'll go to APA and see
12 if they'll get involved in supporting us. So it's
13 kind of trying to model for them what they could
14 do. Believe it or not, it's turned out pretty
15 well. I'm fortunate that Dr. Gerry Koocher is the
16 current president of APA. He's been fabulous and
17 very responsive to us. I think it also helps that
18 in approaching the board of directors, I really
19 came at it as a family/child issue, because I
20 think all psychologists and mental health
21 providers know if you're not taking care of the
22 parents, you're not taking care of the children,

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1 and you can't separate the adult mental health
2 from the child mental health. I think that really
3 struck a cord with the APA board and all the APA
4 members. So that's where we are and I'm very
5 hopeful about what we're going to be able to do
6 through this task force. Ideally, I would like to

7 be able to coordinate with the DoD in general,
8 because I think there's great things being done,
9 but in little spots all across the country and
10 around the world, and it really needs somebody to
11 look at the big picture and connect the dots and
12 reduce redundancy. And when something's working
13 really well in a certain area to be able to get
14 that word out, and share our ideas and be creative
15 together. Also in looking at the big picture
16 leadership piece, really needing someone who can,
17 when there's a plan that's developed, that really
18 follows it through to the end. I'm just going to
19 use as an example as this health assessment that's
20 been developed. If we could really have someone
21 who is in charge of implementing that, making sure
22 people are trained, monitoring and tracking to

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1 make sure it's being used consistently everywhere,
2 and then measuring whether it's effective and when
3 it's not and when there's barriers to go back and
4 troubleshoot. Because, I mean, I don't know if
5 you've heard about some of the problems with the
6 health assessment, but it's not being used
7 consistently. People are not being trained and a
8 lot of people are falling through the cracks as a
9 result. Are there any questions so far?

10 COL ORMAN: My question is: Could you
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11 elaborate further on your work with the APA and
12 the nature of the collaborative effort you're
13 trying to put together?

14 LCDR JOHNSON: Yes. I may just -- if
15 it's okay, I don't know what the rules are here,
16 but if I can send around an e-mail that I actually
17 sent out if any of you are psychologists in
18 Division 19, you might have got it. But I sent it
19 out to the Division 19 e-mail group, and this does
20 spell out the three areas. We're going to get
21 together the second week in November in D.C. to
22 create a report and we've been collecting data.

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1 And the group consists -- there's currently eight
2 of us and all the branches are represented. The
3 VA is represented. People from the academic
4 community are represented. A lot of people focus
5 on evidence-based services, so it's a very
6 well-rounded group, and pediatric psychologists as
7 well as people who are more focused on the
8 operational side.

9 COL DAVIES: Could I clarify that
10 Division 19, is that not the -- that's the
11 military sub-committee of the American Psychology
12 Association?

13 LCDR JOHNSON: Yes, sir. Yes, sir.

14 DR. BURKE: Commander could you, please

15 just for the record, tell us what EDIS means, and
16 which APA you're talking about?

17 LCDR JOHNSON: Okay. Absolutely. Yes,
18 sir. EDIS is the educational, developmental, and
19 intervention services, and it's mostly located
20 overseas. There are some programs here in the
21 states, mostly on the east coast. What that is is
22 we're kind of the -- well, we're the early

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1 intervention services for overseas in the zero to
2 three population looking at developmental delays
3 in children and providing services. Then we also
4 provide mental health services for children three
5 through 21, and also occupational therapy and
6 physical therapy within the DoD school system. So
7 we're kind of this catchall. It's a pretty
8 complicated program, truthfully, and a very hard
9 to staff program.

10 The APA, that's the American
11 Psychological Association. And Division 19, is
12 the military division of APA. So this actually --
13 our APA task force for deployment issues is being
14 run out of the APA practice directorate, which is
15 even a separate directorate, and also the
16 involvement from the youth and family service
17 division of APA. And I'll just pass around -- I
18 developed a letter that kind of talks the three

19 areas our report is going to focus on.

20 First of all we're looking at what is
21 the current impact of four or five years of these
22 operations and multiple deployments on our

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1 families, on our service members, and on our
2 providers, our mental health community. Really
3 looking at what are people seeing in the schools,
4 the school functioning, behavioral issues, what's
5 the situation with our marriages, domestic
6 violence rates, alcohol issues, obviously, the
7 post traumatic stress issues that are coming back,
8 and how well we're able to respond to them
9 currently.

10 The second part of our report is what
11 programs are working. And this is the good news,
12 because I want to be positive and solution
13 focused. There's a lot of good things that people
14 are doing, a lot of good programs. We're really
15 trying to focus on resiliency, building resiliency
16 in our children and families. Also, I know
17 there's a lot of places where we're trying to do
18 that with our troops before they go over, focusing
19 on resiliency. We don't have an option, we have
20 to do that, we have to cope. There's a lot of
21 good programs and I can talk about them, but we'll
22 have a report that we'll be able to pass off to

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1 you eventually that will be going over a lot of
2 things.

3 DR. MacDERMID: Do you know when your
4 report will be ready?

5 LCDR JOHNSON: We hope by the end of
6 November. That's our goal. I know it's a big
7 goal but we have a lot of good people working hard
8 on this right now.

9 DR. McCURDY: You mentioned some
10 programs, some things that are working well here
11 and there and you. Is there a collation of best
12 practices that are put together for military
13 across services as well? Is that one of the
14 targets of what you're trying to do, one?

15 Two, say something about the work force
16 available for children and families in where
17 you've been in the pacific.

18 LCDR JOHNSON: The first part of your
19 question was in regards to --

20 DR. McCURDY: Best practices.

21 LCDR JOHNSON: Best practices. That's
22 something we are going to do. We're going to

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1 meeting the 10th, 11th and 12th. We've all been
2 collecting data and that's what we're going to get
3 together and determine. We're really looking at
4 establishing some best practices, because the
5 third part of our report that goes back to the APA
6 board of directors is what our recommendations to
7 them are for best practices and for how the
8 150,000 APA members can get involved in supporting
9 military communities, and what are the programs
10 that we recommend be implemented. I had lots of
11 issues to address today, but one of them is the
12 importance of research, and that is one area where
13 people are encountering frustration is trying to
14 do research about what is effective, because we
15 have a lot of programs with anecdotal evidence
16 that they seem to be really effective and people
17 are appreciating them, and the communities are
18 appreciating them. We have a lot of programs
19 we're implementing in schools. If any of you are
20 familiar with the APA practice directorate
21 resiliency program, we've tailored that for the
22 military communities and military schools. So

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1 there are a lot of things that seem to be
2 effective, but we don't have the data to back it

3 up, and people have run into resistance in a lot
4 of places who are trying to get that data.
5 Sometimes people are threatened by, I don't know
6 if it's the mental health part or if it's the
7 research part or what it is. Again, that kind of
8 goes back to having a flag-level person to really
9 help advocate for getting that research done.

10 Services for our families and children
11 overseas, it -- I can tell you my experience in
12 Japan, mainly in Japan. I was in Yokosuka and
13 this is where the fleet and family could not --
14 just couldn't get the staffing. It's very hard to
15 hire qualified -- they only hire social workers at
16 a GS-11 rate overseas to get people to move
17 overseas and that have the competence to provide
18 services to families. That was another big thing
19 I've been working on and was working with Admiral
20 Kelly who's the commander of Naval forces in Japan
21 and about the need to bump that up to at least the
22 GS-12. So the services in the fleet and family

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1 were not adequate, and the people -- and the
2 quality was not good and people had stopped going
3 there, because that's the other thing, word gets
4 around the community if the services are not good
5 and people are not going to bother to go. That
6 was a problem we were having. Also the family

7 advocacy program was not adequate. I don't know
8 if it was training or what the problems are, but
9 keep in mind that overseas there is no CPS, child
10 protective services, so your family advocacy
11 program is all you have, and we had a lot of
12 problems over there as a result of that. I would
13 actually have to hospitalize children sometimes.
14 Not because there was anything wrong with the
15 child, but because I had to get them out of the
16 house and there was no other way that I could
17 ensure they would be safe. So that was a
18 frustration. I was the only child mental health
19 provider for -- I was covering Misawa, which is
20 several hundred miles away, and Yokota and
21 Yokosuka. At times it feels impossible but then
22 you add to it the fact that they deployed our

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1 adult mental health, our psychiatrist, our
2 psychologist and they gapped the person who was
3 running the drug and alcohol program there. So
4 for the last part of my tour there I was the only
5 psychologist at all, and on-call 24 hours a day
6 and trying to run the alcohol and drug program,
7 trying to run EDIS, and be the child psychologist.
8 It becomes impossible. So if you ask me about
9 services for families overseas I would say we are
10 not where we need to be.

11 DR. McCORMICK: I happened to have been
12 with the group that went to Okinawa actually. We
13 met with some families -- was it Okinawa or
14 Hawaii? It was Okinawa. We met with some
15 families who were being serviced from EDIS, and
16 ironically many of them said actually they were
17 getting better services there because there was a
18 mental health team. Then they got in the states
19 where they had to rely on local resources and the
20 local school system. Is your task force going to
21 be looking at the issue of how easy it is for a
22 family to patch together, if they're over here,

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1 the services they need between TRICARE and its
2 adequacy, and the responsiveness of local school
3 districts around bases?

4 LCDR JOHNSON: Yes. Yes, sir. That is
5 one of the things we're definitely looking at and
6 it is absolutely more difficult here in the states
7 than overseas with EDIS when it's working right,
8 because I know Okinawa has really built a strong
9 program because they got millions of dollars
10 because they had a deprocess lawsuit as a result
11 of them not being adequately staffed EDIS. So
12 when I arrived in Yokosuka we were probably at 60
13 percent manned with our EDIS, and there were a lot
14 of children with severe developmental delays who

15 were going without services. I won't tell you all
16 I went through to get that staffing but we finally
17 got staffing up to 100 percent and that is not
18 easy and it was pretty much a full-time job when
19 I'm supposed to be the child psychologist, I was
20 pretty much fighting battles with HR0 most of my
21 time to get the staffing up. So it's not a given.
22 There are times -- when that program is running

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1 right, it's a great service to families. We do, I
2 think, provide better services than you get in the
3 states, but it's not a guarantee, and that's kind
4 of another reason to have someone flag level, high
5 up, who is responsible for monitoring those
6 programs because they are not always well
7 understood by the COs and XOs of the hospitals
8 that are ultimately responsible for them. It's
9 just another concern I have about the services
10 overseas.

11 COL ORMAN: You strike me as somewhat
12 burnt out by your experience. That's sort of a
13 segue into a question we've been asking all the
14 sites we've been visiting: What do we need to be
15 doing for providers in uniform both to attract new
16 ones to replenish the pipeline but perhaps more
17 acutely and importantly in the here and now to
18 retain the quality people we have that we've

19 invested a lot in and themselves have invested a
20 lot in the system?

21 LCDR JOHNSON: Thank you for asking that
22 question because that gets to a whole other area

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1 that I think it's important for me to talk about
2 today. I am a little burnt out, but I'm also real
3 relieved, because I just passed off all the EDIS
4 duties to Commander Russell. So I'm pleased he's
5 taking over, and I know that program will continue
6 to stay strong as long as he's there. But as a
7 result I had known this -- I'd known there was
8 problems for a long time and that was one of the
9 reasons too that I went to APA initially. As a
10 result particularly of sending out this e-mail to
11 Division 19 members requesting feedback about what
12 they see as the needs and problems, I wasn't
13 anticipating hearing back as much about the
14 burnout. And people are saying it's not just
15 burnout, it's secondary PTSD, in some cases
16 primary PTSD. And mental health providers -- if
17 you think it's hard for our soldiers and sailors
18 to seek mental health treatment, mental health
19 providers seeking mental health treatment is even
20 more unlikely. We have lost -- and I don't know
21 if any of you have personal experiences knowing
22 people who have had their own experiences with

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1 PTSD who are providers, but I know several within
2 the Navy community who have gotten out of the Navy
3 and have said they have PTSD now and they have not
4 fully recovered from their deployment experiences.
5 I don't think people understand or are prepared
6 before they go over there for just how gruesome
7 and difficult and horrible it is, and the stuff
8 they're debriefing over there they say they're --
9 if you're familiar with CISD, the critical
10 incident stress debriefing courses that people
11 take here, they say those in no way prepared them
12 for what they've had to deal with over there. And
13 I know Commander Russell hit on the training, but
14 people are not feeling adequately prepared, and
15 they're also themselves casualties of the combat.
16 A lot of burnout and a lot of suffering just as a
17 result of either primary or secondary PTSD. And
18 another area of training, just before I get off
19 the training issue, yes, I think we need to do a
20 better job of preparing our mental health
21 providers both for dealing with acute stress, post
22 traumatic stress, but also they're going over

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1 there, and I believe they need to be there. I
2 totally believe in the OSCAR program and all these
3 programs we have, but needing to train them in
4 really the organizational psychology. I think the
5 power in having a mental health provider join up
6 with a Marine division is really in their ability
7 to be advisors to the leadership about morale and
8 just good communication within the division, and
9 training the leaders about how to identify the
10 issues. We just assume a lot and Commander
11 Russell's already addressed this so I don't want
12 to re-go over it, but we assume a lot of our
13 people in uniform that they have skills and
14 training that they don't have. So we just need a
15 more thoughtful approach to our training, and I
16 know that we've just started up because the person
17 who started it is actually on my task force, the
18 center for deployment psychology or something. So
19 I know that we're starting to really try to train
20 our new people that we're bringing in but we've
21 got a lot of people that are already in who didn't
22 get that training and those are the ones that are

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1 over there. And I just have to address it because
2 it's another concern, but we're sending also brand

3 new, and in some cases, I know from Yokosuka, we
4 deployed someone over there to take care of our
5 troops, the people who need our very best
6 providers and services, we sent someone who hasn't
7 even finished their dissertation. They're not
8 even a doctor, they're not licensed, they're brand
9 new to the profession, and I think we need to not
10 just fill these billets over there, you know? We
11 need to really make sure that we're setting people
12 up to be successful in those billets. So the
13 burnout -- and I will tell you, it's not just
14 mental health providers, because I'm also talking
15 a lot with people at Walter Reed and part of --
16 since I've taken on this chair of the APA, I just
17 keep getting more information, but it's also
18 everybody involved in the medical community. It's
19 our surgeons and everybody who's working in the
20 emergency medicine, our corpsmen. Everybody's
21 pretty burnt out and there's a lot of some kind of
22 traumatic reaction, and a lot of grief and loss.

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1 Just because people don't meet full-blown criteria
2 for post traumatic stress, I think we need to
3 acknowledge that there's just a great level of
4 grief and loss that people are dealing with. A
5 lot of the providers that have come back and have
6 talked to me, they just say it takes -- they're

7 just -- they still haven't gotten closure on that,
8 on what they experienced over there. It's really
9 changing people, and I think we just have to
10 acknowledge that and I don't know what the answers
11 are necessarily, but I think we need to prepare
12 people for that, and then give them the space and
13 normalize their need to kind of work that threw
14 when they get back. That is one thing that we're
15 going to address through APA is providing
16 services, because I don't think mental health
17 providers, military mental health providers, want
18 to go to their colleagues to get services. So
19 perhaps setting something up through APA where we
20 can begin to provide some kind of support of
21 services for our mental health community and maybe
22 the medical community in general. Any other

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1 questions related to that?
2 I think I've talked about -- and I'm not
3 sure how much you guys have -- I know the focus
4 today has been a lot on the services, post
5 traumatic stress services for returning service
6 members, but one of the things we're really going
7 to be looking at with our APA task force is really
8 approaching this in a family centered way because
9 it has a tremendous affect on families. And what
10 families are asking for is information for how

11 they -- they know their returning service member
12 is really different, and so they want to give them
13 time to readjust, but they want information on
14 when do we know that we need to get more help?
15 And they want to know what to expect. I know some
16 places are doing a good job of outreach, but I
17 think we need to, again, provide a broader
18 approach to our outreach services for families.
19 And there's a great program that's being
20 implemented through the Oklahoma VA called
21 Operations Enduring Families, and this will
22 probably be one of the things we recommend to the

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1 APA board is taking this and implementing it other
2 places. But when a service member comes back and
3 they've been found to have some kind of post
4 traumatic stress reaction, this is how we can get
5 the whole family involved in providing care and
6 getting them involved in the recovery process for
7 that individual. So looking at family services
8 and outreach for those individuals, the whole
9 community. I don't know how much else, more
10 information that you guys might not already have
11 collected. For those of you, who are familiar
12 with the positive psychology movement, but we're
13 really trying to get the positive psychology --
14 Seligman is getting involved with developing some

15 programs with us. He is somebody who has been
16 very involved in programs that build resiliency
17 and looking at building optimistic families and
18 children. Are we short on time?

19 DR. MacDERMID: Well, we've had a
20 request from someone who can't be here this
21 afternoon was hoping to make a couple of remarks.
22 So I wanted to see if there are questions from

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1 members of the task force that we can take care
2 of? Thank you, very much for your remarks, and
3 please make sure that we get a copy of the --

4 LCDR JOHNSON: The APA report. Sure.
5 Thank you.

6 DR. MacDERMID: Just for the record,
7 I'll note that I requested a copy of the APA task
8 force report. And do you have the note? Thank
9 you.

10 Captain Frieda Vaughan, the director of
11 mental health at the Naval Medical Center San
12 Diego has asked to make a few remarks before we
13 break for lunch in about 10 minutes. She can't be
14 here this afternoon so I wanted to try to
15 accommodate here. So will you come forward, ma'am
16 and tell us what you want to tell us. I hope I'm
17 not breaking any FACA law by doing that?

18 CAPT VAUGHAN: Thank you. I didn't

19 really plan on speaking to you. I was going to
20 hide in the corner, but I guess this has sort of
21 stirred up a lot of thought and concern that I've
22 had for the last few years in terms of mental

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1 health care. I've been in 23 years. I can't
2 really speak too much to what the other services
3 are doing, but I feel like I really do understand
4 what's happening in Navy medicine in terms of
5 mental health. I can honestly, with all my heart,
6 say that everyone in the system is doing the best
7 they can with what they have. There is not a
8 single individual I know within our system that is
9 not committed to doing the best by our active duty
10 folks.

11 But a few years ago someone -- perhaps
12 you've hear this, described military medicine as
13 the managed care organization that goes to war.
14 Well, that is just not true. It just is not true.
15 You end up going in two different directions. I
16 think part of our problem at this time is we're
17 seeing some of the impact of that in that our
18 medical system is counted on so heavily for the
19 medical care for beneficiaries as well as retirees
20 that we get pulled in so many directions that we
21 can't stay totally focused on our combat troops as
22 we should be at times like this. This is when we

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1 cannot meet all of those different taskings. So I
2 think as we focus on the business of medicine it
3 does pull us away from doing things that are not
4 part of the business of medicine in the civilian
5 world, and that is taking care of combat
6 casualties, also preparing them to go to war.
7 We've heard a few comments about preparing people
8 through resiliency training. It's really what we
9 need to be doing. We need to focus as much
10 research on the prevention of PTSD in combat
11 situations as we are of treating it once they
12 return. I do think we have an obligation to
13 prepare people not only mentally and physically,
14 but also emotionally to go into a combat
15 situation. So in the business of medicine,
16 prevention services are not necessarily valued and
17 that is what happens as we try to run mental
18 health services. Prevention is going to take away
19 resources that you need to provide required care.
20 My last comment is really on staffing.
21 I don't think I heard Commander Russell say
22 anything this morning that really wasn't true, at

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1 least in a general sense. His comments about
2 organizing, training, better preparing people are
3 absolutely right on target. None of these
4 programs will happen without people. We have
5 counted on our active duty mental health providers
6 to provide so much support in Iraq, Afghanistan,
7 Jabudi, Guantanamo, the list goes on and on, that
8 we have eroded the infrastructure of our mental
9 health system in the military. We have also had
10 initiatives to convert active duty positions to
11 civilian, and we've had other initiatives to try
12 to give us resources with contract dollars.
13 Contract individuals don't necessarily fit the
14 bill for these services, they just don't. They're
15 not people with the necessary experience, they're
16 temporary workers. But we don't have an
17 infrastructure of people to do any of these
18 programs that have been talked about. And I know
19 because I, along with Captain Klam, tried to keep
20 our ship afloat in providing services when people
21 deploy. They're responsible for major programs
22 and they deploy. Commander Johnson who spoke,

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1 she's coming to me next week as a member of my
2 command. I can guarantee you she'll deploy. So

3 all the programs you just heard about, she'll be
4 trying to implement probably from Iraq or
5 Afghanistan. It doesn't work. So the basic issue
6 here is getting people, a stable force of active
7 duty, not contract, but supplemented by our
8 civilians. They're a valuable part of our system,
9 but they can't run the entire program and they
10 can't deploy. So you see a lot of turnover. And
11 I will be one of those that's leaving and just one
12 more loss to our community because we can't bring
13 people in and we can't sustain the force. I guess
14 if there's anything, I hope your message is
15 realistic and doable and for that it has to be
16 based on getting the right number and the right
17 types of people to carry out these programs.
18 Thank you.

19 COL ORMAN: Before you leave, what are
20 your recommendations for enhancing the base,
21 retaining people other than Commander Russell's
22 stop loss which may or may not fit with your

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1 personal agenda?

2 CAPT VAUGHAN: When I saw that I went oh
3 no. In all honesty, I can't believe we haven't
4 had a stop loss before now. We've had them when
5 we were in far less a crisis as we are now. There
6 needs to be an immediate retention program, there

7 needs to be retention bonuses, there needs to be
8 pro-pay. We need to also be sure that we maintain
9 the infrastructure of our system. And right now
10 we are so desperate to deploy people that we are
11 absolutely robbing any sort of stability we have
12 in our programs. Some of you may have heard about
13 a research program we have going here in virtual
14 reality. Dr. McClay is scheduled to deploy. What
15 happens with that research program? So we have to
16 create an infrastructure and set some limits
17 because we're just sort of feeding on ourselves.

18 COL ORMAN: And one follow-up question
19 since you're retiring and I know you can be
20 totally honest.

21 CAPT VAUGHAN: I always have been
22 honest.

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1 COL ORMAN: I'm not debating it. What
2 kind of feedback mechanism does Navy medicine have
3 so remarks that you're making right now, other
4 than to the task force, make it up to your
5 leadership level? The Army has our surgeon
6 general here, I can assure you he's hearing this
7 stuff, but what mechanisms are available to you
8 and to your colleagues that gets up to your
9 Admiral Arthur that says, "Sir, we're melting
10 down," and where's the fix?

11 CAPT VAUGHAN: Well, I think our
12 specialty leaders are key to that. So I think the
13 message goes -- I'm just not sure what the
14 mechanisms are for doing something. That's why I
15 just -- there has to be a more organized fashion
16 and a public recognition of the crisis we're in.
17 What we all have in the military a tendency to go
18 "Oh, well, we'll fix that but let's not display it
19 too publicly." And I do think there's part of
20 we're just trying to swim as fast as we can and
21 there are many initiatives going on that are
22 fixing problems, but they are disjointed and there

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1 is not a focus. There's considerable amount of
2 money out there that was given in support of the
3 PDHRA, and the problem is they gave contract money
4 to hire mental health professionals for Twentynine
5 Palms, California. There is not an unemployed
6 mental health professional within a hundred miles
7 of Twentynine Palms. Again, this is where that
8 active duty base has to be there and then you can
9 supplement with other areas but the programs are
10 being developed in isolation of each other.
11 There's an educational program being developed DoD
12 for psychologists, but it's also a bit
13 disconnected, one of the big three Ds from other
14 programs. So that consolidation and continuity is

15 not happening.

16 DR. MacDERMID: This will be the last
17 question.

18 SPEAKER: Actually, this is more of a
19 comment. You just mentioned PDHRAs. VHA was
20 never funded for that either even though we're
21 required to attend.

22 CAPT VAUGHAN: Attend? I'm not sure --

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1 SPEAKER: Attend the PDHRAs.

2 CAPT VAUGHAN: It's the post-deployment
3 health reassessment.

4 SPEAKER: I know what they are. We just
5 had one last weekend here at Mesa Armory. There's
6 a VHA directive that requires VHA presence at each
7 PDHRA. There's a schedule sent out by Colonel
8 Walsham to all the sites. So that's what I'm
9 talking about. It's another requirement for this
10 that no funding was provided for. We sent out a
11 dozen people.

12 CAPT VAUGHAN: Yeah. Thank you very
13 much. I appreciate it.

14 DR. MacDERMID: Thank you very much for
15 your contributions. I believe we now go into
16 closed session until 1:00 p.m., correct? Okay.
17 Thank you. So we will adjourn for an hour, and
18 the task force members will return back to our

19 other space. Thank you.

20 (Recess taken until 1:10 p.m.)

21 COL DAVIES: Thanks, Dr. MacDermid. As
22 the acting designated Federal official for the

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1 Armed Forces Epidemiological Board, a federal
2 advisory committee of the Secretary of Defense
3 which serves as a continuing scientific advisory
4 body to the assistant secretary of defense for
5 health affairs, and the surgeon's general of the
6 military departments, I hereby call this meeting
7 of the congressionally-directed task force on
8 mental health an armed forces epidemiological
9 board subcommittee to order. Dr. MacDermid.

10 DR. MACDERMID: We've invited speakers
11 from the TRICARE system. Task force members know
12 that we've been learning a lot about TRICARE, we
13 have lots of questions about TRICARE and so this
14 afternoon's session is intended to help us
15 understand that. So we have prepared remarks and
16 then time for questions. So welcome to our
17 guests.

18 MR. SPARKS: My name is John Sparks.
19 I'm with the TRICARE regional office west here in
20 San Diego, and on behalf of Rear Admiral Nancy
21 LaScavage, (?) who is the regional director here,
22 we have prepared some remarks for you, and I hope

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1 during the process you will have lots of
2 questions.

3 I oversee the provider network
4 operations for the region and in a former life was
5 a mental health therapist so that's part of the
6 reason I'm here along with our other clinicians
7 Kris Large and Colonel Sherilyn Curry. So what
8 we'll do is -- it's a high-level briefing, so,
9 again, please at any point, if you have questions
10 jump right in and we'll -- that's the best way to
11 do a thing like this.

12 Benefit information. As you probably
13 all know our beneficiaries are all of the
14 Department of Defense beneficiaries, active duty,
15 active duty family members, retirees and their
16 family members, and other people that blow in
17 through the different designee areas. On the
18 benefit itself; having been on both sides of the
19 fence, being retired Navy and having been out in
20 the commercial world for a while, our benefit
21 structure is really a very rich benefit. And I
22 know Chris Large and I were discussing that this

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1 morning. The outpatient benefit is basically an
2 unlimited benefit. By policy it's -- there's a
3 baseline of two sessions per week, but if there is
4 medical necessity you can really have two, three,
5 four sessions a week. If you're an inpatient you
6 can have five sessions a week. The inpatient
7 benefit based on medical necessity is broken into
8 the acute levels which again would be
9 pre-authorized based on medical necessity, unless
10 it's an emergency. There is also a full continuum
11 of care with a partial hospital program,
12 residential treatment programs, and also substance
13 abuse rehab for the chemical dependency.

14 This is just -- in fact I won't read
15 these to you. I know you can all read. This is
16 how much behavioral health that was done just in
17 calendar year 2005 in the west region. Again,
18 we're 21 states including Alaska. So as you can
19 see pretty close to three quarters of a million
20 visits. So we did a fairly healthy amount of
21 work. Psychiatry didn't take up as much as you
22 might think.

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1 Current issues. These are probably
2 issues that you're hearing out in the field. How

3 many of you have heard issues with child and
4 adolescent psychiatry? Everybody in the room. It
5 is a real issue because unfortunately there are
6 such a small number of child and adolescent
7 trained psychiatrists in the entire country. And
8 so in areas that are rural, and fortunately or
9 unfortunately, we tend to put our warriors and
10 war-making folks out in areas where they can
11 practice their trade. So there aren't many child
12 psychiatrists around and it presents a real
13 problem for our beneficiaries. Access to
14 residential treatment centers. How many of you
15 have had clients or patients go to RTCs and how
16 hard was it to find one? Mrs. Krall is going to
17 talk about how many we have in the region. But it
18 is difficult, and a lot of the difficulty comes
19 because so few facilities want to participate with
20 TRICARE because they literally have to go through
21 a dual certification process. And, again, I'll
22 let Marge talk more about that. Developmental

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1 disorders are always an issue, and right now
2 treating autism spectrum disorder with alternative
3 behavioral analysis is proving doable but somewhat
4 dicey in areas. Any questions on any of these?
5 Anything jump --

6 SPEAKER: You didn't mention IOPs.

7 MR. SPARKS: IOP. Oh, well, we're going
8 to mention IOP. IOP is, to me, one of the real
9 problems in our benefit structure because we don't
10 cover it as a benefit. It is the standard of care
11 in the real world in the commercial area, and
12 especially for children and adolescents. You can
13 keep a kid out of the hospital using a good IOP,
14 you can also step them down from hospitals. In
15 the chemical dependency side, again, it is the
16 standard of care. That is one area that I think
17 -- and it's being looked at now. There is a
18 working group looking at redoing the benefits. So
19 it's an area we really need to hit hard. What
20 else? What questions do you have from this?

21 DR. McCORMICK: As a civilian federal
22 employee, you have mandated mental health parity

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1 in your health benefits plan, but there isn't in
2 TRICARE; is that correct? There are limitations
3 on inpatient days for mental health and not for
4 medicine?

5 MR. SPARKS: There are statutory
6 limitations, granted. But as with any statute in
7 the government, if there is medical necessity to
8 support it, those limitations can be expanded.
9 Would you agree with that, Dr. Chandler?

10 DR. CHANDLER: Yes. Absolutely.

11 DR. McCORMICK: The other point is one
12 thing that's been unclear, because we actually
13 frankly got -- providers in Fort Hood, Texas, we
14 met with a large group of providers, and it was
15 their perception that outpatient substance abuse
16 for teenagers was not a covered TRICARE benefit.
17 Is that true? Are there diagnostic limitations on
18 what kind of outpatient treatment can be covered?

19 MR. SPARKS: I'll let our clinician
20 speak more to that. There are limitations on the
21 provider's credentials.

22 DR. McCORMICK: I understand that. I'm

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1 talking about the diagnosis. Is substance abuse
2 an adequate diagnosis to get a benefit for simple
3 outpatient care?

4 MR. SPARKS: I would answer yes to that.
5 Would you not agree?

6 MS. KRALL: Substance abuse for
7 teenagers is a covered benefit. What is not
8 covered is individual services for substance
9 abuse, it's only group therapy. So if you were in
10 a hospitalization program, a rehab program it is
11 covered. But as an individual provider doing
12 services, that would not be.

13 DR. McCORMICK: So the answer is no?

14 MS. KRALL: The answer is in the right

15 circumstances it is. They need to be inpatient.
16 They need to be covered by a facility that offers
17 substance abuse.

18 DR. McCORMICK: I'm just pointing out
19 the reality that in many places you just said, the
20 teenager can only get residential care by
21 traveling many, many hundreds of miles. So you're
22 basically saying that a kid with substance abuse

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1 problems, to get care has to go to a residential
2 center rather than to get outpatient substance
3 abuse counseling?

4 MR. SPARKS: Unless there is a dual
5 diagnosis and many instances there is and you can
6 then do individual, or you can do group --

7 MS. KRALL: Actually, I think the caveat
8 here is it must be delivered by a substance abuse
9 hospital or a joint commission hospital offering
10 substance abuse programs. It doesn't mean they
11 have to be inpatient, they can get outpatient
12 treatment, but it has to be that level of provider
13 that gives it. And individual provider offering
14 individual sessions would not be covered for the
15 substance abuse diagnosis.

16 DR. McCORMICK: Even if they're a
17 certified (off mi ke)?

18 MS. KRALL: That's right.

19 MR. SPARKS: Other questions? Let's
20 drop down one more slide. Anymore benefit
21 questions? Going once, going twice.

22 MS. FRYAR: It's in regard to the ABA

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1 therapy; is that a covered benefit as far as the
2 sessions with the providers. Can you speak to
3 that a little bit?

4 MR. SPARKS: I'll let Marge speak to it
5 more than me. What particular questions did you
6 have about ABA?

7 MS. FRYAR: I'm just curious if someone
8 is going home if they're actually given care
9 that's covered, if there's so many hours of
10 coverage for those providers, or how they actually
11 work?

12 DR. CHANDLER: The caveat about coverage
13 for applied behavioral analysis is that it is a
14 benefit and it's covered only under the ECHO
15 program. If the child is enrolled in ECHO and has
16 a pervasive developmental disorder, then they can
17 receive applied behavior analysis up to a maximum
18 limit of \$2500 per month, and therefore, the
19 number of sessions would depend upon how much is
20 charged per session. And it must be delivered by
21 a certified provider. Good question.

22 MR. SPARKS: Any other benefit specific

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1 questions? Well, let me introduce Marge Krall
2 from TRIWEST.

3 MS. KRALL: Good afternoon, everybody.
4 I am Marge Krall. I'm the director of behavioral
5 health for TRIWEST health care alliance, and we
6 are the contractor that administers the benefit
7 for the western region. And with me is Dr.
8 Chandler, who is the senior behavioral health
9 medical director for TRIWEST. Dr. Chandler
10 actually resides here in San Diego, I'm based in
11 Phoenix. I come to San Diego in the summer.

12 We prepared these slides based on the
13 questions that we had and it looked liked there
14 was interest in how providers are credentialed.
15 So I'm taking a shot that we're answering what I
16 think you want. Otherwise, just throw the
17 questions at us.

18 The list that you see in front of you
19 are the providers, the mental health providers
20 that are authorized by TRICARE to see TRICARE
21 beneficiaries. So it's the usual run of the mill
22 that you would find in the commercial sector. I

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1 don't think there's any level there that you
2 wouldn't see. What you don't see are things like
3 addiction counselors and some of the substance
4 abuse specialties. They are not TRICARE certified
5 providers. So the question was how do you
6 credential these? Everybody up here has of course
7 the basic training requirement, they also have an
8 experience requirement, and it's usually in the
9 vicinity of two years supervised up to 3000 hours.
10 It's a little bit different for each level, but
11 there is a requirement beyond the basic education
12 for the credentialing of this. Next slide,
13 please.

14 TRIWEST actually subcontracts the
15 network for the whole west region. TRIWEST, as
16 you may or may not know, is owned by Blue Cross
17 Blue Shield companies. We've got 13 owners. So
18 each of those owners actually provides a network
19 for TRIWEST, we have 21 states. So these might be
20 one state, it might be two states, it might be a
21 conglomeration of states, but those net-subs
22 actually provide the contract -- the network

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1 providers and they do the credentialing. TRIWEST
2 itself does Iowa and Nevada; we do not use a

3 subcontractor for those two states. These are the
4 areas that we look at for primary source
5 verification for providers. They must all have a
6 criminal background check. We look at the
7 national practitioner databank. The Medicare
8 eligible, we always look at the education level.
9 The training being the amount of experience,
10 supervised, et cetera, the license, they must
11 carry malpractice insurance and a clinical nurse
12 specialist must be on the national certification.
13 Next slide.

14 The question was asked: How does a
15 beneficiary find these people? You do two things
16 -- well, you actually can do three things. You
17 could be referred by a primary care physician.
18 It's not necessary to get this specialty care
19 because we can self-refer in behavioral health.
20 But you would call 1-888-TRIWEST, which would take
21 you to an IVR customer service representative, you
22 say behavioral health, it takes you right to the

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1 front end of the crisis line that can do OS and
2 referral, give provider locator sorts of services.
3 They also could go to the TRIWEST website that has
4 the directory listed. It's listed by state, it's
5 listed by specialty, and it's broken down in
6 several ways, zip codes -- it's very easy to

7 navigate. So that's how a beneficiary would find
8 the network. Next slide.

9 And in the west region we have over
10 12,000 behavioral health providers contracted and
11 we have 89 facilities. Now, the other thing that
12 you need to know and you probably do know that you
13 can provide TRICARE services without being
14 contracted. We want to use network providers, but
15 if you're certified you can also deliver those
16 services. We have many beneficiaries in the
17 hinterlands, so to speak, the white space, that
18 will not have contracted providers because they'll
19 be onsies/twosies, but those TRICARE certified
20 provider may see these people. These are our
21 standard beneficiaries. So the network, or the
22 availability, is actually larger than the network

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1 is. Is that confusing? Next slide.

2 COL ORMAN: The issue we hear from both
3 our colleagues, perhaps our own personal
4 experiences of behavioral health providers, we
5 hear it from beneficiaries, we particularly hear
6 in installations that are geographically isolated,
7 the hinterlands, which is that the networks look
8 relatively robust when you pull up the website,
9 but when you start calling them either is a
10 provider to facilitate a handoff for one of your

11 patients, or you're an E-2's wife trying to
12 navigate the system. You find out that what looks
13 good on the web in fact doesn't really exist in
14 terms of actual availability. I was wondering if
15 you could perhaps speak to how TRIWEST attempts to
16 scrub those lists so that they represent reality
17 as opposed to this is who's contracted with us,
18 but for a variety of reasons, perhaps economic,
19 they don't make appointments available to the
20 beneficiary population?

21 MS. KRALL: In the first place, when
22 there is a network contract there are

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1 requirements, access requirements that that
2 provider signs. If we're finding providers that
3 have just signed a contract and have not really
4 carried through -- now we all know there are
5 specialties and John already mentioned the child
6 psychiatrists, I mean, we can't manufacture those.
7 There's -- I don't know, very few in the whole
8 nation when you're really looking at the per
9 capita, but if we find that a provider is not
10 doing the access that is within their reach to do,
11 that's when provider relation service would be
12 educating those people or removing them or
13 whatever needed to happen. If we're talking about
14 particular pieces of the country that don't have

15 then we're probably going to be in the same boat
16 that everybody else. We're going to be on the
17 telephone. I've had provider locaters use the
18 phone book to call providers and to see if they
19 are available to see these patients. Then we'll
20 get them certified if they're qualified. So
21 there's a lot of behind the scenes work that
22 occurs that you would never see on a provider

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1 directory. The directory is there for easy access
2 and for the most part it works very well,
3 particularly in the metropolitan areas. We all
4 know there are issues in other areas. And you
5 asked that -- I think the second part was how do
6 we know if they're doing this? Usually people
7 will complain that's the first thing you'll know.
8 You'll hear it from the MTF, you'll hear it from
9 individuals, we'll hear it on our crisis line that
10 they've tried to get a provider, they can't get
11 in, help us find one, that's how we know.
12 Provider relations also does focus reviews. They
13 just did one in Colorado to focus certain
14 specialties. They made cold calls. They do this
15 regularly to see if they're meeting the standards.

16 COL PEREIRA: So you have no obligation
17 to try to bring in more providers to areas where
18 you're short to entice them to provide them any

19 kind of incentive to pad up those areas where
20 services are not available or very few services
21 are available?

22 MS. KRALL: We have an obligation to

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1 provide a network, but we have to provide that
2 network within the standards of TRICARE, and I'm
3 sure that Chris and others -- do you want to add
4 anything to that? John?

5 MR. SPARKS: Your point is well taken.
6 We have a lot of areas where providers just don't
7 exist, and if I'm hearing your question; you're
8 asking if TRIWEST has an obligation to perhaps pay
9 providers to come into an area? Is that the
10 question?

11 COL PEREIRA: Yes. Somehow entice them
12 or recruit them, to find them, to somehow bring
13 services up to the level that they need to be.

14 MR. SPARKS: Exactly. And the question
15 is a marvelous one, and it is -- I've lived in
16 rural areas with the military and it is so
17 frustrating to try to get good services. The
18 answer to that question, though, is: I think
19 TRIWEST is not able to do that, to pay or entice
20 providers to come to an area. Now, do they
21 encourage people when they go out? Absolutely.
22 They encourage people to participate. But if a

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1 particular specialty does not exist, say somewhere
2 in North Dakota, or even Alaska. Paramedics in
3 Alaska has been a devil of a place to get
4 providers. Even if you enticed a provider to move
5 to an area, you would still have to guarantee him
6 or her an income and a patient population. If
7 it's a small rural area, chances are a child
8 psychiatrist for instance is not going to be able
9 to survive, nor would the facility hiring one at
10 250- or 300,000 a year. There's just not the
11 workload to really be able to support it even
12 though -- we can send them plenty of business from
13 the military but not enough to really support it.
14 So to answer your question, in many areas it's
15 just not possible to get a provider to come and
16 work in the community.

17 MS. LARGE: So the contractor doesn't
18 have the ability to recruit like that. There are
19 mechanisms that the individual MIFs where they
20 have the ability to bring on contractor providers
21 through the resource sharing program and through
22 other contract vehicles. So if they can establish

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1 a need and have the volume of patients to support
2 that, then they can put out that need to the
3 contractor and they will go out and they will go
4 out and try to find these providers to come in.
5 So that is the vehicle. It's not to bring the
6 provider into the network and physically move them
7 out in the community, but it is to bring them to
8 the military treatment facility to care for
9 whatever that capacity is that's not being
10 addressed.

11 COL PEREIRA: How about to recruit them
12 in the local communities then?

13 MS. LARGE: That's not the vehicle we
14 use. We use bringing them into the MIFs, so
15 they're -- there's some ideas, and in some places
16 they work with the local communities. We have
17 lots of sole source community facilities where the
18 community may need that additional capacity or
19 provider, and also the VA. So there's different
20 types of ventures out there where they try to do
21 these types of things, but the vehicle that exists
22 currently is the contracting within the MIF to

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1 bring in through the resource sharing mechanism,
2 those providers that they do not have adequate

3 numbers of.

4 COL PEREIRA: One of the things that
5 we're hearing is that the reimbursement rates are
6 quite low. Are you able to adjust the
7 reimbursement rates to try to encourage providers
8 to be providers particularly in areas where there
9 are few available?

10 MS. LARGE: There's a mechanism that's
11 called the CMAC waiver, so there's a package
12 that's put together in these rural areas that
13 address the need and ask for additional allowances
14 above what the CMAC rate is, the Champus maximum
15 allowance rate, and those go through a vetted
16 process and they get approval and we have numerous
17 one all across our region. So that's on a
18 case-by-case basis. Specialty by specialty.

19 COL PEREIRA: Are the reimbursement
20 rates standardized in the regions, do you know, or
21 in all of the regions?

22 MS. LARGE: The CMAC rate is by zip code

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1 and region specific. So there's a website
2 actually. If you go on the TRICARE management
3 activity website, you pull it up by your zip code.
4 So just say for San Diego region what the CMAC
5 rate is for various procedures and things. So
6 that's set, and so that's the base. So if you put

7 in for a waiver, you're going in for something
8 above that because there's due cause because of a
9 sole provider in the area. So it's supply and
10 demand, and that's what it's kind of generated
11 from.

12 COL PEREIRA: I'm sorry to keep going,
13 but I have another question about providers. One
14 of the things that we hear is that it's difficult
15 for providers to get credentialed. There's a lot
16 of paperwork involved, there is a long waiting
17 period. And we've heard that both from
18 installations and from individuals. Could you
19 talk to that a little bit?

20 MS. LARGE: When you're saying
21 "providers," you're still saying mental health,
22 right? You're focusing on mental health?

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1 COL PEREIRA: We're all about mental
2 health.

3 MS. LARGE: Okay. Marge you want to
4 speak to those, because I know you've got some of
5 that in your slides coming up.

6 MS. KRALL: I don't know if I've covered
7 much more of that, but I can mention the process I
8 just showed you, what we're looking for, is the
9 process that goes with credentialing. I mean the
10 primary source verification. If you're talking

11 individual providers I'm not so certain that its'
12 such an onerous process. I mean, it's filling out
13 the paperwork completely the first time and for
14 TRIWEST it goes through the net-sub and they
15 process that. The hospitals, if they're joint
16 commission hospitals, are not going to have a lot
17 of problems. It's a matter of signing the
18 contract and then getting it through the systems.
19 So I'm not --

20 MS. LARGE: Are you speaking to the RTC
21 PHP certification with the addition of the MAXIMUS
22 or is that the issue because I'm not really, like

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1 Marge --

2 COL PEREIRA: Could you translate? I
3 have no idea what you just said.

4 MS. LARGE: For residential treatment
5 facilities and partial hospital programs there's
6 an additional requirement by policy for our
7 national quality monitoring contractor which
8 currently is MAXIMUS, to do -- and approve that
9 certification for that. So this is what is
10 different from a private sector and what John
11 spoke to is an additional layer that is perceived
12 by facilities is expensive, not worth the hassle
13 for the reimbursement rate, and those are the
14 issues that we have been dealing with. And this

15 controlled by the code of federal regulations so
16 that's some of the tie-in to here.

17 DR. McCORMICK: Let me make sure I
18 understand. So that's something that might be
19 changed. So are you saying that a facility that
20 has, for example, CARF accreditation would
21 normally be able to be paid by Blue Cross, but to
22 be a TRICARE provider they have to get this

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1 additional certification?

2 MS. KRALL: That's correct.

3 DR. McCORMICK: I guess for me the
4 Litmus test on your credentialing process is this:
5 I know Blue Cross obviously has a lot of
6 beneficiaries who aren't TRICARE. I know you
7 carve out the mental health benefits someplace as
8 well. For me the question is is the -- for an
9 individual psychologist, psychiatrist, social
10 worker in mid-town America, is the process of
11 becoming credentialed to be a TRICARE provider
12 significantly different than becoming a provider
13 for your general other mental health benefit that
14 you might give to Company X's employees?

15 MS. KRALL: I don't think so. The
16 credentialing is pretty standard and that's why
17 the Blue Cross programs are usually just taking
18 what they have and adding whatever TRICARE

19 requires. TRICARE has the experience level in it
20 that might not be in your commercial sector. A
21 psychologist must have x number of hours in
22 addition. Say the marriage and family therapies

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1 for instance must have several hours, 150 hours of
2 individual supervision. A lot of different
3 criteria that you may not see in the commercial
4 sector, but the basics would be the same.

5 DR. McCORMICK: One more question on the
6 payment to providers and it's a very similar vein
7 to what I just asked. Does anyone look at or do
8 you know whether the TRICARE rates in a given
9 locality are competitive with the rates paid by
10 Blue Cross, for example, in a commercial account,
11 or Aetna with the general standard practice?
12 Because what we hear from providers is that their
13 perception is that they get less from you, from
14 TRICARE, than they do from other behavior health
15 managed care entities.

16 MS. KRALL: John, you want to --

17 MR. SPARKS: Actually, I wanted to weigh
18 in on that one earlier. TRICARE, as you may or
19 may not know, in 1992 was tied was to Medicare,
20 and Medicare reimburses on a locality-based
21 system. So for instance, in Seattle, Washington,
22 a provider is going to make just a little bit more

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1 than a provider 25 miles up in Everett,
2 Washington. A few dollars, but a few dollars
3 count. So in 99 percent of the cases the TRICARE
4 reimbursement rate will be exactly the same as
5 Medicare, and for those of you that are physicians
6 are practicing, Medicare and TRICARE don't size up
7 very well to our commercial counterparts. Blue
8 Cross and Blue Shield in most places pay
9 substantially more on the commercial side. So
10 that is one of the major battles that we have been
11 fighting for since 1992, and my hats off to the
12 network reps that are out there every day. I've
13 got a major up in -- Lieutenant Colonel select, up
14 in Alaska that literally almost begs providers to
15 continue to participate because the reimbursement
16 rate is so low. And that's where Congress can
17 really help us.

18 MS. LARGE: One more thing on the
19 credentialing and mirroring what Marge said, we
20 are not at different -- in our credentialing
21 requirements, one thing that is -- that is the
22 major thing that sticks out is the criminal

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1 history background check. That is not a
2 requirement on most of the commercial side, that
3 is on ours and that was put in place for very good
4 reason. So when they get accredited by
5 accrediting bodies that -- and when we look at
6 them, that's the one that stands out that is different.

7 DR. McCORMICK: Do you feel there's any
8 political added value to having this additional
9 accreditation to a facility that already goes
10 through Carver JCAH (off mike)?

11 MS. LARGE: Well, we can say you're
12 preaching to the choir. And I just mentioned this
13 to Mary in the back of the room and it's ironic.
14 The 2nd of November, I'm going back to D.C. to be
15 part of a mental health workgroup initiated by
16 General Granger off of TMA, and we're looking at
17 benefit, and we're looking at network adequacy.
18 So I had to ask Mary, does one side now the other
19 side is doing this? Not all the time in
20 government we know left hand or right hand here.
21 So those are exactly the things that are on this
22 agenda. Looking at value added of this additional

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1 certification -- everyone has their reason why it
2 was started, but things have changed from 30 years

3 ago and so we have to move on. So we're trying to
4 put this together and get a better rationale and
5 some data support. Why are we continuing to do
6 this and what value added and has it really given
7 us better outcomes? Or we didn't do anything
8 pre-numbers so we don't know anything post-
9 numbers, what's the difference? So those are what
10 we're going head on right now. And while I'm up
11 here on the bandwagon, another thing is trying to
12 get this out of the code of federal regulations so
13 as standards of care change we have a process for
14 new and emerging technology on the med/surg side.
15 So when new technologies come about, standards of
16 care change, there's a process for this going
17 through and it becomes benefit. We don't have
18 that parity on the mental health side. We're
19 stuck in a time warp here and to have to go
20 through congress every time, we need to re-look at
21 the benefit to keep up with our needs and changing
22 needs of standards of care. That's a very onerous

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1 process. We need to get that out of that code of
2 federal regulations so that we could modify the
3 benefit in terms of how practice changes over
4 time.

5 DR. McCORMICK: I just want to make sure
6 I understand. What I thought I heard you saying

7 is that if there's change in practice, standard of
8 care for med/surg you're able to modify the
9 benefit without having to modify a regulation, do
10 something at a very high level, but when there's a
11 change in standard of practice for mental health
12 there's some regulatory --

13 MS. LARGE: You're correct. For some
14 reason all the mental health issues got wrapped
15 around the code of federal regulations. With the
16 med/surg components we have a process that's
17 called new and emerging technologies. So for
18 instance the IOP, if that was something we saw as
19 new and emerging technologies and includes
20 standards of care, too. So there'd be a whole
21 evidence-based medicine group that exists there to
22 review the literature, evidence based, rank it,

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1 put it out there, make the recommendations, get
2 the costing on it, boom, benefit.

3 COL PEREIRA: Back to the issue of
4 providers. We don't want to put any more barriers
5 in front of providers than already exist because
6 we're -- especially in some areas we're very
7 short. And you mentioned criminal background
8 checks. Now, we who have to go through security
9 clearances know that some of those things can take
10 a very long time sometimes. Were you mentioning

11 that because that is one of the things that slows
12 down the process? No?

13 MR. SPARKS: No.

14 COL PEREIRA: So there is no one element
15 that makes the process slower?

16 MS. LARGE: To my knowledge the process
17 is not slow. I've never heard a provider say that
18 the process is slow. The comments in terms of the
19 time of complexity of certification has only been
20 related to the added certification required by
21 MAXIMUS, the national quality monitoring
22 contractor for those residential treatment centers

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1 and the partial hospital programs. So it's not
2 the individual providers. Those go very smoothly
3 as long as the provider provides all the
4 information that they're requested.

5 MR. SPARKS: It can be slow if the
6 provider is not sending in the materials correctly
7 or leaving documents out.

8 COL PEREIRA: I understand. One of the
9 issues that we're hearing from providers is a slow
10 reimbursement time. Is there something -- who
11 controls that? And is there some mandate that
12 that be done in a timely manner?

13 MS. KRALL: That actually is the
14 contractor's responsibility, and claims are to be

15 paid within 30 days. Now, a clean claim is to be
16 paid within 30 days, and that's the key. It has
17 to be a claim that is filed properly, filed with
18 the proper authorization. All of the elements
19 need to be met and it will go through in 30 days.
20 And the percentage of TRIWEST claims through in 30
21 days is quite high. But those providers that are
22 not getting paid there's a glitch somehow, and

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1 we're working those all the time, but those are
2 probably the ones that they are not electronically
3 filing or they are electronically filing in a way
4 that the system isn't picking it up, and we see
5 some of that, because of the systems not being
6 compatible. But as a general rule, in a high
7 percentage they're paid in 30 days.

8 COL PEREIRA: What's the process for
9 getting the correct information if the paperwork's
10 not filed correctly? Does somebody contact the
11 provider and say you didn't dot this "I" or cross
12 this "T"?

13 MS. KRALL: Their explanation of
14 benefits should tell them. If it does not, they
15 no doubt will call the claims department and they
16 can do that. They can go right to WPS, Wisconsin
17 physicians does the claims for TRIWEST. They can
18 get a customer service and they can look that up

19 to see what's wrong with that. If it's a
20 behavioral health claim, they're probably going to
21 go through the Phoenix office. I have two project
22 managers in Phoenix that do nothing but that. We

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1 work directly with providers and those complex,
2 cumbersome claims are the ones that they go
3 through onesies, twosies, and work them out and
4 they almost always something in a mismatch between
5 what they requested and what they billed or
6 something like that that doesn't -- the system
7 doesn't pick up.

8 COL PEREIRA: How long would a provider
9 wait -- or what would happen if a provider didn't
10 call and say, hey, what happened to this claim
11 that I submitted six months ago? If they didn't
12 call would that be the end of the story?

13 MS. KRALL: Probably because nobody
14 would know there was a problem. They would get
15 their EOB that would probably either deny, or say
16 it didn't pay; they're going to get a
17 communication when they file. It's going to say
18 something. But if they don't get the check, I
19 mean, trust me, they'll call. But if they didn't,
20 no one would know the difference. They wouldn't
21 know that they were expecting that. But we do a
22 lot of hands on behavioral health claims.

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1 DR. McCURDY: I think sometimes it gets
2 too complex for me so I try and look at it like a
3 simpleton. And I want to just ask about two
4 different statements that have been made that I'm
5 trying to figure out how they go together. One is
6 that there was a slide you had up there earlier
7 that showed the number of mental health providers
8 in the network, network facilities, and I think
9 the comment was we have a very robust network of
10 providers. And I'm trying to reconcile that with
11 we only reimburse a Medicare rate and then we have
12 to beg and cajole providers to be a part of our
13 network. So in my way of thinking about it either
14 one of those statements isn't right or somehow
15 we're able to have a robust network despite that
16 difficulty in reimbursement. Maybe the answer is
17 more complex, but I'm curious what you could say
18 to that.

19 MR. SPARKS: When you're building a
20 behavioral health network, and I did that for the
21 last contract, you're selling not just the
22 reimbursement rate, because most providers and

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1 I'll say most, are in the business to be
2 caregivers. And they will take a lower rate
3 especially if they know it's associated with the
4 military, especially in today's operational tempo.
5 I mean, we're seeing more providers come out of
6 the woodwork wanting to provide services I think
7 than we ever have. But there comes a point when
8 in areas where the reimbursement rate is so
9 off-the-scale high, like Fairbanks, Alaska, that
10 providers do start really pushing for
11 locality-based waivers, which we try to affect for
12 them. But to answer your question, there are a --
13 in fact the total network, medical and mental
14 health is over 109,000. So we have a lot of good
15 patriotic providers in this country. But in rural
16 areas we do have to cajole and sometimes beg them
17 to keep practicing, but we do what we have to do
18 to provide services. Did that answer your --

19 MS. KRALL: I think I can add to that as
20 well. The incentive for many providers is market
21 share too. If you're a behavioral health provider
22 and you're sitting in the lap of a high military

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1 community, you're going to get a lot of patients
2 and the volume makes up the difference. So we can

3 keep them very full, so that would be one
4 incentive to sign up.

5 DR. McCURDY: I'd like to build on that
6 question. Did I see the chart correctly when you
7 talked -- your chart, in terms of number of
8 visits, I guess that was in a year about 676,000?

9 MR. SPARKS: There was 725 and change.

10 DR. McCURDY: Of outpatient visits in
11 TRIWEST?

12 MR. SPARKS: In the 21-state region.

13 DR. McCURDY: That struck me as a low
14 number. I don't know. I don't have anything to
15 compare it with except I operate in an
16 organization that deals with med/surg and
17 psychiatry and we do about 800,000 a year in one
18 little place in Charleston, South Carolina. That
19 number just rattled in my head.

20 MR. SPARKS: That was the number that we
21 pulled out of the M-2 database. That was just
22 purchased care, I'm sorry. That was not the

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1 direct care. The military treatment facilities,
2 it was just purchase care. So that was the number
3 of visits we paid for in the civilian sector.

4 COL DAVIES: That might be interesting
5 to compare those.

6 MS. KRALL: Well, I think we lost our

7 slides, huh?

8 DR. MacDERMID: This computer is running
9 on battery and they need to go get a power cord.
10 So they are going to do that. Unfortunately we
11 don't have hard copies of your slides. So if you
12 can do the best that you can.

13 MS. KRALL: Well, now I can say anything
14 I want and you won't even know if it was written
15 down. Are we okay with the credentialing? Do we
16 have all those questions answered?

17 The next thing I had was a bit of an
18 overview of levels of outpatient care. John
19 talked about the benefit and I thought I would go
20 a little more in depth of what outpatient care
21 entails for TRICARE. As we mentioned outpatient
22 services really do not have a limit as far as it's

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1 medically necessary, so we're not saying x-number
2 of visits, we're saying whatever you need. What
3 we do have is initial eight visits that are self-
4 referred visits. The patient can pick out any
5 provider that is qualified to see them and go for
6 eight visits without anybody ever touching it.
7 And we know that for our last two years in the
8 contract, 74 percent of the behavioral health
9 outpatient visits fell in the initial eight. So
10 we don't manage those. That's for them to do.

11 Anything that the provider needs in addition they
12 send in a treatment request form and then we
13 allocate what they ask for, whatever seems
14 appropriate. I will tell you that the denial rate
15 for outpatient visits is less than one percent.
16 We deny very, very little, as long as it's
17 appropriate. Occasionally we get an off- the-wall
18 therapy request that doesn't quite fit. So then
19 we have to do that. But what we cover in
20 outpatient would be individual and family therapy,
21 psychological testing, and we see quite a bit of
22 that in the region. We have neuropsych testing as

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1 well as straight psych testing. We offer some
2 multiple services in lieu of IOP. And we're going
3 to hit IOP. We've taken the liberty of throwing a
4 few things that we'd like to see and IOP is
5 certainly one of those. But in lieu of IOP we do
6 offer some multiple services and that would be
7 maybe several sessions a day or for several
8 sessions a week. It isn't the same as IOP. We're
9 paying for individual sessions or group sessions
10 and what that does to the beneficiary is increase
11 the co- pay. In an IOP world that's a program.
12 So one co-pay for that program per day. In the
13 multiple services world that's several services
14 that require a co-pay. So taking a standard,

15 maybe a retired person with a child and what might
16 be an IOP, might go from \$17 co-pay if it was an
17 IOP program, to \$57 a day, if it's multiple
18 services. So I'll just give you that flavor. But
19 the way we can make this work and get the care is
20 to do a multiple services. And those are TRICARE
21 services that are authorized with a TRICARE
22 provider.

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1 The initial eight policy, I just would
2 mention, used to be mandated for about 20 years it
3 was mandated. It left the policy manual when (off
4 mike) a couple years ago, and TRIWEST kept it in
5 because of the 74 percent being taken care of. I
6 mentioned the self-referral. I think that's a big
7 benefit for beneficiaries. Mental health, I don't
8 care how thin you slice it; it's got a stigma
9 attached. And we try to avoid that. We're trying
10 to work through those issues. But even the
11 beneficiary population doesn't always like to go
12 to a primary care physician or somebody to be
13 referred. They would prefer to pick their own
14 therapist, get their evaluation, get their
15 treatment in as private of an atmosphere as they
16 can. We give, without pre-authorization, we give
17 every provider one 908.01, which is an evaluation
18 code per beneficiaries, per year. We don't

19 pre-authorize that, they can just have that. They
20 can have medication management up to two times a
21 month without us ever touching it. So what we
22 have with the initial eight is really an initial

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1 10 or 12 or whatever, depending on the service.
2 So it's the contractor's method of trying to stay
3 out of their business so that they will get the
4 care and still monitor the quality of what's going
5 on.

6 When we look at inpatient, emergency
7 admissions can go directly into the hospital.
8 They do need to meet medical necessity, but we
9 won't look at them for 72 hours, or we'll look at
10 them when they send them in. They don't have to
11 scrambling for an authorization; they go in, as
12 long as it meets the medical necessity, it will be
13 authorized. But we will look at it within 72
14 hours to put an authorization in the system. The
15 non-emergent admissions will have to be
16 pre-authorized. And those will be like your
17 chemical dependency, rehab. They're planned
18 admissions and they need an authorization in
19 place. The partial hospitalization programs are
20 pre-authorized as well. We have half day, we have
21 full day. Anything four hours and under is
22 considered a half day, and anything over is a full

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1 day. The only problem with that is because of our
2 certification process that Chris mentioned,
3 MAXIMUS needing to certify, we only have eight of
4 those in the whole region. Now, we're 21 states.
5 Now, you can't service 21 states with eight
6 partial hospitalization programs that are day
7 programs going home at night. So that's a benefit
8 that is only of value in very few areas. We can
9 use a partial hospitalization program for chemical
10 dependency, because it doesn't have to be MAXIMUS
11 certified, but you can't use it for mental health,
12 and this is policy.

13 Residential treatment. Chris mentioned
14 that. These are these residential treatment
15 centers that are for kids. They are for kids up
16 to age 19. I don't think there are any in the
17 region that will take a 19 year old, but that is
18 the benefit, and we have nine of those in our
19 region. We actually use three in Texas that are
20 not in our region. We have contracted on in
21 Arkansas that's not in our region, because we're
22 close enough to those areas to still make that

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1 available. But once again, nine for this big of a
2 region is not very many. There are many, many
3 facilities that call themselves RTCs, but they are
4 not MAXIMUS certified, so they're not TRICARE
5 approved. Questions about any of that?

6 DR. McCORMICK: Is reimbursement an
7 additional problem? I understand that the dual
8 certification and I can certainly understand that.
9 I mean, more than one certifier come through is
10 only good for your quality assurance people's
11 longevity. Is reimbursement for residential and
12 partial hospitalization also an impediment to
13 people, your rates; is that also an impediment to
14 people trying to get in the network?

15 MS. KRALL: I don't think so. Jim, do
16 you believe that? I believe that our partial
17 rates and RTC rates are very competitive. Again,
18 it's market share. They have to -- to go through
19 the certification process you have to be able to
20 have enough TRICARE business to make it worthwhile
21 and that seems to be one of the drawbacks.

22 DR. POWER: I have just three quick

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1 things that came to my mind so they really don't
2 make sense in terms of logically connected. So

3 I'm just going to go with it.

4 MS. KRALL: We're mental health, that's
5 fine.

6 DR. POWER: The first is, within TRICARE
7 is there an individual plan of care that is
8 expected for every individual you serve?
9 Secondly, is there an electronic health record
10 that's connected to that individual plan of care?
11 And thirdly, do you track the use of psychotropic
12 medications within your primary health
13 practitioners?

14 MS. KRALL: Jim, you want to deal with
15 those?

16 MR. CHANDLER: We do expect a plan of
17 care, that's a standard requirement. There is no
18 electronic medical record connection to that. And
19 the tracking of psychotropics within the primary
20 care arena is something that we do from a very
21 high level. We at this point do not do it at the
22 level of the individual patient, if that answers

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1 your question.

2 DR. McCORMICK: Let me first of all give
3 a positive note. One of the things we have heard
4 positively about was that the process for
5 approving treatment plans was really very
6 reasonable in TRICARE. So I want to say that.

7 The one thing I forgot about your
8 providers to bring up is an issue we've been
9 trying -- in this war we have a lot of national
10 guard, a lot of reservists who are returning, not
11 to Killeen, Texas, where there's a whole bunch of
12 providers who understand military and PTSD, but to
13 Oshkosh, Ohio, where they may be the only one. So
14 the issue is, especially in areas where there
15 aren't a lot of former active duty who are
16 practicing, what do you do to try to require or
17 urge providers to become educated in the new
18 treatment approaches for PTSD and stress
19 reactions?

20 MS. KRALL: You couldn't have done that
21 any better. Actually, let me jump to our
22 initiatives. We'll skip chemical dependency.

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1 Just keep forwarding. We'll skip this one for
2 right now. There are no programs particularly for
3 TRICARE that actually address what we're seeing with
4 the national guard and reserve. We're seeing
5 deployed units that are going out two, three, four
6 times coming back with horrendous PTSD, combat
7 stress, et cetera. TRICARE, other than the basic
8 benefit, doesn't really address that. What
9 TRIWEST has done, and I'll bring this up because
10 if you like any of this maybe bring it forward and

11 let's make it a benefit. So this is our time to
12 showcase a little bit. What we have done and this
13 came from the company board to allocate
14 administrative dollars to do some pilot programs
15 to see if we can help these people. So this is
16 not government money, this is TRIWEST money. One
17 of our initiatives is a pilot national guard
18 reserve project that we're piloting here in
19 California. We're sponsoring about 30 units at
20 this point. We do it by request. We do it by
21 command request and we embed a provider into these
22 units when they return. We have one unit in

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1 Bakersfield that we've actually gone before they
2 deployed. We're doing training, we're doing
3 educational things. We're working with families
4 that we actually pay a provider to drill with
5 these people. We've been doing this since May and
6 we actually have had a provider in unit since May,
7 and we're seeing some amazing things because these
8 soldiers are coming and talking to these guys.
9 And they're embraced by the command. One
10 commander put the provider in a room and set a
11 guard outside. I'm not sure who it was he thought
12 was not going to escape, but this is -- the
13 soldier as they become more comfortable with this
14 provider they're telling them things that are

15 requiring referrals. These people are not
16 necessarily doing therapy. They are doing
17 identification, they're doing education and
18 they're normalizing these processes. So if
19 there's anything in the future, we believe that
20 that's something that's very effective, and we'll
21 have more data when this is finished. We're
22 following a unit for six months to a year after

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1 they return.

2 DR. McCURDY: Is it possible for us to
3 have one or more of those providers identified for
4 us to talk with telephonically or maybe even visit
5 firsthand?

6 MS. KRALL: Actually, on Saturday, if
7 you listen to NPR, one of them is going to be
8 interviewed. And, yes, I can get you names that
9 I'm sure they would be happy to talk with you.

10 Another thing that we're doing as a
11 pilot project, we've started a project in Hawaii
12 with an integrated model with psychologists
13 actually being in three of Hawaii's clinics, one
14 at Tripler, Kaneohe and Pearl Harbor. They're
15 sitting in the primary care setting and they are
16 -- I mean, this is not a brand new model, it just
17 happens to be new for TRICARE. We actually have
18 that off the ground now. It took a little while to

19 get everything in place, but it is off the ground
20 and we'll have some data surrounding that as well,
21 to once again, normalize this process. What we
22 know is that people come back with combat stress

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1 and PTSD and may not be identified for a long
2 period of time, might be out of control and the
3 earlier the intervention the better will be.

4 Operation purple actually is a project
5 that was done with the national family members
6 association TRIWEST sponsored administratively
7 these camps, but we also put providers in those
8 camps as well. These were for kids whose parents
9 were deployed or they had at least one member
10 deployed. This was just a respite for kids to get
11 away to find out that they weren't alone in these
12 situations. I had a project manager that actually
13 went to those camps and our feedback has been very
14 good. This was a smaller project, but something
15 that seems to have added to the deployed family.
16 Next slide, please.

17 We have a web portal that anybody can
18 sign into, it's triwest.com, it's a behavioral
19 health portal. This information is geared to the
20 soldier and their family, to providers, and to the
21 command. We started out with some basic
22 information, depression, some anxiety disorders,

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1 and then we set the second stage, it has a little
2 more family information in it. We're getting
3 several thousand hits a month off of this portal.
4 This is for providers as well, and these are these
5 PCMs sitting in northern Montana that are seeing
6 the PTSD soldier from the national guard and
7 saying, you know, I haven't dealt with this for a
8 long time and I need something a little more
9 current. They can tap into this and find us from
10 the phone.

11 DR. McCORMICK: Let me throw out one
12 suggestion we had from somebody we visited. The
13 VA/DoD, the national PTSD center has a mediated
14 package for mental health providers on PTSD, a
15 training package. And a suggestion was made that
16 perhaps it would be meaningful if at the time of
17 authorization of a treatment plan for PTSD, the
18 authorizing official, the authorizing clinician
19 suggested to the provider that they look at these
20 treatment approaches and consider availing
21 themselves of that package. It could be, for
22 example, put on your web; is that a feasible idea,

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1 is that something that TRIWEST and the other
2 behavioral carve outs might consider?

3 MS. KRALL: Jim?

4 MR. CHANDLER: Well, we're certainly
5 familiar with the national center, and they're
6 certainly -- at least as far as I can think of
7 Marge, there's no barrier to that particularly.

8 MS. KRALL: No barrier. The only thing
9 I can see is that we may not see it in time with
10 the initial eight visits and that sort of thing.
11 They might already be in treatment before a
12 clinician looks at it, but there isn't a barrier
13 to it other than that.

14 MR. CHANDLER: I'd also say that a lot
15 of treatment of PTSD occurs that is invisible to
16 us, because it occurs within the direct care or
17 within the VA. So we wouldn't really know about
18 that.

19 DR. McCORMICK: We understand that.
20 Again, what we're really thinking of is the
21 well-meaning psychologist in a small little rural
22 town who just doesn't have experience and just

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1 trying to give them at least the opportunity to
2 have the information that they might need for what

3 or them is a unique case whereas for the VA it is
4 not.

5 MR. CHANDLER: Right.

6 MS. KRALL: We're pushing information as
7 much as we can and the web portal is certainly one
8 thing that we do. We've got links on the web
9 portal that will take to all sorts of other
10 resources that are very informative, I think, for
11 the provider that doesn't deal with this all the
12 time. So we're working really hard to get that
13 information out, but your point is well taken.
14 It's just that intervention point would be, do we
15 see it fast enough. Next slide, please.

16 We have a 24-hour crisis line. TRIWEST,
17 I believe, is the only contractor that has a
18 crisis line, and ours is 24/7, it's staffed with
19 clinicians. So we take all sorts of calls. We
20 actually take other calls from other contract
21 areas. We take them from all over the nation, but
22 that wasn't our purpose, but we're seeing more and

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1 more through the crisis line with combat stress
2 and PTSD. Following on to that TRIWEST put out a
3 DVD, and I actually took the liberty of putting
4 some in the back table. Feel free, I don't want
5 to carry them back to Phoenix. This DVD was put
6 together in conjunction with some of the VA

7 providers in the northwest. This is specifically
8 for the soldier, talking about combat stress,
9 identifying what those things might be, a few
10 interventions; we've got representatives from the
11 Navy, from the Army, from everywhere else. We've
12 got a few true stories by soldiers on that, but
13 it's had very good reception. We sent out over
14 80,000. People order it through going through the
15 website and we send it out. It was designed for
16 the west; we sent it across the nation. Have a
17 chaplain in Minnesota that puts one of these in
18 every packet for soldiers returning and believes
19 that this is something that they'll use with their
20 families and when they see those problems coming
21 up with too much drinking and the marital strife
22 and the things that we see, will at least know you

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1 can call this place and maybe get some help.
2 The other thing we're trying to do to
3 get some information out is that we're running
4 PTSD seminars. We've been doing this now for
5 almost two years and these are just some of the
6 places that we have had seminars. Tacoma, I
7 think, was left off of that list, as was El Paso,
8 but we're getting from 50 to 150 providers going
9 to each one of these. We've had over 800 attend.
10 They're designed for not just behavioral health

11 but also primary care if they're in areas that
12 they're seeing PTSD or combat stress. It's a
13 two-part program. It's two hours. We give CME's,
14 we give them dinner and then we show them slides
15 and talk to them. Half of that is done by
16 vice-Admiral Koenig who was part of the surgeon
17 general's office. He does more of a historical
18 review and then we have Dr. Mike Roy who is out of
19 Walter Reed doing a little more of the clinical
20 focus. There is a part two of that that we will
21 probably launch next year. We've done it once in
22 Alaska already and this is really treatment

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1 modalities. But these have been very well
2 received, and once again these are TRIWEST
3 initiatives. These are not sponsored by any part
4 of the government, but they have been well
5 received.

6 If I may go on to a few of our
7 challenges so I can do this little soapbox thing.
8 I think you probably have guessed what we think
9 that we might need attention. The PHPs we
10 mentioned there are only eight certified in the
11 region. If there was another recognition of
12 certification that could make this a little more
13 accessible that would be something that I think
14 that we as contractors would probably enjoy

15 seeing. That would mean another look at
16 credentialing bodies. Do we need one particular
17 body to credential or could we accept CARF and
18 other things? That's something to consider.

19 Substance abuse services. They
20 currently, as I mentioned earlier when the
21 question was asked, that they must be delivered by
22 hospital-based services. They are either SUDRFs,

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1 substance use disorder facilities, which is a
2 standalone, or a joint commission hospital that
3 offers substance abuse services. Those are the
4 only two entities that can actually offer
5 substance abuse kinds of things. And we know that
6 the problem is bigger. We know that if we had for
7 instance outpatient detox to look at that, which
8 has been a standard of care for a while. That
9 might be something that would be of value. We
10 know that adolescents are underserved. We have
11 one in the whole region that specializes in
12 adolescents, and we ship people to Colorado all
13 the time from everywhere. There are other
14 hospitals that treat adolescents but there are not
15 many of them and the problem is very, very large.
16 Intensive outpatient service I would be on the
17 bandwagon forever about the effectiveness of
18 intensive outpatient services and offering

19 services to people who really need them. We know
20 it's a standard of care, particularly for
21 substance abuse, and right now if you are an
22 inpatient in a CD rehab, the national step down in

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1 IOP. It's the standard of care for the industry.
2 If we can't offer it as a program, we go to the
3 multiple services and give people what we can, but
4 we cannot authorize the individual service part of
5 that, which is part of the package. Let's go to
6 the next one.

7 The other one we find a lot of
8 shortfalls is eating disorder. Eating disorder is
9 an entity that we see growing in the military
10 population of the families. Most of these
11 programs are partials, and they once again are not
12 certified. So because the facility is using over
13 all of the meals, they're wanting to do the
14 observation during eating time, they're wanting to
15 do, of course, nutritional counseling, which is
16 not a benefit. It becomes problematic when you
17 cannot authorize the partial hospitalization
18 program. Those are kind of our wish list to have
19 some correction of the benefit.

20 DR. McCORMICK: Let me ask a
21 clarification. For other disorders of impulse
22 control, eating disorders, and with soldiers,

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1 pathological gambling; are those diagnoses that a
2 patient can get straight outpatient services for
3 or do they have to be linked to a hospital.

4 MR. CHANDLER: There are no regulations
5 about compulsive gambling and those sorts of
6 things which is interesting. It's all strictly
7 about eating disorders and about substance abuse
8 that we have all the regulations.

9 DR. McCORMICK: I guess my question
10 would be that if there was a soldier with
11 pathological gambling who was seeing, let's say, a
12 fully licensed psychologist for that as a problem
13 that would be a covered benefit then?

14 MR. CHANDLER: Potentially, yes.

15 MS. KRALL: And we should make the
16 distinction between a soldier with the problem and
17 a beneficiary with the problem. A soldier with a
18 problem, we can send to many facilities that may
19 not be TRICARE certified, but we know they're to
20 be credible. But a beneficiary, the regulation
21 applies to the beneficiary.

22 DR. McCURDY: You may plan to cover this

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1 a little bit later, but could you speak a little
2 bit to not so much your oversight, but how are you
3 able to feed back into the local direct care
4 system, the military commander, MPF commander
5 locally for issues that you just mentioned, for
6 instance, as challenges so that the word gets out
7 not only within your hierarchy, but within the
8 military leadership up to health affairs level
9 that these are ongoing issues and problems. And
10 how does that work? I mean, where is the feedback
11 loop that says we're no longer delivering the
12 standard of care, for instance for step down for
13 substance abuse?

14 MS. LARGE: Well, the contractor in the
15 TRICARE regional offices, we talk every day. So
16 we're just as aware as they are of what the issues
17 are and the challenges. And we present those. We
18 have monthly forums with TRICARE management
19 activity office of the chief medical officer.
20 There's medical director's meeting every month.
21 These get brought up and this is what this task
22 group has now been assigned. We actually

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1 developed an issue paper and submitted it up the
2 chain to TMA and General Granger and this task

3 group is a result of that issue paper that the
4 time has passed that this has not been addressed,
5 and we made recommendations that we haven't now.

6 DR. McCURDY: For the record, I've been
7 doing this for 30 years. I ran a huge contract at
8 Fort Hood for years before TRICARE was ever born.
9 One of the things that strikes me we have this
10 challenge list probably within a year and a half
11 after TRICARE got started and my concern here is
12 somehow we're all colluding, participating in the
13 system that won't listen internally to push up the
14 issues at a level to be addressed. And I'm
15 wondering where the disconnect is, because my very
16 real sense of all of you are you are very well
17 meaning people, you want to do right things by the
18 beneficiary population. This isn't really your
19 money that you per se have to worry about, so why
20 aren't we getting these issues pushed up so that
21 they get addressed at the level they need to be
22 addressed at?

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1 MS. LARGE: Well, I can speak of what
2 we've done in the last ten years with this. I'll
3 put this politically correct, there's always
4 different political agendas at the top. A lot of
5 these things originated 20 years ago particularly
6 on the mental health side. They were a knee jerk

7 to onesie, twosie bad outcomes and these overlay
8 of an additional certification process came into
9 being because of one big case that made the news
10 and the knee jerk went off and let's have another
11 certification and we can prevent this.

12 The changes in the IOP, again, they're
13 tied to that code of federal regulations. It
14 literally takes an act of Congress to change it.
15 And with the great turnover that we have within
16 all the different layers, it takes a lot of
17 tenacity, and I think some of that has been part
18 of that. There hasn't been a critical mass to
19 come together at one time to get it gone. But for
20 all those reasons we have a tendency to put
21 patches to address one single bad outcome, and
22 lots of times it's directed by Congress. You know

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1 how many times you report to the hill, what's
2 going on here? Do now we're on the hook for these
3 annual clinical quality reports that go to
4 Congress. How well are we doing, ta da da. So
5 people are reluctant to pull back from something
6 that was put together as a patch 20 years ago
7 because they think the dam is going to overflow
8 again. So there's this emotional thing and fear
9 you're going to get lost if you do this. So it
10 takes that tenacity, and critical mass, and the

11 moon and the stars lining up to get it going each
12 time. So that's how I can speak to that and I
13 think you're probably aware of that. And it is a
14 patchwork system. It's not put together as an
15 integrated process. It's a patchwork system that
16 a problem comes up, oop, let's plug that one up
17 and you've got this mishmash going on so it's not
18 integrated. People say, when we say we want to
19 look at IOP, well, we have the richest benefit,
20 it's better than the commercial sector. Well,
21 yeah, but it's not the right benefits. It could
22 be more than the commercial sector, but also I

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1 think we can't benchmark ourselves to the
2 commercial sector in terms of what our culture is.
3 If this is OSCHA what does your workforce look
4 like? If you have a bad outcome you're doing root
5 cause analysis on it. If we go back to do root
6 cause analysis, we'd change this whole benefit
7 design. It does not work for our workforce, which
8 is the active duty military, their family members
9 and the culture that exists that does not exist in
10 the civilian sector; you do not have parents going
11 away six months at a time. If they do they're
12 going to be shot at. You do not have people going
13 back for two and three tours. So that climate does
14 not exist in the commercial sector so the benefit

15 structure has to reflect that need and not try to
16 benchmark it to the commercial sector.

17 MS. KRALL: I think those are the end of
18 my comments. We're open to whatever questions.
19 I'm not going to back to the substance abuse. I
20 think I've already been on the podium long enough
21 for substance abuse and everything else. But
22 we're open to whatever else you want.

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1 DR. MacDERMID: I have a question.
2 Maybe I should know the answer, so I apologize,
3 but I don't. I'd like to understand more about
4 what, if anything you do to monitor the quality of
5 care that's provided for mental health and how
6 those procedures compare to what you do for care
7 for physical health or the med/surg side?

8 MS. KRALL: Actually our processes are
9 very similar. We have a quality department at
10 TRIWEST, and anything that is out of the ordinary
11 for behavioral health, we submit what we call a
12 PQI, potential quality issue. It goes to the
13 quality department and it's researched. This gets
14 surfaced to ProQMC, which is physicians and
15 outside physicians monitoring the quality of our
16 behavioral health beneficiaries. If we get an
17 incident that occurs in a residential treatment or
18 something it all goes, it's fed there and it's

19 analyzed. Everything is analyzed. The clinicians
20 pick these up, the clinicians submit them. So
21 it's a robust system as far as identifying what
22 might be wrong.

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1 DR. MacDERMID: So the mechanism is that
2 at clinician -- a clinician says I might have done
3 a really bad job treating that client so I'm going
4 to send up a report?

5 MS. KRALL: No, I'm thinking the
6 clinician --

7 DR. MacDERMID: I don't mean to
8 oversimplify. I'm sorry.

9 MS. KRALL: The clinician doing the
10 review. If we have, for instance, an adverse
11 incident, we have a suicide. Whoever knows of
12 that suicide will write up that whole incident and
13 it is submitted to quality. It's also submitted
14 to a variety of other people. But we will totally
15 investigate that case. The other clinicians, the
16 provider, do what they should do. Was there a
17 plan in place? Was somebody discharged without a
18 discharge plan? Did somebody not follow up? All
19 of those things, and we would submit that as an
20 incident.

21 DR. MacDERMID: And what other kinds of
22 events or mechanisms would prompt a quality

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1 review. For example, would you monitor -- would
2 you know for example if a therapist never had
3 anybody come back for a second session because
4 they happen to be pretty incompetent and were
5 driving people away. Would you know that?

6 MS. KRALL: We would know it if they
7 complained about it or if we saw something in any
8 request.

9 DR. MacDERMID: So it's a reactive
10 system. Somebody has to say something to you and
11 then you review?

12 MS. KRALL: We might get a treatment
13 request form that's way off the wall and that
14 would cause us to want to look into that provider
15 and into their practice. We might get a
16 beneficiary saying something happened. We have
17 some things that we always refer as Pies with
18 readmission within 30 days from a hospital, we'll
19 always research that. So we're looking constantly
20 at what providers are doing. And we see this as
21 requests come through and that's why clinicians
22 are doing the review.

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1 DR. MacDERMID: I see. Thank you.
2 MS. LARGE: I'd add one more thing to
3 that. There's another layer of review to that.
4 Part of the national quality monitoring contracts
5 activities is to review monthly all inpatient
6 psych admissions. So they see those in terms --
7 they request those charts, they review them. They
8 review them for a litany of things. So standards
9 of care, documentation, and all that is reported
10 back to the contractor and the contractor responds
11 to that, agree, disagree, partial agree. We get
12 all those reports and we see that at the true
13 level. So all that trending analysis done from
14 that if it's a particular institution that is
15 having several problems that are small but not
16 bubbling up, then the national quality monitoring
17 contractor does onsite inspections and audits of
18 those facilities. So that's another layer that's
19 built into that. And they also do random chart
20 analysis by the national quality monitoring
21 contract each month and they review those records
22 and mental health is part of that and they will be

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1 reviewing those for standards of care the same
2 litany that they do for the med/surg side.

3 COL PEREIRA: Sometimes that ongoing
4 monitoring is done through the credentials
5 process. For instance we come up for annual and
6 bi-annual review and part of the requirement is
7 that we have peer audits or supervisory audits or
8 something like that built in that goes to
9 credentials when our packet is up for review. Do
10 you know if there's any kind of process in place
11 like that for those folks who are credentialed
12 through other agencies?

13 MS. KRALL: I know that there's
14 something in place that when they re-credential,
15 they're credentialed for three years, they have to
16 re-credential. And so if there are any adverse
17 marks against them will be reviewed at that time.
18 So it's a fresh packet at that point. I'm not
19 hands on doing that, but that's the process that I
20 know is in place.

21 COL PEREIRA: And for those that you
22 credential, do you do any of those kinds of

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1 reviews.

2 MS. KRALL: That would be the same
3 process for the ones TRIWEST credential as well as
4 what the net subs do. The process is the same.

5 COL PEREIRA: I have a couple of other
6 questions. One is closely related to a question

7 that was answered earlier, but this is a little
8 bit more specific. How often, and who has the
9 responsibility of actually going through and
10 scrubbing the lists that are available at
11 individual areas or MIFs? Lists of providers?

12 MS. KRALL: The responsibility runs
13 through our net subcontractors who actually own
14 that network. They do periodic review. If we
15 find if our clinicians or our BSRs find that
16 there's somebody not taking patients or wants to
17 be removed, it goes back to that net sub that owns
18 that contract. They submit a request to add or
19 subtract to the network. Once they credential, it
20 comes through the quality committee for TRIWEST.
21 So there are about three eyes, three sets of
22 bodies that look at the provider directory.

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1 DR. MacDERMID: Can I just interject
2 something here, Angela? To follow up on exactly
3 what you're asking. Would it surprise you to hear
4 that we've been told more than once that people
5 are finding kind of functional networks that are
6 about 10 percent the size of the list?

7 MR. SPARKS: Going back to -- that's a
8 great question, and I don't believe there are
9 functional networks that are 10 percent the size
10 of the list. We have over 109,000 providers

11 contracted in the network and that's not counting
12 the other providers that participate. Just as
13 with any business, and medicine is a business, you
14 can only take as a practice -- I can only handle x
15 number of clients in a practice. So I may be a
16 TRICARE network provider, but if I am at my max
17 capacity, I can't ethically take any more. And
18 that's what happens in a lot of these areas
19 especially if there's a large contingent of
20 military plus the local population. So we may
21 see, especially in the ABCs in the list, they fill
22 up quickly and when I check networks, I start in

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1 the middle. I start making calls, and usually I
2 can find providers but it is fascinating though.
3 A, B, C, D and E, they'll all be full. So that
4 doesn't mean they aren't network providers. It
5 just means at that given day at that given point
6 in time, they are booked solid and I can't fault
7 them for that. Now, I have beneficiaries calling
8 routinely saying well, in Albuquerque, New Mexico,
9 I can't find a dermatologist. And when that
10 happens I go to provider services and I start
11 calling providers myself to see if, indeed, what
12 you're describing is actually happened or do we
13 have a shadow network. And I'll be hones with
14 you, in the last two years; we have a good viable

15 network out there. But there are community norms
16 with regard to the amount of time it takes to get
17 an appointment for a given specialty.

18 LT COL CURRY: And that's one of the
19 issues that we continuous bring up to TRIWEST. I
20 get a lot of calls in my office saying I can't get
21 to a provider, something is wrong. I pass that
22 on to TRIWEST. There is a contractual requirement

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1 that an authorization is goof for a certain time
2 frame. There's also a contractual requirement
3 that a beneficiary has to be seen for specialty
4 care within a certain time period called our
5 access standard. And a lot of times a provider
6 can't see a patient within that time frame. We go
7 back to TRIWEST, speak with them and say, "Listen,
8 we recognize the fact that you have a shortage of
9 this type of particular provider. You're setting
10 the authorization for x amount of days, which
11 means that it expires; the beneficiary has to go
12 back to their primary care provider and get
13 another authorization. Take a look at this, if
14 you need to expand it, please do." So in areas
15 where there is shortages especially that's one of
16 the things that they have worked on with us.

17 COL PEREIRA: But we're talking about
18 mental health, mental health patients, mental

19 health clients. As a mental health client how
20 many providers do you expect me to have the
21 emotional energy to try to call and to get an
22 appointment with when I'm barely hanging on? And

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1 how are you preventing me from having to do that?

2 MR. SPARKS: That is a great question,
3 and I think that's where your portal comes in.

4 MS. KRALL: That's also where the crisis
5 line comes in. Those are exactly the kind of
6 calls our crisis line takes. I mean, we have
7 customer service people that are trained to deal
8 with those and to find the referrals. I mean,
9 these people call everybody. And we take to 6- to
10 700 calls a day. And most of them are beneficiary
11 calls. So you're absolutely correct, if you can't
12 hang together you're not going to call 10 names to
13 try to find help.

14 DR. POWER: I have a follow up question
15 to Shelly's question about quality. The reason
16 we're concerned about quality obviously is because
17 we want to be sure that we're focused on improved
18 outcomes for the people that are served. And I
19 have a federal program that Congress expects me to
20 report every year on the improved outcomes for
21 people that get mental health and substance abuse
22 care. And there's 10 national outcome measures

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1 that are identified. And they include things like
2 perception of care, improved social functioning,
3 social connectedness, reduce symptomology, et
4 cetera. Do you have a set of outcomes that you
5 identify and that you can report on back to DoD
6 and the TRICARE system?

7 MS. LARGE: There's no requirement for
8 the contractor to do that. To my knowledge none
9 of the contractors have that type of survey that
10 they go in and ask the patients or measure any of
11 that. We do attempt to use some of the other
12 measurements such as follow up of depression and
13 medication and refills and see if they're on them
14 at x number of time after their diagnosis and
15 follow up again certain of the HETIS measures and
16 those types of things so trying to get into some
17 of that data is where we are right now.

18 DR. POWER: Do you have an interest in
19 looking at that from the standpoint of being a
20 provider and a contractor of care?

21 MS. LARGE: I think it's great if we can
22 get that. That would take surveys of our

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1 beneficiaries to get at that you chart review. So
2 none of that is undoable. It's certainly
3 something that could be done as another quality
4 point of care.

5 MS. KRALL: Actually the one section of
6 the delivery that does do some monitoring of that
7 would be case management. Case management does
8 have the authority to survey beneficiaries, so
9 they could see their functionality based on that,
10 but that's not -- those go to, I guess, you get
11 those, the TRO gets the case management reports,
12 but that's -- I don't think they go any higher
13 than that.

14 MS. LARGE: The other think that I just
15 got reminded of the contractors have been
16 specifically instructed by TMA not to do patient
17 surveys so that would be within that. But that is
18 something that could be done but it would take a
19 directive and money and resources to do it.

20 MS. KRALL: There's a gentleman behind
21 you that has a question.

22 MR. HEVEZI: Hi. I actually have a few

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1 questions. I'm a veteran. The lady in the pink
2 asked a question about electronic record keeping

3 and the answer was that there is no electronic
4 record keeping. There's no record keeping for
5 individuals prescribed psychotropic medications.
6 And I want to ask if anyone can talk to why that
7 is.

8 MS. LARGE: When they responded there's
9 no electronic medical records, the Department of
10 Defense is developing electronic medical records,
11 but they will be within the context of the
12 military hospital systems. And I think some of
13 the question was directed to how does the
14 information with a person who is being seen in the
15 community get back and forth between the community
16 and the MTF. And the community doesn't have any
17 standards for electronic medical records, so you'd
18 have to have two that talk. So right now there's
19 no push back in the MTF for any of the care that's
20 delivered out in the network. If someone is sent
21 out for a referral med/surg side, you get back
22 what the outcome of that consultation or the

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1 treatment plan. But with mental health, to my
2 knowledge, you still -- that's under the privacy
3 --

4 MR. CHANDLER: The Adam Act specifies
5 that behavioral health information and substance
6 abuse information cannot be shared unless there is

7 a specifically signed permission and not just a
8 general permission, but a specific permission
9 signed by beneficiary.

10 MR. HEVEZI: So if a person or a family
11 member is treated at an MTF and then they're care
12 is transferred to a civilian provider through
13 TRICARE currently there is no way for the records
14 to be shared even if the patient were to sign such
15 a release? So the electronic records can be
16 passed from an MTF to a --

17 MS. LARGE: It would be a hard copy.

18 MR. HEVEZI: I think that the woman's
19 question concerned electronic records and tracking
20 and so my question is why is there no electronic
21 connection between MTFs and TRICARE providers?

22 MS. LARGE: In the commercial sector

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1 there is no requirement for them to have an
2 electronic record system. So that doesn't exist
3 out in the community. That's not something that's
4 mandated and I don't see any time soon that it
5 will be mandated. So this electronic medical
6 record is something that the military is
7 developing to improve continuity of care so as
8 members go from one duty station to another or
9 OCONUS to CONUS that that communication and that
10 continuity can occur. When a patient is being

11 seen in a military treatment facility and now
12 they're being referred out into the civilian
13 community, it wouldn't be an electronic medical
14 record that goes with time, but it would be a
15 summary of the care to date for that patient. And
16 if the patient signs an agreement, they can send
17 the significant medical record in a hard copy out
18 to that treating physician in the community. So
19 that electronic medical record -- we haven't had
20 that in the past. Information has been passed
21 back and forth. But specific to mental health,
22 the patient has to sign to and release there'd

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1 just be that electronic be downloaded into a hard
2 copy, given to the patient to take to the provider
3 when they go out into the civilian sector. So
4 that electronic component is not a necessity.

5 MR. HEVEZI: The lady asked about was
6 there a tracking mechanism for individuals
7 prescribed psychotropic medications, and the
8 answer was no; and my question was, why?

9 MS. LARGE: There's not a formal
10 tracking mechanism for psychotropic medications
11 being delivered. And I think the question was in
12 the primary care setting. I think that's what the
13 question was. So if it's a non-mental health
14 provider providing psychotropic medications so

15 that your primary cared doctor is treating someone
16 for depression or something. There's no formal
17 requirement to oversight that. There's no formal
18 requirement. A lot of these are within the scope
19 of practice of non-mental health providers. It's
20 the same in the commercial sector, so this is no
21 different than the commercial sector.

22 MR. HEVEZI: And the DVDs the TRICARE

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1 DVDs, my cousin just got back from Iraq last week
2 and I wanted to know -- someone said that 80,000
3 were passed out and they were given to each
4 soldier. Not 100 percent of combat vets receive a
5 DVD.

6 MS. KRALL: I mentioned that there was a
7 chaplain in Minnesota that has put hose in the
8 packets of every returning soldier for the
9 national guard.

10 MR. HEVEZI: Oh, for that particular
11 unit? Okay.

12 MS. KRALL: And we have many units that
13 have requested them and many soldiers have them
14 and you can have them by just requesting them off
15 of the website. They're free.

16 MR. HEVEZI: My question is for
17 distribution to the 80,000; how were those 80,000
18 distributed? When and where? And if it's put in

19 the hands or a care packet for a soldier coming
20 back from combat, most likely they are not going
21 to be too concerned about getting that in the
22 hands of their mom and dad just simply because of

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1 the nature of the whole behavioral health arena.

2 MS. KRALL: Absolutely.

3 MR. HEVEZI: So I'm wondering, has there
4 been any thought to other maybe more effective
5 ways to get such DVDs into the hands of families
6 of returning veterans?

7 MS. KRALL: We've done a lot of
8 different things. I mentioned the chaplain in
9 Minnesota who put them in the returning vet
10 packets. What I'm finding the requests are coming
11 usually from units that want 100 at a time and
12 they distribute them. We've dealt with family
13 groups and handed them out at family groups.
14 They've been at benefit when TRIWEST does their
15 benefit education they're available there. So
16 they're all over the region and by several
17 different kinds of people. So the audiences are
18 different, and then of course by request.

19 MR. HEVEZI: I've been patient or so I
20 just -- in TRICARE west, do you track suicides?

21 MS. KRALL: Yes.

22 MR. HEVEZI: So that the data is

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1 available for each calendar year?

2 MS. KRALL: This data is probably not
3 available. As the clinical mechanism anything
4 that is in the care of one of our providers we
5 would be revealing and then submitting to quality.
6 That is non discoverable when it goes to quality.
7 It's certainly investigated and researched but it
8 isn't something that you're going to put out for
9 national publication.

10 MR. HEVEZI: Also I'm wondering how was
11 this event promoted. I notice very few civilian,
12 average Joe vets here and I was just wondering how
13 this event promoted and when -- how did that
14 process work. I was expecting kind of a full
15 house and I was shocked when I came in and I was
16 -- I don't know if anyone else here is just
17 public.

18 DR. MacDERMID: I need one of the staff
19 members to come up and tell us about that because
20 I know the general answer but I don't know the
21 specific answer. Tom?

22 DR. BURKE: Thank you. We go through

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1 the public affairs office at the offices of the
2 surgeon general. They are our support for public
3 affairs and they contact the local public affairs
4 office at the site that we're going to and then
5 it's publicized through newspapers and we also
6 have information and registration about it on the
7 website that is a part of the OSD health affairs
8 and armed forces epidemiological board website.
9 And it can be found under DoD mental health task
10 force by using any one of the search engines. And
11 it is also published in the federal register.

12 DR. MacDERMID: I'll add two things
13 though before you continue with your question.
14 The notice for this meeting, I know did not go up
15 on the web until fairly shortly before the
16 meeting. So that's something we want to try to do
17 a better job of. And also General Kiley said
18 yesterday that he felt that he had not been active
19 enough in sort of letting command -- doing
20 command-to-command notification about our visit.
21 People do know that we're coming in advance on the
22 installations, but he wants to initiate sort of a

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1 higher level heads up and hopefully that will help
2 get the word out. Please continue.

3 MR. HEVEZI: BH is just such a dark kind
4 of secret thing within the military community. So
5 I think things like this are a rare opportunity
6 for vets and families and other people in the
7 community who have an interest in military people,
8 veterans and families who are dealing with BH
9 issues to come to these things. And I didn't see
10 anything in the paper until yesterday. I think it
11 was on -- I don't know if it was in print or on a
12 website. I'm a chronic web surfer and I just
13 happened to see it.

14 DR. MacDERMID: Good for you.

15 MR. HEVEZI: I don't know if there's
16 some strategy maybe to not publicize things like
17 this because it's a huge issue in this community.
18 Camp Pendleton is --

19 DR. MacDERMID: Sure. In fact, you're
20 preaching to the choir in the sense that everyone
21 on the mental health task force is very passionate
22 about mental health and most of us have left

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1 behind other significant responsibilities to be
2 here. So it's a disappointment to us too when
3 there are 12 or 13 of us sitting in a room talking
4 to three or four people at an open town hall
5 meeting. So we're very interested in having
6 strong participation. There may be some ways that

7 you can help us being a chronic web surfer. One
8 thing is you can help get the word out to your
9 colleagues, networks of people that you know at
10 other installations. We will be visiting other
11 installations and our standard practice is to hold
12 an open town hall meeting when we make visits. So
13 you can let people know that that's coming. If
14 there are things you or your colleagues really
15 want us to know, you don't have to wait for a
16 mechanism like this to tell us; going up very
17 shortly on the website, if it's not there already
18 or on the AFEB website, is the request for
19 organizations or groups who wish us to have
20 information to submit it. We don't want there to
21 be any barriers. The reason we structure visits
22 the way we are, the way that we have is that we

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1 said we don't want to be rooms full of Ph.D.s and
2 M.D.s and officers talking to each other for the
3 next year. If there's an E-2 out there that has
4 an issue and wants to tell us what it is, please
5 let us know. So if there are things you have to
6 tell us, our names are all up on the web. You can
7 e-mail us, you can send us letters, you can,
8 whatever information we can get we're happy to
9 have it. I will add, however, that our job is to
10 make recommendations to the Secretary of Defense

11 about how to design a mental health care system
12 that meets the need and does what it needs to do.
13 So the more you can tell us about ways to make it
14 better as opposed to what's wrong with it, the
15 better we'll be able to use the information
16 because we're looking for ideas for
17 recommendations.

18 DR. McCURDY: You might mention, Shelly,
19 we would invite veteran's organizations (off
20 mi ke).

21 DR. MacDERMID: Yes. We have done so.
22 There is time on the program tomorrow in fact

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1 where veterans organizations have been invited to
2 present at our open meeting in December in
3 Washington, D. C. there will also be an opportunity
4 in particular for veteran's organizations to
5 present. So we're trying. If there are things
6 that we're missing you should let us know. We
7 have about five minutes left, but we will end on
8 time because the task force members have a lovely
9 long meeting into the evening to look forward to.

10 MR. HEVEZI: I surrender.

11 DR. MacDERMID: So are there additional
12 questions?

13 MR. HEVEZI: I surrender.

14 DR. McCORMICK: Thank the TRIWEST people

15 and the TRICARE people; it's really been very
16 useful. I had one question and it has to do with
17 my ignorance of how the contract and the financial
18 incentives work, both for the prime contractor and
19 for the carve outs, the behavioral health carve
20 outs. Is it a capitated system; is it a fee for
21 service plus, with some incentives? What does the
22 contract call for? How is the contractor and the

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1 subcontractor's paid? What are the financial
2 incentives? Is that clear?

3 MR. SPARKS: If I'm hearing your
4 question correctly, you're asking how the
5 providers themselves are incentivized?

6 DR. McCORMICK: I'm trying to find out
7 how does the contract work. Does TRIWEST get a
8 certain amount per covered life? And does that
9 then trickle down if the behavioral health is
10 carved out in Texas to Valuecare? Or what is the
11 financial incentives for TRICARE and the
12 subcontractors? How are they paid by DoD?

13 MS. LARGE: These current contracts what
14 we call performance based contracts and each of
15 the contractors actually bid a cost for the health
16 care that they anticipate they will be providing
17 for -- based on the data that's been submitted by
18 DoD. So for the west region we use some

19 historical data. This much is under the direct
20 care auspices and this much has been provided
21 within the purchase care sector. So having that
22 they bid on what they think it's going to cost to

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1 deliver that care. So that's paid. On top of it
2 with a performance based contract you have some
3 performance guarantees that are put in there. So
4 once a quarter we look at different matrix.
5 There's a pot of money over here for doing good
6 things and hitting certain matrix. So we have an
7 award, it's an award fee. So that's a quarterly
8 process. So the TR0 gets together and we look at
9 different data sets and we come up with, "Okay, we
10 recommend 60 percent of this award fee pot go to
11 that." There's also another performance
12 incentive. If proposed care was thought to hit
13 this target threshold, for this year it was
14 anticipated that \$100,000 million it was going to
15 cost to deliver the care. If the contractor comes
16 under that amount, the contractor shares in that
17 savings. It's kind of like an 80/20 split. Don't
18 quote me on that one, but there's a mechanism for
19 that. So that's the performance fee. So each
20 year there's a target health care cost that's set
21 and if the contractor comes under that then they
22 get part of that savings.

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1 DR. McCORMICK: And if TRIWEST chose to
2 in a particular locale, subcontract like in Texas
3 with Valuecare; is the same kind of incentive
4 process used?

5 MS. KRALL: I can't speak for the south,
6 which actually has a subcontract for behavioral
7 health. TRIWEST is an integrated program, so
8 behavioral health is part of TRIWEST. So there
9 isn't a sub involved in the mental health part.
10 Having been part of a carve out before, the prior
11 contract, it usually is a per member, per month
12 contracted basis with that subcontractor.

13 DR. McCURDY: Let me just express a
14 concern about that. My concern is what was true
15 in 2000, 2001, even 2002 is no longer true
16 anymore. And when I hear performance based
17 systems recognizing the government as the entity
18 that's designing these contracts I'm concerned
19 that the incentive is actually not to deliver more
20 care even though there is demand for more care
21 than I think we all recognize. Again, I have to
22 wonder if that doesn't speak to why there's

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1 reluctance, probably, primarily on the part of the
2 government not to recognize these challenges that
3 you all are aware of and that we're aware of in
4 terms of delivering what's needed in the
5 beneficiary population.

6 MS. LARGE: Just a little bit to that
7 point. I think that's some of the things that
8 we're trying to change in the future, is to build
9 more quality outcomes into the performance. And
10 there's various ways. In this one now we use some
11 HEDIS measurements. I mean there's all kinds of
12 national -- the healthy people of 2010, the HEDIS
13 and HRQ and patient safety and all these types of
14 things and we can measure directly from our
15 databases. So there's that possibility and it's
16 doable to build those quality outcomes into a
17 performance based contract also.

18 DR. MacDERMID: Looks like Rick and then
19 Angela -- okay. Rick, Angela, Aaron, and then
20 we're done.

21 LT COL CAMPISE: If I could ask a
22 two-part question about the provider network?

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1 DR. MacDERMID: No follow-up.

2 LT COL CAMPISE: If my understanding is

3 correct, when there are complaints about the
4 provider network then you go back and you examine
5 it, but is there a standard time frame that you
6 say on an annual basis we'll scrub this list or
7 not?

8 And then if there is is there an
9 acceptable rate for instance, 40 percent of the
10 providers have to be available for us to consider
11 this an adequate provision of services.

12 MS. KRALL: Right now I wouldn't say
13 that there's a certain percentage that anybody
14 would assign. Is the network scrubbed? Yes, it
15 is. I spoke with the vice president of provider
16 services before I came so I wasn't misrepresenting
17 her, but it's a routine -- it's a routine
18 evaluation of the network. So when I mention
19 these net subs who own these networks they're
20 constantly going through them and feeding --
21 sometimes I think we see a delay and the
22 beneficiary would feel a delay is that the time

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1 that they get through all of that process it takes
2 a little bit to hit the directory.

3 LT COL CAMPISE: Can you define what
4 "routine" is? Annual, six months, every three
5 years?

6 MS. KRALL: At least annual and probably

7 six months.

8 MR. SPARKS: Actually the network is
9 scrubbed every month.

10 MS. KRALL: For the directory. The new
11 patients.

12 MR. SPARKS: The directory. The
13 directory, yes. So the providers on there, again,
14 almost 110,000 of them are statistically surveyed
15 every month and when we find changes then they
16 update the web and move from there.

17 LT COL CAMPISE: So if that's accurate
18 if you've actually gone back and done those scrubs
19 you could provide that data for us for what the
20 availability was?

21 MR. SPARKS: Availability on a daily
22 basis? Whether they have appointments available?

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1 LT COL CAMPISE: For instance, if you
2 actually go back and scrub those on a routine
3 basis we could say in the state of Texas, can you
4 give us the availability for this particular zip
5 code since you've scrubbed that?

6 MR. SPARKS: Well the only place in
7 Texas we cover is El Paso.

8 LT COL CAMPISE: That's just an example.

9 MR. SPARKS: Okay. Actually within 30
10 days, normally, we can do that. One question

11 asked was could you say that it was 40 percent
12 accurate to get an appointment? We do operate off
13 the 32CF199 access standards. So, yes, the
14 network is set up to provide specialty care within
15 28 days.

16 LT COL CAMPISE: Great. So then the
17 committee could come to you and say that we just
18 got back from Fort Hood and they did an informal
19 survey and found 10 percent were actually
20 available, but you could provide the actual data
21 for what a scrub for availability would be for
22 that area?

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1 MR. SPARKS: I think Lisa Stevens at
2 provider services could probably give you pretty
3 documentation on their scrubs. Again, we don't
4 cover Fort Hood.

5 LT COL CAMPISE: Yeah. But for instance
6 an area that we went to, because there have been
7 other areas also.

8 DR. MacDERMID: Last question. Oh, no.
9 Sorry, then Aaron.

10 COL PEREIRA: I'm going to say this is a
11 two- pronged question, but it's really not. Are
12 reimbursement rates as low for other specialty
13 areas, and would it be possible for us to get the
14 same kinds of data that you showed for numbers of

15 visits for the other specialty areas so that we
16 could take those back and kind of compare your
17 number of mental health visits with your other
18 specialty area visits to what we're seeing in our
19 MIFs?

20 MR. SPARKS: You mean special --

21 COL PEREIRA: That's a request for data.

22 MR. SPARKS: It's available in M-2. I

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1 mean, you can get the data. That's where I pulled
2 it.

3 COL PEREIRA: So we just go in there and
4 look at your numbers?

5 MR. SPARKS: Have your analyst go in and
6 you pick a specialty and beneficiary category and
7 it spits out the numbers.

8 COL PEREIRA: Okay. Good.

9 MS. LARGE: I just warn you though you
10 have to have a correct hypothesis when you go and
11 enter you won't get the right data. Just a while
12 ago you looked at the numbers and you assume
13 that's all mental health utilization, that's only
14 purchase care. So if you're looking at active
15 duty, if you're looking at family members, if
16 you're looking at retirees, if you're looking at
17 direct care versus purchase care. So you have to
18 the right question for your data puller to go in

19 there to make the answer come out. So you're not
20 basing it on something that's erroneous. But is
21 all in M-2. So all the direct care is in there
22 and the purchase care is in there.

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1 COL PEREIRA: Then can you direct us to
2 somebody who can help us work through that?

3 MS. LARGE: Oh, sure.

4 COL DAVIES: Up at the offices of the
5 surgeon general we have a decision support center.

6 MS. LARGE: Yeah. HPENA does this every
7 day.

8 COL DAVIES: We do that and if you guys
9 give us the information, we can have our folks,
10 Colonel Dot Smith heads up that directorate up in
11 our area.

12 DR. MacDERMID: Angela, while it's fresh
13 in your mind can I ask you to sort of jot down
14 some specific questions so we can start to craft a
15 data request. Last question, Aaron.

16 LCDR WERBEL: My question is really a
17 little bit of the follow up on the veteran
18 gentleman's question about suicide. Not concerned
19 about whether it's releasable or not releasable
20 information, but just curious about the data
21 whether it exists or not. Two levels to the
22 question. It's not a two-part question, but two

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1 levels to it. But the first level being, do you
2 have the data on beneficiaries who are in some
3 level of treatment who then die by suicide, just
4 knowing that? Or who enter treatment as a result
5 of a suicide attempt or gesture? That's the one
6 level of the question.

7 The second piece is would there be data,
8 does the information exist if a beneficiary who is
9 not necessarily in treatment in any way for a
10 suicide related issue, but who is a TRICARE
11 beneficiary and then is not a TRICARE beneficiary
12 anymore because of death if that death was a
13 result of a suicide?

14 MS. LARGE: That's a big one. First of
15 all the data that we access to get any of that
16 would have to come through coding in a hospital
17 setting or an outpatient setting. So it would
18 have to be a claim submitted. So the limitations
19 would be we could find is that member ever had a
20 diagnosis related. So that would be in there if
21 they (off mike) any of the system so we could find
22 that. If there was a suicide it would have to be

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1 an attempt where the patient was taken to the
2 hospital and died as a result of suicide so the
3 admission discharge diagnosis would reflect that.
4 If it was suicide outside a health care facility
5 with no coding and it goes to the coroner and all
6 that, that would not come through our system. But
7 for the active duty members, I'm sure I've seen
8 that data already. So that's all kept.

9 For the other, once they leave the
10 system, they're no longer tracking in ours so --

11 LCDR WERBEL: If a provider knows their
12 patient died by suicide and was under their care,
13 do they report?

14 MS. LARGE: No. There's no requirement
15 for that provider to report. The data is from
16 hospital systems, clinic systems. There has to be
17 a claim generated with a diagnosis or like in the
18 inpatient setting, you have an admission diagnosis
19 and you have a discharge diagnosis. You can find
20 deaths and reasons for deaths. So that's all
21 within hospital systems. Nowhere on the
22 commercial side none of that occurs. So that's

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1 only anecdotal. You can get it for the active
2 duty because they would follow that in or out of

3 the hospital. But for family members, didn't
4 occur in the hospital, didn't come in as
5 attempted, didn't die as a result, that's not
6 going to be captured. You get MMR you can see
7 suicides because they get coroner's records. They
8 don't tap just into the claims systems, Medicaid,
9 Medicare.

10 DR. MacDERMID: I want to thank our
11 guests very much for obviously a stimulating
12 presentation. I believe this concludes the open
13 sessions for today. Then members of the task
14 force will reconvene at 3:30. And Kate, are we in
15 the other room again? In the other room at 3:30
16 and that will be our working session for the rest
17 of the evening. And dress for the meeting is
18 civilian clothes if you wish.

19 COL DAVIES: Dr. MacDermid, I did want
20 to say that we will reconvene for our open session
21 tomorrow at 12:30. Tomorrow at 12:30. And for
22 the record, this session is closed this afternoon.

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1 (Whereupon, the PROCEEDINGS were
2 adjourned.)

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