

ARMED FORCES EPIDEMIOLOGICAL BOARD

DAY ONE

Doolittle Hall
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United States Air Force Academy

Colorado Springs, Colorado

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

2 DR. POLAND: Welcome all to this meeting
3 of the Armed Forces Epidemiological Board. We've
4 got a number of important and surprisingly timely
5 topics on our agenda for today, so I did want to
6 get started. Ms. Embrey, would you please call
7 the meeting?

8 MS. EMBREY: Good morning, everyone. As
9 the Designated Federal Official for the Armed
10 Forces Epidemiological Board, which is a Federal
11 Advisory Committee to the Secretary of Defense,
12 that serves as a continuing scientific advisory
13 body to the Assistant Secretary of Defense for
14 Health Affairs and the Surgeons General of the
15 Military Department, I hereby call this meeting to
16 order. Colonel Walsh, please accept my
17 appreciation for your willingness to host this
18 meeting and the outstanding support that you and
19 your staff have provided to the Armed Forces
20 Epidemiological Board.

21 DR. POLAND: Thank you, Ms. Embrey.
22 We're going to go around in just a minute here to

1 introduce all of the Board Members, we have
2 several new people with us. I just wanted to make
3 a couple of comments, some of which Colonel Gibson
4 will reiterate. One is for the Board members to
5 be aware that the comments are -- that we make are
6 transcribed and become part of the public record.
7 We also want to call your attention to something I
8 would like to have as a permanent part of our
9 meeting and that is that we would start the
10 meeting and end the meeting with this slide in
11 front of us. Later in the Executive session,
12 we'll ask you to help us refine and hone this
13 down, it's a bit long, but the concept is that we
14 would have ever-present before us what our mission
15 is so that our minds, our hearts and the work that
16 we do here is focused on the needs of the service
17 member. So we'll have some time as a board to
18 work on that. Also, we have provided some
19 guidelines after various discussions with Board
20 members for the presenters and we will share those
21 with you. We'll give them a trial run today. But
22 for each presenter, we've provided guidelines on

1 how we would like the briefs to progress and what
2 specifically should be included on them. Finally,
3 we will have time, again at the request of the
4 Board, for subcommittee meetings and reports. So
5 with that, let's go around the table and we'll
6 introduce the Board members. But, first, our
7 distinguished guests that are with us, to my
8 right, Major General Kelley, who is the joint
9 staff Surgeon. Captain David Rutstein, who is
10 attending in place of Admiral Carmona and Dr.
11 Douglas Wear, who I didn't have the chance to
12 meet, representing Dr. Mullick from AFIP.

13 (Board Members and Guests introduce
14 themselves.)

15 DR. POLAND: Okay. Colonel Gibson has
16 some administrative remarks before we begin the
17 morning session.

18 COL GIBSON: Thank you. Good morning
19 and welcome. I want to thank Colonel Walsh and
20 particularly Tech Sergeant Lisa Taylor and her
21 staff at the Academy for helping us set up this
22 meeting. Did an absolutely great job, as you can

1 tell from the venue and the rooms and the
2 mountains and everything else. This is a
3 wonderful place. Rampart Lodge staff also was
4 very helpful. Jean Bickford and Deborah Lawless,
5 they helped us coordinate the conference space.
6 And support from the Officer's Club. Also want to
7 thank Severine Bennett and Karen Brawley for their
8 help in getting the agenda together and the
9 speakers, et cetera. Uniformed Services
10 University, we're able to get through them 5.75
11 continuing education credits for this meeting. To
12 receive the credits you need to sign the
13 physician's attendance roster, preferably today,
14 and complete the evaluation form for the meeting
15 and hand it in tomorrow. Again, I want to stress
16 the meeting is being transcribed. Before
17 speaking, state your name clearly so we can keep
18 track of who said what. The meeting transcripts
19 will be on the website in a few weeks and the
20 slides will be posted in about two weeks once we
21 go back through the speakers and make sure that we
22 have their approval to post the slides. If you

1 haven't signed in, we want to get your attendance
2 on a sign-in roster that was back by the door.
3 Tonight we are having dinner at the Cactus Rose.
4 It's open to all attendees, but we'd like to --
5 let us know whether you're going to attend or not,
6 but what we'd like to do in just a second, I'll
7 ask you to raise your hands if you're going to
8 come to the dinner tonight and if your wives are
9 coming, raise two hands so that we can get a good
10 count on it. For this meeting, the refreshments
11 are available both in the morning and afternoon
12 sessions. We have a catered working lunch that's
13 going to be upstairs in the atrium right above us.
14 Doing things slightly differently for the Board
15 members this time and for all of the folks here.
16 The lunch is \$8.95 per person. We're going to
17 collect that money to pay for the lunch. So, we'd
18 like to get it paid in advance. So get the money
19 to Severine or to Karen to take care of that. But
20 what that does, on your travel voucher, you won't
21 be marking that as a meal provided by the
22 government because you paid for it already.

1 Restrooms are outside. If you need telephones see
2 Karen. I'm sorry. What? We take checks and
3 credit cards as well as cash. And if you need to
4 send a fax, Jean Bickford, if you go out these
5 glass doors to that counter out there, they can
6 take care of a fax for you. And, let's see, for
7 those who are not leaving tomorrow night, we have
8 an opportunity to attend the Academy's retreat
9 ceremony tomorrow afternoon after the tour. The
10 ceremony runs from 4:30 to 5:00 tomorrow
11 afternoon. If you're interested in attending,
12 raise your hand so we can get a count on that.
13 And, finally, the next AFEB meeting is the 6th and
14 7th of December. That's the first Tuesday and
15 Wednesday of December. It's at Fort Bragg in
16 North Carolina. Tentative agenda includes a
17 question to the Board on recruit health
18 surveillance and low-dose, short-term chemical
19 agent exposure. We'll also be provided a tour of
20 Fort Bragg including the special forces training.
21 Let's get a count on lunch now or -- no, dinner
22 tonight. How many are going to go to dinner

1 tonight? Okay. That's all I have.

2 DR. POLAND: Okay. Colonel Walsh wanted
3 to take a few minutes to welcome the Board to the
4 United States Air Force Academy.

5 COL WALSH: On behalf of General Rosa,
6 the Academy Superintendent as well as my Wing
7 Commander, Suzanne LeClaire, I'd like to welcome
8 you. We're very aware of what you do here in
9 terms of the impact it has on the Academy as well
10 as the military in general. Appreciate the fact
11 that all of you take the time to actually
12 participate in this. I had very little to do with
13 setting this up. I think Colonel here kind of
14 pointed out Tech Sergeant Lisa Taylor is really
15 the one you need to thank for everything that
16 occurred prior to getting here. And I want to
17 stress the fact that if there's something you need
18 to support you better, please let us know while
19 you're here so we can make that happen. So Lisa
20 will be our conduit. Also like to introduce Chris
21 Benjamin in the back, Colonel Chris Benjamin.
22 He's the Commander of the Cadet Clinic, also

1 Harris Base Medicine Squadron. Reason why I point
2 that out is if you're interested in kind of like,
3 the ground truth in how a session standards impact
4 facilities and some of the processes we created in
5 terms of accessing individuals to the service
6 academies, he's a great firsthand person in terms
7 of the knowledge. I'm also, I'm the Med-Group
8 Commander here and I'm also the person who's the
9 waiver authority for those who are disqualified by
10 DNBI to come here, so I do have some perspective
11 on that. But, Chris is really the one who can
12 give you the cadet medicine firsthand picture.
13 That's all I have to say other than to welcome you
14 and also please let me know if there's something
15 you need that we haven't provided to support you.

16 DR. POLAND: Thank you, Colonel Walsh.
17 It's a beautiful facility. Walked out of my room
18 this morning and there were two deer, a flock of
19 turkeys and a bluebird. So it's just an
20 outstanding beginning. On behalf of the entire
21 Board and the Office of the Assistant Secretary of
22 Defense for Health Affairs, we'd like to present a

1 certificate of appreciation and an AFEB coin. The
2 Office of the Secretary of Defense presents this
3 certificate of appreciation to Colonel Peter
4 Walsh. Thank you very much. And similarly, the
5 Office of the Secretary of Defense presents this
6 certificate of appreciation to Tech Sergeant Lisa
7 Taylor.

8 COL GIBSON: If you could see Karen at
9 the break to provide your \$8.95.

10 DR. POLAND: Apparently, several members
11 of the Board did not get the memo. When we meet
12 on an Air Force Base, we'll wear a blue shirt.
13 Okay.

14 Before we begin the session, I do want
15 to take a few moments to recognize one of the real
16 AFEB greats and that was Dr. Ted Woodward, who
17 passed away in July of this past year. I have to
18 say when I first came on the Board in the early
19 '90s I was privileged to have lunch with Dr.
20 Woodward and one other person who I can't recall
21 right now, but I was incredibly impressed at the
22 breadth of knowledge that he had and this seeming

1 photographic memory for all of the actions of the
2 Board over about a quarter of a century. He just
3 seemed to know those inside and out and just a
4 marvelous man. I was privileged to meet him. As
5 you know, he made many contributions to the world
6 of medicine and was nominated for a Nobel Peace
7 Prize. Amidst his contributions to medicine and
8 teaching students as well as tending to his
9 patients, Dr. Woodward also made incredible
10 contributions to the AFEB. He served as Board
11 President for 12 years, which I can tell you, I
12 can't imagine the amount of energy that must have
13 taken and he is the author of the history of the
14 AFEB called, It's First 50 Years: 1940 to 1990.
15 And that book was published in 1990. He thought
16 that the AFEB was a phenomenal meeting of minds
17 and a powerful resource to the Department of
18 Defense. As clearly expressed by that quote, he
19 felt that the people that made up the AFEB are the
20 true resource and that together this group of
21 individuals has and can continue to do great
22 things and I would endorse his vision for this

1 Board. Dr. Woodward died at his home on 11 July
2 2005 and will be sorely missed. So if we might
3 just take a moment of silence for Dr. Woodward.
4 Thank you.

5 Today we're going to hear a series of
6 presentations related to DoD's role in response to
7 public health emergencies. Let me stress that
8 these briefs that we'll hear today are
9 informational. We are not being asked a direct
10 question at this point. There are many committees
11 and entities within DoD looking at and reviewing
12 this, particularly in view of recent events. But
13 it will be important background, I think, for the
14 Board. When this topic came up at our last
15 meeting, you as Board members had requested
16 further details on the policy, processes and
17 execution. None of us, of course, would have
18 imagined that this issue would be so timely and
19 that we would have a very real-world experience in
20 front of us. The briefings today, as I stressed,
21 are informational. There is no question before
22 the Board requiring an official letter or report,

1 but do feel free to ask questions and provide
2 comments on the policy, planning and execution of
3 DoD resources in response to national public
4 health emergencies. The discussion will hopefully
5 stimulate ideas in how the process may be improved
6 and also validate what is working well.

7 We're honored to have Ms. Embrey as our
8 first speaker this morning. She will be
9 discussing DoD's medical support contingency
10 effort, including DoD's policies related to
11 Homeland Defense. Ms. Embry's slides are in Tab
12 2.

13 MS. EMBREY: This is walking up to the
14 podium music. Maybe.

15 (Slide presentation shown.)

16 MS. EMBREY: The person who was supposed
17 to give this briefing, Mark Roupas from the Corps
18 of Engineers, is busy handling and representing
19 the Department in the President's interagency task
20 force on recovery for the region down in the Gulf
21 Coast area. So at the last minute, I was asked to
22 fill in. This is a topic that has been a focus of

1 my professional attention for the last nine years.
2 So I'm familiar with it and I'm a little
3 passionate about it and I'm also a little cynical.
4 So hopefully I can control the cynicism and get to
5 the facts. I'm here to talk to you about, really,
6 medical support in a contingency event, but the
7 reality is it's how the Department of Defense fits
8 into the overall federal response capacity to deal
9 with disasters of any kind, whether they're
10 terrorist, manmade or natural. Next slide.

11 These are the four broad areas that I'll
12 be talking about in this presentation. A little
13 bit about how we came to organize the way we are
14 in the federal government with respect to
15 capability to respond to emergencies. The role of
16 my office, my office is the Office of the
17 Assistant Secretary for Health Affairs, and how we
18 coordinate and participate in the process. How
19 the department itself understands the requirement
20 and prepares to respond to it as requested. And
21 then a little bit about the road ahead. And at
22 the end there's a little bit of a commercial about

1 how the department is preparing for other kinds of
2 anticipated emergencies, public health
3 emergencies, with respect to Avian influenza.
4 Next slide.

5 Homeland Security. It's important to
6 understand there's a difference between Homeland
7 Security and Homeland Defense. Homeland Security
8 became an issue after 9/11 and the President and
9 Congress enacted a law that took the response
10 capabilities of the federal government to respond
11 to disasters of significant size and even small
12 size, and put it into the Department of Homeland
13 Security. The issue, however, is that the focus
14 had been anti-terrorism or counter-terrorism and
15 being prepared to respond to terrorist acts and
16 that became the principal focus of the new agency.
17 The traditional responsibility of responding to
18 disasters was something that had been embedded for
19 a long time. There was a well-established process
20 and so the agency didn't really focus that much on
21 it at that point in time, because they thought it
22 was a well-entrenched capacity. So the Department

1 of Homeland Security is the lead for all disaster
2 response. If they're unable to keep things from
3 happening within the U.S., it's primarily
4 law-enforcement oriented and Department of
5 Homeland Security collaborates with the law
6 enforcement capacities in the states and with the
7 FBI to get most of their job done. Their focus is
8 to keep things from happening, not trying to
9 respond to it afterwards. Next slide.

10 The President, before 9/11, even issued
11 a directive, Presidential Directive No. 5, that
12 said that we need to get our stuff in one sock.
13 That we will have all kinds of responses to events
14 put into one place. And so the Department of
15 Homeland Security is the place where that
16 occurred. So the response capacity, in terms of
17 public health, from HHS, the emergency response
18 elements and the apparatus and the control
19 mechanisms that used to reside in the Department
20 of Health and Human Services, shifted over to
21 Department of Homeland Security. However, the
22 Department of Health and Human Services is still

1 responsible for leading public health response in
2 this country, and under the National Response
3 Plan, which we'll get to in a minute, continues to
4 coordinate and lead the federal interagency's
5 effort in ESF-8, Emergency Support Function No. 8,
6 which is health. Next slide.

7 The National Response Plan is a
8 compilation of plans, capacities, authorities,
9 responsibilities as identified in this list of
10 some laws, some regulations, some plans and they
11 applied to different parts of the federal
12 interagency and when the Homeland Security Act
13 occurred, it tried to align these requirements to
14 the responsibility and authority in the Department
15 of Homeland Security. These four, specifically,
16 identify how the Department participates in the
17 process and what the rules of engagement are for
18 the Department of Defense and the conditions under
19 which we can operate in the U.S. Posse Comitatus
20 specifically limits Department of Defense to
21 non-law enforcement. We cannot be engaged in law
22 enforcement activities and we cannot lead

1 civilians unless the Insurrection Act kicks in.

2 The two DODDs, that means directives,
3 MSCA, Military to Support for Civil Authorities.
4 MACA is Military Assistance to Civil Authorities.
5 Assistance to civil authorities primarily talks
6 about providing assistance to the law enforcement
7 agencies, usually in mitigation and small events
8 to help keep things from happening. It's a crisis
9 management type of function.

10 The MSCA is a consequence-management
11 type function and it involves support to civil
12 authorities in executing response mostly in, well,
13 what you've seen in Hurricane Katrina. All the
14 things that DoD has been doing have been
15 accomplished as military support to civil
16 authorities. We do so at the request of the civil
17 authority and we do so on a reimbursable basis
18 from FEMA under the property authority if a
19 disaster's been declared or an emergency has been
20 declared. But we do that as requested and if
21 approved by the Secretary of Defense. That's
22 important to know because we use resources of the

1 Department that have been identified, trained and
2 equipped for a military mission. When we use them
3 for support to civil authorities for any extended
4 period of time, we are degrading our readiness to
5 perform the mission those units and capabilities
6 were designed to do. Since we're in a war on
7 terrorism that becomes extremely important. So
8 there needs to be a balancing act between what our
9 country needs and what our defense needs are.
10 Next slide.

11 The National Response Plan was compiled
12 from all those things, using all those authorities
13 in the previous slide and it has these five
14 elements. A base plan which has the concept of
15 operations. A coordinating of structures and
16 defines the roles and responsibilities of the
17 federal government in national response
18 requirements. The Emergency Support Function
19 Annexes groups capabilities and response into
20 functions that are most likely needed and that
21 will be on the next slide. I'll show you that.

22 This is where you have, in the case of

1 healthcare, you have a lead federal agency that is
2 responsible for developing how they're going to
3 work together and provide support in a given
4 functional area. The Support Annexes talk about
5 how administratively the federal government will
6 support the function of executing a response.
7 Legal issues, financial issues, contract issues --
8 those kinds of things. Incident Annexes have to
9 do with specific scenarios that may occur for
10 planning purposes. They lay out if a biological
11 event, chemical event, HAZMAT event, anything like
12 that, there is supposed to be procedure, role and
13 responsibilities laid out across the federal
14 interagency on how the federal interagency would
15 coordinate and respond in those circumstances.
16 Then there are Appendices. Appendices provide
17 acronyms, definitions, glossaries, MOAs,
18 Memoranda's of Agreement, things like that.
19 Addendums, exceptions to the plans above. So
20 that's what it's supposed to look like. Is it
21 complete? No.

22 DR. POLAND: Sorry for that

1 interruption. We're having the next speaker, he
2 will be giving his slides by tele-con and we
3 wanted him to be sure to hear your comments Ms.
4 Embrey. So I apologize that we're having a little
5 difficulty.

6 MS. EMBREY: No problem. Welcome Joint
7 Staff, General Kelley is listening, so be good.
8 The National Response Plan has been published in
9 draft for a good long time, but is not as complete
10 as it should be and clearly not everyone
11 understands how it all has been laid out because
12 it has just been compiling all of the old plans
13 into one place and there's still gaps and mixes.
14 So I wouldn't say it's perfect yet, but it's there
15 and that's what we're working to. Next slide.

16 ESF. Emergency Support Function. This
17 is part of those Functional Annexes that describe
18 how the federal government will organize to
19 provide support in emergencies in this country
20 along these 15 areas. Number eight is Public
21 Health and Medical Services and HHS has the lead
22 for doing that. Next slide.

1 Military Support to Civil Authorities.
2 I talked a little about that that's how we engage
3 in providing support during disasters. It's
4 important to know that after 9/11 and after the
5 Department of Homeland Security was established,
6 the Department did a few things. Well, actually
7 we did it before 9/11, but just barely. We
8 created NORTHCOM, which is both a functional and a
9 geographic sync. A combatant commander
10 responsible for planning and training and
11 executing these kinds of responses, both MACA and
12 MSCA capabilities, in response to requests for
13 support from the Department of Defense. Since DoD
14 assets cannot report, I mean they need a command
15 and control structure, and so NORTHCOM provides
16 the command and control structure, the plan and
17 the mechanism by which any forces that are
18 delivered to the U.S. to provide support are done
19 through the command and control structure
20 established by NORTHCOM. That would occur
21 primarily on mass casualty situations or large
22 disasters.

1 For relatively small disasters, NORTHCOM
2 would be engaged through the Joint, JDOMS, Joint
3 Directorate of Military Operational Support.
4 What's the name of it? DOMS, Directorate of
5 Military Support. That's right. But it's in the
6 joint staff. The idea here though is, in the
7 past, before NORTHCOM was established, the Army
8 was the executive agent for making that happen and
9 the Army operated a DOMS, a Directorate of
10 Military Support to receive requests from FEMA and
11 other federal agencies and respond to them. They
12 were usually short-term things, not more than a
13 couple of weeks. They were small floods,
14 earthquake support, firefighting; those kinds of
15 things.

16 We didn't have a large structure to deal
17 with large terrorist attacks and as a result when
18 we created a whole combatant commander to address
19 this issue, the Army responsibility was
20 transferred to the Joint Staff and now we handle
21 all requests for support in the same way that we
22 handle any other operational requirement; or at

1 least that's the theory. That any request for
2 support for our resources comes in through the
3 Executive Secretariat of either the combatant
4 commander or outside the department, it comes to
5 the Joint Staff. They work with Joint Forces
6 Command, who is the force provider, and end up
7 defining and validating the requirement against
8 other requirements and then execute the
9 requirement. So we changed the way we do business
10 in order to try to normalize, especially for the
11 larger demand on our resources, by
12 institutionalizing it and aligning it with the way
13 we do business in the Department. The Joint Staff
14 is growing into that position. The JDOMS is
15 growing into that role, because there are caveats
16 to how we do business in the U.S. So we don't
17 have the authority to just go do what we want. We
18 have to coordinate with who requested. We have to
19 make sure that we have money identified to
20 resource it. We have to more carefully evaluate
21 what the legal implications are of going into a
22 place and doing different things. And when you're

1 working in a state, if you're a federal entity,
2 the state actually has more authority than the
3 federal government does unless they have been
4 overridden through some other legal authority.
5 But in this country, the states are responsible,
6 have the legal and constitutional responsibility
7 for the health and safety of their citizens. They
8 control formulary, they control credentialing,
9 they control a whole bunch of other things. So
10 when we go into a place, we have to subjugate
11 ourselves to that state's requirements. Next
12 slide. This is the definition of what Homeland
13 Security is and what we're trying to do. DoD does
14 not have the authority to seek out or arrest
15 terrorists in the U.S. They go to the Justice
16 Department. I think I've talked about this
17 briefly, but Homeland Security is more focused on
18 this than consequence management. Next slide.
19 Homeland Defense, there is a difference.
20 This has to do with protecting the U.S. against --
21 from the outside to protect the infrastructure and
22 to make sure that we are capable of continuing to

1 perform in the way that is necessary for us
2 economically, politically and otherwise. A lot of
3 people don't understand the difference. And the
4 law and the constitutional authority of the
5 Department of Defense to operate underlies that
6 and we get a lot of confusion when the DoD is
7 engaging in the U.S. So we have to be very
8 careful and we rely a lot on our lawyers. The
9 problem is that there's a lot of different lawyers
10 in all of the federal agencies and they all
11 disagree. Next slide.

12 We call this Civil Support. This is
13 where our health community gets engaged. You've
14 seen in the papers the number of individuals in
15 uniform that have been providing support. This
16 happens because we've been asked by FEMA to
17 provide support in specific areas. We can't just
18 send what we think they need, we have to send what
19 they've asked for and what FEMA has paid for.
20 Next slide.

21 This is the process. This is how it's
22 supposed to work. The lead federal agency will

1 determine through an office on the ground called
2 the Joint Federal Office. There is a Joint
3 Federal Officer and embedded in that staff is a
4 Defense Coordinating Officer. That Defense
5 Coordinating Officer gets from the Federal
6 Coordinating Officer's mouth what is needed. He
7 in turn coordinates that requirement through a
8 very interesting morass of bureaucratic processes,
9 but nonetheless, a request for assistance would be
10 sent, once it's validated by the people on the
11 ground as something that is needed and that DoD
12 can ultimately provide support for. They send a
13 request to the Executive Secretary of the
14 Department of Defense. That alerts the Secretary
15 of Defense that we are being asked and it also
16 provides the pipeline to go straight to the Joint
17 Staff to start working the request.

18 The Joint Staff begins evaluating what
19 resources are available to do that and at the same
20 time, the Assistant Secretary of Homeland Defense
21 is evaluating it in the traditional of the OSD
22 staff elements. He has to look at whether or not

1 it meets the criterion for support. He has to
2 coordinate with the legal people to make sure it's
3 legal and that we are ethically doing the right
4 thing. He will coordinate with other staff
5 offices and in the case of when they're using
6 medical resources, he'll coordinate with our
7 office and then the request will be validated, the
8 order will be filled. The order for specific
9 resources to go to a place for a specific time
10 goes through the process, the SECDEF approves it
11 and the people get on their way. That's the way
12 it's supposed to work, but perhaps General Kelley
13 might want to talk about how it actually worked in
14 Katrina.

15 GEN KELLEY: I think it did, it worked
16 kind of like that, but I think some of things is
17 that those coordinating officials, as they're
18 sending through the official requests, they are
19 making phone calls. So on the Joint Staff, the
20 requirements are identified and plans are already
21 beginning to form for what specifically is needed
22 in this specific case. You can't execute those

1 plans until it actually comes through. So we're
2 much farther along in terms of we're not delaying
3 the planning process and identifying. So, for
4 example, medical forces that were needed were put
5 on notification that were to be ready to deploy
6 within six hours before the request actually came
7 through as we looked at what was there and what
8 was needed. But you had to wait for the states to
9 officially request that the federal government
10 help before we could actually deploy those forces
11 under federal control. We're not even talking
12 about the National Guard, which can be under state
13 control and can go under a different command and
14 control authority.

15 MS. EMBREY: And, "Lead federal agency,"
16 is open for interpretation. The Department of
17 Homeland Security is the lead federal agency for
18 response in general, coordinating that and FEMA is
19 a component of that. HHS is lead federal agency
20 for health response requirements and their job is
21 to coordinate the health components of that inside
22 that process. Now HHS often did not work inside

1 of that process and so we had two lead federal
2 agencies giving us, at times, conflicting
3 requests. Eventually it all worked out, but it
4 created confusion. Next slide.

5 This is an abridged org. chart showing
6 how the health affairs policy structure exists.
7 Policy does not respond to emergencies so this is
8 sort of an informational slide. We are
9 responsible for developing the policy and working
10 with the services to ensure that we are prepared
11 to provide support, but since it isn't our
12 mission, we are not allowed the resources to train
13 and equip to function in the United States,
14 because that's not our mission and we are not
15 given appropriated dollars to do this. Mr.
16 Rumsfeld is very clear that we should not be
17 organizing training and equipped to do this, but
18 we, of course, should provide those resources if
19 they're requested and needed. So I'm in one of
20 those boxes and my job is to try to help us be
21 prepared to do that. So when it's not our mission
22 to be prepared to do a good job and to understand

1 how to do business, that's a really hard thing to
2 do. Next slide. Commercial for my organization.
3 This is what we do, this is our vision and that
4 would include providing support to civil
5 authorities when requested and approved. Next
6 slide. This is the role of the office as defined
7 by my boss. We do provide advice to the Secretary
8 of Defense about medical services and support,
9 whether it's in the U.S. or anywhere else. We
10 oversee what's going on and see if there are gaps
11 in policy that need to be developed and fill in
12 those gaps. We own the bulk of the Department's
13 health program monies. Since we have those
14 monies, we have to make decisions about how to
15 reallocate those resources and still maintain all
16 of the mission requirements. We have
17 responsibility for COOP, Continuity of Government
18 Operations and Continuity of Government
19 Operations, both defense capabilities need to be
20 performed in locations where disasters have
21 occurred and decision-makers and functions of the
22 Department and of the healthcare community need to

1 continue. So we have responsibility for planning
2 for that and making sure that lines of authority
3 and responsibility continue even in an emergency.
4 We support coordination throughout the
5 organization with the Joint Staff and make sure
6 that we okay things when we're asked to okay them.
7 It's our job to develop the policy and shape the
8 preparedness programs for this and we'll get into
9 that in the next few slides. Next slide.

10 Our job is to assess the regional
11 response architecture that is developed by
12 NORTHCOM and the services and evaluate whether or
13 not they accomplish what we are going to be asked
14 to do in peacetime and in wartime and advise the
15 Secretary on alternatives. We work with the
16 Department of Defense, Mr. McHale, the Assistant
17 Secretary to collaborate on consequence management
18 issues and crisis management issues involving the
19 medical community. An important footnote, other
20 federal agencies really have the lead on this and
21 so we need to resist the urge and we have to
22 frequently pull ourselves back. We are the

1 Department that does a lot of deliberate planning.
2 We understand how to plan, we understand
3 logistically how to support that plan and we know
4 how to execute, because that's what we do on a
5 day-to-day basis around the globe. It's very
6 difficult, when you know how to do that and other
7 people are in charge and they don't know how to do
8 that, to not want to take charge. But that's our
9 jobs and that's what we're doing. So our job now
10 is to encourage the other lead federal agencies to
11 become just as good as the Department is
12 institutionally at doing these things. Next
13 slide.

14 GEN KELLEY: I'll make a comment there
15 that we did place some of our planners into other
16 departments so that they would better understand
17 the planning process, the emergency planning
18 process and the capabilities of DoD so that could
19 help them help themselves.

20 MS. EMBREY: In fact those planners came
21 from my staff. Interagency coordination is the
22 key for success as far as DoD is concerned. Next

1 slide. How does the military health system
2 support forced health protection, prevention,
3 surveillance, preparedness, response and recovery
4 in these kinds of situations? Our job is to
5 "influence peddle"; convince the other agencies
6 that they have the capability, that if they
7 cooperate with the states, who have the
8 responsibility, that they can work with them to
9 make sure that when we come in that we're doing
10 the right thing and it's within a structure that
11 makes sense to that state. Next slide. Since
12 Secretary Rumsfeld is not allowing us to resource
13 train and equip to do domestic response, I keep
14 asking this question: Are we prepared to support
15 the needs of our population? We have multiple
16 installations around the country. We have 9.1
17 million beneficiaries and we have responsibility
18 to take care of them if something happens in this
19 U.S. So the question is, are we prepared if
20 something happens at a DoD installation or outside
21 a DoD installation because we can't train and
22 equip to do this, but we're responsible for these

1 beneficiaries. It's sort of a conundrum. We have
2 major force projection points, 26 of them, 9.1
3 million folks, almost 520 installations here and
4 more overseas and we have 175 MTFs. So we have to
5 do something that will enable us to respond to
6 these same kinds of things for our population in
7 collaboration with the civilian authorities
8 outside the gate; both the town, the county, the
9 state, the region. We need to work with those
10 folks, but in addition to that we need to work
11 with industry, the folks who build toxic chemical
12 plants and things like that. We need to work with
13 all of these folks to figure out how to deal with
14 the vulnerabilities in our nation. Next slide.
15 We know from years and years of experience that we
16 have these kinds of threats, but the scenarios in
17 the annexes that were talked about, they're not
18 well developed nor are they agreed upon at the
19 interagency, at this point, across these kinds of
20 things. We have lots and lots of experience in
21 earthquakes and fires and floods and tornadoes,
22 because they're very short-term events. They're

1 bad, but generally speaking, the civilian
2 authorities have a lot of experience and are fully
3 capable of dealing with most of the circumstances.
4 These other things are a little more difficult.
5 Next slide. From our perspective, our military
6 health system needs to be focused on who is
7 responsible for what and how we engage them to
8 help them prepare to anticipate. We also need to
9 have a much better grasp of what our DoD assets
10 are and what state they're in. With the global
11 war on terrorism, we have a very high tempo for
12 our medical community. We have peacetime demands.
13 We have wartime demands. When we have a disaster,
14 we have demands to provide for ourselves. So the
15 same resources are being asked to meet all three
16 objectives, so we need to figure out how we're
17 going to do that and get real time visibility on
18 where people are, how vaccinated they are, what
19 kinds of capabilities exist, where geographically.
20 Lastly, we need to have a better understanding of
21 how to align and to give the Joint Staff the
22 information they need to make good decisions.

1 When they borrow a capability from one place, what
2 does that do to the capability they borrowed from?
3 That is something that we simply don't have. The
4 information systems don't give us instantaneous
5 information. We need to improve on that. And, of
6 course, it all goes to HA options, but really
7 we're just the drivers to support the Joint Staff,
8 because they are the operators. Next slide.
9 You've seen this before, the way that federal
10 response works in this country. The local
11 incident commander is in charge until he runs out
12 of resources or realizes it's bigger than the
13 capacity they have. Next click. They usually
14 have agreements with local communities around
15 there. It's usually a county or a city and they
16 get surrounding counties or cities to help them.
17 When that get overwhelmed, click, they ask the
18 state emergency management folks to bring specific
19 resources they need in to help them with the
20 problem. When the state emergency's resources
21 start to run out then they go to other, click,
22 full-blown state response where the state sort of

1 collaborates with the local incident commander on
2 coordinating the response statewide to this. The
3 state then engages with resources that it has
4 identified in surrounding states to bring in to
5 help resolve those problems. When the surrounding
6 states and the state that's affected still don't
7 have the resources to do what's necessary, click,
8 they call the President and they say we need help,
9 please. We'd like you to declare a disaster
10 situation or an emergency situation so that we can
11 get FEMA to help us. FEMA is two things. It's a
12 coordinator of federal response to the incident
13 and it is also a check writer. They do both well
14 at different times and not so well at other times.
15 Click. FEMA activates the National Response Plan
16 and brings in all of the lead federal agencies to
17 coordinate the response based on the requirements
18 that come from the guy who's in charge, right
19 here. The philosophical approach here is that the
20 local person understands their city, the state has
21 all the authorities and laws that apply to the
22 circumstances and they understand the geography of

1 their city and where their people are. These
2 other support processes are supposed to fall in
3 and provide support based on their direction. But
4 just as DoD has a hard time not wanting to take
5 charge, the state has a hard time not wanting to
6 take charge and FEMA has a hard time not wanting
7 to take charge and then within the FEMA all the
8 lead federal agencies have a hard time not wanting
9 to take charge in the context of their specific
10 areas. When you have that many competing elements
11 in a disaster situation, it requires a lot of
12 cooperation, a lot of communication and a lot of
13 syncing of egos and getting to the task of what
14 needs to be done, because it's lives, it's
15 infrastructure, it's economy that's being affected
16 here. Small events, usually not a problem. Big
17 events, well, we've read about it recently. Next
18 slide. When DoD is asked to help, I talked before
19 about the legal requirements. DoD does not need
20 permission from Mr. Rumsfeld to -- an installation
21 commander can, for the first 72 hours, engage what
22 they call an immediate response. That's if the

1 Commander, he can put as many of the resources
2 that are under his disposal to provide support if
3 it meets the three things there; save lives,
4 prevent human suffering and mitigate great
5 property damage. So, he has the authority or she,
6 has the authority to send DoD resources in for
7 that first 72 hours. The first 72 hours, usually
8 communications are out, the people who are in
9 charge may be affected -- who are supposed to be
10 in charge -- may be affected by the disaster. The
11 ability to get situational awareness of what's
12 happened is the most vague those first 72 hours
13 and we saw that in the news. That's what happened
14 in Katrina and it was multiplied over 300-square
15 miles of vague situational awareness. So there
16 was more than one town, county, state involved and
17 no situational awareness. Katrina was the perfect
18 storm for consequence management coordination, if
19 you will. And you could see that when you saw in
20 those first 72 hours there was a presence of
21 military and they were there, not because FEMA
22 asked them to be there, but because the local

1 installations around the area had the authority to
2 go out and try to help for that first 72 hours.
3 Now, they have a responsibility to let their chain
4 of command know and NORTHCOM was being informed as
5 to who was doing what, when, so they understood
6 where our people were. But that's a very
7 important capacity that the Department provides.
8 Next slide. These are the key organizations I've
9 already talked about that. What I didn't talk
10 about is Northern Command is responsible for the
11 execution of DoD military support to civil
12 authorities during disasters and to mitigate
13 crisis, but TRANSCOM also has a role. TRANSCOM is
14 a combatant commander responsible for movement of
15 things and coordinating transportation around the
16 globe for logistical support and movement of
17 people and things to execute the mission.
18 TRANSCOM in the case of the U.S., is the home of
19 the GPMRC, which is --

20 GEN KELLEY: Global Patient Movement
21 Requirement Center.

22 MS. EMBREY: You got it. Basically what

1 that does is it allows us and in the federal
2 response plan or the national response plan under
3 the ESF-8s or 7s or 12s, DoD has the
4 responsibility to assume the lead for
5 transportation movement of patients. We've tried
6 to get out of that over the last few years because
7 we don't have dedicated medical aircraft anymore
8 in our infrastructure. We've agreed to do it, but
9 we are trying to transition that responsibility to
10 the Department of Transportation, because the U.S.
11 is not short of airplanes and DoD really needs the
12 ones it has to do its other missions. Joint Staff
13 is really the focal point for how we organize and
14 get from the services the resources we need and
15 really General Kelley should be up here talking,
16 not me. Now, I shouldn't forget Joint Forces
17 Command. Joint Forces Command is a force
18 provider. They provide trained, ready forces for
19 all of the combatant commanders to function in the
20 joint environment. There are multiple headquarter
21 staffs with responsibility for identifying,
22 training, equipping and moving ready resources to

1 respond to any DoD asset. That's what we do for
2 every operation, so it isn't any different for
3 Homeland Defense as it is for anything else, but
4 Joint Forces Command is growing into their
5 responsibilities as well. This is sort of a
6 unique mission for them. They used to be the
7 Atlantic Command, geographic folks and they got
8 bifurcated. NORTHCOM is a part of it and Joint
9 Forces Command continues their force provider
10 role. To complicate this, just so you know,
11 STRATCOM has just been designated the functional
12 combatant commander responsible for combating WMD,
13 counter-proliferation, counter-terrorism related
14 to weapons of mass destruction. They are going to
15 be evaluating and assimilating a large amount of
16 capacity of the Department's ability to deal with
17 weapons of mass destruction under one functional
18 sync. So we're going to need the sync for
19 STRATCOM and the sync for NORTHCOM and the sync
20 for any of the combatant commanders, will need
21 support from STRATCOM on situations when weapons
22 of mass destruction are used. It will be very

1 interesting as we move forward trying to
2 coordinate our authorities and responsibilities in
3 that arena. Next slide. This sort of talks about
4 how we do business medically. It talks really
5 about how we do business in any operation. We
6 have to know what our requirements are. We have
7 to identify the resources. We have to go to the
8 proper authority to get approval to execute that
9 and then we have to coordinate and make sure we're
10 not doing the wrong thing. In the interagency
11 effort, identifying requirements when we don't
12 have good communication on the area that's gone
13 on, it's very difficult for anybody, DoD or any
14 other federal agency to know what to bring to the
15 party that will actually help. Because if you
16 bring too much you're just putting additional
17 burden on the area to deal with the situation.
18 Understanding what your requirement is, is very
19 important. Understanding what DoD can best bring
20 to that is a part negotiation with the local
21 authorities and part what we have available and so
22 we have to negotiate that. The National Response

1 Plan clearly, you see the long list of federal
2 agencies, they all have a role and responsibility
3 and we don't do anything without coordinating with
4 them. Lastly, who makes the decisions? The old
5 adage; this has been a problem in consequence
6 management in this country for a long time. Who's
7 in charge? We have books that say who's in
8 charge, but the reality is there are natural
9 leaders in circumstances and those natural leaders
10 come to bear at all levels. Those natural leaders
11 end up making the process work, sometimes outside
12 the process, but most of the time we hope that we
13 have the right leaders in the process so the
14 process really does work. But sometimes it
15 doesn't. We know this, DoD is not a leader and
16 they're not in charge, but we do make decisions to
17 support them. Next slide. How does it break down
18 in the Department? In the OSD realm, we develop
19 policies. If there is none, we create one. If
20 there's a gap we do interim guidance, but the
21 bottom line is OSD doesn't do anything but provide
22 guidance about exceptions and update policies that

1 don't make sense. The Joint Staff is all about
2 execution and they do that in support of the
3 combatant commander with the functional
4 responsibility or the geographic responsibility.
5 The Combatant Commander actually supports that
6 execution by going out on the ground and leading
7 the plan that is developed and executed and
8 supported. Then the services are the ones that
9 provide the resources through Joint Forces Command
10 to execute the requirement. Next slide.

11 These represent discrete medical
12 capabilities of the Department in little bubbles.
13 Some are separate agencies. Some are agencies in
14 a department that acts on behalf of the
15 department. Some are embedded capabilities that
16 have been developed for the war fight. Some are
17 very small, some are very large, but these are a
18 lot of the -- it's an alphabet soup. This gets
19 back to the need for, internally, for us to have
20 better visibility of how we organize, train and
21 equip our resources to do these kinds of things
22 and how they're allocated over time to meet all of

1 our requirements, not just for a specific
2 incident. I can't even tell you what some of
3 those acronyms mean. Some of them I can, but if
4 you have any questions about it, I'll get all the
5 answers later. Next slide.

6 It's our job to make sure that in the
7 DoD installations worldwide we have response
8 preparedness plans in place. That the individuals
9 who are there, medically speaking, are trained and
10 have the proper credentials to operate in that
11 environment. That they have equipment that they
12 can use in an emergency and the necessary supplies
13 to address their population at risk for which they
14 have responsibility. We need both medical and
15 non-medical equipment and ask different other
16 kinds of things in order to be effective in a
17 medical emergency, a public health emergency. In
18 terms of patient management, DoD has a long
19 history of having a fairly good process for
20 triaging and accessing patients and making
21 decisions, that's part of what we do. At the
22 civilian level, I'm not sure it's the same in

1 disaster situations, so we need to, and we have
2 been engaged at the interagency in trying to come
3 up with a more common way to address these kinds
4 of issues in emergencies, a standard way. But
5 because, again, medical practice is one of
6 judgment and not of standardization it becomes
7 difficult to do. Next slide.

8 Medical intelligence and Alerting
9 Systems. You've heard of BioWatch, you've heard
10 -- health surveillance in this country is not
11 connected, because the states have the ability to
12 do what they want and CDC is not a regulatory
13 agency. We do not have a way to, as a nation,
14 understand these things, both in terms of
15 surveillance and medical intelligence and if we
16 truly want to get ahead of public health
17 emergencies, we need a national capacity that we
18 do not have right now and DoD needs to be a part
19 of that, because we're fairly large and we have a
20 good footprint. But these are the things that we
21 absolutely need to have in place in order to do
22 our job and to be able to understand what's coming

1 down the pike for us or to evaluate what the
2 health effects are of natural disaster such as
3 Katrina. Next slide.

4 Another important part of the Homeland
5 Security program is called the Critical
6 Infrastructure Protection Program. It was
7 designed to identify capacity; Industrial
8 production capacity or capability that if it was
9 destroyed, for whatever reason, by an enemy, by
10 nature or by a terrorist, if we lost it we
11 couldn't function. So we need to plan to ensure
12 that that infrastructure is well protected and
13 that if it is damaged, we have backup plans to
14 make sure that we can still function. Our office
15 is the functional proponent for the health sector
16 and some of our critical infrastructure is not
17 owned and operated by us, it's contracted. As a
18 nation, we still do not have a corporate way to
19 look at our health infrastructure to find out, in
20 terms of our ability to support our populations,
21 what are we doing to protect this and what are our
22 backup plans for getting these things done?

1 That's one of the other policy things that we're
2 working on and I'm working on at the interagency
3 level. But it's important, especially logistical
4 control and distribution systems. When they break
5 things don't work. Next slide.

6 Mortuary Support. Clearly a very
7 important function. Medical examiner functions
8 are very, very important. Generally they are
9 doctors of one sort or another, however, under the
10 DoD way of doing business, mortuary support is not
11 a medical function. So we do not engage in policy
12 oversight of those things, which is why it's
13 difficult to come to a conclusion on how we deal
14 with contaminated remains or how we dispose of
15 them because it's an interesting mix of capacity,
16 personnel policy and medical knowledge. We get
17 involved, but we're not in charge in this arena.
18 Next slide.

19 Risk Communication. Huge. We learned
20 early that this is very, very important to make
21 sure people who are affected by whatever
22 understand what they can do themselves. What

1 threats they've been exposed to and how they can
2 help themselves. The time of the disaster is not
3 the time to develop those messages, so we are
4 actively engaged in doing that for every scenario
5 that's been defined. We also want to help
6 decision-makers understand that if it's this kind
7 of threat, these are the decisions you are likely
8 to be involved and then train decision-makers so
9 they can make good decisions with ambiguous
10 information, quickly. Of course the Media. The
11 Media's going to get what it needs and it will
12 define what it wants so I'm not sure that any
13 communication that we give to the media is
14 necessarily going to be embraced, but we should
15 still try to feed the Wookie. Next slide.

16 This is an approach that I'm pushing
17 very hard because we do not have the authority to
18 resource for domestic operations. I think that in
19 order for us to be successful, DoD must at a
20 minimum, have a response force available which
21 would take care of the folks to preserve our
22 mission capacity at our installations. Over the

1 next eight years, I'm pushing to make sure that
2 those resources are available at installations, so
3 the 40 percent of its population at risk can be
4 handled locally. Why? Because the first 72 hours
5 are the ones that are most important and the
6 federal apparatus cannot get its act together,
7 even in the most effective coordination process,
8 before then, to really respond effectively to
9 human needs. For us it's about making sure that
10 we're taking care of ours. If we are prepared to
11 do that, we are prepared to do it for other people
12 too. But we will not be able to resource for that
13 ourselves and if we do it in a vacuum without
14 collaborating with folks outside the gate, if we
15 don't understand our place in society -- we have
16 so many capabilities and there's so many
17 capabilities out there, if we don't plan together,
18 exercise together and train together, we will not
19 be effective. My perspective is that we must work
20 outside the gate and define ourselves in the
21 context of the communities' preparedness, not in
22 terms of DoD's preparedness. Next slide.

1 That's the plan. That's what I'm
2 pushing. It's been difficult to make this happen
3 in policy because the Department of Homeland
4 Security has not defined how it wants to operate
5 in this country and what role the states play in
6 this in a coordinated fashion. Understanding what
7 the requirements are and what the capabilities
8 are, the capacity at every state and city, is
9 something that everyone needs to be doing, but
10 they need to be doing it community to community to
11 community, and have networks of reinforcing and
12 augmenting capability between communities. And if
13 DoD is located in a community, then they're in the
14 community so they should be able to do what they
15 have to do and support, not only themselves, but
16 the community. Next slide.

17 That sort of flies against the face of
18 everybody's turf. So we have to make sure that
19 when we plan with a community that we can back up
20 what we say and that requires a lot of
21 coordination up our chains of command. And it
22 requires local communities to be willing to share

1 information about what is important and what those
2 vulnerabilities are. Ultimately one community can
3 work with another community to help improve
4 overall response to a community in a region. If
5 we take a regional response and connect all the
6 communities' capacities together, we should strive
7 as a nation, to have the ability to support 50 to
8 60 percent of the population at risk, regionally,
9 because they are closer than assets in Washington.
10 NORTHCOM is working through regional concept. HHS
11 is working through a regional concept, but there
12 is still no national mandate to collaborate,
13 communicate, work out who's in charge first as a
14 part of the plan. That's the part that needs to
15 be done for a region. Next slide.

16 This talks a little bit about the scale
17 of response in Homeland Defense, talks about how
18 DoD engages in these areas. We have certain
19 skills and talents, specific units with unique
20 capabilities that we built for the same kinds of
21 mission worldwide, and now we do so for special
22 events. We support the FBI on counter-narcotics.

1 We do a lot of humanitarian assistance. The
2 tsunami was an example. It's from small scale to
3 large scale and we try to do that in the context
4 of also doing our military mission and we just
5 want to make sure that when we do that, we do that
6 in a coherent way. Next slide.

7 NDMS stands for the National Disaster
8 Medical System. It is an invention of the
9 Department of Defense and HHS and VA and FEMA. It
10 used to serve two purposes; to take private
11 hospitals around the country, engage them in an
12 MOU that basically says, in the disaster you'd be
13 willing to take patients that are casualties of a
14 disaster. It's two-pronged. There are two
15 elements of it. One part of it allows FEMA and
16 HHS to activate the NDMS system to understand how
17 many beds are available of what type so we know
18 how to move patients to those beds. Get the right
19 person with the right need in the right place and
20 that, for natural disasters FEMA and the
21 Department of Homeland Security engages in
22 activating that system for receiving patients who

1 are affected by NDMS. DoD's hospitals are part of
2 the NDMS system, so we may end up having some
3 casualties brought to us. As long as we're
4 reimbursed by FEMA, we're happy to that. On the
5 other hand, DoD has the authority to activate NDMS
6 to use civilian hospitals that are part of it to
7 receive military casualties from OCONUS. This is
8 if our capacity, our military treatment facilities
9 capacity, exceed the casualties that are flowing
10 in from overseas, war-fighting casualties, that
11 those institutions can accept our casualties. The
12 VA is our first place that we would go, when we
13 are exceeded, the VA would be the next place we
14 would go and then if they became exceeded or they
15 didn't have the capacity at the time we needed
16 them the we'd go to the civilian hospital
17 structure of the NDMS. It's an ingenious idea,
18 but it generally has not been exercised on a very
19 large scale until Katrina and I think that we
20 have, I think here from the public health service,
21 a person who was responsible for one of the
22 medical shelters that was set up. I'm not sure it

1 was part of the NDMS, so you might want to comment
2 on that when you have the chance. The NDMS,
3 generally speaking, is a onesie -- twosie person
4 placement to the right place, right time and a
5 system to support that, not for mass casualty
6 kinds of situations where you high patient flow.
7 We're looking to evaluate ways to improve this
8 system, but right now it works. They have small
9 specialty teams also that they pull from the
10 public health service and the Department of
11 Defense specialists who, mortuary affairs or
12 hazardous materials or search and rescue or
13 different other kinds of things. Those capacities
14 are also part of the NDMS and they're a
15 specialized team that go in, do their thing, and
16 then come out. Good for a short-term disaster,
17 not good for a long-term disaster. Next slide.

18 This is the governing structure for the
19 NDMS. I'm not sure why secure communications is
20 on there but, nonetheless, this is how we are
21 collaborating. I think that in the future we'll
22 be rearranging what the NDMS does and make it

1 different. We will have a lot of lessons learned
2 from Katrina to help us understand how we need to
3 structure this differently. Next slide.

4 Quickly, I'm sorry I'm taking so long.
5 Avian influenza, it's a real threat. Dr.
6 Winkenwerder has been leaning quite forward and
7 making sure that since we have a significant
8 population in the Pacific Rim area, which is where
9 we think is the hotbed of Avian influenza
10 cocktails, that we are very concerned about this.
11 We are engaged in significant planning and I think
12 you'll probably be getting other briefs today. Is
13 that correct? Okay. So I won't go into detail on
14 it. We are actively engaging with the federal
15 interagency USAID and HHS and CDC to make sure
16 that what we do is in concert with what their
17 doing and that we're prepared to deal with this
18 pandemic if it occurs. Next slide.

19 Basically, what our role is, again, this
20 is another medical response effort, but it's
21 different than a disaster. This is a disaster in
22 the making and we're trying to plan for it.

1 Essentially we are going to work on enhancing our
2 ability to support both domestic and international
3 efforts to minimize the risk of this actually
4 occurring and you can see what we're doing here.

5 Next slide.

6 Countermeasures. We do have antiviral
7 stockpiles in PACOM, CENTCOM and CONUS, at least
8 we've ordered the materials. They haven't
9 actually materialized yet, but they should be here
10 soon. November, I believe is the first launch.
11 Influenza vaccine is actively being developed by
12 NIH and assuming we have those, we have a request
13 in for five million of those and you'll hear about
14 that later. Surveillance, big deal. That's
15 what's going to help us see what's going on. We
16 are engaging in a significant restructuring of our
17 surveillance capabilities. We're not doing
18 anything with the capability itself, but we're
19 tying the capabilities together and we're making
20 sure that we are collecting samples in the same
21 way. We're using the same kinds of analytical
22 constructs to help us communicate because we have

1 a unique advantage of having a global footprint,
2 we ought to improve that by being connected
3 globally so we can see this as a corporate entity
4 rather than individual stove pipes of labs and
5 surveillance centers. We're working on that and
6 we're also looking at working with the interagency
7 to improve medical intelligence gathering with the
8 Department of Homeland Security and I think
9 Colonel Rizzo could probably fill you in on some
10 of those things later. Next slide.

11 Laboratory capacity and capability. We
12 have requested and received authorization to
13 expand the capacity of our labs and to improve and
14 accelerate, both in terms of equipment and
15 tech-qualified individuals to access information
16 about where the influenza is occurring. We're
17 doing that in collaboration with USAID, the State
18 Department, through the embassies and also through
19 the World Health Organization, getting our foot in
20 the door wherever we can and PACOM has an
21 extensive plan on how they're going to accomplish
22 that on our behalf. You can see the response

1 capacity that we're trying to build, trying to get
2 our EPI teams out there. We have had a plan in
3 place since September of last year, a guideline on
4 how people should be planning for this. I guess,
5 General Kelley, I know PACOM has one, I think the
6 other COCOMS have been provided that plan as a
7 template for them to move from there to get their
8 own plans in place, but this is really important
9 to us and we're taking a lot of actions now. Next
10 slide.

11 Thank you for the opportunity to talk
12 about this. I'm sure the whole rest of the next
13 day, today and tomorrow will probably either
14 augment, reinforce or contradict what I've just
15 said. I appreciate the opportunity.

16 DR. POLAND: Thank you, Ms. Embrey.
17 This was meant as background information. We're
18 going to have a variety of talks that will
19 reinforce some of this and probably answer some of
20 the questions you may have. So for that reason,
21 let me confine the discussion to just a few
22 questions or comments that Board members might

1 have.

2 DR. OXMAN: During that first 72 hours,
3 if it's very clear that it's going to exceed the
4 local capacity, is it legal and possible to call
5 on much broader help than the military?

6 MS. EMBREY: Anything's possible. In
7 fact that's what happened. But the reality is, is
8 that the governor of the state, under the rules,
9 because the state has the legal responsibility for
10 health and safety in that state and they control
11 what goes in and out of that in a public health
12 emergency, DoD does not have the authority to
13 bring in folks and just start responding without
14 the blessing of that state. Therein lies the
15 problem, which is why I think this community-based
16 thing is the way to go. But we'll see.

17 DR. LEDNAR: Ms. Embrey, in all this
18 learning that we're having, especially at sort of
19 the local response level, but thinking back
20 through the last several years, there's been
21 really quite a critique of our nation's public
22 health system that's really eroding capabilities.

1 Are you sensing that this is a turning point to
2 really start strengthening, again, our local
3 public health?

4 MS. EMBREY: What I would say right now
5 is the media is not identifying this as a failure
6 of the public health system. They're identifying
7 it as a failure of the federal government, which
8 is the wrong target. But I think as we learn and
9 as things come out and as we examine how things
10 came down, we will see that -- and I don't think
11 that the States are evil, I think they had
12 competing requirements. They had immediate
13 demands for public health that were addressing the
14 normal things and I don't think they had the
15 resources to shore up the public health systems to
16 deal with emergencies. Part of it is an awareness
17 that you can't ignore this problem and that
18 hopefully will be one of the huge outcomes of this
19 Katrina event. As long as the States own that
20 responsibility and their legislatures don't give
21 them the authority and the resources to do what
22 they have to do, it becomes extraordinarily

1 difficult for the federal government to assist
2 without being requested. And assisting is not a
3 granting function, in my opinion, it's a true
4 planning and framework and architecture function
5 and that I'm not sure we have the authority to
6 work out yet. I think that will be another one of
7 the outcomes of this. I agree it needs to be
8 strengthened but I don't know that -- everything
9 I'm reading says, it's the federal government's
10 fault that we didn't do a good job and I think
11 that's wrong.

12 DR. HALPERIN: I just have to say I'm in
13 awe of the complexity of it all and also your
14 ability to function in this complexity and
15 succeed. So that's congratulations. I do want to
16 clarify something. You were also quite clear that
17 DoD is not going to be doing sort of war college
18 like preparation for natural disasters on U.S.
19 soil. You were clear on that. So then the
20 question is, does DHS do that kind of war college
21 preparation? Does HHS do that? Who does that
22 kind of preparation? Is it on the horizon or is

1 it just so complex that it's never going to
2 happen?

3 MS. EMBREY: The answer to that is, DoD
4 participates at several interagency forums and
5 initiatives to develop courses that will help in
6 terms of triage in disasters or mass casualty care
7 environment. There is an annex that was developed
8 for catastrophic incidents in specifically dealing
9 with mass care under those circumstances, but all
10 it did was pin the rose on who's in charge. It
11 did not address how to do it, how to train for it,
12 how to exercise for it. The White House, as early
13 as two years ago, identified an initiative to
14 improve training programs for the civilians to
15 increase capacity in the nation. There are
16 agencies of HHS, it's the one co-located with NIH,
17 the quality programs there. NHRQ? ARQ. They
18 have been pushing this initiative. They've been
19 trying to say, this is important, this is
20 important, this is important and the White House
21 is trying now to engage, how do you do that in an
22 environment where there are so many colleges and

1 universities who are developing capacity and
2 capability independent of themselves? Since we
3 don't have a single medical governing authority in
4 this country, per se, we have a very difficult
5 time getting collaboration and cooperation. The
6 American Medical Association, JCHACO, we've worked
7 with them about what the outcome should be, but we
8 don't have the standards, the things in place yet.
9 So we've identified the problem but we haven't
10 solved it.

11 DR. POLAND: Maybe just two short
12 comments so we can get back on our schedule.

13 COL BERRY: All right. I'll try and be
14 short. That was a very striking set of comments
15 that you had about the difficulty in responding to
16 domestic disasters by the Department of Defense or
17 by the federal government and the local
18 governments in general. I was thinking as you
19 were speaking about a similar story that occurred
20 internationally with the tsunami response where,
21 as I understand it, Department of Defense was
22 credited nationally and internationally as doing

1 just a stupendous job in responding to a similar
2 situation, getting there with supplies, logistics,
3 bringing fresh water, emergency hospital care in a
4 very rapid ability. So the implication seems to
5 be that we're facing a sort of domestic management
6 problem. We just aren't good at -- we can manage
7 this well internationally, but not well nationally
8 for some reason. I think that your comments about
9 a community-based planning for thinking about that
10 first 72 hours, how to have something in place for
11 that first 72 hours, where communities might be
12 functioning pretty much on their own. I think that
13 sounds like a good idea and I think that's very
14 consistent with Department of Veterans Affairs
15 thinking about what we expect from our facilities.
16 You know we have facilities, hospitals located in
17 communities and that's kind of our own experience.
18 I guess my question is, in terms of that type of
19 planning where you involve the community, you're
20 involving multiple branches of the executive --
21 multiple agencies within the executive branch,
22 where do you think is the right -- what is the

1 right forum for that to take place? How exactly
2 would you recommend proceeding with that kind of
3 planning?

4 MS. EMBREY: The Department of Homeland
5 Security has responsibility for developing a
6 national response plan. It used to be called a
7 federal response plan because it was to coordinate
8 the federal activities. Now it's called national
9 and the reason for that was to address our
10 national capacity to respond. The Department of
11 Homeland Security has had a lot of challenges
12 trying to take 22 different agencies and
13 assimilate a culture and learning platform. They
14 have been focused on keeping terrorists from doing
15 bad things to the country and shoring up our
16 ability to understand that. I think when they are
17 more mature, I hope when they are more mature,
18 that they will be the ones that will facilitate
19 that forum, that will create the framework of
20 response where it's not just federal, it's a
21 national evolution of capacity and capability and
22 it will be in those functions, but it won't

1 necessarily be HHS is responsible or anybody else.
2 It will be that capacity of our nation, whoever
3 owns that, whether it's a state or local, those
4 individuals are part of a community that is
5 responsible to itself to be excellent. Until we
6 come up with that framework, we are always going
7 to have this kind of problem and it will be left
8 to natural leaders to end up saving the day. And
9 some natural leaders are in the Department of
10 Defense and some natural leaders are in other
11 parts. I think that's the reality, in my opinion.

12 DR. POLAND: Mike. Final comment.

13 DR. MALMUD: Thanks, Ms. Embrey. That
14 was great. It strikes me that there's two phases.
15 One is, how do we accelerate initiating requests
16 so that the people who are authorized to
17 constitutionally initiate the request know how to
18 do it, they do it fast and they do it right. And
19 there's actually a model that I think we used for
20 senators and congressmen. When a new congressmen
21 comes into office, they ship him off to this
22 wonderful thing called the Kennedy School of

1 Government for a three-week orientation course on
2 how to be a representative. I'm not sure it's any
3 good. But imagine if the NGA for all new
4 governors and their key staff, sent them off to
5 the federal disaster preparedness institute, which
6 is sponsored by Hopkins or Harvard, you could do
7 it as a pork barrel so somebody gets the credit,
8 but it trains all their key staff to say, "Here's
9 how it works," so that you don't get this tension
10 thing. It seems like a nice model, it's something
11 that everybody could buy into in terms of funding
12 but yet stand back so that people knew how to pull
13 the trigger when they had to.

14 I think part of the knowledge is, you
15 know, take the state of Virginia. You've got a
16 mandated four-year term and then they're gone. So
17 every four years you're losing expertise on how to
18 initiate response. Then the second piece, of
19 course, is how do you coordinate it. But our job
20 in coordination can only be done if the response
21 is initiated and that to me, as I look back on it,
22 was probably the biggest problem, it never got

1 initiated in the first place.

2 MS. EMBREY: I don't think it was -- I
3 think there's a couple of reasons, there's a lot
4 of reasons for it and until we get the lessons
5 learned we really aren't going to know the real
6 things. First of all, when you have a disaster
7 the size we had, the people who had the
8 responsibility to make the request had no
9 information coming to them except what they saw on
10 the news. They knew, gosh, it's beyond my
11 capacity and they probably said we need to do
12 something. I'm not sure that they don't
13 understand the system. I do think that we don't
14 have a framework for the system to mandatorily
15 work itself. Planning has to be together in a
16 place and that isn't required. It isn't required
17 because everybody has their own responsibility and
18 authority. That's a good idea but somebody needs
19 to establish the framework that gets trained.

20 DR. POLAND: Thank you, Ms. Embrey. We
21 will take a somewhat truncated break. Ten
22 minutes. We'll recess just for ten minutes and

1 start again.

2 (Recess in proceedings.)

3 DR. POLAND: Ten minutes is up. Let's
4 reconvene. Can I ask the Board members to
5 reconvene? Also, very important is if you do not
6 pay for your lunch now, you will not be able to
7 get lunch. So if you have not yet paid for lunch
8 you need to do so now. Although I would sell mine
9 for twice the price.

10 COL GIBSON: One quick check. I need
11 those folks who plan on going to that retreat
12 ceremony tomorrow, raise your hands again. We
13 need to actually see who you are.

14 DR. POLAND: Our next speaker is
15 Lieutenant Commander Brian Tolbert from the Joint
16 Staff, who will be presenting on the DoD Response
17 Plan Development Process. He couldn't be here in
18 person because of Joint Staff duties associated
19 with the response to Hurricane Katrina, but I
20 believe we do have him on telecon, is that right?
21 We are in Tab 3. It was not in the tab and so you
22 were given a handout that looks like this. We

1 have Lieutenant Commander Tolbert? Okay. Go
2 ahead. Proceed.

3 LCDR TOLBERT: Good morning, ladies and
4 gentlemen. My name is Lieutenant Commander
5 Tolbert and I've been asked to discuss the
6 planning process with you today. I'm very pleased
7 to have had the opportunity and thank you for the
8 invitation and I do apologize that my duty
9 schedule would not allow me to be there with you
10 today and I certainly hope you understand. Next
11 slide, please.

12 This will be our agenda. I'll briefly
13 discuss the overarching planning guidance, the
14 deliberate and crisis action planning process and
15 then discuss the Annex Q, which is the medical
16 portion of the planning process. Next slide,
17 please.

18 This slide depicts the strategic
19 guidance with the National Security Strategy
20 developed by the President and his principal
21 staff. Being at the top, the NSS, I'm sorry, the
22 National Security Strategy is the driver of two

1 parallel and near simultaneous planning events.
2 On the left side, in the blue circle, the National
3 Defense Strategy is the Secretary of Defense's
4 interpretation of the National Security Strategy.
5 From the National Defense Strategy, two additional
6 documents are generated. The Strategic Planning
7 Guidance and the Joint Planning Guidance. These
8 two documents direct the major movements and
9 relocation of assets of within the DoD and provide
10 programming guidance to the Services for their
11 future procurement processes. On the right side,
12 in the green circle, the National Military
13 Strategy is the Chairman's interpretation of the
14 National Security Strategy and frames the process
15 in military terms. The Chairman's planning
16 guidance provides the overarching direction to the
17 COCOMS, combatant commanders, and aids in
18 development of the joint strategic capabilities
19 plan, the JSCP. The JSCP is the driving document
20 for the COCOMS planning process and provides very
21 specific direction on what plans must be
22 developed. The products coming from the blue

1 circle provide capability packages and resources
2 to the COCOMS. The products coming from the green
3 circle, the joint strategic capabilities plan,
4 provide direct guidance to the COCOMS, combatant
5 commanders, on the plans that they are directed to
6 develop. Next slide, please.

7 As I've said, the joint strategic
8 capabilities plan identifies which COCOMS will be
9 responsible for having particular plans. It also
10 identifies what force will be used in support,
11 assigns tasking and provides direct guidance,
12 assigns lift, et cetera. And by, "lift," I mean
13 the movement vehicles, aircraft, sea lift, et
14 cetera, et cetera. This is the initiating
15 planning document which directs the actions that
16 we will discuss throughout the remainder of this
17 presentation. I've given some examples on there
18 about apportionment of forces, et cetera. For
19 example, Army brigades or larger equivalents, Air
20 Force squadrons, Navy Carrier Battle Groups,
21 Surface Action Groups or Marine Corps MAGTFs,
22 Marine Air Ground Task Forces. Next slide,

1 please.

2 Additional planning guidance is within
3 the joint operation planning and execution system,
4 commonly referred to as JOPEs. The JOPEs is a
5 series of documents which directs the manner in
6 which a plan is technically developed. It
7 provides the format on how the plans are to be
8 developed, what sections must be within the plan,
9 for example, a medical annex Q must be in a plan
10 and the information that is resident within each
11 section. It also is a family of computer-based
12 planning tools which aids in the development of
13 time-phased force deployment data. The actual
14 movement schedules which forces deploy and are
15 employed. It allows you to alter those scheduled
16 movements and identifies resources and provides
17 visibility of deploying assets to those personnel
18 who need to look at it. For example, as the Joint
19 Staff can work within the TPFDD to see what forces
20 are deploying and monitor their status. Next
21 slide, please.

22 All of that guidance being said,

1 planning is a process that's somewhat complicated
2 and a mix of forces, documents and logistics
3 movements. However, without conducting, it would
4 be much more difficult to manage any undertaking,
5 certainly as large as most of the ones the DoD is
6 involved with. Additionally, as no plan survives
7 first contact with the enemy, if the plan is not
8 known, it is very difficult to adapt to the fluid
9 situation that is presented. What I'm trying to
10 say is if you don't have a plan to adapt or alter
11 it in any way in order to meet the situation, as
12 it changes, is very difficult and almost can't be
13 done. Next slide, please.

14 I find it very difficult here. I'm not
15 sure if there are any questions or the like, so
16 please somebody just stop me if there are.

17 DR. POLAND: What we'll do is have you
18 go through your entire presentation and then we'll
19 have Q and A afterward.

20 LCDR TOLBERT: Very well, Sir.

21 DR. POLAND: And we need to do this
22 within a half-hour time period.

1 LCDR TOLBERT: Moving right along. The
2 next slide should be of planning. There are two
3 types of plans. Deliberate and Crisis Action.
4 Although the timelines for the deliberate process
5 is much longer than the crisis, the processes are
6 very similar and we will discuss them later in the
7 presentation. There are additionally three
8 formats that each of the plans can follow. They
9 can be Operation Plans or OPLANS, Concept Plans or
10 CONPLANS and Functional Plans. These formats
11 differ quite significantly in items that are or
12 are not required in the completed product.
13 However, the variation is primarily in the level
14 of detail that is required and whether or not the
15 plan was directed from the Joint Strategic
16 Capabilities Plan. There are two primary
17 deliverables for the planning process. They are a
18 written formal plan and the Time-phased Force
19 Deployment Data or TPFDD. The written plan is the
20 direction on how the event is going to be
21 conducted, how it's going to unfold, what's going
22 to happen when the forces are conducting the

1 operation. The TPFDD, Timed Phased Force
2 Deployment Data, is the deployment document and
3 how the deploying forces are going to move forward
4 and consolidate in theater. Next slide, please.

5 This slide depicts a variation of the
6 three formats that were previously identified and
7 provides some examples of the types of events that
8 would be planned for. For example, under the
9 OPLAN on the far left is compelling national
10 interest. Things that have specific threats to
11 the United States or its friends and allies.
12 Large-scale operations and certainly events where
13 very detailed planning is required. In the middle
14 section under the CONPLAN, Concept Plan, with or
15 without a TPFDD, these are events that would be
16 deemed critical to national security, but not
17 likely in the near term. On the far right under
18 the functional plans would be things such -- would
19 potentially be peacetime events or non-hostile
20 environment. For example, disaster relief, such
21 as Katrina, could be a functional plan that
22 NORTHCOM may develop. Humanitarian assistance,

1 peace-keeping operations, counter-drug operations
2 or something like a NEO and Non-combatant
3 Evacuation Operation. Next slide, please. This
4 slide compares the two planning processes.
5 Deliberate on the top and Crisis Action on the
6 bottom. The primary take-away is that there is a
7 process governing both and although the triggering
8 mechanisms are different within each, the end
9 products will be very similar and provide a
10 written plan as well as a TPFDD in most instances.
11 Next slide, please.

12 I think this slide sums it up pretty
13 well. At best, deliberate planning is educated,
14 organized guesswork for success is defined as
15 achieving an estimate that is reasonable. It's an
16 art, it's a skill and the more you use it, the
17 better we get at it. Next slide, please.

18 This is the deliberate planning phases.
19 Phase I: Initiation. In Phase I, the COCOM,
20 combatant commander will derive their tasks from
21 the joint strategic capabilities to plan and
22 determine, based on the JSCP allocation, what

1 forces they have available to conduct their
2 planning. The outcome is that the combatant
3 commander, there identified as CC, takes task from
4 the JSCP and determines their forces that they
5 have. Next slide, please.

6 Phase II in Concept Development. The
7 combatant commander will develop their mission
8 statement and their commander's intent. They will
9 then develop courses of action, usually several,
10 as well as their estimate on success based on the
11 time to accomplish the mission. The end status is
12 their submission to the Joint Staff of their
13 concept of operations for review and ultimate
14 approval. Next slide, please.

15 In Phase III of plan development, the
16 force listing will be developed. These are the
17 forces that the combatant commander feels that are
18 going to be necessary to utilize in conducting the
19 plan. Additionally, support planning will be
20 conducted with the additional commodities such as
21 transportation, fuel, medical, et cetera, that are
22 affected within the plan and that are going to be

1 vital to its success. Additionally, the nuclear,
2 biological, chemical threat will be analyzed and
3 planned for. Not only for the type of posture,
4 but how the forces will be arrayed, what types of
5 medical assets are going to be necessary to
6 respond, should an NBC-type event take place.
7 Additionally, any shortfalls that are not
8 apportioned within the plan will be identified so
9 that they can be brought forward to the Joint
10 Staff and adjudicated. And lastly, there will be
11 TPFDD refinement where detailed movement planning
12 will be conducted and an executable movement plan
13 will be developed. The in-state will be for a
14 written plan for final review, that is
15 transportation feasible, be submitted to the Joint
16 Staff for final review. Next slide, please.

17 The next slide is just a very simple
18 depiction of what a TPFDD is. The supported
19 combatant commander determines the required
20 delivery date, noted on the right side of the
21 slide by the abbreviation, RDD. To the left of
22 that is the phrase, LAD, that's the latest arrival

1 date that something can arrive in theater in order
2 to meet his requirement. And further to the left
3 is the EAD or the earliest arrival date, which
4 identifies the earliest date that something can
5 arrive in theater. The planners, at the service
6 end or at the component levels, will then take
7 that earliest arrival date and further backward
8 plan from that on when things have to be prepared
9 at their origin to get to theater to meet the RDD
10 of the combatant commander. Next slide, please.

11 This slide is -- I tried to make it in
12 very plain language, the combatant commander of
13 the theater makes the decision on when his assets
14 are required. He calculates the earliest dates
15 that will get the asset to their point of
16 debarkation, APODs or SPODs. Once the combatant
17 commander sets his requirement and then everyone
18 supporting the plan determines the day that they
19 need to get their forces prepared for embarkation.
20 Additionally where the asset is coming from;
21 they'll have to determine is it going to come by
22 plane or ship or possibly even surface, other

1 surface transportation, depending on where it's
2 coming from. Next slide, please.

3 And the final slide on time-phased force
4 deployment data is the one that takes the asset
5 from origin all the way to the theater to meet the
6 combatant commander's required delivery date or
7 COCOMS' required delivery date. And this slide
8 depicts that movement of an asset over time. In
9 this scenario, the capability package is required
10 to be on station by C+15. C+15 is identified as
11 just a date in the future. In order to meet this
12 timeline it needs to be ready to load at C+6,
13 available to load at C+8, with an earliest arrival
14 date of C+10 and a latest arrival date of C+15 in
15 order to meet its required delivery date. For
16 those of you who have not done it or those of you
17 who may one day, developing deployment data within
18 a TPFDD is a very cumbersome, time-consuming and
19 somewhat tedious task, because there are so many
20 competing assets trying to move with a limited
21 number of lift assets available. Next slide,
22 please.

1 In Phase V of the deliberate planning
2 process is plan review. The near final phase of
3 the deliberate process is plan review and where
4 the plan is ultimately approved or disapproved.
5 If approved, the plan goes back to the COCOM and
6 then it's further pushed down to its various
7 components for preparation of their supporting
8 plans. If disapproved, the plan goes back to the
9 COCOM for additional refinement. It's important
10 to keep in mind though that once this final plan
11 is received for review, it or at least portions of
12 plan have been to the Joint Staff for review and
13 comments several times. Almost daily I will look
14 at the medical portions of a plan in order to make
15 sure that they're meeting the directed taskings
16 from the chairman and that they meet the
17 feasibility, that they are sufficient in lift
18 assets and capabilities. By keeping the Joint
19 Staff involved throughout the process, at final
20 review only critical omissions or fatal errors
21 should prevent the plan from being approved. Next
22 slide, please.

1 At the end of the deliberate planning
2 product a final product with its transportation
3 feasible is produced with service units
4 identified, sourced and scheduled for movement by
5 day in a time-phased force deployment data list.
6 Next slide, please.

7 We've seen this slide before and as I
8 said, the deliberate process is identified in the
9 blocks at the top. I'd now like to briefly
10 explain the crisis action planning process. Next
11 slide, please. Crisis action, Phase I. Crisis
12 action planning in contrast is generally begun as
13 a situation develops or begins to unfold
14 somewhere. The planning process may either be
15 started by the Joint Staff as we look at the world
16 or it could be started by the combatant commander
17 as they look at their region specifically. The
18 outcome at Phase I will be an assessment on the
19 situation to the national command level, the
20 President and the Secretary of Defense being
21 briefed by the chairman in order to identify what
22 the problem is and potentially pose some

1 Department of Defense responses. Next slide,
2 please. In Phase II, as the situation continues
3 to develop the monitoring continues through
4 reporting from the combatant commander. The Joint
5 Staff continues its assessment and continues to
6 advise leadership on proposed military options.
7 The end of Phase II is marked by the return to a
8 pre-crisis where the crisis has de-escalated or if
9 the situation does not de-escalate the leadership
10 will begin to decide on military courses of
11 action. Next slide, please. In Phase III of
12 course of action development the process is
13 directed to the affected combatant commander for
14 further refinement. And I'm going to make
15 something up. For example, if an event continued
16 to unfold on the Korean peninsula, the Pacific
17 commander, working with his subordinate commands
18 in United States forces in Korea, would continue
19 to refine and develop their courses of action.
20 They may assign responsibility to one of their
21 components and they will begin developing a TPFDD
22 and a time-phased force deployment data list, of

1 forces that may or may not be involved in the
2 fight in refining their course of action. The
3 in-state of this phase is that the course of
4 action -- the combatant commander submits his
5 course of action and estimates to the chairman for
6 review and approval. Next slide, please.

7 In Phase IV we have course of action
8 selection. The chairman will advise leadership,
9 the President and the Secretary on the course of
10 action that has come up from the combatant
11 commander on how they want to respond to the
12 crisis that's developing. They may send out a
13 planning order at this time to the combatant
14 commander in order for them to continue
15 development of their plan. The in-state of this
16 phase is that the leadership selected course of
17 action and then an alert order, an order to the
18 combatant commander to prepare their forces and be
19 ready to execute some time in the near future
20 their course of action that they've proposed. The
21 alert order is not only the plan, not only the
22 direction to the combatant commander to continue

1 to refine their plan, but also to anticipate its
2 execution. Next slide, please.

3 In Phase V, Execution Planning, as the
4 planning continues, the combatant commander
5 develops their operation orders, similar in
6 construct to the OPLAN and CONPLAN we previously
7 discussed, as well as refine their time-phased
8 force deployment data in preparing their forces
9 for deployment. The outcome of Phase V of
10 execution planning is the decision to implement
11 the operation order by the leadership. The
12 decision that the course of action is going to be
13 executed. And Phase VI is execution. In
14 execution the chairman sends out his execution
15 order by authority of the Secretary of Defense.
16 The combatant commander executes the operations
17 order, begins to flow or implement their
18 time-phased force deployment data plan and they
19 generally will begin their redeployment plan on
20 how they plan to bring those forces and resources
21 home in order to reconstitute and ultimately
22 employ them somewhere else. The outcome of the

1 execution phase is the crisis is resolved and the
2 redeployment of forces usually begins or the plan
3 for redeployment begins. Next slide, please.
4 I've quickly covered the planning process in both
5 deliberate and crisis action planning. Now I
6 would like to talk a little bit about the products
7 that are developed during those processes. This
8 slide depicts the basic plan that is developed in
9 either a CONPLAN, OPLAN or is part of an
10 operations order. All plans are very similar and
11 all plans carry the same five basic paragraphs.
12 The situation, which is a general assumption of
13 the enemy or friendly to include their centers of
14 gravity. It could be things, for example,
15 Hurricane Katrina. We don't really have an enemy,
16 but we have a natural event that is occurring.
17 And as NORTHCOM, and I believe they're going to
18 speak with you all later today, can discuss the
19 types of assumptions that they will be putting
20 into their plan for things that happen inside the
21 continental United States.

22 The next paragraph or section is the

1 mission. The third paragraph is the execution,
2 which includes the concept of operation, the
3 phases of the plan, who's going to do what, what
4 types of actions will move from one phase into
5 another, et cetera. The fourth section of the
6 basic plan is the administration and logistics.
7 It will have the basic concept of support. It
8 will generally refer you by type of logistics
9 required to different annexes of the basic plan.
10 For example general logistics are contained in
11 Annex DoD, medical is contained in Annex Q, et
12 cetera. And the final section of the basic plan
13 is the command and control section, which is
14 something of a wiring diagram with who is going to
15 be in charge and who reports to who. What reports
16 are going to be required. What is the
17 communication plan, et cetera. And I have on
18 there refer to Annex K, because Annex K carries
19 that communication plan within it, the very
20 specific communication plan within it. Next
21 slide, please. In addition to the basic plan, a
22 full OPLAN will have the following annexes. I

1 won't go through them all. Annex A to Z are
2 listed there. Organization, Intelligence,
3 Operations, Annex Q medical services, Chaplain
4 activities, Execution checklist and then a
5 distribution plan for who's going to receive the
6 plan, how many copies are going to be out there
7 available, et cetera. Although the basic plan is
8 the large-scale muscle movements and how things
9 are going to unfold, the details that support
10 those operations are very specific and embedded
11 within the annexes of the basic plan. Next slide,
12 please. This slide holds the items that are
13 embedded within the Annex Q as appendices. For
14 example, patient movement, blood, blood products,
15 blood distribution, the hospitalization plan, how
16 personnel are going to be hospitalized, how long
17 we plan to hold them at different levels of care.
18 The return to duty plan. Medical logistics, et
19 cetera. For the medical personnel the Annex Q has
20 the medical plan to support the basic plan, but
21 the very detailed granular facts of how the medics
22 are going to support the plan are embedded within

1 the particular appendices of the base annex. I
2 hope that make sense. Next slide, please. A
3 simple quote from General Hollingsworth, he's an
4 Army general, primarily USSK at the time, talked
5 about that anybody can write a plan, it's the
6 execution that's oftentimes difficult to follow.
7 Next slide, please. In summary I would like to
8 say that planning is a continuous process. It's
9 not a write a plan as the Secretary has said, it's
10 not a simple write a plan, put it on the shelf and
11 forget about it until it's time to do it. They're
12 almost living documents that need constant
13 refinement in order to improve them and make them
14 fit the situation as it's changing with
15 technology, et cetera. They almost certainly
16 require revisioned execution. I know that, as an
17 example, with the 1003 plan, which was the
18 invasion of Iraq, the plan that was available at
19 the time was somewhat dated. It was about a year
20 old and we were able to pull it off the shelf,
21 revise it significantly and ultimately execute it
22 to success. Resources are almost always going to

1 limited, particularly with lift, particularly with
2 strategic lift, large aircraft in order to move
3 things. Everyone is competing for lift to get to
4 the theater at the same time. That's why the
5 time-phased force deployment data lift is so
6 important because it's a way to de-conflict the
7 assets. I've explained to my boss at different
8 jobs that medical can't get there quick enough
9 because there's not enough lift and some of them
10 have turned to me and said, "It doesn't matter.
11 If I can't get tanks and ammunition to theater in
12 time, it doesn't matter how much medical we have
13 there." So, it's quite a delicate balancing act
14 and sometimes it requires an acceptance of risk on
15 what assets are and are not going to flow on the
16 timetable that they have. Certainly have to be
17 ready for the unexpected because the enemy always
18 gets a vote, whoever the enemy is. No matter how
19 good your plan is, once implementation begins,
20 certain things are going to happen that are beyond
21 your control and that you may not have planned
22 for. But by knowing the plan and having a plan,

1 you can certainly flex it a little bit in order to
2 adapt it to the situation. Next slide, please.

3 Ladies and gentlemen, I went through
4 that pretty quickly, but subject to your
5 questions, that concludes my presentation.

6 DR. POLAND: Thank you very much. Very
7 nice overview of a huge topic. Comments or
8 questions from the Board?

9 DR. HALPERIN: This is a complex process
10 but I wonder whether we've gone through this
11 process for the earthquake scenario, pandemic flu,
12 Chernobyl kind of thing in the U.S., a Bhopal or
13 tsunami, or is this kind of like the architecture
14 for how you do the planning? Have we actually
15 done the planning for those kind of major events?

16 LCDR TOLBERT: Yes, sir. If I
17 understand your question, actually it's a two-fold
18 question. I'll answer the second part first. On
19 the architecture, yes. What I just described to
20 you is an architecture process. How the process
21 works and how it is done. On the other side of
22 your question, for some of those events that you

1 described, to include the natural disaster
2 Hurricane Katrina, et cetera, the various
3 combatant commanders have or are working on plans
4 in order to support things that are likely to
5 occur within their area of responsibility. And I
6 can speak very specifically about NORTHCOM at this
7 point and I know that they are, I believe they're
8 coming to speak with you some time in the near
9 future. They are in the process, and
10 unfortunately their plans were not completed.
11 They are developing plans to support numerous
12 scenarios for military-to-civilian responses
13 within the continental United States. I don't
14 know that had their plan been on the shelf for
15 Hurricane Katrina, would it have been perfect?
16 Almost certainly not, but they would have had a
17 better product than what they did have, not that
18 they did not do a great job once they were called
19 upon. I've talked to, I have a very good friend
20 who's there at NORTHCOM, Commander Bill Mackie, is
21 the NORTHCOM medical planner and they've certainly
22 taken many of the lessons learned from, goods and

1 bads, from Katrina and they will be able to
2 incorporate those types of things into their
3 deliberate planning process that they're underway
4 with now. Sir, does that answer your question?

5 DR. POLAND: In fact, our next
6 presentation will be from NORTHCOM so if we could
7 hold those sorts of questions and comments those
8 may be answered. Other comment or questions? If
9 not, thank you very much for that nice
10 presentation. We'll move on.

11 LCDR TOLBERT: All right, sir. Thank
12 you very much for having me. Again, I apologize
13 that I could not have been there with you today.

14 DR. POLAND: Thank you. Our next
15 speaker is Amy Kircher of NORTHCOM. She's going
16 to present on the execution of DoD Response in
17 National Public Health Emergencies and the public
18 health issues that have arisen out of Hurricane
19 Katrina. We don't yet have copies of those
20 slides; we will get those and provide them to the
21 Board members. We have a half-hour scheduled for
22 this.

1 MS. KIRCHER: Thank you. I'm glad it's
2 in Colorado Springs you all are here, because
3 instead of TDY, this is my lunch break from
4 Hurricane Katrina. As I asked some questions
5 about the level of knowledge of NORTHCOM, I got
6 varying answers. Some of you may be very familiar
7 and some of you not so much. Very quickly, I'd
8 just like to go through a few background 101
9 NORTHCOM slides and then talk about the surgeon's
10 office, who primarily executes the public health
11 response within NORTHCOM and then pull it all back
12 together about how do we go from a request all the
13 way through NORTHCOM and forces, boots on ground.
14 Why NORTHCOM? I think this is evident to everyone
15 what the catalyst was. Slide, please.

16 Our mission is twofold. The first being
17 conduct operations to deter, prevent and defeat
18 threats and aggression aimed at the U.S.
19 territories and interests within the assigned area
20 of responsibility. I think that's similar to most
21 combatant command's mission statements. We call
22 it before the semicolon. The after the semicolon

1 part is the part that's somewhat unique to
2 NORTHCOM and PACOM as well, considering they have
3 Alaska and Hawaii in their area of responsibility.
4 As directed by the President or Secretary of
5 Defense provide military assistance to civil
6 authorities including consequence management
7 operations. We've been doing a lot of that
8 lately. Slide, please. This is not a new mission
9 as you can see here and many of the folks in this
10 room have taken this oath. Slide, please. This
11 is a look at our area of responsibility. Slide,
12 please. Who is in that area? You'll see the
13 flags representing the countries, territories,
14 island nations and European possessions. Alaska
15 is in our AOR, however, Alaskan forces and the
16 state of Hawaii remain with U.S. Pacific commands.
17 AOR, we work closely with PACOM and with their
18 surgeon's office in our planning. Slide, Please.
19 Admiral Keating is our commander for
20 NORAD and U.S. NORTHCOM. The building at the top
21 is Building 2 and I now refer to it as home.
22 You'll see underneath, these are the folks that

1 support NORTHCOM. JTF, Joint Task Force Civil
2 Support, Joint Task Force North. We have the
3 headquarters being the National Capital Region,
4 Joint Force Headquarters, NCR and then Cheyenne
5 Mountain Operation Center, CMOC. Underneath that
6 you'll see the supporting folks being NORTHAF,
7 RNORTH, MRFRNORTH and NAVNORTH, those are all one
8 person that's dual-hatted that also reports to
9 Admiral Keating and then as forces are chalked to
10 Admiral Keating, they come under that category.
11 Slide, please. Here are our partners. You can
12 imagine not living in this AOR and in CONUS, we
13 coordinate with just about everybody. This is
14 just a few of those partners. Currently we have
15 the JIACG, Joint Interagency Coordinating Group is
16 up and running and has been since Katrina started.
17 We have 50 in-house liaisons from all of these
18 agencies supporting us. We have another 20
19 liaison officers that will fall into the command
20 when something spins up. Slide, please.

21 How do we operate? Again, kind of based
22 on the semicolon in our mission, we have the

1 traditional Homeland Defense mission and then
2 Homeland Security and we are part of that national
3 effort. Slide, please.

4 When do we assist? Only when directed.
5 We provide military assistance to civil
6 authorities when requested and when directed.
7 We'll talk more about that at the end when we talk
8 about the request process. Slide.

9 Who does what and when? As we've seen,
10 and we've got a great example being Katrina, the
11 locals are the first responders. Once they're
12 overwhelmed, it goes to the state and then to the
13 federal level. Ms. Embrey did an excellent job of
14 explaining that the local level is the first to
15 respond and they need to ask for help. We found
16 that asking for help was hard. I talked to the
17 Department of Health director in Mississippi and I
18 said, "How do the hospitals look? What's going
19 on? How can we start thinking about how to
20 support you, sir?" And he said, "I don't know. I
21 don't have a phone. I don't have a computer. I
22 don't have access to anybody who's in the southern

1 part of Mississippi. I have no idea what
2 hospitals are still there." As horrible as this
3 sounds, we got reports that there was a county in
4 Mississippi where there was looting. They
5 couldn't find any local government. They didn't
6 know what to do with some of the bodies; they were
7 just bringing them to the fire station. It was
8 hard. It was hard for the locals to ask for help
9 when they had no idea. They had no assessment of
10 what was going on. Slide, please.

11 What do we bring? We bring special
12 skills. Obviously special equipment,
13 communications and information sharing. We found
14 that our ability to help with communications was
15 critical. Most places did not have and still
16 don't have cell phone coverage. If any of you
17 have tried to call into the operating area, a lot
18 of times you'll get the message, "Due to Hurricane
19 Katrina this person is unavailable to be reached."
20 What we brought in was some communication
21 packages, beefed-up broadband on installations to
22 help support those folks so that they could, FEMA

1 could co-locate on installations. We had federal
2 medical shelters on installations and helping them
3 to communicate back to their headquarters and
4 communicate across to different federal partners.
5 Slide, please. Here are just some of the examples
6 that NORTHCOM has helped in. National special
7 security events such as the State of the Union,
8 political conventions, the Ricin incident,
9 hurricane relief, obviously, wild land fire
10 fighting we do every year. Slide, please.

11 And what we don't do. Slide, please.

12 I want to talk a little bit about, since
13 the topic is really execution of that public
14 health response, the Surgeon's Office, how we're
15 set up within NORTHCOM and how NORTHCOM operates.
16 Slide, please. Our mission is similar to the
17 mission of the command in that we support mission
18 effectiveness through the spectrum of deter,
19 prevent, defeat, mitigate. The key pieces there
20 are, by anticipating health threats, planning,
21 coordinating and exercising with other federal and
22 civilian agencies to reduce vulnerabilities. We

1 advise the commander on force health protection
2 and execution of medical consequence management.
3 Slide, please. What does that boil down to?
4 These phases: We advise the commander and staff on
5 all medical issues. We anticipate, as much as
6 possible, threats of disaster, natural or
7 otherwise. We forge plans and relationships
8 before the event, as Commander Tolbert explained.
9 We're working hard on the planning process. We
10 have several plans that are in draft and being
11 finalized to include Homeland Defense, also to
12 include CBRNE events to include support to civil
13 authorities. Coordinate DoD medical response
14 during and after an event. Obviously we're busy
15 doing that. The next thing we're busy doing is
16 Hurricane Rita. As I was walking out the door, it
17 went from tropical storm to hurricane. We've
18 helicopters moving. We've got Joint Regional
19 Medical Planners supporting our defense
20 coordinating officers. We attend to the health
21 and welfare of the people of the command every day
22 and try to make the system better. Slide, please.

1 How do we fit into this? The first part
2 of the mission statement we do with planning,
3 anticipating, doing critical infrastructure
4 protection for medical. The second part we do by
5 providing SME expertise that we may have to
6 support, to coordinate, to plan and to exercise
7 with our federal partners. Slide, please.

8 This just a laundry list of some of our
9 roles and responsibilities. We've talked about
10 them a little bit. I want to pick up on the
11 second bullet, that we provide medical support in
12 the adaptive headquarters. We're a typical makeup
13 of staff. We have a personnel director, we have
14 intel, we have special staff to include the
15 surgeon's office and chaplains and the lawyers.
16 When we go into an operations mode we have an
17 adaptive headquarters where we all fall into what
18 we call "eggs" to help support the crisis or the
19 event that's happening. I'll share that with you.
20 Slide, please.

21 Specific health service support
22 functions. We have disease and environmental

1 threat assessment. Force health protection we've
2 talked about. Our medical operations cell is our
3 medical stand-up cell to support events,
4 exercises. I'll talk a little more about that.
5 Then a big piece, our Joint Regional Medical
6 Planners who've been very busy lately and I'll
7 share their work. Slide, please.

8 Like I said, we live in the United
9 States, so we coordinate with everybody and here's
10 just a laundry list. On the left-hand side you
11 can see the strategic national level and who we
12 coordinate with there. Lower left is the
13 strategic theater that we coordinate with. On the
14 right side, operational. We're talking to those
15 folks every day. I think that one of the biggest
16 pieces is this piece here, interagency. Every day
17 we're in contact with, during an event and even
18 not during an event, with HHS, with CDC, Homeland
19 Security, Veterans Affairs. We have a regional
20 medical planner assigned to us that as soon as
21 something hits they go to Health and Human
22 Services op center and that's where they sit. We

1 have a regional medical planner that goes to NDMS
2 when they decide to turn on federal coordinating
3 centers and sits with NDMS and helps to support
4 and provides that liaison. Even though that box
5 is small that is a huge piece to what we do.
6 Slide, please. This is how we look. Our command
7 surgeon is Colonel John Powell. We're in three
8 divisions. One being health service support plans
9 and ops, preventive medicine and force health
10 protection and then our joint regional medical
11 planners. Slide, please.

12 Medical Ops Cell or the MOC is a
13 combination of all those folks. As we stand up
14 for an event our ops cell stands up. Our Ops Cell
15 stood up four days prior to Hurricane Katrina
16 landfall. We started putting rears in seats for
17 all of the NORTHCOM operations cell. All the
18 medics started falling in on that on the Sunday
19 prior to landfall. We were pre-positioning
20 ourselves for what was to come. Slide, please.

21 The health service support, the planning
22 group, Commander Mackie's group. They run our

1 operations cell. The do all the theater medical
2 plans for both Homeland Defense, civil support.
3 The provide input to the national response plan,
4 NDMS, bi-national planning with our Canadian
5 friends. Slide, please.

6 The Joint Regional Medical Planners.
7 There are 12 of those folks, they're NORTHCOM
8 assets. They are located in four geographic areas
9 and I have a map to show you that. There is an
10 Army, Navy and Air Force officer in each of those
11 offices. They know, more than anybody, about
12 what's going on in those regions and can tell you
13 who the players are, what their plans look like.
14 They exercise with the people in those regions.
15 They've been very busy. As soon as something
16 happens once, a DCO goes to the site. For
17 instance, Hurricane Rita. The Defense
18 Coordinating Officer went yesterday, by noon, to
19 Tallahassee. Our joint regional medical planner,
20 or JRMP, unfortunately is their nickname, fell in
21 right behind him, was about two hours behind that
22 person. Of the 12 JRMPs that we have, I think we

1 have one at home resting right now and the other
2 11 are busy dealing with severe weather. They do
3 a lot of relationship building planners by
4 background. Slide, please.

5 This is where they're located: Fort
6 Mead, McPherson, Sam Houston and then Lewis and
7 you can see the FEMA regions that they support.
8 Slide, please.

9 The current ops, that's the force
10 protection, force health protection group, that's
11 where I fall as the epidemiologist. We also have
12 preventive medicine. A vet who's very busy and a
13 bio-environmental engineer. Just some of the
14 capabilities they bring to the table. Slide,
15 please.

16 I told you a little bit about our
17 adaptive headquarters. When we go from
18 traditional staff, we fall into adaptive
19 headquarters. In the middle of the slide is the
20 commander's executive board; that's Admiral
21 Keating's group and we all support that. There is
22 a joint operations group and that's sort of the

1 nerve center of NORTHCOM where everybody falls
2 into, all of the requests come into, all of the
3 exhorts come in and out of. That's our J-3.
4 There's a planning group, support group which is a
5 lot of the logistics piece. I told you a little
6 bit about the interagency group and then a joint
7 information synchronization group and they really
8 manage information flow in and out of the command.
9 Supporting all of this are these smaller cells
10 which make up the joint support group logistics.
11 They're dealing with water, ice, MREs, slings for
12 helicopters and that's where the MOC fits in, the
13 medical operation cell. That's where our planning
14 happens. All of the medical planning piece
15 happens to support the operations here. Slide,
16 please.

17 The roles and responsibilities. Capable
18 of doing 24/7. As I stated, we went 24/7 Sunday
19 prior to landfall for Hurricane Katrina and been
20 doing that since. Characterize disease and
21 environmental threats. We provide all the FHP
22 guidance to our components. Situational

1 awareness, we do a lot of coordination, again,
2 with other ESF-8 medical partners. Slide, please.

3 Let's talk a little bit about response.
4 Slide. Incident happens and the locals are
5 engaged. Mayor and county executives. We have an
6 incident commander and first responders. Then the
7 State gets involved with the Governor, their
8 emergency agency and a state coordinating officer
9 is designated. At the federal level, DHS and
10 often FEMA is that emergency response team. A
11 federal coordinating officer is designated.
12 Slide.

13 The state, the federal and now the
14 defense coordinating officer will become the joint
15 field office. Currently for Katrina, I believe
16 that's located in Baton Rouge. Slide.

17 Then the Department of Defense,
18 Secretary of Defense to, in this case, U.S.
19 Northern Command, to a joint task force if the
20 incident requires it and it does and I'm sure
21 you've all seen General Honore on TV and then the
22 response units. Slide.

1 Looking at it a slightly different way,
2 just looking at the build, incident happens.
3 Slide please.

4 We'll have a local response. That
5 includes, medically, first responders, public
6 health departments, emergency ops centers and any
7 DoD medical forces at the installation level that
8 can support under immediate authority. That might
9 include MTFs. It might include ambulances. It
10 might include investigation teams, preventive
11 medicine, maybe some decontamination. Slide.

12 They now are overwhelmed. Slide,
13 please.

14 The state and regionals start to
15 respond. They can respond with their WMDs, CSTs,
16 weapons of mass destruction, combat support teams.
17 Those are guard assets. Their State health
18 department. Title 10 folks, regional folks.
19 Click. They become overwhelmed. Lastly, you'll
20 see the national response. For us that means the
21 RC SMRF, which is our immediate entry force. It's
22 the CBRNE consequence management response force.

1 Some of the capabilities that are held in that are
2 some mental health teams, some deployable medical
3 assets to include the Air Force's EMEDS team that
4 can go in, labs, advisory teams. Slide, please.

5 How does this process work? How is this
6 process supposed to work? Is that correct in
7 summary? We have talked it through. It goes
8 local, state, federal. The lead federal agency
9 then initiates an action request form. That form
10 goes to the federal coordinating officer or FCO
11 for tasking and allocation of funds. The FCO
12 sends the action request form to the Defense
13 Coordinating Officer. That person is the one who
14 needs to and/or the JTF if the JTF is there, those
15 folks are the validation before the action request
16 becomes a mission assignment. The key thing to
17 know, the mission assignment puts money toward it,
18 which is very important. If the capabilities on
19 hand are inbound, the mission assignment can be
20 executed. For instance if the State says we
21 really need X, Y and Z type of medics. Perhaps we
22 already have that capability somewhere in the

1 operating area and they're not heavily tasked, we
2 can then move them to execute this MA. This has
3 happened with Katrina where there have been
4 certain areas where our mobile medical units have
5 been tasked, have been utilized and now are, I
6 don't want to say out of business, but everything,
7 the locals now have a hold of it and/or the DMATS,
8 the medical assistance team, have a hold of it.
9 Now, those assets can be retapped to go somewhere
10 else. An example is the combat support hospital
11 that was at New Orleans airport. That is now
12 being identified, they're not having a lot of
13 capacity. Not a lot of folks are coming in there
14 to the airport, but the need, if and when we
15 repopulate New Orleans is that that medical
16 capability needs to be closer. We're looking at
17 moving that combat support hospital to support the
18 convention center, which is closer to the area
19 where the re-population will happen. NORTHCOM
20 reviews the MA, sends it to JDOMS, ASD/HD for
21 validation and then the SECDEF approves or
22 disapproves that request. Upon approval, JDOMS

1 issues an exhort to NORTHCOM, JFCOM, TRANSCOM and
2 other services as applicable and then NORTHCOM
3 follows up to ensure those resources are there.
4 We make sure they get to the area, able to do
5 their function and we make sure they get home.
6 Until they're at home station, they're ours to
7 worry about. So we've got a lot of folks that
8 we're worrying about right now. Slide, please.

9 I went through that really quickly and
10 I'm sure there are questions and there may be
11 Katrina questions, which I'm happy to answer.
12 Just a couple notes how the process has been
13 different with Katrina in that. I went on shift
14 Monday and landfall was Monday. Tuesday happened.
15 I believe it was late Tuesday or Wednesday morning
16 -- the days are kind of blurring -- we started
17 getting requests very quickly. The hospitals that
18 were on generators were running out of -- the
19 generators were going down. What we were having
20 is we had evac'd a lot of folks out, but the
21 hospitals on generators were then, once the
22 generators went down, they were having some crisis

1 issues. At one point, we got a call that four
2 neonatals needed to be moved now. The civilian
3 helicopters could not move, could not put the
4 incubators in -- it didn't fit in the helicopter.
5 We were looking at potentially are there DoD
6 things, helicopters, that can move these four
7 babies. Then we go, okay. What's the process,
8 what's the paperwork? At that point we realized
9 those babies would not make it through the
10 paperwork. At that time we said, okay, can we
11 send them vocal? Who needs to get on the phone
12 and make phone calls? General Roe, Admiral
13 Keating, we started working through that process
14 and by the goodness of a civilian's heart, he flew
15 his helicopter in and moved those babies before we
16 knew about it, before we got to being able to move
17 them. Once that started, more and more of those
18 things came up. There was more and more crisis.
19 As things started going on vocal orders, to people
20 who really like paperwork, not me, that was a
21 problem. It started with Admiral Keating and
22 Secretary Rumsfeld saying, "Yes. Just start

1 moving things on vocal. Paperwork will follow."
2 Everyone below said, "Wait a minute. That's not
3 how it works. That's not the process." It took a
4 long time, longer than you would expect for things
5 to start moving and everyone to say, okay, it's
6 got to go now. We all had to, at least where I
7 sit in the ops cell, we all had to say, okay.
8 Wait a minute. Is this valid? Is there someone
9 else that can do this? Is this really a DoD need
10 right now? We had to raise the flag if we didn't
11 think it was and we did on occasion. That was one
12 thing that wasn't normal. The other thing is that
13 things got pushed from above into the states.
14 That's somewhat problematic if you're the state.
15 There was one request generated for DoD to look at
16 credentials of 1,000 volunteers to go into
17 Mississippi. To me that makes sense. Yes, we
18 should check their credentials before we send
19 medics in to help people. What the issue was,
20 though, Mississippi didn't want those volunteers.
21 That was a request being pushed by a federal
22 agency in on Mississippi. They said we don't need

1 that. We've got enough. We've got medics and we
2 can manage with the medics we've got and we're not
3 sure what we'll do with those extra 1,000 people.
4 So that mission assignment got turned off. That
5 push from above, when the state's saying we don't
6 want that, that also is problematic and is not the
7 way it flows according to the diagram. Those are
8 just a couple things that happened that aren't
9 according to normal. I think every exercise I've
10 been in, none of them have been the same and
11 certainly this disaster has not been like anything
12 we've exercised. It's always a challenge.

13 DR. POLAND: Let's ask if Board members
14 have any questions or comments for Ms. Kircher.

15 MS. EMBREY: Awesome, Amy.

16 DR. POLAND: You described, for example,
17 the neonatal situation. What do you anticipate
18 the fastest timeline in a request like that would
19 ever actually be?

20 MS. KIRCHER: With paperwork or without?

21 DR. POLAND: Maybe both.

22 MS. KIRCHER: We knew that there were

1 helicopters at Fort Polk and we knew that they
2 were big enough to probably carry those
3 incubators. Once we had the vocal and I always
4 stand in the back of the room and think, wow, am I
5 going to get fired for this or not? The 0-6 in
6 the JOC and then a two-star General Roe and then
7 Admiral Keating standing there and I said,
8 "Gentlemen, there are four neonatals that have to
9 move now or they won't survive." First question I
10 get is, "What's a neonatal?" Okay, babies. We
11 got through that and they got on the phone right
12 away. They called Joint Staff, they talked to
13 JDOMS, we had the process working. It was the
14 time to get the helicopters from Fort Polk to
15 Charity Hospital, whatever that distance was, once
16 we got the vocal to do that. Then, again, someone
17 stepped in, thankfully with helicopters.

18 DR. POLAND: Is there not at, sort of
19 the macro level, the equivalent of the good
20 Samaritan? In other words, something happens and
21 I happen to be there, I don't have to show any
22 credentials, I basically just have to aid, in fact

1 I have a duty to render aid. You've talked about,
2 or we've heard previously about this 72-hour
3 golden time period. Is there anything sort of at
4 the macro level like that? In a case like this it
5 frankly seems to be ridiculous that there would be
6 paperwork generated and a thousand phone calls and
7 favors pulled.

8 MS. KIRCHER: Sir, I see you raising
9 your hand, do you want to answer?

10 GEN KELLEY: There is and in -- response
11 is really for local area. What is local area?
12 How big a circle do you go? Most of the time
13 those areas have mutual agencies, so you know
14 who's there and you know what's available. This
15 type of situation is a phone call and here's to
16 follow verbal orders, go and do it and we publish,
17 the Secretary of Defense and the Chairman of the
18 Joint Chiefs, published and said, you are
19 authorized to respond on verbal orders. Then it
20 just became a matter of somebody (inaudible)
21 insistence you had the order to do that. There
22 were lots of people -- actually the air boss who

1 was doing all the helicopters, did a very good job
2 coordinating when they knew things were happening
3 getting the right (inaudible) we don't want to use
4 DoD helicopters or we do, it's where's the closest
5 one that can do it? Let's respond with that one.

6 MS. EMBREY: I think the fundamental
7 question is do we have a process that allows us
8 not to have a whole lot of good Samaritans to
9 suddenly show up to respond to a requirement
10 without some kind of coordination. The reality is
11 that's what that field office exists for is to
12 coordinate the response to the requirements so
13 that you do not unduly over respond to the
14 requirements. The problem with that office and
15 with any other disaster in past, present and for
16 the future, is nobody has perfect knowledge of the
17 requirement. It's like pop-ups of this is a
18 crisis, this is a crisis and everybody wants to
19 get there quickly so everybody reacts. When
20 everyone reacts, you get too much and you don't
21 have the ability to support the people who are
22 doing it.

1 DR. POLAND: Certainly could become part
2 of the problem.

3 MS. KIRCHER: The other thing is that as
4 soon as this all happened the other cell that we
5 set up is our threat working group. This has
6 happened, now is this a prime time for something
7 else to hit? Maybe a manmade event. How do we
8 not put so much in that we can't support something
9 in Seattle? What if something happens there?
10 What if something happens in New York? How do we
11 continually think, we're supporting this, but we
12 also have to think Homeland Defense and think
13 threats. What else might we have to support?

14 MR. RIZZO: Tony Rizzo, Armed Forces
15 Medical Intelligence Center. I'm aware that
16 NORTHCOM in the past had plans and exercised for
17 this sort of event and the plan usually involved
18 moving patients out of the area as opposed to
19 moving large medical assets in. It seems in this
20 case, it at least appears that there was a push
21 from above to move a lot of assets in while
22 simultaneously patients were being moved out and

1 consequently, it at least appears from this
2 perspective, that perhaps those assets moved in
3 were unnecessary and maybe contrary to NORTHCOM's
4 plan. Can you discuss that?

5 MS. KIRCHER: Sure. You're correct in
6 saying that we did do both. We did move assets in
7 and we did move patients out. The assets that we
8 moved in of course are mobile assets. So they
9 have, I don't want to say minimal capability, but
10 they don't have the capability of a large
11 hospital. The most critical patients we moved out
12 or the people that had to move before our mobile
13 units could get in, we moved out. We did that
14 NDMS and through the federal coordinating centers.
15 We did have a lot of DoD medics in the area and
16 what we've learned is that folks maybe didn't know
17 about them right away or couldn't get to them.
18 The airport became a busy place. So we have
19 medics there that were busy. The ships, however,
20 we had a lot of medical staff on a float on our
21 ships, but what the problem was is we couldn't get
22 a lot of the folks to the ship and so they were

1 not as heavily utilized as we hope they would have
2 been. Yes, ma'am.

3 MS. CLARK: Also from AFMIC. I just had
4 a quick question about the threshold or the
5 specificity of the orders that the JDOMS issue and
6 it would seem like for something like a neonatal
7 evacuation that perhaps at some point they could
8 issue a less specific order, somewhat akin to a
9 task order contract where then NORTHCOM could say
10 when the requests come in, yes, they fall under
11 this particular task so we can go ahead and do
12 them without -- until you gave this presentation
13 with -- when Ms. Embrey was giving her
14 presentation, I was envisioning these orders to be
15 more global-type orders of yes, you have
16 permission to help within these certain arenas.
17 It actually sounds like these requests and orders
18 have to issued every time there's a specific
19 request?

20 MS. KIRCHER: There's a couple things on
21 that. There's the, as General Kelley said, the
22 immediate authority to do that. Then we got the

1 authority from Joint Staff to do the vocal, which
2 meant, if we thought it was appropriate, "we,"
3 NORTHCOM, we went ahead and said go, we'll have
4 paperwork follow. The other thing that's happened
5 with Katrina that doesn't always happen often is
6 that there have been sort of these blanket mission
7 assignments. I'll never forget this one, mission
8 assignment DoD LA, Louisiana, DoD No. 31 is to
9 assist in medical and healthcare and provide
10 disease prevention. That is at, I think, 150
11 million. Anything medical now falls under that
12 mission assignment or gets tasked to that mission
13 assignment. Aerial spraying is tasked to that.
14 Our vet support that's going in to help with food
15 inspections is tasked to that mission assignment.
16 Does that answer what you were looking for?

17 MS. CLARK: Yes.

18 MS. KIRCHER: Sir, did you have a
19 comment on that?

20 GEN KELLEY: I was going to say that you
21 don't task for those specific for those patient
22 movement, you task, for example, we moved about

1 5,000 patients with assistance from the DoD
2 civilian side. But the tasking was first for 500
3 patients, then for 1000 patients. So there was a
4 specific task to move patients and (indiscernible)
5 responded by moving patients, the individuals were
6 determined by the air boss on the ground there who
7 was saying this patient needs to go between the
8 medics and the air lift team.

9 DR. CLINE: I was just wondering, at
10 this point in time the mental health issues must
11 be very important. Certainly the military has
12 more experience in dealing with post-traumatic
13 stress than just about anyone. I'm wondering
14 where that's going and what kind of lengths or
15 actions are underway or envisioned.

16 MS. KIRCHER: We've coordinated that
17 heavily with ESF-8, primarily health and human
18 services. There is a DoD mission assignment and
19 we do have forces on the ground to provide
20 support. I believe the request came in, and
21 again, it's not a one-to-one person, it's to
22 provide mental health capability to support 10,000

1 persons. The other capability we have are our
2 chaplains. If any of you meet the NORTHCOM
3 chaplains, they're an amazing group in that a lot
4 of them have been trained in critical stress
5 management, they sit on CISM teams, they know
6 exactly who is credentialed to be a chaplain and
7 who is credentialed to be a mental health provider
8 and they're a great asset. Oh, by the way, they
9 are some of the scariest people, because of all
10 the exercises, biological ones I've reviewed for
11 the command, they've created the most traumatic
12 ones in that they were dropping -- in one exercise
13 they were dropping something from the Goodyear
14 blimp, blowing up part of a racetrack and
15 contaminating the water bottles in the racetrack
16 at the same time. I said, oh, my goodness, the
17 chaplains are thinking of this. They really are
18 an incredible group and they do support. If you
19 looked, if you have the opportunity to come into
20 our ops center, there's the main domains that sit
21 there every day and then it's the meteorologists,
22 the surgeon, the chaplain and the lawyer that sit

1 right next to each other. They have a permanent
2 seat in that ops center.

3 DR. POLAND: Just to follow up on that,
4 when you say there are people there on the ground
5 and you have the chaplain, how many people are we
6 talking about?

7 MS. KIRCHER: Gosh, that's a great
8 question.

9 DR. POLAND: You talking about tens or
10 hundreds, thousands?

11 MS. KIRCHER: I'm trying to think the
12 split out with the guard. It's like 30,000 with
13 the guard assets --

14 DR. POLAND: So 30,000 mental health --

15 MS. KIRCHER: And you, too, may know
16 better --

17 MS. EMBREY: No, no, no. He's talking
18 specifically mental health support.

19 MS. KIRCHER: Oh. Mental health
20 support?

21 DR. POLAND: Yes.

22 MS. KIRCHER: I don't know that,

1 actually. I think the task came down that it was
2 going to be sourced by two and/or three critical
3 stress teams. Then there are chaplains that are
4 embedded in some of the assets that are out there.
5 There are mental health people that are in our
6 deployable medical folks. There are mental health
7 people that are on the ships. There are mental
8 health people that are in the 82nd. In addition
9 to the ones that have been requested, there are
10 mental health supporting our DoD folks. There are
11 mental health folks in the mortuary affairs group
12 that are out there.

13 GEN KELLEY: The DoD is not the lead in
14 mental health. They have some taskings. It's
15 public health service that has the lead and are
16 mobilizing people --

17 MS. EMBREY: I would say that we have
18 two types of services that we're providing
19 organically to support our forces to help them
20 cope with what they're seeing and then forces that
21 are providing support to the civilians that are
22 affected. It's both. In fact I think we didn't

1 (indiscernible) us to send the ones for the
2 former.

3 MS. KIRCHER: Right. The organic ones,
4 they go, it's not a question. The vets are also
5 another example in that there has been a request
6 for vet support to assist the state of Louisiana
7 in planning for future Ag things to include,
8 they've got 2500 animals right now that need to be
9 treated, Ag support for future planning. We also
10 have vets going in to support our troops,
11 inspecting the cafeterias, inspecting the MREs,
12 so, again, organic things and then requested
13 things.

14 COL GIBSON: You may have already
15 covered that, I saw your alphabet soup of all of
16 these agencies that you coordinate with. They all
17 look federal. Does NORTHCOM have pre-coordination
18 with the Governor's office, et cetera? In other
19 words, the liaisons that you've established ahead
20 of time so that you've got a face, a name that you
21 can talk to or do you have to legally go through
22 FEMA or some other agency to do that?

1 MS. KIRCHER: Yes, we have to. The
2 coordination that we have -- my friend is the
3 epidemiologist in South Dakota or I know a
4 responder in Missouri or we've exercised with
5 Virginia several times so we know most of the
6 players, but that's because we've shared business
7 cards.

8 MS. EMBREY: There is a natural with the
9 Department of Defense with every state and that is
10 through the National Guard. Every state has an
11 adjutant general who is the commander of the state
12 guard to be dual-hatted to do state missions and
13 federal missions. Part of NORTHCOM's strategy
14 when it was set up was to leverage that
15 connection, so that we understood with the eyes of
16 the TAG and their resources to understand what the
17 state response was, to get situationally aware, to
18 lean a little forward to understand what might the
19 federal part of DoD might be asked to provide in
20 the way of support to understand the situation as
21 it evolves.

22 MS. KIRCHER: The other persons we have

1 that assist in that are our Joint Regional Medical
2 Planners or our JRMPS, in that they know and
3 exercise with the people that are in their region.
4 They have made some of those connections, at least
5 from the medical side.

6 DR. CATTANI: I wanted to follow up on
7 that question. I'm sure all of you have heard that
8 there had been a table-top exercise a fairly short
9 period of time before Katrina. Was that exercise
10 just the state or was it just the local or were
11 the feds involved in that?

12 MS. KIRCHER: Yes, ma'am.

13 DR. CATTANI: If they were, do you have
14 any insight on why it wasn't more useful?

15 MS. KIRCHER: Do you want to answer
16 that, Ms. Embrey?

17 MS. EMBREY: This is a public forum, so
18 I'll reserve my comments other than to say that it
19 was a federally sponsored, Louisiana-run exercise
20 that evaluated what would happen if a Category 5
21 hurricane hit New Orleans. That occurred last
22 fall and a lot of scenarios, a lot of issues were

1 talked through. A lot of roles and
2 responsibilities were discussed. Vulnerabilities
3 were identified. Initiatives and follow-on
4 actions were recommended. I think that's all I'm
5 going to say.

6 DR. POLAND: I might just point out to
7 the Board, if you're interested, if you look at
8 the October 2001 issue of Scientific American,
9 there's an article in there called aptly,
10 "Drowning New Orleans." It's a comment on all the
11 federal planning, particularly through the Corps
12 of Engineers, et cetera and what the scenario was
13 going to be. It's as if you're reading the
14 newspaper, only they predicted 10,000 deaths.
15 What I think it does point to and it's not of much
16 value for this Board to look backwards, but it may
17 well provide the tipping point for saying in a
18 zero-sum game, we're going to have to devote
19 resources to things that happen uncommonly because
20 of the major consequence. They're
21 low-probability, but high-consequence events.

22 DR. LEDNAR: I guess two observations.

1 One is if the whole process of table-top exercises
2 are getting the focus for action, either we need
3 to revise our way we do table-tops (indiscernible)
4 exercises with the players where they physically
5 get together. I guess that's a question of
6 learning about how we best prepare and assemble
7 our experience. The second is a bit of a more
8 ethical point and that is if we're going to commit
9 some time to gather, to plan, it almost brings on
10 us a responsibility for the vulnerabilities or
11 actions that are identified to do something in
12 response. If the pre-meeting decision is we have
13 no intention of doing anything about this
14 planning, then we shouldn't even get together to
15 plan. Obviously, what can be done, given the
16 actions that are done, is obviously a list that
17 needs to be prioritized and resourced. That
18 should also be in a transparency sense a
19 discussion that the right people can have some
20 visibility to.

21 MS. KIRCHER: On your first comment
22 regarding exercising, people have said we haven't

1 exercised to this and we may not have exercised to
2 this scenario, but I can tell you that a least
3 from my seat at Northern Command, exercising
4 helps. I know who to call, I know where to go, I
5 know how the process works. If someone calls me
6 up on the phone and says I'm from the state of
7 Mississippi, and I need X, Y and Z, I know that's
8 not the appropriate way. I know what capabilities
9 that the DoD can bring to bear, how quickly they
10 can get there. I know that when they ask for a
11 combat support hospital, a CSH, that it can't get
12 there real fast and that we need to look for
13 another option. If they say we need to treat 350
14 trauma patients now, I know now, after exercising
15 what's the best and the fastest thing to send. I
16 know several have said it. We didn't exercise, we
17 haven't exercised to this, but exercising helps.
18 I know from exercises we've had, I knew how to
19 respond to this. Medical is medical. It would be
20 different if it was a contagious biological agent,
21 yes. But I know what capabilities we have and I
22 know how to get them there and the most

1 appropriate ones to get there. So I do think
2 exercising helps. I hope that answers that
3 question.

4 DR. HALPERIN: Ms. Embrey talked about
5 natural leaders evolving in these episodes and I
6 think some of the things you did, demonstrate what
7 she was talking about. The example being those
8 neonates. I think the question then gets to how
9 do you know in a crisis, who is going to follow
10 the rules pedantically and who is going to do the
11 right thing and the rules will take care of
12 themselves? I think that's a very hard issue and
13 it may be that exercising is one of the ways you
14 find out, because if people are going to be
15 pedantic, that's probably not exactly the right
16 word, they're going to express that in the
17 exercises as well and I'm sure the organization
18 determines we want somebody like that or we want a
19 problem-solver like that who ought to be running
20 the organization. There have to be other ways
21 that, in this crisis somebody knows to do the
22 right thing and maybe that statement's sort of

1 broad overlaying; you will get in there, you will
2 do the right thing, you will make the military do
3 the right thing and look good. There have to be
4 other ways to ensure that good people come forward
5 and the right things are done. How that happens,
6 I don't know, and I doubt it's probably, well I
7 don't doubt, it's probably not in all of these
8 highly detailed plans.

9 MS. EMBREY: I do think though, there
10 are initiatives at the federal level and the
11 national level to develop leadership talents and
12 capabilities to make decisions in ambiguous
13 situations. Because you do not have all the data
14 you need, the problem is that what you're trying
15 to do is restore public confidence in an
16 infrastructure that has been destroyed. The
17 person who may have been trained may have been
18 killed. There needs to be a deep bench in how to
19 deal with crisis decision-making and that's
20 leadership issue, it's an education issue and it's
21 a consequence management issue and DoD doesn't
22 have all the answers to that question.

1 DR. POLAND: I'm sorry. I'm going to
2 have to cut off discussion just because we're
3 almost getting irrevocably behind here. Thank you
4 very much. We have a series of presentations now
5 that will happen right before lunch. We're going
6 to get an introduction to DoD Emergency Health
7 Powers by Captain Chen, who works in Health
8 Affairs. His slides are in Tab 5. Before he
9 begins, I would like to note that these
10 presentations we're about to launch into encompass
11 a different approach to the issue of response than
12 we typically deal with. Executing all of the
13 intricate details of emergency health powers of
14 course, as we've seen, is not an easy task. It's
15 a phenomenal undertaking and requires intricate
16 choreography and coordination by many people and
17 agencies. Keep that in mind now as you listen to
18 the next few presenters. I do want to, just to
19 keep us on task here, for each of the presenters,
20 we have about 15 minutes for each of you and then
21 I'll have to stop you. As it is, we will get to
22 lunch about an hour late. So we'll plan on trying

1 to finish these presentations by 1:00.

2 CAPT CHEN: Thank you very much, Dr.
3 Poland. I'd like to thank you and also Colonel
4 Roger Gibson for inviting me to visit with the
5 Board this morning and to provide an informational
6 briefing on Department of Defense Directive
7 6200.3, Emergency Health Powers on Military
8 Installations. As Dr. Poland mentioned, I am
9 assigned to the Office of the Assistant Secretary
10 of Defense for Health Affairs, where I work for
11 Ms. Embrey in force health protection and
12 readiness. I assist Ms. Embrey in coordinating
13 working many of our equities in Homeland Defense
14 and consequence management and Ms. Embrey laid out
15 for you many of those different activities with
16 which we are involved. Many of the topics that
17 the Board will be discussing and learning about,
18 both today and tomorrow, including the looming
19 specter of an H5N1 pandemic and the ever-present
20 threat of a bio-terrorist attack and certainly all
21 the discussions we've had on providing support to
22 catastrophic natural disasters such as Katrina, I

1 think serve to illuminate how important successful
2 implementation and execution of this directive is.
3 I think the Department feels very strongly that
4 this is a linchpin in the Department's portfolio
5 of emergency preparedness, emergency response
6 roles and responsibilities and I hope this
7 information is helpful to you, along with all the
8 other presentations today and tomorrow in
9 enhancing your understanding of and your
10 continuing conversations surrounding this very
11 important topic.

12 I'm going to be spending the next 15
13 minutes basically summarizing and walking you
14 through the major or salient features and
15 requirements of this directive. Spend just a
16 moment talking about an initiative underway right
17 now involving a number of program lanes within
18 health affairs of services in NORTHCOM to advance
19 this particular directive. And finally, just
20 touch on how this specific policy guidance is
21 germane to the successful execution of two or
22 three other very important Department of Defense

1 directives and special initiatives. I'm joined
2 this morning on this panel by three of my
3 colleagues from the services, who after my
4 overview, will be providing some more specifics on
5 the extent to which the respective services have
6 made progress on implementing this particular
7 directive, some of the approaches they've taken,
8 some of the obstacles and challenges they've
9 encountered as well as some their plans on moving
10 forward in a way ahead on this. The first slide,
11 please. I'm going to walk pretty quickly through
12 these slides, since I have 15 minutes and they're
13 all very straightforward.

14 DR. POLAND: Twelve minutes.

15 CAPT CHEN: This is a Department of
16 Defense directive. This is a department-wide
17 policy guidance, it's not an instruction, which is
18 more of an execution document. Here you see that
19 this particular directive contemplates
20 eventualities that are both intentional and
21 unintentional in nature. Next slide.

22 This applies to all organizational

1 entities in DoD, both here in U.S. and outside
2 OCONUS and CONUS. Next slide.

3 This directive builds upon existing DoD
4 policy and philosophy that on a military
5 installation, property, personnel and very
6 importantly, individuals who may be visiting a
7 military installation shall be protected against
8 public health emergencies. Next slide.

9 This is the first time in a policy
10 guidance that the Public Health Emergency Officer
11 or we affectionately term as a PHEO, is
12 identified. As you will see the laundry list of
13 responsibilities that an incumbent who serves as a
14 PHEO is so huge, in addition to their regular day
15 duties, that I think having a pheochromocytoma
16 might be in order to do the work. I think the
17 PHEO piece does work. This PHEO should be a
18 fairly senior person and with some training in
19 public health emergency management. Next slide.

20 Every healthcare provider shall report
21 promptly to the appropriate PHEO of any
22 circumstance suggesting a public health emergency.

1 Next slide.

2 Now you're starting to see some of the
3 laundry lists of responsibilities a PHEO must
4 execute. A PHEO shall, and this looks a lot like
5 bread and butter epidemiology and preventive
6 medicine in terms of determining cases, index
7 cases, epi curves, so on and so forth. Next
8 slide.

9 The PHEO shall share that information,
10 including personally identifiable health
11 information with civilians at the federal, state
12 and local officials and very quickly I will tell
13 you, most of you know, that the military health
14 system, the MHS, must comply with the health
15 insurance portability and accountability act or
16 HIPAA. This particular provision is consistent
17 with privacy rules waivers, which basically state,
18 in the HIPAA regs, that information can be
19 disclosed without consent of a patient if that
20 information is used by a government agency who is
21 involved or engaged in bona fide public health or
22 public safety work. Next slide.

1 Installation commanders can declare a
2 public health emergency on one or more military
3 installations under his command. Must report that
4 up the chain of command. A military installation
5 commander must go all the way up through the Joint
6 Staff to the SECDEF and the PHEO must also in this
7 directive, report in a parallel track to their
8 cognizant surgeon general, all the way back up to
9 the Assistant Secretary of Defense for Health
10 Affairs. Next slide.

11 These are an enumeration of some of the
12 special powers that an installation commander can
13 exercise in relationship to property. One piece
14 that's not missing here is that an installation
15 commander, in consultation with the PHEO may do
16 the following items, and I'll just point out,
17 Roger gave me one of his trusty laser things here.
18 Give you some examples: they can close and
19 evacuate a facility; they can control routes to
20 and from military installation and do lots and
21 lots of other things related to property. Next
22 slide.

1 Similarly, an installation commander
2 with consultation advice from his or her PHEO may
3 exercise the following special powers related to
4 personnel, and I'll show you. These things
5 include: submitting folks to testing and exams
6 necessary to diagnose, restriction of movement,
7 isolation, quarantine. These are all the kinds of
8 special powers. Next slide.

9 In the case of a quarantine, the PHEO
10 shall coordinate with CDC. A quick comment here,
11 many of you are very familiar with quarantine
12 authorities enforcement, a very, very complex
13 issue. In generalities, as you all know, the
14 federal quarantine authorities are vested in the
15 Secretary of HHS as delegated to the director of
16 CDC. Most, if not all, states have some kind of
17 legislation on the books that empower governors or
18 state health officers to restrict movement or
19 isolate patients or quarantine within their state
20 boundaries. Large cities, in some instances also
21 have similar kinds of ordinances within their
22 jurisdictions. Of course, on a military

1 installation, the commander can close the gate as
2 he or she sees fit. This is a very important
3 piece I'm going to come back to in terms of
4 military and civil interactions and lines of
5 communications, things that have already been
6 stated very, very well to date by Ms. Embrey and
7 the folks from NORTHCOM. Next slide, please.

8 No person may enter quarantine premises
9 without authorization. Some other pieces that
10 describe how to do this in the best or most
11 effective way. Next slide.

12 Very interesting. Military personnel
13 may be ordered to submit to vaccination or
14 treatment. People other than military personnel
15 may be required to do the same in order to gain
16 exemption or release from restriction of movement.
17 That is, people that may be visiting an
18 installation and in some instances contractors and
19 others who may be working on an installation. We
20 talked a little bit about health information.
21 Next slide.

22 These are some of the sanctions and

1 criminal penalties that are actually codified in
2 the U.S. code regarding those who don't adhere or
3 comply with, for example, a special emergency
4 power such as quarantine. Interesting, in the
5 case of persons who refuse to obey or violate this
6 directive, the commander of the installation can
7 detain these civilians, who are not subject to
8 military law, to military law until the civil
9 authorities can arrive to do their thing. Next
10 slide. Again, the PHEO shall maintain close
11 contact with local and state health departments.
12 This is a recurring theme about the relationships
13 both inside and outside the gate. The
14 relationships they have, the lines of
15 communication, all very important in terms of, in
16 this instance, of the exercising of special
17 emergency health powers. I'll come back to that
18 at the end. Next slide.

19 Cooperate with law enforcement agencies
20 especially if it's a deliberate terrorist attack.
21 Next slide. Again, the Assistant Secretary of
22 Defense for Health Affairs is the responsible

1 principal for issuing necessary instructions and
2 regulations and basically being the proponent of
3 this particular policy guidance. Next slide.

4 That's pretty much in a nutshell what
5 the requirements are of the directive. I
6 mentioned that I wanted to give you and share with
7 you some information on an initiative that's
8 currently underway to further advance this very,
9 very important directive. Back in July 2003 --
10 one of the things I didn't mention is that the
11 effective date of this directive was May 2003.
12 July, 2003 the Undersecretary for Acquisition
13 Technology and Logistics in the Department tasked
14 the Defense Science Board to establish a task
15 force to look at the SARS epidemic and to look at
16 existing quarantine guidance and to sort of
17 balance and look at weighing national security
18 needs versus public health measures. The timing
19 of this was very important, because as you all
20 recall, back in late 2002 and early 2003, this was
21 during the SARS evolution so a lot of attention
22 was paid by a number of parties including the

1 department on this. The tasking went to the DSB.
2 Next slide. Here's what the DSB found. They
3 issued an interim final report in December of 2004
4 and basically this is what they found. The
5 current DoD policies and procedures vis-à-vis
6 6200.3 provide an adequate basis to control a
7 significant public event. Having said that, they
8 did recognize or recommend that in order to make
9 this directive all it can be, they recommended
10 establishment of criterion upon which a PHEO could
11 base advice advocating specific public health
12 powers. That these PHEOs have adequate training.
13 Finally, again, we need to strengthen the ties of
14 communication, both inside and outside the gate
15 between military and civil authorities. They
16 recommend that the PHEOs be the folks to initiate
17 such cooperative planning. Next slide.

18 Based on those findings, an action memo
19 or tasking memo went out as a data call basically
20 in February of this year to the services,
21 basically to inquire -- given these findings of
22 the Defense Science Board. Services, how well have

1 you done in terms of implementing this directive
2 that went into effect in May of 2003? And please,
3 as you conduct this sort of inventory, tell us
4 about the folks that you've asked to serve as
5 PHEOs, whether or not you have such criterion for
6 implementing special powers, look at
7 recommendations for training of PHEOs and finally
8 take some steps to harmonize both the containment
9 strategies both inside and outside the gate.
10 This, again, is from a 50,000-foot level. That
11 data call, some of the results have shown that
12 indeed the services have all taken very
13 conscientious efforts at implementing this
14 directive, but they've taken different approaches.
15 They've all identified some barriers and
16 challenges to implementation and have actually
17 asked for some additional guidance in some
18 instances to further execute this particular
19 directive. Next slide.

20 Very, very recently another action memo
21 went out tasking the services to establish a new
22 working group to further advance this directive.

1 Here are some of the things based upon the
2 findings of the Defense Science Board and upon the
3 data call to the services, what we'd like this
4 work group to sort of look at. Core competencies
5 and training requirements for PHEOs, instructional
6 requirements, orientation requirements for
7 non-medical personnel and command on public health
8 emergencies. Very importantly developing
9 criterion to be used in decision algorithms for
10 implementing the special powers and finally
11 developing strategies and improve lines of
12 communication. We recognize of course that the
13 services have taken very different approaches. We
14 want to learn from each other. Draw from best
15 practices lessons learned and at the end of the
16 day develop some kind of final report which may
17 result in some type of additional instructional
18 guidance from the office of the Secretary in light
19 of that. Next slide.

20 Finally, and last slide, I wanted to
21 tell you, we weren't talking about some of these
22 other directives here. This particular directive,

1 the public health emergency office, for example,
2 the exercising of special emergency health powers,
3 there are many other directives and initiatives
4 whose successful execution is dependent upon
5 successful execution of DoD 6200.3. In fact, some
6 of these other things mention PHEOs and give them
7 taskings to do, because this particular directive
8 6200.3 does not exist in a vacuum singly by
9 itself. Following the attacks of 9/11, I'll just
10 walk through these very quickly, following the
11 attacks of 9/11, Deputy Secretary of Defense, then
12 Deputy Secretary of Defense, Wolfowitz issued a
13 memorandum basically mandating that all military
14 facilities worldwide be prepared for a CBRNE
15 attack and that resulted in a DoD directive
16 2000.18, DoD installation CBRNE emergency response
17 guidelines, basically mandating that every
18 military installation in CONUS and OCONUS shall
19 have an emergency and preparedness response plan
20 dealing with a potential CBRNE attack. That
21 includes medical pieces. It includes possible
22 restriction of movement with biological attack.

1 Medical treatment, triage, so on, so forth.
2 Medical surveillance. JPM guardian for those of
3 you unfamiliar with this program. It is an
4 installation protection program that actually
5 follows from this tasking from the Deputy
6 Secretary. It's a family of systems that provide
7 detection against a potential chem/bio/rad attack
8 and also provides medical countermeasures and
9 proportional protective equipment to protect
10 mission-critical personnel on installations. The
11 JPM guardian program actually got enough money
12 when it first came to sustain this program to
13 2011. They projected to have 200 installations
14 deployed with the guardian family of systems.
15 Currently there are four, which are pretty much
16 ready to go online. Eight are on the go here to
17 have surveys done. One of the things that JPM
18 guardian has is a bio-detection program and Ms.
19 Embrey mentioned BioWatch. BioWatch is a DHS
20 program that does bio-detection and this is an
21 attempt to harmonize that. Lastly I'll just
22 mention BioNet. For those of you who don't know

1 what BioNet is, BioNet is a collaborative effort
2 between DoD and DHs to look at harmonizing and
3 integrate military and civilian concept of
4 operations, detection, identification systems.
5 They used San Diego as a pilot study. They
6 recently finished and complete their studies and
7 have a bunch of recommendations and I'll just
8 mention the most important one and it is that the
9 lines of communication between obviously military
10 and civilians in terms of situational awareness
11 are very important. The way you need to do this
12 is to institutionalize those through mechanisms,
13 not to just base them on personalities and people
14 which may come and go. With that, I thank you
15 very much for your attention and look forward to
16 my colleagues and their presentations.

17 DR. POLAND: I'm going to, in the
18 interest of time, just move through each of the
19 presentations and hold questions and discussion to
20 the end, because I do think the presentations are
21 likely to build upon one another. Colonel Eng
22 will move into the specifics on the status of

1 public health emergency officers from each of the
2 services.

3 COL ENG: I'm Bob Eng from the U.S. Army
4 Medical Command, the Director of the Proponency
5 Office for Preventive Medicine in San Antonio.
6 The way we implemented the DoD directive is by
7 tasking our regional medical commands and our MTFs
8 to actually look at and plan for SARS and Avian
9 flu outbreak. Next slide, please.

10 Key issues are our readiness for the
11 epidemic and pandemic. When to implement and way
12 forward. Next slide. This is information
13 briefing. The background, as Captain Chen
14 mentioned, is there are a lot of things to happen.
15 The appearance of SARS in March of '03 and then
16 the DoD directive came out in May of '03 and then
17 what they did is they tasked the services to
18 implement this. When we received it we went out
19 and tasked, specifically, our regional medical
20 commands. If you look at the world, we have the
21 world divided among regional medical commands. We
22 have six of them. The Pacific, we have the

1 European, in the United States we have Western,
2 North Atlantic, Southeastern and Great Plains.
3 That's a specific tasker and I'll say a little bit
4 more about that. The Avian influenza appeared in
5 Asia and again Health Affairs tasked the services
6 to be ready. Again we tasked the Regional Medical
7 Commands and the medical treatment facilities,
8 combine what you're doing for SARS and Avian flu
9 plan, don't have a plan of the day, but combine
10 it, because the way we're going to deal with each
11 of them is very similar if not close to being
12 identical. Next slide, please.

13 In our MEDCOM tasker, we had our
14 consultants develop a template. We asked our
15 consultants and the functional principals in
16 medical command, what are the things that you will
17 need to have your folks at the Regional Medical
18 Commands and the medical treatment facility have
19 in their plan? Give them the specifics and
20 outline as much as possible. These are the areas
21 that our consultants went into detail and we
22 provided guidance out there. It was a template.

1 It was a road map for them. Rather than say, do
2 it, and we'd get a hodgepodge, at least we had
3 some uniformity in this. The legal
4 considerations, our MEDCOM lawyers, of course a
5 lot of people have been saying some different
6 things about lawyers, but they provided exact
7 references and guidelines in terms of, use these
8 references. These are your key references to use
9 in initiating and invoking the special health
10 powers on military installation. All these are
11 real key in terms of the specimen collection, the
12 laboratory referral network. Certainly, Colonel
13 Webster here, he's the laboratory consultant and
14 provided tremendous input to us. Next slide,
15 please.

16 One of the things is the fact that this
17 is not a medical problems by itself. As mentioned
18 in the DoD directive, the installation commander
19 takes a tremendous responsibility. That
20 installation commander owns real estate on the
21 Army bases and that installation commander owns
22 the law enforcement, owns the housing that a

1 potential quarantine may be invoked, the
2 subsistence and everything else. There's a lot of
3 planning that he owns. Key individual. That's
4 why when the tasker first came out, we went back
5 to manpower and reserve affairs and said, Hey,
6 this is not just us, we can't do it ourselves. We
7 recommend you go to installation and to G357.
8 What they did is they went and made sure that
9 tasker went to the Assistant Chief of Staff for
10 Installation Management, who then put down to the
11 headquarters installation management. Now it's
12 the garrison commanders or installation commander
13 with his lawyer and the PHEO who will make certain
14 decisions to protect the mission commanders and
15 everybody on the installation. Next.

16 The installation commander appoints the
17 PHEO, but the way we wrote the guidance, it's the
18 Regional Medical Command commander who is a
19 general officer who recommends the PHEO to be
20 appointed at each medical treatment facility.
21 That was important so that we had a GO doing that,
22 because sometimes on bases we have a medical

1 treatment facility commander as an O-6 and then we
2 had a mission commander of a medical command, a
3 TOE medical command as a general officer. We
4 didn't want them butting heads and getting into a
5 disagreement, so we put one level above. Next
6 slide, please.

7 The status. These are the number of
8 PHEOs that have been appointed for the six
9 regions. We have also an installation medical
10 emergency officer, an assistant to the PHEO, also
11 appointed. We've expanded beyond what just the
12 DoD directive said. The PHEO has training and
13 expertise or immediate access to personnel trained
14 in public health. In some of the depots that we
15 have, we have an officer in charge of a clinic,
16 who could be Captain Physician with very little
17 public health. We couldn't name that individual
18 as a PHEO, but we could name that individual as
19 the installation medical emergency officer, who
20 has to deal very closely and is supervised by the
21 PHEO. Therefore, the planning for that particular
22 installation, a depot normally, at least can have

1 coverage and there's someone on site. I think we
2 can all agree that the initial response that
3 occurs on the installation affected is critical.
4 You have to have some medical authority on there
5 to take the ball with communications with the
6 PHEO. We also have another situation that on some
7 bases we do not have a captain, we do not have a
8 -- we do not have a GS physician, sometimes we
9 have a contract physician providing the medical
10 support. A contract physician cannot be a PHEO
11 and so what we said is assistant to the PHEO.
12 That individual could have tremendous public
13 health training. He's a contractor, he's a
14 contract person, physician, providing that care.
15 We named that individual assistant to the PHEO and
16 again that individual has to work very closely
17 with the PHEO. 94 percent of our MTFs and clinics
18 have a plan. Next slide, please.

19 We've had six full exercises. Eleven
20 table-tops conducted as of March and a few more
21 since then. In our tasker to the Regional Medical
22 Commands and MTFs, we made it very critical that

1 communications and planning with local and
2 regional health departments is essential. We
3 gathered this information. How effective are they
4 in executing in case there is an outbreak? We do
5 not know. We see the plans are written. Some are
6 not so good and some are good, and maybe someone
7 has an excellent plan. A person with an excellent
8 plan can also fail if they don't execute it
9 correctly. Next slide.

10 I'm going to get back to that. This
11 just tells you what I've just told you about PHEOs
12 and IMEOs and assistant to the PHEOs. Just
13 clarity. Next slide.

14 One of the things in the decision
15 algorithm for possibly invoking emergency health
16 powers as a concept is to keep it as simple as
17 possible, because things are already complex. If
18 you can keep things simple, we believe that's very
19 important. Have total control, no declaration.
20 If you see a loss of that control you may be very
21 close to declaration of the emergency health
22 powers. Next slide. Sort of a basic concept of

1 having total control is that, let's say that you
2 do have a case of H5N1 in your city, but you've
3 been able to identify and quarantine all the
4 contacts with the confirmed patient. Fourteen
5 days have passed and you don't have a case and you
6 continue the vigilance. Sounds like there is
7 control in that community. Next slide.

8 No total control. Confirmed case, have
9 not identified and quarantined all contacts with
10 the patient within two to three days. You all
11 know that doing a thorough epidemiological
12 assessment takes time and to do it in two to three
13 days is pretty quick, but if you let it lag any
14 longer than that, you have a tremendous
15 uncertainty in terms of the potential spread and
16 incubation of x number of individuals. Other
17 positive cases are appearing in adjacent and/or in
18 the locality. That means you do not have control
19 and you may want to restrict movement and do those
20 other things in the special health powers. Next
21 slide, please.

22 Some of the things we look at way

1 forward is to reinforce the existing agreements
2 with the local public health officials. It would
3 seem that if indeed we on military installation do
4 invoke, take certain actions, those actions should
5 be identical to the actions taken by the public
6 health, the local public health folks. If they
7 don't do it, we don't do it because we've agreed
8 we do have control. If there's an inkling that
9 we've lost control, we should both initiate those
10 actions. As mentioned before, the laws required
11 for a quarantine on a military installation may be
12 very different from the state and the timing of
13 that may be very challenging. The table-top
14 exercises, you have to understand that a lot of
15 the exercises conducted are planned by our medical
16 treatment facility and if you were a commander,
17 what would you plan your table-top exercise or
18 full exercise for? Success of course and declare
19 success. What we want to do is to see about them
20 exercising and ratcheting it up to the point where
21 they fail. That's realistic. What we may do is
22 put more patients into the facility. We may take

1 out the commander. We may deny them a resource
2 because in a real situation, they may not have
3 adequate resources. We may not have enough to
4 allocate in terms of med law. That is an
5 important thing and we like to see that happen.
6 It is a gap that is identified for them to see how
7 they would address that gap. Certainly from
8 Katrina helped us with some of the other lessons
9 to learn. After the gap analysis, you do the
10 remedial plan, apply resources to fix the fatal
11 gaps. The Do-Loop, I will show you in the next
12 slide what I mean by Do-Loop to continue the
13 process because there will always be gaps and you
14 want to minimize those gaps with time. We
15 developed a checklist for self-evaluation. In
16 that checklist, it looks at a lot of the key
17 factors of the DoD directive, but it also looks at
18 some of the implied tasks. Some of the things
19 that are very obvious but aren't listed there. If
20 someone were to go through that checklist and
21 compare it to their plan, did their plan address
22 this and this. If they address everything, they

1 were pretty good. It addresses risk
2 communication, public affairs, the whole gamut. I
3 think we addressed about 99 percent of the issues
4 that one would really have to address if they're
5 in an outbreak or pandemic. The template and the
6 script for the response. What we're looking at
7 here is developing sort of using the template or
8 the checklist, but all a time sequence event. And
9 also from the clinic to the medical activity to
10 the medical center to the medical command, there's
11 things that have to happen at each level all the
12 way to Army to Joint Staff to health affairs.
13 There's things that will happen in terms of
14 planning if a case occurs in a clinic in one of
15 our installations. When it ratchets up and
16 becomes even more severe, then there are other
17 steps that each of them have to take. That's the
18 sort of template we're taking a look at for
19 table-top and an exercise. Next slide, please.

20 This is the Do-Loop. The response plan,
21 test response plan with a table-top or full-blown
22 exercise, identify the gaps, make sure that you do

1 identify gaps in a reasonable fashion, and they
2 are real gaps. Then, again, redevelop the
3 response plan, make any changes possible and again
4 go through the process. Next slide. Immediate
5 response with a good plan is better than a delayed
6 response with an excellent plan. That concludes
7 my briefing subject to your questions. But we're
8 going save the questions for later.

9 DR. POLAND: Right. Thank you very
10 much. Lieutenant Commander Thomas Luke will speak
11 for the Navy.

12 COL GIBSON: His slides are in the back
13 of Tab 5.

14 LCDR LUKE: Good afternoon, ladies and
15 gentlemen. My name is Lieutenant Commander Luke
16 and I'll be speaking to you about emergency health
17 powers on Naval installations, but I'm going to
18 give you a nugget here. There it is. During an
19 epidemic the need is for a strong central
20 authority with a grasp of basic epidemiology. Any
21 plan, any procedure, table-top exercise that you
22 have heard about in the past, this morning. When

1 I'm talking to you during this briefing or in the
2 future, you need to just pull that out and lay it
3 on top. If it does not provide for a strong
4 central authority with an understanding of
5 epidemiology or public health, it cannot work. It
6 won't work. The more arrows you see, the more
7 bubbles, the less likely it is that you are going
8 to achieve the desired outcome. Next, please.
9 We'll start with an analysis of 6200.3 and we need
10 to know what the purpose is. It is to protect
11 installations, facilities and personnel in the
12 event of a public health emergency due to
13 biological warfare, terrorism or other public
14 health communicable disease epidemic. So we
15 defined exactly what needs to occur. Next,
16 please. Then we take a look, who has got
17 responsibilities. We've got military commanders,
18 we've got public health emergency officers, we've
19 got every health care provider, medical examiner,
20 pharmacist and veterinarian. We've got
21 requirements from the secretaries of the military
22 departments, combatant commanders through the

1 Joint Chiefs of Staff and ASD/HA. We've got some
2 issues here, folks. I'm just telling you right
3 now. Next, please. The fact is that 6200.3 is
4 not all-inclusive. It needs some help, so it
5 calls in some other directives and this basically
6 is going to tell us who is going to be tasked with
7 instituting public health. They had this old
8 instruction called Security of Installation and
9 Resources, which is really focused on protecting
10 men and material and so forth against conventional
11 attacks and it lists a whole bunch of folks. The
12 Army, the Air Force, the Navy and the Marine Corps
13 have all got a little paragraph that says, "Who is
14 responsible?" If you analyze this, it lists a
15 whole bunch of folks. But it says that the end
16 result is that every Navy ship, including
17 tugboats, needs to have a PHEO.

18 Well, that's patently ridiculous. It
19 won't in all cases. If you have a Navy destroyer
20 and so forth with maybe 220 individuals with a
21 \$500 million ship, it's important that that
22 captain protect it. His need for a PHEO is very

1 low. In that regard, it has some serious
2 problems. Further analysis talks about the PHEO
3 and the installation commander and the fundamental
4 aspect about the directive is that this program is
5 unfunded. There's no personnel reorganization.
6 There's no set training or expertise that's
7 necessary from either that individual or that
8 individual. There's an uncertain chain of
9 command. The question is: What is going to be
10 the adequacy of response? You can make up your
11 own mind. Next, please.

12 I went through 6200.3 and basically made
13 a schematic of how this is supposed to work.
14 These are the requirements of 6200.3. Every
15 health care provider, pharmacist, medical examiner
16 and veterinarian within an installation who may or
17 may not work for the PHEO probably does not
18 because there the hospital complexes as well as
19 the organizational, need to somehow magically talk
20 to this individual right here. We're talking
21 hundreds of people in some cases. It's not
22 possible. One individual cannot possibly take all

1 this information any kind of sensible way through
2 a reporting process. My daughter helped me with
3 this, actually. There's just no way. They don't
4 know his phone number; how are they going to be
5 speaking to him? There's nothing in there that is
6 standardized whatsoever.

7 Somehow this PHEO is going to have to
8 talk to this installation commander and the PHEO
9 is going to have to use names like neonatal, and
10 case replication rate, mean and mode and herd
11 immunity and so forth. I will guarantee you that
12 this guy right here is going to say, huh? We'll
13 be back to the issue of the difference between
14 viruses and bacteria and parasites and so forth.
15 This relationship is not well established. The
16 PHEO is also specifically tasked with talking to
17 the Surgeon General, the senior medical officer of
18 the Joint Staff, ASD/HA, CDC, state and local
19 individuals. No way. It just can't happen. It's
20 nice to say that it needs to happen and probably
21 does, but this indicates that this is problematic.
22 The installation commander is not the senior guy

1 on the block. In many cases, he's the junior
2 local commander. He's a facilities manager. It's
3 an 0-6 captain in most cases, is going to be
4 telling a one, two- or three-star flag officer
5 what they're going to do. Well that might happen.
6 Would you stand up, please? You're in charge now
7 for the next day-and-a-half, all right? Don't let
8 anybody leave. It won't work, folks. It can't
9 possibly work in this type of arrangement and
10 we'll talk about that.

11 This installation commander is going to
12 be attempting to tell very powerful flag officers
13 what their people can and cannot do. As well as
14 civilians, hospitals. We've got some issues here.
15 Then we've got two different problems, the
16 installation commander, at least in the Navy, goes
17 up to the Chief of Naval Installations, that's his
18 chain of command. His tenant commands go up
19 through different chains of commands. You've got
20 entirely two different reporting requirements.
21 Maybe this model works. I don't think so. Next,
22 please.

1 Here's two public health emergency
2 response models. Here's the PHEO as a special
3 advisor to the installation commander along with
4 all the other staff members that the installation
5 commander works with on a daily basis. The PHEO
6 is brought out of his closet when there's a
7 problem. He introduces himself into a staff
8 arrangement. The installation commander is going
9 to attempt to coordinate with all the forces
10 necessary that he does not control and we are
11 going to get disaster response, or in this case,
12 just control highly infectious, virulent disease
13 which will turn your children into changelings or
14 will cause you to die of pulmonary edema and
15 massive overwhelming infections. So it's pretty
16 important. The other model and the other side of
17 this is that we have someone who truly has public
18 health emergency expertise who is telling
19 commanders that have the authority to direct
20 forces to do the disaster response. You can
21 figure out which works better. Please, next.

22 Here's the Naval issues as I see it

1 specifically. Naval installation commander, he
2 controls the facilities and fixed assets, not the
3 tenant units and vessels. Again, he may be the
4 junior local commander on the block. He may have
5 no public health or disaster response or medical
6 experience of any kind. The reporters, that is
7 every medical officer, veterinarian, et cetera, et
8 cetera, may not or are not in the chain of
9 command. The responders that are necessary may or
10 are not in the chain of command. We come back to
11 the PHEO here is authority, accountability and
12 responsibility really haven't been outlined very
13 well. He's kind of this peripheral advisor guy
14 and he has no ability to require reporters to do
15 anything. He doesn't have a mechanism by which
16 the reporters are supposed to contact him and
17 allow him to take action through all his other
18 responsibilities. Next, please.

19 The question is: What has the Navy
20 done? We took a look at this document and Navy
21 emergency health powers actions. There was an
22 OPNAV instruction based upon the DoD directive

1 3440.17 came out July 22nd of this year. It is a
2 Naval installation emergency management program,
3 all hazards approach. The Chief of Naval
4 Installations has overall responsibility. Tenant
5 commands have been directed, these other people
6 that live on the base have been told that they
7 must coordinate with the installation commander's
8 emergency management program and requires an
9 appointment of PHEOs in accordance with DoD
10 6200.3. That process is ongoing. There was a lot
11 of scrambling for this latest incident down in the
12 Gulf Coast to find this PHEO individual. Let me
13 just say, there's a way to go as far as --
14 conceptually as well as actually having a PHEO
15 serving in an effective capacity as far as the
16 overall mission and goals of this directive are
17 concerned. Next, please.

18 We plan to fully cooperate and assist
19 the Assistant Secretary of Defense for Health
20 Affairs, with Captain Chen's emergency health
21 powers working group. This is the memorandum that
22 Dr. Winkenwerder signed. We fully support all of

1 these stated objectives of this working group.
2 Next, please. We certainly do have some
3 recommendations. We think that the DoD directive
4 needs to be followed by a DoD instruction. There
5 is a significant difference between the two and
6 you need to understand that. A directive
7 establishes or describes policy. The Defense
8 Department will protect the United States from
9 enemies foreign and domestic. That's what a
10 directive does. High-level policy. Instructions
11 implement policy or prescribe uniform methods or
12 delineate a specific plan of action, provide
13 directions or details. We believe that the ASD/HA
14 has the authority to take this action and probably
15 should. Next, please.

16 You'll know this because you can go to
17 Paragraph 5 of the directive and it tells you the
18 various different authorities. It is my opinion
19 that if you want the PHEO to be effective, the
20 ASD/HA needs to issue a DoD instruction. If
21 you'll take a look here, this is a very powerful
22 statement here. The secretaries of the military

1 departments and the heads of other DoD components,
2 shall implement this directive and any
3 implementing issuances of the ASD/HA. That's a
4 very important statement. That tells you exactly
5 who is responsible for issuing the instruction and
6 if he's required to coordinate with anybody. The
7 answer is he probably should coordinate, but he
8 has the authority to do this on his own. As
9 importantly, 5.3, combatant commanders shall,
10 through the Chairman of the Joint Chiefs of Staff,
11 implement this directive and any implementing
12 issuances of the ASD/HA. This is essentially
13 carte blanche. This is carte blanche. The PHEO
14 can direct the activities, basically, of DoD in
15 the issuances and how the PHEO program is going to
16 work. I strongly recommend that we come up with
17 an instruction which seeks to have a strong
18 central authority with knowledge of public health
19 and basic epidemiology. If that's the goal, we
20 have a good chance of being very successful.
21 Thank you very much.

22 DR. POLAND: We have another

1 presentation. Last but certainly not least, is
2 Lieutenant Colonel Donna Hudson with the report
3 from the Air Force. She will also provide us with
4 our next segment on the Air Force's approach to
5 containment planning. Although I think we're
6 going to that latter part immediately after lunch.
7 We'll divide your presentation into two parts.

8 LT COL HUDSON: I realize that I'm
9 stopping everybody from getting to lunch, so I
10 will make this brief. They're all standing up
11 ready to line up out there. I'll be very quick
12 about this and tell you two things. One, the Air
13 Force, I would agree with what Lieutenant
14 Commander Luke just said, that there are some
15 areas that are deficit in 6200.3. What we did was
16 we created an Air Force instruction to help
17 provide that fidelity where it did not exist to
18 begin with and we created the fidelity for that
19 Air Force instruction through another effort that
20 we were working out of our office. That was our
21 CBW effort, which I'm going to speak a little bit
22 to, here momentarily. Go ahead to the next slide.

1 Actually, you can go to the next one. Quickly
2 some background out of my office, which is a
3 counterproliferation division at the air staff,
4 who works directly for the deputy chief of staff
5 for air and space operations, the XO who owns the
6 installation commanders out there. We've been
7 working the CBW effort for quite some time and we
8 actually started in earnest in September of '01,
9 ten days before 9/11, I might add. Started in
10 earnest back in '01. A lot of our activity, of
11 course, picked up in '02 and '03 with the 9/11
12 events and the subsequent anthrax attacks in terms
13 of the bio. What we were originally after, out of
14 our office, was developing a CBRNE concept of
15 operations. How the Air Force can operate and
16 sustain the mission, given a CBRNE attack. We
17 were going to work that spirally. We were going
18 to start with chem, which we had, and we started
19 that back in 1999 and moved our way through the B,
20 the R, the N and the E. However, the events of
21 9/11 sort of accelerated things. The Chief of
22 Staff directed a bio-defense task force to be

1 stood up back in March of '03. I'm just going to
2 show you how those efforts parallel to the 6200
3 effort and how those two trains sort of merged
4 into our office and we came up with this Air Force
5 instruction in implementing 6200. Two keys to
6 success. One, that effort, the bio-defense task
7 force was led by the XO. We had key leadership
8 right from the start. Secondly, it was a
9 cross-functional approach. We knew it was not
10 medical only that could work this issue. We knew
11 that security forces were involved. We knew that
12 those people who owned some of the assets at the
13 installations were involved and many others. So
14 it had to be a cross-functional approach. That
15 group came together and I believe General Kelley
16 was part of that originating group a couple of
17 years back. That group came together and
18 identified a huge laundry list of mission critical
19 shortfalls for the Air Force and ways to address
20 those. It was not just a list of 59 items, but
21 each one of those items had detailed work plans as
22 to how we were going to work them and we worked it

1 all towards the operational capability
2 improvements. That was a big focus out of our
3 office. Go ahead to the next slide.

4 How to get after those operational
5 issues we had developed, continuing on through all
6 of this work, we had developed an effort where we
7 wanted to go to an installation to really focus
8 our efforts in the CBW arena. Our objectives for
9 that was to come out with some operationally
10 focused strategies, plans and procedures that
11 would work for all Air Force installations. We
12 were not going to wait around for the next
13 bio-detector to come out because we knew that
14 would be quite some time. We knew we needed to
15 get after non-material solutions. We needed the
16 functional experts that we knew of in the Air
17 Force to come together to work this. We wanted
18 this based on scientific data and a robust ops
19 analysis and we did all of that. We also knew we
20 wanted to go to an installation that already had
21 some sort of infrastructure in place in terms of
22 C-BW. Maybe had some detectors in place and some

1 other capabilities like that. We wanted to
2 complement the work that we had already done in
3 the CW arena. We wanted to go to an installation
4 that was already working some of those issues as
5 well. Where we chose to go was Kunsan Air Base,
6 which is obviously in the Korean peninsula and we
7 spent quite some time over there and that became
8 known as the Kunsan Focused Effort. All of the
9 work for that has become the basis for what we've
10 recently drafted as the C-BW CONOPS. Go ahead to
11 the next slide. Just, real quickly to give you a
12 sense of the timeline, we spent a little over a
13 year going back and forth over to Korea to work
14 some of these issues. We spent a lot of time
15 gathering data from them. What did they already
16 have in place? And then we started developing a
17 lot of products with them working them and
18 refining them with them and going back and testing
19 out these procedures and processes. Throughout
20 each of the visits, we either did table-tops or a
21 field exercise. We culminated the very last visit
22 this past April with a three-day exercise that

1 gave us profound amounts of information towards
2 the work that we were doing. Go ahead to the next
3 one. Quickly, a laundry list of some of the
4 products that we did develop for this KFE effort.
5 After lunch, I'm going to talk a little bit about
6 the disease containment plan. I highlighted that
7 one. I highlighted the other two to tell you that
8 they gave us huge amounts of fidelity towards our
9 implementing 6200 in terms of some of the legal
10 issues, some of the risk com issues that Ms.
11 Embrey talked about earlier. We were able to
12 actually test all of that out over there and get
13 better fidelity for instruction. Go ahead to the
14 next slide. Now we're back to the task at hand,
15 implementation of emergency health powers. When
16 that directive came out, which came out around the
17 same time that this bio-defense task force was
18 stood up, we sought information from the air
19 staff, from the cross-functional group at the air
20 staff as well as from our folks at the major
21 commands in terms of feedback on that document.
22 It's pretty much the same thing that Commander

1 Luke just talked about. You can see some of that,
2 that it was not providing a lot of information or
3 a lot of clarity in terms of the legal issues.
4 For security forces, they felt like they weren't
5 manned to impose some of the restrictions in terms
6 of restriction of movement.

7 Our commanders were asking for a risk
8 management decision tool to help them with. When
9 do I make this decision? If I choose to make this
10 decision right now, how will that give me pay-off
11 in terms of operations? Is it a pay me now, pay
12 me later sort of situation? Whatever. Based on
13 all of that information, we saw the need to use
14 what we were doing at Kunsan to help us figure
15 this whole thing out. It allowed us to examine
16 this issue. In particular, look at it in a
17 wartime environment. For us, can we pull back
18 from that and apply it in peacetime as well and we
19 think we can. Go ahead. We've created an Air
20 Force instruction that's 10-2603. It provides
21 that guidance that's lacking in 6200 in terms of
22 how to protect Air Force installations. We do not

1 have the same problem that the Navy has. It's
2 very clear, direct lines of communication between
3 the installation commander down to the med group
4 commander to the other commanders there.

5 This Air Force instruction is pretty
6 cross-cutting. It can apply whether it's
7 bio-warfare or deliberate attack or whether it's a
8 naturally occurring communicable epidemic that's
9 going on. For us, we needed it to apply to both
10 the active and the guard and the reserves so we
11 managed to cover all of that. We have studied and
12 looked at all the national guidances out there,
13 the NRP, the NIMs, all those sorts of things. Air
14 Force guidance, DoD guidance to make sure we've
15 incorporated a lot of that and linked to a lot of
16 that in this particular Air Force instruction. At
17 the time the SGO, which at the time happened to be
18 General Kelley, sent out a letter to all the
19 installations to say and outline who specifically
20 should be the PHEO and you can see that lined up
21 here. Pretty much in line with the other
22 services. Go ahead. I've already mentioned that

1 this AFI gives a little bit more fidelity to
2 what's already out there and we have specific
3 sections on these issues that are listed here and
4 we received that fidelity through our Kunsan
5 focused effort. It was through that robust
6 three-day table-top exercise that we were able to
7 see some of the issues that were involved with
8 restriction of movement, with quarantine, et
9 cetera, et cetera. Where are we at with it? Our
10 Air Force instruction is almost close to being
11 signed out. It will be signed out by the XO, so
12 therefore, he has direct responsibility for it.
13 In fact it's heading its way to that office as of
14 this morning. We anticipate releasing it to the
15 field on the 15th of October and of course we are
16 participating as well with Captain Chen's
17 workgroup. With that, I believe that's the last
18 slide.

19 DR. POLAND: We have about 10 minutes.
20 Thank you for helping us get caught up there. We
21 have about 10 minutes for questions or comments.
22 First from the Board and then if there are none,

1 I'll try to look back and catch others.

2 MS. EMBREY: Make an editorial remark.

3 That directive was the first thing on my plate
4 when I came to the office of Health Affairs. The
5 reason it was put out there as a policy without a
6 lot of specific guidance is in direct relationship
7 to the anthrax scares that occurred after 9/11 and
8 it was clear we had no policy out there that
9 assigned responsibility for addressing public
10 health emergency issues. We did not have any
11 specific authority outlining who had to take
12 action and some central decision-maker. If we had
13 waited for every service to articulate what
14 applies to their command and control structure, we
15 would still be waiting for the policy to be
16 issued. I would say to you that, yeah, it isn't
17 perfect. It doesn't set out perfect guidance and
18 it doesn't align with the way everybody does
19 business. It does assess a responsibility and
20 authority and it does say that there are emergency
21 powers that need to be undertaken. You're
22 absolutely right, we need further guidance to work

1 that together. But I will not make excuses. That
2 was needed and it's out there and I apologize that
3 we didn't give you better guidance, but it's what
4 we got.

5 DR. LeMASTERS: This is just a comment.
6 I just have to say I have one concern that the
7 PHEO has to have knowledge in public health and
8 basic epidemiology, but not necessarily medicine.
9 The concern is that medical decisions are going to
10 have to be made in terms of quarantine, et cetera.
11 Physicians are not only trained in medicine, but
12 they are decision-makers. They make
13 life-and-death decisions and that's part of their
14 training. Someone like myself, with a Ph.D. in
15 epidemiology, we're not trained to make life and
16 death decisions. My concern is about the
17 background and the authority of the PHEO. Also
18 the PHEO will be dealing with maybe a civilian
19 counterpart, who may or may not be trained in
20 medicine. You cannot control that, but you could
21 control the PHEO in the military to have that
22 training.

1 Lastly, my concern is a PHEO making
2 decisions regarding public health as well as
3 medicine, in terms of quarantine, et cetera, and
4 symptoms and who needs to be quarantined. Dealing
5 with commanders. I have dealt with commanders in
6 research for 20 years and I would say that a
7 physician will have a lot more credibility than
8 someone just with knowledge in public health. I
9 think physicians can receive that knowledge in
10 public health and some training in epidemiology
11 much quicker than a person without a medical
12 degree can get that kind of medical training.

13 CAPT CHEN: One of the things the
14 workgroup is going to be tasked to look at, very
15 importantly, is this decision algorithm and
16 criterion upon which to make decisions, sort of a
17 tool kit for a PHEO to have handy. Providing some
18 sort of direction and guidance on that. The other
19 part is listing some core competencies. You were
20 very right on mark in terms of your comments
21 there. I think the identification of core
22 competencies of whoever it is that is selected to

1 serve as a PHEO, what should their skill sets be?
2 The services have very variable approaches on who
3 is the incumbent who sits in the PHEO position.
4 It could be a nurse, it could be a physician, it
5 could be a veterinarian, it could be someone else.
6 It's usually collateral duty in many instances and
7 sometimes it may be their sole job. I think the
8 purpose of this working group is to try to find
9 some additional ways to provide guidance on those
10 competencies and some additional tools that a PHEO
11 can have handy in making these life-and-death
12 decisions or important decisions.

13 DR. LEDNAR: I think another aspect you
14 can anticipate for the commander who's going to be
15 facing the reality of imposing local restrictions
16 and quarantine, surely there will be medical
17 aspects to this and they'll turn to some medical
18 person to advise them. Very quickly the attention
19 will turn to their legal advisor, to their JAG and
20 say, what really am I authorized to do. It's
21 clearly different than business as usual and there
22 will be clearly some people who will be of a

1 different opinion. I think to the extent that the
2 legal staffs in the services are equipped as much
3 as possible in this area of health law, which is
4 not typically one of those areas of strength in
5 legal education. Until you need to confront it
6 you're not going to get familiar with it. It's
7 going to be really important for the JAG sitting
8 there with the commander and the PHEO to have the
9 commander have the confidence that they can really
10 believe is a fully justifiable position.

11 MS. EMBREY: In fact, the directive was
12 written in conjunction with our general counsel.
13 General counsel actually crafted the language of
14 this directive with us.

15 GEN KELLEY: With the service inputs
16 from the service JAG, medical legal advisors.

17 DR. PARKINSON: Well if it hasn't been
18 said directly I think we should, at least this
19 Board member feels very appreciative to the
20 department of Ms. Embrey for doing this. I think
21 the DoD directive has operated just the way it's
22 supposed to and that is for each of the services

1 to take that as broad guidance and AFIs and use
2 the Air Force or whatever and say how does it play
3 on an Air Force base versus a ship. After
4 considerable experience in the military, I've come
5 to learn that nothing really applies on a ship as
6 far as I can tell. With all due respect, Tom, I
7 know it's just a different universe. If I listen
8 to the three presentations, all three have
9 wrestled this tiger to the ground to say this is
10 the way it works on an Air Force base. This is
11 the way it would probably work on a ship. This is
12 the way it probably works on an Army installation,
13 which is great. As far as I know, this country
14 has not had any real case of quarantine in many,
15 many years. The clarity that this DoD directive
16 brings to DoD is something that I think ASTHO, the
17 state and territorial health officers and the
18 council of state and territorial epidemiologists
19 had better grapple with in very, very near terms,
20 like weeks. Because if we have to quarantine one
21 person in this country, on or off a military
22 installation for H5N1, it is going to be front

1 page New York Times and I don't care where you're
2 at. The entire public health infrastructure
3 better be ready. I think there might even be an
4 action item here, DW or whatever, to take this
5 model and say it was discussed at the AFEB and go
6 back to your colleagues at CDC and NIH and say at
7 ASTHO, where are we? If there's anything we can
8 do here is raise issues that are of national
9 import. I think this was very timely and useful.

10 DR. POLAND: There's another piece of
11 this plan with the PHEO that I think might have
12 slipped by the Board's notice that I think is
13 worthy of comment. That is the tie-in with
14 situational awareness of what's happening with
15 infectious disease epidemiology at the local and
16 state level. That, to the extent that it's
17 implemented, could be very, very powerful and of
18 benefit to the nation. So I'm very pleased to see
19 that piece of that highlighted in there.

20 LCDR LUKE: I just want to make clear
21 that I've got a little different concept. I'm not
22 against the PHEO. I am for the strong central

1 authority. If we have problems with laws and
2 customs, essentially a Gordian knot, we will never
3 be able to, by a legal statute or regulation, come
4 up with all the possible scenarios which will lead
5 to a crisis situation. What we need to have is
6 strong central authority and authorization. The
7 feeling from these commanders, whoever they may
8 be, that they don't have to go to their lawyer and
9 wait while they consult on esoteric meanings of
10 the Stafford Act and Posse Comitatus, Insurrection
11 Acts, Article II of the Constitution, we need to
12 work on clarifying those legal issues.

13 Fundamentally, it's not the PHEO that we should be
14 interested in on this particular instruction, it's
15 the strong central authority, which right now
16 rests with the installation commander. Whether
17 that proves to be wise or what we should be doing
18 next month, a year from now, I don't know. That's
19 where it's at right now and he needs to be
20 empowered.

21 COL ENG: Comment was tremendous
22 responsibility by the PHEO. I think that whoever

1 the PHEO is, they will be coordinating with other
2 PHEOs and using the chain of command within
3 MEDCOM. They're not going to be acting
4 independently. We're going to be acting as a
5 group. Once a case occurs in Asia that's going to
6 really activate us to say, it's coming. It's
7 potentially coming. So we're going to get as
8 ready as possible and do the "what if" games and
9 the PHEOs are going to do the same thing as well
10 as the IMEOs and everybody else. Our big
11 leadership is the TSG and we're using the chain of
12 command and making sure things do happen. The
13 installation commander, yes, they grapple with
14 issues of leadership and decision every day. This
15 is going to be different. This is going to really
16 challenge them, but they do that on a day-to-day
17 business and we just need to help them prepare for
18 this. One of the things, as I mentioned, is the
19 fact that the installation commander is going to
20 have the lawyer in his left-hip pocket and the
21 PHEO in his right-hip pocket. They're going to be
22 key individuals as well as his many staff

1 officers.

2 DR. POLAND: Thank you, all the
3 presenters. We will recess for one hour and
4 gather at 2:00. Colonel Gibson has some
5 administrative comments before we leave.

6 COL GIBSON: Just one quick comment. If
7 you decided not to eat with us, we do have maps of
8 the base. If you go out the south gate from the
9 base there's a whole boatload of restaurants out
10 there. If you want to eat out there we can
11 provide you with a map. That's it. We're
12 upstairs for lunch.

13 (Recess was taken from 1:00 p.m. to
14 2:02 p.m.)

15 DR. POLAND: We had delayed one part of
16 Lieutenant Colonel Hudson's presentation to right
17 after lunch. Colonel Hudson, if you want to
18 proceed we'll do that. Fifteen to 20 minutes.

19 LT COL HUDSON: Actually, that will work
20 out well, because I pre-explained a lot of stuff
21 in my previous brief, so go ahead and go to the
22 next slide. You saw a lot of this from the last

1 brief. Really, what I'm here to now talk about is
2 continuing on from what I talked about before
3 lunch is the Air Force effort towards this disease
4 containment plan that I spoke to you that was a
5 product from our Kunsan focused effort. It sort
6 of started in a vacuum from 6200 in the sense that
7 as we were working with Kunsan, we saw a need for
8 a disease containment plan that was not a specific
9 one to SARS, not specific to smallpox. Those
10 plans that were already out there, but one that
11 the whole installation could take and use should
12 there be a biological event on an Air Force
13 installation.

14 It started that way, however, as like I
15 said earlier the two trains sort of merged into
16 our work with implementing 6200 and all of that
17 effort we sort of began to merge the two efforts.
18 You've already seen all of this, so we'll go to
19 the next slide. We wanted to get a little bit
20 beyond 6200, knowing the DoD had put out several
21 plans and we were trying to struggle with getting
22 those implemented at our Air Force installations

1 and was there a better approach, at least for the
2 Air Force to ensure that we met the intent of all
3 those plans. We kept with that very
4 cross-functional approach that we needed and that
5 it was led with the XO direction. What we were
6 looking at is adopting a holistic approach.
7 You'll hear the constant theme of the need to have
8 a cross-functional group of folks working this,
9 because while it's the installation commander who
10 pretty much, for the Air Force anyway, owns
11 everything, you've got to work in concert with
12 some of these other folks.

13 It's not solely a medical issue. Moving
14 a little bit beyond what the medics were doing in
15 terms of managing large numbers of casualties and
16 could we look at focusing on containing the
17 disease. For the installation commanders, what
18 was important to them was knowing that they had to
19 balance, do that risk-based decision making,
20 balance mission criticality with the risk to their
21 personnel. Keep in mind that most of the work
22 that we had done in Kunsan was in a wartime sort

1 of setting. We're now beginning to pull back to
2 see how can we apply this to our CONUS bases here
3 in the states that are not under wartime footing.
4 We also recognize for the commander in a
5 biological event, whether it be a deliberate or a
6 natural occurring event, that they will be making
7 critical decisions in very short timelines with
8 very limited amounts of information. Often they
9 may not know what the agent is and they may not
10 recognize that they need to quickly get things
11 such as medical interventions underway. We have
12 to account for that uncertainty and how can we do
13 that for commanders. The key to success as we've
14 talked about all morning long is preparation and
15 planning. Within this plan that we have begun to
16 draft out, there's a large section that addresses
17 the need for preparation and planning. Then of
18 course, we get to the cross-functional approach in
19 the security, the resource issues, the legal
20 issues, et cetera, et cetera. Of course the
21 bumper sticker there that these interventions
22 obviously work best if they're implemented early

1 in a timely amount. Go ahead.

2 I just want to lay out for you, as we
3 were doing our work, this is what was coming
4 across the top from DoD in terms of the response
5 plans and 6200 splashed in there as well. Then
6 bumped up against that, some of the work that we
7 were doing in the Air Force, I've spoken about a
8 little bit of this that you see up here. I've
9 already talked about bio-defense task force that
10 stood up and some other activities that we've done
11 out of our office. We actually began our work on
12 drafting out a DCP, I'm not real sure that it was
13 back in October of '03, but it was late '03, early
14 '04 that we started actually drafting this
15 product, validating it with Kunsan focused effort.
16 Go ahead. I'm probably preaching to the choir as
17 to why one might want to consider consolidating
18 those approaches. But for the Air Force, what we
19 recognized is that we had four plans that were out
20 there, you can see all of those that are listed
21 there. The actions in those plans were very
22 similar, but yet each one describes certain

1 elements differently.

2 For instance, the concept of operations.

3 It's described and presented a little bit

4 differently in each of those plans, so it was a

5 little bit sticky to sort of make your way through

6 as to where were the common elements there. The

7 plans as they exist right now are very medically

8 centric and they don't necessarily address some of

9 the other issues that we were interested in

10 getting after in terms of some of the other

11 functional areas that needed to work this issue.

12 In some cases for the Air Force, that information

13 was resident in other plans that already existed

14 as well. For instance, for the medical community

15 and their medical contingency response plans, a

16 lot of the same information was already there.

17 For the Air Force, many exercises that we have

18 done in other evaluations reveal that there was a

19 lot of confusion out in the field and very limited

20 implementation of these plans. In some cases they

21 weren't even implemented at all. What the

22 existing plans don't address right now is the need

1 for operational considerations. They all assume
2 that's it's a known disease. We have the SARS
3 plan; they're very specific to specific diseases.
4 As I've said numerous times, they lack a
5 cross-functional approach. Dr. Chu, in November
6 of '03 mentioned that development of one
7 overarching plan could be a successful event and
8 would ensure consistency across the board and sort
9 of eliminate some of this confusion. That's sort
10 of the approach that we're talking. Go ahead to
11 the next one. We're drafting this as we speak.
12 We had a product that we took with us to Kunsan.
13 We came back after working that with them and
14 decided to scrub that approach, go with one
15 overarching plan that incorporated some of the
16 elements that were in the existing plans and
17 that's where we are right now. In general, what
18 it's beginning to look like is we have a huge
19 section on purpose, and you can sort of read the
20 purpose statement up here. Actually, this is the
21 whole purpose of why we're wanting to do this.
22 I'm jumping ahead of myself to the next slide

1 already, but don't go to that one yet. Obviously,
2 the purpose was to translate all of those things
3 that are out there into one plan. We wanted it to
4 apply to both a deliberate attack as well as a
5 naturally occurring event, so that one could pull
6 it out for either/or. In some cases, and you'll
7 see this under the baseline assumptions, the
8 installation commander may not know what it was,
9 all he knows is that he's got sick folks that have
10 shown up at his installation, that the med group
11 commander or the PHEO or whomever is reporting to
12 him. He may not know whether it was a deliberate
13 attack or whether it's from a naturally occurring
14 event. We have some assumptions that are built
15 into this plan, the first being that, that
16 sentinel casualties may be their first indication
17 of an attack or an issue that's going on. That,
18 as I just said, those sick individuals, you may
19 have a difficult time distinguishing whether that
20 is from a naturally occurring event or a
21 deliberate attack that's occurred on your
22 installation. You can see some of the others

1 here. Several days may pass before we actually
2 have confirmation as to what the agent is and that
3 the commanders need to make some critical,
4 time-sensitive decisions very quickly. Go ahead.
5 In terms of how it's outlined, there is a
6 preparation phase and we begin to state how
7 critical it is to prepare a front before the event
8 occurs and there's many activities that can occur
9 in terms of preparation, and to plan for that
10 event. There are a lot of activities that need to
11 coordinated amongst the entire installation in
12 order to pull this off successfully. After the
13 preparation phase, we go into immediate response.
14 We speak to avoiding exposure and some medical
15 interventions. In terms of avoiding exposure,
16 there's a lot of non-medical actions, such as
17 restriction of movement, personal hygiene, those
18 sorts of things that can occur that will help
19 mitigate some of the outcomes and allow operations
20 to continue. Remember, what we're very interested
21 in is making sure that the Air Force installation
22 can continue to operate through this environment.

1 Then, of course, we speak to the timelines for
2 action for some of the medical interventions. We
3 wrap that up with continued response. What we
4 found through Kunsan and our work at Kunsan was
5 that once decisions are made, there needs to be a
6 plan in place to sort of begin to sustain those
7 and then to back out of those. Once you put
8 everybody in quarantine, can you sustain that? If
9 you've decided yes, I can sustain that for this
10 amount of period of time, at what point in time do
11 you then decide to back out of that? We have some
12 of that built into this as well. What it provides
13 then is a layered approach, and again, allowing
14 the mission to continue. Go ahead. This is just
15 a sample of one of the checklists. Up front there
16 are those sections that I just described. A lot
17 of verbiage sort of looks like some of the
18 guidance documents that we put out. At the end,
19 right now it's pretty thick, we're getting ready
20 to sort of trim these down. There's a lot of
21 checklists and here's a sample of one. I realize
22 there's a lot of acronyms over here that some of

1 you may not understand. We've talked about the
2 PHEO, the MBGs, the med group commander; what you
3 can see over here is that it is very cross
4 functional. We have public affairs that's
5 associated with this. We have services. We have
6 the com squadrons, the legal folks, that's JA,
7 transportation. There's just a host of things for
8 all of them to be doing in terms of these
9 checklists. The checklists are set up so that
10 there's a set of checklist for prepare. There's a
11 set of checklists for the continued response.
12 Then there's a group of checklists that one would
13 go to depending on the event that occurred and how
14 they knew of that event. Whether it was a
15 sentinel casualty, whether a detector went off,
16 there's actually four of those. They sort of
17 organized in that fashion. Go ahead. I've
18 talked, obviously, a lot about how we use KFE to
19 validate the need, first for a DCP and it did do
20 that for us. We worked extensively with the
21 subject matter experts at Kunsan to help us flesh
22 this out. Then we exercised it extensively at the

1 end of our effort there in a three-day exercise.
2 I think it was mentioned earlier the critical need
3 for doing planning, preparation and then exercise.
4 That certainly held true from our efforts at
5 Kunsan. I'm not suggesting that we all go out
6 there and do a year-long effort at one
7 installation. I'm not suggesting that at all.
8 We're certainly not going to do that. It was very
9 time intensive, labor intensive, resource
10 intensive, however, there are many exercises that
11 we can fold in on or build and sort of flesh these
12 things out. I think I've already mentioned almost
13 all of these before. We can go ahead to the next
14 one. Here's some of the benefits, again, I think
15 I'm probably preaching to the choir, at least for
16 the Air Force, as to how we recognize that having
17 this one plan will help us with incorporating the
18 elements of the plans that are out there and any
19 other future plan that may come. It does
20 eliminate the need for disease specific plans or
21 at least it can. It will promote consistency and
22 avoid confusion across the board, I think. The

1 key is that we think we have it set up right so
2 that for every emerging disease that comes down
3 the pipe, the use of this plan or modifications to
4 this plan may help and assist with that particular
5 issue as well. Again, I've talked numerous times
6 about the cross-functional approach. This plan,
7 we have it set up, we've done an extensive annex
8 of all the other DoD plans out there to see what
9 specific, perhaps to the smallpox response plan,
10 that we can't just set that aside, but we need to
11 incorporate into an annex into this plan. We're
12 in the process of doing that right now. There are
13 some things that are pretty specific to those
14 issues that we're going to incorporate into
15 annexes to this plan. I've already said that it
16 can address the whole dual nature of either a
17 deliberate event or a naturally occurring. I also
18 mentioned briefly in my last talk that we just
19 drafted out for the Air Force a CBW CONOPS, it's
20 in draft right now and it's in review right now.
21 What we're trying to do is link that document with
22 this document and some of the other products that

1 we're doing, because the themes are all there,
2 they're all the same. We have an extensive amount
3 of risk based decision making information in the
4 CONOPS and we're trying to extrapolate some of
5 that into here. Commanders are interested in
6 knowing, if I make this decision today, what's my
7 payoff over here? If I put all my troops in
8 quarantine, can I generate sorties. That's what
9 they're interested in knowing. We're trying to
10 help them through that decision-making process.
11 That's it, unless there's any questions.

12 DR. POLAND: Thank you. Questions or
13 comments from the Board?

14 DR. LEDNAR: I think one point that you
15 made sort of in passing along the way, I'd just
16 like to come back and just bring a little more
17 attention to, because I think it's important. We
18 tend to put a lot of front-end thought process
19 about how to get started in disease containment
20 and add on layers of actions. One of the points
21 that you mentioned, I'll call it an exit strategy,
22 be thinking before you need to act, at what point

1 can you begin to step back from some of these
2 actions and do it with some confidence that it's
3 safe and appropriate? At the time this is all
4 going on, that would not seem like the right thing
5 to be doing in light of the anxiety of the event.

6 LT COL HUDSON: That's true. What we
7 recognize, and I'll just use this as a quick
8 example, at Kunsan if the commander put everybody
9 on a prophylactic medication, antibiotic, for how
10 long? You figured out you no longer have an
11 issue, do you continue to have them -- and they
12 would forget about that. What we're trying to do
13 is develop tools that allow them to remember these
14 are the decisions I made last week or three days
15 ago or whatever, okay, now let me go back and
16 reassess and see where I'm at. Some of those
17 things begin to fall through the cracks if you
18 don't remember those. It was key to getting back
19 to the sustainment of it. Can you sustain it?
20 Don't make the decision to do it if you can't
21 sustain it and you can only do it for a day. Can
22 you sustain it and how do you back yourself out of

1 those decisions and get back to normal operations?

2 DR. BROWN: Quick question. Maybe you
3 addressed this and I just overlooked it. This
4 plan you developed, did you address the issue of
5 how you're going to respond differentially to
6 people who are in military service versus
7 everybody else? The complicating thing, it seems
8 to me about bases, CONUS bases, is you have a
9 mixed population.

10 LT COL HUDSON: Yes. We are beginning
11 to address that now. The plan originally was
12 designed for OCONUS bases. That, in itself, has
13 huge challenges when you start looking at host
14 nation issues and working with foreign governments
15 and what have you. One of the reasons we picked
16 Kunsan was they didn't have a lot of dependents
17 and it was an issue we didn't want to deal with at
18 that point in time because we just thought it
19 would be too huge of an elephant to jump on.
20 We're working through that now. Of course 6200
21 and then the AFI that we've developed addresses a
22 lot of that right now in terms of what command

1 authority does the installation commander have
2 over the civilians and we're working our way
3 through that at this point in time. We don't have
4 all the answers yet other than right now he can
5 say, yes, you have to be in quarantine. We're
6 sort of working our way through that and I think
7 one of the best ways to feel that out, if you
8 will, is going to be through an exercise. We have
9 some exercises that we can look and gather lessons
10 learned that we have been partnering with the SG
11 folks on and we're looking at that. Those have
12 been table-tops and we've just been talking
13 through the issues. We're trying to find a forum
14 that will allow us to really exercise that to
15 really see what the issues are going to be. It's
16 a difficult piece to attack. It's going to be
17 hard to tell people, no, you can't come on base to
18 go get your child from the childcare center.
19 Katrina's a good example, I guess. In some cases
20 as people are being displaced and separated and
21 what have you, it's not a total analogy to the
22 issue, but we're seeing some of the same issues

1 that are coming up. We're looking at that now.

2 DR. LEDNAR: A thought that occurs to
3 me, structurally to try to support this,
4 especially knowing that there's a lot of
5 outsourcing going on, reliance on vendors, but
6 what we've found helpful at Kodak is where we have
7 wide-area purchasing arrangements, we need a
8 certain kind of understanding in advance by our
9 supply chain. We write that into our contracts.
10 If there's a thought that this need to invoke
11 special public health powers is in place, the
12 thought might be to incorporate that as a template
13 language into your DoD contracts. Whether it's
14 with Burger King or whoever some of these
15 suppliers are so that there's no surprise that if
16 an installation commander has to impose some sort
17 of special restrictions, they can't cry foul in a
18 purchasing, legal kind of way. You line them up
19 to be supportive to you.

20 MS. EMBREY: The idea is a good one, but
21 we're talking about biological agents for which
22 there are limited prophylactics and vaccines. To

1 the extent that we have the availability of both
2 they are in such short supply to the vulnerable
3 population that it becomes problematic for us to
4 contract for our own population, let alone others.
5 It creates a demand on the entire community to
6 prioritize what needs to be responded to first,
7 second and third order.

8 DR. LEDNAR: I would think less in terms
9 of trying to provide some, let's call it public
10 health response, like prophylactic vaccine or
11 medicinals. I'm thinking more in terms of
12 restriction of movement. If you're going to close
13 down the base, your vendors are going to say
14 you're restricting my business. Now I expect some
15 relief.

16 DR. POLAND: Let me just make two
17 comments and then use that as background for the
18 question. One is that in the context of
19 transmissible infectious disease outbreaks, people
20 flee, making the outbreak worse. The second
21 comment is that when you have VIPs/special guests,
22 et cetera, they can perturb or pervert the

1 standard operating procedure and unwittingly make
2 things worse. This has been commented on multiple
3 times, for example, after an assassination attempt
4 on one of our presidents and the level of care
5 that was received and how that care was perturbed
6 by the fact that he was a VIP, obviously. Does
7 this plan take anything like that into account?
8 In other words, you have the head of another
9 nation on a military installation where something
10 occurs and they're going to have a helicopter land
11 and they're going to leave.

12 LT COL HUDSON: We haven't gotten to
13 that level of fidelity. Back to the first issue
14 that you addressed, I think what will be key is
15 this plan is heavily reliant on MOUs, MAAs and so
16 are some of the other plans, being worked out and
17 established with your then local civilian
18 counterparts. Some bases do it very well in terms
19 of Air Force installations. I can't address the
20 others. Some have a lot in place and they're very
21 robust and some have none in place. We now have a
22 requirement out there to, and soon through some

1 other vehicles, there will be requirements out
2 there that they must evaluate all of those
3 necessary MOUs and MAAs and get those into place.
4 Of course DoD's got some requirements out there as
5 well. We're sort of linking with that effort.

6 DR. POLAND: I understand that
7 component. It was just a little poke to think
8 about that that's the way something like that will
9 come down and then you've never contained the
10 outbreak because --

11 LT COL HUDSON: No, you're right. We
12 probably have some experience before at
13 installations like Bolling Air Force Base where
14 just about every general is there who now wants to
15 come help or hinder in some cases, whatever the
16 case may be. We'll have to look at those. We're
17 trying to look at every gamut from the
18 installation that is just out there by itself,
19 Minot Air Force Base, for example, that's out in
20 nowhere by themselves where they don't have those
21 hindrances to the others that do. We'll have to
22 figure that one out too.

1 DR. POLAND: Any other comments?

2 Colonel Gibson.

3 COL GIBSON: I just wanted to thank the
4 Air Force for bringing this containment concept to
5 the table. Dr. Chu's letter, when it was written,
6 this is what I understood, because I helped write
7 the letter, that he was thinking about an
8 overarching plan that allows for this whole
9 concept and brings all of the players together,
10 transportation services, et cetera, as well as the
11 medical ideas under one overarching concept. The
12 other advantage, it allows for a disease that we
13 don't know about. We didn't know about SARS until
14 it occurred. It allows for that flexibility in
15 containment. I commend the Air Force for working
16 on this and moving this process forward.

17 DR. ENNIS: Please provide us with a
18 helicopter if the commander closes the base.

19 DR. POLAND: To sort of continue the
20 analogy that was built, starting with Ms. Embrey's
21 presentation, we've laid some bricks on the
22 foundation of the house of the rising sun, now

1 we're going to put some walls on it and see how it
2 plays out. Next is going to be Colonel John
3 Grabenstein, who, I think is well known to all of
4 the Board members. He's going to present the
5 smallpox outbreak response plan. I believe, Tab
6 7, you'll find his slides.

7 COL GRABENSTEIN: Thank you, Dr. Poland.
8 Appreciate the opportunity to come demonstrate the
9 new Army urban camouflage uniform to you, courtesy
10 of some baggage handlers didn't quite get the word
11 as what my destination was. The bad news is that
12 my prop of the 430-page smallpox vaccination plan
13 is in that suitcase. If you can imagine a ream of
14 paper, you've got it down pretty well. This
15 presentation will be in stark contrast to Colonel
16 Hudson's excellent presentation. I think it's an
17 interesting exercise in comparison and contrast.
18 The generic common theme approach and this very
19 specific approach are yin and yang to each other.
20 I'll make some other comments as we go. My charge
21 is to talk about a document that we developed in
22 September of 2002, three years ago now, and show

1 you the fruits of that effort.

2 DR. POLAND: John, if you wouldn't mind
3 just a brief interruption, particularly for the
4 new Board members. You may not realize the huge
5 role that the AFEB and DoD played in the civilian
6 smallpox response plan. I want to particularly
7 note, Colonel Gibson, Colonel Riddle before him
8 and Colonel Grabenstein. The joke I used to have
9 with John is I couldn't reach him during the work
10 day because he was out in the field. If I called
11 during the second or third shift at the office I
12 could always get a hold of him. That very much
13 informed the civilian policy and even the
14 recognition of this syndrome of myopericarditis
15 for example and the changes that that engenders.
16 Just to acknowledge the immense amount of work
17 that John in particular and his agency put into
18 this.

19 COL GRABENSTEIN: One of our constant
20 themes was, to amplify Ms. Embrey's remarks from
21 this morning, you're a member of your neighborhood
22 installation and widen the bridge between you and

1 the county or the city health department that's
2 right around you and that serves us very well in
3 that exercise. What we developed was a 430-page
4 plan that describes the global responsibilities of
5 the Department of Defense and we did it in a
6 relatively few number of months by having 10 teams
7 of subject-matter experts work on their own piece
8 of the puzzle independently and then I was the
9 bandleader who brought it together as a document.
10 I don't play any instruments, but was able to play
11 editor and bring it into, what I think is a
12 coherent document. The purpose for the plan was
13 to prepare for and respond to a smallpox outbreak,
14 regardless of magnitude or location, meaning not
15 just if it was, quote, unquote, easy, like in the
16 Central United States, but what if it was hard
17 like a ship at sea, or one of our overseas
18 locations. If you'll remember from the newspapers
19 there was discussion of well, we should use ring
20 vaccination. Well, we should use mass
21 vaccination. We decided we wouldn't know what the
22 right answer was ahead of time so we would have

1 plans for both and would adjust to the situation
2 that we confronted. I think that was the wiser
3 approach. Our scope, obviously we're responsible
4 for taking care of our own folks on our own
5 installations, but what about the force in the
6 field? This was, of course, prior to Operation
7 Iraqi Freedom and a major component of the thought
8 processes was conserve the fighting strength.
9 Keep that military force on the battlefield, not
10 on the sidelines licking its wounds so that it
11 could achieve it's military missions. Then, in
12 addition, understanding our role in the federal
13 response plan, the national response plan, if
14 there was a civil smallpox outbreak, provide
15 military support to civil authorities. The plan
16 was approved by the Deputy Secretary of Defense at
17 the end of September, three years ago. Next.
18 This graphic bears three lessons, at least three.
19 The top row illustrates the early onset of
20 smallpox is relatively non-specific. The
21 diagnostic suspicion of a clinician is crucial to
22 the early detection of a smallpox outbreak. The

1 middle panel shows that smallpox is a very
2 distinct disease and a pretty severe disease as
3 well. The third panel is the optimistic reminder
4 that yes, it's true that 30 percent of smallpox
5 cases die, 70 percent live. We need to remember
6 that we need to provide care to these cases. No,
7 they're not cases, they're people, of course, and
8 we must work to maximize their survival and get
9 that outbreak under control as quickly as
10 possible. Next, please.

11 The reputation of smallpox from
12 literature is the most terrible of the ministers
13 of death. We saw in the news media as the
14 smallpox issue arose in 2002 a great hyperbole
15 about what a smallpox outbreak would be like, but
16 in fact it would spread very slowly. My words
17 are, tortoise, not hare. If a smallpox outbreak
18 were to occur, it would last months. You know
19 that Katrina thing? It blew through and now we're
20 just picking up the pieces. I'm oversimplifying,
21 obviously, but a smallpox outbreak would not be
22 over in hours, it would build and build and build

1 and build and be a challenge to public confidence
2 in government like few others. Smallpox is a
3 contagious disease caused by variola virus and the
4 orthopox family; 30 percent case fatality rate.
5 Certain rare forms of it with an almost certain
6 risk of death. Smallpox as a contagious disease
7 is not as contagious as measles or chicken pox.
8 The average smallpox case would infect three to
9 five people and one of the things that I found
10 most instructive was in villages in developing
11 countries, if you had a smallpox case in the hut,
12 in the little house, home, about half of the
13 people in that same dwelling would contract the
14 disease. Face-to-face contact for an hour or
15 more, that's not the people you rode an elevator
16 with, about 15 days between generations of
17 smallpox cases.

18 I've got a graphic that will justify
19 what I'll say verbally and that is, if smallpox
20 were maliciously released, the first cases would
21 be out there and they would probably infect a
22 second wave of cases before the detection

1 occurred. The race would be to stop or trim or
2 minimize the third wave of cases. The skill with
3 which we were able to do that would determine
4 whether there would be a fourth or a fifth or a
5 sixth wave of cases. The quickest way to contain
6 or halt a smallpox outbreak, isolate the people
7 who are infected, trace and vaccinate their
8 contacts as well as the contacts of the contacts
9 and then, depending on the setting, if it was a
10 battlefield, for example, or if it was a remote
11 area without good infrastructure we might need to
12 just go straight into wide-area vaccination.
13 Next. The assumptions that went into our DoD
14 policy was the smallpox virus exists outside of
15 sanctioned stockpiles and would pose a terror
16 threat. We could be attacked with that virus in
17 one or more locations here or overseas. Our job
18 was to preserve the critical missing capability
19 and then be prepared for military support to civil
20 authorities. We were going to develop a policy
21 for our people, our families, retirees and other
22 DoD workers. We were going to work in concert

1 with the HHS plan and internationally work with
2 our analysts and host nations overseas. Next.

3 The document was a base plan, which can
4 essentially be considered a base plan for any
5 contagious disease and then ten specific annexes.
6 The first was, in the sequence of the ten, matched
7 the HHS sequence. We took their document,
8 plagiarized it, taxpayer paid for it after all,
9 Department of Defense has one luxury and that's
10 that we are an integrated health care system. We
11 knew our own setting in a way the CDC might not
12 know what's available in Maine or in Montana or in
13 South Dakota and we're able to adapt it to our own
14 world, use our own jargon and adjust it
15 accordingly and include our international
16 responsibilities. The first annex deals with the
17 public health issues. The contact tracing,
18 quarantine issues and the like. Annex B was on
19 the giving of the vaccine and all of the site care
20 and the contraindications and all of those kinds
21 of issues. C was on isolation and quarantine
22 guidelines. This is isolation of cases of

1 smallpox, quarantine of those suspected of having
2 been exposed. Annex D, Colonel Webster was
3 actually the proponent for Annex D, which was
4 laboratory issues and specimen collection. E was
5 communications, Risk Com and public affairs. F
6 was infection control, decontamination issues,
7 which was actually one of the harder ones to put
8 together because there wasn't a lot available to
9 us on that. We had to go inventing a bunch of
10 things. G, I think G, H and I were where we added
11 on to the HHS plan. G was our desire to get
12 across to people, don't abandon those smallpox
13 patients, treat them. It may be hard, it might be
14 you might have to do it out of the home, you may
15 not be able to give your standard tertiary level
16 of care. Do the best you can for them and here
17 are some guidelines. H was care of adverse events
18 after vaccination. Talks about vaccinium and
19 globulin. I was medical logistics and product
20 distribution. I was reminded this morning of the
21 old saw that amateurs debate strategy and
22 professionals debate logistics. It is definitely

1 in the logistics where the devil is in the
2 details. H was a variety of resources. Then my
3 proudest accomplishment was an index so that the
4 people inexperienced with the document could find
5 the thing they wanted to in a hurry. Each of the
6 annexes has a one-page summary, because the other
7 thing I knew was that in a crisis, there would be
8 a few people who had read the whole thing and
9 there would be a whole lot of people who would be
10 in a hurry to learn as much as they could to go do
11 something with it. There's a one-page summary at
12 the end of every annex that summarizes the annex.
13 Behind my slides in your tab are those one-page
14 summaries for you to have. Next.

15 The plan calls for before an outbreak
16 for the combatant command services installations
17 to develop, exercise and improve their local
18 response plans. Tasks the installation and the
19 medical commanders to identify where they would
20 give the vaccinations. For crowd control reasons,
21 they may not want to give it in the usual clinic.
22 They might want to commandeer the theater or a

1 mess hall or some other facility. Identify other
2 facilities for where to put contagious smallpox
3 cases, what CDC calls type "C" facilities. Where
4 to put people who have a fever who might be
5 infected, but they don't have a rash yet, so
6 you're not really sure. That's type "X" for
7 unknown. They should be in a different building
8 because they might not be infected. And then for
9 contacts, they can stay, quote, unquote, at home
10 unless they get feverish. Those were type "R"
11 facilities, residential. For us it might be the
12 barracks or that sort of thing. Train the
13 providers in recognizing smallpox. Great poster
14 from the CDC we distributed. Implement
15 surveillance for defined rash-fever illnesses.
16 Then train response teams, the most notable being
17 the epidemic response teams that each of the
18 services developed as well. Next, please.

19 In terms of diagnostic suspicion, the
20 clinical entity that smallpox is confused with
21 most often is chicken pox or varicella, so we
22 distributed some tips on that. Next, please.

1 If somebody found the generalized
2 febrile vesicular-pustular rash illness case, the
3 rash that makes you nervous, they should report it
4 up through their disease reporting system and send
5 a serious incident report to their higher
6 headquarters like they usually do. Tell CDC and
7 tell the State or, overseas, the host nation. In
8 the hospital or in the clinic what should they do?
9 Look for more cases. Are there more cases out
10 there that you don't realize yet, that haven't
11 come in for care? Isolate the cases to reduce
12 spread. Start working on who their contacts are,
13 vaccinate them and the contacts of the contacts
14 and begin to monitor them for fever. Vaccinate
15 other high-risk personnel, the healthcare workers
16 who are going to care for the folks to be
17 vaccinated. More security folks to get things
18 under control and then according to as the
19 situation would warrant, consider wide-area
20 vaccination. Graphically, it looks like this, the
21 case is given care and isolated. The contacts are
22 vaccinated as soon as they can be found. If they

1 have fever and no rash, they go into a type "X"
2 facility. If they have no fever, they can go
3 home, but they need to call in daily to tell us
4 what their temperature is. Similarly, the
5 contacts of the contacts vaccinate and as long as
6 they don't have a fever we're okay. Ring
7 vaccination conquered smallpox, eradicated it from
8 the globe. Wide-area vaccination is attractive,
9 but you then give this vaccine to a whole lot of
10 people and if you haven't screened them well,
11 there are some pretty substantial side effects to
12 smallpox vaccination in somebody with atopic
13 dermatitis or with immune suppression or the like.
14 Drawing on a map where the borders are of who's in
15 and who's out of the area to be vaccinated seems
16 simple, that's two-dimensional. And people move
17 and how many people pass through O'Hare Airport
18 four days ago, it gets very complex to trace these
19 things. They tend to be, those clusters tend to
20 be administratively simplified. With military
21 units it's a little simpler. There are some of
22 the same clustering issues but also for command

1 and control issues, if we're going to use the unit
2 in some military mission, then vaccinating the
3 whole unit has some logic to it. How close is
4 close enough to a likely case or how far is far
5 enough? Is it measured in time? Is it measured
6 in distance? If we start picking multiple cities
7 are we going to do everybody who is one air hub,
8 air link away from Atlanta, for example? If the
9 case is in Indonesia, would we vaccinate everybody
10 in the Pacific Rim, everybody in CONUS? Those are
11 very difficult questions and you can't anticipate
12 ahead of time what the right answers are. To a
13 military commander, what would you do with your
14 unit? We've talked about restriction of movement
15 a bit today. If you are a ship that's been at sea
16 for quite a while, stay there, because we know you
17 don't have any cases, because they'd either have
18 manifested by now or you didn't have any aboard.
19 We took care of ships first. Imagine an outbreak
20 in Atlanta. What would we do at McPherson at
21 Atlanta Naval Air Station at Robins, Beaufort at
22 Charleston, Cutter and Charleston? Active

1 surveillance for fever. Limit entry into the
2 compound. Then there's that tempting thing that
3 seems like a great idea and doesn't have a whole
4 lot of direct value and that's closing the gates,
5 because you may well be locking in people who are
6 infected. Locking the gate by itself isn't
7 enough. By the way, it's not the gate, it's the
8 fence that's the issue. How good is your fence?
9 If Romeo's on one side of the fence and Juliet's
10 on the other side of the fence, now, how good is
11 your fence? Air crew, the general instruction was
12 minimize air traffic between installation until
13 the crew could be interviewed about fever, rash,
14 travel history and vaccination status. There is
15 no value to isolating people without symptoms,
16 they aren't contagious. They do need to be told
17 to speak up if they get a fever. If you're in a
18 building, don't shut off the ventilation system
19 unless you know what that does in your air
20 handling. Does it force the air to one side or
21 another? The building engineers need to advise
22 you on that. Closing the gates won't keep

1 contagious people out, they may already be inside.
2 Restrictions imposed today would require two weeks
3 to have a beneficial effect. There might be value
4 in having the gate guards look for people trying
5 to leave post. If you know who's been exposed,
6 the contacts on your contacts list, if you want to
7 find so you can interview. We touched on this
8 earlier that it might be appropriate to require
9 vaccination to enter the installation or
10 conversely to leave the installation. That was
11 discussed in the PHEO section. The plan
12 identified several next steps. The services to
13 form the teams that they did and the training that
14 they did and the vaccination that we did and the
15 exercises that we've done. Installation
16 developing local support plans. Services training
17 providers in recognition and surveillance.
18 Teaching people how to use the bifurcated needle.
19 That was new in '02. Not new, but out of
20 practice. Bandaging, isolation and duty
21 limitations after vaccination. We've accomplished
22 that learning curve. At this point, DoD has now

1 screened 940,000 people for smallpox vaccination
2 and vaccinated 850,000 of them, which is a tribute
3 to lots of clinics around the world, ships at sea
4 in a time of war, it's the quality and the
5 integrity and the clinical success that they've
6 had in accomplishing that.

7 I'll stop here. The last few slides
8 give you the update of the statistics I've given
9 you in previous sessions. Suffice it to say it's
10 more of the same and this is the website where we
11 have all of our documents posted,
12 www.smallpox.mil. I'll just close with one other
13 thought about Colonel Hudson's Air Force plan and
14 mine in contrast to each other and that's this
15 document is so big, maybe because it's more than
16 just a plan, it's all of our collection of
17 educational tools. It's a plan plus. We can talk
18 over a beer about what the right way to create the
19 documents are and distribute them. Here's where
20 we are. I'll pause here and take any questions
21 you might have.

22 DR. POLAND: Thank you, Colonel

1 Grabenstein. Comments or questions?

2 MS. EMBREY: Context comment. At the
3 time the smallpox plan was implemented, we had
4 just gone to war in Afghanistan. There was a
5 perception that we were at risk for deliberate
6 exposure to smallpox through al-Qaida and other
7 actors. There was a real pucker factor from the
8 President on down that this was a possibility and
9 that we at the time had no licensed vaccine. In a
10 matter of six months this program got implemented,
11 developed and implemented, and smallpox
12 vaccinations started going in arms in December of
13 '02. Huge accomplishment thanks to the task force
14 that you led and that the services embraced and
15 implemented. I would tell you the similar kinds
16 of plans that have been developed since then were
17 in response to specific concerns or
18 vulnerabilities. SARS was an unknown threat and a
19 specific set of response capabilities and plans
20 were put into place to deal with the specific
21 threat. The Air Force's recommendation is
22 absolutely right, we need to come up with

1 something that's more generic. I don't apologize
2 for having the specific plans.

3 DR. GARDNER: My comments follow on
4 that. I think that there's room for both the
5 generic, particularly for the unknown mystery
6 illness. Once you understand either the specific
7 organism and smallpox, the good thing about
8 smallpox is it is only human reservoirs -- then
9 you can go into modifications. Those of us who
10 have spent a lot of time in hospitals, once we
11 understand even the epidemiology as a respiratory
12 versus a contact versus food-borne, it seems to me
13 you move into some modifications on the generic
14 approach. I also want to just comment on John's
15 been a spectacular leader in this field for so
16 long, but I think there's always been this tension
17 between the military response, which was
18 predicated on force protection versus the
19 reluctance that was generated in the civilian
20 response, which sort of said show me a case before
21 I'm going to immunize the world. I think actually
22 both turned out to be okay. I don't think you had

1 to go all one way or all the other and I think
2 that, I for one find, I think we can come to peace
3 between those two factions.

4 COL GRABENSTEIN: I'll just comment that
5 as a citizen, I'll feel better when my county
6 tells me where my kids should go if they need
7 Cipro, Prussian blue, potassium iodide vaccination
8 or whatever. I think we ought to get to the level
9 of detail that that's accomplished.

10 DR. GARDNER: That's true. What came
11 out of it was the preparedness to do it rather
12 than the actual doing it. We all are awaiting,
13 hopefully, a newer vaccine product that will
14 reduce the anxiety over the complications. When
15 that will happen, we're not sure.

16 COL GIBSON: Like to comment on what you
17 were talking about. I don't see a conflict
18 between an overarching containment plan and very,
19 very specific plan for a specific disease. The
20 concept is you have this big overarching plan that
21 brings together all of the transportation
22 services, security, public affairs issues and then

1 you hang specific diseases in minute detail like
2 we have in this plan, off of that basic plan.
3 They're together, they're synergistic and would
4 help us really move down the road on this whole
5 concept.

6 DR. PARKINSON: John, great. But as I'm
7 listening to this and Dr. Gardner's parallel
8 conversation, what happened in the civilian
9 sector, more likely what didn't happen, what has
10 aggressively happened with responsible science in
11 the military sector. It's not inconceivable to me
12 that if there ever were to be a civilian case of
13 smallpox, that the military would rapidly become
14 the only national reservoir of protected health
15 care providers and people in general. I just
16 wonder in the dialogues that you have is, someone
17 will make in a nanosecond the assumption that
18 whatever happened to the public health
19 responsibility to provide a protected health care
20 worker workforce. I think it leads us to kind of
21 suggest, as all of us as medical professionals,
22 what is the ethic nowadays about medical

1 professionals taking the lead in the light of the
2 Katrina experience where, for rightly or wrongly,
3 where was that backbone? Everything from the
4 Hippocratic Oath or anybody who's in a
5 professional field. It's a little scary to think
6 about and actually, Pierce, your comment triggered
7 that as I thought about it.

8 DR. GARDNER: John pointed out that
9 smallpox isn't the sudden bomb. It takes some
10 generations. I think everyone would agree when
11 the first case of smallpox occurs in the world,
12 then the whole situation changes. The goal here
13 is to have us highly, highly prepared in vaccine
14 close to where it can be given. John's pointed
15 out we haven't achieved that goal yet, but that
16 certainly would -- I think many people feel that
17 we could get our public health people whipped into
18 shape within a matter of weeks to months and that
19 this would be okay for a relatively slow-moving
20 epidemic. We're not going to prevent every case,
21 but we would certainly move to where we want to
22 get much quicker. Right now you can't bring the

1 number of people getting immunized, even though
2 the same rules were on the books, the number of
3 civilians being immunized is a dribble, if that.
4 I think there's a practical -- the public health
5 level of anxiety hasn't risen to the stage where
6 we can get that done. If we get a case at some
7 point, then everybody will join.

8 DR. POLAND: Colonel Grabenstein, thank
9 you. You and MILVAX should be nominated for some
10 sort of award. We'll move on now to Lieutenant
11 Colonel Wayne Hachey who will provide -- I'm not
12 sure if we're going to do two or one, two okay --
13 briefings. Pandemic influenza response plan and
14 the Avian influenza preparedness. Tab 8 contains
15 those slides.

16 LT COL HACHEY: Good afternoon, again.
17 My name is Wayne Hachey and I'll be presenting
18 Avian Influenza and DoD Pandemic Planning. We're
19 going to combine the two in hopes of sparing you
20 an extra 20 minutes so I can give that cheerfully
21 to Dr. Poland for his multimedia influenza
22 extravaganza to follow. First slide. The agenda

1 for today is just an overview of Avian influenza
2 followed by the description of DoD planning to
3 include goals, preparedness, strategy and some
4 current initiatives. Next slide.

5 Influenza viruses are single-stranded
6 segmented RNA virus. They can change rapidly,
7 either by mutation or through the exchange of gene
8 segments. They're found in a wide variety in both
9 birds and mammals to include humans, pigs and
10 horses. Matter of fact, back in the 17- and 1800s
11 when the flu kind of swept through, everybody lost
12 their horse. Now we have Chevys so I guess it
13 doesn't matter quite as much. The natural host is
14 waterfowl, geese, ducks and gulls. Again, in the
15 1800s there were fowl plagues, f-o-u-l, that wiped
16 out large bird populations. Next slide.

17 Influenza A in people is well known.
18 Every year it kills about 36,000 people in the
19 U.S. alone. Pandemic strains with novel surface
20 proteins can and have caused significant increases
21 in both illness and death. A case in point is the
22 1918 Spanish Flu, which actually started in

1 Kansas, I guess good PR, and that killed about 50
2 million people and almost 1,000,000 here in the
3 U.S. alone. This is most likely due to an Avian
4 flu that adapted without re-assortment. The
5 characteristic W shaped mortality curve that's
6 associated with the 1918 flu may have actually
7 been due to some prior exposure to a pandemic that
8 occurred in 1889. Our current projections as far
9 as worst-case mortality using the 1918 data, may
10 actually be an underestimation. Its impact on
11 DoD, in World War I about half of our casualties
12 came from influenza and not from bullets and
13 bombs. There have been two other pandemics, one
14 in 1957 and one in '68 with a lower degree of
15 mortality but still quite impressive. They were
16 due to an H2N2 and H3N2 viruses. Avian influenza
17 is a diverse group of those influenza A viruses,
18 but it infects both wild and domestic birds.
19 There's 16 hemagglutinins and 9 neuraminidase
20 serotypes, so 144 possible combinations although
21 we only have a handful of Avian influenza that's
22 currently active. They usually affect the avian

1 GI or respiratory tract and it's usually of a
2 low-path variety. This will be important when we
3 look at what the real risk for H5N1 is. Low-path
4 disease usually causes mild or no symptoms in wild
5 birds. High-path disease is a disease primarily
6 of domestic poultry and here only H5 and H7 allows
7 for systemic replication in birds. The bird will
8 get the flu and then essentially his innards turn
9 to mush. If you're a chicken, you catch it in the
10 morning and you're dead by sunset. Next slide.

11 Some recent high-path outbreaks started
12 back in 1997 in Hong Kong where 18 people were
13 infected. Six died along with a million and a
14 half chickens and they wind up pulling tens of
15 millions of poultry that were slaughtered. In
16 2003 in Northern Europe, 90 people were infected.
17 There was one death of a veterinarian, who by
18 report, refused to take antivirals and millions of
19 poultry were slaughtered. That was a different
20 serotype there, H7N7. The current bird flu that
21 even Time magazine had on its front covers, has
22 started in 2003 through five and you can tell this

1 is a very old slide. I revised this on Wednesday.
2 Now there are currently, over the past two years,
3 116 infected and 61 dead with, again, over 150
4 million domestic and wild birds dying from the
5 disease. In fact, if you're a tiger or you're a
6 person who eats a dead chicken carcass who had
7 died from H5N1, you will follow that path of the
8 chicken shortly thereafter. Matter of fact, the
9 third to the last fatality, that's what happened.
10 It was a local farmer grabbed a dead chicken, ate
11 that and he soon, again, followed the path of this
12 chicken. A little closer to home in 2004 in
13 British Columbia, two infected, no deaths, but 19
14 million birds were slaughtered. Next slide.

15 The strain that's gotten the most press
16 is H5N1. H5N1 viruses today are genetically not
17 the same one that was occurring in 1997. Human
18 infections have generally been associated with
19 really massive doses of the virus. A chicken dies
20 before your very eyes and you snatch the chicken
21 up and eat it, you will die. These are the folks
22 that for the most part have been our fatalities

1 with H5N1. It is spreading out of Southeast Asia
2 and migrating birds have been accused, perhaps
3 wrongly, of this. Ill birds with the virus are
4 most likely to be dead and not able to act as
5 carriers. We'll see some more data that suggests
6 that, again, migrating birds are not the answer.
7 Next slide. This is where the birds are. These
8 lines depict different migration patterns. This
9 red area here is the hot spot for Avian flu with
10 these little dots up here representing the Avian
11 flu that has left, essentially, the hot zone. If
12 you look at the migratory bird patterns, the
13 migratory bird patterns don't go this way, they go
14 north and south. What does travel in that
15 direction are trade routes where smuggled birds go
16 across international boundaries. Next slide.
17 We're still concerned about the migratory bird
18 routes, especially when those migratory patterns
19 go from, again, the hot zone here a crossover into
20 Alaska. There still is that concern that we might
21 be wrong, that maybe it is migratory birds. Next
22 slide. Are the flyways a risk or really much ado

1 about nothing? On August 25th of this year, the
2 chief veterinary official from the European
3 commission concluded that because further
4 information was necessary in order to implicate
5 migratory birds, the immediate risk of those birds
6 introducing Avian flu to the European union was
7 remote. However, the director of the United
8 Nations Food and Agricultural organization
9 expressed an opposing view. Next slide.

10 Should we be blaming wild birds? A
11 recent outbreak in Russian PCR of the waterfowl
12 that was dying and the domestic birds that were
13 dying revealed two different strains. The wild
14 birds weren't giving it to the domestic
15 population. A recent outbreak in Mongolia with a
16 large bird die-off, the Wildlife Conservation
17 Society, funded by the FAO sent 800 samples and
18 only one was positive for H5N1 and their
19 conclusion was that the deaths were due, not to
20 AI, but AI was probably an incidental finding.
21 The World Health Organization did not agree with
22 their findings. In Northern Kazakhstan a recent

1 outbreak of AI, the pattern did not correspond to
2 migratory patterns, but did correspond to trade
3 routes. Again, strongly suggesting that it's
4 smuggled poultry and not the migratory birds that
5 I don't think that we should be worried about.

6 Lastly, in Alaska from 1998 to the
7 current date over 12,000 samples have been sent
8 from wild birds to be analyzed for the potential
9 of H5N1 and none has been found to date. Is the
10 problem our gentleman up top here or is it the
11 migratory birds down here? The answer is still
12 unknown. It may be a little bit of both or we may
13 be chasing our tails as far as looking at geese
14 and we should be looking at poultry going across
15 the borders. Next slide.

16 The next question is, is H5N1 the next
17 pandemic strain? There's no current evidence that
18 the virus is adapting to humans. Also,
19 re-assortment is possible, but even with
20 re-assortment we still don't know what the
21 pandemic risk really is. Adaptation without
22 re-assortment is also possible, but you need 40

1 base pair changes specifically to do that. We
2 have already had 39 and we're waiting for that
3 last one or are we at number one and we have 39
4 random changes to go? Also, there's no historic
5 precedent for a high-path Avian influenza
6 initiating a pandemic. All of the known
7 pandemics, H1, H2 and H3 were from low-path AI.
8 The problem is that our historical perspective is
9 very limited. We go back to 1918 and not further
10 beyond that. The other question is does H5 have
11 what it takes? Can an H5 virus get there from
12 here? Is there a biological barrier to adaptation
13 to humans? That, again, we don't know.
14 Regardless, a pandemic coming. All pandemics
15 come, sooner or later, from birds. When that
16 happens, we'll have a naïve global population.
17 Complicating that we have a limited global vaccine
18 capacity and to boot, folks are require both a
19 priming dose and a booster, further limiting our
20 vaccine capacity. We also have limited global
21 anti-viral capacity. At least with H5N1 some
22 neuraminidase inhibitors have been shown to be

1 effective in both prophylaxis and treatment.
2 However, the amantadines, primarily because the
3 Chinese were feeding it to chickens, have limited
4 or no use due to the resistance already
5 demonstrated for this particular virus. Next
6 slide.

7 The current threat H5N1 is now endemic
8 in Southeast Asia and has expanded in Siberia and
9 spread to Mongolia and Kazakhstan but it's still
10 primarily just an avian disease. Again, some have
11 expressed concern that flyways may spread the
12 disease both to Europe and North America. Right
13 now it's still a bird-to-swine or bird-to-human
14 transmission and that's been confirmed. However,
15 there's been no confirmed sustained human-to-human
16 transmission. Supporting that, if you massively
17 infect a pig and put him in close proximity with
18 another pig, there's still no transmission.
19 Again, fortunately or unfortunately, we're very
20 close to pigs. Downside for all you cat lovers,
21 the domestic cat easily transmits the disease from
22 one cat to another. And some feel that a genetic

1 drift or shift resulting in human-to-human
2 transmission may be inevitable. Next slide.

3 The current threat, particularly in
4 Southeast Asia, in regards to containment, 75 to
5 80 percent of poultry farms are these small
6 backyard operations. That's going to
7 significantly limit our bio-security. Also
8 there's a lot of nasty bird bugs out there. The
9 endemic viruses result in a 50 to 70 percent
10 baseline in poultry deaths. An individual farmer
11 has no idea whether his bird die-off is due to
12 bird cholera or whether it's H5N1. Remember,
13 these are fairly small operations and there are
14 multiple disincentives for them to report a
15 die-off. The host nations are unable to
16 compensate folks after they come in and wipe out
17 someone's livelihood. They're very unlikely to
18 report that they have a potential problem. Most
19 Southeast Asian countries also lack a
20 comprehensive public health system or plan for AI.
21 They also have a poor public health and civil
22 service infrastructure. In fact, Indonesia has

1 been unable to control the spread by culling
2 because they don't have the resources to cull,
3 although they've had hundreds of thousands of
4 birds who have died from Avian flu, they've culled
5 97. Not 97,000 but just 97. There's a low degree
6 of buy-in from their leadership. Next slide.
7 This is what we're left with. We have folks in
8 small operations who are in intimate contact with
9 their poultry. We have some poultry that clearly
10 aren't doing terribly well and after they die they
11 may be sold for human consumption. Next slide.

12 This kind of gives you an idea of the
13 scope of the problem. This is a picture that
14 delineates a density of poultry in Southeast Asia.
15 You can see a hot zone for Avian flu is where the
16 birds are, at least as poultry. This is where we
17 could potentially expect where the spread of
18 disease is going to be. Next slide.

19 This leads us into the second topic, DoD
20 AI pandemic planning. Next slide. Our goals, and
21 this would be a recurrent theme is to preserve the
22 ability to provide for national defense. As far

1 as AI is concerned, this would include protecting
2 that total force from Avian influenza, conducting
3 aggressive global surveillance, educating the
4 total force, beneficiaries and providers in
5 regards to prevention, containment measures and
6 treatment. Next slide.

7 Now I've divided the preparedness
8 categories into these five areas which correspond
9 to the WHO Global Influenza Pandemic Plan. They
10 include planning and coordination, situation
11 monitoring and assessment, prevention and
12 containment, health system response and
13 communications. Next slide.

14 As far as planning and coordination, DoD
15 has actively participated in an interagency global
16 pandemic influenza planning process. The emphasis
17 on this has been early regional containment at the
18 site of the initial outbreak. The nice thing
19 about this is money if it's attached to this.
20 Congress has appropriated \$25 million for this
21 reason and things are progressing along reasonably
22 well as far as actually making this happen. The

1 Department of Health and Human Services has
2 released its pandemic influenza plan and DoD has
3 submitted its comments to the plan. Again, we're
4 always in a supportive role, but as you can see
5 from the earlier presentations today, that
6 supportive role can be somewhat substantial.
7 Also, the DoD pandemic influenza plan has been in
8 place since 2004. There's been a variable degree
9 of readiness at the installation level, but,
10 again, from presentations earlier today, we're
11 probably closer than farther away. PACOM has
12 completed their plan and other COCOMS are to
13 follow. Next slide. Going from the 50,000-foot
14 level down to maybe at least 5,000, locally
15 commanders are including preparation in medical
16 and non-medical contingency planning that address
17 out-of-season immunization clinics, immunization
18 tracking systems, medical triage and expanding the
19 provision of medical care. Combatant commands are
20 developing and exercising their DoD specific
21 contingency plans. In fact, PACOM has a table-top
22 exercise exercising their plan in less than two

1 months and DoD is coordinating with the World
2 Health Organization, HHS and allies on pandemic
3 planning at multiple levels. Next slide.

4 As far as training, commanders are
5 scheduling, conducting and evaluating training.
6 Military medical departments will be training
7 providers and special surveillance control
8 measures, immunization, chemoprophylaxis and
9 chemotherapy of influenza. The next component of
10 DoD's program is situation monitoring and
11 assessment. Our current surveillance efforts
12 hopefully will ensure the earliest possible
13 detection of an emerging pandemic. When a novel
14 strain of influenza is identified, enhance
15 surveillance will be instituted and that's already
16 in place. With human-to-human transmission, that
17 surveillance will be further enhanced and
18 extended. Next slide. The first component here
19 is the DoD worldwide influenza surveillance
20 program and this is a laboratory-based program
21 with the goals of detecting local respiratory
22 outbreaks, providing isolates to the WHO and the

1 CDC in detecting emerging strains. Within the
2 system, there's 19 sentinel bases. Nine
3 Stateside, three in Europe and seven in Asia. We
4 also have sites located in Lima, Peru, a travel
5 clinic in Nepal and the Kwai River Christian
6 Hospital on the Thai/Burmese border. Next slide.

7 Another component of our surveillance
8 program is the DoD-GEIS program, the global
9 emerging infections systems. This leverages the
10 surveillance and response assets of a network of
11 DoD service hubs and overseas medical research
12 units. They also participate in a consortium that
13 includes U.S. Army Center for Health Promotion and
14 Preventive Medicine, U.S. Army Medical Research
15 Institute of Infectious Diseases and the Naval
16 Environmental Health Center. They've also
17 established strong working relationships with the
18 CID and international agencies, an example of
19 which is the World Health Organizations Global
20 Outbreak Alert and Response Network. Next slide.
21 This is the list of the GEIS hubs and they include
22 facilities in Texas and San Diego as well as

1 Indonesia, Egypt, Kenya, Peru and Thailand. Next
2 slide.

3 The next component of the DoD
4 surveillance program is ESSENCE, the Electronic
5 Surveillance System for Early Notification of
6 Community-Based Epidemics. This system collects
7 data from all TMA, MTFs worldwide. At present,
8 there are 121 Army, 110 Navy, 80 Air Force and two
9 Coast Guard installations. Data's provided within
10 approximately three days. From what I understand
11 that timeline is being shortened a bit. What they
12 use is similar ICD-9 codes that are grouped
13 together in seven syndromes that best represent
14 presenting signs, symptoms and diagnoses. By
15 establishing pre-existing baselines, the new
16 baseline is compared in these seven groups and you
17 can notice fluctuation in the groups that may
18 represent a new onset of disease. Next slide.

19 Early in a pandemic, the way it's
20 supposed to work is the Secretary of Department of
21 Health and Human Services notifies the Secretary
22 of Defense and the Assistant Secretary of Defense

1 for Health Affairs that there's a pandemic. Then
2 they notify the Joint Staff and Surgeons General
3 and the commanders are notified via command
4 channels. What probably will happen due to GEIS
5 and ESSENCE and interactions with the CDC and the
6 WHO, DoD is likely to be aware of the pandemic
7 long before HHS or at least a little bit before.
8 Next slide. With an early pandemic, the
9 importance of containment can't be stressed more.
10 Early containment measures would be instituted by
11 local government, assisted by the Department of
12 State, USAID and the Department of Defense. Once
13 a pandemic outbreak is confirmed, the Joint Staff
14 or combatant commands will provide strategic
15 forces with instructions to implement available
16 medical and non-medical countermeasures to include
17 antivirals, quarantine, closing schools,
18 restricting movement, reinforcing hand washing,
19 PPE and so on. Next slide.

20 Operational priorities, again our
21 recurring theme is to maintain operational medical
22 readiness. We'll be doing this by immunization,

1 if we have them, or chemoprophylaxis of deployed
2 forces. After that, then non-deployed forces who
3 are on alert or designated to conduct contingency
4 operations and then the rest of the active duty
5 personnel and critical civilian support. Other
6 priorities include preparation of MTFs to provide
7 mass immunization and to care for large numbers of
8 patients. Immunization and chemoprophylaxis of
9 other beneficiaries and risk communication with
10 beneficiaries. Next slide.

11 The health system response. DoD will
12 provide administrative and medical responses to
13 minimize operational impact through vaccination or
14 chemoprophylaxis of targeted subpopulations.
15 Again, the deployed forces, especially those
16 engaged in armed conflict, will have priority for
17 any resources. Next slide.

18 Following the pandemic confirmation, the
19 antiviral stockpiles will be eligible for release.
20 We currently have purchase two million treatment
21 courses of Tamiflu with delivery expected to occur
22 no later than mid-November, probably, from what

1 I've been told, even a little bit earlier than
2 that. Final delivery to be completed of the two
3 million by February of next year. These will be
4 stockpiled in CONUS, PACOM and CENTCOM and this is
5 to provide prophylaxis for 350,000 front line and
6 critical headquarters and health care personnel as
7 well as treatment courses for 17,000 OCONUS
8 beneficiaries and that leaves us an additional
9 500,000 treatment courses to be held in reserve.
10 Next slide. As far as the vaccine, the Avian
11 influenza or at least H5N1 vaccine is currently
12 not available. Clinical trials are underway,
13 which are promising. One thing that's not
14 promising though is that the amount of vaccine
15 that we need is much larger than originally
16 anticipated, which will further our vaccine
17 supply. After determination of a pandemic
18 specific H5N1 strain, even then the flu vaccine's
19 not going to be available for approximately six
20 months, which increases the importance of
21 antivirals. Again our naïve population will
22 require two doses. Initial supply will be

1 severely limited and needle and syringe supplies
2 are likely to be in short supply. Next slide.

3 As far as communication, local
4 commanders will designate an influenza
5 coordination cell to coordinate the DoD response
6 and provide a focal liaison with DoD, other
7 federal and local response coordinators. Local
8 commanders will also evaluate and report the
9 operational impact of the disease. The military
10 treatment facilities will report on the impact of
11 disease to include the response to therapy, supply
12 and staffing requirements. The military vaccine
13 agency will facilitate this latter transmission
14 through the chain of command. Some potential
15 strategies that we're exploring is ones to obtain
16 the generic H5N1 vaccine when licensed and
17 administer it to our troops before pandemic
18 strikes. This has a number of advantages. One is
19 that our personnel will already have received
20 their primer dose and only require a booster and
21 you may also get some interim protection prior to
22 that specific vaccine development and

1 distribution. Another potential strategy is the
2 use of dose-sparing syringe technology. Those
3 syringes have a low dead space so you get more
4 vaccine that you can actually put into people
5 rather than into the trash in your wasted
6 syringes. This stockpile of syringes would also
7 ensure that we do have syringes available for
8 immunizations. In fact the CDC and other nations
9 are considering this strategy. Next slide.

10 The current DoD strategy is enhance the
11 DoD's ability to support the U.S. governments
12 domestic and AI programs. The first priority is
13 always to protect the critical DoD forces and
14 beneficiaries. Also included in our strategy is
15 to increase global capacity and capability of our
16 ability to identify and report AI. Also, the
17 ability to contain an outbreak with global
18 projection so we can stop it before it gets to our
19 shores or at least slow it down before it gets to
20 our shores. To do that this requires improved
21 allied military capability to prevent, track,
22 report and respond to AI in their countries and

1 that's where our planning and policy folks really
2 take the lead. As far as our strategy can also be
3 divided into key components. The first,
4 countermeasures. This would be to acquire and
5 preposition antiviral treatment. We already have
6 the two million treatment courses that we've
7 already purchased and we'll be requesting an
8 additional 700,000 treatment courses of Tamiflu.
9 Also to acquire and administer a pre-event vaccine
10 when it becomes available. Next slide.

11 As far as surveillance, to enhance DoD
12 global situational awareness. The first step is
13 connecting the disparate DoD surveillance
14 activities. We have a number of activities, what
15 we need to do is have them all talk to one another
16 and to standardize collection, reporting and
17 analysis of information. Also to support the
18 initial U.S. government integration of medical
19 intelligence within AFMIC. Next slide.

20 As far as our strategy in regards to
21 laboratory capability and capacity to expand DoD
22 existing lab capacity and capability necessary for

1 sampling, analysis and reporting to the CDC and
2 WHO. This would be including increasing our, both
3 our numbers and capabilities of real time PCR,
4 both on floating platforms and in fixed
5 facilities. Another component would be increasing
6 the laboratory capability at the lab in Thailand
7 from a BSL-2 to a BSL-3 facility and increasing
8 personnel in diagnostic capacity across the board
9 to handle a potential surge capacity. Next slide.

10 As far as response, enhancing our
11 capability of military treatment facilities and
12 our PHEOs to respond to outbreaks. Augmenting the
13 epidemiological teams to enhance their surge
14 capacity. Assisting the CDC in identifying
15 specific isolated viruses for the use in building
16 vaccine, and we've been doing this for actually
17 quite some time now. DoD is an integral component
18 as far as identifying what the next flu vaccine is
19 going to be each year. Completing the CONOPs for
20 response for all of the COCOMS. The last
21 component is our military-to-military capacity
22 building. Here we need to work with PACRIM allied

1 countries' militaries to expand their limited
2 capacity to prevent, identify, track, report,
3 contain and respond to AI outbreaks. Next slide.
4 A few new initiatives that are currently underway.

5 There's an AI work group established to
6 determine the current state of our clinical
7 readiness. This will be looking at the current
8 capabilities and assets; what measures we're using
9 to validate our readiness; what our current
10 surveillance capabilities are, depending on where
11 we need to go from here; determine how clinical
12 activities are integrated internally and then how
13 these activities are interfaced with other U.S.
14 government and NGO venues. Next slide. Another
15 new initiative is the Joint Health Surveillance
16 Center Implementation Planning Task Force. This
17 has the goal to develop an implementation plan to
18 organize existing and proposed DoD surveillance
19 assets to achieve a comprehensive, continuous and
20 consistent military health surveillance within the
21 armed forces. Next slide.

22 Another initiative the DoD Avian

1 Influenza Website. That, from what I understand
2 may be actually up and running before we actually
3 get home from this conference. This will provide
4 information and guidance to either commanders,
5 providers and beneficiaries all regarding Avian
6 influenza. The last initiative is the DoD AI
7 Communications Group. This is primarily at the
8 lowly action officer level with representatives
9 from Health Affairs, the Joint Staff and policy
10 and this is to ensure clear lines of communication
11 regarding AI planning and response within DoD
12 itself. This last slide depicts some approved
13 supplemental OMB requests. We already mentioned
14 the Tamiflu for an additional 700,000 treatment
15 courses, which has been approved and hopefully
16 we'll actually see the money. Vaccine for 18
17 million doses so we'll be able to provide that for
18 all beneficiaries. Surveillance activities, \$40
19 million to upgrade capabilities and surge
20 capacity. And mil-to-mil capacity building, \$10
21 million. We also asked additional funds for
22 education, PPE and dose-sparing strategies but

1 that was not approved by OMB. That concludes my
2 presentation.

3 DR. POLAND: Thank you very much. Dr.
4 Gardner?

5 DR. GARDNER: Couple comments and a
6 question. Delighted to see the surveillance
7 activities expanding. I've always been curious or
8 a little unhappy that we don't look harder at
9 other places where there are a lot of pigs and
10 chickens and humans intermixed. That would
11 include South America and you've got Peru on the
12 active surveillance list and Africa, where I don't
13 see much happening. Although you said in the GEIS
14 programs we've got Egypt and Kenya, but are they
15 different than the laboratory base? Are they not
16 laboratory based GEIS?

17 LT COL HACHEY: They are laboratory
18 based but each of the GEIS hubs has somewhat of a
19 unique niche where they have a different area of
20 focus.

21 DR. GARDNER: My next comment was going
22 on we learn so much and the military contributed

1 so much to our understanding of the smallpox
2 vaccine and we contributed a lot, even this
3 committee that was not picked up in the civilian
4 efforts. It seems to me that as we introduce a
5 somewhat different vaccine Avian influenza and
6 into a closed health system such as the military,
7 we have the responsibility to look hard for the
8 rear adverse reactions that should be looked for
9 in this vaccine. I would encourage careful
10 surveillance of vaccine recipients. The third
11 component, I know that Tony Fauci's talked about
12 this, Steve Ostroff's addressed this, when do we
13 begin? Do we begin now or do we wait until we see
14 more evidence of pandemic flu? I think again one
15 could conceive, I think for military preparedness
16 purposes we should begin the military first,
17 perhaps before we consider immunizing everybody.
18 With a limited amount of vaccine, is the plan
19 really to start with the military before we get
20 into more civilian uses? How do you feel about
21 that?

22 LT COL HACHEY: How do I feel about that

1 or how does the DoD feel about that?

2 DR. GARDNER: Fauci, his line of
3 reasoning is well we get a little antigenic drift
4 and shift and the fact that we immunize everybody
5 each year even though it's still H3N2 probably
6 helps. You can build up some background over the
7 years for the years where the vaccine and the
8 circulating virus don't exactly match. He thinks
9 we should begin to immunize now everybody with
10 H5N1 to try to get ahead of the curve. That's a
11 debate that we'll see more of as we see more human
12 cases.

13 LT COL HACHEY: I think you have to
14 convince yourself the H5N1 is likely. If it is
15 and if there is vaccine available then clearly
16 immunizing, at least the critical DoD population,
17 does give us that advantage of one, a potential of
18 some partial protection and then two, only needing
19 that booster. In a sense it's kind of a public
20 service to the nation that there's more vaccine
21 for everybody else, because we've already been
22 primed.

1 DR. POLAND: Let me ask Colonel
2 Grabenstein to comment and then Dr. Gray and Dr.
3 Halperin.

4 COL GRABENSTEIN: I would like to hear
5 from a virologist that using an H5N1 vaccine now
6 that is not human-to-human transmissible would be
7 of value or should we wait for a human-to-human
8 transmissible strain? Maybe there's some value to
9 giving some folks the one priming dose where any
10 old H5N1 might work and waiting for the really
11 good batch down the road. That's the science
12 part. The policy part is there is no policy for
13 pandemic influenza or Avian influenza vaccination
14 right now. To do a program with anything other
15 than an FDA-licensed vaccine would be horrendously
16 difficult.

17 DR. OXMAN: I'll give you my opinion as
18 one virologist. I don't think it's universal.
19 Any H5 would have benefit. How much benefit it
20 would have, it would have priming benefit and how
21 much depends on how much drift there is between
22 the H5 you use and the H5 that hits you. There's

1 no question that it would be a benefit in terms of
2 priming people. Frank Ennis is another, he's an
3 immunologist as much as a virologist and he ought
4 to have a view on that as well.

5 DR. ENNIS: I'd agree with what Mike
6 Oxman says. I don't know enough about H5 and
7 antigenic drift, but that's certainly been the
8 case with the H1s and H3s. So at some point there
9 will be enough drift that the vaccine from four
10 years ago may not be worth very much. I think --
11 to go from that to a comment, if I might. I think
12 we're talking about, at least I find, two
13 distinctly different things here. One is a
14 SARS-like situation with a bird virus and it can
15 be controlled and studied and sequenced. Once
16 something happens and it adapts to humans, I don't
17 think there will be much time to worry about
18 controls and reporting and isolating. It will
19 spread fast. It won't be smallpox, it will be
20 around the country in weeks, around the world in
21 months. We've been through this with swine flu in
22 '77 and people were criticized for the decision

1 that was made. Obviously the virus didn't adapt.
2 It was infecting a few people at Fort Dix, one of
3 whom died, but it didn't take off. Once it takes
4 off, how many people can you immunize fast to
5 protect. I would certainly lean in favor of
6 giving the military a dose of H5 vaccine as soon
7 as it becomes available.

8 DR. GRAY: I have a few comments. One,
9 we're focusing largely on H5, but there are plenty
10 of other opportunities for other virus such as H7.
11 How many have followed the Wisconsin resurrection
12 of the 1918 pandemic strain through reverse
13 genetics, but it certainly alarmed a lot of people
14 in that in two animal models they had
15 histopathological evidence that they had a very
16 virulent strain that caused some of the same
17 changes, so concerned that some hemorrhagic fever
18 experts culled that to remain in BL-4. If you do
19 a pub med search today with the key words
20 influenza-A and Chimeric virus, you'll see over
21 220 hits. These are publications that people who
22 have been able to combine two different viruses to

1 come up with a unique strain. Laboratory
2 accidents certainly are another threat to us that
3 we need to consider. In addition, malfeasance,
4 just talking to WebEE in Webster the reverse
5 genetics recipe is not that difficult to do in the
6 lab. So if we had a rogue nation, if you would,
7 that was the intent on adapting this technology
8 and orchestrating a unique virus for which only
9 they would have a vaccine. It sounds like a
10 science fiction novel, but it's a remote
11 possibility. There have also been some unusual
12 changes I think in the literature. In this week's
13 JID, there's an article here from an Italian
14 group, who found in surveying 900 poultry workers
15 during low-path outbreaks in Italy, a 3.8 percent
16 serum conversion, meaning it's not just the
17 high-path viruses that can infect man. We're
18 finding this in our institution in some
19 unpublished work that hunters and DNR workers have
20 serologic evidence of strains such as H11. I
21 think some of the data regarding human-to-human
22 transmission, maybe some of the folks here don't

1 accept it, but I thought the New England Journal
2 article, I think it was an Indonesian series of
3 cases was quite compelling to suggest familial
4 transmission in the home. Finally, if you look at
5 the Netherlands outbreak, the H7N7 outbreak that
6 was a high path, but there's some data again
7 mentioned in this paper, not yet in the peer
8 review literature that suggests that 50 percent of
9 the colors and 50 percent of their family members
10 seroconverted to H7. I guess I'm saying that I
11 think there's a lot of different dimensions that
12 we can have problems with Avian influenza today
13 and we need to be rightfully, really concerned.
14 Finally, let me do an Oprah Winfrey-type
15 commercial. This is a new book by University of
16 Colorado Historical, she's a military medical
17 historian, that archives how military officers
18 responded to the 1918 pandemic. I think those of
19 you that are in this work group would find it very
20 interesting.

21 DR. POLAND: Who's the author, Greg?

22 DR. GRAY: The name of the book is Fever

1 War and the subtitle is, The influenza epidemic in
2 the U.S. Army during World War I, by Carol R.
3 Byerly. B-y-e-r-l-y. It's sort of obscure but I
4 think you can get it on Amazon.

5 DR. HALPERIN: I'm curious about the
6 very, very last line of your presentation, which
7 said that education, PPE and dose-sparing
8 strategies were not approved by OMD. I'm
9 wondering whether that included fit testing for
10 the PPE and whether it included intramural -- I'm
11 getting waved off -- intradermal injection for --

12 MS. EMBREY: It's not that they
13 disapproved the strategy. They disapproved giving
14 DoD additional money for things that we should be
15 doing already with the money we have.

16 DR. HALPERIN: Okay. Then I presume
17 that people are being fit tested. The other
18 question would be the intradermal route, you've
19 got too little vaccine for too many people. Again
20 and again people seem to demonstrate fairly the
21 same as other routes of immunization, but it's not
22 discussed as an alternative here --

1 MS. EMBREY: It's being discussed at the
2 interagency level. HHS has the lead on developing
3 all those types of strategies and DoD is
4 participating with that, but we're not engaged in
5 the clinical trials for that, DoD is not.

6 DR. LEDNAR: This whole discussion
7 reminds me and I realize we're talking about Avian
8 influenza, but if humans become infected, it would
9 be clinically indistinguishable from the more
10 familiar influenza infections. I guess it's a
11 reminder about how we need to get that level of
12 our traditional, familiar trivalent influenza
13 vaccine up at its highest possible levels
14 especially in countries where if there is some
15 illness that may be suggestive of Avian influenza,
16 those country ministries of health will not sit on
17 their hands. They will probably take aggressive
18 and early action to screen arriving travelers,
19 quarantines and other kinds of interventions. It
20 will certainly help the continued ability to
21 operate to try to have those who are sick with a
22 preventable infection, normal influenza,

1 prevented. This raises in my mind of immunology
2 and we have some experts here, is there any
3 advantage for immunologic prevention of Avian
4 influenza to have levels of H1 or H3 influenza
5 protection? Is there any cross protection between
6 our familiar influenza strains and H5?

7 DR. GRAY: In our studies, none.

8 DR. POLAND: I wouldn't expect that
9 there would be. They are, in essence, different
10 viruses.

11 DR. OXMAN: I think the issue of supply
12 is going to be critical. Therefore, I think it
13 would be very useful, I'm ignorant as to how much
14 progress, reliable progress there has been in
15 terms of the dose-sparing techniques of
16 intradermal. That's the only approach that really
17 provides the hope of expanding the amount of virus
18 or the number of people whom you immunize. I'd
19 like to also comment on the issue of a high level
20 of protection against known viruses. One of the
21 important pathways to the emergence of pandemic
22 influenza, as you know, is re-assortment. The

1 more opportunities there are for human infection
2 by a non-human-to-human transmissible Avian virus
3 of somebody who's also infected with H3 or H1N1,
4 the more opportunities there are for
5 re-assortment. That's an added reason to do the
6 best we can in terms of immunizing people against
7 the current influenza viruses. The trouble is
8 that we're not doing that level of immunization in
9 Southeast Asia where those encounters are going to
10 happen most often.

11 COL GIBSON: As a follow-on to that,
12 Captain Rutstein, Wayne and I went to a meeting
13 with USAID, HHS, CDC and all of that. Can you
14 comment any on CDC's concept or at least what they
15 threw on the table that day? I'd prefer you did
16 it than me.

17 CAPT RUTSTEIN: Sure. As you mentioned,
18 \$25 million was appropriated by Congress to
19 address this. It actually came out of the
20 appropriations that followed the tsunami and the
21 events in all of the tsunami-affected regions of
22 Southeast Asia. \$10 million went to USAID to

1 focus on birds. \$15 million was really assigned
2 to CDC to focus on actually three or four
3 Southeast Asian countries. Thailand, Vietnam,
4 Laos and Cambodia as well. The idea is this money
5 has to actually be spent by December of 2006, so
6 it's not a lot of time to actually go to those
7 countries and institute surveillance programs.
8 The idea is to raise up the lab capacity in those
9 countries to train local personnel, to work with
10 WHO and other entities that are already there, to
11 mitigate any emerging issues before they can come
12 here. That's the plan, so HHS is ramping up, not
13 just CDC, but all the other agencies within HHS
14 has been brought together to try and do this.

15 COL GIBSON: The comment I was referring
16 to and you're dead-on exactly with the position
17 that HHS and CDC had at that meeting. CDC also
18 talked about ramping up production of influenza
19 vaccine in the United States to the tune of
20 billions of dollars would be -- this is notional,
21 but they were presenting it as a concept at this
22 meeting so that we could do exactly what you were

1 talking about Dr. Oxman, literally having enough
2 vaccine for every man, woman and child in the
3 United States, plus knowing that the vaccine would
4 probably not all get used, have vaccine available
5 for Southeast Asia.

6 MS. EMBREY: If I could put some
7 comments on that in context. The White House is
8 very concerned about the vulnerability,
9 particularly in light of what happened with the
10 Chiron, the big lots of vaccine that we lost last
11 year. As a result he's concerned that; a) If we
12 don't have good capacity for the known influenza
13 cocktail that we will certainly not be prepared to
14 deal with one that we don't have a vaccine for.
15 He challenged USAID and HHS to create a U.S.
16 government strategy on how to address this issue
17 to improve all of the WHO categories in terms of
18 coming up with this grand strategy and scheme.
19 HHS turned to FDA and NIH and CDC and the Public
20 Health Service to craft a whole series of
21 alternatives with costs that OMB and then Congress
22 would have to consider in how we might address

1 this. It included at least four different
2 alternatives on how to increase capacity to
3 produce production for the U.S. in the U.S., from
4 warm basing elsewhere and then actually producing
5 here to leveraging and incentivizing drug
6 producers, to government purchasing and actually
7 running its own production capacity to a hybrid of
8 any of those three. That kind of strategic
9 thinking and alternatives and proposals were
10 proposed to the President and he incorporated that
11 into a fairly aggressive strategy that would be
12 implemented by USAID via the State Department in
13 our relationships, diplomatic relationships,
14 OCONUS with the countries at risk working
15 sensitively with the countries for which we have a
16 good relation and working with WHO for the
17 countries we don't. Either way, to address the
18 whole region in a way that addresses their
19 ownership of their response capacity and to
20 understand the risk, because they may not
21 understand it and help them economically with
22 incentives and helping hand from the

1 big-money-loaded U.S. On the other hand, we had
2 the U.S. which through the HHS is going to work on
3 how we're going to take care of our population and
4 that is, again, production capacity, response
5 capacity, how the public health service will fit
6 in, what kind of surveillance we need to be doing.
7 All of that. There are whole strategies and
8 initiatives that must be considered and resourced
9 by Congress before we can actually move out on it.
10 This next fiscal year, you're going to see a whole
11 lot of interesting initiatives being proposed to
12 Congress that will end up with some money being
13 applied to it and DoD will have its share of the
14 resource pie and Wayne has outlined the specific
15 pieces of dollars that would be given to DoD to
16 expand its part in that total strategy. Because
17 we haven't talked about it doesn't mean it's not
18 going on. It's not a prima facie DoD
19 responsibility.

20 DR. POLAND: Might also add for the
21 Board members that aren't necessarily involved in
22 these areas, there are a number of studies going

1 on as Mike alluded to intradermal studies, which
2 to date, appear to be immunogenic and safe.
3 Efficacy may be a separate issue. Also trying to
4 expand the capacity either through antigen-sparing
5 capabilities and new methods of production. Right
6 now we're beholden to very labor intensive, slow,
7 egg-based strategies but there are companies
8 working on cell culture based strategies.
9 Although it's not happening in the U.S., outside
10 of the U.S., companies working on adjuvanted H5
11 vaccines which will be another antigen-sparing
12 capability. Finally, there are companies,
13 including companies in the U.S. taking a very
14 novel approach and looking at vaccination
15 procedures that would use highly conserved
16 segments of the H and N gene so that you wouldn't
17 have to necessarily, or at least theoretically
18 come up with a new vaccine every year. We have a
19 ways to go and to date, to my knowledge, there's
20 nobody in DoD who legally could authorize the use
21 of these vaccines. The President can suspend the
22 rules that are imposed by the regulatory agency in

1 charge, FDA, but that would have to obviously be a
2 public health emergency and a lot of reasons that
3 would have to happen before that would occur.
4 Thank you very much for the presentation. We will
5 continue to move on. Are we going to take a
6 biologic break? We have time for a 10-minute
7 biologic break. You'll have to be quick about it.
8 We'll reconvene right at 1600.

9 (Recess was taken from 3:51 p.m. to
10 4:07 p.m.)

11 DR. POLAND: We are ready to start
12 again. Colonel Gibson has a couple of remarks.

13 COL GIBSON: I want to get hands for
14 who's going to be available for the tour tomorrow
15 of the Academy. This isn't your typical tour.
16 We're actually going to be able to go down into
17 the cadet area which is off the beaten track of
18 who show up here. Keep in mind, if you can't go
19 for all of it, you can follow the bus and leave
20 when you want to leave, instead of having to come
21 all the way back. Please raise your hand for
22 who's going be available for the tour. The

1 transportation list for tomorrow to get to the
2 airport and for Thursday is on its way around.
3 Sign up if you need that.

4 DR. POLAND: Dr. Oxman asked if he could
5 make one comment. I thought it was an appropriate
6 comment.

7 DR. OXMAN: I'd like to make a comment
8 about the residual allergy affecting influenza
9 vaccine policy derived from the swine flu debacle.
10 I believe, and I'm unfortunately old enough to
11 have been active at the time, I believe it was
12 exactly the right choice. What was wrong with it
13 was the way it was sold. We underestimate as
14 often we do, the wisdom of the American public.
15 Instead of selling this, that the information that
16 we have at the time is such that if it happens,
17 this is the opportunity to prevent it. Using the
18 analogy of automobile liability insurance, because
19 voters mostly drive cars and know about insurance.
20 Every year when I haven't hit somebody, I thank
21 God and happily pay my premium again for my
22 liability insurance recognizing that if I wait

1 until after I hit somebody, I'm not going to be
2 able to get it. That was the analogy that should
3 have been used to justify the swine flu
4 immunization program, which given the knowledge at
5 the time, I believe was absolutely the correct
6 decision. In retrospect, it's gotten a lot of bad
7 press and that's too bad. I think that it still
8 has a negative impact on our influenza vaccine
9 policies and that's very unfortunate.

10 DR. POLAND: Just a sideline comment to
11 that because it's relevant to something Wayne
12 brought up earlier. One of the other issues in
13 there is we didn't have a good exit strategy.
14 Once we realized that it was not going to be
15 pandemic, we didn't have a way of smartly stopping
16 the program. Next we have Commander Craig
17 Mallack. He will be presenting on the Response
18 Capabilities of the DoD Medical Examiner's Office.
19 His slides are located at Tab 9.

20 CDR MALLACK: Thank you. I appreciate
21 the opportunity to come forward and talk about
22 this. It's a little bit different than talking

1 about swine flu and other issues that normally
2 come before this group, but we have brought you a
3 few issues in the past and we appreciate the input
4 you've always given us. Thank Ms. Embrey and
5 Colonel Gibson and especially General Kelley who
6 supports our mission up at Dover and we couldn't
7 do it without the Air Force. I'm going to go
8 through what we do and I'm going to show you
9 Dover. Not very many people get to see Dover and
10 that's why your slides are in black and white and
11 why what's on this computer will be deleted right
12 after this because those pictures need to stay in
13 Dover. We'll show them to you here, but I can't
14 provide any slides afterwards. On the left there,
15 that's the FIP crest and on the right, that's our
16 patch, Aces over eights. For those that know, out
17 here in the Wild West know what that means, that's
18 a deadman's hand. Wild Bill Hickok was holding
19 that poker hand when he was shot in the back in
20 Deadwood, South Dakota over a hundred years ago.
21 It's become our unit crest. Next.

22 Our lawyer makes us put this up. I

1 haven't seen anybody put this up today, but our
2 lawyer at the FIP says I always have to say even
3 though I'm the Armed Forces Medical Examiner, I
4 don't represent DoD. So whatever I say is not
5 really the view of the government. Next.

6 This is where we're located. We're in
7 Rockville, Maryland. We're right along 270, we're
8 about 100 yards off the highway. The only way you
9 know that we're there is if you ever come in the
10 building you'll never know that that's the worlds
11 most advanced DNA/Tox lab and operational medical
12 examiner's office. Next.

13 We started in 1988. It was kind of a
14 wishy-washy system at first where we sort of had
15 jurisdiction, we didn't have jurisdiction. It was
16 a global effort and it was totally dependent on
17 when we got called and if we wanted to respond and
18 it has evolved. Next.

19 In 1999 a new federal law came into
20 effect. I've listened all morning about NORTHCOM,
21 JDOMS. Running paperwork through this wicket and
22 that wicket before you can go places. 10 USC1471

1 gives our office the authority to engage with any
2 other federal agency if they open a death
3 investigation. If the FBI calls and says we need
4 your help, we go. We send the paperwork up
5 through the chain and we're gone. We don't have
6 to wait for JDOMS. This is what happened during
7 the space shuttle, we were gone, because the FBI
8 opened a case file as soon as Columbia went down.
9 We were down on scene within 24 hours. Two weeks
10 later we got a call from NORTHCOM asking us to
11 respond. By then we were all done. It gives a
12 lot of flexibility that a lot of DoD doesn't have.
13 The other flexibility that we have is we have
14 several court decisions that the Posse Comitatus
15 Act does not apply to doing autopsy or laboratory
16 testing. Those are not considered acts of search
17 and seizure within the definitions of the federal
18 law. So we're allowed to engage in that way also.
19 We've got five major divisions. The OFME is the
20 investigative division, that's the medical
21 examiners. Forensic toxicology. Probably the top
22 forensic toxicology laboratory in the world. We

1 do a lot of work for other government agencies. A
2 lot of issues that come up around the world where
3 they're trying to figure out what different
4 poisons are, they come to our lab in the basement
5 of our building. The Armed Forces DNA
6 identification laboratory, far and away is the
7 gold standard in the world for DNA identification.
8 Most recently they identified one of the crewmen
9 from the Hunley, the CSS Hunley. We also did the
10 Czar from Russia. If you're not familiar with
11 that, the tomb of the unknown soldier and it goes
12 on and on. One of our newest two divisions are
13 mortality surveillance. You've heard from Dr.
14 Lisa Pierce, she's been here before and she's
15 presented. She's done such a good job collecting
16 data and surveilling the deaths across DoD that a
17 lot of her information can no longer be published.
18 I'm not allowed to show any graphs or charts here
19 any more. The Chief of Staff of the Army has
20 forbidden us from even showing it to a group like
21 this right now. Back in January, we were sending
22 out information to commanders in the field and

1 somehow it got into Army Times and the way that
2 they were killing our soldiers in Iraq was
3 published. That's a big threat to our soldiers
4 out there. If they know where to shoot our guys
5 and what to shoot them with and what munitions to
6 use. We have a Behavioral Science division. The
7 first time that we know of that there's a
8 psychiatrist assigned to a medical examiner's
9 office. This has come up this week with Katrina.
10 We're collecting all these DNA samples down there,
11 hundreds and hundreds of DNA samples. We have no
12 references to figure out who these people are.
13 You have to compare the reference to the unknown,
14 there's a very nice database right now called
15 CODIS, which is the FBI's offender database with
16 all these DNA profilers. There's also something
17 called EDIS, which is a state-based system. The
18 moral dilemma right now is, do we run those
19 samples against EDIS and CODIS and the lawyers are
20 deeply involved in that because there's a civil
21 rights issue there whether you can do that. As of
22 right now, there was a meeting last week and our

1 psychiatrist was up in Massachusetts and they said
2 absolutely not. You will not break into those
3 criminal databases to make these identifications.
4 It's not like the military, where we have
5 everybody on file. Next.

6 Again, OAFME has our medical/legal
7 investigations. Odontology/anthropology scene
8 investigations. Next. This is what we do.
9 Medical/legal death investigations. Operational
10 safety investigations. Federal agency support in
11 operational research. I'll talk about one of our
12 research projects in a few minutes that's going to
13 come into play with mass disasters. Next.

14 Something we have to deal with on a
15 daily basis that most medical examiners don't have
16 to, matters of death are natural, accident,
17 homicide, suicide and undetermined. Where do you
18 put the combat related. We have soldiers and
19 Marines getting killed in Iraq and if you put
20 homicide on their death certificate, their
21 families take offense to that. We've had several
22 Congressional inquiries saying that's not a

1 homicide. They died in service to their country.
2 It's a human killing a human so we put homicide
3 and we try to stay away from separating them into
4 combat related. Next.

5 We were involved in the Pentagon attack,
6 the Space Shuttle Columbia. The great thing about
7 the Space Shuttle Columbia; in the state of Texas,
8 Justices of the Peace are also the coroners in the
9 counties down there and they immediately backed
10 off when the FBI came in and said we're opening a
11 case file. So we had no problem. The UN bombing.
12 The IDs of Uday and Qusay. And we were also the
13 laboratory that identified Saddam Hussein. Next.

14 This is where we did our mass disaster
15 work-up for the UN bombing. That's the tent where
16 we tried to ID everybody that was killed in the UN
17 bombing. When the question comes up, what is a
18 mass disaster? Is 10 people a mass disaster? Is
19 20 people a mass disaster? Is 100 people? There
20 were 23 here, but there were six different
21 nationalities. As far as I was concerned, that
22 was a mass disaster because we were just trying to

1 sort it out. All we had was that tent. Next.

2 We've moved up since into an old
3 bombed-out building there. It's not much better.
4 Next. That's where we have to work when we have
5 to go and do EPW cases. Next.

6 It's building slowly and next. Just
7 another view. They're actually going to build us
8 a building there that we'll be able to work out of
9 if there's another Beirut bombing-type incident.
10 Next.

11 This is more scenes from Camp Sather.
12 One more. This is the new building they're
13 building us there. We're actually going to have
14 space to work. What we're worried about is a
15 mixed nationality mass fatality in Iraq where
16 we've got Iraqis, Americans and others and for
17 political reasons we can't take the remains out of
18 country. So we will actually have a place to work
19 in and also will be concrete block, unlike the
20 tent, where the mortar shells did come right
21 through. We weren't there, fortunately, when they
22 did. Next.

1 Let's talk about Dover. In November
2 2003 we opened the state-of-the-art mass disaster
3 processing center. 75,000 square feet, the
4 largest in the world. It can handle more cases
5 than any other facility worldwide and it's got
6 some very unique features. Next.

7 This was the old facility. This was
8 built back in the 50s, 60s, 70s, 80s and 90s.
9 Those large buildings you see in the back, those
10 are actually tents that had steel put over the top
11 of them -- were put up for Gulf War I. That
12 trailer you see here, for the first part of this
13 war, that was the medical examiner's office.
14 Next.

15 This is the brand-new Dover Port
16 Mortuary. I don't know if any of you have been up
17 there, but it's incredible. They put this
18 together in less than two years and it's amazing
19 what they can do in that short of time when they
20 have to. Next.

21 This is inside. Its got a place for
22 families and escorts to come in where it's nice,

1 that's peaceful and calming and it kind of hides
2 what's behind those walls. Next.

3 Its got the reflecting pool. Next. Its
4 got this wall up here. Most people who come and
5 visit the facility, they spend most of their time
6 standing looking at this wall. This lists all the
7 major disasters and major incidents that have
8 happened in U.S. history in the last -- well,
9 since Vietnam. Everything from the Jonestown
10 disaster, shuttles, Beirut bombing and numerous
11 other major disasters that have happened. A lot
12 of experience on handling mass disasters have come
13 through the old facility and now the new facility.
14 Next. You can just see from the side there, it
15 just goes on and on. Currently OIF and OEF are
16 not on that wall. They will be eventually. Right
17 now, between the two of them, the counts, military
18 alone are over 2100. There's hundreds of
19 civilians that have also come through there that
20 aren't even in the counts. Next.

21 This is the dignified transfer ceremony
22 at Dover. It's very dignified but it isn't

1 something where they have a big, big ceremony.
2 Families can come and watch, but they don't know
3 whether that's their family member or not. Next.

4 This is our refrigeration in the back.
5 We can hold 200 bodies in the back in these
6 refrigerators. Next. The other capacity is right
7 outside the building. It was designed to hold
8 seven trailer trucks that could be hooked up right
9 into the building power. It can hold 500 remains.
10 There's parking area for another dozen trailers
11 where we can put another 1,000 remains if we had
12 to. Then there's something called the forensic
13 hold area. After bodies are embalmed, they don't
14 have to be refrigerated anymore. There's a rack
15 system where they can put up to 450 cases that can
16 be held. Next.

17 This is the unloading dock. This is
18 where it starts. I don't know if you can really
19 see it, but back against the wall there's a big
20 red button. I know Colonel Grabenstein said don't
21 turn off the air handling, but throughout this
22 whole building it was designed that if a case got

1 in here that was smallpox or some other infectious
2 disease that we weren't sure what it was, these
3 big red buttons get pushed. The fire department
4 is notified. CDC is notified and the concentric
5 circle plan is put into affect. You talk about
6 Romeo and Juliet and about kissing through the
7 fence, if you go up to Dover around the perimeter,
8 it's not just designed to keep the outside people
9 from getting in, it's designed from us being able
10 to get out in the case of a quarantine. Most of
11 it is surrounded by about a 10-foot-tall concrete
12 block fence. I don't care, Romeo and Juliet are
13 on either side of that I don't know if the virus
14 can get through that. When they lock it down,
15 everybody inside knows that if that place gets
16 locked down, you're staying there. Next.

17 This is how the cases arrive. These
18 look like coffins. They're transfer cases.
19 They're reusable. They're made of aluminum.
20 Next. Every day, including today, we had four
21 cases. This is how it starts with an intake.
22 We'll go through some of the computer systems up

1 there that aren't in use any place else in the
2 country including the DMORT teams that are down in
3 Louisiana and Mississippi right now. They don't
4 have the tracking systems that we have. They asked
5 to mobilize this last week. It isn't designed to
6 be mobilized, we can't bring it down there yet,
7 but I think in the months to come it will become
8 part of a national mass disaster tracking system.
9 This is a couple of our investigators every day
10 checking all the paperwork as it comes in, making
11 sure that we correctly identify each fallen hero
12 as they come into the facility. Everything is
13 bar-coded. There's a computer at each station and
14 they can be bar-coded as they move through the
15 process. Next.

16 This is what it looks like when they
17 open one of those transfer cases. Paperwork's on
18 top. These are services squadron personnel.
19 Those of you who don't know what services squadron
20 personnel are, in the Air Force, services
21 squadrons take care of the hotels, the food
22 service, the golf course. All the ancillary

1 services around the base. Then they also get to
2 help us. They volunteer to do it and they are
3 great people to work with. Next.

4 We have something special here. EOD
5 screening. We don't know what's going to come in.
6 All the ordinance should be off these bodies
7 before they come in, but in a mass disaster
8 situation here, even in the United States, we
9 could have ordinance planted on a set of remains
10 that would go through the system and kill several
11 more along the process. These are baggage
12 scanners and the first thing that happens before
13 we even start trying to ID this person, they go
14 through that baggage scanner. Next.

15 EOD is there every morning. They are
16 checking everything out. We have found hand
17 grenades, we have found live rounds. During the
18 first Gulf War, there was an RPG embedded in a
19 soldier that came back. Nobody's ever been hurt.
20 It's because of the dedication in these folks
21 here. Next.

22 This is just what it looks like. You

1 can barely see under here that there's several
2 M-16 rounds that came across on that airplane. I
3 wish there was a way to scan them in the front
4 before they got on those airplanes. I'm sure the
5 Air Force does too, but they get on at so many
6 different points that they can't all fully be
7 scanned before they get to Dover. Next.

8 This is just their board every day that
9 they look at. This is to train their eyes with.
10 Next. This is the first station. Everything gets
11 photographed and this is also where the bar-coding
12 is opened up. Every morning it's pretty much a
13 lot of activity and then it all settles down and
14 gets into the daily routine. Next.

15 Every single portion and every single
16 set of remains that comes through is bar-coded and
17 tracked through this whole system. This is what
18 DMORT doesn't have. They are doing it on an Excel
19 spreadsheet down in Louisiana right now. Once
20 they leave the system there, there's no way for
21 them to track them. Once they leave their tents
22 and their facilities. That's what this MOM system

1 here is behind. They're putting on these
2 bar-codes so that we track everything through the
3 whole system. Next.

4 Take intake photos. We're the only ones
5 in the world, we take photos of closed body bags.
6 Why? Because people ask, families ask, how did
7 you receive my son or daughter, husband, wife? We
8 take pictures of closed body bags and exactly how
9 they arrive. Next.

10 Next is the FBI. They send up two FBI
11 fingerprinting experts, they're there every day
12 with us. They're up there on six-day rotations.
13 They're able to pull the right index finger off
14 the computer the night before in anticipation of
15 the cases for the following day. They make 97
16 percent of the initial identifications. In the
17 case of mass disaster within the United States,
18 they'd be able to the same thing. There's a lot
19 of civilians that have their fingerprints on file
20 with the FBI. They can pull it off and they can
21 do it right there. They're working on a very nice
22 table there behind them. In the old facility

1 there was an old wooden table that was just nailed
2 together with some plywood. In the facility the
3 Air Force was nice enough to build them a custom
4 table they can work on and it really helps a lot
5 because the families get to know, get their
6 positive IDs right away. Next.

7 This is them working. They're great.
8 If you ever had a chance to work with the FBI
9 fingerprint folks, they'll go anywhere. There's a
10 whole bunch of them down south with DMORT right
11 now and in Mississippi. They're doing their best.
12 They don't have any references for most of what
13 they're looking at down there and they don't have
14 any way to pull up the files down there, because
15 once again, they have no computer systems. The
16 DMORTS don't. Next.

17 Next goes into dental. We have dentists
18 who come in and do full dental identification.
19 Unfortunately on the lower right what you see is
20 we get a lot of fragmentation. Our soldiers don't
21 die with one gunshot wound in them. They've been
22 through a blast and a lot of times they come back

1 in pieces. And in a mass disaster in the United
2 States, we would have the same thing. But we have
3 the ability to do digital dental x-rays and put a
4 lot of these IDs -- put them back together and
5 make the IDs with the dental. Next.

6 This is just some more scenes. Again,
7 it's all digital. It all feeds into one system so
8 at the end you have a very nice record of all your
9 digital x-rays, digital photographs, digital
10 dental information. Next.

11 Next, every set of remains, every piece,
12 gets fully x-rayed. This has found a lot of, not
13 only munitions, but a lot of disease processes
14 with the digital radiographs that also become part
15 of the digital record. Next. That's just more of
16 them setting up. They can now do the full-body
17 x-rays in less than five minutes where it used to
18 take an hour or longer to do one case. That's Dr.
19 Bill Rodriguez with the apron on. He's a forensic
20 anthropologist some of you may have run across.
21 He can take a piece of bone, he can tell you
22 exactly where it's from, what side, how old, race

1 sometimes, sex sometimes. It's amazing. Next.

2 This is our new project. This is our
3 DARPA grant. DARPA came up -- Dr. Sataba, many of
4 you may know him. He said we're going to take
5 this one step further. They gave us several
6 million dollars and we bought this 16-slice CT
7 scanner. Every single is now -- it's a full 3D CT
8 scan. These 3D CT scans are opening a whole new
9 world for us as far as describing wound paths,
10 head injuries and natural disease processes that
11 we didn't see otherwise. It's going along so well
12 that this is about a year old and it's going to
13 get taken out and we're going to get a 64-slice CT
14 scanner. This one takes about two minutes to do a
15 full body. To CT scan, the new one's going to
16 take 16 seconds. One of the problems they're
17 having right now in Louisiana is as the bodies
18 come through they don't know which ones are dead
19 because of the storm and which ones are actual
20 criminal cases. A machine like this would be a
21 great triage to be able to tell whether a case
22 needed to be investigated criminally or could just

1 be signed out a result of the storm. There
2 actually is going to be the first international
3 virtual autopsy conference in Sydney, coming up in
4 November. We're going to be presenting at that.
5 This is a whole new world. This scares my
6 colleagues to death. They think this is going to
7 replace the autopsy. Right now it just augments
8 it. Next.

9 Click on that. The great thing about
10 this is, I don't know how many of you work with
11 radiologists, but this is a fully fleshed skull.
12 We're able to subtract soft tissue. We can
13 subtract bone. We can look at just soft tissue.
14 We can look at just organs. What that shows is a
15 keyhole defect up there in the parietal area of
16 the skull of a gunshot wound. You may not see
17 that on a fully-fleshed set of remains. With this
18 I can take that to court or we can show that to a
19 family and it's far less traumatizing than if we
20 had to show the real thing. Next.

21 This is our autopsy suite. We have 24
22 autopsy stations. Each one has a computer

1 station. You can see above the sync there, you
2 can look at your x-rays or your CT scans right
3 there while your working. Again, one of a kind.
4 One of those 24 rooms is an isolation room where
5 we can do infectious cases. It has its own air
6 handling system. It's where we would do cases
7 probably with you in consultation real quick if we
8 thought we had a problem. Next.

9 This just shows the room in action.
10 Next. This is what we see a lot. These pictures
11 here, I don't mind showing these, these are the
12 bad guys. This is a bomber. We have a lot of
13 vehicle-born improvised explosive devices, where
14 they drive the vehicle up and set off a bomb next
15 to an American convoy. Our biggest problem here
16 is Secretary Rumsfeld says you aren't putting any
17 terrorists in Arlington. So we've got to sort
18 this out and make sure that the terrorists, they
19 get incinerated and cremated and they're gone. We
20 cannot afford to put any remains in Arlington that
21 come from a terrorist. Next.

22 We also look at all the personal

1 effects. Everything is cataloged. Back in
2 December 2003, Dr. Chu signed a memo that said
3 that every single fallen soldier, Marine, airman
4 or sailor, you're supposed to leave them alone and
5 send them to us so that we can evaluate all their
6 gear to see if we can make it safer, more
7 effective on the battlefield. Next.

8 We've been looking at every helmet,
9 every vest and this is a lot of the data that
10 we're not allowed to talk about because we've been
11 able to figure out what munitions go through what
12 vest. What works. What doesn't. What helmets
13 that work. Which helmets don't work. What they
14 protect against and what they don't protect
15 against. That all is fed right back to Marine
16 Corps Systems Command and what is it called, PEO
17 soldier, and they come and collect all these.
18 Unfortunately we still don't get them all because
19 if you look at every memorial service for soldiers
20 you always see an M-16 in the ground with the
21 boots and what's on top of it? The helmet.
22 That's a really hard habit to break. That's a

1 ceremony that they will not give up. So we don't
2 get all the helmets. We get a lot more vests than
3 we do helmets.

4 Next. This is the second autopsy
5 station. It's just used for embalming. Next.
6 They have the largest uniform store or group of
7 uniforms in the U.S. military. If you get one
8 from here, it's the last uniform you'll ever
9 receive. Next.

10 That kind of tells the story right
11 there. That's how it would be treated if we had
12 to deal with civilian casualties up there also.
13 Right now, NTSB called us the day Katrina happened
14 because they knew all the DMORT teams are down in
15 Louisiana, Mississippi. There are no mortuary or
16 forensic identification teams within FEMA
17 available right now. They are all being used. So
18 if an airliner goes down someplace in the United
19 States, Dover is the backup. Next.

20 This is something that happens every
21 single day up there. It's a sign of respect, but
22 every time a soldier is sent home, everybody lines

1 up out front and they salute and the escort who is
2 with those remains will relay to the family about
3 the dignity and the treatment of that soldier as
4 they left Port Mortuary. Next.

5 Again, in the new facility. Next.
6 Let's talk about what we've got that nobody else
7 has for mass disasters. MOMS, that's the mortuary
8 tracking system. After 9/11, about a year later,
9 year-and-a-half later, maybe General Kelley
10 remembers, we found seven pieces of human remains
11 in the mortuary that we simply lost. It caused
12 some problems because we had to go back and tell
13 families. We have a brand-new proprietary system
14 up there, again DMORTS don't have it, that we know
15 where every piece of every human remains is at all
16 times. AFMETS is a medical examiner tracking
17 system. This is the core for the medical examiner
18 case work. It's going to track DNA, tox,
19 photography, x-rays, everything to do with that
20 case, the helmet, the vest, all the personal
21 effects is all in that tracking system. That will
22 also produce the reports that are important to

1 groups like yourselves. We have soldiers that all
2 of a sudden are dead in their cots in the morning
3 that we find in Iraq. Two summers ago, we had a
4 couple of them and we never really did figure out
5 what happened to them. We tested and tested and
6 tested. We want to keep track of cases like that
7 and see if there's a trend. That also tracks, not
8 only the war cases, but the cases across the
9 country and across the world to see if we're
10 having an outbreak or a pandemic or something we
11 need to be looking at. Are we seeing three or
12 four cases of something unusual that's just not
13 right that we really need to be looking into more?
14 Otherwise they're just single cases that you
15 really don't put together. This will put it
16 together. The LISA system tracks all the DNA
17 samples. It's so good it is down in Louisiana and
18 Mississippi right now. It's being used to track
19 the DNA samples. It is so good that the New York
20 City medical examiner's office took it and copied
21 it after 9/11. They released 12 sets of remains
22 with the wrong identification. You never even

1 heard about it because it never got into the news
2 much. If I released a body to the wrong family,
3 I'd be on the front page of the Washington Post.
4 With that we've been able to keep -- we haven't
5 had any problems. Most of you don't know about --
6 does everybody here know what DCIPS is? That's
7 the Defense Casualty Information Processing
8 System. That is the system that talks about all
9 casualties living and dead, if they're sick,
10 they're hurt or they're dead, that's how they
11 report everything up the chain into the personnel
12 systems. Mostly into the personnel systems, but
13 also some of the medical systems. It's also a
14 powerful tool for tracking worldwide. We have
15 direct feeds into MOMS and AFMETS for that for our
16 portion. Next.

17 What do we have to bring to bear? We
18 have seven forensic pathologists at Rockville. We
19 have eight regional around the country and around
20 the world. One forensic anthropologist. At JPAC
21 we have 30 anthropologists if we had to use them.
22 JPAC is the Joint Personnel Accounting Command.

1 They're the ones that go to Vietnam and Laos and
2 Korea. The Smithsonian also brings resources to
3 the table. Next.

4 Dover. The 436th support squadron.
5 They're the group that come out and help us. We
6 had the 512th memorial affair squadron, that's a
7 reserve unit. There's three other reserve
8 services squadrons. The 436th med group, they're
9 all at our beckon call if we need them for mass
10 disaster. Currently they're standing up what they
11 call UTCs which are an Air Force acronym.

12 UNIDENTIFIED MALE SPEAKER: Unit type
13 code.

14 CDR MALLACK: Unit type codes that are
15 going to also provide augmentation in case of a
16 mass disaster or an extended period where we have
17 thousands of casualties we have to work with for
18 dental and radiology support. Next. We have Army
19 CID, Navy NCIS, Air Force OSI at our beckon call,
20 the FBI is always there when we need them. The
21 State Department is a big help with the civilians
22 that die and lots of other government agencies

1 come and we work with them. Next.

2 This is AFMETS. This is what we're
3 building. We were not able to find a program off
4 the shelf that tracks fatalities in mass disaster
5 situations. So we're building it ourselves.
6 Every week it changes. Every week it gets better
7 and we hope within a year that it will be the
8 premier system to be copied by any system out
9 there that needs a mass disaster piece of
10 software. Next. This is LISA. The amazing thing
11 about this is it makes the matches for you. You
12 get your DNA profiles and it will tell you which
13 ones match and which ones are close matches so
14 that your scientists can go and make your DNA
15 identification. 97 percent of them are made by
16 fingerprint, but when you need DNA it works.
17 Next. This is our DoD DNA registry. The strong
18 part about this in the mass disaster situation is
19 that in peacetime, they do a lot of different
20 missions. They do AFMES, A-F-M-E-S is us. JPAC
21 SIL, that's the Vietnam cases. We have outside
22 casework which we're allowed to take. We have

1 lots of grants. We just got another \$3.5 million
2 from NIJ because of some of the work we're doing.
3 We're doing some work for some other government
4 agencies right now, because we have that
5 flexibility that a lot of other DoD agencies don't
6 have. The great thing about this is after 9/11,
7 everything shoved to the left and we were able to
8 use all those resources, bring them to bear on a
9 mass disaster. If it was just that little piece
10 at the end, it would have taken us months and
11 months to do the DNA work. We were done in under
12 60 days after 9/11. We had everybody identified,
13 including the bad guys. We couldn't do this
14 without this flexibility. All the other groups
15 that come to us, they love our expertise, they
16 love what we can do and they also are willing that
17 in the case of a mass disaster that their
18 resources all come to bear on that one incident.
19 Next. A little over two years ago we came, right
20 before the war started actually, we came to this
21 group and said what do we do about contaminated
22 remains. We were all worried. What's going to

1 happen if we have a biological, chemical or other
2 type of atypical incident over there? We wanted
3 to make sure that we could fully account for
4 everybody. Safety of the living was paramount and
5 we had weapons of mass destruction. We didn't
6 want to put anybody back into the tomb of the
7 unknown soldier. Next.

8 So we went to lots of groups, including
9 this group, which gave us our marching orders on
10 what we had to do and we went back and looked in
11 1991 and they said there was no DNA option, they
12 were just going to be buried in country and
13 hopefully some day we could come get them. Next.
14 We believe that for the chemical or nuclear
15 remains that most of them can be decontaminated
16 and brought into the country. Even the Air Force
17 said if you can get them to a certain level, we'll
18 even put them on our planes. If it's a massive
19 attack, the dead are the lowest priority and we
20 realize that. Next.

21 Our capabilities that we could handle
22 100 intact remains per day falls with

1 fragmentation, co-mingling and then if we have
2 these weapons of mass destruction. We have this
3 triage-level investigation required and that's
4 where that CT scanner will come in. Next. This
5 was the plan to bring them back. They were going
6 to be cleaned in country and brought back and then
7 they could be buried here. The families get to
8 have their funerals. Next.

9 This is what you said to us. You said
10 if you can triple-seal them, you can bring them
11 back if they're biologically contaminated or you
12 can cremate them in country or you can bury them
13 in country. We tried tons of options to get them
14 triple-sealed. Next. I don't know if you know
15 what bio-seal is. It's a Seal-a-Meal bag for
16 bodies. It works great for an intact set of
17 remains, but often our guys aren't intact. We
18 tried commercial Ziegler cases. They were tested
19 by the Air Force in San Antonio. If you dropped
20 the commercial cases three feet, they broke wide
21 open, so there really wasn't any way to triple
22 seal. Next.

1 They talked about cremation and they
2 talked about putting retorts out on ships and
3 cremating remains and logistic nightmare. Next.
4 What we came down to is that they'd be temporarily
5 interred in country if there was a biological
6 threat that we couldn't bring into the United
7 States. Next.

8 We wanted to be able to fully account
9 for them. There's something called the League of
10 Families out there. They're a very, very strong
11 political group and they demand that you account
12 for every fallen military member. These are the
13 criteria that we set up. We can't bring the body
14 back, we have only one chance to make positive ID.
15 Protection of the living is paramount. We expect
16 that 92 mics be in MOPP gear which means they're
17 not going to be able to move around very much. We
18 must have a scientific method. Next.

19 We talked about dental Ids. That just
20 wasn't going to work. You can't be out there
21 charting teeth. Next. Fingerprints. Could you
22 fingerprint them in the field? Maybe. Maybe not.

1 Long exposure time, often when you do fingerprints
2 on the dead, they're very difficult to read. Need
3 experienced personnel. Next. DNA. DNA was the
4 key. We had no battlefield technology, we had to
5 figure out a way to bring it back. Dr. Eng's back
6 there and he helped me figure this out. You heard
7 from him earlier and he was at AFRRRI at the time.
8 Next.

9 We talked about what do we bring back?
10 Jaws, hands, tissue sample? Next. It had to be
11 easily obtainable tissue sample, minimal exposure
12 time. No needles, no scalpels, minimal training
13 for the Army mortuary techs. We had to have a
14 sample we know will work enough to test and retest
15 if needed and a second method if possible. Next.
16 We proposed and it was accepted that the right
17 index would be taken off before the body was
18 interred in country. We knew that there were
19 going to be public relations problems and
20 religious issues. But it gave us both a
21 fingerprint and a DNA sample. Next.

22 It takes less than one minute. No sharp

1 instruments. We'll show you how were going to do
2 it. Minimally invasive and the mortuary folks
3 said that they could rebuild a finger if the body
4 came back. Next. We talked about getting a blood
5 sample. Some folks said why don't you get a blood
6 sample? In the desert that's more difficult than
7 it sounds. Next.

8 Skin biopsies are a poor source of DNA.
9 Next. We came up with this procedure. This is
10 basically the procedure that's being used right
11 now down in Louisiana and Mississippi because they
12 can't keep these bodies forever. They're being
13 buried, as soon as they get done with them, in
14 unmarked graves. They're given a number but they
15 don't know who's in them. Next. This is a
16 shipment container we were going to use and it's
17 still available to use. Go. It was easy to use
18 in the field. The Air Force approved the use of
19 this containment system. Next.

20 These tubes are what's being used in
21 Mississippi and Louisiana right now to store the
22 DNA samples. They're not taking fingers. What

1 they're doing is taking a piece of tibia. It's
2 the same basic idea. Next. What we're going to
3 do is bring these materials back and they were
4 going to radiated. Next.

5 These are the supplies. Easy to get.
6 We were going to put them with 10 percent formalin
7 or isopropanol solution. We talked about putting
8 ethanol in these tubes and sending them over. We
9 figured that fingers would come back in water so
10 ethanol was not used. The formalin has a problem.
11 Those of you who work with DNA know that it
12 cross-links DNA after a number of weeks and you
13 can no longer test for DNA. Next. This is just
14 the procedure. Dip it in the bleach solution.
15 Next. They are getting sealed in that container
16 and then dipped in bleach, next. Sealed in that
17 case for shipment back to the United States.
18 Next. That meets all those regulations. Next.

19 We made sure legally we were set to go
20 if we had to. We went over and got some fingers
21 and tried it out. Next. We put the fingers in
22 the formalin and we fingerprinted them. All

1 right. We put some blood in there to see if it
2 changes toxicology. Next. Samples were all put
3 in those cases. Next. Sealed in dosimeters and
4 all the other testing materials were put in there.
5 Next. They are taken over to AFRRRI and put in a
6 cobalt field. We knew what the testing curves
7 were to kill the majority of biologicals. Next.

8 They were also placed in formalin, five
9 days, 10 days, seven days and 30 days so we could
10 see how long it would take to bring them back.
11 Next. We were able to return them and they were
12 able to be fingerprinted. We got good DNA results
13 out of them. Next. It was high quality, full
14 profiles and most importantly, the correct
15 profile. Next. The tissue hardened but we were
16 still able to get fingerprints off of them. It
17 inactivated the biological threats, but the
18 biological threats were still present there in an
19 inactive status so that they could be tested.
20 Next.

21 This was the bottom line. We were going
22 to collect and we were going to make sure that we

1 were able to ID. This is the same plan that we
2 would use for a mass disaster here in the United
3 States if we had a biological attack. That's it.
4 Can I answer any questions?

5 DR. POLAND: I have one question. For
6 the DNA testing, how many loci do you use?

7 CDR MALLACK: We use the 16, the
8 multiplex 16. We just brought on the Y-plex,
9 which is a very, very strong -- just does the
10 Y-chromosome. Also we have mitochondrial DNA and
11 using the snips, the little pieces we're able to
12 put together the large piece of mitochondrial DNA
13 even if they're highly fragmented.

14 DR. POLAND: You do all of that or you
15 do it only if the 16-plex doesn't --

16 CDR MALLACK: If the 16 doesn't work,
17 then we go on to the other ones.

18 DR. POLAND: I'm no expert in it by any
19 means, but I thought I understood that the 16-plex
20 still led to the potential for an unacceptable
21 level of false matching. Am I off there?

22 CDR MALLACK: The old dot blot systems

1 did. Mitochondrial definitely does.
2 Mitochondrial, up to seven percent of the people
3 sitting in this room have the same mitochondrial
4 profile. With our 16, on the STRs we're in the
5 quadrillions. One out of several quadrillions.
6 With the Y-plex, that's what we used when we
7 brought that on line. That's very strong for rape
8 cases and we were able to match up Uday and Qusay
9 to their father with the Y-plex and that was one
10 of the reasons were able to turn that around.
11 Most DNA labs take between six weeks to six months
12 to do DNA work, we turn it in eight hours. That's
13 because we've got families waiting.

14 DR. POLAND: One other question in that
15 regard. When you're having trouble with
16 identification, are you allowed to test the
17 samples of family members for matching?

18 CDR MALLACK: We go to family members,
19 yes sir, and request it. We'll set up a family
20 assistance center. That's what happened after
21 9/11 is we set up a family assistance center with
22 the assistance of the FBI victims unit and

1 collected that. Right now they're just starting
2 to set up those collections down in Louisiana and
3 Mississippi. One of the problems -- the FBI has
4 come to us and told us that down in Mississippi
5 and Louisiana, a lot of the diseased, their family
6 members are not going to come forward because
7 their profiles are in CODIS and they're actually
8 wanted felons.

9 DR. POLAND: That's an interesting
10 comment. Some of the reports you hear and how
11 verified they are is unclear. Upwards of 15,000
12 convicted sex offenders are unaccounted for.

13 CDR MALLACK: Yes, sir.

14 DR. POLAND: Could you, maybe, elaborate
15 on why the decision was made that you couldn't use
16 those databases? It's not entirely clear why.

17 CDR MALLACK: Right now, it's just an
18 ethical opinion. Actually came out of Harvard
19 last week that they should not use it. There
20 hasn't been a government decision yet. I don't
21 know how many people here are from Harvard. They
22 got together right away, the next week, and said

1 should we do this or shouldn't we? And they said
2 absolutely not, don't touch those. That's a civil
3 rights issue. Fortunately, DoD, we're collecting
4 the samples. We aren't testing them and we're not
5 matching them up. Somebody else is going to do
6 that right now.

7 DR. GRAY: How do you determine the
8 remains are part of a terrorist's body?

9 CDR MALLACK: We do a lot of DNA
10 testing, sir.

11 DR. GRAY: You look for ethnic
12 identifiers.

13 CDR MALLACK: Most of the cases, we can
14 do it by elimination. If you're talking about --
15 ethnic profiling is another big problem right now.
16 It's another civil rights issue and the area that
17 we code in the mitochondrial DNA, that we look at,
18 is a non-coding area. We stay out of those areas
19 that have anything to do with any disease process
20 or actually function in the cell. Once we get
21 into those areas, then you get into questions
22 about insurance and all kinds of questions about,

1 should a baby be born? We stay completely away
2 from any part of the genome that actually
3 functions when we do our testing.

4 DR. POLAND: Wait, you said you tested
5 the y chromosome.

6 CDR MALLACK: Right. The
7 non-functioning areas.

8 DR. POLAND: Other questions or
9 comments.

10 COL UNDERWOOD: Commander Mallack, you
11 mentioned that the various days that you put the
12 fingers in formalin. What was the upper limit of
13 normal for which you could have recoverable data?

14 CDR MALLACK: At 30 days we got full
15 data. We thought we would have a problem. This
16 comes from an experience, if some of you know what
17 the punch bowl is. There's a big cemetery in
18 Hawaii called the punch bowl. It's got hundreds
19 and hundreds of remains from the Korean War in it.
20 We've disinterred several sets of remains and to
21 this date we cannot get one piece of DNA out of
22 any of those remains because they used some type

1 of hardening or embalming fluid. To this day we
2 work -- every month we try something different
3 trying to get DNA out of them. We know eventually
4 at some point we won't be able to. 30 days, we
5 figured that was long enough that we could get
6 those samples back within 30 days. Thank you very
7 much.

8 DR. POLAND: Thank you. I want to thank
9 all the speakers from this morning and this
10 afternoon for their presentations. We are going
11 to be meeting in the hotel lobby. We're going to
12 make it a little bit later, right? 7:00, because
13 we want to be good role models. Those of you when
14 we finish after the Executive Session, go out for
15 a walk or a run and we'll meet at 7:00 for dinner
16 at the Cactus Rose. We have another full day
17 tomorrow with the continuation of the open session
18 in the morning and a tour of the Air Force Academy
19 in the afternoon. We'll reconvene here tomorrow
20 at 8:00 a.m. The open session of the meeting is
21 now adjourned. We do need the Board members and
22 preventive medicine consultants to remain for the

1 Executive Session and the Subcommittee sessions.

2 (Proceedings concluded at 5:00

3 p.m.)

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