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**DoD TASK FORCE ON MENTAL HEALTH
FULL TASK FORCE MEETING
FORT HOOD
DAY TWO**

**The Plaza Hotel
1721 Central Texas Expressway
Killeen, Texas**

Thursday September 21, 2006

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- 1 PRESENT:**
2 DoD Members of the Mental Health Task Force:
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- 3 LTG KEVIN KILEY, Surgeon General, U. S. Army -
4 Falls Church, VA
- 5 COL ANGELA PEREIRA, PH. D., Department of
6 Behavioral Health Dewitt Army Community
7 Hospital - Fort Belvoir, VA
- 8 COL DAVID ORMAN, Director of Residency Training
9 in Psychiatry, Tripler Army Medical Center,
10 Oahu, HI
- 11 CAPT WARREN KLAM, Senior Medical Officer,
12 Mental Health Director Navy Psychiatry
13 Specialty Leader, Staff Child/Adolescent
14 Psychiatrist - Naval Medical Center, San
15 Diego, CA

11 Other Federal Members:

- 12 ANTONETTE ZEISS, PH. D., Deputy Chief
13 Consultant, Mental Health Services Healthcare
14 Group of VA Central Office, Washington, D. C.

14 Non-Federal Members:

- 15 DR. DAN BLAZER, II, M. D., MPH, PH. D., Professor
16 of Psychiatry and Behavioral Sciences,
17 Professor of Community and Family Medicine -
18 Duke University Medical Center
- 19 MS. DEBORAH FRYAR, Deputy Director of Government
20 Relations Military Family Association
- 21 RICHARD McCORMICK, PH. D., Assistant Clinical
22 Professor, Psychiatry Dean Case Western
Reserve School of Medicine

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1 PRESENT: (continued)

- 2 SHELLEY MacDERMID, PH. D., Professor of Child
3 Development and Family Studies and Director
4 Military Family Research Institute, Purdue
5 University
- 6 DR. THOMAS BURKE, Executive Secretary to the
Task Force

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P R O C E E D I N G S

LTG KILEY: Colonel Davies, are you ready to open the meeting?

COL DAVIES: Thanks, General Kiley. As the acting designated federal official for the Armed Forces Epidemiological Board a federal advisory committee to the Secretary of Defense, which serves as a continuing scientific advisory body to the Assistant Secretary of Defense for Health Affairs, and the Surgeons General of the military departments, I hereby call this meeting to order. General Kiley.

LTG KILEY: Thank you, Colonel Davies. Very nicely done, again. Okay. The mission this

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15 morning is to read back in the public record a
16 little bit of work that the three working groups
17 that we're going to report on today have been
18 working on. And I think I'm going to ask with Dr.
19 Burke to start with the working group report on
20 Family on behalf of Ms. Fryar who was here
21 yesterday. Tom, are you ready to do that?

22 MR. BURKE: Yes, sir.

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1 LTG KILEY: The floor is yours.
2 MR. BURKE: Thank you, sir. I'm Dr.
3 Thomas Burke, I'm the Executive Secretary for the
4 task force, and I'll be reading the preliminary
5 report of the family member workgroup for the
6 co-chairs Ms. Deborah Fryar and Commander Aaron
7 Werbel. The other members of this working group
8 are Captain Margaret McKeathern, Dr. Shelley
9 MacDermid, and Ms. Kathryn Power. The elements
10 that the family member work group are addressing
11 are elements D, F, and G from the Congressional
12 mandate in the FY 2006 National Defense
13 Authorization Act, Section 723.

14 Element D is the access to and programs
15 for family members of members of the armed forces
16 including family members overseas.

17 Element F is the awareness of mental
18 health services available to dependents of members

19 of the armed forces whose sponsors have been
20 activated or deployed to a combat theater.

21 Element G is the adequacy of outreach,
22 education and support programs on mental health

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1 matters or families of members of the armed
2 forces.

3 In general terms, the framework and the
4 goals that this working group are using to address
5 the taskings in elements D, F and G, are ongoing
6 dialogue about what is meant by the definition and
7 the term mental health. They considered what
8 mental conditions needed to be assessed including
9 substance abuse, domestic violence, adjustment
10 disorders, suicide prevention. The working group
11 also developed questions for families in family
12 forum groups. They developed outlying for future
13 family workgroup briefings, and coordinated
14 closely with the continuity of care workgroup
15 because many of the workgroup issues coincide with
16 that group. They wanted to put a special emphasis
17 on child and adolescence issues, in elements D, F
18 and G. And in Element G, they intended to spend
19 some time looking at community resources
20 determining what mental health services can and/or
21 should be provided through schools. Both DoD
22 schools and local independent school districts

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1 working with military children will be addressed,
2 because schools in areas affected by high
3 deployments are seeing increased mental health
4 issues and may not have personnel to deal with
5 them. This working also intends to look at school
6 serving the children of guard and reserve members
7 because these schools may not have familiarity of
8 working with military families.

9 The working group will access mental
10 health resources and available programs for
11 families of the wounded service members including
12 the Military Severely Injured Center, the Army
13 Wounded Warrior Program, the Marine for Life
14 Injured Marine Program, the Navy Safe Harbor
15 Program, and the Air Force Palace Heart.

16 The working group will interview case
17 managers of wounded service members. They intend
18 to offer focus groups with families of wounded
19 service members potentially at Fort Sam Houston,
20 San Diego, Walter Reed Army Medical Center, and
21 Bethesda Naval Medical Center.

22 The work group will evaluate areas

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1 concerned with the deployment cycle mental health
2 issues that affect families. They want to
3 identify existing reports that are available that
4 identify these issues and the mental health needs
5 of families during deployments. They intend to
6 find out what the specific mental health issues
7 and needs of families are during the entire
8 deployment cycle.

9 They intend to look at TRICARE
10 beneficiary mental health benefits. The working
11 group had a TRICARE briefing as part of a larger
12 full task force meeting in July, but they have
13 determined there is a need to assess access
14 standards and specific types of mental health care
15 that is covered under TRICARE.

16 The working group also intends to meet
17 with veteran's service organization and military
18 service organizations including but not limited to
19 the Military Coalition Healthcare Committee, the
20 National Military Family Association, Military
21 Officers Association, the Veterans of Foreign
22 Wars, and the Disabled American Veterans.

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1 Observations to this point are that
2 family members seem to have a lesser priority than

3 active duty service members. DoD and community
4 schools can be challenged by children of deployed
5 service members. The reintegration needs of the
6 family unit need to be evaluated for
7 effectiveness. And the families of service
8 members need to be treated as a whole unit. Some
9 of the stigma about mental health issues is
10 getting better for service members. However, the
11 stigma that service members experience is also
12 felt by family members. Many spouses seek
13 professional mental health service through private
14 professional, because they want to keep any
15 reference to mental health treatment out of their
16 military medical records.

17 Early recommendations are to formulate a
18 more coherent statement acknowledging that mental
19 health services must be provided across a wide
20 continuum from basic deployment support, to
21 prevention, to stress management, to more clinical
22 services.

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1 Family members should be given equal
2 treatment as service members and it should be
3 recognized that the definition of family for this
4 committee includes many who may not be ID
5 cardholders. Including spouses children, parents,
6 siblings of service members and interested others.

7 The task force needs a briefing on what
8 specific services are covered under TRICARE. They
9 would like to invite HealthNet to brief the task
10 force about the TRICARE mental health firm that
11 oversees the overall TRICARE mental health issues.
12 They need to carefully assess access to TRICARE
13 networks and ease of accessibility. The working
14 group will assess who is monitoring the TRICARE
15 website for accuracy and to see that providers
16 that are listed are actually taking new patients.

17 Three primary areas of concern emerged
18 about TRICARE, the first was credentialing for the
19 TRICARE network providers, specifically the
20 restrictive nature and timeliness of
21 credentialing. The second was TRICARE
22 reimbursement rates. And the third was referral

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1 or authorization for operational cases.

2 The working group would also like to
3 continue to assess its knowledge about Military
4 One Source and to assess if Military One Source is
5 actually serving the purpose of being the conduit
6 to mental health care for all beneficiaries. That
7 concludes the written report submitted for the
8 family member work group.

9 LTG KILEY: Thank you very much, Dr.
10 Burke. I think the next report, if we could ask

11 Dr. McCormick to give a quick lay down on the
12 working groups efforts in current active duty.

13 DR. McCORMICK: Thank you, General. The
14 active duty subtask force. The format of this
15 that I'll try to use is issues that are needing
16 attention and that we're working on the further
17 research and develop for possible recommendation.

18 The first mega issue, if you will, is
19 assuring an accessible, comprehensive continuum of
20 mental health care for active duty personnel.
21 Under that, first of all we'll be looking at
22 services provided by military providers and

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1 civilians at the medical treatment facility. And
2 the issues we're looking at there is, first of
3 all, is there a full array of programming, full
4 continuum of care? Are the programs adequately
5 staffed. Understaffing, first of all, we're
6 recognizing the need to look at whether the
7 current methodology for determining staffing
8 levels is optimal. And right now it is a workload
9 based system based on relative value units and
10 such systems do of course serve the purpose of
11 seeing whether provider X is sufficiently busy and
12 sufficiently utilized. The problem with workload
13 systems, in our view, is that they don't often
14 well attack suppress demand, because if somebody

15 is maxed out it tells you very little bit about
16 how much more is needed.

17 So we are asking the question: Would a
18 risk adjusted population based methodology be an
19 improvement on the current system? And in terms
20 of risk adjusters, that could include deployment
21 schedules, the nature of the unit. Certainly the
22 location of the unit in terms of its proximity to

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1 other population areas.

2 Secondly under the general staffing
3 issue is the issue of whether we're able to
4 recruit and retain sufficient military, green
5 suit, mental health professionals. And if not
6 what can be done to address that problem? What
7 recommendations could we realistically make that
8 would improve that? We've had discussions, both
9 in the task force and our visits, on the issue of
10 length of deployments. There have been some
11 discussion on the financial incentive package and
12 the strengthening of the training incentives that
13 attract professionals into the military.

14 Third under this topic of the MIFs is
15 are we able to compliment with adequate numbers of
16 civilian providers employed by the medical
17 treatment facility. Under that the issues so far
18 we've looked at is whether there are adequate

19 funds to hire, if that's the impediment. And what
20 are impediments to recruitment. Specifically, is
21 the military treatment facility financially
22 competitive with other providers who would be

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1 trying to hire similar personnel. And that could
2 mean other public institutions like a VA
3 hospital, now or down the road, and of course the
4 local community which is also competing for that.

5 And, lastly, under this general issue of
6 staffing of the MIFs is is the contract staff
7 process that is contracting for staff to work in
8 the medical treatment facility capable of coping
9 with the surging and fluctuating needs due to the
10 war and its deployment.

11 The next issue that we're looking at is
12 whether there are barriers to assessing the
13 military treatment facility mental health
14 programs. That obviously includes looking at
15 waiting times and particularly in the area of
16 substance abuse, the dilemma of needing to notify
17 command for good reasons of substance misuse
18 disorder referrals, but its affect on discouraging
19 treatment and screening. Particularly at earlier
20 stages of the problem, in other words, someone who
21 is just starting to have an alcohol problem, the
22 literature suggests that may be a good time to

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1 intervene. It's very possible that that would be
2 the person who is most likely to be discouraged to
3 go and have command learn that he has a problem
4 versus someone who has a much more full-blown
5 problem where command already knows it anyway.
6 And here we're looking at whether there should be
7 some alteration in policy. We've been discussing
8 that, and better ways to improve the education of
9 line command on the issues to try to impact the
10 dilemma.

11 The second broad area that we're looking
12 at is are services provided by other on-post
13 programs that interact with the core mental health
14 services. And there the issue is whether they're
15 coordinated. Whether it's chaplains, family
16 services, the other people, social work service,
17 which is usually part of mental health, but
18 separate. Are there effective mechanisms in these
19 to place -- to ease the access. In other words
20 for a soldier who is faced with this array of
21 programs, are there mechanisms in place to help
22 them understand where it would be best to go and

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1 to navigate the set of different programs.
2 Thirdly, there are services provided by
3 the TRICARE network for active duty either not
4 provided by the MTF. It might be someone who is
5 stationed too far away from the military treatment
6 facility, for example, to get services. And
7 sometimes to supplement military treatment
8 facility resources like at Fort Drum for example,
9 they contract for all inpatient psychiatry care.
10 Here the issue is does the mental health component
11 of the TRICARE contractor, and some of these are
12 carved out to other behavior -- sub-contracted to
13 behavioral health firms, maintain a full array of
14 providers and services. And this overlaps with
15 the concern of the family group, of course, since
16 family members are more dependent on the TRICARE
17 network. Under that what we're looking at is does
18 the military treatment facility play a role of
19 oversight in assuring that there is, in fact, a
20 full array of services, a full continuum of care,
21 and that is accessible. In other words, is it not
22 left just to the contractor. Is someone -- I

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1 guess the example I would use is that there are
2 places, I understand, where the military treatment

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3 facility does see families provide the care for
4 them as well. There obviously the military
5 treatment facility commander does look at and is
6 responsible for looking the full continuum of
7 care. I guess one way to look at it is that even
8 if it's being done by the network, there is still
9 some responsibility, someone ideally would have
10 some responsibility to look it over. As was
11 mentioned by the family group, we are of course
12 looking at whether the credentialing of TRICARE is
13 user friendly. Whether the authorization process
14 is reasonable and at least comparable to other
15 payers of mental health services in the market,
16 and whether the reimbursement rate is competitive
17 with other payers in the market. We've actually
18 have heard anecdotal reports that it isn't, which
19 could have the affect of having the family of a
20 service man go to the bottom of the list when they
21 go to try to find service with a busy provider in
22 the community. That's just -- hopefully

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1 patriotism would work in the opposite direction
2 with that. But there is also the case to be made
3 that TRICARE ought to be at least competitive with
4 other providers.

5 And then lastly, are the TRICARE network
6 providers adequately educated in the special needs

7 of the military. Frankly this is less of an issue
8 when you're at a place like Fort Hood where many
9 of the providers are -- have a large caseload of
10 military people and are often ex-military
11 themselves. It's more of an issue, clearly for a
12 recruiter in central Ohio who is out there with
13 his family, maybe just having come back from
14 deployment recently and having to rely on
15 providers. And that's a difficult issue that
16 we've been trying to think about and how you get
17 some expertise to those people. One suggestion
18 was actually made that the authorization process
19 by TRICARE may be ideal that some training were
20 offered to a provider if the authorization was for
21 example PTSD. Some mediated package that they
22 could at least chose to take if they thought that

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1 they needed extra help.
2 And then lastly, are there effective
3 mechanisms to assist in accessing the network,
4 getting into the network. And are the services
5 well coordinated with the military treatment
6 facility services.
7 The other thing we want to look at again
8 are the services provided by Military One, is
9 there adequate compliment of local providers under
10 the Military One contract, and are their services

11 coordinated with TRICARE.

12 The second mega issue that we're trying
13 to look at is are there effective programs for
14 prevention screening. Is there adequate privacy
15 during screening is one issue we've been looking
16 at. And is attendance at the prevention efforts
17 for other mental health and substance abuse
18 related issues given priority. Are soldiers
19 really able to and expected to come.

20 The third mega issue is what can be done
21 to further reduce stigma. How can we -- the thing
22 we've been looking at so far is how we can improve

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1 training of command. The last thing I'll say is
2 some suggestions or some things -- some data
3 sources that we're going to be trying to use to
4 answer some of these questions, we have developed
5 a template for each of the national services,
6 Army, Navy, Air Force, to fill out that will give
7 us some information on a mega sense of their
8 programs. We are going to be asking for briefings
9 with the representatives of the three TRICARE
10 mental health subcontractors. In one case it
11 belongs to the company and the other cases it
12 seems to be a subcontract. And the DoD oversight
13 personnel, we need to get our hand around exactly
14 what is expected and whether it's being done

15 consistently across the three contracts. We'll be
16 trying to compare rates. It is possible to get
17 rates paid by other large companies, Aetna, Blue
18 Cross Blue Shield, other behavioral health firms
19 by locality so that we can look and see if TRICARE
20 is, in fact, competitive in the markets that are
21 most important particularly around large bases.
22 And then we will be having a briefing on the

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1 military one contract. That's it.
2 LTG KILEY: Thank you very much, Dr.
3 McCormick. That was very good. Our last
4 workgroup report back is by Dr. Zeiss on the
5 continuity of care.
6 DR. ZEISS: And my report will be fairly
7 brief because there is considerable overlap
8 between each of the groups and I'm going to try
9 and highlight things that this group is working on
10 that are distinct from things that you've heard
11 about so far. I also want to mention at the start
12 of the report that Colonel Pereira is the co-chair
13 of this group, and I don't think it's been
14 mentioned the overall task force did make a
15 decision that each of these workgroups should have
16 one co-chair who is from the civilian membership
17 of the task force, and one from the military
18 membership of the task force. And I think that's

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19 been a wise decision. I think we really are
20 looking at things in a balanced way in having both
21 perspectives in each of the workgroups. And I
22 will welcome Colonel Pereira's comment after I do

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1 the brief report I'm going to do.
2 Our charge elements from the
3 congressional mandate look at continuity of care
4 not within active duty, in the way you've just
5 heard the report, but really in a broader scope
6 and between active duty and them leaving the
7 military or for a reserve and guard in their
8 periods between active deployment. So I'm just
9 going to read the charges and then talk about some
10 of the things that we're doing that compliment what
11 you've already heard about. So we are asked to
12 look at the efficacy of programs and mechanisms
13 for insuring a seamless transition from care of
14 members of the armed forces on active duty for
15 mental health conditions through the Department of
16 Defense to care for such conditions through the
17 Department of Veteran's Affairs after such members
18 are discharged or released from military, naval or
19 air service. I happen to be the VA representative
20 to the task force so it's not surprising that I
21 was interested in co-chairing this particular
22 subgroup.

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1 Our second charge is the availability of
2 long- term follow up and access to care for mental
3 health conditions for members of the individual
4 ready reserve and the selective reserve, and for
5 discharged, separated, or retired members of the
6 armed forces.

7 Third is collaboration among
8 organizations in the Department of Defense with
9 responsibility for or jurisdiction over the
10 provision of mental health services.

11 Fourth is the coordination between the
12 Department of Defense and civilian communities
13 including local support organizations with respect
14 to mental health services. So as you can see
15 there is certainly some overlap with both the
16 family and the active duty groups, but also some
17 distinct things that we need to be looking at.

18 The issues that we've been paying
19 particular attention to and will hope to develop
20 recommendations about, but have not yet developed
21 recommendations, are the following:

22 First, we're very interested in issues

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1 of communication between VA in particular, but we
2 also are thinking more broadly about other
3 civilian providers, and active military. And this
4 is particularly with regard to reserve and guard
5 components who might be seeking services for
6 mental health issues during the time when they are
7 not deployed. Then maybe redeployed back to Iraq
8 or Afghanistan, they are certainly -- if they were
9 receiving services within the military, command
10 would have information about their conditions and
11 their capacity to participate fully in mission.
12 However, if they're receiving services from a
13 civilian providers like VA or other community
14 services there are different standards guided by
15 HIPPA and just basic ethics and expectations of
16 confidentiality. And so this is an issue that we
17 want very much to explore and develop
18 recommendations about how this might be handled in
19 an effective and fair way. To do that we are
20 certainly looking within VA at what the legal
21 precedents are what the expectations are. And
22 we're also wanting to explore this in other

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1 context for service provision.
2 Another issue that we're looking at that

3 is particularly relevant to VA is the eligibility
4 for VA services following active duty
5 participation. This currently congressional
6 mandate that anyone who is in combat theater has
7 full eligibility for all VA services for a
8 two-year window. After that the determination
9 would be based on other factors concerning their
10 priority level and the nature of their military
11 service is different for guard reserve and for
12 people who were active duty military. And we want
13 to look at whether or not that eligibility
14 standard which is set by Congress is something
15 that we may wish to make recommendations about.

16 We're also looking within VA there is a
17 seamless transition office. We've had a briefing
18 from them as has the whole task force, and we also
19 are looking at a data collection process within VA
20 on patient self-reports regarding their experience
21 of transition to care to VA from the military.
22 This is particularly focused on the very active

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1 transition sites for those who have been most
2 seriously injured. So it's not all returning
3 veterans, but is certainly an important VA data
4 collection piece, and we are looking currently at
5 the methodology and we'll look at the data as that
6 becomes available.

7 Another issue that is more related to
8 provision of services in the community is wanting
9 to look at state programs and the coordination
10 within states of mental health services, outreach,
11 understanding ability to meet the needs of
12 returning military and their families. And we
13 will be getting briefings from three state model
14 programs that will help us focus in on the issues
15 and understand where some of the best practices
16 are and what some of the potential problems are
17 and what recommendations we might want to make.
18 In the capacity, especially looking at longer-term
19 care, and care for dependents longer term, we will
20 be receiving a briefing from the TRICARE reserve
21 select, as will most of the other committees be
22 looking at obtaining more information about

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1 TRICARE and how it functions. So we are in the
2 process of very actively collecting information.
3 We have focused in, as I mentioned, on areas where
4 we plan to make recommendations but have not yet
5 gotten to the point where we would want to suggest
6 what those recommendations might be. Anything
7 you'd like to add?

8 COL PEREIRA: Yes. I just have one
9 thing to add. In addressing seamless transition,
10 we're also looking specifically at how medical and

11 mental health records could be better shared
12 between the VA and the DoD in both directions to
13 enhance the continuity of care.

14 LTG KILEY: Very good. Thank you Dr.
15 Zeiss and Colonel Pereira. I think Dr. Blazer has
16 a comment he'd like to make.

17 DR. BLAZER: I just wanted to mention
18 that this task force currently is under the
19 auspices of the Armed Forces Epidemiological
20 Board, which Colonel Davies mentioned. I would
21 point out just one significance of that
22 association, the Armed Forces Epidemiological

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1 Board has historically been interested in
2 prevention and specifically has focused
3 historically upon two areas. One is infectious
4 disease and one are injuries and accidents of
5 various types. More recently there's been
6 increased attention placed on mental health issues
7 from specifically a prevention perspective and so
8 I think that one sort of overarching theme that is
9 being carried forth in this task force is not just
10 treatment, but also prevention of mental health
11 problems among our forces.

12 LTG KILEY: Very good. Thank you. Are
13 there any other comments from the task force? Any
14 comments from the audience. Okay. Well, seeing

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15 none, then on behalf of the task force I'd like to
16 thank the community of Killeen and the leadership
17 of Fort Hood and the garrison and MEDCEN command
18 on a great visit. I think we learned a lot. I
19 think we learned a lot about the process of
20 running our task force, as well as a lot about
21 mental health services and some of the challenges
22 we still face. We're particularly appreciative of

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1 those who presented yesterday to the public forum
2 and gave their testimony to the issues and the
3 concerns that they had that they wanted our task
4 force to be made aware of. And subject to any
5 other administrative requirements that I'm unaware
6 of, I would ask Colonel Davies to officially close
7 the public session and to close the task force
8 visit here. Can you handle that Colonel Davies?

9 COL DAVIES: Yes, sir. I certainly can.
10 This task force open meeting is closed. Have a
11 great Army day.

12 (Whereupon, the proceedings were
13 concluded)

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