

AFEB 6-22-2005.txt

ARMED FORCES EPIDEMIOLOGICAL BOARD

DAY TWO

The Hope Hotel and Conference Center
Building 823, Area A
Air Force Research Laboratory
Wright-Patterson Air Force Base
Dayton, Ohio

wednesday, June 22, 2005

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1 PRESENT:

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- 2 BOARD MEMBERS:
3 David Atkins, M.D.
4 Dan German Blazer, II, M.D., M.P.H., Ph.D.
5 Barnett L. Cline, M.D., M.P.H., Ph.D.
6 Jean Lois Forster, Ph.D., M.P.H.
7 Gregory C. Gray, M.D., M.P.H.
8 William E. Halperin, M.D., M.P.H.
9 Wayne M. Lednar, M.D.
10 Grace K. LeMasters, Ph.D.
11 John Glen Morris Jr., M.D., M.P.H.&T.M.
12 Michael N. Oxman, M.D.
13 Michael D. Parkinson, M.D., M.P.H.
14 Kevin Patrick, M.D., M.S.
15 Gregory A. Poland, M.D. (President)
16 Roger William Sherwin, M.D.
17 Roger L. Gibson, Colonel USAF, B.S.C., [AFEB
18 Executive Secretary]

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Major Dennis Kilian
CANADA/EVALUATION OF EPI-NATO IN BOSNIA
Dr. Maureen Carew
COAST GUARD
CDR Sharon Ludwig
HEALTH AFFAIRS
Lt Col Bruce Ruscio
MARINE CORPS
CDR David McMillan

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1 P R O C E E D I N G S
2 DR. POLAND: We do have some individuals
3 that this is their last meeting. We recognized
4 David Atkins yesterday who was our chair for the
5 Subcommittee on Health Promotion and Maintenance.
6 We also have another long-time friend
7 and oft- time presenter of the Board and that's

8 Commander Sharon Ludwig. I don't exactly know.
9 Are you retiring or moving on?

10 CDR LUDWIG: Promoted.

11 DR. POLAND: Promoted. Yes, ma'am.
12 wow. Okay. We also want to knowledge soon-to-be
13 promoted Colonel Stephen Phillips, the Health
14 Affairs, Preventive Medicine Liaison Officer who
15 was unable to come to this meeting.

16 Also unable to make the meeting was
17 Colonel Sandra Pufal, who served as the Reserve
18 Affairs Preventive Medicine Liaison Officer.

19 Both are moving on to new jobs and new
20 adventures. We thank them for their service to
21 the Board and wish them luck in their future
22 endeavors.

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1 Commander Ludwig, will you come up?

2 (Applause)

3 DR. POLAND: This reads, "To Commander
4 Sharon Ludwig with sincere appreciation for your
5 service and contributions as Coast Guard
6 Preventive Liaison Officer, Joint Preventive
7 Medicine Policy Group."

8 I have to say I think for my entire time
9 on the Board Sharon has always been here. So,
10 I'll miss seeing you.

11 (Applause)

12 DR. POLAND: And then for the AFEB,
13 Commander "Sharon Ludwig with deepest appreciation
14 for your outstanding contributions as Coast Guard
15 Preventive Medicine Liaison Officer. Thank you
16 for your selfless and dedicated support."

17 (Applause)

18 CDR LUDWIG: It's been a tremendous
19 pleasure. I will miss the group a great deal.
20 Fortunately this is not actually going to be my
21 last meeting because I'll be mentoring my
22 replacement. So, I will be there in september and

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1 possibly even December. So we don't need to say
2 good-bye yet. I really do appreciate these.
3 Thank you.

4 (Applause)

5 DR. POLAND: Our first presenter then is
6 Major Dennis Kilian, Preventive Medicine Officer
7 from the Joint Staff who will be briefing us on
8 deployment health information systems. Your
9 slides are in Tab 3.

10 MAJ KILIAN: Good afternoon, Ms. Embrey,
11 Dr. Poland, Board. Major Smith came back from the
12 last board and said you all had some questions
13 concerning information management and information
14 technology systems within the theatre operations.

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15 So, I have been asked to bring you all
16 up to date on what those systems are. What I hope
17 for you all to have a concept of when we leave
18 here is to understand the MHS IM/IT portfolio
19 architecture, what the various systems of the
20 information management, information technology
21 are, how they are structured underneath Health
22 Affairs.

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1 I understand the programs that
2 constitute Theater Medical Information Program, or
3 TMIP, as it's called, which specifically are the
4 deployable medical assets from the IM/IT
5 perspective.

6 I understand the relationship of TMIP to
7 the Service component information systems and how
8 there may be some designed systems friction.

9 Next slide, please. This will be the
10 agenda that I will be following throughout the
11 briefing.

12 Next slide, please. I want to take just
13 a second here to discuss the organization of the
14 Department of Defense because this is how the
15 acquisition process will proceed whenever someone
16 comes forth with an information management,
17 information system.

18 The Services are over here, the Army,
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19 Navy, Marine Corps, Air Force, the Joint Chiefs of
20 Staff and then the Office of the Secretary of
21 Department of Defense.

22 It would be the responsibility of OSD to

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1 come up with a policy to do something. The joint
2 staff is responsible for operationalizing it and
3 the Services underneath Title X, U.S. Code are
4 responsible for training and equipping the force.

5 An example of this would be OSD would
6 come up with a policy that every officer would
7 have a personal firearm, okay, as an example. The
8 Services then would go off and get an idea of, oh,
9 well, I want it to be handheld or I want it to be
10 shoulder mounted, I want it to be something else.

11 All three come up with their different
12 ideas. They then bring it to the Joint Chiefs of
13 Staff underneath the JCIDS process, which is the
14 Joint Capabilities Integration Documentation
15 System where the product or products would come
16 forth to a respective board. This example would
17 be the Force Protection Board.

18 All the Services would come and look at
19 the product and then they would chose which one
20 would be best at the three star level, take it to
21 the four star level, which is the JROC, the Joint

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22 Requirements Operations Council and then the very

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1 Services would either sign up and say this is what
2 we want to do or if no one wants to do it, it
3 would get kicked back to the Services and
4 sometimes they can go their own way.

5 This is how many IM/IT solutions that we
6 have today came about.

7 Next slide, please. I want to take a
8 moment because in health care systems the central
9 IM/IT office is located in the Department of
10 Defense, specifically. It would be underneath the
11 Assistant Secretary of Defense for Health Affairs.

12 Next slide, please. Specifically, it's
13 underneath the CIO, the Chief Information Officer,
14 who was Mr. Reardon, and I'm not aware of whether
15 his replacement has been named yet.

16 Next slide, please. Underneath the CIO
17 is the PEO. Then these are the various programs
18 that are underneath the Program Executive Officer.
19 There's CITPO, which is the Clinical Information
20 Technology Program Office, TIMPO, which is Theater
21 Medical Information Program, RITPO, which is
22 Resource Information Technology Program Office,

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1 and there's Executive Information Decision Support
2 Section and then the Tri-Service Inter-Service
3 Management Program Office.

4 From an operational medicine
5 perspective, the one that is most impacting us is
6 the TMIP Office. Other program offices may have
7 components that are there, much like CHCSII, but
8 then there is a variant of their program that TMIP
9 will integrate and deploy into the field.

10 Next slide, please. This is what it
11 looks like. It's clear as mud. One important one
12 to keep in mind here is DEERS, which is a
13 personnel system, but we do keep shot records and
14 other things, permanent data records in there.

15 DMDC, the Defense Manpower Data Center,
16 also runs their database, so that whenever we try
17 to do epidemiological studies they are the ones
18 who are ultimately responsible to track where
19 people are on the battlefield.

20 Next slide, please. So, let's focus on
21 TMIP. It's interesting. I have recently set the
22 POM review, which is the Program Objective

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1 Memorandum for FY 07, where the budget lines were
2 and who was going to be funded and unfunded.

3 This actually comes from the TMIP office
4 and many of these things we didn't necessarily
5 have visibility on. But these are alphabetized.
6 BMIST is basically the handheld device that
7 independent duty corpsmen, medics in the field are
8 able to work with the soldier, sailor, airman or
9 Marine as they are injured.

10 The day will come whenever they are
11 supposed to have their CAT card. I'm a medic. I
12 get it from the wounded soldier. I stick it into
13 the hardened case. It looks a whole lot like a
14 PDA.

15 Some selection is already pre-arranged
16 in there. I can tap on it that he had a head
17 wound, put in some basic file statistics, take the
18 card out and the CAT card flows with the wounded
19 service member.

20 Some of the other ones, you can see CHCS
21 NT and CHCS II-T. These ultimately will merge,
22 but because we are having to operate CHCS in

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1 theater there's an NT version.

2 As CHCSII comes on, the full operational
3 capability, it will absorb, be like the "BORG"
4 and assimilate that capability.

5 Some of these DBSS, the Blood Standard
6 System, has to be FDA-compliant.
7 DMLSS is the Defense Medical Logistics
8 Standards Support System. It has the capability
9 to reach all the way back to the Defense Logistics
10 Agency, DLA, who is the executive agent for Class
11 8 medical supplies. There had to be an interim
12 fix into that one called TOOLS that you will
13 see later as an Army specific component because at
14 the time of the briefing we were still waiting for
15 a decision on when it moves over to the DMSS which
16 maybe you all are familiar with with
17 Colonel Rubertone.
18 All the way down to JPTA is on here.
19 It's not officially a program of record yet. It's
20 a program of policy. Dr. Winkenwerder saw it
21 briefed in Germany and liked it and instantly
22 grabbed it and ran with it. Its capability is

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1 Soldier X, Sailor X, where they are in the
2 hospital, they are on Ward 3, Fifth Floor, Room
3 601, and it has a whole bunch of what might be
4 getting into the HIPAA arena of very specific
5 medical detailed history. But it's web-based.
6 There are gatekeepers on who can access this data.
7 It's supposed to allow much capability to see

8 health records of the service member.
9 It works in conjunction with TRAC2ES
10 which is the TRANSCOM Patient Movement Module,
11 which is responsible for asset allocation on how
12 do I get Sailor X, Soldier X moved intra-theater,
13 all the way back to whatever of care they need,
14 Walter Reed, for example.
15 You will see the PDHA get tapped
16 several times. This is the Post-Deployment Health
17 Assessment. There's a model of it that's on a
18 PDA, but the services also are working on models.
19 So, some consideration for synergy of work to be
20 considered on that one.
21 Next slide, please. So, what do all
22 those programs bring you? Well TMIP Block one

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1 came out, so these are the various functions that
2 it can do for you or these are the things it's
3 supposed to be able to do for you.
4 Next slide, where the folks who recently
5 were using these capabilities in the theater
6 operations. Some of these are active. Some of
7 these are reserve component and it's across the
8 services.
9 Obviously, if it's Block One there must
10 be a follow on block. These are the Block Two
11 capabilities. Services have received it and are

12 starting to test it now. Towards the bottom here
13 you see GEMS. GEMS is an Air Force tool. SAMS is
14 a Naval tool. So, even though this is the TMIP
15 Program profile, it is talking to service specific
16 components.

17 This Block Two is also stratified, as
18 you can see.

19 Next slide. There are currently five
20 total releases on the books. Full operational
21 capability for TMIP isn't expected until 2009.
22 One thing to note on this, too, is that the ACTD

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1 doesn't show up in here until it gets integrated
2 into the TMIP purview of how it's going to
3 integrate and become a program of record, get
4 funding beyond the ACTD thing. I thought it best
5 not to track it, as the assimilation tool that we
6 hope that it will be, that we expect that it will
7 be.

8 MS. EMBREY: Part of the process of
9 getting it identified as an ACTD is to identify
10 the target system that would absorb and integrate
11 the capability. TMIP has been identified as that.
12 So, the program manager of TMIP is responsible for
13 not only planning, but taking responsible for
14 programming funding to sustain whatever comes out

15 at the end.

16 So, by regulation TMIP has to identify
17 MSAT dollars at the point at which it is no longer
18 a demonstration project, which is FY 07. So,
19 there is money in the TMIP program for MSAT right
20 now in the POM.

21 MAJ KILIAN: So, from a timeline
22 perspective, next slide please, it was commented

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1 previously that you all wanted to see when
2 capabilities, not systems, but the capabilities
3 come one line.

4 Between that slide and this slide you
5 can see how the releases are developed and when
6 they were released. The release authority in
7 these cases is DASDHA, Dr. Winkenwerder.

8 Next slide, please. Now we'll go into
9 some of the service capabilities. The CDA is the
10 Army's solution to dental readiness. The ePPDHA,
11 again the Army-centric one, obviously, my opinion,
12 not the Joint Staff opinion, is that it seems like
13 we could save some time, effort and have synergy
14 if the services didn't all do these things
15 independently, which is what the CIO Office in
16 Health Affairs is trying to bring all these guys
17 in line to do.

18 MEDPROS is a medical readiness system.

19 It does not necessarily bring up medical records.
20 It's a service members - it tells you when they
21 had their last flu shot, had their last HIV draw,
22 when the last serum was placed in the repository,

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1 when the last 2795 pre-deployment health
2 assessment was done, when the last postponed
3 health assessment was done. It's actually a
4 system of systems, MEDPROS.

5 You can get anthrax immunization dates
6 and it feeds what will soon be the IMR for the
7 Army side.

8 TAMIMIS and Tools are two systems of
9 concern recently within the Army. TAMIMIS is
10 hitting its sunset date. It simply cannot
11 maintain its accreditation due to the fact that it
12 was designed and built two decades ago, before the
13 advent of viruses and everything else.

14 Tools is the solution for the way ahead.
15 Next slide, please. These are the Navy systems.

16 Again, they have something that's like
17 the Army CDA. They call it DENCAS. SAMS is the
18 Navy's equivalent to MEDPROS.

19 You can see that the services seem to
20 have like type systems. Now, each one has their
21 own strengths and each one has their own

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weaknesses. For example, MEDPRO's is web-based or

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1 you can go into a mainframe access and you can
2 talk globally.

3 SAMS talks to itself real well, but if I
4 was the commander of the 7th Fleet and I had three
5 aircraft carrier subordinate to me, neither one of
6 those three aircraft carriers could talk to each
7 other, nor could their SAMS system talk to me and
8 I'm their higher headquarters. So, that would be
9 a significant limitation to that system.

10 However, the Navy has identified that as
11 an issue and is working on trying to have SAMS
12 talk to itself.

13 Next slide, please. AFCITA is the Air
14 Force equivalent to the Navy SAMS and the Army
15 MEDPROs. Actually, talking to folks who use all
16 three systems to get base immunization data,
17 AFCITA may be the easiest to operate of the three
18 systems. As a green guy I think it's okay to
19 occasionally say the Air Force builds a good
20 product.

21 In short you can see that there's a
22 multitude of efforts going on out there with a

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1 whole host of information programs.

2 I understand you all had some questions
3 or you all had concerns that there seems to be,
4 you know, software operating systems do jour.

5 The services have commented that
6 sometimes they build service specific things in
7 the absence of a system that can do what it is
8 that they need to do. They use service specific
9 dollars and not necessarily the core dollars out
10 of their MHS to get their answers resolved.

11 This is sort of where the friction point
12 comes in, where if you are Chief of Staff of the
13 Army you have readiness issues that you have got
14 to answer underneath Title X.

15 Those requirements may be slightly
16 different than one of your sister organizations,
17 like the Assistant Secretary for Health Affairs
18 who has a slightly different mission, well, a lot
19 different mission.

20 The services would then say that they
21 build systems that answer their needs. That's a
22 lot of why there is a multitude of different

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systems out there.

Wherever I did my brief or I put it together -- we can go ahead and skip over the SOH stuff, I mainly was going to focus on DOEHRs-I have. Since I'm an environmental health guy, I was really going to bring some of that forth.

Since we have already done that, we'll skip through DOEHRs-IH.

Then other DoD systems, as I was mentioning, there's DEERS. There are systems like DIMRS, which is the next system for the personnel community to track individual people on a day-to-day basis.

There's the potential for something called Blue Force Tracking, which could address some of the epidemiological concerns that we have of where service members are at any given time, because if I'm a commander of an armor battalion, Blue Force Tracking actually sends me a signal of where everyone is within my area of operation and it's real time.

But we don't necessarily track

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operational feed data back to -- and each one of those Blue Force Trackers has an identifier indicating it's a friendly force and if I'm Colonel Painkiller I know where each of my service

5 members are.

6 But there currently isn't a system in
7 place to pull that data in and move that to BMDC.

8 Subject to your questions on IMIP stuff,
9 that concludes my briefing.

10 DR. POLAND: Dr. Carpenter.

11 DR. CARPENTER: You mentioned that
12 immunization data is stored, is in the DEERS
13 database.

14 MAJ KILIAN: Yes. Ultimately it gets to
15 DEERS. It migrates through the services to their
16 immunization tracking systems and to DEERS. DEERS
17 is the master, ultimate gold standard.

18 DR. CARPENTER: So the information about
19 immunization is entered by one individual at one
20 point in time and then it's transferred to the
21 various databases?

22 MAJ KILIAN: The systems do talk to each

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1 other. For example, with MEDPROS the data is
2 entered in either via the web or via a direct feed
3 into the mainframe. Then once per week there's a
4 data download out of the MEDPROS database into the
5 TAPD, Total Army Personnel Database into DEERS.

6 So, if you hit the wrong cycles it could
7 take you two to three weeks to get your

8 immunization moved all the way into DEERS.
9 COL WHITE: What's the technology that
10 Blue Force Tracking is based on? I mean how does
11 it work? How do they know where people are?
12 MAJ KILIAN: It's a combat arms system
13 to minimize fraternization.
14 COL WHITE: I'm just wondering how would
15 you actually know where they are?
16 MAJ KILIAN: There is a GPS coordinate.
17 They have little transponders.
18 COL WHITE: Okay, fine.
19 MAJ KILIAN: If you have a picture, you
20 will have photography in the terrain that you are
21 in. It will show your forces are there arranged
22 on the battlefield.

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1 DR. POLAND: I guess I have two
2 questions. The first one is ultimately, are you
3 going to have a system, though there may be
4 different levels of access to it, where the full
5 sweep of broadly defined medical care can be
6 recorded?
7 For example, outpatient counseling,
8 optometry visits, podiatry visits, dental visits,
9 physical therapy as well as the standard sort of
10 medical inpatient, outpatient immunization, et
11 cetera.

12 Is there going to be a database that all
13 three services can appeal to?

14 MAJ KILIAN: well, CHCSII is the way
15 ahead. It was determined that CHCS needed to go
16 away and CHCSII would be the new system. CHCS
17 original was a big monolithic system that did all
18 those types of things.

19 CHCSII, by law they interact. It
20 requires them to look at commercial, off-the-shelf
21 technology. So, each system within there, the
22 optometry thing, the lab, the pharmacy, each of

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1 that, they go out to industry every day. So,
2 Bill's Software Company gives you your X-ray
3 module and Ted's Software Company gives you the
4 other module.

5 Then every time there's an update you've
6 got to decide how long you'll continue to update.
7 Ultimately, CHCSII will have what we think of as
8 inpatient visits, outpatient visit data
9 incorporated into it, into the clinical data
10 repository.

11 There will be several CDRs. There's the
12 warehouses for master archiving.

13 DR. POLAND: The point is there would be
14 one integrated record.

15 MAJ KILIAN: Theoretically, yes, sir.
16 DR. POLAND: Across the services?
17 MAJ KILIAN: Yes.
18 DR. POLAND: Including the Coast Guard?
19 MAJ KILIAN: Yes, sir. Now the upside
20 of the CHCSII over the original CHCS is if I was
21 at Tripler Army Medical Center in Hawaii and I was
22 going to PCS or leave or somewhere and I was going

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1 to Fort Bragg, North Carolina, their CHCS system
2 couldn't make that appointment for me.
3 CHCSII will allow me to access other MHS
4 hospitals.
5 DR. POLAND: This will include the Coast
6 Guard or not?
7 MAJ KILIAN: It should. I mean they are
8 covered underneath the benefit.
9 DR. POLAND: Then the last question, and
10 maybe I just didn't understand part of it, why do
11 each of the services then have distinct IT
12 systems? In other words, whether you are in the
13 Army or the Navy --
14 MAJ KILIAN: What side am I arguing on?
15 DR. POLAND: The basic tracking should
16 pretty much be standardized and the same.
17 MAJ KILIAN: The services would argue
18 that the systems that are there produced by the

19 MHS historically, traditionally, maybe not now or
20 in the future, but were more centered on MTF
21 capabilities and were not responsive enough to
22 their needs in a deployed environment; i.e., a

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1 battalion aid station or a force forward medical
2 clearing company.

3 So in the absence of a system, they need
4 to develop their own. So in interoperability when
5 you look at who does what similarly, you can make
6 an argument that native Marine Corps medicine is a
7 whole lot like Army deployed medicine.

8 So you could see leveraging that while
9 as was mentioned earlier, Air Force medicine, if
10 you are at the forward air base in Kuwait, 29CFR
11 probably still applies to you there as much as it
12 does here at Wright-Pat. The fact that it's a
13 fairly secure, stable environment and you are not
14 moving fluidly like the ground components do.

15 So the Air Force systems have often
16 looked much more like the IM/IT portfolio systems,
17 although they have their own. GEMS is an Air
18 Force system. Depending on who you ask, some
19 folks love it; actually in the Air Force some
20 folks love it and some folks aren't as enamored
21 with it.

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Command Corps was another one. Some

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1 folks loved it. Some folks thought that Jim's was
2 better.

3 MS. EMBREY: Dave is not an IMIT guy
4 either. He's representing -- really Health
5 Affairs has the responsibility for designing and
6 developing the architecture for the whole military
7 health system.

8 what you have here is outcomes of at
9 least 20 years worth of changes in acquisition
10 strategies, policies of the department,
11 under-funding requirements that were identified,
12 ridiculous acquisition life cycles for the
13 development of major information systems and the
14 impatience of the services to wait for six or
15 seven years to implement an automated capability.

16 what you have now is a series of a very
17 common set of capabilities built in the services,
18 primarily for deployment because the dollars that
19 were identified throughout the MHS as a matter of
20 priority in the early decades was to make sure
21 that in our MTS we had common data collection and
22 enterprise-wide understanding for population

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1 health management because we had a peacetime and a
2 war fighting requirement.

3 In the deployment system information
4 capabilities, A, we were limited by band width,
5 and B, technology didn't really help us much in
6 the deployed environment. So there was less of a
7 priority to resource that.

8 I speak only out of speculation because
9 I wasn't in Health Affairs at that time. But I
10 will tell you now, since I have been in the job,
11 since deployment health is my objective, my
12 mission, I have been one raving, screaming
13 advocate for theater applications for the deployed
14 forces.

15 The TMIP was an identified program more
16 than 15 years ago, but it was never funded. Over
17 700, I don't know, millions of requirements were
18 identified. Block 1 wasn't even fielded until
19 this last year, after 15 years worth of work.

20 So I would tell you that I became not an
21 advocate, more of a critic, frankly. They have
22 moved a lot of distance between two years ago and

1 now and it's because if they couldn't deliver
2 something I created a demonstration project that
3 answered the mail in between times.

4 We have JMews. We have MSAT. We have
5 JPAT. We have all these other capabilities that
6 are not application oriented as much as they are
7 interfaces to a database that allows people to do
8 business the way they do business across the
9 services and to exchange and enter information
10 from that interface.

11 So I think the attitude, if I have
12 anything to do with it, will be to continue to
13 allow the services to evolve in their business
14 practices because the Air Force, the Navy and the
15 Army do do business differently.

16 So as long as they are feeding common
17 data on a regular basis and they agree on the data
18 definition, we shouldn't give a rat's ass what
19 kind of application they are using.

20 MAJ KILIAN: An example of what would
21 the data look like, this is an active duty
22 military ID card. There's a little computer chip

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1 on here. One of the things that help up some of
2 the MHS stuff is this little ID card because the
3 services could not agree on how many bits of data
4 should be stored on this ID card.

5 It seems silly, but this was holding up
6 some of the systems that were in the CIO, but it's
7 true. You know, there has been some systems in
8 the TMIP arena that TRACES, for example, that
9 initially for a number of years was a poor
10 performer. A lot of money went in and not a whole
11 lot came out.

12 Now, it seems to be real close to fuller
13 operational capability. You call it codes. They
14 call it CODS. It's something similar like
15 that.

16 But Ms. Embrey got quite forceful with
17 TRANSCOM on making sure that if they had this
18 separate database that it could talk to the other
19 clinical databases so that, you know, it wasn't
20 just another stovepipe to nowhere.

21 DR. POLAND: Dr. Patrick.

22 DR. PATRICK: At the risk of grossly

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1 oversimplifying this, it seems that there are
2 really two issues. One, the whole notion of
3 deployed forces, the unique needs to access and
4 use in a multitude of ways health related
5 information and out of the individual population
6 level for deployed forces.

7 Then there's the rest. It seems like

8 the larger sort of tectonic force that's going on
9 now is this whole movement on the part of the Bush
10 Administration, and it has been one of the most
11 progressive things to come out of the
12 administration, to come up with a unified
13 electronic medical record.

14 I don't think there's really anything
15 unique for the non-deployed issues because there
16 you are going to need immunization registries
17 which really rest better at a geopolitical unit
18 than they do at an organizational unit. It's
19 communities and groups of individuals.

20 So I guess I wonder what, separate from
21 the deployed issues which do get into the newer
22 technologies and newer strategies and approaches

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1 to monitor, how is DoD thinking about how it will
2 partner with this national program to in fact not
3 invent it's own things but do things in concert?

4 I think it's called the Medical Record
5 Community, if I'm not mistaken. That's the
6 overall thing. This is well beyond DoD and it's
7 well beyond DoD-DA. This is what we need to do as
8 a nation to accomplish a unified data information
9 system that relates to health and medical events.

10 DR. PATRICK: I think what you are
11 saying is the VA's position, because I have heard

12 him say this, is, you know, that the medical
13 record -- and it makes sense that it should be a
14 seamless transition if you are an active duty
15 service member.

16 unless you are dishonorably discharged
17 you are going to have VA benefits and if you are a
18 member of the VA you would think that if I'm
19 active duty today and I'm retired tomorrow that I
20 should be able to take my health records straight
21 to the VA and it would continue to serve as a good
22 health record.

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1 Today that's not necessarily true. The
2 VA, I know has worked with Health Affairs on
3 trying to make that a more seamless process.
4 There has been, from a policy perspective, there
5 has been some changes in the last two or three
6 years on retirement or separation physicals so
7 that as you transition to the VA system versus the
8 normal active duty MHS system, that they can still
9 read your records or that some of their
10 requirements for data are already being addressed.

11 DR. PATRICK: But my question goes
12 beyond the DoD VA transition. It's actually being
13 a participate in the national dialogue of the
14 Unified Patient Medical Record. It's not just

15 clinical medical. It's basically unified health
16 information systems which will feed both the
17 clinical and population-based health processes.

18 It's a very, very important issue. I
19 think it's the type of thing which will
20 essentially encapsulate that whole mess of coat
21 hangers there and create something that in fact
22 will be, as you called it, I think, a way ahead.

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1 This really is the way ahead. All of us
2 are recognizing that this is what really needs to
3 be done. To my mind this is the clearest mandate
4 that there has ever been at the national level
5 that this is something we are going to do, again,
6 straight from the top.

7 So I guess I would say is DoD a
8 participate? And if not, why not?

9 MS. EMBREY: I know that I'm not, but
10 that doesn't mean anything. My bet is that there
11 is a representative from DoD or a cadre of
12 representatives from DoD on that effort. We are
13 doing out best to understand the whole
14 architecture that was described. That big wiring
15 diagram is trying to gather together old Legacies
16 into a modern-day database mining capacity.

17 The path ahead has been to frame and
18 normalize the data between and among all the

19 systems into what they call a central data
20 repository. That central data repository would
21 begin by ensuring that there's common terms of
22 reference and aliases for all of the systems

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1 feeding into it and pulling out of it for whatever
2 reasons.

3 That would apply to surveillance,
4 population health issues. It would apply to
5 tracking specific things like immunizations and
6 blood types of blood management and all the
7 clinical practices.

8 We are trying to apply smaller versions
9 of that for deployment applications. There's a
10 CDR for theater that mirrors the CDR for the
11 permanent medical record data repository.

12 So that it will allow us to take theater
13 data in that repository and automatically update
14 the main medical records in the data repository.
15 That's the architectural dream that we are
16 building, but it's hard to do that when you have
17 moving targets all the time.

18 So I'm sure we are working on whatever
19 the national is going to be; but I am sure that
20 DoD will have many more data in it than the
21 medical record that will be determined because

22 ours is much more robust and we are by law

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1 required to now even link exposure data in our
2 medical records by law.

3 So we have a much, much larger demand
4 for our medical system than the national system
5 ultimately will be because I can't imagine any
6 private doctor creating a medical record of the
7 kind that we have to maintain.

8 MAJ KILIAN: Actually, I think that may
9 not be the case. I think in fact there may be
10 special circumstances and settings in which this
11 overall architecture would in fact come.

12 I think the spirit of this is that DoD
13 shouldn't necessarily feel that it has to do all
14 the heavy lifting by itself internally; that this
15 is a real opportunity to begin to solve some of
16 these interoperability questions in concert.

17 Don Detmer gave a wonderful talk on this
18 at the Health Conference about a month ago in
19 Bethesda. I mean there's more talk about this
20 than anybody can possibly imagine, as we all know.

21 But I think while there are unique needs
22 in various settings and populations, I think the

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1 intent is to have the ability to be sufficiently
2 flexible with these systems. At least that's my
3 read at the policy level in terms of what's
4 happening with IT to be able to accommodate a
5 number of these, again, separate from -- and
6 that's what I said at the beginning, -- separate
7 from deploy.

8 The deployed issue is obviously a very
9 special kind of an issue and a unique thing in
10 this occupational setting, if you will. But other
11 than that, corporate environments, other
12 environments where very, very interesting
13 challenges are coming down the pike.

14 So I would just encourage as much as
15 dialogue as possible because I think it could
16 ultimately save a lot of hassle down the road of
17 trying to connect things where there wasn't the
18 initial thinking ahead of time about these return
19 functions that should be filled in.

20 DR. OXMAN: I agree with what you are
21 saying, but I think just to really focus it back,
22 though, I think there are issues with

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1 compatibility with the VA system, with the VA
2 CPRS. Speaking as somebody who works in a VA
3 hospital, you know, when you try to figure out
4 what's happened to a veteran before they showed up
5 on your doorstep, that becomes exceedingly
6 difficult.

7 So there would be huge benefits if the
8 systems at least between the VA and DoD were
9 compatible, including the deployment systems
10 because it would make a tremendous difference long
11 term in our ability to figure out what's happened
12 to these guys.

13 MS. EMBREY: Yes, I think that the
14 department is actually committed to the data
15 exchange. I think the practices are different and
16 they may become more and more similar as "TRICARE
17 for Life" begins to invade our capabilities.

18 Essentially, I think the commitment has
19 been made that we are going to work together
20 toward some kind of common, fluid exchange of data
21 electronically. So I have no doubt that we will
22 get to that point, probably not as quickly as they

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1 would want us to.

2 we are exchanging electronic data now,
3 but the folks that are getting out of the force
4 generally have, you know, one-third electronic and

5 two-thirds paper. So we've got to migrate our way
6 into that capability. But everybody coming in now
7 has electronic medical records. So we are moving
8 forward in that direction.

9 MAJ KILIAN: Some of the difficulty lies
10 within how the law is written. If there are
11 Congressional dollars for special demonstrations,
12 there are joint ventures between the VA and the
13 Department of Defense.

14 However, let's go back to Tripler for
15 just a moment. Outside of Tripler Spark Matsunaga
16 Veterans Health Clinic which is touching Tripler
17 Army Medical Center. However, even though it's on
18 the same grounds, they specifically had to build a
19 separate power plant, they had to specifically
20 build separate sewer lines, water lines, HVAC
21 systems.

22 Even though they physically touch and

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1 you could use the same awnings, the same
2 passageways could not adjoin each other, could not
3 open to each other. Yet, we routinely whenever I
4 was at Tripler would have consults back and forth
5 back and forth between each organization because
6 actually Senator Inouye had really worked hard to
7 improve the Asian-Pacific veterans access to care

8 there.

9 But the law would not allow the two
10 facilities to be conjoined where they actually
11 opened up into each other.

12 DR. POLAND: Dr. Oxman.

13 DR. OXMAN: Again, looking at your
14 presentation without understanding all the
15 alphabet soup, it still looks as if there's a
16 competition between the attempts to have one
17 integrated program which contains the data from
18 all services and simultaneous investments of time
19 and money in continuing to develop service
20 specific, in a sense competing smaller programs
21 and units.

22 Is that true or am I just totally

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1 missing the boat?

2 MAJ KILIAN: The services would say they
3 are trying to respond as quickly as possible by
4 using some of their O&M dollars, their separate
5 service dollars; they can create something out of
6 the normal acquisition process to address their
7 immediate needs.

8 Routinely, there are new fact of life
9 changes, which means Congress passes laws that
10 affect health care records like HIPPA, for example,
11 that were, whenever the POM was put together four

12 or five years ago, whenever a system was supposed
13 to go the full operational capability today and
14 now there's a bogey out there, an unfunded mandate
15 that I have to take money from this to deal with
16 this new HIPA concern.

17 There's a host of systems that impact
18 the portfolio. So the services would say that
19 they are not trying to compete against each other;
20 they are trying to get what they can control done
21 today, now; that if the Air Force has to wait for
22 the Army to develop a system, bring it up and then

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1 bring it back down, that's not effect for the Air
2 Force.

3 DR. OXMAN: But isn't there also a
4 completely central endeavor working simultaneously
5 to develop a system that will fit all three
6 services?

7 MR. SPELLMAN: I am Steve Spellman, the
8 Army Secretariat. I worked at CITPO (?) and RITPO
9 for about four years before I moved to the Army
10 Secretariat.

11 Talking to both the federal efforts and
12 also this sort of friction between the services
13 and the central, there's something called the
14 Management Modernization Program that has put some

15 control over this process that has been identified
16 as a risk, specifically that systems of \$1 million
17 or more need to pass what we call the BMNP
18 check to get a milestone.

19 So that is the hammer in terms of trying
20 to get some control over these service specific
21 systems. In other words, they are aware that this
22 is something that really we have to get some

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1 control over from a central perspective.

2 Right now it's a million dollar system
3 change request that's the cutoff for that. That
4 will probably go down. Also, for the last six
5 months from the hazardous material perspective, I
6 have been working with a business enterprise
7 architecture. We see what you guys are calling
8 the medical record as a human resources issue
9 that's going to have to touch other domains.

10 So it's moving. The BMNP has its own
11 challenges. There's some GAO activity. But there
12 is an effort to get both fiscal control over this
13 spaghetti as well as the realization that the DoD
14 is going to have to work with other agencies
15 outside of the DoD.

16 So it's happening, slower probably than
17 this group would like to see, but it's happening.

18 DR. OXMAN: Because as a taxpayer, those

19 aren't Army dollars; they are my dollars. To a
20 certain extent it looks as if they are being --
21 from my perspective -- being misused because they
22 are working at the very least in parallel when

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1 there ought to be an Army, a Navy and an Air Force
2 representative on a joint program that's the only
3 effort being made to upgrade and integrate the
4 system.

5 MS. EMBREY: Would you mind coming to
6 DoD for a short period of time?

7 DR. OXMAN: Ms. Embrey, you're right as
8 far as participation in the national medical
9 record, whatever you call it, TMA. Before I
10 volunteered the individuals, I would offer to the
11 Board that I could bring back some information or
12 have that individual talk to the Board to let you
13 know.

14 DR. POLAND: Okay. If there are no
15 other questions I think we should move on.

16 MAJ KILIAN: Hopefully next time I'll
17 get to discuss something simple like ENP or
18 something like that.

19 DR. POLAND: Thank you. Commander
20 Carpenter, our Canadian Forces liaison officer,
21 will introduce our next presenter, Mrs. Maureen
22 Carew who will provide an evaluation of Epi-NATO

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1 in Bosnia. Copies of those slides are in Tab 8.

2 CDR CARPENTER: Thank you very much.

3 Good afternoon. Yesterday, Commander Sharon
4 Ludwig, United States Coast Guard, told me that a
5 number of people had asked her if she was
6 Canadian.

7 The reason for this apparently is that
8 she was in a uniform that apparently some people
9 didn't recognize and she spoke American. This is
10 the Canadian Navy uniform.

11 But I have to tell you, I have to make a
12 confession, I purchased this Canadian Navy uniform
13 at the National Naval Medical Center in Bethesda.
14 Now, that's what I call interoperability.

15 There is, however, a way to tell us
16 apart. As Canada's contribution to the
17 proceedings today, it is my pleasure to introduce
18 Dr. Maureen Carew. She will be talking about
19 Epi-NATO, a study she did in Bosnia.

20 Now, of course, Bosnia has sort of gone
21 way in the background in view of current events,
22 however, this is still relevant because in fact

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1 Epi-NATO is being used by coalition forces in
2 Afghanistan. So it's still in use. The study is
3 still very relevant.

4 Dr. Carew graduated from Memorial
5 University in Newfoundland. We fondly call them
6 Newfies. Newfoundland is the rock. She practiced
7 family practice for several years and then decided
8 to specialize in epidemiology. She actually
9 earned her fellowship in community medicine and
10 epidemiology at the University of Ottawa.

11 She worked for a while in Indian and
12 Inuit affairs for a public health service and saw
13 the light and now she works for the Department of
14 Defense as one of our esteemed epidemiologists.

15 DR. CAREW: Thank you, David, and thanks
16 to the Board for this invitation to present the
17 findings of our study that we conducted looking at
18 the EIP NATO surveillance system in Bosnia.

19 I should credit some other individuals
20 who actually carried out the evaluation, Barb
21 Strauss and Jean Wilson who are both
22 nurse-epidemiologists who work with us.

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1 Another colleague I should give credit
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2 to, Dr. Martin Tepper. When I was preparing this
3 presentation to send to the Board, he came by and
4 asked me what I was doing and I told him. He
5 said, oh, Epi-NATO, that's not ever going to help
6 you win the war. I thought that was a catchy
7 title and I really owe credit to him for helping
8 me out with that.

9 So basically, the reason we conducted
10 this evaluation was because we were receiving
11 anecdotal reports from the field from various
12 people that the data was very poor with Epi-NATO,
13 people weren't happy with it; it wasn't being
14 utilized and it was of limited utility.

15 So we went and looked in the literature
16 and really, we were unable to find an evaluation.
17 we couldn't find an evaluation that had been
18 conducted since the system was implemented in
19 1996.

20 At the same time we were faced with a
21 constant need to have reliable and valid
22 deployment health data so we could respond to

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1 questions we get from the field and also from the
2 media.

3 So that brings me to the next slide. So
4 we embarked on this evaluation. This slide just

5 gives you an outline of what I'm going to present
6 today.

7 As everyone is aware, health
8 surveillance systems are essential to military
9 forces both on deployment and in garrison because
10 they face a variety of operational scenarios,
11 including war, peace-keeping, national disasters
12 and potential terrorist attacks.

13 Epi-NATO was approved by the NATO
14 Surgeons General in 1996. Then it was adopted by
15 Canada in the Bosnian theater initially.

16 Next slide. The general purpose was to
17 monitor disease and injury morbidity trend so that
18 they could define emerging health threats, to look
19 at troop strength and readiness, how many people
20 were available to fight. It was also intended to
21 guide disease prevention and control programs and
22 policies.

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1 Finally, NATO wanted a standardized
2 coding tool so that they could compare
3 multinational health trends for countries that
4 were operating in the same theater of operation.

5 Just to give you a little bit more
6 information, the system was based on a
7 surveillance system initiated by the British Army
8 which is known as the J-95. It was adopted, as I

9 mentioned, mainly for use in the Bosnian Conflict
10 Stabilization Force, which is I-4, F-4.

11 The system is based on groupings of 25
12 codes essentially. Those codes closely resemble
13 chapter headings from ICD-9 and ICD-10. So the
14 patient is assigned one of those 25 codes but is
15 not assigned a specific ICD code.

16 It does capture first visits versus
17 subsequent visits for one particular problem. It
18 collects information on the disposition of the
19 patient, whether they are on light duty or off
20 duty, whether they were hospitalized or referred
21 to a specialist.

22 These are the 25 Epi-NATO codes. So as

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1 you can see, even before we began the evaluation
2 we had concerns about this list. The big problem
3 from an epidemiology standpoint is that the
4 categories are too broad to be very useful to us.

5 That being said, we did detect two GI
6 outbreaks; one in Bosnia and one in Althena
7 just because we saw a big bump in Code 1.

8 The other problem is that certain
9 conditions could potentially be coded under more
10 than one category. So for example, a
11 streptococcal infection that manifested as a rash,

12 some people might code it under dermatological
13 problems and other people might code it under
14 number 3, which was an infectious disease.

15 Next slide. So we were concerned right
16 off the bat about the validity of the tool that
17 was being used. Our specific objectives were, I
18 guess going back a little bit, the purpose was we
19 wanted to find out if Epi-NATO was really
20 fulfilling its original mandate.

21 Then we wanted to look at it and see
22 what ways we could improve deployment

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1 surveillance. So the specific objectives for our
2 valuation were, one, we wanted to find, if there
3 were any original objectives for the Epi-NATO
4 surveillance system.

5 The second was we had no idea how the
6 data was flowing or where it was flowing or who
7 was getting it. So we wanted to document the data
8 flow process and also the operational process, who
9 was analyzing it and who was reporting it.

10 we wanted to look at three key
11 attributes of the surveillance system which were
12 mainly data quality in terms of liability. We
13 wanted to look at timeliness and acceptability.
14 Finally, we wanted to see if the data was being
15 used for public health action.

16 Next slide. This slide is a map of
17 Bosnia. Unfortunately, it's missing for some
18 reason a couple of the camps that we went to. But
19 the evaluation involved two of the larger CF camps
20 in Bosnia which were located, one, just south of
21 Banja Luka, and the other one was northwest of
22 Banja Luka.

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1 Two of our epidemiologists traveled to
2 all three of those camps. Banja Luka was a
3 multinational camp. It was the brigade
4 headquarters for the northwest section of Bosnia.

5 Next slide. Essentially, we had two
6 components. The first was we wanted to do a chart
7 audit to look at data reliability. The second was
8 to capture information about data flow,
9 acceptability, timeliness. We did stakeholder
10 interviews at various levels with various
11 personnel.

12 I should mention that it was a huge task
13 trying to get two civilians over there. If it
14 wasn't for the task force surgeon who was a public
15 health physician who had worked with us, I don't
16 think this ever would have happened.

17 Essentially, they had a very short time
18 period. They had five days to complete the whole

19 evaluation. while they were there a large GI
20 outbreak took place and they ended up getting
21 pulled off.

22 So some of our original methods had to

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1 get changed because we were dealing with a really
2 tight schedule. what they did was, they took a
3 convenient sample of 128 consecutive patient
4 visits from the roster of July in the unit medical
5 station that was in the largest camp in VK.

6 Each of our epidemiologists assigned an
7 Epi-NATO code. Then it was compared to the codes
8 which had been signed previous by the unit medical
9 station or the UMS. Both were blinded to each
10 other. So the FHP epidemiologist did not know the
11 codes of the UMS and the UMS codes had been
12 assigned before the evaluation took place.

13 They had no knowledge of the evaluation
14 coming up so they weren't sensitized to improve
15 their coding. we did kappa analysis looking at
16 all of the codes collectively and then we looked
17 at the injury-related codes because injuries are a
18 major cause of morbidity for the Canadian forces
19 and we wanted to get an idea of how reliable the
20 data was.

21 Finally, once the RODO had finished
22 in October, the task force surgeon gave us a copy

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1 of the sick parade register. It had all the
2 Epi-NATO codes. We were interested in looking at
3 the things that were coded as 'other' to see if
4 they could have been classified under more
5 specific categories.

6 The next methodology was the
7 questionnaire. It was essentially an open-ended
8 questionnaire that we were trying to get at, the
9 things I mentioned, the data flow, the
10 acceptability, timeliness and the other aspects of
11 our evaluation.

12 It was conducted with various personnel.
13 We interviewed 14 people on site in Bosnia at the
14 three different camps. They were all users to
15 some degree of the system.

16 We also interviewed three personnel from
17 NATO who were in SHAPE -- I'll show you what that
18 is in a minute -- and also people at Canadian
19 forces headquarters.

20 So what we found looking at the chart
21 audit, examining all codes collectively, the
22 capital was .4 and actually the confidence

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1 intervals aren't here but they were .3 to .5. So
2 it was marginal reliability.

3 Then when we examined the injury codes
4 the KAPPA was .8 and the confidence intervals were
5 .1 to .3. So that was very, very poor data
6 quality for injury codes.

7 Looking at the log audit, about 25
8 percent of all visits were coded in other
9 categories. We examined them and a number of them
10 could have been captured elsewhere, things like
11 hemorrhoids and some muscular skeletal problems.
12 The other thing we noticed were the very common
13 conditions that were always being coded under
14 'other' like smoking cessation, immunizations and
15 administrative visits because there is nowhere
16 else to put them.

17 So we were a bit concerned about that
18 because we didn't want administrative things
19 lumped in with diseases and surveillance.

20 Next slide. From the stakeholder
21 interviews, I guess a couple of the most obvious
22 issues that arose were that we really couldn't

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1 find anyone who had been involved in the
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2 implementation of this.

3 It was difficult to find objectives or
4 find any kind of documents. That was because of
5 the very high turnover in staff. But we did not
6 identify any specific objectives for the
7 surveillance system. There was no identifiable
8 implementation plan.

9 So most of the information we gathered
10 was pieced together on the data flow from the
11 stakeholders involved and a little bit
12 from -- there was one study done in the UK in 1995
13 by the UK Army that piloted Epi-NATO before it was
14 used. It had three physicians code a number of
15 clinical scenarios.

16 They did find a concordance of about 65
17 percent. But it was conducted under ideal
18 conditions where the physicians had training, they
19 knew they were being evaluated and it wasn't
20 really under normal operational theater
21 conditions.

22 Next slide, please. So the way it was

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1 working in Bosnia was when patients presented to
2 the unit medical station they were seen by a
3 physician or a physician assistant and they wrote
4 up their diagnosis in the chart. At the end of

5 the day, based on that diagnosis and the
6 information from the chart, either a med tech or a
7 clerk would assign one of the 25 Epi-NATO codes.
8 Then that was compiled into a database.

9 Next slide. The next slide shows the
10 data flow through the CF reporting structures and
11 also through NATO. So our two camps, Zgon and VK,
12 were compiling the reports locally and sending
13 them weekly to our Canadian Force task force
14 headquarters.

15 From that point on they were sent to
16 Banja Luka, to the Multinational Brigade in Banja
17 Luka on to S-4, the stabilization force in
18 Sarajevo, then NATO headquarters in Naples for the
19 Balkans and then on to Supreme Headquarters Allied
20 Powers Europe, which is SHAPE in Belgium.

21 It was intended that the data was to
22 flow to Canada as well, and it had been, but at

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1 the time of the evaluation we actually found it
2 had stopped; there were no reports coming back to
3 us at all. There are various reasons why that
4 happened. They were sending an alternate
5 surveillance report which I'll talk about in a
6 minute.

7 So we initiated this and they did start
8 sending reports again after this, but there was no

9 data feedback to us at all.

10 At this point, I should mention as well
11 that the data was flowing through NATO but there
12 was no analysis, no reports, no dissemination of
13 the epidemiological data at all, to any country.

14 Next slide. So when we talk to the
15 stakeholders they did report that they found the
16 tool to be ambiguous and vague. They also
17 mentioned that there were common things they saw
18 that they couldn't give a specific code for.

19 None of them had received any training
20 about the system before they were deployed. There
21 were very few dedicated resources or people they
22 could turn to for help. We did have another

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1 competing system at the time for the Canadian
2 forces called the MEDSITREP.

3 The purpose of that was mainly to look
4 at troop strength and readiness. It was just
5 collecting information in a rather gross manner on
6 surveillance. But they did have to fill out two
7 reports.

8 When we looked at timeliness, although
9 the UMS appeared to be coding the information on a
10 daily basis, it was only being send through NATO
11 monthly and the reports back to headquarters had

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ceased completely.

So looking at acceptability, to the users it was not an acceptable system for the numerous reasons I mentioned and largely as well because they weren't getting any feedback.

From an epidemiological standpoint the system wasn't acceptable because the codes are too aggregated and they are really not useful in order for us to respond to questions about health concerns.

Overall, the system appeared to be of

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low acceptability because it was not being used to drive public health policy or actions.

The limitations of our study were that because we couldn't contact anyone who'd really been involved in it, it's possible there could be objectives and documentation sitting on a shelf somewhere in the UK, but not find anything.

The other thing was just a snapshot in time, looking at one rotation, one particular theater. It's possible things could be different, especially for other countries or other theaters.

We were unable to do a randomized chart selection. That was mainly a logistical problem in trying to get the charts pulled when they got there. The intent was for each FHP coder to do

16 one set each and we would compare and do
17 reliability. But they were so pushed for time we
18 had to just split the charts.

19 Next slide. So in summary the system
20 was found to not have any objectives. There was
21 no obvious planning or implementation. We found
22 it had poor data quality, that the coding was not

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1 reliable.

2 There was no analysis interpretation or
3 reporting of data through NATO. There were
4 certainly gaps in timeliness and reporting and it
5 wasn't being used for public health action.

6 Next slide. So we felt that the system
7 was not meeting our deployment surveillance needs.
8 What we did was once the evaluation was completed
9 we struck a deployment surveillance working group.

10 Next slide. This group was tasked with
11 deciding, one, what to do, and then how they were
12 going to proceed. So I think everyone felt that
13 we wanted to move on. We weren't going to try and
14 change the system. We felt it was broken and we
15 wanted to start somewhere new.

16 The first thing they did was look at
17 objectives, specific objectives for deployment
18 surveillance which took a few months and have been

19 developed and they have also developed objectives
20 for general surveillance for the Canadian forces,
21 health surveillance.

22 The other thing is we are considering an

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1 electronic coding system. I'm going to talk about
2 that in the next slide where the coding is
3 actually automated and hopefully will remove some
4 of the reliability problems.

5 we are developing a clear plan, a
6 business plan documenting roles and
7 responsibilities. For any new system there will
8 be training and resources. We want to consider
9 what types of reports to generate back to the
10 users at various levels.

11 Next slide. The new system that we'd
12 like to embark on actually is we would like to
13 have deployed operations, have automatic ICD codes
14 assigned based on the diagnosis. This is partly
15 coming from the fact that we have in development
16 an electronic health record in the Canadian forces
17 and it will be using ICD 10 coding which will be
18 automatically generated for diagnosis.

19 Right now, the electronic health record
20 is being rolled out. It's phase one where it's
21 just a scheduling and immunization component.
22 It's going to be probably another three or four

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1 years before we have clinical notes.

2 we really don't want to wait that long
3 to have a proper deployment surveillance. So
4 we've submitted a proposal and some information.
5 we're getting involved in setting up the database
6 right now.

7 we went through and looked at about 1500
8 symptoms and diagnoses and have assigned ICD-10
9 codes to them. We wanted something that user
10 friendly, that's easier to use but would still
11 allow comparison between theaters and countries
12 and that provides us with more useful detailed
13 health data, but it could still be rolled up into
14 larger categories if that's required by NATO and
15 it's presently under development.

16 Next slide. Finally, the evaluation was
17 presented to the COMEDS, which is the Chiefs of
18 the Military Medical Services to their working
19 group in Budapest last April. They were quite
20 keen on the findings. They are waiting for us to
21 give a demo once we have something tangible to
22 work with.

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1 It was also presented at the meeting of
2 the Surgeons General in Prague last spring as
3 well. That being said, we recognize that this is
4 mainly a CF effort and there are certainly other
5 countries that have developed their own electronic
6 systems.

7 I guess it remains to be seen how the
8 data can be compiled and compatible and can be
9 used at a higher level. That's it.

10 DR. POLAND: Thank you, Ms. Carew.
11 Commander Ludwig.

12 CDR LUDWIG: I'm looking around the room
13 for the senior preventive medicine folks because I
14 need somebody to help me out here. But I realize
15 it's me now.

16 In January of 1996, I was preparing to
17 go to Bosnia right after the Dayton Peace Accord.
18 We saw that Epi-NATO, it was called J-95 at the
19 time, had been suggested. But because the Joint
20 Forces for the U.S., the Joint Staff, had already
21 approved our form of medical surveillance and we
22 had used it in the field and some of were very

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1 familiar with it and others were not, we decided
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2 to go ahead with the joint forces.

3 There was no mandate from EUCOM or
4 any of the higher-ups to use Epi-NATO at the time,
5 J-95. So we used the Joint Staff format. I know
6 a lot about development of that, too, because I
7 was involved with that.

8 About halfway through the year, Colonel
9 Tom Jefferson, who claims that he was related to
10 our Thomas Jefferson, came through and talked to
11 me more about J-95. We agreed that it looked
12 like it was going to become the surveillance
13 system adopted by NATO.

14 We agreed at that point that when I
15 transferred out and a new person came in, it would
16 be the time for our Armed Forces because a lot of
17 Americans at that time were leaving and a whole
18 new set were coming in after a year; that the new
19 people who came in would learn Epi-NATO and that
20 everybody would be using Epi-NATO.

21 Now, I don't know what the U.S. is using
22 in Bosnia now, but I kind of feel proud to have

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1 been the one who set up the surveillance for the
2 American forces over there.

3 But in developing these surveillance
4 categories they purposefully did not use ICD-9

5 codes. I'm talking about both the U.S. Joint
6 Forces or the Joint Staff requirement and Epi-NATO
7 because those were days of stubby pencil only.
8 There just weren't enough computers around to do
9 it electronically.

10 So we needed to be very simple, a
11 minimal number of categories because it was really
12 only going to be a gross picture of what the
13 medical status of the forces was and not to be
14 used for epidemiologic analysis really except for
15 an almost real time indication of things like GI
16 outbreaks and so on.

17 So anything that you are developing now
18 that would use ICD-9 or ICD-10 codes, of course,
19 will require either an electronic format, which I
20 assume is what you are doing. We couldn't do that
21 at the time because people would have to carry
22 around an ICD-9 code book with them and it just

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1 wouldn't have made sense.

2 I'm very curious to see what you come up
3 with. If anybody is familiar with what the
4 Americans are using in Bosnia these days, I had
5 thought that it was going to be converting to a
6 system where all of theater would be using the
7 same system.

8 DR. CAREW: I think they are all using
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9 it. In Budapest last year I did meet the CHPPM
10 representative from the U.S. That's what they
11 were using on deployment. Just to mention a
12 little bit about the codes, we did do a review
13 looking at coding, reliability of coding in
14 physicians.

15 I did find a few studies. It seemed
16 that the problem was it looked like a simple
17 system because it only has 25 codes, but you have
18 to understand the classification and what codes go
19 where and what the rules are.

20 Part of the problem I found when I
21 looked at the other studies was that physicians in
22 particular tend to not have a reason to understand

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1 the classification. They tend to memorize the
2 common codes. I know that because I was a family
3 doctor. In order to get paid I had to give a
4 code, which was an ICD code.

5 I knew my top 20 codes and I always
6 forced everything into those. That's the problem
7 with asking people to assign a code, even it's
8 simple, it really isn't. That's why we didn't
9 want to try -- initially people thought let's just
10 train people that are -- but really the amount of
11 improvement in the reliability, we thought, was

12 going to be not great.

13 It's not a system that's used in
14 garrison. They only use it for a few months when
15 they are deployed. It looks simple but it really
16 is not simple. It's not intuitive. We just want
17 to take away physicians or anyone having to assign
18 the code. Once they enter the diagnosis, we are
19 going to try and pull them in the right direction
20 and get a code assigned automatically.

21 DR. POLAND: Dr. Halperin.

22 DR. HALPERIN: You know, all of the

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1 articles on evaluation of surveillance systems
2 mention that it's essential to look at the goals
3 of the surveillance system, what you are trying to
4 accomplish with it. Then they get into process
5 measures, you know, sensitivity, specificity,
6 acceptability and on and on and on, and then get
7 away with why you have the surveillance system.

8 I think you came to the same conclusion
9 about the surveillance system you critiqued, which
10 is nobody knew why it was there. What was it
11 trying to accomplish? Was it trying to identify
12 new problems or recurrence of old problems or
13 magnitude or trends? What was it supposed to be
14 doing?

15 Then I thought that in your description

16 of the new surveillance system that you weren't
17 much clearer on what the goals were.

18 DR. CAREW: We do have goals and
19 objectives. I just didn't present them here.

20 DR. HALPERIN: All right. Because it
21 seems to me that the goals and objectives drive
22 what the surveillance system is going to be about.

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1 The enemy of sort of the functionality of the
2 surveillance system is information technology.

3 There's the 'what do you want it to do?'
4 well, I want it to pick up GI outbreaks, I want it
5 to identify new ways that soldiers are getting
6 injured or whatever. But oftentimes the bulk of
7 the people who work on these surveillance systems
8 are essentially the IT people who want to code
9 everything to the point where the ICD-10 may not
10 be able to codesomething new. It doesn't go in
11 any code, so it goes in lots of codes and you kind
12 of miss the outbreak.

13 So the only thing that I can say is that
14 Eisenhower said, 'Beware the military-industrial
15 complex' and I think our motto ought to be beware
16 the military information technology complex.
17 Let's stick to the goals.

18 DR. POLAND: Dr. Cattani.

19 DR. CATTANI: I guess one of the things
20 you didn't mention, and this goes back to the
21 objective of surveillance system which is
22 timeliness.

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1 Presumably, you want to pick up outbreak
2 very quickly. One of the limitations that occurs
3 using ICD-9 or ICD-10 is that very often things
4 are not coded finally or entered into even an
5 electronic record until beyond the point at which
6 you would like to capture them.

7 So in terms of the ability to take
8 differing electronic systems and merge them into a
9 common data set with a digital bridge, that's not
10 very complicated for IT people.

11 I think the more realistic question is
12 what do you want it to do and I think when you
13 know what you want it to do, if it's to serve as a
14 smoke alarm, say, in an outbreak, then you should
15 look into some of the literature on syndromic
16 surveillance which doesn't use codes at all. It
17 uses groups of symptoms. There are a very small
18 number of groups. That, as a real-time alert of
19 disease outbreaks, may be the answer to this if
20 that's what you are looking for.

21 DR. CAREW: Well, we did look into that
22 quite a bit. Actually, I have attended the last

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1 two conferences on syndromic surveillance. Our
2 big concern with that, well, part of it is that
3 yes, it's based on, you know, different syndromes
4 or chief complaints that present to an ER or a
5 various place.

6 This is a primary care diagnosis where
7 the patient is presenting. There's no
8 definitive -- someone shows up with diarrhea -- I
9 mean that's what we want to do, to try and funnel
10 it in so it is coded and we know which codes to
11 look at.

12 So I guess what I'm saying is because
13 it's a primary care system, we are capturing that
14 patient's symptoms because we don't know that it's
15 E. coli. So part of it is that we will be
16 capturing that.

17 One of our issues was with the
18 syndromic, that no one has shown yet
19 prospectively. It has never been shown
20 prospectively to pick up an outbreak.

21 DR. POLAND: I'm not sure that's true.
22 The CERES system, for example, that Al

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1 zellicoff designed, it's been table-topped and now
2 is utilized. I have forgotten how many major
3 urban public health settings.

4 DR. CATTANI: There are a number of
5 different systems. In fact, all of them have
6 picked up outbreaks. The complaint you will hear,
7 there are two complaints about syndromic
8 surveillance systems. One of them is that you
9 don't know because of a symptom, you don't know
10 what the outbreak is. Well the whole point is
11 that it's a trigger to go investigate an outbreak.
12 It's not going to give you a definitive outbreak.

13 You don't need it to show -- I think
14 when you say it hasn't been validated -- there
15 haven't been any good studies that have either
16 shown the chief complaint or ICD Codes are
17 consistent with the symptom. But, again, that's
18 not why you're doing it.

19 You are doing it because it's really a
20 smoke alarm, and there have been. We've shown
21 everything from picking up five cases of fifth's
22 Disease in South America in theme parks in five

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1 children, a mini-outbreak, where it was
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2 identified, all the way to picking up influenza
3 before the Sentinel Surveillance System.

4 In syndromic surveillance they are
5 always looking for an algorithm. We need to code
6 this and we need an algorithm that will tell us
7 exactly what's happening. That isn't what
8 syndromic surveillance is about at all. It's to
9 say hey, look, over the standard number of
10 influenza cases that you might see during flu
11 season what's the threshold above which you begin
12 to suspect, hey, we've got an unusual flu season
13 or we've got something else going on here. That's
14 really what syndromic surveillance is all about.

15 DR. CAREW: I appreciate that. If there
16 is a study that has shown prospectively that it
17 has identified an outbreak which led to improved
18 health outcomes in that group, we would welcome
19 that because I have not been able to find it.

20 I guess part of what we're going to do,
21 and I didn't show you the objectives, but part of
22 the objectives of the system are very broad. We

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1 do want a trigger for outbreaks, but at the same
2 time we also require very specific information,
3 for example, a couple of years ago, Commander
4 Carpenter was involved in this, we had a report

5 from Afghanistan that there was E. coli in the
6 air. It was ridiculous where the potential
7 exposure came from.

8 But at the time it would have been nice
9 to look at. We had all the environmental sampling
10 data but we didn't any specific respiratory. We
11 couldn't say how many URITs there were, whether we
12 had pneumonias, whether there was asthma, because
13 we couldn't drill down far enough to say what we
14 had.

15 So we've got a surveillance system that
16 requires broad level data to look at the trigger
17 for outbreaks like GI.

18 But then we also need to respond to very
19 specific concerns and to be able to pull out,
20 tease out specific conditions, depression, PTSD,
21 chronic diseases. So we need something that can
22 do both.

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1 I appreciate that and the way you plan
2 to look at it. So any of these specific codes
3 that someone enters, we're going to roll up and
4 pull them together and see if those groupings are
5 showing a potential GI outbreak or potential
6 respiratory.

7 But we still have to have the ability to
8 drill down in a very quick turnaround time, too.

9 We spent many, many weeks and months developing
10 the objectives. I just didn't bring them here,
11 and the purpose.

12 DR. POLAND: Dr. Halperin.

13 DR. HALPERIN: This is a fascinating
14 topic. You know, it's quite conceivable that your
15 different goals of surveillance mandate different
16 surveillance systems. There's not going to be one
17 that does all of these things.

18 On the one hand, if you get the
19 infection control practitioners in one city
20 talking with each other, they'll tell you very
21 quickly if there's something going on in the
22 hospitals in that city.

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1 It's not a detailed ICD coding of
2 mortality that, you know, can be used. So again,
3 I would just emphasize and agree with the idea
4 that you've got to really focus on what it is that
5 you want out of the system and design a system
6 that gets you that, otherwise, it degrades into a
7 process.

8 As you pointed out, nobody could even
9 figure out why they were doing it.

10 DR. POLAND: Colonel Ruscio.

11 LTC RUSCIO: Prior to this assignment, I

12 was in OSD policy and one of the items that
13 Ms. Bronson had us look at was Epi-NATO. One of
14 the things that we identified was there's multiple
15 STANAGs, directives or guidance referencing
16 Epi-NATO with a variety of different goals and
17 objectives out of each of those different STANAGs
18 for that one surveillance system.

19 There wasn't necessarily a cross-match
20 with those. I don't know if you looked.

21 DR. CAREW: The STANAGs?

22 LTC RUSCIO: Yes.

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1 DR. CAREW: There is and they're being
2 developed by the COMEDS Preventive Medicine
3 working Group. But I don't think there ever was a
4 final STANAGA for Epi-NATO, even though it was
5 being used. It was never completed.

6 LTC RUSCIO: Yeah. There are multiple
7 drafts and then I know the NBC one also
8 referenced -- the different co-meds didn't
9 necessarily -- and that happens when they talk
10 about what they expect out of the surveillance
11 system.

12 DR. POLAND: Okay. I think we probably
13 ought to move on. Thank you.

14 Our next speaker is Commander Ludwig who
15 will provide the Coast Guard's preventive medicine

16 update. The handouts of those slides were given
17 and belong in Tab 8.

18 CDR LUDWIG: I hope that my successor is
19 more successful at getting handouts to the Board
20 in time. But anyway, as you know, I'll be leaving
21 my position, actually I already have left my
22 position, but my replacement will not be here

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1 until september. So I'll be showing my face
2 occasionally.

3 My phone number will not change until I
4 move down the hall to my new desk and I'll alert
5 everybody when that happens.

6 Next slide. I only have four things
7 that I want to talk about and those are listed
8 here. In terms of TB policy, we are in the
9 process of completely rewriting our TB testing
10 policy so that it is completely risk-based with no
11 periodic testing in any occupational group.

12 We determined that there was no Coast
13 Guard occupational group at high risk of
14 contracting tuberculosis, including those who were
15 actively involved in alien migrant interdiction
16 operations and other previously considered high
17 risk occupations.

18 Looking at them closely, what kinds of

19 activities they did and the length of their
20 exposures, et cetera, we determined that they were
21 not at high risk. We've never had an active case
22 as far back as we can go in the records and also

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1 including corporate memory, nor was I able to ever
2 find an epidemiologic tie of a cluster of positive
3 TSTs which I've reported on here before, to any
4 active case.

5 I would contend also that each
6 deployment ought to be evaluated in terms of its
7 risk as well so that even just having been
8 deployed would not be an indication for doing a
9 TST.

10 The only place then where the cutoff for
11 a positive test would be anything other than 15
12 millimeters, except for individual cases where
13 there are high risks involved, is at basic
14 training where we don't know what their history is
15 and we have maintained the cutoff of ten
16 millimeters for further evaluation to determine if
17 they have any risk factors.

18 Then that extra evaluation will lead the
19 provider to decide whether they will actually
20 receive prophylaxis or not.

21 Next slide. We have, unfortunately, a
22 very small laboratory system in the Coast Guard.

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1 Really, only two of our laboratories are moderate
2 complexity labs. The rest are waived or preferred
3 provider.

4 So we don't have a lot of opportunity to
5 do serologic testing. However, I have been
6 working with the director of the laboratory at the
7 Cape May Basic Training Post. She is highly
8 motivated to try new things. She is very
9 interested in working with us on maybe initiating
10 the use of Quantiferon on TB Gold and also
11 looking at titers for vaccine-preventable diseases
12 so that we can do, I think, what the Air Force
13 does and maybe no other service right now. That
14 is to give them only the vaccines that they need.

15 There's a lot of resistance to changing
16 to this kind of a system because they've always
17 done it where they just run everybody through the
18 line. They repeatedly told me that, you know,
19 it's just too logistically complicated.

20 But some of us believe that that can be
21 changed and that it's the right thing to do for
22 the members.

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1 Next slide. I just want to touch
2 briefly on Methicillin-resistant Staph aureus. We
3 have continued to have reports of cases and
4 clusters. I don't think we are unusual in any way
5 in that regard.

6 We have tried to get out some education
7 to the providers because they are still treating
8 it as either all staph infections are alike and
9 thus are susceptible to the standard antibiotics
10 or if they do get a culture and find out that it
11 is Methicillin or other resistant, kind of going
12 off the deep end in how they respond to it. So
13 the main thing right now is our education.

14 Next slide. The next slide is the one I
15 want to spend the most time on. It's kind of
16 ironic because it's a joint publication that I
17 think they probably just sent to the Coast Guard
18 for the very few places where Coast Guard actually
19 appears in the joint publication.

20 The title of it is Health Service
21 Support in Joint Operations. I was asked to
22 review what was, I believe the second draft update

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1 and I looked through it and I found the places
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2 where the Coast Guard was relevant and everything,
3 made a few minor changes based on that.

4 But what I observed as I read it was a
5 concerning shift in the sort of paradigm of how
6 force health protection is carried out in joint
7 operations.

8 To me it seemed big. I don't know,
9 maybe some of you will interpret otherwise, but I
10 felt that I ought to bring it to the attention of
11 the Board. When I shared the document with my
12 GIPUM PEG colleagues, none of them had been asked
13 to review the document or were aware of some of
14 the changes that were in there.

15 In the document the Joint Task Force
16 Surgeon's staff no longer contained a position for
17 a preventive medicine officer. In every place
18 that I could find where there was any reference to
19 the duties that a preventive medicine officer
20 ought to be doing, it was replaced with
21 community/public health nurse or a new term, a
22 preventive medicine science officer, which was a

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1 puzzling term to me because it did not refer to a
2 physician, it referred to a collection of science
3 officers who were not physicians.

4 what I'm going to do here is based on

5 not having talked to the folks at the Joint Staff
6 who developed this, so I don't know what their
7 motivations were and I'm probably going to soapbox
8 a little bit because I found it concerning. So
9 I'm going to kind of go into a little bit about my
10 concerns.

11 Medicine is a term that refers to what a
12 physician does. I looked it up in the dictionary
13 just to make sure that I had it right. Medicine
14 is what a physician does. Of course, you can have
15 a doctor of dentistry and a doctor of veterinary
16 medicine and so on, but medicine is what a
17 physician does, as in Doctor of Medicine.

18 So you use the terms 'Preventive
19 Medicine Officer, Preventive Medicine Specialist,
20 Preventive Medicine Practitioner.' By definition,
21 to me they all mean physician.

22 Adding science to the title, 'Preventive

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1 Medicine Science Officer,' to me does not change
2 that term or that collection of term refers to a
3 physician.

4 I want to make it clear that I'm the
5 last to minimize the contributions of other
6 professionals to the field of preventive medicine.

7 In my family there are two Ph.D.
8 scientists, non-physicians, and three nurses and

9 they would be on my case if I ever tried to
10 minimize the contributions made by other
11 professionals, and also my husband is an
12 environmental scientist and I am very appreciative
13 of the work that he does.

14 There is a preventive medicine team, as
15 we are all aware, analogous to a surgical team.
16 All the members are vital. You have to have at
17 least a sort of core number of members of this
18 team to make the mission successful, but their
19 duties are not interchangeable, such as a scrub
20 nurse cannot take the place of the surgeon.

21 Preventive medicine specialists are the
22 professionals, as a group now, I'm just kind of

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1 simplifying things, the professionals who have the
2 training in clinical and basic sciences and arts
3 and in public health.

4 Community health nurses and
5 environmental scientists and sanitary engineers,
6 et cetera, cannot take over duties that only a
7 preventive medicine officer is credentialed to do.
8 It's a credentialing issue, too.

9 Perhaps, I think, the field of
10 preventive medicine has not done a very good job
11 of delineating what it is we do and what it is

12 that we are credentialed to do and why it is that
13 preventive medicine physicians are the head of the
14 team.

15 My 15 years as generally the head of the
16 team, and again please keep in mind that I'm
17 simplifying and I in no way want to minimize the
18 contributions of any of the people in this room or
19 anybody else because I have quite a bit of
20 experience in the field and I know that they are
21 all needed.

22 My 15 years of military preventive

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1 medicine exhibit a number of examples of where I
2 had to kind of pick up the pieces after other
3 members of the preventive medicine team attempted
4 to do some of the things that only the preventive
5 medicine physician was truly credentialed to do.

6 A lot of people think they can made
7 recommendations on travel medicine by looking at
8 the CDC website. It's very simple, you just look
9 at the country you are going to and that's what,
10 you know, you need to do. Or, they can look at a
11 preventive manual and go down some kind of
12 algorithm and decide, make some preventive
13 medicine decisions based on that.

14 A couple of examples I wanted to
15 mention: when I was in Bosnia a person called

16 very vehemently to close the only dining facility
17 in a remote camp in Bosnia. There was no other
18 dining facility. After a handful of people came
19 in with gastrointestinal illness.

20 It could quite well be that they came
21 from the dining facility, but this person wanted
22 to make that call based on not knowing anything

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1 about the outbreak, whether in fact it was an
2 outbreak, what had caused it and so on.

3 That would have left us without a dining
4 facility. Now, it's not that we would have
5 starved because we did have MREs, but it was not
6 appropriate to make that decision based on that
7 information.

8 Another example, also in Bosnia, was the
9 ordering of the use of an IND vaccine, Tick One
10 Encephalitis, in a large deployed military
11 population, using an IND vaccine where there was
12 no epidemiologic basis for using the vaccine. And
13 that was done and I think some of you are aware of
14 some of the fallout from that.

15 Another example was a decision about a
16 rabies vaccination on a Cutter crew in the Coast
17 Guard who had sustained a number of dog bites.
18 That was also presented in this group. The

19 situation was actually much more complicated than
20 it appeared at the surface.

21 The decision about using rabies vaccine,
22 of course, is a medical decision. It's a

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1 pharmaceutical and has to be prescribed by a
2 physician.

3 And a similar that I mentioned already,
4 I think, was using malaria prophylaxis just based
5 on looking on the CDC website and seeing that
6 there's malaria in that country without asking
7 what are the people going to be doing, how long
8 are they going to be there, what part of the
9 country are they going to be in, et cetera, et
10 cetera. That all goes into making preventive
11 medicine decisions, more than just following an
12 algorithm.

13 Specifically, of course, of course, we
14 know that only physicians are credentialed to
15 diagnose disease and prescribe treatment or
16 prescribe pharmaceuticals anyway.

17 Now, I have kind of gone through my
18 notes from my soapbox and I just want to reiterate
19 that I don't know what the considerations were in
20 drafting this document, making those changes.

21 I don't know if there are too few
22 preventive medicine officers; i.e., preventive

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1 medicine physicians in the military or maybe what
2 I'd prefer is that they are just too valuable to
3 deploy, I don't know. But I find this a
4 concerning trend and if this joint document is
5 published in this way, I think the military is
6 opening itself up to some issues that could cause
7 some problems.

8 I think we as a preventive medicine
9 community, epidemiologic community, ought to take
10 an interest in it. So since I am very, very
11 unlikely in my future to be on a joint operation
12 like this, it's really not a personal issue to me
13 in that regard, it bears looking at.

14 Thank you for your attention.

15 DR. POLAND: Thank you, Commander
16 Ludwig. Does anybody here know any details
17 about --

18 Major Kilian?

19 MAJ KILIAN: I haven't seen the document
20 specifically. I can speak fairly in depth on
21 procedures. As the publication goes out for
22 staffing it goes to the service planners. It is

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1 incumbent upon the service planner to get it to
2 the appropriate position, not physician, but
3 position.

4 For example, during last year's
5 influenza vaccine shortage, Colonel Syncore over
6 here made a recommendations that the folks in the
7 Air Force who were the football carriers, you
8 know, the guys that made things go boom with a
9 great big glow in the sun kind of stuff, that they
10 would not be the ones who would necessarily get
11 the vaccine because they were underground and
12 fairly well contained and not necessarily going to
13 get sick.

14 I appreciated his input, however, the
15 Air Force planner, and there's three of them, said
16 yes, heard the doc, however, Air Force policy is
17 you will vaccinate them. They said that was going
18 to be their position.

19 I coordinate with Colonel Underwood all
20 the time. I listen to her. I go ahead and start
21 drafting the way I think it's going to go. But
22 until I get thumbs up from one of the three Army

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1 planners -- each service has three planners who
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2 speak for the Chief of Staff or the CNO or the
3 Commandant of the Marine Corps -- I can only take
4 that as unofficial heads up.

5 So in this case the Coast Guard planner,
6 they I actually only have two of them, they
7 actually respond very quickly usually because they
8 say that they usually don't hear it unless the
9 Joint Staff sends stuff.

10 DR. POLAND: Do you have any knowledge
11 specifically about the issue?

12 MAJ KILIAN: As it comes to this, as I
13 think Commander Ken Christopher is in charge of
14 writing this document down at JFCOM. From his
15 perspective, the JTF he is talking about is a
16 three-star task force.

17 Having served on those, usually that's a
18 four-person MEDCEL, with one person being a
19 physician, regardless of service, and then one
20 Army, one Navy, one Air Force. The Air Force
21 person is pretty much dedicated to air movements,
22 air evacuation.

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1 Then it's incumbent upon the Navy and
2 the Army to figure out who's going to be the
3 medical planner and who is going to be the
4 preventive medicine sciences guy. The preventive

5 medicine sciences guy has to show up with TSSCI
6 clearance and be able to do some MEDLOG pad
7 logistics, understanding of air routes, so it's
8 really a MED planner who does preventive medicine
9 or you could say a preventive medicine guy that
10 knows a whole lot about medical planning.

11 we do not grow necessarily,
12 systematically, physicians to do those things.
13 The people in those positions are not seeing
14 patients. You're submitting your SIT REPS,
15 you're working on the future operations, the
16 current operations, you're working evacuation
17 routes. The concern about a preventive medicine
18 physician being on the JTF, below the JTF there
19 will be --

20 CDR LUDWIG: Can I just comment? I did
21 bring the document along. I'm not talking about
22 necessarily the Corps JTF staff, but as it's

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1 outlined in the document it says, 'The JTF surgeon
2 staff shall consist of:' and it lists a lot of
3 people and then 'The Deputy JTF surgeon staff
4 shall consist of' and so on.

5 what I'm talking about is not, you know,
6 I don't know a physician alive who wants to sit in
7 a MEDLOG position. That's one reason again why it
8 shouldn't be called a preventive medicine science

9 officer. Preventive medicine is a physician's
10 specialty.

11 MAJ KILIAN: So the specific focus
12 question is it appears to be a change in the
13 terminology used to identify somebody who has
14 credentialing and a distinct set of expertise.

15 Is the change to 'preventive medicine
16 science officer' a deliberate and informed
17 direction or was somebody just being loose with
18 terminology?

19 CDR LUDWIG: It's actually a larger
20 staff, too. Maybe what I didn't make clear, and
21 I'm talking about the whole list of duties that
22 used to be performed by the preventive medicine

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1 officer is now kind of broken up and set under
2 these other people's positions.

3 Much of what they are being asked to do
4 is activities that a physician only is
5 credentialed to do. I'm not talking about seeing
6 necessarily individual patients, but a decision to
7 use a vaccine on a population is a preventive
8 medicine decision.

9 It is a prescription. That's what we
10 do. We do population medicine. Other people may
11 think they can do it, but if it comes down to a

12 legal defense, they'd better have a doc who's
13 willing to step up and say I approved the use of
14 this vaccine. It's a prescription.

15 MAJ KILIAN: And that would be the task
16 force surgeon?

17 CDR LUDWIG: And if the task force
18 surgeon doesn't have a preventive medicine
19 physician advising him, he or she probably doesn't
20 have the information that he or she needs. Some
21 of these examples that I gave were even decisions
22 made or suggested by other physicians. We can go

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1 on and on on this, but preventive medicine
2 physicians have the blend of skills and
3 responsibilities and I am just concerned about
4 this change.

5 DR. HALPERIN: I share your concern, but
6 the issue here may be that we're looking through a
7 window of the Coast Guard and to a more general
8 phenomenon that's happening. You know, health
9 officers in States by and large used to have more
10 formal training in public health preventive
11 medicine than people who are getting those jobs
12 now.

13 when it comes down to it, you know, if
14 you look at the salary structure of preventive
15 medicine people in the armed forces, they are

16 certainly not at the level of orthopedic surgeons,
17 but it's still cheaper to hire Ph.D.
18 epidemiologists than it is to hire a physician in
19 jobs where it looks like there are replaceable
20 parts.

21 In fact, it gets complicated because in
22 some instances the preventive medical science

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1 officer; i.e., Ph.D. epidemiologists actually may
2 be more qualified and expert in epidemiology, but
3 have less expertise in the kinds of things you are
4 talking about.

5 CDR LUDWIG: That's right, we need the
6 team.

7 DR. HALPERIN: Yeah, things you never
8 thought were important until you need them and
9 suddenly it's part of your medical training.

10 There's an effort in schools of public
11 health now to identify a sixth theory of
12 competency along with epidemiology and
13 bio-statistics and health education, which is
14 basically medical knowledge. You know, it's sort
15 of a recognition that it's going in one direction
16 and maybe it ought to be coming back in another.

17 So I think you are probably looking
18 through the Coast Guard into a much broader

19 phenomenon that's going on, a good phenomenon,
20 it's a judgment, but I share your judgment, but it
21 is probably a broader phenomenon that's going on.

22 CDR LUDWIG: You are saying it's not

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1 even a DoD or governmental phenomenon. It's much
2 larger, so maybe this isn't the appropriate forum
3 to bring it up. I did want the Board to be aware.

4 DR. HALPERIN: For example, the Army, as
5 it's getting ready to release its revised 40-5
6 preventive medicine regulation, historically the
7 role of chief of preventive medicine was reserved
8 for the medical corps, without regard to rank.

9 A guy could be a captain right out of
10 the basic course and could have a lieutenant
11 colonel or colonel staff and yet the Medical Corps
12 person was the chief.

13 The Army has since changed its position
14 or is in the process of changing its position and
15 saying the chief of the Department of Preventive
16 Medicine will be the senior officer, which is in
17 line with all other Army doctrine. If you are the
18 senior and you are in charge, take charge until I
19 fire you and replace you and you work for your
20 subordinate.

21 COL UNDERWOOD: I just want to correct
22 that for the record. 40-5 assigned that to a

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1 residency-trained preventive medicine physician,
2 regardless of rank; not a physician right out of
3 the basic course. So that's not right.

4 DR. POLAND: Dr. Oxman.

5 DR. OXMAN: I would agree with your
6 major point, and that is the responsibility for
7 making those decisions needs to lie to a large
8 extent with the physician trained in preventive
9 medicine.

10 I think, however, that preventive
11 medicine is being used as a descriptive or a
12 field. So if you really want to specific it you
13 have to say a preventive medicine physician.
14 There's nothing wrong with having a preventive
15 medicine officer who's not a physician given that
16 title, but he shouldn't be given that
17 responsibility.

18 MS. EMBREY: A comment to put this in
19 context for the Board: A joint task force is an
20 animal that had usually been created ad hoc and
21 staffed ad hoc in a joint fashion.

22 This publication is proposed and is

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1 being drafted by Joint Forces Command, the joint
2 force provider, as a way to deliberately plan for
3 the component pieces of a joint task force in any
4 operational area around the department.

5 It is a new animal. It could very well
6 be that these terms were written by a person who
7 was uninformed. Frankly, it's the intent that's
8 important, not the terms.

9 I hope that before you depart you would
10 provide your comments to the Joint Forces Command,
11 because I don't think they are deliberately trying
12 to usurp the preventive medicine intent of a joint
13 task force.

14 So just so you know, I don't think they
15 are sinister here. What I do think is the poor
16 schmuck who got stuck with writing this was trying
17 to use a term that would apply across the three
18 services.

19 CDR LUDWIG: And like I said, inadequacy
20 on the part of preventive medicine specialties to
21 clearly delineate what it is we do and why, if we
22 are important in that occupation.

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1 DR. POLAND: Thank you, Commander
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2 Ludwig. I want to keep us moving along here. I
3 think what we'll do, maybe Colonel Ruscio if you
4 are ready, why don't we go ahead with your
5 presentation and we'll break after yours.

6 Colonel Ruscio will provide us with the
7 Health Affairs update. His slides are also at Tab
8 8.

9 LTC RUSCIO: Good afternoon. Again,
10 thank you for the opportunity to provide the
11 Health Affairs update to you this afternoon.

12 what I would like to do is spend a
13 couple of minutes on pandemic influenza
14 preparedness. Some of this will be familiar to
15 you and some of it will be new. I think in both
16 cases, though, measured progress is being made in
17 pandemic influenza preparedness.

18 I just want to give credit where credit
19 due. Steve Phillips, to use the term, has been
20 doing yeoman's work for the past multiple months,
21 specifically in anti-viral stockpile and working
22 that issue. He has done a great job. We're going

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1 to miss him in Health Affairs.

2 Fifteen million doses of Tamiflu, you
3 know, our model on pandemic influenza borrow from
4 CDC and WHO guidelines and our experience in the

5 04-05 influenza vaccine shortage effort.

6 So with a lot of work, as Steve has done
7 with the Preventive Medicine Officers, the
8 logistics folks and CHPPM-PG, multiple CHPPM-PG
9 meetings and input from the Joint Staff, we have a
10 model that has identified 15 million doses.

11 with any model there are assumptions
12 made. Generally our assumptions are that the
13 outbreak will initially be identified in Southeast
14 Asia, it will be a wave-like outbreak. We took
15 the CDC's worse case scenario of a 30 percent
16 attack rate and the final assumption is that we
17 are not going to have enough Tamiflu to go around
18 everyone. I think that's an easy assumption.

19 This is where our exercise with the
20 influenza vaccine shortage last year really helped
21 out. Working again with the Joint Staff and the
22 Joint Preventive Medicine Officers identified some

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1 categories or prioritized categories.

2 In general those are those forward
3 deployed and critical operational forces, critical
4 health care workers. That's about 25 percent.
5 That's the snow day critical health care
6 assumption. OCONUS beneficiaries who don't have
7 access to the national stockpile, that's some of
8 the major assumptions.

9 This is an unfunded requirement for
10 year, but monies have been obtained and all
11 funding requirement monies identified and in fact
12 this week the contract with Roche is being signed.
13 So we expect to have the first shipment in August,
14 as mentioned on the slide and then the final
15 shipment in October.

16 As far as the stockpile, we are looking
17 at about percent to PAYCOM, 30 percent forward to
18 CENCOM and then the rest in Mechanicsburg,
19 Pennsylvania, where we'll be able to ship it
20 anywhere within 48 hours, supposedly.

21 The other thing I wanted to mention here
22 is interagency cooperation on this slide. There

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1 has been a lot of ongoing activities. I know
2 Ms. Embrey and Steve are working very hard with
3 Health and Human Services and the State
4 Department, not only on the stockpiling issues,
5 but on surveillance issues. So there's a lot of
6 work going on there.

7 Next slide, please. As far as
8 surveillance, I think it's important to point out
9 that our surveillance is an on-going program, so
10 there has been on plus-up or additional funding
11 for surveillance programming within DoD.

12 The key agencies for surveillance, this
13 board has heard from them recently, the AFIOH, and
14 GIS, NHRC and the services, of course. Overseas
15 lab participation remains critical. NAMRU II
16 continues to build its strong relationship with
17 CDC, WHO and Jakarta.

18 A recent example of that, you may have
19 heard in the press a week or week and a half ago
20 about the first Indonesia H5N1 in a human. NAMRU
21 II, working with the Jakarta government and CDC
22 identified that that was a false positive and that

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1 was not the case. That relationship is growing
2 and very important.

3 Also this week Dr. Winkwerter is sending
4 a letter to Dr. Gerberdink indicating a desire to
5 further strengthen the relationship and the ties
6 between CDC and DoD efforts in this part of the
7 world.

8 Next slide, please. I'd like to talk a
9 little bit about the status of response
10 preparedness. As a little bit of background, you
11 may be aware of DoD 6200.3 which is our emergency
12 health preparedness directive out of DoD. There
13 is also a DoD pandemic influenza guidance that's
14 out on our website.

15 we have had in the past year or year and

16 a half when Colonel Gibson was here the SARS
17 Defense Science Board Task Force looking at our
18 preparedness as far as the SARS plan and also the
19 Small Pox response plan. So all these kind of fit
20 together.

21 One of the items Dr. Winkenwerder is
22 pursuing is the status of our preparedness

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1 position throughout the services. A couple of
2 months ago he asked the services to respond to
3 where they are, an assessment of where they are
4 and identifying public health emergency officers,
5 having plans, having memos, understandings with
6 the local and State public health departments and
7 agreements, legal agreements and what not.

8 We've just received that information
9 back from the services. It looks like the
10 services are taking it very seriously, of course,
11 with a variety of different progresses being made
12 and some identification, certainly, of more work
13 that needs to be done as far as pandemic
14 preparedness. But these are the items he asked
15 the services to respond to. We are in the process
16 of compiling that and reporting that to him.

17 Very quickly, that was pandemic
18 preparedness.

AFEB 6-22-2005.txt
19 DR. POLAND: A couple of questions,
20 actually. How is the 15 million dose threshold
21 reached? Was that, we have this amount of money
22 or?

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1 LTC RUSCIO: well, I think it was more
2 reached based on our high risk priorities, using
3 what we looked at in the 04-05 vaccine shortage.
4 These individuals we must vaccinate, using the CDC
5 30 percent attack rate.

6 DR. POLAND: Is this a rotating
7 stockpile? In other words, you will use some this
8 coming year and replace it so that if a pandemic
9 occurs and you realize, woops, we've got a
10 three-month outdate and we can't use it after
11 that.

12 LTC RUSCIO: That's a good question with
13 about a three-year shelf life on Tamiflu.

14 MS. EMBREY: I think it's longer. I
15 think it's five years, five with an extension.

16 LTC RUSCIO: Okay. I stand corrected.

17 DR. POLAND: But even then,
18 consideration to rotating.

19 LTC RUSCIO: Yes, absolutely.

20 MS. EMBREY: We were going to buy it
21 incrementally over time and now we are buying it
22 all at once.

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1 DR. POLAND: The other question I'm sure
2 people are aware of, but in terms where you
3 mentioned it might be stored in Pennsylvania and
4 could be shipped, could be shipped within 48
5 hours. Of course, you really have 24 to 48 hours
6 once symptoms develop. So when you actually
7 backtrack and count up all that time, can you get
8 it there in time? That's an open question.

9 LTC RUSCIO: Hopefully or ideally with
10 forward deployment and PACOM and forward
11 deployment and UCOM will give us that time there.

12 DR. POLAND: Offload some of the bottled
13 water and the vaccine.

14 LTC RUSCIO: Well, I can't comment on
15 the bottled water.

16 MS. EMBREY: PACOM is engaged with us
17 on our planning and is actively committed to
18 support a U.S. government aggressive surveillance
19 effort in the Pacific Rim region.

20 For reasons that I'm not going to speak
21 to exactly right here, we've already identified a
22 forward place in which to move some of the Tamiflu

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1 for immediate response in the PAYCOM theater.

2 We're working through other initiatives
3 with the CDC and USAID as well as specific
4 surveillance and training and education programs
5 for the surveillance components of the countries
6 over there.

7 So it's a fairly broad effort. You
8 know, using OPM again, other people's money --

9 DR. POLAND: I like that acronym.

10 MS. EMBREY: Yes. What we are trying to
11 do is to ensure that the people who's primary
12 mission is to deal with global health are the ones
13 that are underwriting this initiative, but they
14 are using our physical placement in the region and
15 our connections with the WHO and with the
16 mill-to-mill relationships that we have
17 established to get further into countries and to
18 facilitate doing what needs to be done.

19 So it's a team effort. Like large
20 bureaucracies trying to talk to each other,
21 sometimes the turtles move quickly and sometimes
22 they don't. But we have a vision now.

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1 DR. POLAND: Still, compared to a couple
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2 of years ago, that's more progress than the nation
3 as a whole has probably made.

4 Dr. Halperin and then Dr. Oxman.

5 DR. SNEDECORE: I have an answer to your
6 previous one.

7 DR. POLAND: Please.

8 DR. SNEDECORE: Our strategy is a
9 prophylactic model, not a treatment model. So
10 time isn't of such essence right off the bat
11 because once it starts off we are going to deploy
12 in a prevention model to the people who we deem to
13 be critical, not as a treatment model to treat
14 those people who are sick.

15 DR HALPERIN: With great respect for the
16 Naval war College and the kinds of things they do,
17 thinking through the imponderable, if you will,
18 has the military thought through what happens if
19 it's pandemic with a mortality rate that is
20 substantially higher than we've seen in 100 years
21 or maybe 80 years to the point where some of the
22 issues about how one would use the small

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1 stockpiles that you have, what would you do.

2 So really the question is: Has a
3 pandemic flu with substantial mortality of young
4 people been gamed by the military to know?

5 MS. EMBREY: Well, we did a game. We
6 determined that there was any level of mortality
7 from very low to very high. There is an
8 assumption that there may be something that's
9 going to move so quickly and cause so many deaths
10 that we needed to plan for it.

11 That was the impetus for the department
12 to build -- the Joint Staff doesn't like us to
13 call it a plan, what do we call it? A policy
14 guidance to the services, a plan to address and
15 respond to specifically a pandemic of that nature.

16 It calls for epidemiological teams. It
17 calls for knowing what to do, how to isolate, how
18 to, you know, manage the situation. Each service
19 is now accountable for building and developing a
20 capability to deal with that.

21 We had SARS as a very good opportunity
22 to deal with that. Fortunately it was slow moving

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1 and it didn't like to do like our vision thought.
2 But that gave us a really good test case.

3 COL UNDERWOOD: I want to also add to
4 what Ms. Embrey said and let you know that the
5 Army is currently at every installation working in
6 conjunction with health care operations and
7 installation authorities are developing
8 contingency plans for pandemic diseases, any

9 quarantine- able disease. They are also working
10 with our local public health authorities as well.

11 LTC RUSCIO: Colonel Underwood, at least
12 as far as the responses from the services, I would
13 echo that, that the Army did respond with a very
14 high response rate in identifying PHEOs in
15 collaboration with the local health authorities.

16 The Air Force and the Navy did also.
17 That coordination is ongoing. The Air Force, for
18 example, the program is under the XO so it is
19 outside the medical. We are there to do the job
20 we are supposed to do and that's advise.

21 But it's a line responsibility. So they
22 are taking it very seriously and moving.

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1 DR. POLAND: That plan might be
2 something worth the AFUD taking a look at.
3 Members of this panel have looked at the U.S.
4 pandemic preparedness plan and also the Canadian
5 one, which actually is probably the best one I've
6 seen of all of the countries, actually.

7 Dr. Halperin, did you have a second
8 point you wanted to mention?

9 DR. HALPERIN: No, thank you.

10 DR. POLAND: Dr. Oxman.

11 DR. OXMAN: I have a question and sort

12 of a comment/recommendation. When you say 15
13 million doses, what do you mean by a dose? Is
14 that a 75 milligram tablet?

15 LTC RUSCIO: That's correct.

16 DR. OXMAN: It's not six weeks of
17 prophylaxis for 15 million people?

18 LTC RUSCIO: Correct.

19 DR. OXMAN: Then that's an enormously
20 small stockpile and I think terribly small,
21 unconscionably small. I'm happy to be quoted with
22 those works.

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1 The other thing is, if there is pandemic
2 disease it may be with Amantadine resistance.
3 There's every reason to respect that Amantadine
4 and Tamiflu would be at least additive if not
5 synergistic.

6 I wonder if the DoD has arranged for any
7 clinical tests to look at that. It hasn't
8 happened because they are made by different
9 companies and no company supports a test of two
10 drugs, one of which is made by somebody else.

11 It's very straightforward. It can be
12 done quickly in tissue culture and followed up by
13 a small clinical trial.

14 DR. POLAND: This is actually an
15 important point, particularly if it is a

16 prophylaxis model versus a treatment model in
17 terms of the size of the stockpile. But the
18 limitation is what it is.

19 COL UNDERWOOD: I want to mention that
20 when we were gaming this at the Joint Preventive
21 Medicine Group policy level this prophylaxis is
22 meant for those at the point of the spear,

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1 basically in the Pacific area, without getting
2 into numbers.

3 So those were the figures used to come
4 up with these dosages. But remember, this is the
5 point of the spear, who would be first likely to
6 be infected.

7 DR. OXMAN: If it's a pandemic they
8 won't be. That's the point. Wright-Patterson
9 might be the first point of the spear if someone
10 travels back here.

11 COL UNDERWOOD: Right. I just want to
12 mention, we also have to be realistic and in terms
13 of the cost and the stockpiling, it was a
14 reasonable model. I don't know that we can show
15 that. I don't think we can. But anyway, just
16 bear in mind that this was not something we pulled
17 out of the air. I mean this was a very reasoned
18 discussion.

AFEB 6-22-2005.txt
19 DR. OXMAN: But incorrect; reasoned but
20 incorrect.
21 COL UNDERWOOD: But Dr. Oxman, I'm
22 telling you, based on the point of the spear in

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1 the way that we had to look at this in the most
2 likely way that it would spread across the world.
3 Anyway, we had some assumptions, but I
4 just want to say that for the record.
5 DR. POLAND: I'm not aware of any
6 research that you are suggesting.
7 Colonel Gibson?
8 COL GIBSON: Remember the meeting we
9 took with CDC down at HHS where they talked about
10 some of the work that they had done with Tamiflu
11 and Amantadine, I believe, and I may be wrong, in
12 a treatment model they looked at combination
13 therapy.
14 To my knowledge they did not look at it
15 in a prophylactic model combining the two, to do
16 the two drugs. I know that there are folks at CDC
17 who are looking at that issue right now.
18 LTC RUSCIO: I would say that we could,
19 as far as presenting our model for that, we could
20 do that. I would suggest that, I would suggest
21 that we do that, if we are going to, that we do it
22 at least in a non-public -- I don't know that it
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1 has to be classified -- but I would prefer that we
2 did that in a non-public forum because of the
3 issues with numbers that we would be talking
4 about.

5 DR. POLAND: Dr. Halperin and then we'll
6 take a break right after that.

7 DR. HALPERIN: Okay. Jeff Jason was a
8 classmate of mine, a much smarter classmate than
9 I. I'm not starting to carry his water on this
10 issue, but I notice that you are the chief Public
11 Health officer. Your title is an impressive one.

12 LTC RUSCIO: Thanks, Military Public
13 Health.

14 DR. HALPERIN: Jeff's editorial in the
15 New England Journal, you know, do all that you can
16 do, I think is a reasonable question and really is
17 a subject for could we get an estimate, if you
18 will, on sort of a thermometer or barometer on
19 what all is going on as far as traumatic brain
20 injury, primary, secondary and tertiary prevention
21 in response to all of the modern things that can
22 be done and in response to the increased incidents

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1 apparently of traumatic brain injuries in Iraq and
2 in response to the increased survival that he
3 points to in Okie's article.

4 I'm sort of aiming at you, but that
5 might not be an appropriate target, but you know,
6 this is something that we ought to be talking
7 about. You seem like an appropriate target.

8 LTC RUSCIO: Thanks. We are doing more
9 than talking about it. I'm sure the PM officers
10 here can address some of the issues.

11 Dr. Deb Warden had presented to this
12 board two meetings ago, I think, on the Veterans
13 and Defense Head Injury Center and the work they
14 are doing.

15 I know most recently the Marines in the
16 first MEF -- you could probably speak better on
17 this than I could -- but are assessing traumatic
18 head injury among members returning on the first
19 MEF.

20 I know also that Colonel Cox in the
21 Force Health Protection are also pulling together
22 some of the information to help guide the further

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1 direction.

2 Do the service representatives want to
3 address that?

4 DR. HALPERIN: Again, the barometer, is
5 there some judgment? Is that the best that we can
6 do? I realize there's a lot going on. I was
7 there at the presentation.

8 MS. EMBREY: I think there are some
9 interesting clinical investigations and studies
10 that are going on that make us assess whether or
11 not we should look into it more. I think we need
12 to define what traumatic brain injury is because I
13 think it's very easy to take a broad spectrum of
14 outcomes and attribute it to traumatic brain
15 injury.

16 I think that's very dangerous to do
17 unless you have a clinical definition of what that
18 is and what it isn't. Frankly, I don't think we
19 have the theater data that would help us to
20 understand the forces that created the injury so
21 much as the injury itself.

22 So we need a lot more information in

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1 order to, I think, credibly evaluate what's the
2 problem. I think it's something we should engage
3 on. Our staff right now is working with the
4 services to understand what that, to define it and

5 then to try to investigate things to really
6 understand the landscape before we start jumping
7 into the pool.

8 CDR MCMILLAN: Yes, sir, one MEF that
9 just came back, they served the last year. They
10 did two things, one to try to better identify it
11 in theater they set up a kind of a certification
12 training program for the providers to make sure
13 they knew what to ask, how to ask it, when to look
14 for it and then how to identify and treat a
15 potential traumatic brain injury that would have
16 maybe mild cognitive impairment without real overt
17 signs or symptoms.

18 The main reason there was to try to
19 avoid a re-injury during a recovery period which
20 can cause permanent sequelae as opposed to
21 basically resolving injury.

22 Then the second thing they have done,

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1 they started and they have been working with the
2 Veterans Brain Injury Center there in San Diego
3 that happens to be fairly co-located with them, in
4 doing an additional assessment with all their
5 Marines with a couple of very specific questions
6 about, you know, any other types of injuries they
7 may have received and/or any symptoms that may be
8 consistent with a traumatic brain injury and some

9 potential ongoing sequelae.
10 The bottom line number is they have
11 identified a lot more of their Marines using that
12 survey tool than they did with the post-deployment
13 health assessment tool. But of all those for the
14 whole group that have been deployed, it's a .5
15 percent that were deemed needing to go on to
16 neurological or neurosurgical or any other
17 specific cognitive testing.
18 So most of the cases by far have been
19 ones that were handled by the local people like
20 persistent headaches and things like that. So the
21 threshold is set pretty low as far as
22 identification. You know, more sensitivity than

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1 specificity,
2 we are starting to get some numbers on
3 that. I did not include those this time. That's
4 something I was going to wait for them to continue
5 to get a little more information to be able to
6 report on in the future. So it's being looked at.
7 LTC RUSCIO: If I could add one other
8 thing, I believe Dr. Warden is going to be out at
9 Fort Carson this coming week with the Army to
10 evaluate. I apologize, I forget the returning
11 organization.

12 DR. UNDERWOOD: There are a couple of
13 units that are just returning from Iraq.
14 Dr. Warden will be working with the commander out
15 at Fort Carson Evans Army Hospital in looking at,
16 as a pilot, what can be done in this regard.

17 Just to again echo what Ms. Embrey said
18 we have had meetings with all the services and
19 Colonel Cox in the way forward on this. There's
20 really more to follow as we get into.

21 DR. POLAND: This is an important issue.
22 I guess we are getting some information together.

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1 It's also something I think the occupational and
2 environmental subcommittee should probably keep on
3 their radar screen and periodically have
4 additional briefings on this.

5 We were just talking about the
6 likelihood that this sort of syndrome, not well
7 characterized or well-framed, could be the new
8 Gulf War syndrome. We certainly don't want that
9 to happen. The response to that is really to
10 decide what sort of information can be collected.
11 And when collected, analyze it appropriately and
12 begin to take remediation steps.

13 We are about 15 or 20 minutes behind.
14 Maybe we could take just a ten-minute break and at
15 15 minutes after the hour we can gather back here.

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(Recess)

DR. POLAND: Last, let me point out, because it's the Marine Corps, certainly not least, we have Commander McMillan with the Marine Corps update.

Originally scheduled to speak was LTC Janet Whitney Spira, but she, I understand, has

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had an injury and was not able to make the meeting.

We thank you, Commander McMillan for stepping in. Copies of his slides were just distributed.

CDR McMILLAN: I guess I'm either demonstrating interchangeability or interoperability, I'm not sure.

Next slide. This is just going to be a brief overview. First, I'll just go through for those who aren't familiar with the Marine Corps structure. We'll kind of go over a quick look at the composition of a typical Marine Expeditionary Force.

We'll look at a program that they have come up with they call warrior Transition. Then a quick look again at their Deployment Health Quality Assurance Program and some of the results

AFEB 6-22-2005.txt
19 they have had with some of their assessments.
20 Next slide. The division, as you can
21 see by the numbers, is the largest component, the
22 largest of the four components at the MEF. This

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1 is basically your ground warfighting unit with
2 tanks, artillery and infantry units. So for one
3 MEF you have the First Marine Division and to
4 continue with the logic, we have the Third Marine
5 Air Wing.

6 So Third and First Marine Air wings got
7 switched at some point in time. They are the ones
8 that provide basically your fixed and rotary wing
9 operation.

10 Then is your service support group, the
11 smaller one. This is where your medical and
12 dental capabilities and all your supplies forward
13 are included.

14 Then finally is your headquarters group
15 with some of your COM and INTEL people.

16 Just to look at the next slide, kind of
17 the disposition, you will see that there are some
18 of the units that are in Japan, forward deployed.
19 You have them between Miramar, Twenty-nine Palms
20 and over at the Marine Corps Station at Yuma,
21 Arizona. So they are spread about a bit.

22 Trying to get this all corralled under
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1 one roof is always a challenge for them.

2 So now what we'll do is take a quick
3 look at what they've come up with for their
4 warrior Transition Program. This is just kind of
5 a quick overview that shows the kind of 30-day
6 cycles of what they do. The first three phases
7 are kind of prior to coming back, containing some
8 of the things they do, then the redeployment
9 itself, return to duty and so forth.

10 The next few slides here, we'll kind of
11 go over those more in depth. So it's kind of
12 pre-redeployment. They have the typical medical
13 briefs for any concerns like in this case for
14 signs or symptoms of leishmoniasis is one
15 example, malaria, prophylaxis for those that
16 require it, suicide prevention briefs, kind of an
17 introduction to the Warrior Transition Brief and
18 then the Commanding General has a video that kind
19 of explains the program and shows the command
20 support.

21 Then upon redeployment they do the post
22 deployment health assessment, either in theater or

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1 upon return to CONUS and then they are granted 96
2 hours of liberty.

3 Then once they come back after that 96
4 hours of liberty, they get a safety brief,
5 basically issues of driving fast, risk-taking
6 behaviors that we sometimes are seeing in our
7 returning troops, your basic equal opportunity
8 brief. It's just a bookmark to get that out of
9 the way for the year.

10 Then we have the actually start of some
11 of the warrior transition discussions. They
12 actually divide those up into E-6 and below and
13 then E-6 and above.

14 Then on the 30- and 60-day, the majority
15 are done, as far as contacts, are done in these
16 small work center discussion groups, typically
17 done at the squad level and stuff where they kind
18 of sit down and have a formal talk to see how
19 everybody is doing and discuss that, just a 'how
20 are you doing?'

21 For those above the tails and/or
22 some of the augmented Reservists that have

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1 returned back to their home station are also
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2 contacted. Basically, it's kind of just a little
3 go-by as far as some of the questions that they
4 are asking.

5 This is not a detailed, at this point in
6 time, EPI study. This is more an effort just to
7 kind of contact to see -- we don't know what we
8 don't know and we don't have, really, any good
9 ideas about whether much is going to come of this
10 or not.

11 So they wanted to implement something to
12 kind of see where they were going to see some
13 issues and find out what they are.

14 So right now they are getting a big
15 chunk of coming up on a 90- to 120-day window. In
16 discussing it with some of the senior guys, I mean
17 the 06's at the headquarters level are very much
18 in support of this. They are actually making a
19 lot of the phone calls to some of the regimental
20 commanders and stuff like that. This is basically
21 how the questioning goes. It's more of a warrior
22 to warrior type of an issue.

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1 Then, at the 90 days, this is where they
2 are actually now, they have the PDHRA, the Health
3 Reassessment form, and this is where they will be
4 doing that.

5 The large group presentation stuff that
6 they are mentioning here is just a little more
7 formal presentation of some information to try to
8 make sure that if anybody has any other concerns
9 that they can understand what's available to them
10 and then again, this is where they start to look
11 at involving family members to make sure nothing
12 is being missed.

13 Once again, we don't know yet what this
14 is going to provide for us as far as information.
15 They are going to play it by ear as they go along.
16 This is the great thing about this being done at a
17 MEF level, is that they can change it very quickly
18 as they determine what they find. They can either
19 scale it back or improve it very quickly.

20 Now the shift to the next thing as far
21 as the quality assurance program, an audit of
22 their programs to make sure that they are

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1 basically getting a deployment health assessment
2 done is a requirement. It is a requirement not
3 only by DoD, but also by Marine Corps orders.

4 We do, from Headquarters Marine Corps in
5 conjunction with health affairs, we go in and do
6 audits of their quality assurance programs. We
7 conducted an audit in April of 2005.

8 One MEP, in kind of looking at

9 themselves, they looked at some GAO audits that
10 were done in the past and then they looked at
11 themselves in the December and February timeframe
12 and they were not real happy with what they saw.

13 The Commanding General, to kind of help
14 show support for this being a lie program, next
15 slide, sent out a message in March of '05. You
16 have a copy of this. I think kind of following
17 what Dr. Poland's brother said, you know, he
18 acknowledges it's the right thing to do for the
19 dedicated Marines and sailors. So he really put
20 some force and top-level involvement behind this.

21 So the internal audit of the MEF in the
22 month following that message was to see that they

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1 appeared to have some better programs in place,
2 better emphasis on getting stuff done, some
3 improvements on their program.

4 We actually see in April that they had
5 some improvements across the Board on this. Areas
6 like the 2796 completion, these were all sample
7 audits. These were not complete audits, so you
8 will see as they do certain units within that, it
9 will vary a bit. They are in the 90 percentile
10 range there, so that's a significant improvement.

11 Then next slide, our April 2005 visit

12 basically confirmed what they saw in their own
13 April internal audit. It was substantiated by
14 ours, so we basically did a thorough review of
15 several different things, but looking for the
16 presence of the forms in the record, referral
17 follow-up and all was confirmed by that.

18 The last slide is a little poster that
19 they developed for themselves. I guess my
20 reaction to the guy on the bottom with the
21 cigarette in his mouth is he is going to be a guy
22 who's going to be tough to kind of convince that

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1 he should take better care of himself because he'd
2 probably respond, well, send me home and I'll do
3 so.

4 Are there any questions?

5 DR. POLAND: We commend the Marine Corps
6 on developing the Warrior Transition Program,
7 particularly given some of the data we heard last
8 meeting on Post Traumatic Stress Disorder and
9 Anxiety Symptoms.

10 Do any of the other services have a
11 formal program like this? I guess it's early
12 stage and it's necessarily sort of soft touch,
13 which I think is not a bad way to approach it.
14 But it would be nice if at some point we got even
15 just enough of a collection of anecdotes to know

16 the power of a program like this.

17 CDR MCMILLAN: And that's, I believe,
18 especially with the HRA assessment coming where
19 there will be some formal data collection using
20 that tool, that we will be able to apply some of
21 the anecdotal evidence as saying, yeah, everybody
22 that we identified with that tool was already

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1 identified or not.

2 So they will be able to look at how many
3 of those that the tool shows as being in need of
4 some additional assistance had or had not already
5 been identified similar to what they found with
6 their TBI tool as far as how many had been
7 identified by the post-deployment health
8 assessment versus what this tool provided.

9 DR. POLAND: One other question, and I
10 know it's straying a bit, has any sort of
11 transition program at any of the services like
12 this been developed for the families of the
13 returning warrior?

14 CDR MCMILLAN: We've talked about this
15 at --

16 DR. POLAND: Not one where the family
17 has to go and seek something, but where, you know,
18 the Commander or somebody touches that family at

19 least once upon return of that service member. Is
20 there anything like that?

21 MAJ CHILLIAN: I'm Major Chillian from
22 the Joint Staff. I know in the Army they are

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1 called reunion briefs. Through the Family Support
2 Group or Family Readiness Group, depending on what
3 we're calling it today, they will establish those
4 even before the return.

5 Usually the folks come back en mass, in
6 unit cohorts. So ahead of time the family
7 members, the children, the spouses will get some
8 read-aheads on expect Johnny to demonstrate this
9 kind of personality. These are the kinds of
10 stresses he has been in. You know, don't take any
11 guff off of him for being a knucklehead, but at
12 the same time, understand that he is being used to
13 being shot at and there may be these kinds of
14 times that, you know, he's going to have some
15 coping issues and is going to need your
16 assistance.

17 Also, extend to them, if Johnny is a
18 knucklehead, here's my phone number, please give
19 me a call. I can help Johnny get back on his
20 feet. Then even after they return there's a
21 period, 30, 60 or 90 days that they keep, you
22 know, contact. They have a support group.

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1 COL UNDERWOOD: I also want to mention
2 that we have 24/7 for all military. It's called
3 Military One Force. It's a 1-800 number and they
4 will answer any question on any topic, whether
5 it's mental stress services, whether it's how to
6 fix a tire or how to get insurance, whatever,
7 either active duty or a spouse or any beneficiary
8 who wants to know, 24/7 access.

9 CDR MCMILLAN: You're ahead of any
10 civilian organization I know of.

11 DR. POLAND: Dr. LeMasters.

12 DR. LEMASTERS: This looks great. I
13 think it's wonderful to evaluate compliance with
14 it. My question is: What's the benchmark if it's
15 doing any good? What changes? Are you monitoring
16 any changes? Are there any things that are
17 dropping because of the transition program? Were
18 there any goals set up to measure if this is
19 working and if it's not, then something else
20 should be done or if it is, good, everyone should
21 be doing it.

22 CDR MCMILLAN: The goal essentially is,

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1 and of course the assessment is to look for
2 unidentified problems that are identified by
3 current methods in place for the warrior
4 transition program.

5 As I said, you don't know what you don't
6 know. So they are looking to see, you know, we do
7 the post-deployment health assessment. We have
8 additional monitoring programs, suicide prevention
9 programs, you know, all those things are in place.

10 But this was something a little more
11 formal, individually addressing each member and to
12 try to look and see, you know, are we seeing more
13 coming through as a result of this assessment or
14 are we seeing essentially no change in the number
15 of referrals or at least consultation requirements
16 with mental health and/or chaplain.

17 This is not necessarily just a medical
18 issue. This is one that is handled by the
19 chaplain and family resource centers. It's a
20 coordinated effort across the whole thing. It's
21 very much, like I said, also the line was very
22 instrumental in starting this. To some degree

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1 they are the counselors among themselves to help
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2 support each other. So that's part of the soft
3 sell business we talk about as far as we just have
4 to be slow as we implement this and get them used
5 to the idea.

6 DR. LeMASTERS: Well, have we identified
7 more, then? I mean that's my question. I
8 understand the goals, but are we tracking anything
9 to see if we are identifying more?

10 CDR MCMILLAN: Yes. I don't have that
11 data with me, but yes, they have a tracking
12 program in place. They are not tracking
13 necessarily by one-on-one individual tracking
14 across time with this, but they are looking for
15 referrals related to this program.

16 DR. LeMASTERS: My concerns is that we
17 start a lot of programs and we don't build in
18 program evaluations as part of that program to see
19 if it's making any difference.

20 CDR MCMILLAN: As I said, they have
21 reevaluation periods during which they determine,
22 you know, one, is it doing any good and should we

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1 continue or it is really not doing any good;
2 should we do somebody else, or we don't really
3 need this at all. We can stop it now.

4 So it's not a perpetual program. And

5 it's great, once again, it's at a low enough level
6 that they can easily do that.

7 COL GIBSON: Dr. LeMasters, from the
8 health side of this, both of those post deployment
9 forms are ways we identify those who need further
10 care to get a follow-up visit. This ties directly
11 in with the post-deployment clinical practice
12 guidelines which, as you know, as a member of that
13 subcommittee, center subcommittee, made strong
14 recommendations about assessing the quality of
15 that issue.

16 So are there things in place to do that?
17 Do we need to improve it? Absolutely.

18 DR. POLAND: Are there any other
19 questions or comments?

20 SPEAKER: I had one question. You
21 talked about the Commanding General's video. Have
22 you seen that?

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1 CDR McMILLAN: No.

2 SPEAKER: My question was, what is he
3 covering? I assume it's one of those 'You served
4 well, atta boy. You've got some issues to deal
5 with as you go home. It's okay to come forward if
6 you are having problems.' Is it that sort of
7 thing?

8 CDR McMILLAN: I think it's somewhat
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9 similar to the little blurb from his message that
10 he sent out regarding we need to take care of
11 people because the ultimate goal is to have a fit
12 and ready force. I think that's really the bottom
13 line behind the warrior transition, it is to get
14 the guys back up to step, not to encourage
15 disability impairment, but to assess it early, to
16 resolve it as soon as possible, to maintain that
17 fit and ready force.

18 MS. EMBREY: I'd like to add a post
19 script. This post-deployment reassessment process
20 at the 90- to 120-day period, it's a policy of the
21 department that we sort of forced on the services
22 because we felt that we needed to have this soft

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1 touch, sort of.
2 we had some research which indicated
3 that not all of the effects of the deployment both
4 physically as well as mentally, manifest
5 themselves immediately upon redeployment.
6 That research indicated that it was
7 really showing up in the 60- to 120-day timeframe.
8 So we felt it was very important to create a
9 standardized mechanism, a 100 percent outreach to
10 everybody that came back to make sure that they
11 understood that we realized that they may not

12 realize it and that we have a lot of resources
13 available to them.

14 This is the department's commitment, to
15 make those resources available, make that contact
16 with the individuals. This is not just the forces
17 that remain in the force. These are the Reserve
18 component guys who have been off duty for several
19 months. They are going to get contacted.

20 The same thing with people who have left
21 the force. They are no longer even affiliated
22 with the department, but if they deployed and

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1 redeployed, it's our responsibility to catch them.

2 Now that has made our task very complex
3 and very difficult to implement in a short
4 timeframe. So we are going to be doing this
5 incrementally over time starting with the folks
6 that we know are going to be redeploying in the
7 fairly near future that are hitting that window
8 and we are going to be gradually implementing this
9 thing over time.

10 But it's important to know that this is
11 a real outreach effort. It's very far reaching.
12 It's very complex and we're not going to do it
13 perfect out of the gate.

14 DR. POLAND: Thank you, Commander
15 McMillan. We have reached the end of the open

16 part of today's session. I want to thank all
17 involved for the tremendous support of the AFEB,
18 and especially to the speakers for the outstanding
19 presentations.

20 I also want to thank Ms. Embrey who
21 takes her time out of what I can only imagine to
22 be a horrendous schedule to spend two days with

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1 us. I think that just tremendous support. It is
2 very much appreciated by myself and the Board.

3 For Colonel Riddle, good to see you
4 again, and thank you for helping to arrange our
5 time here.

6 (Applause)

7 Also to Colonel Gibson, to Severine and
8 Karen, it takes a lot of people to put a meeting
9 like this together. So thank you very much.

10 I would ask that the Board members and
11 the preventive medicine officers stay a bit longer
12 for our executive session.

13 Otherwise, we are adjourned. Thank you.

14 (Whereupon, at approximately 3:35
15 p.m., the PROCEEDINGS was
16 adjourned.)

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