

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD MEETING

Washington, D.C.
Monday, December 15, 2008
ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

2

1 PARTICIPANTS:
2 DR. GREGORY A. POLAND
2 Professor of Medicine and Infectious Diseases at
3 the Mayo Clinic in Rochester, Minnesota.
3
4 ELLEN P. EMBREY
4 Designated Federal Official
5
5 CDR. EDMUND FEEKS
6 Executive Secretary
6
7 DR. GAIL WILENSKY
7 President-Elect.
8
8 GEN. RICHARD MYERS (Ret.)
9
9 DR. JAMES E. LOCKEY
10 University of Cincinnati
10
11 DR. WAYNE M. LEDNAR
11 Global Chief Medical Officer, Dupont.
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12 DR. EDWARD L. KAPLAN
13 Professor of Pediatrics, University of Minnesota
13 Medical School
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14 DR. WILLIAM E. HALPERIN
15 Chair, Preventive Medicine, New Jersey Medical
15 School
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16 CMJ. LAWRENCE W. HOLLAND (Ret.)
17
17 DR. MICHAEL D. PARKINSON
18 President of the American College of Preventive
18 Medicine

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DR. JOSEPH E. PARISI
Pathologist, Mayo Clinic
Chair, Subcommittee of Pathology and Laboratory
Services

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PARTICIPANTS (CONT'D):
DR. THOMAS J. MASON
Professor of Environmental Epidemiology,
University of South Florida, College of Public
Health.

DR. WARREN BREIDENBACH, III
Associate Professor of Reconstructive Extremity
Surgery, University of Louisville

DR. BONNIE BENETATO

DR. DENNIS O'LEARY
President Emeritus of the Joint Commission.

DR. JOHN DAVID CLEMENTS
Chair of Microbiology and Immunology, Tulane
University School of Medicine, New Orleans.

DR. ROBERT G. CERTAIN.

DR. NANCY W. DICKEY
President, Texas State A&M Health and Science
Center

DR. DAVID H. WALKER
Chair, Department of Pathology
Executive Director, Center for Biodefense and
Emerging Infectious Diseases, University of Texas

DR. JOSEPH SILVA, JR.
Professor of Internal Medicine and Microbiology
and Dean Emeritus, School of Medicine, University
of California

DR. ADIL E. SHAMOO
University of Maryland, School of Medicine.

HON. CHASE UNTERMEYER

PADDY ROSSBACH

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DR. DAVID BOONE
Chief Technology Officer for Arthro Care
Innovations

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4 DR. BARBARA COHOON
4 National Military Family Association
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5 DR. TENLEY ALBRIGHT
6 Director of the Collaborative Initiatives at
6 M.I.T.
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7 DR. ROSE MARY PRIES
8 Office of Health Education and Information,
8 Department of Veterans Affairs
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9 DR. ANNE MOESSNER
10 Traumatic Brain Injury, Mayo Clinic.
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11 DR. P.K. CARLTON
11 Texas A&M Homeland Security
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12 DR. CHERYL HERBERT
13 President of Dublin Methodist Hospital in Dublin,
13 Ohio
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14 PHILLIP E. TOBEY
15 Smith Group
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16 DR. KENNETH KIZER
16 Chairman, MCR BRAC Committee
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17 DR. ROBERT REDDICK
18 University of Texas Health Science Center in San
18 Antonio
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19 DR. PATRICIA THOMAS
20 Professor and Chair of the Department of
20 Pathology, University of Kansas
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21 DR. ALAN J. RUSSELL
22 McGowan Institute for Regenerative Medicine
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2 University of Texas, School of Public Health
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3 DR. CLIFF LANE
4 National Institution of Allergy and Infectious
4 Diseases
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5 DR. NILDA PERIGALLO
6 Dean and Professor at University of Miami, School
6 of Nursing and Health Studies for Health Care
7 Delivery.
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8 DR. GREER GLAZER
8 Dean and Professor, University of Massachusetts,
9 Boston
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10 DR. MARY E. EVANS
10 University of South Florida, College of Nursing

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DR. KENNETH R. MATTOX
Cardiovascular and Trauma Surgeon

DR. JOHN KOKULIS
Health Care Delivery Subcommittee.

DR. MARIAN E. BROOME
Dean of the School of Nursing at Indiana
University

MAJ. GEN. GEORGE ANDERSON
Executive Director of the Association of Military
Surgeons

DR. PIERCE GARDNER
Professor of Medicine and Public Health, Stoney
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DR. BRETT LITZ
National Center for PTSD, Boston.

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PARTICIPANTS (CONT'D):

DR. THOMAS UDHE
Professor and Chair of the Department of
Psychiatry and Behavioral Sciences, and Director
of the Institute of Psychiatry at the Medical
University of South Carolina.

DR. CHARLES FOGELMAN

DR. JAMES QUICK
Goolsby Professor of Leadership at the University
of Texas

DR. PATRICIA RESICK
Director of the Women's Health Science Division.
National Center for PTSD.

DR. SHELLEY McDERMID
Military Family Research Institute at Perdue
University

DR. CHRISTOPHER COLENDIA
Dean of the College of Medicine at Texas A&M
Health Science, Professor of Psychiatry and Health
Services Research

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Chair of the School of Nursing, Old Dominion
University in Norfolk, Virginia

DR. THOMAS DETRE
Professor of Psychiatry, Sacropharmacologist

DR. MARY ANNE DUMAS
Chair, Adult and Family Nursing at Stoney Brook

19 University
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 20 DR. SUZANNE E. COLLINS
 20 Department of Nursing at the University of Tampa
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 21 DR. WILLIAM BLAZEK
 22 Center for Clinical Bioethics at Georgetown
 22 University

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 3 CMR. MIKE MEIER
 4 Joint Staff J-4 Health Service, Support Division
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 5 DR. RICK ERDMAN
 5 Institute of Medicine, National Academies
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 6 DR. MICHAEL KRUKAR
 7 Director of Military Vaccine Agency
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 8 DR. DAVID MCMILLAN
 8 Bureau of Medicine for the Navy
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 9 CDR. ERICA SCHWARTZ
 10 Preventive Medicine Officer for the Coast Guard
 10
 11 CDR. CATHY SLAWNWHITE
 11 Canadian Forces, Medical Officer
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 12 LT. COL. MEL FOTINOS
 13 Consultant to the Air Force Surgeon General for
 13 Preventive Medicine
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 14 ALAN COWAN
 15 British Liaison Officer for Deployment Health
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 16 Director of Preventive Medicine, OSD Health
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 19 Care Delivery Services
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 21 CAPT. GEORGE MCKENNA
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 2 Office of the U.S. Army Surgeon General

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4 Chief EMT Care Service at Walter Reed
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5 Director of the Air Forces Institute of Pathology
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6 MAJ. GEN. NANCY ADAMS (Ret.)
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8 Senior Oversight Committee
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14 Deputy Director of Military Infectious Disease
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3 COL. MIKE BAYLES
4 Public Health Nurse, Department of the Army
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5 Public Health Nursing, Walter Reed Army Medical
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7 COL. WILL ROGERS
7 Armed Forces Pest Management Board
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8 DENNIS DUFFY
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9 MAJ. PAULINE LUCAS
10 Public Health Consultant, Air Force School of
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11 COLLEEN WEESE
11 U.S. Army Center for Health Promotion and
12 Preventive Medicine
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15 MIKE FISCHETTI
16 AFD Health Affairs and TRICARE
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17 COL. JOHN SEVORAK
17 U.S. Army, Medical Research Institute of
18 Infectious Diseases
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19 OLIVERA JOVANOVIC
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21 PAULA UNDERWOOD
21 Army Surgeon General's Liaison Officer to Health
22 and Human Services
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2 U.S. Armed Forces Medical Examiner.
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3 MAJ. CATHY WITHE
4 Legal Counsel for the Armed Forces Institute of
4 Pathology
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5 ERIC PEIPELMAN
6 Armed Forces Institute of Pathology, Director for
6 Integration and Transitions
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16 Deputy Assistant Secretary of Defense for Clinical
17 and Program Policy
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18 MAJ. GEN. DEBORAH WHEELING

18 Deputy Surgeon General
19 MAJ. GEN. DAVID RUBENSTEIN
19 Deputy Surgeon General

20 CAPT. ALI S. KHAN
21 Assistant Surgeon General.

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22 BC PHIL VOLPE
22 Deputy Commander, Joint Task Force
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1 P R O C E E D I N G S

(8:33 a.m.)

2
3 DR. POLAND: I'd like to welcome
4 everybody to this literally full board meeting of
5 the Defense Health Board. I'll ask Ms. Embrey to
6 please call the meeting to order.

7 MS. EMBREY: well, thank you, Dr.
8 Poland. This is a very formal opening remark. As
9 the Designated Federal Official for the Defense
10 Health Board, which is a Federal Advisory
11 Committee and a continuing Independent Scientific
12 Advisory Body to the Secretary of Defense vis the
13 Undersecretary of Defense and the Assistant
14 Secretary of Defense for Health Affairs, and the
15 Surgeons General of the Military Departments, I
16 hereby call this meeting of the Defense Health
17 Board to order.

18 DR. POLAND: Thank you very much. One
19 of the traditions we started for the Board when it
20 was the Armed Forces Epidemiological Board was the
21 moment of silence. And I'd like to continue to
22 carry on that tradition by asking all in the room

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1 to stand for a few minutes that we might honor
2 those that we are here to serve.

(Standing silence observance)

3 DR. POLAND: Thank you, all, very much.
4 Since this is an Open Session, before we begin I
5 would like to go around the table and have the Core
6 Board and Subcommittee members introduce themselves.
7 Core Board members will introduce themselves first,
8 then Subcommittee members. Commander Feeks, our new
9 Executive Secretary, will have some administrative
10 remarks. We'll start with those and then the
11 introduction.

12
13 CDR. FEEKS: Thank you, Dr. Poland.
14 Good morning and welcome everyone. I want to
15 thank the staff of the Ronald Reagan Building and
16 International Trade Center for helping with the
17 arrangements for this meeting and all the speakers
18 who have worked hard to prepare briefings to the
19 Board.
20 I also want to thank my staff, Lisa Jarrett,
21 Olivera Jovanovic, Elizabeth Graham, and Farah
22 Bader for helping with the arrangements for this

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1 meeting. And I'd also like to thank Ms. Jean Ward
2 for her invaluable assistance in putting the
3 meeting together.
4 One of the requirements for holding a Federal
5 Advisory Committee meeting is to record
6 attendance. So I ask everyone please to sign the
7 general attendance roster on the table outside, if
8 you have not done so already. And I also ask
9 members of the media to sign the media roster.
10 This open session is being transcribed. Please
11 make sure you state your name before speaking and
12 use the microphones so our transcriber can
13 accurately report your questions. If time allows,
14 the Board will take comments from the audience
15 here at the meeting room. Members of the public
16 should also sign the speaker roster at the front
17 table before speaking.
18 Thank you.

19 DR. POLAND: So we'll go around, have
20 the Core Board members introduce themselves first
21 so that people understand who's on the Core Board.
22 We'll go back around for the Subcommittee members,

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1 and then lastly audience members. So if I could,
2 I'll start with the incoming President Dr. Gail
3 Wilensky, and we'll proceed that way.
4 DR. WILENSKY: Thank you, Greg. My name
5 is Gail Wilensky. I am the President-Elect of the
6 Defense Health Board. My day job is a Senior
7 Fellow at Project HOPE.
8 GEN. MYERS: I'm Dick Myers, retired
9 three years ago as Chairman of the Joint Chiefs of
10 Staff, and I'm self-employed.
11 DR. LOCKEY: Jim Lockey, University of
12 Cincinnati, occupational pulmonary and lung
13 disease specialist.
14 DR. LEDNAR: Wayne Lednar, Global Chief
15 Medical Officer, Dupont.
16 DR. KAPLAN: Ed Kaplan, Professor of
17 Pediatrics, University of Minnesota Medical
18 School.
19 DR. HALPERIN: Will Halperin, Chair,
20 Preventive Medicine, New Jersey Medical School in
21 Newark, New Jersey, and Chair of Quantitative
22 Methods in the School of Public Health, CDC,

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1 Retired.
2 CMJ. HOLLAND: I am Commander Major,
3 retired, Larry Holland. I look at myself as the
4 one to lookout for our enlisted personnel and

5 their families.
6 DR. PARKINSON: Mike Parkinson. I am
7 currently the President of the American College of
8 Preventive Medicine; formerly was a Medical
9 Director with Lumeno, a consumer-driven plan and
10 well point.
11 DR. PARISI: I'm Joe Parisi, pathologist
12 at Mayo Clinic, and I'm Chair of the Subcommittee
13 of Pathology and Laboratory Services for the DHB.
14 DR. MASON: I'm Tom Mason, Professor of
15 Environmental Epidemiology, University of South
16 Florida, College of Public Health.
17 DR. BREIDENBACH: Warren Breidenbach.
18 I'm at the University of Louisville, Associate
19 Professor of Reconstructive Extremity Surgery, and
20 my area of interest has been hand transplantation
21 and face transplantation.
22 DR. BENETATO: Bonnie Benetato -- sorry
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1 about my voice -- I'm from the Department of (off
2 mike) Repairs -- (off mike), and I'm here for Dr.
3 Mark Brown.
4 DR. POLAND: Continue on to other Core
5 Board members. We're not quite seated in that
6 order, so we'll come up the line on this side. I
7 don't know where to quite start it. Let's see,
8 probably -- yes.
9 DR. O'LEARY: I'm Dennis O'Leary,
10 President Emeritus of the Joint Commission.
11 DR. CLEMENTS: John Clements. I'm
12 Chair of Microbiology and Immunology at Tulane
13 University School of Medicine in New Orleans.
14 DR. CERTAIN: I'm Robert Certain, former
15 combat aviator, a prisoner of war, a PTSD guy,
16 then Air Force Chaplain, retired.
17 DR. DICKEY: Nancy Dickey, family
18 physician by training, President of the Texas
19 State A&M Health and Science Center.
20 DR. WALKER: David Walker, Chair of the
21 Department of Pathology and Executive Director for
22 the Center for Biodefense and Emerging Infectious
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1 Diseases, University of Texas, Medical Branch at
2 Galveston.
3 DR. SILVA: Joseph Silva, Professor of
4 Internal Medicine and Microbiology and Dean
5 Emeritus, School of Medicine, University of
6 California, Davis.
7 DR. SHAMOO: Adil Shamoo, -- (inaudible)
8 -- University of Maryland, School of Medicine.
9 HON. UNTERMEYER: I am Chase Untermeyer.
10 I'm in private business in Houston, but in a
11 former life I was Assistant Secretary of the Navy
12 for Manpower, Reserve Affairs.
13 MS. EMBREY: I'm not exactly a Core

14 Board member. I'm the Designated Federal Official
15 on behalf of the Department of Defense to this
16 Board, and it's been my pleasure to be associated
17 with this Board for quite some time now, at least
18 seven years.

19 DR. POLAND: And I'm Greg Poland,
20 Professor of Medicine and Infectious Diseases at
21 the Mayo Clinic in Rochester, Minnesota. So we'll
22 take off where we left, right over here for

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1 Subcommittee members.

2 MS. ROSSBACH: Paddy Rossbach, former
3 CEO and President of the Amputee Coalition of
4 America.

5 DR. BOONE: David Boone, Chief
6 Technology Officer for Arthro Care Innovations,
7 and I'm on the panel for care of persons with
8 amputation and functional limb loss.

9 DR. POLAND: I think we left off a
10 couple people here. If we could --

11 DR. COHOON: I'm Barbara Cohoon. I'm
12 with the National Military Family Association, and
13 I sit on the TBI Caregiver Panel.

14 DR. ALBRIGHT: Tenley Albright. I'm on
15 the Ethics Subcommittee, and I'm the Director of
16 the Collaborative Initiatives at M.I.T.

17 DR. BREIDENBACH: Warren Breidenbach.
18 I'm sitting on the Subcommittee that's looking at
19 Biodefense Initiatives.

20 DR. PRIES: I'm Rose Mary Pries. I have
21 the Office of Health Education and Information at
22 the V.A., and I sit on the Family Caregiver Panel.

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1 DR. MOESSNER: Good morning. Anne
2 Moessner also from Mayo Clinic where I am the
3 Traumatic Brain Injury clinical specialist. I
4 also coordinate the TBI model systems at Mayo, and
5 I am chairing the TBI Family Caregiver Panel.

6 DR. CARLTON: Good morning. I'm P.K.
7 Carlton. I'm Texas A&M Homeland Security,
8 retired, Air Force Surgeon General, and I sit on
9 the National Capital Board.

10 DR. HERBERT: Good morning. I'm Cheryl
11 Herbert, President of Dublin Methodist Hospital in
12 Dublin Ohio, and I sit on the MCR BRAC
13 Subcommittee.

14 MR. TOBEY: Good morning. I'm Phil
15 Tobey with Smith Group. I'm an architect and
16 health care planner. I sit on the MCR Health BRAC
17 Committee. Thank you.

18 DR. KIZER: I'm Ken Kizer, Chairman of
19 the MCR BRAC Committee, and I'm from California.

20 DR. REDDICK: Robert Reddick. I'm at
21 the University of Texas Health Science Center in
22 San Antonio, and a member of the Scientific

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1 Advisory Board for Pathology and Laboratory
2 Services.
3 DR. THOMAS: Good morning. I'm Patricia
4 Thomas, Professor and Chair of the Department of
5 Pathology at the University of Kansas, and I'm on
6 the Pathology and Laboratory Services
7 Subcommittee.
8 DR. RUSSELL: Alan Russell of the
9 University of Pittsburgh where I direct the
10 McGowan Institute for Regenerative Medicine. I'm
11 on the Occupational and Environmental Health and
12 Medical Surveillance Subcommittee.
13 DR. HERBOLD: John Herbold, University
14 of Texas, School of Public Health, Director of the
15 Center for Biosecurity and Public Health
16 Preparedness, retired Air Force.
17 DR. LANE: National Institution of
18 Allergy and Infectious Diseases where I'm the
19 Clinical Director and on the Biodefense Panel.
20 DR. PERIGALLO: Nilda Perigallo, Dean
21 and Professor at University of Miami, School of
22 Nursing and Health Studies for Health Care

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1 Delivery.
2 DR. GLAZER: Greer Glazer, Dean and
3 Professor, University of Massachusetts, Boston.
4 I'm on the Health Care Delivery Subcommittee.
5 DR. EVANS: Mary Evans, University of
6 South Florida, College of Nursing. I'm also on
7 the Health Care Subcommittee.
8 DR. MATTOX: Kenneth Mattox, Houston
9 cardiovascular and trauma surgeon; on the Health
10 Care Subcommittee.
11 DR. KOKULIS: I am John Kokulis, and I'm
12 a former Deputy Assistant Secretary of Defense,
13 Health Affairs, and I'm on the Health Care
14 Delivery Subcommittee.
15 DR. BROOME: I'm the Dean of the School
16 of Nursing at Indiana University, and retired
17 nurse from the Army Nurse Corps. And I sit on the
18 Health Care Subcommittee.
19 MAJ. GEN. ANDERSON: George Anderson,
20 Executive Director of the Association of Military
21 Surgeons in Bethesda, and I'm on the Health Care
22 Delivery Subcommittee.

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1 DR. GARDNER: I'm Pierce Gardner. I'm a
2 Professor of Medicine and Public Health at Stoney
3 Brook University, School of Medicine, and I'm on
4 the Infectious Disease Subcommittee.

5 DR. LITZ: I'm Brett Litz. I'm at the
6 National Center for PTSD, Boston VA, and Boston
7 University.
8 DR. UDHE: Tom Udhe, Professor and Chair
9 of the Department of Psychiatry and Behavioral
10 Sciences, and Director of the Institute of
11 Psychiatry at the Medical University of South
12 Carolina.
13 DR. FOGELMAN: I'm Charlie Fogelman.
14 I'm the Interim Chair of this subcommittee here,
15 and I was asked by the members of the subcommittee
16 to point out that this is an example, a living
17 vivid example, of the stigma of psychological
18 concerns. I asked Greg's permission and my
19 colleagues' permission, since they've heard a
20 little bit of this before, just to say this very
21 briefly about why I'm here.
22 I'm here, professionally, because I have a broad

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1 and varied career as a psychologist, including
2 nowadays I volunteer one day a week providing
3 clinical services at the Adult Behavioral
4 Outpatient Clinic at Bethesda Naval Hospital. I
5 make my living now as a coach and consultant in
6 health care and mental health delivery, and
7 leadership development and organizational
8 development.
9 But the real reason that I'm here and that I serve
10 on the committee is this: I am a very, very
11 grateful first generation American. My parents
12 were born on the other side, and were it not for
13 this miracle of the country, they would have been
14 trapped in land of endless oppression, and I would
15 not have been born. And were it not for the
16 generosity of my home town, New York City, my
17 mother would not have become a teacher, my father
18 would not have become a doctor, and I would not be
19 here today.
20 So I have this sense of unrepayable debt, and I
21 sort of think of this service as one of my small
22 attempts to make a dent in that unrepayable debt.

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24

1 It's a privilege to serve here with all of you and
2 an honor to serve on behalf our military and their
3 families.
4 DR. QUICK: I'm Jim Quick, Goolsby
5 Professor of Leadership at the University of Texas
6 at Arlington. I retired United States Air Force,
7 expertise in Preventive Stress Management.
8 DR. RESICK: I'm Patricia Resick,
9 Director of the Women's Health Science Division of
10 the National Center for PTSD in Boston VA, and
11 also Professor of Psychiatry and Psychology at
12 Boston University.
13 DR. MCDERMID: I'm Shelley. I direct to

14 the Military Family Research Institute at Perdue
15 University. I'm the former Cochair of the
16 Department of Defense Task Force on Mental Health.

17 DR. COLEND: Chris Colenda, Dean of the
18 College of Medicine at Texas A&M Health Science,
19 and Professor of Psychiatry and Health Services
20 Research.

21 DR. BENJAMIN: I'm Richardean Benjamin,
22 Chair of the School of Nursing, Old Dominion

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25

1 University in Norfolk, Virginia, and I'm on the
2 Psychological Health Subcommittee.

3 DR. DETRE: I'm Thomas Detre, Professor
4 of Psychiatry, Sacropharmacologist. I'm a full
5 Board member and a member of the Subcommittee on
6 Psychological Health.

7 DR. DUMAS: I'm Mary Anne Dumas, and I
8 am Chair Apparent of Adult and Family Nursing at
9 Stoney Brook University, President of the National
10 Organization Nurse Practitioner Faculties, and on
11 the Medical Ethics Subcommittee.

12 DR. COLLINS: Good morning. I'm Suzanne
13 Collins. I'm from the Department of Nursing at
14 the University of Tampa, and I'm on Medical
15 Ethics.

16 DR. BLAZEK: And I'm Dr. Bill Blazek
17 from the Center for Clinical Bioethics at
18 Georgetown University, and I'm also on the
19 Subcommittee for Medical Ethics.

20 DR. REYBOLD: Ridge Reybold, Armed
21 Forces Institute of Pathology.

22 CMR. MEIER: Commander Mike Meier
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26

1 representing the Joint Staff J-4 Health Service,
2 Support Division.

3 DR. ERDMAN: Good morning, Rick Erdman
4 from the Institute of Medicine, part of the
5 National Academies.

6 DR. KRUKAR: Michael Krukar, Director of
7 Military Vaccine Agency.

8 SPEAKER: -- Proponency Officer,
9 Preventive Medicine of the Army Surgeon General's
10 Office.

11 DR. McMILLAN: David McMillan, Bureau of
12 Medicine for the Navy.

13 CDR. SCHWARTZ: Hi, I'm Commander Erica
14 Schwartz and the Preventive Medicine Officer for
15 the Coast Guard. And I also want to introduce the
16 Chief Medical Officer for the Coast Guard, Admiral
17 Mark Tedesco.

18 CDR. SLAWNWHITE: Good morning. I'm
19 Cathy Slaunwhite, Canadian Forces, Medical Officer
20 in a liaison role in Washington, D.C.

21 LT. COL. FOTINOS: Good morning. Lt.
22 Colonel Mel Fotinos. I am the Consultant to the

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27

1 Air Force Surgeon General for Preventive Medicine.
2 MR. COWAN: Good morning. Group
3 (inaudible) Alan Cowan. I'm the British Liaison
4 Officer for Deployment Health. I'm located in the
5 (off mike) area in the Force Health Protection
6 Readiness.
7 LTC. HACHEY: Wayne Hachey, Director of
8 Preventive Medicine, OSD Health Affairs for
9 Self-Protection and Readiness.
10 LTC. PORTER: Lt. Colonel Becky Porter
11 from the JTF CAP MED, Behavioral Health Officer
12 for Health Care Delivery services.
13 COL. JEFTS: Colonel Barb Jefts, JTF CAP
14 MED, J-3 Health Care Delivery Ops.
15 CAPT. MCKENNA: Captain George McKenna
16 from JTF CAP MED, Force Health.
17 COL. CAMPBELL: Colonel Stuart Campbell,
18 British Liaison Officer, Office of the U.S. Army
19 Surgeon General.
20 MR. SCOVILLE: Chuck Scoville, Chief EMT
21 Care Service at Walter Reed and the Executive
22 Secretary for the Panel for the care of

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28

1 individuals with amputation and functional limb
2 loss.
3 DR. MULLICK: Dr. Florabel Mullick, the
4 proud Director of the Air Forces Institute of
5 Pathology, and also the Executive Secretary of the
6 Subcommittee on Pathology and Laboratories of this
7 Board.
8 MAJ. GEN. ADAMS: Nancy Adams, Major
9 General retired, member of the DOD Task Force on
10 the Future of Military Health Care.
11 COL. BADER: Good morning. Colonel
12 Christine Bader, Executive Director of the
13 Military Health Systems Senior Oversight
14 Committee.
15 MR. JHA: Prakash Jha, Surgeon General's
16 Office, Army.
17 MS. BROWN: Nancy Brown, I'm line of
18 Action 8 for the Air Force, part of Seth MRM.
19 MS. MARTEL: Susan Martel with the
20 National Research Council of the National Academy.
21 MS. KITCHEN: Lynn Kitchen, Deputy
22 Director of Military Infectious Disease Research

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29

1 Program.
2 LT. CDR. LUKE: Lt. Commander Tom Luke,
3 Department of Virology, Naval Medical Research
4 Center.

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5 COL. GIBSON: Roger Gibson, outgoing
6 Executive Secretary, Defense Health Board.
7 MR. MARTIN: Chris Martin, Armed Forces,
8 Health Surveillance Center.
9 LTC. GOULD: Lt. Colonel Phillip Gould,
10 Air Force, Medical Support Agency.
11 MS. SEKIS: Branko Sekis, Social and
12 Scientific Systems.
13 CAPT. COLLIER: Captain Collier, Army,
14 Public Health Nurse, Walter Reed.
15 COL. BAYLES: Colonel Mike Bayles, Army,
16 Public Health Nurse.
17 MAJ. HORTON-HARGROVE: Major Telecia
18 Horton- Hargrove, Public Health Nursing, Walter
19 Reed Army Medical Center.
20 COL. ROGERS: Colonel will Rogers, the
21 Armed Forces Pest Management Board.
22 MR. DUFFY: Dennis Duffy, concerned
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30

1 citizen.
2 MAJ. LUCAS: Major Pauline Lucas, Public
3 Health Consultant with the Air Force School of
4 Aerospace Medicine and Tech Analogy Consult
5 Services.
6 MS. WEESE: Colleen Weese, U.S. Army
7 Center for Health Promotion and Preventive
8 Medicine.
9 MR. RENNIX: Chris Rennix, Navy and
10 Marine Corps Public Health Center, Epidata Center.
11 MR. FISCHETTI: Mike Fischetti, Deputy
12 Chief, Acquisitions, AFD Health Affairs and
13 TRICARE.
14 COL. SEVORAK: Colonel John Sevorak,
15 U.S. Army, Medical Research Institute of
16 Infectious Diseases.
17 MS. JOVANOVIC: Good morning. Olivera
18 Jovanovic, Defense Health Board, Support Staff.
19 MS. PEARSE: Lisa Pearse, Associate
20 Program Director, General Preventive Medicine
21 residency at USHUS.
22 MS. UNDERWOOD: Good morning. Paula
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31

1 Underwood. I'm the Army Surgeon General's Liaison
2 Officer to Health and Human Services.
3 MR. MALLICK: I'm Craig Mallick. I'm
4 the U.S. Armed Forces Medical Examiner.
5 MAJ. WITHE: Major Cathy Withe. I'm the
6 Legal Counsel for the Armed Forces Institute of
7 Pathology.
8 MR. PEIPELMAN: Good morning. Eric
9 Peipelman, Armed Forces Institute of Pathology,
10 Director for Integration and Transitions.
11 CAPT. BELLAN: Captain Kris Bellan,
12 Preventive Medicine Resident, Uniform Services.
13 LT. COL. SENSINTAFFER: Lt. Colonel

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14 Lowell Sensintaffer, Air Force Medical Support
15 Agency, Deputy Chief of Preventive Medicine.
16 MR. DOWLING: Glen Dowling, Preventive
17 Medicine Resident, Uniform Services University.
18 MR. FOSTER: Bob Foster, Office of the
19 Secretary of Defense.
20 DR. POLAND: We'll start up here with
21 Dr. Chu, and then we missed a few people that have
22 come in.

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32

1 DR. CHU: David Chu, Undersecretary of
2 Defense for Personnel Readiness.
3 MR. KELLEY: Joe Kelley, Deputy
4 Assistant Secretary of Defense for Clinical and
5 Program Policy.
6 MAJ. GEN. WHEELING: Major General
7 Deborah Wheeling, Deputy Surgeon General, Army
8 National Guard. Office of the Army Surgeon
9 General.
10 MAJ. GEN. RUBENSTEIN: Major General
11 David Rubenstein, Army, Deputy Surgeon General,
12 and in my private life, Chairman of the Board of
13 American College of Health Care Executives.
14 CAPT. KHAN: Assistant Surgeon General
15 Ali Khan, U.S. Public Health Service, Ex Officio
16 Member for the Health and Human Services.
17 BC. VOLPE: Phil Volpe, Deputy
18 Commander, Joint Task Force, National Capital
19 Region Medical JTF CAP MED, Integrating Health
20 Care Army Air Force/Navy Medicine in this region,
21 and overseeing a BRAC execution.
22 MS. EMBREY: That's a large group.

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33

1 Before we formally start our meeting, I'd like to
2 take this opportunity to honor the illustrious
3 career of Dr. Poland to my left, to your right.
4 He is the Mary Lowell Leary Endowed Professor of
5 Medicine, Infectious Disease, Molecular
6 Pharmacology and Experimental Therapeutics at the
7 Mayo Clinic. He's also the Director of the Mayo
8 Vaccine Research Group and the Translational
9 Immunovirology and Biodefense Program. He was
10 also the Associate Chair for the Research in the
11 Development of Medicine and the North American
12 editor of Vaccine.
13 Dr. Poland has devoted many years to the service
14 to the Defense Health Board, first with a
15 three-term membership with the Armed Forces
16 Epidemiological Board, and currently as the
17 president of this Board. His extensive background
18 in immunology and vaccine development and delivery
19 has contributed greatly to the Board's ability to
20 provide recommendations, advice, guidance, and
21 friendship to the Department of Defense on
22 numerous Force Health Protection and Readiness

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34

1 issues by serving on the Infectious Disease
2 Subcommittee, the Pandemic Influenza Preparedness
3 Subpanel, and most recently on the Task Force
4 Review of the Department of Defense's Biodefense
5 Research portfolio.
6 For his numerous contributions in May of 2003, he
7 was awarded the Secretary of Defense medal for
8 outstanding public service and nominated for the
9 Eugene G. Fubini Award in 2004. Dr. Poland is now
10 going to be transferring his duties as President
11 to the President-Elect, Dr. Gail Wilensky, but
12 he's not going to leave us; he's going to continue
13 to serve as the Vice-President to the Board.
14 Dr. Poland.
15 DR. POLAND: Thank you. If you'll bear
16 with me for about 10 minutes here, I decided I
17 would fly the flag, literally. Karen, if you
18 could make sure no one throws a shoe at me,
19 though.
20 Only some of you watched the news last night,
21 okay. Beyond that of service, the one privilege
22 or gift given to the Board president is time on

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35

1 the agenda to make some remarks at the end of his
2 or her tenure. I've spent some hours reflecting
3 on what I want to say, typed it out so I don't
4 miss anything. They are heartfelt words, so if
5 you would bear with me.
6 First, words fail at adequately expressing the
7 privilege it has been to serve as President of the
8 Armed Forces Epidemiological Board and now the
9 Defense Health Board. As many of you know, I grew
10 up in a military family.
11 The family joke is that if you cut us, we bleed
12 camel. You'll see why in a minute.
13 My family's military history dates back to the
14 Civil War where my great, great grandfather,
15 Zimmer Poland, was decorated for battlefield
16 heroism. My father, Colonel James Poland, went to
17 college on a Navy ROTC scholarship and retire 30
18 years later serving his entire career as a Marine
19 Corps Infantry officer with two tours in Vietnam.
20 I was born in Quantico delivered by a Navy
21 lieutenant. My brother, Sergeant Major Bruce
22 Poland, recently retired from the Marine Corps

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36

1 after 30 years, again as a ground pounder serving
2 in multiple wars and on every continent except
3 Antarctica. Now the family torch has been passed
4 to my middle son, Cadet 4th Class Eric Poland, now

5 at the United States Air Force Academy. So for me
6 the AFB and now the DHB was my opportunity to
7 serve and to do my duty. So thank you for the
8 opportunity you gave me for service.
9 But, importantly, my family history has also
10 provided a critical guiding star. For me, the
11 deliberations and recommendations of the Board
12 always had to pass a critical test. Is this what
13 I want for my dad, my brother, my son, and other
14 families' fathers, brothers, sons and daughters?
15 The answer to that question always influenced me
16 to do the right thing even when I'm popular.
17 I also want to ruffle a few feathers and be a bit
18 politically incorrect. I leave this office with
19 some warnings: we've become big from over 30 -- a
20 gather usually of 30 intimate members to some 150
21 members. And big is not always better. Clay
22 Christensen, professor at the Harvard School of

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37

1 Business said this: I will always vote against
2 the big guy.
3 The processes people, politics of what he called
4 "disrupted innovation" isn't in their culture or
5 soul. The products always shaped the product, and
6 it never works. The point is that we often miss
7 the obvious, perhaps because we are sometimes more
8 in love with our ideas about truth than truth
9 itself, more adept at rationalizing than
10 recognizing the insidious harm of organizational
11 or even personal self- interest and stovepipe
12 thinking rather than the larger advantages of
13 self-effacement, courage, justice, and joint
14 solutions to big problems.
15 George Weigel has written a book entitled The Cube
16 in the Cathedral: Europe, America, and Politics
17 Without God." It's a superb book, and I commend
18 it to each of you.
19 Mr. Weigel observes that the west's, as he calls
20 it "deepening anemia" is a consequence of living
21 on the thin gruel of secular humanism that
22 excludes transcendent reference points for

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38

1 cultural and political life. These reference
2 points are, he says, prerequisites for freedom
3 understood this way: As the capacity to choose
4 wisely and act well as a matter of habit.
5 Mr. Weigel challenges us -- that is to say you and
6 I -- by questioning -- really doubting whether
7 it's possible to sustain a democratic political
8 community absent transcendent reference points for
9 ordering public life and political community. So
10 the lesson is the need of guiding transcendent
11 reference points in what we do: Concepts like
12 truthfulness, justice, courage, and others before
13 self. And in this regard I can truthfully say

14 that I'm proud of the work that we've done
15 together and accomplished.
16 I can't say "never," but at least rarely did I
17 ever sense that politics played a significant part
18 in reshaping or changing the Board's
19 recommendations. It sometimes made people
20 unhappy, and I understand that. But each of us
21 has to be ever vigilant in this regard. With
22 changes in our size, new members, new agendas, and

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39

1 new administration, we must only and ever be true
2 to the needs of the servicemen and women we're
3 privileged to serve, and increasingly two key
4 words must characterize the work of the Board:
5 innovation and transformation.
6 Professor Christensen is right in history
7 reinforces the truth, that the processes people in
8 politics have disrupted innovation isn't in the
9 culture of huge bureaucracies. The politics
10 always shape the product, and it never works.
11 So I implore you to do what needs to be done even
12 when it makes politicians, generals, and others
13 uncomfortable. Do the right thing. You have the
14 every-day soldier -- airmen, soldier and Marine as
15 well as history -- to hold us accountable. I have
16 always felt that as a Federal Advisory Committee
17 we had a singular overarching task that could be
18 summarized very simply: Speak truth to power.
19 Second, change is a time for reflection on how the
20 race has been run. It reminds me of G.K.
21 Chesterton's maxim that with every step of our
22 lives we enter into the middle of the new story

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40

1 that we're almost certain to misunderstand.
2 The DHB now enters into that new story, a bigger
3 and more influential Board than at any time in its
4 history, a Board more active than ever before; a
5 Board intimately wrestling with the truly big
6 issues DOD faces, issues like TBI and wounded
7 warrior care, pandemic influenza, environmental
8 hazards, health care delivery reform, biodefense
9 and many others, issues whose story we're almost
10 certain to misunderstand absent diligent,
11 transparent, and open deliberations and critique.
12 It remains to be seen how best to organize a Board
13 of this size, how independent we're willing to be
14 in raising and pushing important issues, and what
15 questions the Board is willing to address and in
16 what manner. Many changes are occurring, and the
17 Board is being utilized in new and important ways
18 than in the past, and yet more work needs to be
19 done.
20 I want to end with a story, and those of you in
21 the ministry know that when somebody says, "I want
22 to end," it means there's about five more minutes

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41

1 --
2 -- with a story and a final personal moment --
3 Bob, that was no personal reflection.
4 First the story. Steven Pressfield in his book
5 Gates of Fire tells the story of the 300 Spartans
6 about to go into battle against the overwhelming
7 Persian army at Thermopylae. Only one Spartan
8 would survive, a single slave. The King of Persia
9 wonders with amazement how and why the 300
10 Spartans would fight, knowing they would all die
11 violent deaths on the battlefield that day.
12 The captures slave tells the king of Persia hat a
13 true king, what a true leader really is: It is
14 how Roger Wayne and myself have tried to conduct
15 ourselves with regard to the Board, and emblematic
16 of many of our members -- people like General Bill
17 Fox, like Joe Silva, who repeatedly put aside the
18 difficulty of particular family hardships to get
19 on a plane and contribute in important ways to the
20 work of the Board.
21 People like Wayne Lednar and Mike Parkinson, who
22 despite moving to new jobs of major corporate

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42

1 responsibility, nonetheless never failed to say
2 yes to service to the Board. In Wayne's case,
3 particularly sacrificing as he continues to live
4 apart from his family during his job transition,
5 and yet never once said no.
6 And people like Ellen Embrey, who many times at
7 personal sacrifice to her relentless schedule and
8 family time, made it a point to come to our
9 meetings, and that's very much appreciated.
10 And finally, people like Roger Gibson, who almost
11 never took any vacation time, and who had to deal
12 with family illness and his own shoulder surgery
13 and near chronic pain to be at work and ensure the
14 work and administration of the Board, thank you,
15 Roger.
16 I hope that when I read this single survivor's
17 description of what a true leader is that you,
18 too, will judge that, on balance, these
19 individuals in this Board did indeed conduct
20 ourselves as the leaders you and DOD deserve.
21 I will tell His Majesty what a leader is: A
22 leader does not command his men's loyalty through

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43

1 fear; he earns their love by the sweat of his own
2 back and the pains he endures for their sake.
3 That which comprises the harshest burden a leader
4 lifts first and sets down last. A leader does not

5 require service of those he leads but provides it
6 to them. He serves them, not they him.
7 And while Pressfield was talking about a leader's
8 conduct during war, it's not a big stretch to see
9 the importance that anyone who sits on the DHB must
10 attach to the conduct of this office. In my
11 opinion, with almost 14 years of service to this
12 Board, four of them as president, the only
13 leadership style that has worked is servant
14 leadership.
15 The idea that the needs of the Board and of the
16 service men and women must always come first are
17 nothing.
18 Put another way, the mediocre leader tells, the
19 good leader explains; the superior leader
20 demonstrates, but the great leader inspires. And
21 I hope that in at least small ways we as a team
22 have inspired you and those we seek to serve, and

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44

1 if it is judged that we served well, those who
2 serve and the race we have run together will be
3 rewarded one day with the resound: "well done,
4 good and faithful servants."
5 I'll finish with one of my favorite poems -- if I
6 can get through it. It was written by Ray Carver
7 and, ironically, it was the last thing he ever
8 wrote aptly entitled Late Fragment. And in it he
9 expresses a universal truth -- I'm sorry to be
10 emotional here. It goes like this:
11 "And did you get what you wanted from this life?
12 Even so, I did.
13 "And what did you want? To call myself beloved,
14 to feel myself beloved on earth."
15 To those of you I've gotten to know so well over
16 these last years, have no doubt that I call you
17 beloved in the sense of the strong bonds of
18 friendship and the crucible of the often difficult
19 and controversial work we have accomplished
20 together.
21 I've been humbled by your support, your friendship
22 and loyalty to the DHB and to our soldiers,

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45

1 airmen, sailors, and marines. I want to
2 particularly express my deepest gratitude to Ellen
3 Embrey, Roger Gibson, Wayne Lednar, Mi,e
4 Parkinson, Bill Halperin, Ed Kaplan, Joe Silva,
5 Adil Shamoo, Pierce Gardner, John Clements, Dan
6 Blazer, Mike Oxman, and many others. But those
7 are individuals who I've particularly worked
8 closely with. I personally know the many
9 sacrifices you all have made when called upon, and
10 I thank you each for what you've done for our
11 Service members.
12 Well, we made it to the finish line. We
13 successfully transitioned from the AFB to the DHB

14 and congratulations to all for a race well run.
15 And now I will assume a supporting leadership role
16 to DHB and to the new DHB president, Gail
17 Wilensky, by serving as one of the vice-
18 presidents. May our efforts continue to be
19 rewarded in the future by the clear prism of
20 history.
21 Thank you, each, and, Gail, congratulations.
22 (Applause)

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46

1 DR. WILENSKY: Thank you very much,
2 Greg. I will not attempt to in any way respond to
3 those very moving words. I think it would be
4 impossible to have heard what you have said and to
5 not recognize how important this position has been
6 to you and how much you have brought to it during
7 the course of the last 14 years, as we discussed
8 this morning, that you've been involved with the
9 predecessor board and the current board.
10 Fortunately, for all of us and most fortunately
11 for myself, you will continue to be actively
12 serving. We have established and Executive
13 Committee of Wayne, Greg, and myself. We will be
14 meeting regularly between the Subcommittee and
15 Core Board meetings and so, well, we are very
16 grateful and thankful to you for all of the
17 service that you've provided. We are in no way
18 about to say goodbye to those services but just to
19 have you continuing on in a slightly different
20 position. And I know that your experience will
21 serve us as we go forward in these activities and
22 with a new Administration.

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47

1 And so I am very honored to accept the gavel from
2 you and to formally thank you for all of your
3 efforts.
4 The first speaking this morning is Dr. David Chu,
5 the Undersecretary of Defense for Personnel and
6 Readiness. As a Secretary Senior Policy Advisor
7 and as a Senate- approved presidential appointee,
8 he is responsible for the recruitment, career
9 development, and pay in benefits for active-duty
10 Guard and Reserve personnel and DOD civilians.
11 His additional responsibilities include overseeing
12 the Defense Health Board, Defense commissaries and
13 exchanges, the Defense education activity, and the
14 Defense Equal Opportunity Management Institute.
15 David has been very helpful to me in various
16 activities that I have personally undertaken
17 during these last several years. I am very
18 grateful for his support, and without further
19 delay, I present you David Chu.

20 DR. CHU: Gail, thank you, and let me
21 take this occasion, if I may, to thank all the
22 members of the Board for their service, their

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48

1 willingness to help the Department and its people.
2 My particular thanks, Dr. Poland, for your long
3 service, for your willingness to continue serving.
4 It's a tribute to you that we've brought this
5 group together. I realized it was large; I didn't
6 realize quite how large. When I was told we were
7 meeting in the ballroom, I thought no, that can't
8 be true, and I wandered around some other rooms
9 first thinking smaller than would be the case.
10 This is a challenge. I think one interesting
11 thing for the Board is how it can be most
12 effective in its many lanes and bringing those
13 separate strands together to form a cohesive, but
14 thank you, Dr. Poland. Thank you for your
15 continued willingness to assist us.
16 I am delighted to have the privilege of working
17 with Dr. Gail Wilensky. I've had the opportunity
18 of working with her in several, not necessarily
19 all, of her various incarnations. In every case,
20 she's offered the Department the kind of
21 trenchant, straightforward advice that Dr. Poland
22 celebrated. I think we've taken a solid fraction

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49

1 of that advice, but perhaps not quite every point.
2 And we look forward to the new advice that she and
3 you will give us.
4 This is, of course, a time of transition, as we
5 all appreciate. It's a good time to ask, I
6 believe, what the new challenges might be, and so
7 I'll take if I may, 15 minutes this morning to
8 outline the challenges I see in three areas.
9 Maybe they aren't new challenges, maybe they're
10 rediscovered challenges or challenges to which we
11 should have paid more attention to past and
12 circumstances now compel us to give them the
13 attention they deserve.
14 They fall, in my judgment, into three lanes, three
15 dens, if you will:
16 A set of medical issues, a set of organizational
17 issues; and a set of issues relating to the
18 construct of the delivery of health care to our
19 people.
20 Let me start with the medical set of issues. They
21 are -- in my judgment recent events have asked us
22 to refocus -- on old injuries that we now pay more

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50

1 attention to, specifically, so-called traumatic
2 brain injury and posttraumatic stress disorder.
3 They've been with us before.
4 Perhaps we haven't seen them as injuries; perhaps

5 we haven't seen them as circumstances that the
6 medical community ought to address. We certainly
7 see them that way now, and they have, as you know,
8 preeminence in terms of our focus. And you can
9 certainly see that in the agenda for this two-day
10 meeting.
11 I leave it to you. I am not a physician. I leave
12 it to you to get with the medical aspects, but I
13 am interested in the social aspects and the
14 question of how we best provide care. On the
15 social front, some of you may have seen or have
16 actually worked by the Center for Naval Analyses
17 that looks at the relationship between various
18 disqualifying conditions and civilian earnings.
19 (off mike) -- economists of one measure to be
20 always is: How well do you fare in civil society?
21 what's fascinating to me about that work, as some
22 of you may be aware, is that there's some

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51

1 relationship between physical injury and civilian
2 earnings. It's not very strong. In physical
3 injury particularly in the era of
4 computer-assisted technology, it does not
5 necessarily mean that you cannot enjoy a
6 satisfying civilian career.
7 Very different if the injury is psychological.
8 What I'm stuck by in the Center for Naval Analyses
9 work is that if the veteran is diagnosed -- and
10 these are largely older veterans, I should
11 emphasize -- if the veteran is diagnosed with some
12 kind of psychological, psychiatric difficulty, the
13 earnings effect is much more, much more
14 pronounced.
15 I emphasize these are older veterans. In fact,
16 one of the phenomenon CNA has separately
17 identified for the Department is that we're
18 entering an age of the Vietnam era veteran coming
19 into his -- mostly his, a few her -- old age
20 period, and they are being rated 100 percent
21 disabled or unemployable at much higher rates than
22 the generation before. We did not see service in

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52

1 a combat theater, and so, obviously, one of the
2 issues for the Department is, how do we ensure
3 that this new generation of veterans that the
4 current conflict creates will not suffer a similar
5 fate.
6 I do think we have an important helpmate in this
7 regard, and that is the difference in the way the
8 military was staffed in this most recent period
9 versus how it was staffed during Vietnam. Vietnam
10 was a conscript force; this is an all volunteer
11 force. And I believe, in terms of the social
12 aspects of how that force was treated over time,
13 that's a key difference, one from which we are the

14 benefit, but the power question is how can we
15 build on that benefit?
16 How can we take the spirit of service and of
17 volunteerism that impelled these young people to
18 join and harness it to their lifetime benefit in
19 the programs the Department, the country advances.
20 In terms of care they receive, particularly for
21 posttraumatic stress disorder, as a nonphysician
22 it is unfortunate to observe that we really only

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53

1 have two, as I understand it, two therapies that
2 have really been proven through evidence-based
3 techniques, which ought to be our gold standard
4 for medical therapies across the board.
5 One of our problems in the Department is how we
6 assess the many proposals for therapeutic action
7 that are coming forward. Proposals are always, of
8 course, advanced with the best of intentions,
9 although sometimes there is an important issue of
10 conflict of interest to be direct, and the
11 question is, how do we in an expeditious way reach
12 the kind of evidenced-based conclusions on which
13 clinical practice ought to be founded? How do we
14 accelerate to the extent feasible the clinical
15 trial process, and how do we organize that process
16 so we use the skills, resources of the Department
17 and the country in an effective way?
18 We cannot test every potential therapy, however
19 promising it may seem in the eyes of its -- in the
20 eyes of its proponents. I think this, in
21 particular, is an area where the Board can help us
22 sort through both what should be tested and how

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54

1 best to carry out those clinical trials.
2 Second, organizational issues. Again probably not
3 a new issue but an issue being rediscovered by the
4 force of circumstance, and that is, how do we act
5 jointly? We are a department that's really
6 composed, as you all appreciate, three proud,
7 separate traditions -- the Department of the Army,
8 Department of Navy, Department of the Air Force.
9 How do we bring these together? And how do we
10 bring ourselves together with other federal
11 partners where that makes sense?
12 We have one, I think, bright shining model on the
13 latter front, and that is the North Chicago
14 Partnership with the Department of Veterans
15 Affairs. We really have, with the Department of
16 Navy's help, created a joint approach, including a
17 joint command structure and a governance mechanism
18 to deal with the issues conjunctively. We have
19 challenged other locations around our system to
20 ask themselves, can they learn from this North
21 Chicago model? Can they apply the principles of
22 the model, not necessarily the specific template

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55

1 that was employed but can they employ the
2 principles involved to assist their situation, so
3 we as the federal government act together as
4 opposed to separately with all the difficulties
5 that that would otherwise imply?
6 We have a new model here in National Capital
7 Region mentioned briefly in some of the opening --
8 in some of the introductions here and opening
9 remarks, and that's the Joint Task Force for the
10 Capital Region for Medical Affairs. Admiral
11 Madison is its chief. Granted this is brought to
12 us by the base realignment and closure process,
13 but it is in my judgment an extraordinary
14 opportunity to create a world-class enterprise of
15 a joint nature. Our individual stovepipe
16 processes often stand in the way.
17 And so the question where I hope the Board can be
18 of assistance to us is, how do we benefit from the
19 strong points of each of those processes, but how
20 do we create a unified whole that is indeed more
21 than the sum of its parts?
22 Because this is not the last area that our

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56

1 external direction impels us to reconsider how we
2 approach. We have been told to look at a similar
3 solution for education in the Department. That
4 really is still, in my judgment, at very early
5 stages in terms of how it might proceed. And the
6 challenge -- the challenge you can see in the way
7 the Department reacts to these instructions when
8 they cut, the Base Realignment and Closure
9 Commission told us to create as joint chaplains'
10 school.
11 I was pleased (off mike) to visit Ft. Jackson
12 where it's being erected and not quite so pleased
13 to learn that basically there will be three
14 chaplain schools and a central conference area.
15 Not perhaps quite the spirit of the BRAC
16 instruction.
17 There's a parallel issue out there in my
18 estimation where again I hope the Board can be
19 helpful because so much of our important business
20 takes place in the field, and that is the question
21 of the role of the command surgeons. There is
22 enormously, it cannot to be senior in- grade often

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57

1 outranked by the commanders of the facilities in
2 their area of responsibility. How should we see
3 the role of the command surgeons going forward,
4 and how do we prepare individuals for that post

5 and division that we might have forth.
6 Final subject, perhaps new, perhaps not so new --
7 when I started my professional career National
8 Health Insurance was just around the corner. That
9 was during the Nixon Administration. It's just
10 around the corner again. It was just around the
11 corner in the last Administration as well, and the
12 issue I think for the Department is if there is a
13 different national construct for the delivery and
14 the financing of health care, how does the
15 military, and the military community with its 9
16 million plus beneficiaries, fit into that
17 construct? And the beneficiary list is growing,
18 because thanks to the work of Ellen Embrey and
19 others, the TRICARE benefit has been paid the
20 wonderful back-handed compliment that more people
21 wish to join. And so the Reserve community has
22 been invited to join this benefit program.

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58

1 I am struck that usually the bureaucratic
2 imperative is to think about the implication of
3 the military after the larger system is designed.
4 I do hope that on this round, perhaps helped by
5 this Board, we can be somewhat more proactive and
6 ask ourselves if that's going to be the national
7 construct, how do we fit into that paradigm? What
8 should we change about our system? Likewise, what
9 lessons from our system might usefully be conveyed
10 to those who will design other new?

11 I am concerned, obviously, with the issue of
12 delivery and the various demands on the set of
13 practitioners in the United States that change in
14 the incentives for create [sic], as Massachusetts
15 discovered, simply offering everybody health
16 insurance doesn't mean everybody will get health
17 care because there is, in the short run, a fixed
18 set of health care providers, and you can make the
19 line longer, but you may also have a lot of
20 dissatisfied people, and its, as the Department of
21 Veterans Affairs has discovered when it opened the
22 doors in the '90s, you might as a result start

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59

1 shutting out the people you most want to take care
2 of with your new construct.
3 I do think in all these areas it would be very,
4 very useful, taking Dr. Poland's challenge --
5 innovation transformation directly -- very, very
6 useful if you could help us think boldly. We are
7 always constrained by what the statutes currently
8 say, by the practicality of getting those statutes
9 changed by directions for higher authorities
10 within the Executive Branch of the United States
11 Government. So I do think a Board like this gives
12 us an opportunity to think beyond normal bounds.
13 At the same time, I hope you will help us tell our

14 story so it's accurately appreciated as these
15 national debates proceed. We've had mixed success
16 in my judgment in that regard. You typically come
17 from communities where the statistical evidence is
18 the way you decide what is the trend. We live in
19 a political environment in which the individual
20 story is often the way in which political youth
21 decide what is the trend. And I hope you can help
22 us get more of the former, not to exclude the

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60

1 important of latter as symbolic, and instructive
2 as to how does the system affect individuals.
3 And let me take just two areas in where I think
4 you can both help us think yet more boldly, at the
5 same time help us tell our story of what we today
6 do well and don't want to lose in any kind of
7 change set that occurs.
8 The first area is the care of those who are
9 actually wounded or hurt during the course of
10 deployed operations. We really have, I think,
11 transformed the Department how we offer care to
12 these individuals from an older paradigm which we
13 tried to bring medical services forward to a
14 present paradigm where we bring those who were
15 injured back to a central point where it can
16 better organize the best facilities, the best
17 talent the country can bring to bear.
18 That story actually has been told fairly well to
19 the American public. We were privileged to have a
20 program on 60 Minutes -- I didn't think I would
21 tentatively live to see a program on 60 Minutes
22 that applauded the Department of Defense, but we

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61

1 did, because it applauded how well this was done.
2 It's an extraordinary -- I'm not a clinician, but
3 I know enough to realize -- an extraordinary
4 clinical achievement to stabilize these patients,
5 to put them on a airplane to fly them for 12 to 24
6 hours back to a point where definitive care can be
7 rendered. It's come to be an expectation,
8 interestingly enough, and I congratulate the
9 clinical staff of the Department for what really
10 is a transformational change.
11 But they've produced other transformational
12 changes haven't gotten quite the same attention.
13 We have a low list disease
14 nonbattle-injury-related issue. Not only in the
15 history of military operations in this country --
16 I think any country in the world -- we have the
17 highest survival rate of those who are wounded.
18 At the same time we are struggling to deal with
19 this question of exposure. In other words, what
20 have you been exposed to during the course of your
21 deployed service? And we don't do as good a job
22 in both tracking that exposure and following up on

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62

1 the exposure, especially if the wound isn't
2 physical in character, as I alluded to earlier in
3 these remarks this morning.
4 I hope you'll help us think about how we do yet
5 better in the delivery of care in a deployed
6 environment which will not always be the kind of
7 environment we see. They may be some very
8 different environment, particularly if some kind
9 of pandemic disease should break out, and also how
10 we get a balanced treatment of the issues involved
11 in that set of challenges by the body politic so
12 that we invest wisely in terms of capacity for the
13 future as opposed to that which is politically
14 salient today.
15 The second area where I hope you can help us think
16 in a transformational way is how we ensure that
17 our people are comfortable with the care they
18 receive and the way they have been treated. We
19 have, I think, an interesting conundrum in the
20 Department in which, if you look at broad polls,
21 we rate reasonably well in terms of satisfaction
22 of our people with the health plan and with the

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63

1 care they are receiving. At the same time, they
2 are often very pointed in their criticisms of our
3 shortcomings: lack of continuity of who the
4 provider might be is one example; quote, "can't
5 find a doctor" as another example; or "doctor
6 won't take TRICARE" as a further example.
7 Perhaps this is partly a matter of education in
8 the patient population. I am struck in the survey
9 results that the older patients who have been
10 through life's vicissitudes, whom we actually offer
11 the least generous package to, typically, in terms
12 of access, they're our happiest customers. It's
13 the younger patient, and whether this is just a
14 matter of age or whether it's also generational
15 phenomenon, it's the younger patients who are
16 dissatisfied.
17 Some of the dissatisfaction, I would argue is the
18 dissatisfaction of the American public with how
19 medical care, generally, is rendered. It tends to
20 be episodic, it tends not to be unified, it tends
21 not only to be inconvenient from the patient's
22 perspective. Records are generally not automated,

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64

1 not electronic, hard to pull things together. You
2 fill out the same information repeatedly, et
3 cetera, et cetera. You all know the various
4 shortcomings that are there.

5 So how do we both improve our system in terms of
6 dealing with our patients and how do we educate
7 our patients what they might reasonably expect
8 from any significant system in terms of what money
9 might do? What, in short, is the delivery
10 paradigm for those who benefit from the military
11 health system now and in the future, and how
12 should we change that paradigm over time?
13 The board challenge, in my judgment -- the broad
14 challenge where I am very hopeful this Board can
15 be of great assistance to the Department is, how
16 do we use this public sector opportunity to create
17 a role model for the country as a whole? We have
18 an extraordinary degree of control over the system
19 that is not generally mirrored in the civil sector
20 either in terms of delivery system or in terms of
21 how we can affect the lives of the patients. We
22 can reach patients, we can educate patients, we

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65

1 can train patients in the way that you could not
2 in the civil sector. How do we benefit from that,
3 and how do we use that opportunity to benefit the
4 patient population so that it is happy with the
5 care it receives and it enjoys the healthy
6 lifestyle that every American deserves.
7 With that, Madam Chairman, I'd be delighted to
8 answer one or two questions if you wish, in the
9 time remaining. Otherwise I'll yield back the
10 balance of my --

11 DR. WILENSKY: Thank you very much, Dr.
12 Chu. Fortuitously, given the role I am playing, I
13 very recently completed a chapter on the VA for
14 this next Administration, and the last section is
15 what might the future of the VA be with health
16 reform adopted, and have been spending some time
17 speaking both with the British and the Canadians
18 about how they have responded in terms of both
19 veterans' care and their military health care as a
20 result of their national health care systems,
21 including meeting with people in the U.K. twice
22 over the last month on precisely that issue.

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66

1 So there are areas in the world we can look to as
2 to how they have adapted their military and health
3 care environments with the adoption of a more
4 broadly-defined health care program, not because
5 that may be what we want to do but to inform
6 themselves of how they responded and see whether
7 there are any lessons to be learned.
8 But I think you for the challenges and
9 encouragement that our services will be needed as
10 we go forward.
11 Seeing what happened with regard to the chaplains'
12 school challenge and the Chicago positive example,
13 do you have some thoughts about what you think has

14 made the difference in what has been the
15 successful model, what has been maybe not quite
16 the model you envisioned, and what may be the
17 future with the National Capital Region? Or is
18 that something we're still too close to be able to
19 discern?

20 DR. CHU: I do think -- let me take it
21 from the last part back up -- I do think on
22 National Capital Region we are bringing the

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67

1 ingredients together. Now, whether they will work
2 in the manner that we intend remains to be seen.
3 The key element in my judgment is giving out of
4 Admiral Madison substantial degree of control of
5 the people in the system.

6 To the larger question you raise, what do I think
7 was behind the success in North Chicago as opposed
8 to how we're coming out on the chaplains -- I
9 don't mean to pick on the chaplains here, forgive
10 me -- but it is symptomatic of how the Department
11 often responds. I think in North Chicago it was
12 the produce of a great deal of attention from the
13 top and persistence. It took several years to get
14 to this outcome. We were helped by the fact that
15 the local congressman was very interested in the
16 kind of outcome that we were advancing and so we
17 had critical local political support. And we were
18 also helped, if I may, Madam Chairman, by your
19 first report in this Administration on DOD-VA
20 cooperation -- put more bluntly, the need to have
21 more of it.

22 And so everyone saw North Chicago as an

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68

1 opportunity to demonstrate we could cooperate. I
2 think that broader political impulse toward
3 cooperation was very powerful in keeping people on
4 track, even though there were many times that the
5 cars did threaten to go off the rails and not
6 produce the result that we wanted.

7 I do think the interesting issue is, can we bottle
8 our spirit, or have we succeeded in bottling our
9 spirit in what we've asked either other locations
10 to look at, not to do exactly the same thing
11 because their individual circumstances are
12 different, and all medical is in the end local,
13 but to accept the spirit. And I'm, candidly, very
14 encouraged at the long-term product of your early
15 report in that there is in my judgment a different
16 spirit there between the two departments and in
17 terms of how a joint team with members from each
18 department is approaching the solution at each of
19 these locations.

20 The issue will be, can we sustain that into a
21 transition to a new Administration? I do think
22 the Joint Executive Council that Congress put into

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69

1 statutes are helpful in that regard because it
2 gave us -- it gave the VA (off mike) myself the
3 venue within which to pursue this agenda. We had
4 a forum in which we could hold people accountable,
5 and we could say, you know, we want to do more
6 here, we want to see more happen here. And we are
7 seeing more happen, including, I'm pleased to say,
8 as I understand it, they're actually going to
9 construct a regular connection between the VA
10 Clinic and the Tripler Army Medical Center in
11 Honolulu, which as been missing for a number of
12 years.

13 So some of the victories are small, but the
14 symbolism in my judgment is powerful, and the
15 trend I am hopeful will accelerate.

16 DR. WILENSKY: Is there another
17 question? All right, Ken Kizer.

18 DR. KIZER: You know, while I think it's
19 instructive to look at the success of North
20 Chicago, there's perhaps more to be gained by
21 looking at where these partnerships have not been
22 so successful such as in Las Vegas and California

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70

1 and Tripler and some other places. There's a
2 longer list perhaps would be more helpful in
3 looking at us as to what has not been working.

4 DR. CHU: I fully agree. That's one of
5 the reasons we've concentrated on Tripler as, can
6 they come up to something more similar to what
7 North Chicago has? I think we're making progress
8 in that regard. It is, typically, two steps
9 forward one step backward. I would characterize
10 Las Vegas as an example of that phenomenon,
11 although I do think Las Vegas it was more the
12 larger state political situation than necessarily
13 the two cabinet agencies that played in this. But
14 you may have a different view, sir, and I'd be
15 interested to be instructed by your insights in
16 that regard.

17 DR. WILENSKY: Any other questions for
18 Dr. Chu?

19 (No response) Thank you very much
20 for sharing the time, and we
21 Hope we will prove of value to you and to your
22 successor.

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71

1 DR. CHU: Gail, thank you very much.
2 The best to all of you.

3 (Applause)

4 DR. WILENSKY: Our next speaker today is

AADHB-121508.txt

5 Dr. Kenneth Kizer, Chairman of the Board of
6 Medsphere Systems Corporation, the leading
7 commercial provider of Open Source Information
8 Technology for the health care industry.
9 Previously, he served, as many of you know, as the
10 Undersecretary of Health and the U.S. Department
11 of Veterans Affairs. As a current Chairman of the
12 National Capital Region Base Alignment and
13 Closure, NCR BRAC Advisory Panel, he will provide
14 an update on its activities.
15 The group met a few times to review design and
16 construction issues regarding the new Walter Reed
17 National Military Medical Center at Bethesda and
18 the new community hospital, Fort Belvoir. Dr.
19 Kizer's slides may be located under tab 2 of the
20 binders.
21 Ken?

22 DR. KIZER: Thank you, Gail. Good
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72

1 morning. I presume, based on the sound here, that
2 everyone can hear okay.
3 Let, me just as a note for those who are looking
4 in the syllabus or the notebook here, the slides,
5 there appears at least in the mind and the couple
6 I looked at next to me, there was a little bit of
7 a mix-up in that the first -- I think there are 13
8 slides or so -- the first half is repeated and the
9 second half was not included. I don't know
10 whether that was a political statement or --
11 because the second half had to do with our
12 conclusions or findings.
13 Also, I would note that the other attachment or
14 statement in there about what does it mean to be a
15 world- class health care facility should have
16 draft on it and should also be noted that this is
17 not to be cited or replicated. The version that
18 is in the notebook actually has been superseded by
19 another iteration. In the time to get this in
20 here, there have been some further comments, and
21 I'll explain that a little bit more when I get
22 there.

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73

1 The Appropriations Act of this 2009, as referenced
2 in this slide, does call for an independent design
3 review of the new or proposed Walter Reed National
4 Military Medical Center as well as for the new
5 hospital at Fort Belvoir with two primary
6 questions that are stated in the legislation:
7 will the design achieve the goal of providing
8 world-class medical facilities, and, if not, what
9 should be done to fix that, in essence? -- which
10 raises of number of corollary questions that were
11 identified, not the least of which is, what is
12 "world-class?"
13 "world-class" is a marketing term. I suspect that

14 when it was used a few moments ago by Dr. Chu that
15 there was, at best, a kid of nebulous idea as to
16 what this meant, but not something that one might
17 measure and objectively put in place and then
18 decide whether billions of dollars of public
19 moneys are going to be used against that. And
20 indeed, when Congress put this in federal law,
21 there was some reference to the best of what's
22 done in the private sector, and that ostensibly

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74

1 was the definition; but again, I don't think one
2 that many of us would feel comfortable using as,
3 in essence, a standard by which federal moneys
4 will be appropriated.
5 So much of our work to date has been around trying
6 to define in more precise terms, what exactly does
7 it mean to be a "world-class" health care
8 facility?
9 This, by the way, has -- this term has been
10 increasingly used in the private sector in recent
11 years, and if you, just as a late-night exercise
12 and diversion from my real work, I googled
13 "world-class medical center," not that -- well, a
14 couple of weeks ago -- and found over 100
15 different facilities that list themselves as
16 either providing world-class care or described
17 their facility as "world-class," none of which
18 provided definition as to what that means.
19 Well, I'll come back to this in a moment. The
20 second corollary question that we needed to focus
21 on is the approach that's being used in the
22 construction of this new facility which is, one

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75

1 might say, a radical departure, certainly a
2 substantive departure from how military hospitals
3 have been built in the past. Does this make
4 sense, and is this basically a good approach and
5 something that we might want to replicate in the
6 future? And with that in mind, because this is a
7 more of a design/build approach that's typically
8 used in the private sector with the full design
9 plans not available. The Congress, in particular,
10 was interested in knowing whether there is any
11 reason that we should call a halt to the
12 construction that is currently underway and finish
13 the plans in the more of the traditional model, or
14 whether things should continue as they are.
15 And then, finally, there is just kind of "capture
16 all" question of, you know, are there other things
17 that need to be done as we're undertaking this
18 review?
19 I should probably note that when the Committee was
20 convened three months ago or so, this was not the
21 topic that we were intended to focus on. Indeed
22 most of our focus and the reason for convening was

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76

1 the design is integrated health care system that
2 Dr. Chu talked about, can we actually achieve
3 that, and we've been somewhat sidetracked,
4 although I think it's a very important diversion,
5 into the issue of whether it's being designed and
6 built -- are these two facilities being designed
7 and built to be world-class -- because it does
8 expose many of the issues that have to be dealt
9 with as far as their being an integrated facility.
10 Just quickly process, as I mentioned, the
11 Committee was convened just about three months
12 ago. Subsequent to that the Appropriations Act
13 was passed, and there was significant debate as it
14 was evolving to actually being signed. And in
15 September and October a number of subject matter
16 experts, those who are more architecturally
17 inclined, if you will, were added to the
18 Subcommittee. We've had a number of meetings in
19 conference calls, and what we present today is
20 more of a work in progress than the definitive
21 answer, and with that, let me -- oh, and I would
22 just add also that the Committee, as it has come

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77

1 to pretty much satisfaction with the definition of
2 "what is world class?," I did send it out to about
3 50 prominent individuals in health care to get
4 their take and those -- that feedback is filtering
5 back with some, by and large, a lot of support,
6 but some minor modifications which are indeed
7 reflected in the current iteration.
8 So with that, let me take a moment here to talk a
9 little bit about, what does this world-class term
10 perhaps mean? And I would encourage you to turn
11 to the statement that's in the handout. I am not
12 going to go through it in depth, but you may want
13 to see what some of the detail is under some of
14 these areas.
15 I think, and we after going through a long list of
16 kind of these are the things that need to be --
17 we're unhappy with that and felt that there really
18 needed to be some sort of general statement, a
19 preamble if you will, that talked about what's
20 world class mean in more general terms.
21 Some of the characteristics in a general term are,
22 as noted here is: Consistent and predictable

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78

1 superior care and outcomes routinely operating at
2 the theoretical limit of what would be considered
3 the best care; incorporating evidence-based design
4 and practices into the design of the facility as

5 well as the processes and procedures; using state
6 of the art technologies, not just in diagnosis and
7 treatment but in all the other functions that are
8 attendant to operating in a large and complex
9 health care delivery system; that caregivers
10 obviously have to be competent and well trained,
11 and there has to be knowledge, management, and
12 other aspects of that; that the care model and the
13 institution is designed to be patient-centered --
14 and again lots of detail as to what exactly it
15 means to be "patient-centered."
16 But I think that this gets to some of the
17 intangible part of what at least the Committee
18 feels is very difficult to lay out in a set of
19 standards or set of criteria, and that's the
20 intangible part of what's world class, or I think
21 what most of us feel when something is world class
22 that it's really more than the sum of its parts;

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79

1 that when you put all these pieces together, you
2 get synergies, and those synergies result in
3 basically making the extraordinary ordinary, and
4 doing things that would not -- that you would not
5 see in a nonworld-class facility. And this means
6 regularly going above and beyond what might be
7 expected.
8 Getting into some of the specifics, there are a
9 number of different categories. Some might be
10 viewed as the floor or the bottom: You've got to
11 have these things if you're even going to talk
12 about this, and some might be a little bit more on
13 the aspirational side. But certainly, we need to
14 start with having all the accreditations and
15 certifications and reporting or satisfying all of
16 the federal government reporting requirements;
17 having comprehensive and definitive acute care
18 services across the aids spectrum from preterm
19 infants to end-of-life care; that the term that
20 we've called "facility readiness," that the
21 facility has to be ready to provide superior
22 quality care.

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80

1 And there's a long list of items that fall in this
2 category, and again in the interest of time, I'm
3 not going to go through those, and you can refer
4 to the statement and what's included there
5 relatively quickly.
6 We think it's also particularly important that our
7 facilities today be "green," to use an overused
8 term, but that they in fact do demonstrate
9 environmental responsibility and sustainability;
10 that they apply contemporary evidence-based and
11 state-of-the-art technology in the design;
12 assuring competence of caregivers; -- and again
13 with each of these there's a menu underneath it --

14 having the governance body engaged, which is
15 something that one might, looking at the private
16 sector, probably unusual to actually have the
17 governance body engaged to the extent that it
18 should be. There's a major movement underway to
19 get boards of directors and governing bodies much
20 more again, particularly in the quality of care,
21 which is something that most boards in the private
22 sector tend to be chair to get involved in

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81

1 because they feel inadequate to do that.
2 Going down this list further, operationalizing
3 evidence-based practices and processes, whether
4 those are things like the 30 -- or at least today
5 -- the 30 safe practices that have been endorsed
6 as national consensus standards by the National
7 Quality Forum, to the patient safety objectives
8 that the National -- or the Joint Commission has
9 espoused are things that can be done to prevent
10 the never-events. And again, there are a number
11 of different buckets under there that were
12 included really as a minimum, and that there is
13 more that could be done.
14 Transparency of processes. This is felt to be
15 critical, and this means having patients,
16 patients's families, employers involved and out of
17 those determining what is done in the delivery of
18 care and other aspects of the operation of the
19 facility.
20 Demonstrating superior performance against
21 standard industry metrics, and again whether those
22 are clinical metrics endorsed by the National

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82

1 Quality Forum; whether it's patient satisfaction
2 metrics, or again a number of other areas
3 performing at the 90th percentile or higher was
4 felt would satisfy this notion of being superior.
5 Gazing in the full range of scholarly activities,
6 research, teaching, et cetera, and not just for
7 physicians but for other health professionals as
8 well.
9 Having a high performance organizational culture,
10 and indeed that's probably the longest list there.
11 There is a robust literature on high-performing
12 organizations, some of it coming from Navy Seals
13 to chemical manufacturing, to aviation, other
14 areas that is routinely not employed in health
15 care, or these concepts are not employed in health
16 care the way that they should be, and, as everyone
17 in health care is finding out today, lots of
18 opportunities to operationalize this in health
19 care.
20 And then, finally, the last category here or
21 bucket is simply involvement in improving the
22 public health of the community and the

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83

1 stakeholders that are -- which the institution
2 serves. As a whirlwind reader's digest 101
3 version of what's world-class facility, we have
4 tried to be a little bit more articulate and
5 thoughtful in the statement and, as I mentioned,
6 there is a somewhat revised version that is
7 currently the most up to date, and it will
8 probably undergo further revision in our report
9 that will be submitted in the not too distant
10 future.

11 So the questions, and I think in your handouts
12 this is the last slide that you have, but one of
13 the first questions that we needed to answer was
14 whether the approach being used to design and
15 construct these facilities, is it a good approach,
16 is it sound? And the Committee enthusiastically
17 endorses the approach being used, feels this is
18 much more like what is done elsewhere today in
19 health care facility construction. It certainly
20 shortens the time line compared to the typical
21 military construction process. While at the
22 moment it is an article of faith, we do believe

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84

1 this will also result in a better outcome than
2 what has been done in the past as well, but since
3 the facilities aren't yet constructed or
4 operational, that remains as an article of faith
5 until that's actually done.
6 I don't think you have these -- if you do, great.
7 One of the other issues is -- and this is perhaps
8 one of the most important issues at the moment --
9 is there a reason to halt construction until the
10 plans or the design is at a more complete or final
11 stage than it is at the moment? The Committee's
12 judgment at this time is no, that there's no
13 deal-breaker, if you will, issue that's been
14 identified. We do have some concerns about what
15 has occurred as is the case at the Bethesda site,
16 and we're still evaluating that, and we will have
17 an intense session in the first half of January to
18 delve into that in some more detail. But all of
19 our assessment to date leads us to believe that
20 the issues there are such that they should be able
21 to be addressed as the construction and design
22 proceeds, and a lot of it has to do with the

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85

1 historical way that different parts of this
2 project have been funded, and that they haven't
3 necessarily come together in the way that we will
4 recommend that they perhaps should.

5 will the design -- and this is really the key
6 issue that the Congress asked us to respond to --
7 will the design achieve the goal of providing
8 world-class medical facilities? And I think we
9 have to preface that in very strong ways that
10 facility design and construction only accounts for
11 a part of what is a world-class facility. Indeed,
12 I would posit that is the minority part, that the
13 majority of what constitutes world class has to do
14 with processes and procedures and the interactions
15 of the staff, and a number of other things that
16 you can't necessarily design or construct into a
17 facility.
18 Having said that, though, looking at the Fort
19 Belvoir hospital, our or the Committee's judgment
20 at this point is that that should provide a very
21 good foundation for being a world-class community
22 hospital. The approach to that has been very

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86

1 different than Walter Reed because, basically
2 building at the nouveau on some green space as
3 opposed to having to remodel and reconstitute
4 something within a number of -- or being limited
5 by a number of parameters in doing that.
6 As I mentioned already, we're still evaluating the
7 Bethesda site. We do have some concerns both in
8 the bricks and mortar part, although perhaps more
9 around some of the nondesign elements, some of the
10 things relating to culture and integrating the
11 different services and other issues which are
12 paramount in actually delivering a world-class
13 care.
14 Just a couple of additional slides.
15 Recommendations, at least at this point we believe
16 that the statement describing what is world-class
17 in whatever final form it evolves to should be
18 used to guide the further evolution of these
19 facilities, and indeed we believe that it may well
20 have a lifetime beyond those two facilities as
21 well.
22 We do think -- and this is reaffirming a comment

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87

1 already made -- that the process, design and
2 construction process that's been used for these
3 two facilities should be the one that's used in
4 future federal hospital construction projects, and
5 the emphasis there is on federal, not just
6 military. And I read with interest that the
7 facility that I was involved in 15 years ago or so
8 in Orlando, Florida, the VA facility they finally
9 turned dirt on a few weeks ago, which is about the
10 typical time line to construct a VA hospital,
11 about 20 years to get it going which, by the time
12 you start building, the plans are way out of date
13 -- but I won't go there.

14 And while we don't feel, based on what we have
15 seen, what the Committee has seen to date, there's
16 any reason to halt construction. We do think
17 there are a number of issues that do require
18 urgent attention, indeed urgent action. Some of
19 these are, as noted here, particularly at the
20 Bethesda site there's a need for a master plan to
21 bring together the different strings or threads of
22 construction that are BRAC-funded, that are not

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88

1 BRAC-funded, and their different plots there that
2 these need to be brought together into a much more
3 coherent whole than at least appears to be the
4 case, based on our review so far.
5 With that, we also need to finish the gap analysis
6 of where the design is, where things are now and
7 what that would entail if they really -- if the
8 facility truly aspires to be world-class.
9 There are some issues that are related to
10 handicapped accessibility, these, again, nothing
11 that would be a show-stopper. These are just some
12 additional things that need to be dealt with,
13 indeed at both sites.

14 We are concerned about the information management,
15 and feel that some additional attention needs to
16 be focused on this, intimately familiar with the
17 evolution of IT systems in DOD and VA, and whether
18 they should ever be similar, but regardless of
19 what ultimately is done in that regard, we want to
20 make sure that the facilities are wired and
21 appropriately designed so they can accommodate
22 whatever applications ultimately are used.

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89

1 We also are concerned about the transportation
2 management plans, parking and other issues there,
3 and need to look at that in more detail than we
4 have to date.
5 And, finally, one of the observations that have
6 been made by Admiral Madison and other is that
7 this, particularly if we're going to view this as
8 an opportunity or a learning opportunity for how
9 one might integrate facilities in the future and
10 develop a much more jointly- operated military
11 health care facility, there is a need to put in
12 place a research program. Some of that is not the
13 bench-type research but much more of an HH R&D
14 approach. But that needs a plan, it needs
15 funding, and it needs to have been started
16 yesterday. And at the moment that is -- well, I
17 think there's certainly recognition of the need to
18 do this. It had not jelled or come together, and
19 that is something that we feel really needs some
20 urgent attention and action to get that moving.
21 Indeed, I think one of the -- if one wants to look
22 at the transformation that occurred in the VA in

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90

1 the latter part of the '90s, there were a number
2 of research projects that were launched
3 concomitant with the changes that have turned out
4 to provide very important and valuable lessons
5 from everything from service lines to a number of
6 other models that were being utilized or at least
7 trying to learn from as part of an exercise.
8 So just in conclusion as far as where we see the
9 further Committee process going, we need to
10 continue to look at the data and do some further
11 evaluation. We need to finalize at least an
12 interim report in the very near term with the
13 expectation that there will be some addendums or
14 additional iterations to that. There, I think, is
15 going to be a need to present our findings and
16 discuss these at a number of different forums
17 based on the seeming interest; in this topic, and
18 continue to review this particularly for some of
19 the nonconstruction/nondesign issues. And,
20 obviously, the Committee will stand ready and do
21 whatever else it's directed to do by the Board, or
22 whatever else may come by this way.

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91

1 with that, I'll be happy to try to address any
2 questions, if there is indeed time for such, Gail.
3 DR. WILENSKY: Absolutely, time. Let me
4 just understand the timeline before I open it up
5 for substantive questions.
6 when do you need to have the interim report ready
7 so that we can think about when the briefing for
8 the Core Board might occur?

9 DR. KIZER: Last week. It will -- we
10 anticipate having it done by just after the first
11 of the year.

12 DR. WILENSKY: Okay. And when are you
13 suppose to report as the interim?

14 DR. KIZER: I believe that we need
15 something by about the middle of January, and
16 indeed one of the reasons why we're having this
17 intense architectural review in the first half of
18 the month is we do need to wrap things up at least
19 on a first pass by -- I forget the exact date, but
20 it's about the middle of the month.

21 DR. WILENSKY: About the middle of
22 January.

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92

1 DR. KIZER: Yes.
2 DR. WILENSKY: Okay. Well, we can talk
3 with you to make sure that we can have that
4 process go in a timely way, so we don't disrupt

5 your time schedule but can do what we need to do
6 as a Core Board.
7 DR. KIZER: Yeah, I think -- I want to
8 applaud the Committee in their willingness to give
9 up time, and this is not a simple task in
10 reviewing a very large amount of both literature,
11 a large number of plans, some detailed
12 architectural plans as well as a lot of other
13 stuff. And certainly for the folks who have real
14 jobs or daytime jobs, they have been very generous
15 in giving their time to the committee process.
16 DR. WILENSKY: Yes?
17 MS. EMBREY: I'm very fascinated with
18 the inclusion of a world-class facility as focused
19 on patient-centered care. That is a culture;
20 it's a process, it's one I haven't seen practice
21 widely even in private sector. So I would be
22 interested if you could give us a little more

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93

1 detail about what you mean by that so that we can
2 make sure that we start the cultural
3 transformation in about the time the building is
4 ready we actually have a culture that can execute
5 it.
6 DR. KIZER: Well, I think that the --
7 and how much time do I have here?
8 One of the reasons for referring to the document
9 is there's actually a fair amount of detail in the
10 statement already about this. Some of it is
11 imbedded in sets of standards and other things
12 that there may be varying levels of familiarity
13 with what is in there.
14 But there are design aspects to patient-centered
15 are from how one designs and constructs the rooms,
16 the hallways, the way finding. I mean there's a
17 number of things that do go to the design.
18 There's obviously cultural issues about how one
19 incorporates patients' background, their
20 knowledge, their health literacy, their spiritual
21 beliefs, other things into understanding or in
22 fashioning the approach to care, to other

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94

1 processes like how do you minimize the amount of
2 movement of the patient.
3 Again, this gets into some of the design issues,
4 but instead of sloughing the patient all over to
5 x-ray and lab and whatever, how can you actually
6 minimize that, particularly with some of the types
7 of casualties or injured patients that we're
8 talking about.
9 So there's a long list of things that goes into
10 this, and I think in the interest of time maybe we
11 can have that as a sidebar conversation or --
12 MS. EMBREY: I just wanted to make sure
13 it was highlighted in the report to the Department

14 because it's very important that, if you're
15 designing to that, that we actually have the
16 people thinking that way that go into the
17 building.

18 DR. KIZER: I think that's one of a
19 number of cultural issues that are going to have
20 to be given a lot of thought if this facility is
21 to be world-class. And again, the decision was
22 made by others, including the Congress, that this

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95

1 is to be a world-class facility. We have
2 attempted to define that in ways that are both
3 measurable and objective, but also captures some
4 of the intangibles of what it means to be
5 world-class.
6 And then the question, ultimately, is whether this
7 can be operationalized by the folks who have to
8 manage the facility. And there will be some
9 challenges here, especially in the area of
10 culture, how one brings the different services
11 together, how one -- the longevity of command and
12 a number of other things, at least in other
13 organizations, have proved to be very important to
14 building world-class organizations but at the
15 moment are not necessarily the standard of
16 practice in military settings.

17 DR. SILVA: So, thank you, Ken, for a
18 very nice report. It's very heady, and hopefully
19 we can achieve it in a 20-year time period.
20 But my question, related --

21 DR. KIZER: By 2011.
22 DR. SILVA: Okay, fine. My question

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96

1 relates to the whole concept of public health.
2 That's an important concept. I flew over the
3 country yesterday, we've had disasters that are
4 weather-driven it seems like every few months, and
5 in your thinking you mention that you're going to
6 be prepared to deal with disasters.
7 Does it take much architectural changes in the
8 design of the facility to prepare for these
9 events? I just don't know.

10 DR. KIZER: The answer is yes and no.
11 You say architectural change. How one lays out
12 this space and how one can convert a space that
13 could be used either to deal with surge needs, for
14 example if there is a particularly bad epidemic of
15 the flu this year and you have many more
16 admissions, there may be needs there. Or at some
17 other mass casualty incident, can you convert in a
18 timely manner existing space so that it could be
19 used to deal with that extra number of patients
20 that one might have within 24 hours or so? And
21 there are definitely design considerations that go
22 into that. Indeed, some of what we're looking at

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97

1 or continue to look at relates to that particular
2 issue.
3 DR. MATTOX: Ken Mattox, Houston. I
4 would like to ask a question about something you
5 did not say. I compliment everything you said.
6 Many of us around the table in the civilian sector
7 have been victims or drivers of acquisitions and
8 mergers which is the same sort of thing you're
9 dealing with. We were wanting to be more
10 efficient, and we were wanting to be more
11 competitive and productive. The BRAC should be,
12 can be, and probably will be the poster child of
13 what we heard Dr. Poland and Dr. Chu talk about
14 and in -- the words "joint" were used, I think I
15 counted 17 times.
16 The thing that destroys or sometimes makes the
17 civilian mergers and acquisitions is how we deal
18 with urban legends, past history, silos, and
19 personality. So I guess my question relates to
20 protection of those old SILOs and egos that can be
21 destructive when we try to do something like
22 respond to the Katrina evacuees from New Orleans

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98

1 to Houston, or when we try to merge major major
2 centers or hospitals or residency programs.
3 So the thing that I did not see in your report was
4 of perhaps you don't have them in the military,
5 and that our silos to protect, egos to protect --
6 DR. KIZER: None.
7 DR. SILVA: -- and past programs to
8 protect, and, if so, then you will get to the
9 joint program very quickly.

10 DR. KIZER: Nice to see you again. The
11 last time I think I saw you we were in Saudi
12 Arabia trying to set up trauma care systems 20
13 years ago or so.
14 Anyway, actually, there are pieces of this. For
15 example, if you look under the Caregiver
16 Competence, there are a number of things that --
17 or at least a couple of those bullets that deal
18 with that in a politically polite way, perhaps, of
19 dealing with some of those issues. The culture
20 and the category dealing with culture is the one
21 that is perhaps most relevant to what you say
22 because most all those things that you mention

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99

1 fall to one degree or another into culture.
2 And also, I would say that that is the area that
3 we are perhaps least comfortable with at the
4 moment. And it's not, though part of the charge

5 of this report, this report specifically focused
6 on design and construction issues because that
7 train is moving quite quickly. But as part of our
8 ongoing review, we do have -- and I think it's
9 highlighted on one of the slides -- concern about
10 the nonconstruction or nondesign issues, i.e.
11 culture. And there are some very specific things
12 as well as some more general concerns that we hope
13 to detail in if not this report one of the
14 subsequent addendums to it.

15 And I think that we're probably on the same page
16 here as recognizing that these will do-in a
17 medical center, and no matter how well it's
18 constructed and designed, if we don't deal with
19 these issues, it's never going to be world- class.

20 DR. MATTOX: If I may comment, Madam
21 President and Chairman, perhaps each of our
22 subcommittees could link and integrate together in

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100

1 a unified way to help each other and help the BRAC
2 to address some of these sticky cultural issues.

3 DR. WILENSKY: We will accept your offer
4 of help. Wayne?

5 DR. LEDNAR: Wayne Lednar. Thank you
6 for your report. As we're talking kind of
7 specifically about two facilities, two locations,
8 Walter Reed and Fort Belvoir, what I didn't hear
9 and I hope would be part of the thought process is
10 the fact that these facilities have important
11 design issues, obviously, on their campus, in
12 their building movement of patients, those kinds
13 of things. You talked about culture, caregivers,
14 culture of patients.

15 The thought I would offer out there is a thought,
16 actually that Dr. Poland mentioned in his remarks,
17 and that's servant leadership. These facilities
18 are a node. They are a piece of an end-to-end
19 care solution, and how the governance of these
20 facilities, their priorities, and how their
21 eventual performance will be judged across the
22 spectrum that they are there to serve, that's

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101

1 tri-service that starts at the battlefield and
2 ends up in rehabilitation centers. It involves
3 the military and our civilian soldiers in the
4 Reserve, the National Guard and their needs.
5 So how is this part of the system that has all of
6 that in view? And to the extent that at this
7 point the design of the facility needs to attend
8 to some of these issues is really an opportunity
9 for leadership.

10 DR. KIZER: That sounded more like a
11 comment than a question, and I will take it as
12 such with just one friendly additional comment.
13 And in the statement about what is world-class,

14 the one area that I have felt that it was
15 sufficient in had to do with leadership. It's
16 also perhaps one of the most difficult to try to
17 espouse in any sort of objective and measurable
18 way in a statement like that.
19 But in the more later (off mike), there's some
20 attempt in so working at some of that with regard
21 to leadership, but it actually -- that's a key
22 issue that we've identified already and we've

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102

1 placed more or less under the nondesign category.
2 But it's something that again, if the Department
3 and the Congress have determined that this will
4 be, shall be, a world-class facility, then they're
5 going to have to deal with some of these issues in
6 perhaps more creative or different ways than
7 they've been dealt with in the past.

8 DR. WILENSKY: Are you done with that?
9 Okay, any other questions or comments?

10 DR. KIZER: I would probably be remiss
11 if I didn't at least ask if other members of the
12 Subcommittee didn't have any comments or want to
13 correct me where I misspoke. Anyone?

14 (No response) Okay.

15 DR. WILENSKY: Ken, maybe --

16 HON. WEST: Ken, Togo West. Are we
17 going to hear, perhaps in the Core briefing or as
18 part of your -- one of your final reports more
19 specifics on the nondesign concerns? Or I gather
20 you're continuing to review?

21 DR. KIZER: We would hope so. Again,
22 this particular report was very focused on design

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103

1 and construction issues. I think that we will at
2 most in this report identify some categories or
3 some themes that need to be addressed. But as a
4 pragmatic matter to do those any sort of justice
5 in discussing them, it's just not going to be
6 possible to incorporate it with the time line that
7 we've been given for at least a round one of this
8 assessment.

9 HON. WEST: Then perhaps I
10 misunderstood. One almost gets the impression
11 from -- well, an amateur such I is obvious -- from
12 the way your report is presented that the
13 nondesign concerns may well be of greater concern
14 to you than were the compliance with the design
15 and construction issues that you examined. Am I
16 wrong about that?

17 DR. KIZER: I think you have corrected
18 assessed what I said. But again, the task and the
19 specific charge that's in the legislation has to
20 do with construction and design, and it may
21 reflect the level of familiarity of the authors of
22 that language with what constitutes being

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104

1 world-class.
2 DR. HALPERIN: Bill Halperin. You know,
3 I've been looking at the report. There are
4 various places where issues of public health and
5 prevention, et cetera, are mentioned, but with the
6 sense that build it and they will come.
7 As a design issue, would it stand greater, a
8 greater emphasis, for example, on facilities for
9 something that's overarching like the continuous
10 improvement of a facility that would incorporate
11 things like preventive medicine and data analysis?
12 And worry -- I've been looking at this very
13 briefly, and I apologize -- that you wonder, gee,
14 is this data analysis going to be part of IT? And
15 we know what happens when it becomes part of IT.
16 You know, they focus more on the computers and the
17 telephones and less on the collection analysis of
18 prevention-oriented data.
19 So I wonder whether a median between talking
20 philosophy and talking concreteness is to make a
21 clear statement that there needs to be a facility
22 that can house adequate resources in the area of

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105

1 continuous improvement, and continuous improvement
2 includes all of the things that I've been talking
3 about -- sorry to be lengthy.
4 DR. KIZER: I think if you -- and again
5 I recognize that most of you probably haven't
6 sighted this statement until five minutes ago or
7 so, and haven't had a chance to digest it. But
8 there actually is a bullet that is very specific
9 through process improvement needing to be
10 incorporated in everything that's done in the
11 institution, and then reference in several other
12 areas in a perhaps a little bit more oblique way
13 to the same sort of thing. And we can go back and
14 look and see whether we need to enhance the
15 verbiage in that regard.
16 I think where we are at this point is trying to
17 achieve a statement that is readable in one
18 sitting and detailed enough that it has some teeth
19 but at the same time isn't, you know, a tone that
20 is something that no one's going to read. So
21 there is some need for parsimony of language, but
22 at the same time we're trying to make it as

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106

1 complete and robust as possible.
2 And some of that is done by reference to other
3 items that, if you're not familiar with those
4 other items, you may not appreciate what is

5 covered in them.
6 DR. KAPLAN: Ed Kaplan. I'm a little
7 bit confused. First, thank you for the report.
8 Is the task of the Board as placed before us this
9 morning to either accept the report, which I think
10 we will, or is it to say there are a lot of
11 questions that have been raised in this report
12 about things that need to be addressed that
13 progress should stop? Stop's a harsh word and
14 probably an unrealistic word, but what is the
15 Board supposed -- what is our job, I guess, in
16 terms of looking at this report, because there
17 have been a lot of questions raised as we've sat
18 here and listened to it?

19 DR. WILENSKY: This is a progress report
20 on the Subcommittee's work which is on a very fast
21 time line. But it, as I indicated a comment or
22 two ago, I'm aware that the Subcommittee has been

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107

1 directed to report back to the Congress sometime
2 in January. And when there is a subcommittee
3 report, which there is not yet but will be in the
4 next couple of weeks, I assume, then I will call a
5 very quick Core Defense Health Board meeting so
6 that we can, either virtual or in person, so that
7 we indeed can be briefed on what is proposed to go
8 to the Congress in response to the legislation.
9 I recognize we are not going to have very much
10 time to response, but we are going to carry out
11 our fiduciary responsibility as a Core Board to be
12 brief, even on this interim. This is only one
13 part of what is or will be a set of ongoing
14 reports from the NCR BRAC Subcommittee, but one
15 that is responsive to a legislative request.

16 DR. KAPLAN: Excuse me, may I just ask
17 one other question in follow-up, then?
18 So if I understand you correctly, a final report
19 will come to the Board, and the Board then has the
20 option of saying we're concerned about his, we
21 like this, accept it? Or does the Subcommittee
22 report go directly to the Congress to meet the

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108

1 deadline?
2 DR. WILENSKY: My understanding,
3 although I, since I have sitting to my right a
4 federally-designated official, is that we do have
5 the right as a Core Board to not approve a
6 subcommittee report, any subcommittee report if we
7 think there are serious questions.
8 On the other hand, I think we will be sensitive
9 and mindful that they are responding as a
10 subcommittee to a very short time line that was
11 put in legislation. For any of you who have had
12 the pleasure of having to respond to
13 congressionally-mandated studies, you do what you

14 can within the time frame and frequently indicate
15 that there are a variety of areas that could
16 usefully be explored further, but you are being
17 responsive to the time line.
18 So I don't want us to be other than thoughtful and
19 reasonable, but I do regard us as appropriately
20 reviewing as we should anything that is a
21 Subcommittee of the Defense Health Board. So if
22 we have some concerns, we can at least make sure

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109

1 that there is language that says that, you know,
2 certain areas we think need to be further
3 explored. They are not going out of business when
4 they have this interim report. So you don't have
5 to regard this as the last word, but we're not
6 going to try to do anything other than facilitate
7 their on-time delivery, but after we've been
8 briefed.

9 DR. KAPLAN: Thank you for clarifying
10 that.

11 DR. KIZER: Gail, if I might, just to
12 perhaps further clarify it, our report that the
13 Secretary of the Department is the one that
14 actually has to transmit the report to the
15 Congress with whatever additional verbiage the
16 Secretary may choose, either accepting it, not
17 accepting it, accepting it with caveats, et
18 cetera. But again we are responding to a very
19 specific query from the Congress that is primary
20 focused on design and construction issues. And
21 again, since they never defined the term
22 "world-class" before it was put into federal

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110

1 legislation, it's not necessarily surprising that
2 their level of familiarity with some of the
3 nonconstruction design issues might not be as
4 great as one would hope before one puts something,
5 in essence a standard, into federal law.
6 But it is what it is. We have to respond to it,
7 and I think that there will be a number of areas
8 where additional comments will be felt to be
9 appropriate in the future, but it's just not
10 possible to be done the time frame and may be not
11 directly responsive to the particular concern.
12 And I think -- and, Ray, you may want to comment
13 on this as well, having more history -- but the
14 real question that the Congress wants to know is
15 whether construction needs to stop and whether
16 they need to call a halt and finish the design
17 plans until the design is complete. And as I said
18 in the report, at this point we don't see a reason
19 to do that. But I think that's kind the real
20 threshold issue.

21 DR. WILENSKY: I think in general -- let
22 me clarify what I guess I thought is understood

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111

1 but make clear, we are a Committee of the
2 Secretary through the -- Assistant Secretary for
3 Health. Everything we do, basically, unless
4 directed otherwise will be to report to the
5 Secretary, in general who the secretary that makes
6 the transmittal.
7 But these are subcommittees of the Defense Health
8 Board, and therefore we are an interim staff.
9 MS. EMBREY: If I could elaborate just
10 -- and maybe we can end on this since we've talked
11 about it longer than our budget -- but I think for
12 the Core Board and the Subcommittee who is
13 proposing this report, to the Department of
14 Defense and to Congress, how we define
15 "world-class" will become the new standard for us.
16 And so it's very important that the Board
17 understands what you are defining as world- class
18 because that becomes the design baseline for the
19 future.
20 And so it's not the details so much as it is that
21 you all, from your various perks and areas of
22 expertise, view how world-class has been defined,

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112

1 and because that will become something that
2 Congress will then, I'm sure, hold the Department
3 responsible for implementing. And that has fiscal
4 and other implications in terms of the
5 transformation of the military health system.
6 So it's very, very important that this Board
7 understand what it says when it says was
8 world-class is. And then whether or not we should
9 stop construction at this time, I think that's a
10 moving target. If your assessment is based on the
11 current definition that we're good to go, that's
12 fine. We know that that can be revisited at any
13 time, so the more important issue is what is
14 world-class and get your best advice on that.

15 DR. KIZER: And that is why we have
16 spent a lot of time, actually, on this. And
17 recognizing that, though, I would encourage any of
18 you who have thoughts or comments or suggested
19 edits for this that you send them to me posthaste
20 so that we will have the benefit of considering
21 those in whatever final statement is produced,
22 because we do have to bring this to closure at

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113

1 least as far as the Subcommittee is concerned in a
2 very short period of time -- certainly within the
3 next two weeks if not sooner.
4 Thank you.

5 HON. UNTERMEYER: Mr. President? Mr.
6 President, I have a comment if we're still on the
7 subject. I'm here. It's Chase Untermeyer
8 commending Dr. Kizer for his and this
9 Subcommittee's work.
10 It strikes me that the 13 items that are laid out
11 here for a world-class health care facility is
12 exactly what you'd want any health care facility
13 to provide -- a county hospital would be the same.
14 And I apologize since I wasn't on the subcommittee
15 and I don't have any particular brilliant insight
16 at this point, but it seems that there is a higher
17 level of review which perhaps this whole Board
18 needs to lend to the Subcommittee as to what takes
19 it to that next level that the Congress had in
20 mind but didn't define.
21 It seems that anything that the Department of
22 Defense puts a great deal of priority and money to

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114

1 and assigns top-flight people to will lead in the
2 direction of being world-class; it certainly for
3 us will be world-class.
4 So I would say the 13 items that the Subcommittee
5 has given us are commendable, but there is
6 something else that needs to be said to lift it to
7 that level, and I'm not sure what that is.
8 DR. POLAND: Yeah, it's a good point,
9 and one thing to consider would be site visits,
10 not to be funny here, but it's a little bit like
11 the old statement of pornography: It's hard to
12 define, but you know it when you see it. You know
13 world-class when you see it, even though it may be
14 hard to define.
15 And so consideration for site visits and putting
16 people who are designers -- not architects, that's
17 a different function -- but people who know design
18 thinking imbedded into this team.
19 DR. WILENSKY: Ken, go ahead.
20 DR. KIZER: Your comment is, Chase, is
21 well-taken. One of the questions that was
22 discussed in the Subcommittee was whether a

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115

1 military facility could be world- class if it
2 didn't first meet the requirement of being
3 world-class, period. And the decision was that
4 you had to meet the threshold of being a
5 world-class health care facility. There may be
6 some additional things or separate things that a
7 military world-class facility might need to meet,
8 but first of all you had to meet the threshold for
9 being world-class.
10 So one, that there was some consideration to the
11 question that you're asking, but also if you go
12 through this list of 13 things, we would certainly
13 agree with you that they are the things that

14 should be done; however, I would posit that less
15 than one percent, probably less than 1/10th of one
16 percent, of the hospitals in the country today
17 could meet what is listed here.

18 DR. WILENSKY: Okay, we will -- I think
19 we need to move on -- and we will alert the Core
20 Board when we're going to schedule a briefing
21 after Ken and I and Wayne and Greg have had a
22 chance to talk about timing with regard to the

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116

1 drafting of a report or a final interim report
2 will be available for us.

3 MS. EMBREY: Dr. Wilensky --

4 DR. WILENSKY: Yes.

5 MS. EMBREY: -- any time the Core Board
6 meets, we have to announce it in The Federal
7 Register.

8 DR. WILENSKY: So we need 15 days?

9 MS. EMBREY: Yes.

10 DR. WILENSKY: Since it will be -- we
11 will have 15 days if we make the decision by the
12 time that we leave here and I assume, given what
13 he said, it will be sometime after January 5th
14 that we can talk about when you think it will be
15 available; we'll find a date to schedule, but
16 we'll be mindful of The Federal Register needs --
17 although it is my impression on occasion you can
18 skinny that down, but we'll try not to use this as
19 an occasion.

20 I'm going to switch hats and report out as the
21 Chair of the Health Care Delivery External
22 Advisory Subcommittee meeting that we held October

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117

1 20th. There is a review there. The slides I
2 think are under Tab 3.
3 The membership which I'm pleased is well
4 represented here mostly over on the far side of
5 the room, many of the individuals who are on the
6 Subcommittee and here today also were present at
7 the meeting that we had in October. We were
8 briefed by Colonel Bader, who is here, who at the
9 time when I had worked with her previously was the
10 Executive Director of the Task Force on the Future
11 of Military Health Care. She is now, has
12 responsibility for the Senior Oversight Committee
13 on Military Health Care, which has the
14 responsibility to implement the various
15 recommendations that are accepted by the
16 Department.

17 We reviewed the concept of operations plan,
18 otherwise known as CON OPS for establishing the
19 Health Care External Advisory Committee, and were
20 presented with questions to the Board from Dr.
21 Casscells.

22 Right now one of the major issues that we have

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118

1 been waiting for is to have an assessment by the
2 Department which, as I recall, was due either this
3 month or next month, that will indicate of the 12
4 recommendations with various bullet points that
5 were made by the Task Force on the Future of
6 Military Health Care, which ones have been
7 accepted and which not with some indication with
8 regard to those accepted and those not, which will
9 then provide information for us going forward.
10 We have tentatively discussed meeting in January.
11 Again my assumption now, given where we are, that
12 we are probably talking about the last week in
13 January or the first week in February, to convene
14 again, hopefully to be responsive to the report
15 that is released by Health Affairs.
16 The Subcommittee tasks, we have been asked to look
17 at the plan by DOD and to particularly focus on
18 better efficiency and integration across the
19 military health systems, an issue that's already
20 come up today, and whether this can be achieved by
21 the recommendations that were put forward by the
22 Department as reflected in the final report of the

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119

1 Task Force on the Future of Military Health Care.
2 We were particularly asked to focus on the
3 integration of direct and purchased care. This
4 was the first recommendation of the Task Force as
5 being one of the most important issues for the
6 Department to address, and also to provide
7 guidance for improving the integration of the
8 purchased care and directly-provided care.
9 We've been asked to look at methods to change the
10 delivery of health care in ways that have been
11 reflected in some of the earlier discussions
12 suggested by Dr. Chu. We will also be serving to
13 assess the strategic plan, as I've indicated, that
14 the Department will be coming forward with.
15 And we will be looking at finding best practices
16 for both the direct and purchased care for
17 military beneficiaries by both looking at and
18 better integrating with other federal agencies,
19 particularly HHS and VA, and with some of the
20 strategies that are used by private companies.
21 One of the issues that was included in the Task
22 Force on Future of Military Health Care is that

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120

1 while many of the military installations have very
2 good preventive and other -- and wellness care,
3 they are not always at the forefront of best
4 practices that has been observed in the private

5 sector, and that this is something that needs to
6 be pursued by the military. And it will require a
7 better integration between the military and what
8 goes on with these best practices in the private
9 sector, but also recognizing that there is more
10 that needs to be done to integrate across other
11 federal agencies.
12 We are, as you can tell, very much at the
13 beginning, in part because the major focus at
14 least at this point has to do with the
15 implementation of the Task Force on the Future of
16 Military Health Care. As I've indicated, those
17 recommendations went forward in March of this year
18 to the Congress, but the Department has been
19 reviewing precisely how to adopt and integrate the
20 findings into their going forward plan, and as
21 soon as that is available it will give us a
22 clearer charge in terms of how we should monitor

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121

1 the Department's action.
2 It will not be the only activity of this Task
3 Force, but at least early on it will be the first
4 focus of the Task Force. There are other
5 activities that we may take on in addition in
6 terms of assessing the effectiveness of delivery
7 of care by the military to active duty, and
8 dependents and also retirees.
9 There are a number of people here. As I have
10 indicated, if any of you would like to comment on
11 what happened in our October meeting, or, Colonel
12 Bader, if you would also like to make a comment.
13 Any of the Subcommittee members who would like to
14 comment?

(No response) Colonel Bader?

15 COL. BADER: Good morning again.
16 Colonel Christine Bader.
17 We are wrapping up the Senior Oversight Committee
18 report. We are preparing it now for coordination.
19 It will be coordinated throughout the Pentagon,
20 and then it will go to Dr. Chu, and then through
21 Dr. Chu the report will be submitted to Congress,
22

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122

1 and at that time it will be available to the
2 public and to all of you for your review.
3 Thank you.
4 DR. WILENSKY: well, that, that really
5 will be the time in which we can then effectively
6 mobilize going forward in terms of how that will
7 affect our Subcommittee work.
8 Any questions or comments that you have?
9 MS. EMBREY: I just want to thank the
10 Board and its predecessor for kick-starting this
11 effort. We have a lot of opportunities in the
12 next several years. Economically we are going to
13 be challenged to do as much with less, and so what

14 you do and what you have done is extremely
15 important to us, and we thank you, Gail, for your
16 leadership in that as well as you, Christine.
17 DR. WILENSKY: There's, I guess, an
18 irony of having first been a part of putting
19 together the recommendations on Task Force of
20 Future Military Health Care and now having an
21 opportunity to assess on how well the Department
22 goes forward. So I look forward to that activity

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123

1 and further working with Christine. Thank you.
2 We're a little ahead of schedule. I'm sorry -- I
3 can't --

4 DR. HALPERIN: Bill Halperin.

5 DR. WILENSKY: Yes, Bill?

6 DR. HALPERIN: Is there a relationship
7 between this to the innovation zones that Dr. Chu
8 was mentioning, or is that something completely
9 different?

10 DR. WILENSKY: It is not -- it is
11 certainly not completely different, and the
12 innovative delivery strategies were contained
13 either by implication or by explicit directive in
14 the recommendations. We can make sure you can
15 access either the full report or the executive
16 summary which indicates the 12 overall
17 recommendations, each of which has five or six
18 action points.

19 And so you can see for yourself how it was
20 referenced in terms of the mean to better
21 integrate and to make use of innovative delivery
22 strategies to, as I indicated, make use of the

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124

1 best clinical practices available, both in
2 prevention and wellnesses. Other parts of care
3 engage in a variety of demonstrations that were
4 indicated in the report.

5 So it's hard for me to think of very many other
6 types of innovations that were not at least
7 consistent with the spirit of the document, but
8 there are specifics that may well come up that
9 were not raised specifically within that set of
10 recommendations.

11 My understanding is the first charge, but again
12 not the only charge of the Subcommittee, is to
13 monitor the effectiveness of the recommendations
14 that the Department chooses to accept from this
15 Task Force. As a Subcommittee, my understanding
16 is we are free to come up with other ideas we
17 think the Department ought to be considering,
18 whether or not it chose to have those as
19 recommendations it accepted from this Task Force,
20 which any of the subcommittees or the full Board
21 in looking at an issue we think is not covered
22 appropriately under one of the existing

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125

1 subcommittees can do.
2 Any other questions?
3 (No response) why don't we take a
4 15-minute break now, and then
5 Reconvene five minutes after 11:00.
6 (Off the record at 10:49 a.m.)
7 (On the record at 11:23 a.m.)
8 DR. WILENSKY: Okay, can we have people
9 take their seats? We have used up our excess time
10 from earlier.
11 (Long pause) We are going to
12 reconvene. Before we go to our
13 Next session, there are several people who have
14 joined us since the time that we introduced
15 ourselves. I'd like to have them have an
16 opportunity to do so. Dr. Casscells?
17 DR. CASSCELLS: Dr. Wilensky, thank you,
18 and I'm sorry I couldn't be here in the morning,
19 but we had a big session with the Service Vice
20 Chiefs on a topic that this Board is informing us
21 about TBI and PTSD, so we had to clear the air on
22 a couple of things there. But I will say, without

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126

1 stealing General Sutton's thunder, that there is
2 intense interest and a lot of desire that the
3 military sustain their interest in this area and
4 be the best in the world, be the pathfinders for
5 traumatic stress and head injury. So that's, I
6 think, a tribute to this Board and to Loree
7 Sutton. I want to thank you for that.
8 Dr. Poland, again we'll have an opportunity to
9 thank you at Mayo Clinic in front of your
10 colleagues and Dr. Cortese out there. But please
11 know that the Secretary and the Service Chiefs and
12 everyone has the highest regard for the Defense
13 Health Board and for the job that you have done.
14 I will say something about that again tonight, but
15 not everyone will be at the dinner, and there are
16 some members of the public here; I think we want
17 to say in public how we admire the integrity and
18 energy and enthusiasm and wisdom you've brought to
19 this job. Thank you very much.

(Applause)

21 DR. WILENSKY: Ray Dubois joined us
22 after we had done our -- excuse me, I think he may

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127

1 have stepped out for a minute.
2 Is there anybody else who has joined us either
3 around the table or among the audience before we
4 go on?

AADHB-121508.txt

5 DR. POLAND: Gail?
6 DR. WILENSKY: Yes.
7 BG. JAMES: Gail, Dr. Jim James with the
8 American Medical Association. I am working on Dr.
9 Kizer's world-class Subcommittee. Thank you.
10 DR. WILENSKY: Any other additions to
11 the room since this morning's introductions?
12 Please stand if you're new.
13 DR. MILLER: Mark Miller from the
14 National Institutes of Health.
15 DR. WILENSKY: Okay. Our next speaker
16 is Dr. Fogelman, who currently serves as the
17 Executive Coach in Leadership Development and
18 Management Consultant at Paladin Coaching
19 Services. The Psychological Health Subcommittee
20 has recently stood up and had its NARAL
21 organizational meeting in late October. Dr.
22 Fogelman will discuss the current status of the

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128

1 Subcommittee, enumerate long-term goals and
2 objectives, expand upon some things that have been
3 developed and delve into detail about the assigned
4 tasks, questions surrounding use of the automated
5 neuropsychological assessment metric, ANAM, as
6 predeployment 204 service members, and applied
7 behavioral therapy for autism.
8 Dr. Fogelman's presentation slides may be found
9 under Tab 4 of your binder. Thank you.
10 Dr. Fogelman?

11 DR. FOGELMAN: Thank you, and you just
12 did my first two slides, so that will make it
13 easier. The brevity of my presentation is
14 inversely proportional to what I know is the
15 importance of our task and all the folks on the
16 back bench there, the folks on there can feel that
17 very strongly. We really had not done a whole lot
18 yet, which you will see.
19 That's us, and that's me. I'm the Interim Chair
20 because in a process that many of you would be
21 familiar with, I raised my hand. These are the
22 people on the Subcommittee, many of whom are back

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129

1 there on the back bench.
2 I do feel a little bit like I'm about to talk
3 about preparations for a flood, knowing that Noah
4 is in the audience. So if any of you back there
5 want to say something about our meeting or
6 anything we've done, I'd appreciate it.
7 Do you want to take a second to read who you are,
8 but you have them on the slides?
9 As Dr. Wilensky said, I'll tell you a little bit
10 about our status, how we're thinking about the
11 long-term, some things we've already talked about,
12 things we've already been asked and then ask you.
13 We had our organizational meeting on the date

14 indicated. Mostly that was filling out paperwork
15 and getting briefings on ethics, but we also had a
16 briefing from Captain Ed Simmer from the Defense
17 Centers of Excellence and Dr. Joyce Adkins of Ms.
18 Embrey's staff to try to get us started. Between
19 now and the next meeting, there's a lot of
20 preparatory work going on. Again that's pretty
21 straightforward.

22 I'm actually doing a lot of the leg work. I've
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130

1 interviewed a number of people in this room, and I
2 expect to interview some more so I can educate
3 myself in my perhaps short-term role. We're
4 trying to get our next meeting together. We have
5 originally decided that we were going to try to
6 meet twice pretty quickly, in January and March,
7 but it's beginning to look like late January and
8 maybe late March.

9 Just let me speak a bit about what the next two
10 slides represent. First of all, they represent
11 what I think I heard my colleagues say and what I
12 think might be a way to begin to address our very
13 large task, so don't blame them if you don't like
14 anything that's uphill. Fundamentally, we're
15 going to try to wrap our brains around all the
16 possible things that we might get involved in. We
17 want to proceed, as the oxymoron goes, with all
18 deliberate speed, but we do want to be as thorough
19 and as well oriented as we can.

20 So the first substantive meeting, which is our
21 next meeting is really going to be devoted to
22 understanding where we're operating. And that's

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131

1 what understanding a landscape of psychological
2 health means. These are some of the things that
3 we think we're going to need to learn about, and I
4 know that many of these things exist in print and
5 people will be able to brief us about it,
6 particularly notice about the relationship to
7 other systems. That's something that's been
8 talked about a lot today. I know it's a personal
9 interest of mine and I suspect of many people on
10 the Committee.

11 Once we get that sort of beginning sense of the
12 landscape, we'll look at some of the rest of the
13 things. We're interested in looking at the
14 relevant research, figuring out what's happening
15 in the rest of DOD and how we can relate to them
16 and learn from them, interact with them in a
17 productive way.

18 We understand ourselves to be fundamentally or
19 functionally autonomous, even though we report to
20 the Board and through the Board to the Secretary.
21 So we're going to think a lot about setting our
22 own agenda as well as responding to the questions

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132

1 we've been asked.
2 These are a couple of things that have come up. I
3 want to say something about leadership
4 development. There were a couple of conversations
5 this morning about culture and changing cultures.
6 On our Committee we have people who are clinically
7 oriented and people who are interested in various
8 aspects of research, but there are also people who
9 are interested in organizational development and
10 leadership development. So although that
11 particular item was originally thought of as
12 developing leaders within the military, we can
13 probably be of assistance on the cultural change
14 questions.
15 Even though we've spoken only briefly, there are a
16 number of things that seem to be pretty clear that
17 the Committee generally agrees on. I know I'm
18 supposed to look at this rather than that
19 (indicating), but it just feels more comfortable
20 to do this. There's a very strong feeling on the
21 Committee that we're not only about the business
22 of clinical care -- that is, the repair end of

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133

1 things -- but we're also about the business of
2 strength-building, of resilience. You know,
3 that's the building part, and in anything that we
4 do we want to pay attention to both sides; as to
5 whether we'll address it as a kind of independent
6 path or not, I simply don't know. We want to keep
7 both things in front of us.
8 We're very interested in research data and many of
9 us represent folks and institutions who do
10 research, we want to be sure to pay attention, as
11 most people here do, to the basic stuff and the
12 applied stuff. And again, forgive me for the
13 redundancy in this statement about redundancy: We
14 want to look at areas in which too many people are
15 doing the same thing, or might be doing the same
16 thing.
17 We have already, even before we started, two
18 questions asked to us, so we will at our first
19 meeting talk about how we will answer or at least
20 begin to answer the questions. I won't read them
21 to you, but one's from Dr. Kelly and one's from
22 Ms. Embrey.

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134

1 Do you want me to wait while you read the slide?
2 Okay, time's up. And there you have it.
3 Fundamentally, we're just getting started. We
4 want to know what we have to do, and we're all

5 prepared, taking it very seriously. And listening
6 to what people said today, I feel even more
7 daunted, but we're prepared to work very hard and
8 do what we can.
9 So with that said, I will ask if there are
10 questions, if there are things that people want to
11 tell us to pay attention to, particularly offer
12 some advice and assistance. And if you don't want
13 to say anything now, I'm sure if you've sent an
14 e-mail to the Defense Health Board, it will get to
15 all of us.

16 DR. WILENSKY: I had a couple of
17 questions and one piece of advice.

18 DR. FOGELMAN: Can you do it in reverse
19 order?

20 DR. WILENSKY: I'll do it. The piece of
21 advice is that you should feel free to raise
22 questions that you think are relevant for your

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135

1 subcommittee to address and to address them, but
2 by all means please respond to the issues that you
3 were requested to look at as a subcommittee.

4 DR. FOGELMAN: Um-hmm.

5 DR. WILENSKY: With regard to those, it
6 may be in the slide that went by quicker than I
7 could read, is there a time line with regard to
8 the request either from Dr. Kelly or from Ms.
9 Embrey?

10 DR. FOGELMAN: No, but there will be as
11 of the next meeting. As I said, we were just sort
12 of organizing ourselves, shaking each others'
13 hands. But that is something that we will attend
14 to at our next meeting.

15 DR. WILENSKY: Okay, thank you. Are
16 there questions that people have? Yes, Mike?

17 DR. PARKINSON: Yes. Mike Parkinson. I
18 really welcome the Committee's comment to explore
19 both baseline at intake -- my words -- and
20 progression through a successful military career
21 of coping skills, resiliency, teamwork.
22 Generations of Americans have said thank God for

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136

1 the military, because I got into the military I
2 didn't have the skills. I didn't realize I was
3 capable. And we have never captured that in a way
4 that I don't think is compelling or quantifiable
5 as the immunization, if you will successive
6 stressors.

7 So having a robust psychological component of the
8 DHB that looks at, quite frankly, what is not an
9 equal representation of mental health in our
10 society, without any stigma saying we are
11 attracting people who are not the highest
12 socioeconomic status sometimes, people who come
13 from some psychological challenges, some childhood

14 events which are very difficult and troublesome.
15 Accepting our people and helping them see in
16 themselves the things they can do and the things
17 they can improve through the military experience
18 is as much a part as the back end of answering
19 complaints about psychological ill health.
20 So I really welcome that and ask that you perhaps
21 create a framework for the broader Board and for
22 the American public to understand that this is a

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137

1 national resource that improves health and
2 improves lifetime productivity and resilience
3 which is very big, as you know, in the corporate
4 sector right now. You are more than your medical
5 claims, you are more than your doctor's visit.
6 Capturing that in a standardized way is critical.
7 So I applaud that work and just cheer you on.

8 DR. FOGELMAN: Thank you very much, and
9 that was much more well-said than I said it, but
10 we will do that.

11 DR. WILENSKY: Yes?

12 DR. CERTAIN: I'm Robert Certain. I
13 also serve on that committee, although I regret
14 not having been present for the last time. On
15 this Board is a reminder both as a combat veteran
16 and ex-POW, I was a PTSD and a clergyman. That
17 full, robust approach to psychological help
18 necessarily, I believe, includes the faith
19 communities that our people originate from and go
20 back to.

21 And so in spite of whatever's going on with our
22 Chaplain Services to understand how they can work

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138

1 together, it would be -- I think it's very
2 important that we enlist both the chaplains as we
3 have them and also do some training with them to
4 help them better understand the nature of combat
5 stressors and what role they have, naturally, to
6 play and how they can enhance their understanding
7 of it.

8 So I would hope that in our future meetings we
9 also kind of try to ponder how it is that we raise
10 the awareness of the clergy of all faith groups
11 that serve in the military as how we deal with our
12 Guard and Reserves as they go back home, to try to
13 enlist that enormously complex system within the
14 country that is there.

15 In a triage level, that's kind of first defense,
16 or second right behind family members for the
17 addressing of postcombat adjustment issues. The
18 psychological wound is the one we need to face
19 head-on now because we're doing so well with
20 physical wounds. But the wounds that don't show
21 last for a very long time and sometimes do not
22 show up in any way that can be identified by the

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139

1 person with the wound seeking help until much,
2 much later in life.
3 It was after the September 11, 2001, that world
4 war II veterans started showing up at Vet Centers
5 in increasing numbers. We have this anecdotal
6 information out there, but I think we can address
7 it with this new generation more quickly than we
8 did with either world war II or Korea or Vietnam,
9 and I would hope that this particular committee is
10 one of my hopes that we can do better.
11 So I look forward to sitting with Dr. Fogelman and
12 the others in the future and trying to get some
13 more comprehensive answers out there that are not
14 quite so onerous. I think that the very existence
15 of PTSD is a psychiatric diagnosis. As we've
16 discussed before, it can be a barrier to help in
17 the minds of our troops, and we need to find a way
18 to overcome that and find a way around it, to --
19 if you will, to subvert our troops into getting
20 the kinds of healing that they need and this
21 country needs for them to have.

22 DR. WILENSKY: General Rubenstein?
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140

1 GEN. RUBINSTEIN: Just on the heels of
2 the two comments made and help inform this
3 Committee, I would ask you to sit down and spend
4 some time with the Army's new Comprehensive
5 Soldier Fitness program headed by Brigadier
6 General Rhonda Cornum, not an Army Medical
7 Department program but an Army program in our G-3
8 Army Operations, which takes a look at the soldier
9 from commissioning or enlistment through
10 separation to understand the skill sets and
11 training and development that's required in a
12 soldier as they go from the very first day on
13 military service to the very last day in
14 continuous training and development in
15 resilience-building in that soldier through every
16 step of a career, whether it's three years or 30
17 years. And we're very excited about this new
18 effort.

19 DR. WILENSKY: Could you repeat what
20 that's called?

21 GEN. RUBINSTEIN: It's called the
22 Comprehensive Soldier Fitness Office, and it's led
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141

1 by Brigadier General Rhonda Cornum, C-O-R-N-U-M.
2 I can certainly get your her e-mail address now,
3 and I'll share that with the Committee's --
4 DR. FOGELMAN: I'll appreciate that, but

5 I should tell you that I know one of the members
6 of our Committee, Marty Seligman, has already
7 spoken with some of the folks involved in that
8 activity. He sent me an e-mail about it which
9 I'll be circulating to the Committee --
10 Subcommittee.

11 MS. EMBREY: Dr. Fogelman, I have to
12 tell you, personally and professionally, I am so
13 grateful not only for your leadership on an
14 interim basis or a permanent, but also to all the
15 members of your subpanel. You've brought in some
16 world-class folks, and, frankly --

17 DR. FOGELMAN: How do you define that?

18 MS. EMBREY: Better than what we would
19 expect. We in the Department have come to a
20 crossroads where health hasn't been defined
21 holistically, as both the physical and mental
22 person, and it took the Mental Health Task Force,

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142

1 I think, to socialize that cultural change. And
2 although we are in the middle of that
3 transformation, we hadn't had the horses to draw
4 upon to inform us about how to do that the right
5 way.
6 And so we look to you to help us truly define what
7 psychological health is because we deal
8 principally with the medical community who says in
9 their own nomenclature: Psychological health
10 doesn't exist; it's mental health. But there's
11 much more than the medical component to building
12 psychological health, and so it's very important
13 to the Department and to me, personally and
14 professionally, to clarify that difference and to
15 nonmedicalize a person's health, emotionally,
16 psychologically, mentally, whatever, and
17 physically.
18 And so the idea of this fitness not referring to
19 any particular type of health is very important,
20 and particularly the role of the individual in
21 recognizing and understanding how to promote and
22 sustain their health.

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143

1 So from that perspective I thank you. I look
2 forward to working with you and your people all
3 the time, because we have a lot of opportunity.

4 DR. FOGELMAN: Thank you.

5 DR. CAHOON: I just want to make sure,
6 going off Ms. Embrey's talking about holistic that
7 you make sure that you include the family when
8 you're looking at mental health and psychological
9 health, because when you have a wounded Service
10 member, you have wounded family members, too.

11 DR. FOGELMAN: Oh, absolutely.

12 DR. CAHOON: And so I just want to make
13 sure that when you're looking at care that we're

14 looking at it holistically, including the
15 families, too.

16 DR. FOGELMAN: Absolutely, and the
17 person who's been most helpful to me as I try to
18 interim my way through things is Dr. Shellie
19 McDermid, who represents that if nothing else on
20 the Committee -- but plenty more she represents.

21 DR. WILENSKY: Are there any other
22 comments?

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144

1 DR. FOGELMAN: Oh, is it a red light?

2 DR. WILENSKY: Yes.

3 DR. MATTOX: I am a surgeon, and I tend
4 on my career, like all surgeons, to deny the terms
5 that everyone's been using the last 15 minutes.
6 But, having said that, let me tell you that 30
7 percent of our patients that are injured in the
8 civilian sector have a mental health or a
9 psychological deficit.

10 During Katrina, although we had a lot of people
11 who came to us with psychological/mental health
12 problems, the rescuers themselves, during every
13 disaster, well-documented, up to 25 percent of
14 those individuals manifest psychological and
15 mental health deficits. That may not have ever
16 been seen before. Even the toughest of the
17 rescuers and cardiovascular surgeons succumb,
18 sometimes unexpectedly.
19 It does not mean unfit for duty. We do not kick
20 them out of the medical profession; we do not kick
21 them out of the residency if they now show some
22 psychological problem. We send them home, and we

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145

1 treat them.

2 And in our society, the singular most eight-ton
3 elephant in the living room that no one wants to
4 talk about is what we're talking about right now.
5 And it has been a problem for the last 20 years,
6 and our approaches to it first are to define it
7 and to talk about it and not to just sweep it
8 under the rug. Or, if there is -- and I have no
9 idea -- if there is a tendency to move them out of
10 the military to say unfit for duty, many of these
11 people manifest one psychological episode and then
12 it's gone away.

13 And that has to be addressed on the benefit of
14 someone who's had some past history.
15 This is throughout our society, and if there's a
16 good solution that comes up from this
17 subcommittee, it can be applied to every community
18 in America as a model.

19 DR. FOGELMAN: You're not the only
20 person to have talked about application broadly.
21 Certainly that's something we've talked about, and
22 I guess together we weigh as much as that

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146

1 elephant, and we absolutely intend to stand up and
2 be in the middle of the room.
3 DR. WILENSKY: Thank you very much, Dr.
4 Fogelman. Other people -- Ken, make it quick, we
5 need to move on. If you want to make a quick
6 comment, go ahead.
7 DR. FOGELMAN: I can listen quick.
8 DR. KIZER: Well, a quick question and
9 after a question of context. Are you looking at,
10 or do you plan to look at stress reduction
11 techniques that are appropriate in the combat
12 theater other than smoking? The context is that
13 the Institute of Medicine is just finishing a
14 report on reducing smoking in the military and the
15 VA populations, a number of that group. And
16 concomitantly there was an article just published
17 in this month's issue of The American Journal of
18 Preventive Medicine about smoking being a
19 maladaptive stress reduction technique, looking
20 particularly at combat soldiers.
21 In our work at IOM, we have found an absolute
22 dearth of information on alternatives that folks

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147

1 in combat situation might actually use, in ergo
2 the recidivism to smoking.
3 DR. FOGELMAN: Well, I actually think
4 there is already stuff going on, but the answer to
5 your first question is I don't know, but I'd
6 presume so because I don't really know exactly how
7 we're going to understand the landscape and chart
8 it, and I don't know the sequence in which we will
9 address things.
10 We're probably going to come up with a list that's
11 as long as this room is big and try to figure out
12 what to take a cut at first. But that particular
13 question you might want to address to General
14 Sutton this afternoon, because there is training
15 that goes on for psychologists who are deployed,
16 and that's another small piece of it. I only know
17 that because I went to the training.
18 DR. WILENSKY: Thank you very much. If
19 anyone has further questions, you can use the next
20 break time perhaps, to share them with Dr.
21 Fogelman or to e-mail them to him.
22 Our next speaker is Dr. Greg Poland, who you know

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148

1 quite well. He will cover the activities of the
2 Defense Health Board's Task Force Review of the
3 Department of Defense, Biodefense Infrastructure
4 and Research Portfolio. A task to provide an

5 external review of the Department's biodefense
6 research infrastructure and portfolio, this group
7 answered a series of questions related to DOD
8 Scientific and Strategic Investments, its
9 processes and procedures related to product
10 development and licensure and evaluated the
11 scientific or strategic return on investment for
12 previous and current research development and
13 training efforts, findings from Task Force
14 meetings and site visits to key bath defense labs
15 were presented in a brief to the Service
16 Secretaries on December 3rd by Dr. Poland. A few
17 Core Board members on the phone were unable to
18 have their questions answered when this was
19 presented, so you may use this opportunity to ask
20 your questions.
21 We will have this extend the 30 minutes. It was
22 scheduled and will eat into a short part of our

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149

1 lunch hour doing so.
2 DR. POLAND: Thank you, Gail. I think I
3 can move it along pretty quickly, too, so let me
4 just acknowledge a number of people, although the
5 slide is missing, who served on this Task Force.
6 It include Joe Silva, Wayne Lednar, John Clements,
7 Wayne Breidenbach, Cliff Lane, Frank Ennis. I
8 don't think I've forgotten anybody.
9 The Committee benefitted quite a bit actually from
10 John Clements' participation. John's also a
11 certified UN weapons inspector, and it was great,
12 John, to have you on those visits as part of the
13 Task Force.
14 Well, what we were asked to address are three
15 questions, and I've sort of given each of them a
16 label, so they're a little easier to remember.
17 But the first was Need, and that is: Was there a
18 national or strategic need for the MSDs to own and
19 operate and into structure and support of mission
20 requirements for defense capabilities both abroad
21 and in the homeland?
22 The second was Translation: Were the current

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150

1 processes effective in transferring the results of
2 basic biologic research into advanced products?
3 And the last was Return on Investment. Did the
4 current infrastructure provide scientific or
5 strategic return on investment for all of the
6 efforts that had gone on?
7 The actual surety questions were not addressed by
8 our Board and are the subject of a separate review
9 by the Defense Science Board.
10 We had a very tight time line within which to
11 work. It really was not conducive to any in-depth
12 review and discussion, so we made several
13 decisions or guiding principles by which we

14 worked:
15 One was that this would be a very high-level
16 review with interim findings and recommendations.
17 The second, that the initial focus would be on
18 biologic/biodefense products, so it would be
19 basically vaccines and immunobiologics, not
20 personal protective equipment, drugs -- and those
21 are large areas where the Department has been very
22 successful and very engaged in -- but we did not

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151

1 address those.
2 We would focus only on unclassified programs again
3 because of the time line, and later meetings would
4 deal with issues that we couldn't deal with on
5 this one.
6 Oh, here, it does show up -- and I did neglect
7 John. John, I'm sorry. John Herbold, who is also
8 a member of the Committee. This doesn't always
9 want to advance.
10 Okay, so we had a number of meetings. First was a
11 teleconference to review our charge and plan of
12 work. November 7 we had face-to-face meetings
13 where we received a variety of briefings from
14 organizations you see listed there. On November
15 19th, three, I think, flag officers -- myself and
16 John -- climbed in and out of that Black Hawk, me
17 cracking my head on the hatch at one point. It's
18 a special danger for those of us blessed to not
19 have to worry about hair.
20 But we visited Edgewood, Walter Reed, and
21 USAMRIID, and got to see first-hand the centers
22 and issues that we were dealing with. And then

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152

1 with the DOD virtual meeting that Gail mentioned,
2 we had presentation and discussion, although some
3 of the members couldn't get their questions
4 through, as we understand it.
5 So let me take the three areas, briefly go through
6 them with you. The first question was of need.
7 Our conclusion was that there was no dispute that
8 DOD Biodefense Research was unique and that the
9 DOD needed a BD infrastructure. There were both
10 easy-to-explain tangible reasons for that and some
11 that are a little less tangible. One of the
12 little less tangible ones was we actually felt
13 that, importantly, having that capability provided
14 the perception of a deterrent capability, which
15 was important.
16 There was also amazing responsiveness and
17 turnaround of military laboratories to threats.
18 For example, during the anthrax letter attacks,
19 there was a huge surge capacity provided to the
20 nation by the military BD labs that would not have
21 been possible absent those laboratories.
22 The other was that we heard clearly that most of

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153

1 the labs in academia, virtually all of them in
2 industry, are unwilling to engage in this type of
3 research that has a lot of risk associated with
4 it, and primary among those reasons was there is
5 no profit motive for orphan vaccine. So making a
6 ebola virus vaccine does not interest industry
7 because they're not going to be able to sell it
8 and make a profit. And so there was this issue of
9 buy versus make.
10 There is a surprisingly high demand for BSL4
11 containment laboratories. Part of this was driven
12 by the FDA's two-animal rule. So, for example, if
13 a ebola virus vaccine were to be developed, you
14 can't ethically, obviously, challenge humans with
15 the virus to see if the vaccine worked. You can
16 do that with animals and license a drug or vaccine
17 on that basis. And so that has driven a lot of
18 demand for laboratories both for small and large
19 animals that can handle this type of research.
20 DOD also has some unique, in fact singularly
21 unique, aerosol and aeromedical isolation
22 capabilities, some unique critical agent and

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154

1 culture archive assets, and they're about the only
2 place in the U.S. where a truly unknown but
3 potentially dangerous and transmissible pathogen
4 can be sent, they'll accept it and identify it.
5 For the issue of translation, we found that the
6 basic science research was sound but there were
7 barriers toward advanced product development and
8 licensure. Among those were a complex and
9 unwieldy table of organization that had multiple
10 and separate lines of authority, a fragmented
11 organizations model that strayed from what we
12 understood as industry-best practices.
13 There was lack of a single high-level person
14 responsible for this, and senior leadership who
15 had vaccine development expertise and experience,
16 some complex management issues by DTRA, loss of
17 intellectual capital oftentimes due to difficulty
18 in retaining these scientists.
19 This is somewhat driven post-911 by the amount of
20 NIH and other money available to the civilian
21 community who sort of snatched up some of those
22 folks who otherwise would have probably stayed in

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155

1 the military.
2 Separate lines of funding from different entities
3 making project sustainability difficult, and I'll
4 have to explain this last line a little bit, but a

5 sense that the processes were more concerned with
6 inputs rather than outputs. So when we'd we
7 briefed, we'd hear a lot about people, square
8 feet, things like that, and a lot less about the
9 actual output, which was the desired outcome in
10 the first place.
11 In terms of return on investment, this was a very
12 difficult one, needs to be looked at in more depth
13 at another time. There were definitely objective
14 markers of considerable return on investment, but
15 more needed to be done. One was to define a set
16 of metrics by which we would agree to judge this.
17 It was difficult to try to get a sense of results
18 over time and reporting those results.
19 We found that there was difficulty in eliminating
20 or killing products that might -- or programs
21 rather that might not be as productive as they
22 needed to be. No systematic evaluation metrics

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156

1 processes or procedures to evaluate some of those
2 programs. and part of all that difficulty -- and
3 this is a nuance that might note be obvious to
4 many in the audience -- is that DOD has moved from
5 a goal of develop products to the IND state, which
6 makes a lot of sense for these sort of orphan
7 biologics, to develop an FDA-licensed product.
8 And that is a huge, huge chasm and step to take.
9 As a result, the people process, these
10 expectations and processes in the middle of this
11 evolution were sort of difficult to sort out.
12 Some other issues: Lack of communication between
13 responsible entities, and again we would push
14 very, very hard here for this being a great
15 opportunity for joint programs, and the Integrated
16 National Portfolio is a good start toward that.
17 TMTI, which is the Transformational Medical
18 Technology Initiative, I think, is really a very
19 novel experiment and DOD deserves a huge amount of
20 credit for something this transformational. It is
21 early in their evolution. The results need to be
22 evaluated, and, if successful, generalized. And

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157

1 we also thought the whole process could benefit
2 from additional external scientific review and
3 input.
4 Bottom line is that the DOD BD enterprise involves
5 thousands of people and hundreds of millions of
6 dollars every year. The clear expectation should
7 be of a tightly focused, highly productive state
8 of the art program with clear priorities, time
9 lines, and accountabilities, and an obvious and
10 timely return on investment to the war fighter and
11 to the nation.
12 In terms of the future, we heard about recent
13 initiatives to integrate the BD portfolio with

14 DHHS, which is referred to as the Integrated
15 National Portfolio, and there're some
16 opportunities there. We need to give more thought
17 to being explicit about what we can and cannot
18 accomplish within DOD for biodefense and DHHS in
19 the interest of jointness. DOD's primary focus
20 here is in preventing, as it should be, morbidity
21 and mortality due to bioterrorism. So it's the
22 prevention aspect, whereas DHHS has more of a

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158

1 focus on once an event has occurred, what do we
2 do? what vaccines, what kinds of things can we
3 pull off the stockpile to do it? And that is
4 different, philosophically and conceptually, in
5 terms of how you approach and staff things like
6 this.
7 So our final point was this observation of a
8 highly dedicated, very hard-working group of
9 scientists and administrators who were determined
10 to make a difference but who were failed by a
11 system that's slow, tolerates complexity, lack of
12 clear priorities, inadequate accountability,
13 redundancy, and lack of experienced leadership.
14 So our draft early or interim recommendations are
15 that the biodefense research infrastructure be
16 retained; that there be greater centralization and
17 joint programmatic planning; the development of
18 evaluation metrics; sustained and identifiable
19 leader accountability; a mechanism to provide
20 education and training for future leaders; time
21 lines and multiyear funding these.
22 For those in the audience not aware, a typical

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159

1 biologic takes one to two decades and about \$1
2 billion for one licensed product, so the idea of
3 getting funding for a year or two or three does
4 not cut it in terms of the length of science that
5 needs to occur.
6 Collaboration and biosurety, because we saw the
7 physical sites, although this was not our arena,
8 we did recommend that they authorize some sort of
9 a red team to define and exploit the
10 vulnerability, some of which we saw.
11 And I will end there and solicit any questions you
12 may have.

13 DR. WILENSKY: Yes?

14 DR. MATTOX: Would you comment on the
15 need or the feasibility of a joint IRB?

16 DR. POLAND: That's actually an
17 excellent question, which we hadn't dealt with. I
18 can tell you from being one of the principal
19 investigators for the anthrax vaccine study that's
20 occurring that the lack of that issue alone
21 probably slowed us down by two years. So that is
22 a great idea, and I will record that idea. Thank

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160

1 you.
2 DR. WILENSKY: Any other questions or
3 comments? There were some people who had
4 questions that did not get raised in the November
5 20th meeting. If you're here and continue to have
6 them, this would be an appropriate time to ask
7 them.
8 (No response)
9 DR. WILENSKY: Okay, thank you very
10 much, Greg. Yes? I'm sorry, yes.
11 CAPT. KHAN: Ali Khan, CDC. Greg, that
12 was absolutely spot on.
13 DR. POLAND: Thank you. You worry when
14 you're being so direct and the room is absolutely
15 quiet.
16 CAPT. KHAN: Thank you for being so
17 direct. The biodefense infrastructure of DOD is a
18 national treasure --
19 DR. POLAND: Yes.
20 CAPT. KHAN: -- and resource. And we
21 have squandered it. With your last statement that
22 all the difficulties in that system and what they,

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161

1 besides fixing funding and other issues -- I think
2 it really is critical that, you know, you can't
3 have metrics until you have a vision mission in
4 goals and a real strategic plan on how do to sort
5 of take care of this enterprise, and how you
6 integrate it into what's going on in the United
7 States.
8 So DOD is no longer alone in these efforts. Even
9 though the mission is a little different from HHS,
10 you know, many of us are working on ebola
11 vaccines, but how do we decide it's going to be a
12 FV vaccine, an admiral vaccine, a DNA vaccine, or
13 viral biparticle vaccine? I mean that has to
14 occur jointly with the full horizon of: These are
15 the candidates we're going to take out to the end.
16 And that has to occur strategically together. So
17 again, excellent recommendation.
18 DR. POLAND: Thank you for that and
19 absolutely right. I mean we clearly saw the
20 science that's going on in DOD in regards to
21 development of reagents, biologics, and vaccine is
22 second to none. It truly is superb science.

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162

1 But it falls through the cracks in terms of being
2 directed toward the outcome of a licensed vaccine
3 or biologic because there are so many stops and
4 starts within the system that are beyond the

5 control of the scientists and administrators
6 working in -- and that's where the jointness, and
7 that's where sort of redesigning, as you were
8 talking about with clear mission and vision and
9 principles on how they're going to do this, would
10 be very helpful.

11 DR. WILENSKY: Yes?

12 DR. SHAMOO: Regular laboratories and
13 research laboratories are not known for high
14 safety security, et cetera. Not all of us have
15 done bench research, and this area it requires
16 such a high degree of responsible conduct of
17 research -- that's general term -- because there
18 are estimates that somewhere between .05 to 5
19 percent of all research and development is sloppy
20 work. And in this area you cannot afford, not
21 even .01 percent is sloppy work. How you inculcate
22 that kind of responsibility on all those involved

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163

1 in that R&D from Day One?

2 DR. POLAND: Yeah. Well, it's a very
3 good question. Everybody thinks of the external
4 threat -- that is somebody, you know, breaking in
5 to get a hold of those agents. There's clearly
6 also an internal threat, and there are physical
7 systems, including a two-person rule where no
8 one's ever working alone.
9 But among the difficulties -- and this is
10 something I think that lay people, the Press, et
11 cetera, don't understand -- for some of the agents
12 we're talking about, the amount of organism that
13 you need is a spot next to the "E" on the penny
14 where it says "E Pluribus Unum." It's not
15 difficult if somebody wants to be evil to try to
16 do evil.

17 And so the complexity of the programs that you
18 need and the cost of that -- for example, two
19 people always working in a room observed and
20 recorded by a videocamera, those are in place, and
21 a lot of programs to look at personnel and follow
22 them over time to ensure that they're

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164

1 psychologically stable, that they're, you know,
2 not engaging in something unusual from their usual
3 work habits, et cetera, were commendably in place.
4 And we didn't -- again, that's the DSB's review,
5 and I've heard their briefing and so I can
6 comment on some of those things. But that didn't
7 seem to be the big issue, actually; the issue is
8 with this fabulous science going on, how do we get
9 it out to the level of a product that can be used
10 and protect the war fighter?

11 DR. SHAMOO: Can I just comment, because
12 I wasn't really talking about the pathological
13 problems with that kind of research. I was

14 talking really about sloppiness. From among all
15 of us in the bench research that is few percent,
16 some people have even estimated as high as 10
17 percent, and so I'm not talking about the
18 pathology that there is somebody "evil," and he's
19 going to --

20 DR. POLAND: I see. You mean --

21 DR. SHAMOO: Yes.

22 DR. POLAND: -- laboratory policies and
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165

1 procedures.

2 DR. SHAMOO: Exactly. You want to

3 inculcate --

4 DR. POLAND: what I can --

5 DR. SHAMOO: -- certain standards are
6 not normal in the regular research laboratories
7 currently in use.

8 DR. POLAND: Yeah.

9 DR. SHAMOO: And that's where all your
10 personnel are going to come from.

11 DR. POLAND: So you may be actually
12 interested to know -- and this was more depth than
13 I'd planned to go into -- but DOD actually holds
14 itself to a higher standard than the national
15 accrediting bodies. So they actually exceed what
16 is required and have been a model for other
17 organizations to look at that sort of thing.

18 DR. WALKER: David walker. I have --
19 the Department of Defense is doing some more about
20 this. I'm on a Department of Defense-sponsored
21 National Research Council standing committee on
22 biodefense, which specifically is trying to assist

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166

1 in identifying the steps to accelerate the TMTI
2 bringing things to FDA approval. So they really
3 are trying to figure out to do it, and it's not
4 easy.

5 DR. POLAND: No. No.

6 DR. WILENSKY: Any other comments? Yes?

7 DR. MILLER: Mark Miller. Historically,
8 vaccines are made by state labs and public sector
9 facilities. Massachusetts and Michigan come to
10 mind. Are you suggesting, then, that the DOD
11 establish a public sector vaccine-like company,
12 effectively? And how well would that compete with
13 other type of mechanisms, cooperative agreements,
14 and could the DOD effectively compete on salary
15 structure, career support, long-term issues that
16 would be important?

17 DR. POLAND: Heady, heady questions, and
18 we really didn't get into that. And there are a
19 lot of creative, you know, ways to do that, and
20 DOD has actually done that in terms of bringing a
21 product to a certain level and then transferring
22 it over to industry. That may take some

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167

1 incentives to do but can work. But we really
2 didn't examine that part, and it's not a part of
3 our recommendation.
4 DR. WILENSKY: Any other comments or
5 questions from people around the room? Trip?
6 DR. CASSCELLS: Dr. Wilensky, I might
7 just say we appreciate the Committee's work and
8 don't take exception to any of it. I think it
9 should be forwarded to the Secretary. If it's
10 done in the next few weeks under my tenure, I
11 certainly will and I'm sure Ms. Embrey will, too.
12 I do want to make sure that, just for the record,
13 I want to say that I don't think we've squandered
14 the opportunity: that we're learning. There
15 certainly are examples of redundancy,
16 inefficiency, and there have been one very famous
17 and deplorable incident where a laboratory
18 scientist seems to have gone rogue and developed
19 mental illness -- due to a mental illness -- and
20 probably was a disseminator of the anthrax episode
21 seven years ago.
22 Obviously, you know, the Army has taken great

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168

1 pains to make sure this never happens again, and
2 just to clarify the accountability term, I do want
3 to make sure we all understand that no where has
4 -- no organization in the country has held health
5 care workers to higher accountability than the
6 U.S. Army. And this is an organization where if
7 patients are unhappy, the boss gets fired. And
8 the boss's boss gets fired. So please understand
9 that the accountability issue is one that we don't
10 just pay lip service to.
11 Quite a few people lost their jobs 20 months ago
12 on a health care accountability issue, so we do
13 take it seriously, and we will take these results
14 very seriously. That's why this is a public
15 hearing. I had not seen them before, and I'm
16 answering you publicly.
17 So thank you, Dr. Poland.

DR. POLAND: Thank you.

18 DR. CASSCELLS: I agree with everything
19 except I think you said "sustained
20 accountability." That means we sustain the
21 accountability we already have, and I would agree
22

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169

1 with it 100 percent.
2 DR. POLAND: Under a single ear. Thank
3 you.
4 DR. WILENSKY: Thank you very much. we

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5 are going to break until 1 o'clock. There will
6 be, the board member service liaison officers,
7 guests, and speakers, lunch will be provided next
8 door. For others of you, there are several
9 restaurants within this complex for you to use for
10 your lunch option. We'll reconvene at 1 o'clock.
11 Thank you.

(Whereupon, at 12:15 p.m., a
12 luncheon recess was taken.)
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A F T E R N O O N S E S S I O N

(1:05 p.m.)

1
2
3 DR. WILENSKY: Can we have people take
4 their seats so we can resume our afternoon
5 session, please.
6 Okay, the sixth speaker today is Dr. William
7 Halperin. He is currently serving as the Chair of
8 the Department of Preventive Medicine and
9 Community Health in New Jersey Medical School; as
10 Chair of the Military Occupational and
11 Environmental Health and Medical Surveillance
12 Subcommittee. He'll provide the Subcommittee's
13 external review of the risk assessment conducted
14 by the United States Army Center for Health
15 Promotion and Preventive Medicine.
16 In response to possible exavalin chromian
17 exposures at a water treatment facility in Iraq,
18 on December 12, 2008, the Secretary of the Army
19 received a briefing from the United States Army
20 Center for Health Promotion and Preventive
21 Medicine, USA CHPPM, the Defense Health Board
22 draft report was discussed during the

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1 presentation, and Dr. Halperin was in attendance
2 to answer questions.
3 Dr. Halperin?
4 DR. HALPERIN: Thank you very much.
5 DR. WILENSKY: The slides are under --
6 the slides are under Tab 6, excuse me.
7 DR. HALPERIN: Thank you very much. All
8 the members of the Subcommittee are here this
9 morning. There are their names. They'll be
10 available to you to answer questions at the end of
11 the presentation.
12 My doing that I thought we should have a little
13 motto for our Subcommittee, and I'm trying this

14 one out: Services Provided in Real Time,
15 Evaluation is Retrospected.
16 So our goal is not a kind of
17 should-have-would-have-could- have blame approach,
18 but rather if there are problems to be found, we
19 view them as learning lessons for continuous
20 improvement. And I think that's the spirit in
21 which we should be approaching this.
22 The goal for the next 30 minutes is first a very

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172

1 brief orientation for the DHB to the problem, a
2 discussion by all of you of the report that is
3 both in your list leaf as well as you're going to
4 hear about, hear modifications, if any, from you
5 and hopefully approval by the Core Defense Health
6 Board of the report.
7 The charge for the Committee came on October 6
8 from General Schoomaker, which is to review
9 occupational environmental health assessments at
10 Qarmat Ali water treatment plant of an
11 investigation that was done by CHPPM in 2003. Was
12 the standard of practice adequate, and are the
13 report's conclusions valid? And we will take you
14 to this evaluation, the answers to this, at the
15 end of our report.
16 As far as background, I'd like to start in
17 Yorkshire, England, where Malcolm Harrington, who
18 is a former Epidemic Intelligence Service with
19 CDC, now professor of Occupational Medicine, did a
20 lung cancer mortality study of all chrome platers
21 in the Yorkshire area. And they have about a
22 twofold mortality for lung cancer. This is

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173

1 adjusted for smoking. So this is a highly exposed
2 group, exposed for working lifetime and Chrome VI
3 is a respiratory carcinogen.
4 I'd then like to take you to my hometown, of all
5 places, Jersey City, New Jersey, that while I was
6 growing up little did I know that the gritty town
7 that it was the primary place where chrome ore was
8 milled and chrome was extracted for the United
9 States. The tailings of that chrome that came in,
10 I suppose by ship into New York Harbor, were used
11 for filling in low spots and building houses upon.
12 So Jersey City in Hudson County ended up as the
13 most contaminated Chrome VI area in the United
14 States with some 40 sites that have now been
15 remediated through the efforts of the EPA, et
16 cetera.
17 Blue is water -- that's the Hudson River. Yellow
18 is areas of low exposure. Medium is green, and
19 orange are areas of very high chrome exposure.
20 CDC as of September 30th, the AFTSDR, the Agency
21 For Toxic Substances and Disease Registries, did a
22 mortality study of people who lived in Jersey City

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174

1 from 1976 through 2003, the 25-year period, and
2 looked at mortality by proximity to the sites. So
3 this is not a high sustained exposure like people
4 who are chrome platers; this is residential
5 exposure, and for males they've come up with
6 anywhere from about a 7 to 17 percent excess of
7 lung cancer in the high exposed areas, and as I
8 recall it's about a 7 to 10 percent excess in lung
9 cancer for females.
10 Now, the first study controlled smoking; the
11 Jersey City study didn't control smoking. This is
12 by residence. You don't know whether some of
13 these people worked in the plants as well as
14 resided in the area. There are lots of "ifs," but
15 I want to put this in the context of why it is
16 that people reasonably could be concerned about
17 occupational and/or environmental exposure. What
18 both of these examples, though, have in common is
19 very, very long potential exposure, decades of
20 exposure rather than what you're going to see in
21 this circumstance.

22 So this is Qarmat Ali -- whoops, it goes by very
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175

1 fast. This is Qarmat Ali and contrary to, you
2 know, thinking of Iraq as a nonurban area, this is
3 the University of Basrah, so this is an urban
4 industrial site. It's much like Jersey City, if
5 you will.
6 The site was the industrial production site for
7 water, for water, salt water, that was going to be
8 pumped into old wells, which is part of the
9 process for producing oil. So this is part of a
10 program called a RIO, a Restore Iraqi Oil. The
11 site before our military got there was ransacked,
12 the steel roofs came off of the buildings. The
13 ground was visibly contaminated with a yellow
14 dusty material which is sodium dichromate which
15 was used in this as an inhibitor of corrosions,
16 put in the water so that the plumbing wouldn't
17 clog up.
18 There was a continue contractor presence, and
19 there were successive military units there
20 guarding the site and protecting the contracts for
21 several months.
22 Now, this is the chronology. In the Spring of

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176

1 2003, the military started providing security for
2 KBR, which was the contractor. In the summer of
3 2003, the contractor identified hazards which is
4 the chromate, remediated the site, meaning they

5 paved it over with asphalt and gravel. And in
6 September or thereabouts of 2003, one of our
7 soldiers remarked that why the contractor was
8 equipped with a moon suit -- basically, it came to
9 the surprise of the soldiers that weren't wearing
10 personal protective equipment -- that very rapidly
11 got to the health provider for our soldiers, who
12 was in Kuwait, who very rapidly went to the site,
13 identified the potential hazard, restricted
14 access, required personal protective equipment,
15 and basically took immediate control of the
16 situation in very rapid form.
17 September 29th and not very much after -- 10 days
18 after the problem was identified -- CHPPM was in
19 the field doing a site investigation, which again,
20 you know, when we're talking about the realities
21 of getting an industrial hygiene epidemiology
22 group within the field with the appropriate

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177

1 knowledge and methods for collecting samples, et
2 cetera, is also really quite active rapid
3 deployment. They, CHPPM, completed its work by
4 October 30th -- the field investigation was
5 completed; it took a little bit longer to get
6 results back on some of the laboratory specimen,
7 but at that time the site had already been
8 remediated.
9 Five years later there was a charge to the Defense
10 Health Board from us to evaluate the effectiveness
11 and adequacy of the CHPPM investigation. On the
12 17th of October, 11 days later, we had our first
13 conference call. It took awhile until November
14 12th and 13th to arrange a review of the report
15 because it was classified, so we could only take
16 with us to the classified meeting those of us on
17 DHB who had a security clearance. So there was an
18 impediment caused by the classification.
19 The report -- we did review the report on November
20 12th and 13th and produced a report that has been
21 going through review. The Army has -- the
22 Secretary of the Army had a draft of the report,

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178

1 and I briefed the Secretary of the Army on
2 December 11th on the draft, not on the final
3 because it's still a draft, not a final. We
4 expect the final to be resolved today, once we get
5 your comments and inclusions, and there's an
6 expectation there would be briefs from for various
7 senators in the next days, weeks, or so.
8 Now, what did CHPPM do and what happened at the
9 site? well, first of all, KBR identified the
10 hazard and the elevated concentrations of
11 dichromate. They encapsulated with asphalt and
12 gravel, as I said. They then tested and founded
13 minimal exposure to Chrome VI. The British Forces

14 also did environmental testing, also came up with
15 the assessment that there was minimal exposure,
16 and CHPPM did the same after the encapsulation,
17 although they tried to mimic what it would have
18 been like preencapsulation and found essentially
19 very little Chrome VI except for the offsite, that
20 is, beyond the perimeter fence.
21 The area in breathing zone samples showed no
22 Chrome VI, so the good news in comparison, if you

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179

1 will, to Yorkshire or even to Jersey City is
2 essentially testing that went on showed very
3 little potential for exposure. The caveat, of
4 course, is that some of the testing was done after
5 the fact of encapsulation.
6 Now, as far as medical assessment, histories and
7 physical were done by our Forces there looking for
8 disease that's associated with chronic exposure
9 which, a pathognomonic are chrome ulcers usually
10 around the second knuckle and perforations of
11 nasal septum, which comes with high chrome
12 exposures.
13 They also did monitoring for Chrome VI, which has
14 to be done really within a month or so of exposure
15 because you can't find it in the urine, you can't
16 find it in the serum if you wait too long. So
17 they did the appropriate testing, which was to
18 look for Chrome VI in whole blood, and the results
19 were basically that the levels were low,
20 inconsistent with the occupational data in the
21 literature and basically that there wasn't
22 evidence of excessive exposure amongst the

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180

1 soldiers that were tested, which is only one Guard
2 unit at the point when they tested.
3 The epidemiologic assessment is, as I've just
4 described, consistent -- not consistent with
5 occupational exposure, and there was no
6 association with length of exposure, as you might
7 think if the longer soldiers were there the more
8 they would have accumulated, and so forth. So it
9 looked like the levels of exposure were fairly low
10 in the soldiers who were at the site.
11 There were plenty of health risk communications
12 directed to the troops who were there and the
13 Guard units that had returned home. There were
14 seven in total. The results of the laboratory
15 medical evaluations were, quote, "incorporated"
16 into the medical charts, and that's now been
17 confirmed that actually this information hasn't
18 really gotten into the medical charts, so it
19 wasn't one of those things that you get and never
20 put in your medical chart; it finally did get in
21 the historical medical chart for the units.
22 Now, what were the limitations of this

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181

1 investigation? well, one is that there were at
2 least three National Guard units and only one of
3 them that is the latest one was tested. That, to
4 the Committee, was thought to be a reasonable
5 assumption that the other contingents were
6 similarly exposed and would have had similarly
7 unremarkable results, plus the reality of, by the
8 time that the last Guard unit was tested, such
9 time had gone by, such depth of results of
10 biological monitoring of the first Guard units
11 would have been falsely negative, even had there
12 been exposure.

13 The next limitation is the assessment

14 postremediation. As I've explained, the

15 contractor was expeditious in paving over the area

16 at least inside the fence, so the assessment of

17 environmental exposure after is not an unbiased

18 estimate of what it might have been before.

19 And the third is the issue of what I call "stove

20 silos," what the military seems to call

21 "stovepipes." It's the delay, the limitations of

22 communicating between different groups that have

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182

1 responsibilities, overlapping responsibilities in
2 the same area. So what's an example of silos
3 here? well, one of them is that it would appear
4 that KRB had information on a potential for
5 exposure at the point where they encapsulated and
6 remediated, and it was a surprise to the soldiers
7 who were on the site. So the information didn't
8 seem to migrate from one group there to another
9 group.

10 Another area of silos that should be of some
11 concern when you consider that this is an urban
12 area is that while our troops are in there and out
13 of there in short order and levels of exposure
14 inside the fence, now, are well controlled and no
15 evidence of substantial biologic absorption, you
16 have civilians on the outside of the fence, not
17 civilian contractors but civilians on the outside
18 of the fence who are working in the area, walking
19 in the area, who may be there for a long period of
20 time who you can't extrapolate from the results
21 inside to the results outside, and it's not clear
22 that this has been transmission of information

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183

1 from the inside to the outside.
2 Our conclusions were that given the war
3 environment that this happened in, given the how
4 expeditious the site evaluation was and the

5 testing was, and so forth, that our Committee felt
6 that CHPPM really did meet the standards of
7 practice for field investigations and occupational
8 medicine. It is very timely, although we will
9 point out, though, that this problem of silos is
10 problematic, and, finally, that the conclusion of
11 CHPPM related to the units that they studied were
12 again reasonable, again one can extrapolate,
13 beyond the fence line, if you will, and there's
14 some chance in extrapolating to the first units,
15 but it was not unreasonable to extrapolate to the
16 first units as well.
17 We have recommendations that are both specific and
18 general to this kind of field investigation that
19 I'll share with you. The first one is that there
20 ought to be an insurance that the communication of
21 the results of this episode has been communicated
22 to the soldiers, to their health care providers,

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184

1 and to their medical records, and that this
2 information really has been -- is in their files
3 and will be in their files for the next 10 or 20
4 or 30 years, as the population ages and as the
5 population develops as we all do, all sorts of
6 naturally-occurring illnesses and injuries. But
7 the information has to be in the charts so
8 somebody years from now has some idea of what
9 we're talking about.
10 The second recommendation is that all parties
11 really need to see the report of what CHPPM was
12 able to do in the field, so expeditiously one
13 needs to declassify and disseminate the report.
14 The results -- really the only result that
15 apparently caused the classification was the
16 geographic coordinants of the plant -- and I was
17 able to go directly from Google to Qarmat Ali, so
18 that doesn't really sustain, you know,
19 classification at this point. So it's one of
20 those things that needs to get done.
21 The third issue is the development of the case
22 study for training. A lot of things were done

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185

1 very well in this investigation. A lot of
2 challenges came up that I think were handled very
3 well, and the question is whether those people who
4 handled this investigation were exceptional or
5 whether this would essentially be the standard of
6 care if you repeated this, or repeated it in other
7 circumstances. Well, there's no way of telling
8 that, so one of the ways to do this is to develop
9 a case study and have those people who would be in
10 a position of responsibility work through the
11 problem artificially, if you will.
12 The next recommendation, specifically, is that all
13 the silos here, including the National Guard

14 units, the contractor, and local public health,
15 that is, local Iraqi public health, needs to be
16 debriefed on what the situation was and is and
17 could be, et cetera, so there's common knowledge
18 there amongst all parties about what the situation
19 is and what was done, needs to be done, et cetera.
20 The fifth recommendation is that there ought to be
21 a simple registry established which has the names
22 of the people who were at the site, any

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186

1 information about how long that they personally
2 were at the site, et cetera. The medical
3 information. This is valuable years from now if
4 there should be, per chance, some assessment that
5 it may be more of a hazard than it is projected to
6 be, or if there's an individual who has an
7 illness. Lung cancer is not that unusual a
8 phenomenon.
9 One needs have a registry to know who was there
10 and who wasn't there. A registry doesn't mean
11 that one should launch off into some detailed
12 cohort morbidity study or mortality study at this
13 point, but it is the basis for that kind of
14 follow-up, and if you don't do it now, it may be
15 impossible to establish a registry later.
16 We have general recommendations. The foot soldier
17 needs to be trained at some level how to recognize
18 and avoid industrial hazards. Walking through
19 yellow cake, essentially, is something to be
20 avoided; it should be part of one's training. It
21 refers, though, not just to yellow cake but all
22 sorts of industrial hazards that a soldier might

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187

1 come upon in the field.
2 The other reason to train the foot soldier and
3 their leadership is because there's a more,
4 sometimes even higher risk, which is avoid the de
5 minimum chemical exposure and incur the much more
6 substantial military exposure; that is, the
7 projectile lead rather than the environmental, and
8 always to avoid the chemical and accept that
9 hazard of the military bullets, basically. It's
10 not an assumption. This needs to be weighed in
11 the theater.
12 The third recommendation that's general is that we
13 need to ensure in-theater capacity for initial
14 investigations. This one went well because there
15 was an occupational physician, I believe -- or I
16 note that there was an occupational physician, but
17 I believe it went well because that person was in
18 the field and were able to understand what to do
19 quite immediately, and essentially pull the
20 trigger on requesting the CHPPM investigation. So
21 it all went very rapidly. So it has to be people
22 in the field, there have to be enough people in

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188

1 the military in these environments to do this.
2 It looks like we have two "3's" so it's actually
3 No. 4, at home base, that is, there have to be
4 enough toxicologists and industrial hygienists,
5 epidemiologists, and they have to have enough
6 access to industrial experts in the country with,
7 you know, thousands and thousands of processes
8 that go on in industry so that given whatever is
9 found in the field, there's some line of defense
10 at home who can be called for backup expertise,
11 and they in turn have people in industry and in
12 academia and wherever to ask pertinent questions
13 on this well.
14 That takes care of the third and the fourth
15 recommendation.
16 The fifth recommendation is that there are times
17 at which both in real time during such an
18 investigation, CHPPM may want advice on how to
19 proceed with an investigation or affirmation that
20 they're doing the right thing or whatever, and, in
21 retrospect, there's also a time when such advice
22 and evaluation is valuable. So we ought to set up

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189

1 or suggest that there be set up the access to an
2 advisory board, if you will, or to DHB such that
3 this kind of advice can be given in real time, and
4 that we prepare for it such that we have more than
5 three or four of us with security clearance at any
6 point in time so that those giving advice can know
7 what they're giving advice about.
8 The next recommendation, which is general, is --
9 this is throughout life, throughout academia, but
10 also in the military -- we need to learn how to
11 bridge these silos and stovepipes because they
12 incur, they cause us to incur delays that's a
13 delaying of information, a delay in accurate and
14 full information, and they get in the way. So we
15 need to figure out how information can be
16 transmitted across silos.
17 And, finally, the system for classification and
18 review of classification, this is really probably
19 the most Don Quixote recommendation of all, there
20 needs to be a review of how to get things
21 declassified or not classified, perhaps in the
22 first place, so that when they are the subject of

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190

1 the review, it doesn't stymie that review. So
2 there's a whole issue of declassification.
3 Now, what I'd like to do is ask for other
4 subcommittee members, if they have additional

5 comments that they'd like to make to make them
6 now, open the floor up to questions for the
7 Subcommittee from you all. If there are any
8 proposed modifications to or report, we can
9 discuss that, and then move on to approval by DHB
10 of the report.
11 wayne?

12 DR. LEDNAR: Wayne Lednar. One of the
13 very practical examples of silo-busting is where
14 DOD might turn to its sourcing, its logistics,
15 expertise. Whose who were writing the contracts
16 with contractors who were doing this work in
17 theater to the extent that it is the expectation
18 of the Department that should this kind of
19 unexpected event occur, that it will be an
20 expectation in the contract with contract language
21 included that they talk to the Command in the
22 area, or whoever the right people are. And I

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191

1 think in the absence of some of that -- call it
2 legal language -- it either didn't occur to those
3 on the ground or there might even have been advice
4 provided from a distance to suggest we better
5 understand this before we have a communication
6 officially. So anything that can be done,
7 structurally, to support those on the ground
8 forward, I do think would be very helpful.

9 DR. HALPERIN: Yes, Ed?
10 DR. KAPLAN: First I'd like to
11 compliment you on an excellent report to the
12 point, facts available and done very well. My
13 question's a little bit off to the side, and that
14 is my understanding is that in Basrah that was
15 mostly the home of British troops. Is there a
16 difference between what you found and what was
17 found by the British, because that could have
18 implications for your final report?

19 DR. HALPERIN: Yeah, the results of the
20 Brit for environmental assessment and the CHPPM
21 environmental assessment inside the perimeter
22 fence was basically de minimum exposure that was

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192

1 totally consistent. It would appear, though, that
2 the CHPPM did sampling outside the perimeter fence
3 as well, so there's an absence, if you will --
4 there's not an inconsistency, there's just this,
5 as I remember, there's no data from, like -- that
6 information, though, is valuable information for
7 the local population. So it's not an
8 inconsistency, it's just a realm of the sampling
9 that was done.

10 DR. KAPLAN: Kaplan. Is that in your
11 report about what the British also found?

12 DR. HALPERIN: Yes. Yes, in the summary
13 for the environmental sampling.

14 Yes, Ellie?

15 MS. EMBREY: Did your subcommittee have
16 an opportunity to review the deployment health
17 instruction that DOD published on this subject
18 matter?

19 DR. HALPERIN: The report that actually
20 went into the medical chart, is that what you're
21 asking?

22 MS. EMBREY: No. There's a deployment
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193

1 health instruction out to the surgeons, the
2 Department on the scope and responsibility of
3 different parts of the Department as it relates to
4 eschewing health in a deployed environment. An
5 environmental sampling and identifying and
6 notifying and all of that information is covered.
7 I was just wondering whether or not you were aware
8 of it, and is there a way I could provide you with
9 that so that you could comment on how that
10 instruction might be complimented by gaps, because
11 this obviously -- I mean there are some things
12 here that are very important, and I would like to
13 build on that. But I also don't know how much of
14 the details of your subcommittee's work, and you
15 might be able to help us with that.

16 DR. HALPERIN: I'm sure we'd be happy to
17 review it. We didn't review -- these aren't like
18 generic advice on how to handle the situation. We
19 didn't review it, but certainly in the next phase
20 of what we do, which is the kind of the overall
21 view of this risk assessment process, it sounds
22 very relevant.

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194

1 DR. MATTOX: My question relates to your
2 fifth specific recommendation on the third from
3 the last slide relating to the registry. Do you
4 have recommendations on the ownership and where
5 that registry should be housed? I have
6 familiarity with the injury registry that is often
7 housed and owned by three or four different
8 agencies making it basically unusable. So that if
9 we have a registry, it must have an owner, and
10 that owner must prudently disseminate those people
11 who have need to know.

12 DR. HALPERIN: Absolutely. There are
13 registries for other exposures with DOD, and the
14 best advice would be whoever has a management
15 responsibility for those registries. This ought
16 to be an add-on. You don't want an orphan
17 registry floating out there because 10 years from
18 now you'll never be able to find the registry.
19 Now, as far as who has it, I don't think I can
20 comment on that at this point, who has
21 responsibility for registries. I know that
22 there's some whole millennium cohort, but somebody

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195

1 else is probably better --
2 DR. WILENSKY: Ellen indicated she was
3 able to respond.
4 MS. EMBREY: On the advice of the AFEB
5 and the Defense Health Board, the Department did
6 create an Armed Forces Health Surveillance Health
7 Center, and the trauma registry, all of the major
8 registries for the enterprise are to be managed
9 out of that Armed Forces Health Surveillance
10 Center. It is the enterprise authority for these
11 kinds of things. So if we accept this
12 recommendation, then what we would have to do is
13 to identify a business process for setting up a,
14 quote, "small cohort of registry," and making sure
15 that it's available to those who need to know.
16 But we did create a enterprise authority, a single
17 point of accountability for registries in the
18 Department.
19 DR. WILENSKY: Adil?
20 DR. SHAMOO: Adil Shamoo. I may have
21 missed it, but did you say anything about the
22 exposure of the local population and whether we

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196

1 are going to give them any advice or not?
2 DR. HALPERIN: Well, I said something
3 about the exposure of the local population, which
4 is the environmental exposure outside the fence
5 line was found to be -- there was found to be
6 exposure out there, and that there were -- there
7 was a comment in the report that there were
8 civilians walking out there.
9 I did also point out that I think the silo problem
10 has gotten in the way of transferring that
11 information to the local public health.
12 There are lots of ways to do it. It's in Basrah,
13 so there is going to be some local health -- but I
14 also, it just happened to be on the -- in the
15 blog-o-sphere, and I was looking at ward
16 Casscells' blog the other day, and I saw that he
17 had met recently with public health school
18 leadership in the United States talking about
19 building public health infrastructure maybe even
20 at school in Iraq. So there are ways to transmit
21 that information and encourage transfer of that
22 information.

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197

1 DR. WILENSKY: John, did you have
2 questions?
3 DR. CLEMENTS: I did. John Clements.
4 I had been repeatedly struck by the observation

5 that it was the troops who noticed that the KBR
6 folks were wearing protective equipment and
7 brought that to the attention of Command rather
8 than vice versa. And I think it's one thing when
9 you're moving through an area on your way to
10 engage an enemy, and that's where the troop
11 ability to recognize and avoid industrial hazards
12 would be particularly important. But once you get
13 into a situation like that, I think Command has
14 the responsibility to ask if there are any hazards
15 in the area that should be reflected back to the
16 troops.

17 So somewhere in here I hope we can reinforce that,
18 because I think that was a major failing here.

19 DR. HALPERIN: Well, that it's again the
20 silos issues. Wayne has addressed this issue as
21 far as contract language. There's a
22 communication-sharing ethos. It is an issue that

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198

1 needs to be addressed, and, quite honestly, should
2 be one of the elements if one develop a case study
3 out of this is, you know, you can't have people
4 treating the same patient in different arms.

5 DR. WALKER: Walker. Does full mention
6 of a registry involve any HIPAA issues?

7 DR. HALPERIN: Within the military? I'm
8 not familiar with HIPAA restrictions within the
9 military. For public health, you know, HIPAA does
10 not pertain to surveillance issues as much as it
11 does in clinical medicine, but within the military
12 it's not. I don't know.

13 DR. WILENSKY: (Inaudible).

14 DR. RUBENSTEIN: I'm David Rubenstein.
15 Before I get to my point, the answer to that
16 question is no.

17 We have a number of registries, and HIPAA does
18 allow for a certain military waiver, if you will,
19 to ensure that the health of the Force is
20 protected.

21 On to my point, our briefings to Congress start on
22 Monday a week, the 22nd. The work of this

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199

1 Subcommittee, Madam Chairman, is important to
2 informing those briefings. We certainly
3 appreciate the work and just speaks once again to
4 the value and importance of this Board and its
5 members to care for the health and welfare of
6 America's sons and daughters, and we want to say
7 thank you.

8 DR. WILENSKY: You're very welcome on
9 behalf of the whole Board and individuals on the
10 Subcommittee who have worked so hard.

11 Are there other questions or comments?

12 CMJ. HOLLAND: Ma'am?

13 DR. WILENSKY: Yes?

AADHB-121508.txt

14 CMJ. HOLLAND: Command Center Major,
15 retire, Larry Holland. Great reports, and the
16 last time we talked about the idea that we really
17 want to make sure that this gets in every
18 serviceman and woman's record because, you know,
19 for the Guard and Reserve, especially -- these are
20 Guard and Reserve units -- we've crossed level
21 folks from a lot of states, so we're only
22 mentioning three states, but I bet you there's

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200

1 multiple states involved, plus looking at the time
2 frame when these units returned, I bet you a lot
3 of their individuals have now retired so they're
4 out of the system, and individual augmentees. So
5 we have some challenges.

6 The last point is, let's not forget our
7 multinational brothers and sisters out there,
8 because they do a great job, and I think we owe it
9 to them to provide the report when it's approved.

10 DR. WILENSKY: So noted. Members of the
11 Core Defense Health Board, this is, as you know, a
12 sensitive issue. Is there anyone who dissents
13 from accepting this report as you've heard it?
14 I've not heard anything, but I wanted to make sure
15 people had an opportunity to register it if you
16 did.

17 (No response) Regard that, then, as
18 approval by the Core Board,
19 And go ahead and, General Rubenstein, good luck.

20 DR. RUBENSTEIN: Thank you.

21 DR. WILENSKY: Our seventh speaker today
22 is Brigadier General Roy Sutton. General Sutton

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201

1 serves as the Director of the Defense Centers of
2 Excellence for Psychological Health and Traumatic
3 Brain Injury, and is the Special Assistant to the
4 Assistant Secretary of Defense for Health Affairs.
5 General Sutton's presentation slides may be found
6 under Tab 7 of the binders. General Sutton,
7 welcome.

8 BG. SUTTON: Thank you so much, Dr.
9 wilensky, Ms. Embrey, distinguished guests.
10 Thanks so much for providing me the chance to be
11 with you this afternoon. Please refer to your
12 slides as reference, but I won't be using them
13 today. I just really, in the few minutes that we
14 have, I'd like to give you a brief overview of
15 where we are with the Defense Centers of
16 Excellence, where we're going, and to get your
17 ideas, to get your thoughts, to get your
18 questions, get your input.

19 First of all where we are: we just passed our
20 one-year anniversary. That is to say that on 30
21 November last year we opened our doors -- and I
22 just thank Ms. Embrey, Dr. Casscells, Dr. Kelly,

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202

1 the entire Health Affairs TRICARE management
2 activity, as well as the Department of Defense at
3 all levels. The leadership and support has been
4 phenomenal. What that meant was that on the 1st
5 of December we had a phone number, a receptionist,
6 a part-time chief of staff, and myself -- and a
7 huge mission in front of us but great support.
8 The foundations that LOA2 and the entire Senior
9 Oversight Council had put together served as a
10 ever foundation for us, but, of course, that was
11 informed by the incredible work of all of the
12 various task forces and commissions, and I'd like
13 to particularly recognize Dr. Shellie McDermid --
14 I saw your name here, Shellie. Great, with the
15 work of (off mike), with the Mental Health Task
16 Force, and that now we are in the position of
17 really being able to implement and make things
18 better because that's what it's all about.
19 We have pulled together over this past year --
20 it's been a time of building the team and growing
21 the capabilities, so we've established
22 directorates headed by key leaders from each of

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203

1 the Services, phenomenal support from the Surgeons
2 General and from the Senior-most leaders.
3 In fact, I just came from this morning a meeting
4 with the four Vice Chiefs and staff, and I will
5 tell you what a tour de force. I just can't even
6 being to tell you what it means to have that kind
7 of support behind our efforts. It is that
8 important.
9 Well, what we've done is we've put together
10 several directorates, anything from resilience, to
11 education and training, to standards of care, to
12 research program evaluation, to PELA health and
13 technology because, after all, it's so important
14 for us to be able to reach out to those remote
15 locations, particularly to be able to connect with
16 our guardsmen, our reservists, our family members,
17 our troops, our leaders are all over the world, as
18 well as the clearing house, a clearing house where
19 we can become the Department of Defenses open
20 front door for all concerns related to
21 psychological health and traumatic brain injury.
22 We have also looked around the Department. We

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204

1 realized early on that this challenge was far
2 bigger than any of us within the Department of
3 Defense, of any of us including the VA. As far as
4 we have worked together, it's phenomenal. We've

5 got a VA deputy Sonia Backman, the VA's best and
6 brightest who is assigned to the Defense Center of
7 Excellence.
8 But we realize that this would be well beyond the
9 efforts of the Federal Government, would go well
10 beyond our TRICARE network; it would go into the
11 nation as a whole and around the world. After
12 all, there are things we need to be learning from
13 other countries and things that we are learning.
14 And so we thought, well, let's take a page out of
15 Gurney's Play Book, let's become that change we
16 want to see first.
17 And so we looked around the Department of Defense,
18 and we found centers of excellence that were
19 already in place doing incredible work that had
20 never really been, oh, palmed or budgeted on a
21 regular basis, hadn't really been able to
22 synergize or fully take their results up to the

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205

1 next level, and we thought this is our
2 opportunity. So we did, we brought in four
3 existing centers. The Defense Veterans Brain
4 Injury Center led by Air Force Colonel Mike
5 Jaffee, incredible reputation of this organization
6 and what they've done over the last 13 years.
7 Second center, Center for Deployment Psychology.
8 Dr. David Riggs came to us from the National
9 Center for PTSD, incredible job, just three years
10 in operation now, but just work and it takes a
11 psychological health training, not look just to
12 our psychological health providers but well
13 beyond, primary care. In fact, Mike Jaffee is
14 back there right now. We know that whether it be
15 traumatic brain injury or psychological health
16 concerns, it is an integrated team approach.
17 There is no one specialty that has it all.
18 The third center, we pulled together the
19 Deployment Health Clinical Center made by Chuck
20 Engel. This has been in existence about the last
21 14 years, came out of the early "Go For" Illness
22 Studies and has really built a phenomenal ability

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206

1 to both do cutting edge research, and the latest
2 research published just this last fall had to do
3 with acupuncture with PTSD.
4 Chuck and his team, they run a three-week regimen
5 throughout the year for both PTSD as well as
6 medically unexplained physical symptoms. Folks
7 around at the (off mike) just aren't getting
8 better, as you might have hoped that they might.
9 Come together for three weeks regimen: Best of
10 Eastern medicine, best of western medicine, truly
11 an integrated team approach that gives them the
12 tools, gives them the structure, brings in their
13 families -- we know how essential their families

14 are -- and gives them hope.
15 In fact, there was an officer earlier this Spring
16 at Congress who testified as to how this program
17 had saved his life. At our Real Warriors
18 Conference just last month at the AMSUS meeting,
19 we had a family member there with her husband.
20 They both said, "This program has saved our lives,
21 saved our marriage."
22 The fourth program, Center for the Study of
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207

1 Traumatic Stress, 20 years in existence led by my
2 former boss, Bob Ursano, retired, Air Force
3 psychiatrist, did a lot of the seminal work -- how
4 are you doing, sir, speaking of Air Force? -- a
5 lot of the seminal work likened to pilots coming
6 out of Vietnam, POWs, his Center for the Study of
7 Traumatic Stress has been involved in every major
8 disaster in this country's history over the last
9 20 years. So phenomenal expertise, bringing them
10 together.
11 The fifth center, we established a brand new
12 center because we knew for telehealth and
13 technology, it was really going to require our
14 concerted effort to be able to reach out and tap
15 into these emerging pathologies, bring tomorrow's
16 solutions into today's. I would recommend to you,
17 take a look: afterdeployment.org is one of our
18 recent tools just rolled out this summer. It is
19 our first sort of down payment working towards a
20 "Sim Coach," and the ability to harness the best
21 of artificial intelligence, expert learning,
22 neuroscience, voice recognition in simulated
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208

1 conversation, headquartered in Fort Lewis run by
2 retired Colonel Greg Gum.
3 The sixth center -- I'm so pleased to have Jim
4 Kelly with us today, Chairman of the TBI
5 Subadvisory Committee for the Defense Health
6 Board, as you know a renowned behavioral
7 neurologist, and we are so thrilled to be able to
8 welcome him on board as of the first of January as
9 our new Director of the National Intrepid Center
10 of Excellence, which that modern-day founding
11 father, Mr. Arnold Fisher, has dedicated his
12 life, fortune, and sacred honor to rallying his
13 fellow Americans to contribute money towards
14 building a center that will be the home of our
15 national and global network, and will serve the
16 needs of our troops and their family members with
17 psychological health and traumatic brain injury
18 concerns, just as the Center for Intrepid that he
19 and his intrepid and fallen heroes have already
20 built in San Antonio.
21 So that's the line in terms of structure, but
22 where are we headed? You'll see in your notebook

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209

1 that there are a number of things that we've done
2 already, but I will tell you, moving out from this
3 year of building the team, the concept, and
4 growing the capabilities, we are now launching
5 into a year of delivery and improving as we go. We
6 cannot wait for the perfect solution set; we have
7 to deliver what we have now and improve as we go.
8 I had a chance to talk with some troop out at Fort
9 Hood last Friday. They had just come through the
10 Warrior Reset Center, which is a two-week program
11 that brings in GILGA. REIKI, acupuncture,
12 biofeedback. (off mike)... to sit down with these
13 troops ranging in range from a sergeant major down
14 to a specialist. He closed the door, let the
15 staff in the other door, and I asked him, "what do
16 you all think?"
17 He said, "well, ma'am, we thought it was a bunch
18 of hocus pocus to begin with, but we knew it was
19 our only chance." One soldier said that he had
20 come to the Center because he had woken up one
21 morning to find his wife cowering in the corner.
22 He was underneath the high-boy dresser. She was

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210

1 crying, scared to death. He said, "why am I
2 sleeping under the dresser?"
3 She said, "You work up last night and were
4 screaming at me. Surely you remember."
5 "Incoming mortar, ordering me down." well, he
6 didn't remember. And we know that for repetitive
7 exposure to life-threatening trauma, whether it be
8 from the experiences that Sophocles wrote about
9 with the Trojan wars, or whether it be for more
10 recent experiences, World War I, World War II,
11 Vietnam, and this conflict, we have got to bring
12 every tool, every resource to bear.
13 We know that for unknown (off mike) conditions,
14 yes, we already have clinical practice guidelines,
15 we're all aware of that. We know about the longed
16 exposure and cognitive behavioral therapy, and
17 we're also aware that, like the civilian world,
18 we've got a tremendous gap to close to make sure
19 that folks are using the guidelines that we have.
20 This year for the first time we're so pleased that
21 we finally had a single clinical practice
22 guideline for the management and treatment of

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211

1 concussion, mild traumatic brain injury. In a
2 deployed setting, that's now up on the joint
3 patient tracking system, and as of January we'll
4 have the revision for the mild traumatic brain

5 injury concussion, CPG in the nondeployed setting.
6 We're also very reassured by the recent Institute
7 of Medicine report that came out, and, of course,
8 the VA had commissioned them to really look at the
9 best practices in terms of screening and
10 surveillance and TBI research, and they came
11 forward with a number of recommendations. It was
12 very heartening as we reviewed that report and
13 that recommendation. Yes, of course, we can
14 always do better and we're continuing to make our
15 best today better and better and better; but every
16 one of those recommendations, which are already
17 either we've implemented them or we are already in
18 the process of implementing them.
19 So we're on a journey. Where are we in this
20 journey? I look at it like this: I feel a little
21 bit like Churchill at the Battle of Britain when
22 he said, "This is not the end. This is not the

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212

1 beginning or the end, but it is perhaps the end of
2 the beginning." And so this is a time as we move
3 forward with the help of great folks like Marty
4 Seligman -- I saw your name where you'd --
5 someplace, Dr. Seligman, the granddaddy of
6 positive psychology -- he's working with us and
7 others. But we can develop a common lexicon so
8 that we can communicate what we're doing.
9 I think of the plebes at West Point earlier this
10 fall. I went up to one of the psychologists
11 there, Dr. Mike Matthews and said, "Dr. Matthews,
12 we know you're a psychologist, we've got a
13 question for you: When we waved our hands, we
14 knew that we were entering the Army at a time of
15 war. We expect to be deployed. But this whole
16 PTSD thing, I guess we just kind of have to expect
17 that we're going to get that, too, right?"
18 That's the challenge that's before us. The
19 reality of our challenge is tough enough, but what
20 makes it even tougher is when we're not even
21 communicating reality, which is, of course, that
22 while many of our troops coming back from these

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213

1 repeated deployments will have posttraumatic
2 stress, many of them will have issues with
3 depression and anxiety. We know that PTSD is not
4 the only thing, that's why we didn't name the
5 Center the Center for TBI/PTSD. If we resolved
6 all of the issues related to posttraumatic stress
7 today, it would be less than half of the
8 psychological health issues that concern our
9 troops, to include pain management, to include
10 substance misuse.
11 And so we are on a journey. We are launching
12 forward with a consortium this next year.
13 Congress has been very generous, we've got

14 research projects that are underway, \$300 million
15 from the first year that have gone out. Those
16 research projects are in progress. We've got a
17 research consortium that the Center is leading and
18 integrating.
19 We've got the research, the clinical consortium,
20 and we've got another consortium for promising
21 practices that we are rapidly moving forward with
22 this coming month, because when it all comes down

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214

1 to it, we're all in this together, and it's not
2 just about the health care sector. This is way to
3 important -- health is way too important to be
4 left to the docs; it's about the faith
5 communities; it's about the employers; it's about
6 the teachers; it's about the families; it's about
7 the policy makers; it's about keeping face with
8 our warriors and our families and our nation.
9 And so I look forward as we go down this journey
10 and as we work to keep faith with our nation to
11 set the example, to show that the medical model of
12 illness, as important as it is, it has not served
13 the larger cause of health very well. And so we
14 see the work that we're doing in conjunction with
15 the rest of the Department's efforts as really
16 being part of that tipping point that can lead to
17 a model of wellness and health for the nation.
18 Let me just close with words that I review just
19 about daily, words that came from a young soldier
20 several months ago. We were at the Army-Navy
21 Club, and he was down from Walter Reed as a
22 wounded warrior, and he was there with several

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215

1 leaders, folks who were very active in supporting
2 the cause of wounded warriors. As he reminded us,
3 he said, "I didn't lose my leg, I gave my leg for
4 my country."
5 And so we started talking about the way ahead,
6 and, you know, as you talk with warriors and their
7 loved ones, you realize just how enormous this
8 challenge is because although this particular
9 soldier was still in the DODO system, many of them
10 are wounded warriors who have been wounded, ill,
11 or injured only in this conflict. They've already
12 gone through the DOD system of care, and the VA
13 system of rehabilitation. And when it comes to
14 (off mike) that reintegrate in their communities
15 of choice, they fall off a cliff, which is why
16 we're going to be hosting a Megacommunities Forum
17 this next year so that we can imagine the future,
18 the next 20 years of what it is to care for
19 warriors and their loved ones and how we, as a
20 nation, can support that.
21 So back to this young soldier. Someone in the
22 group said, "You know, I'm kind of worried. The

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216

1 election's coming up, and they looked at me and
2 said, you know, like you, you had a reasonably
3 promising career before all of this. Don't you
4 know that the Department just looked at this as an
5 election year ploy? Don't you know that you're
6 just here, and you're going to be plucked away,
7 and it'll be like everything else with DOD that,
8 you know, great leaders, great energy, but then,
9 you know, no continuity of leadership, and we're
10 left holding the bag?"
11 This young soldier was listening to that. There
12 was a Vietnam vet who was there. He talked a
13 little bit about what happened after Vietnam.
14 Finally, the soldier looked at me, and I looked
15 back at him, and he said, "No." He says, "I don't
16 believe it. I don't believe that my nation is
17 going to turn its back on me and my buddies."
18 And I looked at him and said, "Roger that,
19 soldier. You're my boss. You're the reason we
20 exist. Let's go on this journey together."
21 Thank you so much. God bless. Any questions now?
22 Sir?

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217

1 DR. WILENSKY: Any questions from the
2 members of the Defense Health Board?
3 DR. SILVA: Yeah, I have one.
4 BG. SUTTON: Yes, sir.
5 DR. SILVA: Silva. Thank you for that
6 very moving rendition of what's occurring. We
7 have the handouts here. Are we going to review
8 them at some point? Or --
9 BG. SUTTON: I'd be happy to address any
10 questions regarding the handouts, sir.
11 DR. SILVA: Well, I only have two.
12 BG. SUTTON: Sure.
13 DR. SILVA: One is, it's mentioned
14 Manhattan Project. That's a very bold name, and,
15 in fact, you have two types of Manhattans.
16 BG. SUTTON: Sir, can I come over there
17 and see (off mike)?
18 DR. SILVA: I couldn't answer that. And
19 then the Center of Centers, it's midway through
20 your handout, it's -- I really can't read it, but
21 it looks like a lot of operative descriptions,
22 what occurs in each center. So to save time, if

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218

1 we can get that blown up, that would be helpful
2 for us to see --
3 BG. SUTTON: Yes, sir.
4 DR. SILVA: -- the overarching program.

5 BG. SUTTON: We will absolutely do that,
6 and we can go into as much detail as anyone would
7 like. We've got a concept of operations that goes
8 into "nitnoy" Detail, but we certainly wouldn't
9 have given you a single slide that you can read,
10 sir [sic], no question.
11 Let me just get back to your original point on the
12 Manhattan Project. When I briefed the Vice Chiefs
13 this morning, I started out by saying, "Gentlemen,
14 thanks so much for allowing me to be here, let me
15 start out by saying each of us wishes it could be
16 five years ago. No question about that, but it's
17 not. It's now, it's here, let's go eyes forward,
18 roll up our sleeves.
19 "What we need is we need an MWRAP, focused urgency
20 mindset that is imbedded upon a Skunkworks
21 innovation platform that is enveloped with a
22 Manhattan Project level of energy urgency and

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219

1 effort." And they completely agreed. That's that
2 reference, sir. Thank you.
3 DR. WILENSKY: Any other questions?
4 BG. SUTTON: Yes.
5 DR. MATTOX: In the handout material,
6 you talk about prospective randomized trials. Are
7 those among active-duty military personnel and, if
8 so, in order to get world-class -- where's Ken
9 Kizer -- prospective randomized trials are
10 important. There is a perception among many
11 people that prospective randomized trials cannot
12 be done in active duty military. How did you do
13 that, and how can we extrapolate that to other
14 areas of subcommittee work?
15 BG. SUTTON: Great question, sir, thank
16 you. We have not yet done it; we are doing it,
17 and that's another reason that the fire power from
18 the Chief is going to be so important, because, as
19 we talked to them this morning, we set out, and,
20 you know, one of the things that we did this last
21 -- earlier this month is we held the first- ever
22 hyperbaric oxygen treatment consensus conference.

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220

1 There's been a lot of debate about this issue
2 going back and back and forth for years, but there
3 just wasn't research to tell us what role, if
4 any, hyperbaric oxygen has for traumatic brain
5 injury.
6 So we brought together 60 folks, scientists
7 brought together their pilot data, we had the
8 group -- this is not just from the Services but
9 from around the country, round the government --
10 and the consensus was, hey, we can move forward
11 with an RCT within this next calendar year. So
12 what we've done is we've put together a time line.
13 It's an ambitious time line, to be sure. We will

14 have the proposal for this study, it'll be a 15 to
15 25 site study, and it will have one arm that will
16 look at concussion or mild traumatic brain injury,
17 six months of symptoms in duration as a minimum
18 for inclusion criteria; it will have one arm that
19 will deal with moderate to severe TBI, again with
20 symptoms great than six months in duration, and
21 I've asked for an arm with PTSD alone, again with
22 symptoms greater than six months in duration,

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221

1 which, of course, the sham element built in as
2 well.
3 Here's the kicker. As you well know, the thought
4 of getting together a multisite study of this type
5 and to launch it in April when we're submitting in
6 March is absurd.
7 That's why I get back to the Manhattan Project.
8 One of the things that we're going to be
9 identifying over these next few days is to figure
10 out, how can we come up with a common IRB? why
11 don't we take the toughest, knarliest, most
12 stringent IRB that currently exists from the
13 services and say, listen, let's have it pass this
14 IRB, and if it can pass this IRB, surely we can
15 migrate it to the other sites.
16 We're not there yet, sir, but that's exactly, you
17 know, if we don't put a high mark on the wall that
18 sounds absurd, we'll certainly never get it, but
19 that's what we're aiming for the first arm of the
20 study of the first base of the study, will be
21 approximately 200 to 250 subjects brought from all
22 over the military to the various civilian and

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222

1 military sites, the second phase of the study
2 likewise, a second arm with 200 to 250 subjects.
3 Jim, anything you want to add to that? I know
4 that you've certainly been part of that
5 discussion.
6 Michael? I've got Mike back in the corner. Mike
7 Jaffee.
8 COL. JAFFEE: The question about
9 randomized controlled trials, when we talk about
10 randomized controlled trials in the world of rehab
11 medicine, it's been very difficult.
12 BG. SUTTON: Yes.
13 COL. JAFFEE: Take out the military, not
14 even counting a DOD, even in civilian medicine
15 there's been very few randomized controlled trials
16 in rehabilitation medicine.
17 Using this network in collaboration we have
18 between the VA and the DOD, we've actually been
19 able to complete some, so in the year 2000 we
20 published the first ever randomized controlled
21 trial of a rehabilitation modality, this cognitive
22 rehabilitation. We were able to take the results

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223

1 of that and actually complete another randomized
2 controlled trial focusing in on the population
3 which may benefit more.
4 Those results are actually being released
5 tomorrow. There's going to be a press release
6 from the Department of Veterans Affairs. It's
7 already posted on the Archives of Physical
8 Medicine and Rehabilitation. But again, it takes
9 time, it takes planning, and it takes
10 coordination. And it was only through this
11 collaborative network that we were able to
12 complete this type of endeavor that's been
13 challenged, not just in the DOD but in the
14 civilian world.
15 Another effort which has been launched that we're
16 doing with DECO is looking at a randomized
17 controlled trial of the use of Ritalin for the
18 management of severe traumatic brain injury and
19 attention. It's a common medicine which is being
20 used by clinicians, but there's never been a Class
21 1 randomized controlled trial looking at it.
22 Because we have this network of these VA hospitals

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224

1 in this population, we are able to do that, but it
2 requires coordination, it requires partnerships,
3 and a lot of what we've been working on over the
4 past few years is reaching out and developing more
5 of these relationships and partnerships so that we
6 can increase our network for randomized controlled
7 trials.
8 An exciting example of that is just what General
9 Sutton was talking about, was being able to do
10 that for the modality of hyperbaric oxygen
11 therapy.

12 BG. SUTTON: And the problem with what
13 Mike mentioned that's just unacceptable to us at
14 this point is the first RCT that he mentioned was
15 published in 2000. The second is in 2008. We
16 don't have eight years to really put this
17 together, which folks have told us, you know, you
18 can't possible do it in that time period.
19 I don't know if we can or we can't, but we know
20 that we'll have the proposal completed. We know
21 that we've brought the country's leading experts
22 together, and we know that they've reached

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225

1 consensus, and so now we've just got to figure
2 out, how do we accelerate using a common IRB so
3 that we can perhaps serve as a model?
4 I know that National Cancer Institute's already

5 led the way on this. We're very interested in
6 learning from their experience, but we also know
7 that we've got troops that their family members
8 are suffering right here, right now today, and so
9 whatever we can do to accelerate it, we'll share
10 with you our progress on that. But that is our
11 plan and more to follow.
12 Thank you.

13 DR. WILENSKY: Mike?

14 DR. PARKINSON: Yes, General -- Mike
15 Parkinson -- thank you.

16 It would be very useful, I think, going forward in
17 order for the DHB and the immediate groups that
18 you deal with -- and again I think it was a good
19 editorial the other day in one of the newspaper
20 saying we create a czar when the infrastructure
21 that we currently had doesn't work. And czars
22 that were created, none of them appear to work at

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226

1 the governmental level. So I always get worried
2 when I see center of centers.
3 And actually, I even get worried when we create a
4 center because it says that, left to its own DNA
5 that the structure as it currently is doesn't give
6 enough emphasis, so we create a center.
7 Having said that, the balance of your portfolio in
8 terms of randomized controlled trials, research,
9 Ritalin, the rehab world, what we can do with RCT
10 -- which is clearly important -- but I'm going to
11 start with a no hypothesis and say that if we
12 don't understand the natural history of most of
13 these disorders, because they have not been
14 researched in the past, we have not funded them --
15 I just saw The Best Years of Our Lives movie.

16 BG. SUTTON: Yes,.

17 DR. PARKINSON: It was about World War
18 II that's came back, and I guess didn't assimilate
19 very well. It's a social, environmental, family,
20 cultural, community thing as much. So can you
21 state a little bit about the relative balance of
22 what we're doing in social and behavioral

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227

1 descriptions of the natural course of the disease
2 and successful reintegration. So do we have 150
3 people who have met some criteria of the three
4 disorders that we now call "disorders," who
5 actually are doing pretty well, in words that we
6 can describe that?
7 And then, secondarily, it would be very useful to
8 me at any rate -- I don't know about the Committee
9 -- to have a portfolio approach to your activities
10 in the relative areas that we consider to be
11 traditional medical R&D, functional PET scanning
12 of people who've got it, people who don't, and
13 what was the Ritalin effect on the PET scans,

14 those types of things. If you've got the money,
15 I'd do those studies.
16 But the other end, where is the balance of your
17 funds going to community reintegration of 25
18 people who have these diagnoses in Topeka, Kansas,
19 where there is no military facility, and there
20 might not even be a VA? What's going on with
21 those people?
22 So because, as is, it's a, you know, a splatter

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228

1 against the wall, but there needs to be a
2 construct that I think, if this could be useful,
3 in buckets that helps us measure outcomes.
4 Because this will be rife in Congressional
5 Oversight money thrown at it, is rife about
6 creating studies and money to research centers.
7 We've seen it in Persian Gulf I; we saw it in
8 Persian Gulf II, and this has all the feelings of
9 that unless we get our arms around it in a very
10 stable construct that we can all buy into here to
11 show we're making progress.
12 I think it's in there somewhere, but I'm asking
13 for more clarity.

14 BG. SUTTON: Certainly. Thank you.
15 First of all, we are reviewing the results, the
16 date of the Millennium Cohort Study, and I think
17 that will be able to inform us somewhat. We also
18 know that whether it be traumatic brain injury or
19 posttraumatic stress and other psychological
20 health concerns, we need a longitudinal -- and
21 we're starting both on the psychological health
22 and on the TBI front -- a 15-year longitudinal

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229

1 study that will help to get at some of those
2 natural history and course of development
3 questions.
4 Because this part of the problem is we don't have
5 a reference baseline population for comparison
6 right now, meaning to say that we don't have a
7 population of, you know, 22-year-olds from 20
8 years ago who had this kind of repetitive exposure
9 of blasts, of trauma, of repeated grief and loss.
10 But we do have -- we do have what we've learned
11 from the Vietnam head study, we will have what
12 we're learning what we're going to learn from the
13 15-year longitudinal study.
14 But more than that, in the very year term, right
15 here right now, we are launching what we're
16 calling the warrior wellness Innovation Network,
17 working with the Samuel Institute, Dr. Wayne Jonas
18 and his team, so that what we can do is, we can --
19 we can really encompass the full spectrum ranging
20 from resilience from Day No. 1 building resilience
21 with tough training, helping our troops and our
22 family members understand what are the normal

1 human responses to trauma. To educate them, to
2 give them a framework, and then leading forward
3 from that into, what are the recovery tools and
4 treatments? And have it integrated so that the
5 things they hear about in basic training are then
6 woven into their operational training cycle.
7 So that when a tanker, for example, goes to his
8 UCOP simulation trainer, he sees similar tools and
9 perhaps we can integrate some of the biofeedback
10 and arousal tools there to help give that troop a
11 sense of control and mastery in the training
12 environment that then perhaps if he or she gets
13 wounded, ill, or injured, they'll recognize the
14 same principles geared towards resilience,
15 wellness, performance within the medical
16 environment.
17 And then, of course, moving from the medical
18 environment back to reintegration, because you're
19 right, it's a community, it's a leader-led, it's a
20 social phenomenon. If you've been a good troop
21 before, it's the leader's job to plant that
22 expectation for the buddies, for the families, for

1 the community to embrace that troop coming back,
2 if they're able to go to their unit.
3 As importantly, if they're not able to go back to
4 the unit and they're going to their community of
5 choice, to prepare that community for knowing how
6 to relate to the troop and to their family and to
7 recognize what an incredible strength they bring.
8 So this Warrior Wellness Innovation Network is
9 going to be a 12 to 15-site study over this next
10 year, but it's really -- it's a living innovation
11 platform for bringing together evaluation tools to
12 evaluate current programs, because after all,
13 that's part of our challenge right now.
14 A lot of the money that came out for ONM programs
15 last year, those programs are just getting
16 underway now. So if they'd had a year under their
17 belt, we'd really be able to evaluate them, but in
18 the meantime there are always programs in place
19 that need to be evaluated like the Warrior Reset
20 Program at Fort Hood, or the Fort Bliss R&R
21 Center, or the C-5 Center down in San Diego, or
22 the H-5 trial that's just about underway at

1 wilford Hall.
2 So in tandem with this effort which will bring in
3 the complimentary alternative forms of therapy
4 that then can be integrated into the bedrock, what

5 we know of our existing clinical practice
6 guidelines, is the Real Warriors Campaign.
7 We just started this just last month on Veterans
8 Day. It started with an AP article on Ms. Pauline
9 Jelinek interviewed Major General David
10 Blackledge. We know the importance of senior
11 leaders stepping forward and talking about their
12 story.
13 General Blackledge was injured twice by an IED.
14 He talked about his struggle with traumatic brain
15 injury as well as PTSD and how he got help and
16 held help. Do you know from that one story alone,
17 General Blackledge has received hundreds of
18 e-mails, phone calls, getting stopped in the
19 hallway, folks who were thanking him because they
20 were unable or unwilling to brook that signal,
21 whether it be personal, whether it be societal,
22 whether it be institutional and that's another

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233

1 piece of this that we're, you know, joining our
2 policy colleagues so that we can really look at
3 what our current policies are, and are there any
4 policies of institutionalized stigmas.
5 Secretary Gates took the lead earlier this year in
6 terms of Question 21 on the security clearance
7 evaluation. That's a great start, and we want to
8 continue the momentum in that area. So there are
9 a number of different areas, but there is no one
10 solution to this.
11 But we also know, for example, that it's not just
12 the military population that's currently still in
13 uniform; we know of the wounded, ill, and injured
14 population. There's a whole spectrum, and to, for
15 example, sit down and spend some time with the
16 families of those who are minimally conscious, or
17 who in vegetate states. The work that we're doing
18 with the VA and with DVBIC now in terms of the
19 pilot study for that population, it just
20 absolutely is dripping in terms of what the needs
21 of these families are right here, right now, and
22 what they will continue to be.

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234

1 And, Mike, you're in a position to provide some
2 more detail.
3 MS. EMBREY: Ellen. Before you start,
4 Mike, if I could just -- I think one of the
5 important things that Loree isn't saying is that
6 when she was asked to open the door a year ago at
7 the end of November, beginning of December, she
8 was given some specific strategic objectives to
9 address. We had seven different independent
10 reports characterizing the gaps and capability,
11 the lapses in access to care, the inconsistency
12 between providers across the system, the lack of
13 evidence to be able to understand, diagnose early,

14 intervene, treat, and recover from particularly
15 mild traumatic brain injury, and a systematic way
16 to handle the management of an individual from the
17 point of entry into and especially the transition
18 from a point of care in the Department to the VA
19 or private sector for reintegrating into their
20 next stage of life.
21 These are important gaps that were repeated over
22 and over again within the Department, intensively

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235

1 managed and shaped over a year period of time.
2 And Loree's had the unfortunate misfortune and
3 opportunity to receive the guidance and adapt
4 that, an infrastructure of support to address
5 those very specific gaps in capability.
6 She's had to manage the, you know, specifically
7 the \$300 million that were provided to the
8 Department for research in those two broad areas,
9 and manage their proposals with the help of the
10 Army, MRMC. She's had to set up an infrastructure
11 to ensure that in remote areas where we didn't
12 have resources that a telehealth capability was in
13 place to support that.
14 She's had to revamp and revise and update and
15 understand and identify those practices, and she's
16 had to garner and bring together a common
17 framework and vision for the team that she's
18 assembled in this Center of Excellence, and -- oh,
19 by the way, deal with Arnold Fisher as he
20 attempted to assist us in creating a facility that
21 would be the best in the world, not necessarily
22 world-class but the best in the world.

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236

1 And I have to applaud Loree for her ability to
2 adapt and be agile in her receiving of direction.
3 And I know that for you sitting around the table,
4 particularly you folks who are used to specifics,
5 the specifics on the stretch of this program is so
6 large that it would take a week for us to get into
7 the details on this. And I think Loree probably
8 wanted to give you a flavor of where we were
9 headed rather than give you the details, although
10 I know you're hungry for those details.
11 Trust me, there are a lot of details. And if you
12 have some specifics that you're interested in, we
13 can get them to you.

14 BG. SUTTON: Thank you so much, ma'am.
15 In minutes I really didn't quite know how to hit
16 the mark.
17 But what I will tell you as well is that this
18 summer we are holding a State of the Knowledge
19 Summit where we will be able to bring in all of
20 the findings to date and be able to organize them.
21 In fact, I've love to follow up in terms of really
22 how we might be best able to organize and

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237

1 communicate it, because communication -- we know
2 that if we can do everything else right, but if we
3 fail along the way to transform the culture to one
4 that is based upon transparency, trust, and
5 communication -- yes, sir?
6 DR. WILENSKY: Please keep the question
7 short and the answer short --
8 BG. SUTTON: Yes.
9 DR. WILENSKY: -- so we can get onto our
10 next session.
11 DR. COLEND: Dr. Sutton, so you have
12 large-scale operational issues.
13 BG. SUTTON: That's correct.
14 DR. COLEND: You have outreach from --
15 that reaches from in theater all the way back home
16 to Central Kansas. What are the key health
17 services questions that you're looking for in
18 terms of how to say the Psychological Health
19 Committee could help you with in terms of specific
20 operational or health services research questions?
21 BG. SUTTON: They include a great, great
22 question. One of the things that we are very

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238

1 interested in doing is evaluating how we can best
2 integrate psychological health aspects into the
3 primary care setting so that we can again do what
4 we can to erode those barriers of stigma as well
5 as to prepare our primary care and other
6 specialties, to be able to recognize and meet
7 these needs.
8 We know at this point that it's a complex set of
9 problems that we know that health quality care,
10 research -- and Chuck Engel was our point of
11 contact on that -- I'd love to bink Linda. I'll
12 be glad to get Chuck in contact with you because
13 that's an important aspect that we'd like to be
14 sure to cover.
15 Thanks so much. ma'am.

16 DR. WILENSKY: There are two more
17 follow-on. Mike, did you want to respond?

18 COL. JAFFEE: I just wanted to remind
19 the Defense Health Board with some of these
20 questions that were the hunger for specifics and
21 the oversight that Ms. Embrey mentioned, that the
22 TBI Subcommittee was set up with parallel duties

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239

1 and missions, one of which was, like other Defense
2 Health Board committees, provide guidance and
3 advice and recommendations with regards to TBI
4 policies to the Department of Defense.

5 The other mission was to serve as an advisory
6 panel to the Defense Centers of Excellence and to
7 the Defense and Veterans Brain Injury Center. So
8 in that regard, every time they had met they had
9 gotten in-depth briefings on the overall DOD
10 research portfolio making sure that there's
11 appropriate resources both for the epidemiology
12 characterization diagnosis and treatment; looking
13 at what's going on with clinical issues in
14 theater; following the entire spectrum of care
15 from the battlefield through air evacuation to a
16 medical treatment facility to the VA; looking at
17 the educational efforts going on to all the
18 stakeholders.
19 So throughout all this, a lot of this information
20 has been feds and coordinated through the TBI
21 Subcommittee, who has been providing a very good
22 oversight making sure that some of these issues

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240

1 and gaps are being addressed, and they are being
2 considered.
3 The conduit to the overall Defense Health Board,
4 most of those briefings, I think, are available on
5 the web, but if members of the general Defense
6 Health Board would like those sent separately,
7 we'll be happy to facilitate that. I have the
8 pleasure and honor of serving as a DOD liaison to
9 the TBI Subcommittee and have been making sure
10 that all the information needed by that panel is
11 available to them.
12 And getting at the question of psychological
13 health, one of the things that we have been
14 discussing and working on with Colonel Gibson and
15 the other leadership is trying to particular a
16 joint session of the TBI Subcommittee and the
17 Psychological Health Subcommittee just to explore
18 those types of synergies and support.

19 DR. WILENSKY: Adil?

20 DR. SHAMOO: Adil Shamoo. I like the
21 thinking beyond the box. I think it's wonderful,
22 but at the same time I think we are very

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241

1 science-based.
2 BG. SUTTON: Sure.
3 DR. SHAMOO: And under resource slide
4 you have there, the very first bullet is
5 complimentary and alternative medicine. And my
6 two-part question is why you highlighted that; and
7 second is you call them therapies, and my question
8 to you is if something is called "therapy," has
9 there been randomized clinical trial for something
10 else, and you're calling them therapies and are
11 going to use them for new modes? And I don't
12 recall that there is that many complimentary and
13 alternative medicine who have gone through

14 randomized clinical trials and have not failed to
15 show efficacy.

16 BG. SUTTON: Sir, I stand corrected.
17 When we will get the terminology correct, I will
18 tell you that in terms of our research strategy,
19 it is a very diverse portfolio that does not focus
20 exclusively or primarily on complimentary or
21 alternative forms of medicine, but it does to a
22 wide variety of both preventive, protective

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242

1 treatment as well as, certainly, animal (off mike)
2 at the models.

3 DR. WILENSKY: Ellen, did you have a
4 further comment?

5 MS. EMBREY: Well, Loree's team actually
6 went out with a broad area announcement and
7 actually awarded \$5 million in prospective
8 alternative therapies for PTSD and mental health
9 issues.

10 BG. SUTTON: And that was really out of
11 looking at the first round of research that was
12 funded and seeing that we hadn't emphasized that
13 as an area, and we wanted to get some folks in
14 that area, but you raise a great point, sir, and
15 we'll make that correction.
16 But we put out the \$5 million RFP this Spring. We
17 got some 82 proposals that came in of which we
18 selected 11 in a wide variety of areas. So we're
19 looking forward to getting some hopefully
20 promising results, in fact, that will lead to a
21 stronger level of evidence. So more to follow.

22 DR. WILENSKY: Thank you very much,
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243

1 General Sutton.

2 DR. CARLTON: : Loree, if I could have
3 one question; Gail, one question?
4 The follow-up we had two clues last year that we
5 discussed in January about treatment and
6 prevention. One was the helmet issue, the other
7 was progesterone. Can you give the Board an
8 update on those?

9 BG. SUTTON: Yes, sir, thanks so much.
10 The helmet issue working with the folks from the
11 Riddell Football Helmet Company as well as with
12 our own internal scientists, both the material
13 developers, the combat requirements folks, as well
14 as our medical team brought together, convened
15 that group and looked at three sets of data on
16 helmet specifications.
17 The point at that time had been to issue a request
18 for information based upon the collaborative forum
19 that we brought together. The decision was made
20 instead to move towards a request for proposals.
21 And my understanding is that that process is
22 underway right now to make sure that we both have

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244

1 a set of helmet specifications that provides both
2 concussive protection as well as ballistic
3 protection.
4 And so I appreciate, General Carlson. Thank you
5 so much for your help in that area and convening
6 that meeting, actually, early last January that
7 really made that collaboration come together.
8 In terms of progesterone, we're -- the folks at
9 Emory, of course, have done a lot of the leading
10 work in progesterone, and we've got some work
11 right now that we're very interested in seeing
12 what the results come out, you know, to see where
13 we can go move forward with this. I'll have to
14 get back to you in terms of any further details,
15 but certainly, whether it be progesterone, or
16 prazelon, or Norend, or a number of different --
17 or Anasetyl cystine for hearing mitigation loss
18 -- I mean there are a number of different agents
19 that we have funded clinical studies to really
20 follow up and see what efficacy we can identify.
21 I don't know, Mike, is there anything you want to
22 add to that in terms of the progesterone trial?

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245

1 COL. JAFFEE: NIH is involved with the
2 multicenter trial --
3 DR. WILENSKY: Can you go to the
4 microphone?
5 COL. JAFFEE: I mean that's a promising
6 therapy. NIH is involved in a multicenter trial,
7 and it's been a key topic of some of the
8 collaborations and meetings that the DOD has had
9 with the NIH, too, to make sure that we're working
10 together on that initiative.
11 DR. WILENSKY: Thank you very much. We
12 are going to move on to Dr. James Kelly, who is
13 currently serving on the Traumatic Brain Injury
14 External Advisory Subcommittee. He's also
15 Professor in the Departments of Neurosurgery and
16 Physical Medicine and Rehabilitation at the
17 University of Colorado School of Medicine in
18 Denver.
19 In addition, he is the attending neurologist at
20 the University of Colorado Hospital of Denver and
21 Aurora, Colorado. Recently, selected Subcommittee
22 members traveled to Fort Carson for a site visit

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246

1 to learn about the postdeployment testing
2 administered to Service members returning from
3 Iraq and Afghanistan. Insights gained from this
4 will be shared in the brief.

5 Dr. Kelly's presentation slides may be found under
6 Tab 8 of your binders.
7 DR. KELLY: Dr. Wilensky, Dr. Poland,
8 Ms. Embrey will be back, I suppose.
9 DR. WILENSKY: She'll be right back.
10 DR. KELLY: I hope so because it was her
11 question that we were addressing, and I would
12 really like for her to hear the answer at some
13 point. If not, I'll have a private conversation.
14 Thank you, all, Board members. This is my second
15 meeting, and perhaps as you've just heard about
16 the announcement as I come inside, I can no longer
17 be an External Advisory Committee member, and so
18 I'm assuming that I won't be doing this again at
19 least from the TBI External Advisory Committee
20 perspective. But it's an honor to provide this
21 information and entertain your questions.
22 These are the 13 members of our Committee, our

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247

1 Subcommittee. With us today are Drs. Lockey and
2 Parisi. I don't think anyone else is here, but
3 what we had was a site visit just last week, and
4 part of the reason that you have such an
5 incomplete handout at this point in your binders
6 is because we just finished and wrapped this up on
7 Friday and did the work on Saturday, and I flew
8 here on Sunday, and so it's a little bit light.
9 And I will be adding slides that you'll see on the
10 screen that do not appear in your binder.
11 The last visit -- my last visit with you -- was
12 followed by a meeting of our Subcommittee at the
13 National Naval Medical Center in Bethesda, and
14 that included a presentation on PTSD research by
15 Colonel Charles Hoge, who I know has addressed
16 this group as well. And then TBI screening was
17 addressed by Colonel Jaffee, actually, along with
18 Kathy Helmick from Defense and Brain Injury Center
19 and David Chandler from the VA.
20 Our Subcommittee then met as a work group only
21 with Drs. Langlois, Iverson, and myself at Fort
22 Carson just last week. Our guests were

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248

1 psychiatrists Dr. and Colonel David Orman and Dr.
2 Lisa Brenner, a neuropsychologist at the Denver
3 VA, who has been engaged in research in this
4 regard, and Commander Ed Feeks.
5 Just so that we're on the same page with some of
6 these things and perhaps the people in the room
7 all know this, but I suppose some won't, what the
8 glossary will need for this brief discussion is
9 what a PDHA is, which is the Post Deployment
10 Health Assessment, which was done within 30 days
11 of redeployment. So when someone is leaving Iraq
12 or Afghanistan, it can be done 30 days before or
13 30 days after.

14 It is typically done right before leaving and
15 returning home.
16 Post Deployment Health Reassessment is done around
17 90 days later, and you actually have those, or
18 should, as paper copies that were just handed out,
19 in case you're not familiar with the content.
20 They have some of my own handwritten notes on
21 there, so we'll be guided by that as well.
22 The WARCAT, which is specific, I believe, just to
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249

1 Fort Carson at the present time is the warrior
2 Administrative Retrospective Casualty Assessment
3 Tool that was created by Colonel Heidi Terrio and
4 her colleagues. And then there's an annual
5 periodic health assessment, the PHA, and I'll just
6 mention that briefly.
7 The question we were asked to address by Ms.
8 Embrey was, are the PDHA and the PDHRA responsive
9 to the postdeployment needs of Service members?
10 That was the basic question we were asked to
11 address, and she went into more detail with the
12 question, but that's basically it. Questions
13 inherent within that question are, what is the
14 optimal way to screen for traumatic brain injury?
15 when should it be done? How does this process
16 guide management?
17 Could this screening be used to inform policy
18 regarding TBI and related disorders? And to bring
19 up Colonel Hoge's concern, are the word "dazed"
20 and "confused" the right words to talk a bout the
21 threshold injury, the mildest form of mild TBI?
22 And then again, how do we accurately attribute

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250

1 symptoms either to psychological distress or to
2 traumatic brain injury? Colonel Hoge has been
3 very articulate in talking about misattribution,
4 the assignment of symptoms to the wrong problem,
5 to the wrong disorder. Also, how do we avoid
6 iatrogenic TBI, if you will, which is when we
7 actually tell somebody they have a problem that
8 they don't; not iatrogenic in the sense of
9 treating and causing a problem, but this is truly
10 assigning a diagnosis when we get it wrong. And
11 then can we influence outcome by introducing the
12 expectation of recovery? Can we actually arrange
13 for people to get better partly because they
14 expect to get better?
15 Traumatic brain injury, the diagnosis is made
16 based on what actually happened to the person at
17 the time of the injury. This goes back to our
18 experience, my experience in the sports medicine
19 world watching the injury happen right before our
20 eyes, or having athletic trainers on the field.
21 And as you may know, many of us who have been
22 doing this research for our academic careers have

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251

1 been brought in by the DOD to help inform the
2 thinking as to what happens, how does it work,
3 what is the natural course of recovery -- Dr.
4 Parkinson?
5 And so we've been watching those sorts of things
6 in some detail in the civilian world, and now
7 we're applying it here, and I am telling you that
8 what's going to happen is quite the reverse. The
9 civilian population is going to benefit from this,
10 somewhat unfortunate, of course, in its origins,
11 but this military experience will then inform us
12 about brain function, dysfunction, psychological
13 overlay and so forth in ways we've never
14 understood before.
15 Under wartime conditions, self preservation often
16 requires that that Service member continue to
17 fight and dismiss the symptoms. Physical injury
18 frequently occurs coincident with that intense
19 emotional response, so now if we're looking at
20 screening, since mild TBI could easily be
21 dismissed under those circumstances as
22 unimportant, given the circumstances of its

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252

1 occurrence, retrospective screening is our next
2 best option, which is really what this is all
3 about, the PDA -- PDH -- I'm sorry, PDHRA. This
4 is the injury event we're talking about largely.
5 In the Fort Carson experience, 88 percent of those
6 reporting a concussive experience received that in
7 a blast exposure, and you can imagine not only the
8 force involved in such destruction but the impact,
9 psychologically, that has on someone anywhere in
10 that vicinity.
11 So what are the obstacles to figuring this all
12 out? Well, this problem is poorly understood, and
13 the individuals who are experiencing it themselves
14 are worried about the possible stigmatizing
15 effects of the invisible injury. People don't
16 seem to understand them because they look fine.
17 They're worried about being perceived as damaged.
18 They won't get where they want to go in life if
19 they're perceived as dysfunctional in some
20 invisible way.
21 They often want to avoid being singled out amongst
22 their herd mentality, as the term was used, the

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253

1 idea that were all uniform, we're doing the same
2 thing, we're members of a team, "I'm not going to
3 say I've got a problem," and then, of course, the
4 career implications down the road.

5 There are other concerns that many of you in this
6 room will understand better than I do as
7 epidemiologists about injury surveillance issues.
8 You have to use the right instruments to be able
9 to produce meaningful information about injury
10 surveillance. And I'm not sure we got that right.
11 Identifying residual symptoms and problems so you
12 have to not only look at what happened right now
13 when you're filling this out, but what is that
14 long-term effect? what about comorbidity in terms
15 of posttraumatic stress disorder. Depression,
16 life stress, all of the things that had been
17 mentioned already with family impact and so forth,
18 huge issues for these individuals. And then the
19 overlapping of mild traumatic brain injury and a
20 multitude of behavioral health issues: people who
21 have not only cognitive defects from a concussive
22 injury but the psychological overlay as well that

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254

1 influences life in so many ways.
2 Then there's also the identification of treatment
3 and rehabilitation needs which is really, how do
4 we help these individuals?
5 Now, I'm sorry this didn't project right, but I'll
6 tell you what the bottom line of this is. Somehow
7 when I transferred this, it changed colors. We
8 got into this business of screening for these
9 injuries late in the game. The Afghanistan
10 invasion occurred in 2001; the Iraq invasion began
11 in 2003; the mandated VA screening began last year
12 in '07, and it was May of this year, 2008, that
13 the Department of Defense mandated the wording you
14 have before you be done on every Service member
15 returning from theater. So you can imagine how
16 many individuals had exposures who are already out
17 there, injuries of various kinds, psychological
18 concerns and so forth that we had not adequate
19 surveillance on.
20 Then we found as we delved into this there was an
21 evolution of the screening tool itself. There
22 really has been only one validation study

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255

1 involving a screening tool, and that was an
2 original three-item tool. You actually have a
3 four-questioned one.
4 I should point this out, in the page that at the
5 top there it says, "Sample," if you go back to
6 what would be the third page and No. 9, there are
7 four parts to Question No. 9 which really
8 constitute the screening for traumatic brain
9 injury, primarily mild traumatic brain injury, and
10 that's really what we are working off of. But
11 that was not the instrument that was used in the
12 validation study.
13 It was also not the instrument used in the Rand

14 Corporation study, so now we've got two different
15 wordings, two different numbers of questions and
16 answers, two different manners of being
17 administered as well. Then we find out that this
18 is not the tool that the DOD studies previously
19 reported had used; this was fairly new, and it's
20 not the tool that's used in the VA screening
21 system. It has different working at the VA level,
22 and actually, also, has the application in a

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256

1 computer sense that if you say no on Question 9-A,
2 let's say, the you skip 9-B,C,D.
3 So if you're really looking for information that
4 could be gleaned by the full complement of
5 questions, the VA system doesn't gather that. The
6 DOD system is different.
7 So the other issue we discovered is that the DOD
8 and VA screening tools are specific to
9 deployment-related mild traumatic brain injury
10 only, not in any other context when they're on
11 duty on off duty in any way. It says,
12 specifically, "during this deployment" in the DOD
13 version, you have.
14 The VA version says "during this or any past
15 deployment." So you could skip over all kinds of
16 injuries that have occurred in the meantime or in
17 different settings.
18 The other issue here in terms of consideration is
19 our VA system really is caring for about 40
20 percent of those eligible in the current wartime
21 returnees age groups. So there are 60 percent of
22 those individuals who have served in OIF and OEF

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257

1 back in the United States now eligible for
2 veterans' care and are not receiving it. So
3 they're in the civilian population. We have no
4 way of getting to them in the current scheme.
5 And as I mentioned, the VA screening requires
6 ongoing symptoms. You aren't considered to have a
7 TBI in their system unless you have ongoing
8 symptoms from the injury. It makes perfect sense
9 if you're a VA, because your concern is taking
10 care of the person with symptoms, but if you need
11 a surveillance instrument, it's deficient
12 immediately because those people have dropped off:
13 You're no longer symptomatic. As far as that
14 system knows, you never had TBI.
15 All of you know that screening has its pitfalls
16 with false positives and false negatives. Both
17 can be problematic in either direction. The issue
18 here for us is that we don't want to fail to
19 identify service members who have been injured.
20 We have to increase the sensitivity as best we can
21 to not miss those people. But we also don't want
22 to misidentify soldiers as injured if they have

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258

1 not, and give them a problem, send them down a
2 pathway in the health care system that is
3 inappropriate for the nature of their problems.
4 One of the problems that we have is terminology
5 with the actual threshold of injury. It's widely
6 accepted in the medical literature that the
7 hallmarks of concussion are confusion, a
8 confusional state, neurologically-based
9 confusional state and/or amnesia. So much of the
10 sports world functions on that basis. The
11 guidelines that I helped write say that a
12 transient confusional state because of a blow to
13 the head on the football field, even if the
14 individual remembers what happened, still is a
15 concussion. It's the mildest form of concussion,
16 but you can understand the problem by using the
17 words "confused" or "dazed," or something like
18 that, because that could easily have happened to
19 somebody startled by that blast who was not
20 actually impacted in any other way.
21 So semantically and conceptually, these can be
22 mistaken for psychological problems, including the

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259

1 dissociative experience, and it adds considerably
2 to the complexity of simply trying to do
3 surveillance of these injuries.
4 The other part of this, of course, is we have to
5 keep in mind that the brain is the organ of the
6 mind, and so when someone has a psychological
7 problem such as PTSD and they have the residual
8 effects of a mild TBI, there is over an overlap.
9 And there's a growing body of evidence in the
10 civilian literature to say that mild TBI increases
11 the likelihood of posttraumatic -- well, stress
12 disorder and various other psychological
13 disorders. And Colonel Hoge's work has helped us
14 with that in the military as well.
15 So since there are several variations on the
16 screening tool, most studies have used slightly
17 different versions. These different versions
18 yield a different results under the circumstances,
19 including different symptoms that are on the
20 checklists, and then we get to what is the annual
21 physical assessment checkbox assessment called
22 "the periodic health assessment," which lacks

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260

1 uniformity across Services. No two Services use
2 the exact same form, and it has nothing specific
3 to TBI or TPSD in it except for areas you can fill
4 in if those are problems. So it doesn't cue you,

5 so to speak.
6 Some of the mild TBIs under the circumstances,
7 whether they are in deployed settings or not, may
8 be missed altogether under those circumstances.
9 So the recommendations that we're able to come up
10 with at the present time is that the DOD should
11 emphasize strategies for improving early
12 identification of mild TBI concussions in theater.
13 The best measure we have of brain injury is what
14 happened to that person's neurological function at
15 the time of the injury.
16 As is typically done now, the PDHA should continue
17 to be done in theater. This is done oftentimes as
18 people are gathering within days or weeks before
19 departing, coming back home, sometimes even on the
20 airplane ride home. We have no particular problem
21 with that if it's done seriously; however, people
22 sometimes get through this system without having

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261

1 had that filled out, so you're not kept in theater
2 simply because you haven't filled out a form. And
3 so we need to have some other way to review
4 whether it's been done and perhaps do it for the
5 first time back stateside, if it hasn't been done.
6 The other part of this is, since right now it's
7 not part of a uniform data set, we would suggest
8 looking into having this part of the AHLTA system,
9 which is the record-keeping computerized database
10 for DOD. The DOD, we would hope consider
11 implementing the automated behavioral health
12 clinic for all Service members. I'm not sure that
13 that's being done, and it's a little bit out of
14 the TBI world and more into the psychological
15 health world. But Dr. Orman was very helpful in
16 talking to us about how that could be used.
17 And then the model that is used at Fort Carson
18 where there's a face-to-face clinician
19 verification of what happened to that individual
20 should be done using somewhat more detailed
21 questions, as you see in the handout that I've
22 provided.

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262

1 Toward the back -- I guess it's the last two
2 physical pages that you have -- are the form that
3 is called the WARCAT that is used at Fort Carson
4 that, as you see if you were to go through it in
5 some detail, would actually be much more specific
6 for mild traumatic brain injury experiences. You
7 see where I scribbled in "witnessed," the problem
8 being here, of course, being it's foolish to ask
9 an individual, "were you rendered unconscious?" I
10 mean if you were, how are you supposed to know?
11 And so we need a witnessed loss of consciousness;
12 otherwise the question is, "Is there a gap in your
13 memory? Is there time you can't account for?"

14 That's the amnesia part of it. We need both of
15 those.
16 So something equivalent to this -- and we're not
17 saying that this is perfect, but certainly an
18 improvement over simply screening by using a piece
19 of paper for an individual.
20 Service members should be instructed by their
21 commanding officers on the importance of doing
22 this honestly. The recommendation was made that

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263

1 somebody who is in their chain of command has the
2 individual before they go into their small group
3 rooms to fill these things out and have their
4 individual sessions; that they're told not by the
5 medical personnel but by their chain of command:
6 You do this right. You take it seriously. This
7 has impact on the rest of your life. Do it right.
8 Then the results of this whole process we would
9 hope that PDHA, the WATCAT, and the behavioral
10 health process could be integrated and shared with
11 the VA as well as the private sector where so many
12 of these individuals ultimately go to. I don't
13 pretend to understand how to make that happen. I
14 don't know how we would even make it available for
15 people like me in my academic career at the
16 hospital where I see patients, but those are the
17 kinds of things we would need to explore because
18 so many of our returning military are returning to
19 those civilian settings.
20 Future issues we will discuss have to do with
21 prioritizing traumatic brain injury research,
22 looking into the fiscal liability for the

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264

1 diagnosis of traumatic brain injury. This is a
2 concern that has come up in the civilian world in
3 particular. Open discussions regarding the acute
4 distress disorder and PTSD, and again as Colonel
5 Jaffee pointed out, our Subcommittee will be
6 engaging with the Psychological Health
7 Subcommittee in that regard.
8 And then inquiring as to the use of electronic
9 medical records and getting more in detail as to
10 what it is that's done in theater, including use
11 of the cognitive assessment called the MACE,
12 Military Acute Concussion Evaluation, which has
13 been used quite a lot already in theater. We will
14 take on the question, and I know Ms. Embrey has a
15 question about the computerized neuropsychological
16 testing. That will be another agenda item.
17 We will look into the joint theater trauma system
18 and engage as best we can with the individuals who
19 are expert in that. We will talk about additional
20 psychological health and merge traumatic brain
21 research. We will look at organizational
22 structure of related military TIB programs. There

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265

1 are almost every month something that I hear about
2 that's happening at a specific military treatment
3 facility or somewhere that I didn't know about.
4 And here, as a member of this Subcommittee, we
5 need that information coming in.
6 And then I would hope that as I move off to become
7 the Director of the National Intrepid Center of
8 Excellence that the TBI Subcommittee would have
9 at least some role in oversight of our
10 organization as we move forward.
11 I'll stop there and take questions. Thank you
12 very much.

13 DR. WILENSKY: Thank you very much. Are
14 there any questions that people would like to
15 pose? Yes?

16 DR. DETRE: Not questions, just a couple
17 of minor comments. As Dr. Kelly pointed out, it
18 is becoming clearer and clearer and clearer that
19 any prior brain injury, even minimal brain injury,
20 may predispose to posttraumatic stress disorders;
21 however, the current psychiatric literature which
22 was still in the tradition at the time when we

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266

1 didn't have an organ system, we just talked about
2 the psyche or, by itself, content that's primarily
3 on comorbidity such as alcoholism and anxiety
4 disorder for PTSD.
5 What I'm trying to say is that when people joined
6 the Armed Forces, then the do not know who has had
7 any traumatic brain injury. In other words, we
8 have no idea with what vulnerabilities they are
9 enrolling people into the Armed Services and
10 whether or not they will be more vulnerable
11 therefore to PTSD. That's one comment I wanted to
12 make.

13 The other comment is that I believe the promise of
14 imaging studies in my TIB at the moment are
15 interesting in an experimental stage but not
16 terribly validated. On the other hand, it's
17 crystal clear that blast injuries do affect the
18 vestibular system, and there are relatively
19 inexpensive, reliable, and valid ways of assessing
20 them, and I was wondering whether that shouldn't
21 be part of the protocol.

22 DR. KELLY: Colonel Jaffee might want to
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267

1 speak to that as well, but that is part of the
2 testing and assessment that we're already doing in
3 the civilian sector.
4 As perhaps you know, blast injury has not only the
Page 117

5 concussive mechanism but also the barotrauma on
6 the ear itself, and perhaps a much more complex
7 and a multitude of causes for internal injury.
8 And, yes, in fact that is being investigated at
9 present time, and there are research protocols
10 that have been begun in that regard.

11 DR. WILENSKY: General Sutton?

12 BG. SUTTON: Dr. Detre, thank you so
13 much for those comments. Regarding your initial
14 point, yes, we are working with the training
15 doctor in personnel communities so that we can
16 identify what would be that brain-based
17 assessment; from the time of accession and early
18 career development, to be able to obtain, for
19 example, what have been the prior exposures or
20 concussion incidents that an individual may bring
21 to the Service as well as, what is their preferred
22 cognitive learning style?

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268

1 Let's figure out, you know, how can we tailor a
2 decision-making strategy and a leader development
3 strategy that really pertains to their diurnal
4 rhythm, you know, a variety of factors now that
5 are coming forward with the recent research that
6 we really do want to take advantage of so that it
7 moves beyond what has been more of an industrial
8 era and olfactory approach to really customizing
9 our care, whether it be in health care or in
10 leader developments.

11 So we would look forward in consulting with you as
12 we do down that road. Thank you.

13 DR. WILENSKY: Yes?

14 DR. BREIDENBACH: Dr. Kelly?

15 DR. KELLY: Yes, sir.

16 DR. BREIDENBACH: Is "dazed" and
17 "confused" the gold standard against which the
18 instruments are tested, or is there something more
19 concrete?

20 DR. KELLY: What actually happens in the
21 clinician verification is talking with the
22 individual Service member about, what actually

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269

1 happened to you?
2 And so if there's a span of time that under the
3 circumstances that individual could not act on the
4 information that they were processing, if they
5 felt as if there was something that they couldn't
6 make sense of for even if it's seconds, which is
7 not uncommon under the circumstances, then that is
8 what is used as the standard for determining that
9 a concussive event had occurred.

10 Better, more certain, would be an amnesia, a gap
11 in memory after the event, certainly at the time
12 of the event, including the event and sometime
13 thereafter, so that a person not uncommonly in a

14 civilian accident, for instance, would not
15 remember the parts of the car crash as it was
16 happening and thereafter. And the next thing they
17 know, they're standing outside the car. They
18 don't know how they got out there.
19 Something equivalent to that would then be also
20 the standard, if you will, that there was as gap
21 in memory.
22 That is well established in the medical literature

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270

1 from animal work all the way through human
2 experience as to the gap in the memory.
3 witnessed unconsciousness is the one that there's
4 absolutely no quibbling about. That's the one
5 thing that people all say obviously, a brain
6 injury has occurred, but it's those milder two,
7 without and with amnesia, that we struggle with
8 even now.

9 DR. BREIDENBACH: So is it so clear-cut
10 that it's not necessary to do the following, or
11 has this been done? Have you taken case histories
12 and asked different clinicians to make or not make
13 the diagnosis? Or it just not necessary?

14 DR. KELLY: That has not been done in
15 this setting, to my knowledge. That's a good
16 point.

17 MS. EMBREY: Dr. Kelly?

18 DR. KELLY: Yes, Ms. Embrey.

19 MS. EMBREY: Thank you so much for what
20 you've come up with to this point. I just want to
21 give you a little bit of deep history on what
22 these forms were originally intended to do, and

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271

1 they're not a substitute for a clinical practice
2 guidelines once you have an assessment of risk
3 that is sufficient to refer for care. And we do
4 need -- we are legislated by law to accomplish the
5 postdeployment health assessment and the
6 predeployment self assessment. The postdeployment
7 reassessment was done based on research findings
8 that indicated that some of the symptomology
9 associated with deployment wasn't appearing or
10 wasn't manifesting until, you know, six to nine
11 months after deployment.

12 The evolution of these forms was to identify
13 people at risk for further evaluation, not to be
14 the evaluation tool itself. And the forms have
15 gone from a four-page form to now a nine-page
16 form, and the time it takes to implement this in a
17 responsible way is becoming increasingly
18 difficult.

19 So the issue really is, do we need to have this
20 level of specific kinds of things in this form, or
21 should it be amended to the provider's clinical
22 practice guidelines for more specific follow-up.

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272

1 In other words, is there a better set of questions
2 that we could be asking that would be sensitive
3 and specific without coming up with a 10-page
4 form, with the same questions being asked inside a
5 period of six months at least three different
6 times, because sometimes I get feedback that we
7 aren't answering the questions right, so we keep
8 asking it until they answer it right.
9 DR. KELLY: Well, I think that last
10 point you make could very well be the case on some
11 occasions, but the other part of it is some people
12 don't recognize they have a problem until later,
13 which is exactly why you say that the PDHRA, the
14 reassessment, is done much later. And, in fact,
15 if you look at that, you'll see that it's more
16 heavily loaded to pick up on psychological
17 behavioral issues, stress-related problems and so
18 forth, and the mechanisms of blow to the head and
19 concussive effects are not so apparent in the
20 reassessment as they had been in the earlier
21 questionnaire.
22 And I don't know that we've actually got the

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273

1 questions right, but I think they're pretty darn
2 close the way they are right now. One of the
3 things we need to avoid is having them be so
4 different that we're comparing apples to oranges,
5 which has happened every step of what we're trying
6 to figure out, what does this assessment show us?
7 And every study used a different approach. So we
8 couldn't really make fair comparisons.
9 But I think the most recent version that you have
10 in your hands now is pretty darn close to what we
11 need. The increased specificity that is added by
12 a clinician interview and making sure that the
13 discussion is had, even if it's very brief, around
14 those questions, that increases the targeting
15 then, ultimately, of care needs for people, the
16 identification of the person with problems, much
17 more so than the form could by itself. And I
18 don't know that we have any other way of doing it
19 except that kind of interview format.

DR. WILENSKY: Dr. Casscells?

DR. CASSCELLS: Dr. Kelly, thank you so
much for you and your committee's hard work on

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274

1 this and independent work. And I want to agree
2 with most of what you've said, and maybe you can
3 persuade me of the rest of it.
4 The issue of a face-to-face encounter I think is

5 very important, and I think it's terrific if
6 you've come up with that. The Chairman of the
7 Joint Chiefs of Staff has made the same
8 recommendation, and he's not a doctor, you know;
9 he's a Navy Admiral, and I think he's right. The
10 pushback is that this is expensive. My feeling --
11 and I better finish the thought now -- I just
12 realized this is a public meeting -- but the point
13 is we don't really have a secret on this. The
14 point is if we are going to do this, it is
15 expensive; but face-to-face eyes-on, you know, is
16 obviously going to have a better specificity and a
17 better sensitivity because a person can fill out
18 that form, you know, no, no, no, I'm fine, I'm
19 fine, because they want to get home, you know,
20 I'll come back to that problem of, you know, to
21 hiding the symptoms even from yourself when you
22 fill out the form.

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275

1 But if you -- the face-to face I think validates
2 some -- if you see just a practicing doctor,
3 internist and cardiologist, if I'm talking to
4 someone, I'll get a better sense than on the
5 questionnaire. My patients fill out a 16- page
6 questionnaire for t he first visit, so I'm not
7 going to apologize to anybody for a mere nine
8 pages after they've had a head injury. But they
9 all fill it out, even the ones with the 6th grade
10 education will fill it out and, you know, with
11 broken spelling. But they'll fill it out.
12 Now, the face-to-face, if somebody has a downcast
13 gaze, avoid your eyes, they may tear up if you ask
14 them about their family or about their pets, or
15 about their, you know, boyfriend or girlfriend,
16 and this is particularly true after you've done a
17 physical examination. So an ordinary internist
18 with no specific psychological training can
19 uncover a lot.
20 So can a chaplain, and Reverend Certain mentioned
21 that earlier, and so can the nurse practitioner or
22 social worker. They all bring different ways of

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276

1 bonding with that person and eliciting the PTSD
2 symptoms. And it's critical, I think, to
3 distinguish them from the TBI to the best you can
4 because so many of the people have had a head
5 injury, they have ongoing symptoms. When you
6 really get down to it, what's bothering them is
7 PTSD, some feeling that they, you know, for some
8 reason the jokes aren't funny, the food doesn't
9 taste good, they feel like they haven't done what
10 they might have done, or perhaps they've done
11 something that they shouldn't have done -- it may
12 not even be true. But this sticks to people like
13 glue. It's hard to strip it away. So I think a

14 face-to-face is very important.
15 Now, to pay for it, we don't have the people, so
16 we're relying on instruments like this: The
17 better they are, the better we can identify people
18 at risk and then use the face-to-face on a subset,
19 the ones who have a high, of a worrisome score,
20 the confinement, I think.
21 I hope this is what you're talking about.

22 DR. KELLY: It actually is a little bit
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277

1 different than that. And we learned a lot about
2 that in the Fort Cason setting where the
3 face-to-face is done typically by a clinical
4 social worker or some other educated person who's
5 a clinician, but not a psychologist, psychiatrist,
6 even internist who's doing other parts of the
7 exam. This is somebody who knows what to look
8 for, has experience doing that part of the
9 questionnaire, and this is a part of a day's
10 processing in which they're getting their hearing
11 tested, they're going back to their pharmacist if
12 they're on medications to see what they're
13 supposed to be taking, they go through their
14 physical examination on postdeployment all in that
15 same span of time. So they're really not adding
16 much in the way of time or high-level professional
17 expertise, but they're still getting at the
18 information with sensitivity that's much improved
19 over what would otherwise be simply gotten on a --
20 on a --

21 DR. CASSCELLS: No, I don't doubt that,
22 and I'm not sure how many layers to build into
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278

1 this. To me, the chaplain, the trained nurse or
2 social worker, or nutritionist, physical
3 therapist, if they have a psychological
4 orientation and they've had some training, they
5 can do a darned good job.

6 DR. KELLY: Right.
7 DR. CASSCELLS: There are still some
8 people who for some reason won't quite say what's
9 on their mind until after there has been some
10 examination. On the other hand, there are people
11 who would tell -- will speak to anybody but the
12 doctor. We have to admit that, we doctors, so it
13 takes a group of people, and we don't catch
14 everybody.
15 But let me turn to this other issue real quick of
16 the filling out the form in theater. That's where
17 I disagree with you, and I've talked to too many
18 soldiers, and I was one over there filling out the
19 form on a little hand-held, sat there in the
20 clinic in Baghdad and did it. And the --
21 everybody, we just were all laughing and saying,
22 heck, no, the answer is no, no, no, no, no, let's

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279

1 get on the plane, don't take a risk of being kept
2 back in the sand here. And that was October --
3 excuse me, November of 2006, and Iraq was a very
4 different place then.
5 But my concern is your recommendation, please put
6 your spoken words on the slide because you said
7 they could fill it out in the theater or on the
8 plane. There's a huge difference. When you're on
9 the plane, you know you're going home, and if
10 you're a Reservist, you want to get home. You
11 don't want to be stuck in theater, detained
12 because you answered yes to a question.
13 Let me ask you a quick bit of advice, though. One
14 issue: what is the pathology of these lesions?
15 You're a neurosurgeon, and you and Dr. Parisi
16 ought to be able to advise me a little bit. On
17 the boxers and the football players, we see
18 micropunctate hemorrhages, we see leukocytes, we see
19 neurons dropped out, we see gliosis, right? We
20 don't know much about these soldiers and marines,
21 but I'm concerned, very concerned about the fact
22 that some of these kids may have hemorrhage, and

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280

1 we haven't made clear to get them to quit taking
2 aspirin. I'm not sure any war fighter ought to be
3 taking aspirin. We're looking very seriously
4 about that, and as a neurosurgeon and as a
5 pathologist, I'd like your thoughts on it, because
6 we're short on data in this area.

7 DR. KELLY: I'd be happy to speak to it.
8 For my entire career and all the writing I have
9 done and in a sports world, aspirin and platelet
10 aggregation inhibitors are all avoided. It's very
11 clear that the acetaminophen products for pain and
12 so forth that can be used safely are offered and
13 recommended, and that anything, especially
14 aspirin, is to be avoided for the first 48 hours.
15 And if I'm not mistaken, Colonel Jaffee, that's
16 what the treatment protocol said as we came up
17 with a variety of different what to use/what not
18 to use medications.

19 DR. CASSCELLS: You're talking like a
20 doctor. I'm talking about what the patient --
21 what the soldiers take themselves. I'm talking
22 like a soldier, and you're telling me like a

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281

1 doctor.
2 DR. KELLY: Again, I don't know --
3 DR. CASSCELLS: What the doctors
4 prescribe is a fraction of the -- it's what the

5 soldiers themselves are taking.
6 DR. KELLY: You make a good point, And
7 actually, in the sports world, those individuals
8 just go into the trainer's office and grab Motrin
9 out of a big jar and take it on their own. They
10 don't even account for it.
11 DR. CASSCELLS: So you don't tell the
12 NFL coaches to stick with Tylenol instead of
13 aspirin?
14 DR. KELLY: Absolutely. Absolutely.
15 DR. CASSCELLS: I do.
16 DR. KELLY: We sure do.
17 DR. CASSCELLS: I stick my nose in it,
18 and all the coaches that my kids are involved with
19 on that basis, am I telling them the right thing
20 to keep the aspirin out of the locker room?
21 DR. KELLY: Absolutely. And one of the
22 things we know, and you're speaking to the issue
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282

1 of neuroimaging is a standard CT scan which is
2 typically done if somebody has a headache, and you
3 have to worry about a subdural or something, will
4 not pick up on the particular hemorrhages that we
5 see commonly on gradient echo MRI scanning in a
6 conventional MRI scanner of 1.5 Tesla strength,
7 widely available here in the United States. And
8 we see petechial hemorrhages not uncommonly now.
9 Those were areas of bleeding and could very well
10 cause a problem, as you're alluding to.
11 And so that preventive strategy is absolutely part
12 of what we do recommend.
13 COL. JAFFEE: I'd like to make a
14 comment, getting back to one of the things that
15 Ms. Embrey said, is are we asking the right
16 questions? And we just heard a presentation from
17 Dr. Kelly, and General Sutton earlier in her
18 presentation said the IOM gave us a set of
19 recommendations. One of those specific
20 recommendations made by the IOM last week was for
21 the DOD to use what they called the brief TBI
22 screening. It's a specific instrument, and what
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283

1 that is, that's that three-question screen that
2 Dr. Kelly was talking about that had been
3 validated.
4 So the fact that we have the IOM, who's making
5 that recommendation to use those as the questions,
6 and the fact that we have the Defense Health Board
7 making these recommendations which pretty much
8 incorporates those three questions, tweaking the
9 language and adding that fourth question, tells us
10 that we're on the right track with only four
11 questions using the recommendations.
12 So it's really, I think, reassuring to us to have
13 both bodies making the very similar

14 recommendations, getting back to your question,
15 ma'am, of are we asking the right questions.
16 DR. WILENSKY: Dr. Parisi, do you want
17 to make a comment?
18 DR. PARISI: Would you go back to the
19 question about the pathology? I don't think we
20 really know what the underlying pathology of these
21 lesions are. We assume that it's a white matter
22 axonal injury similar to what other traumatic

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284

1 injuries are, but we really -- it hasn't been
2 studied, and that's something we desperately need
3 to do to try to get a handle on this.
4 And after I go to Dr. Kelly's comment about MR --
5 MR's a very important part of the picture that
6 could provide (off mike) imaging of white matter
7 and potentially identify lesions.
8 MS. EMBREY: Yes.
9 DR. WILENSKY: Let us make it short,
10 please, because we need to take a break so we can
11 get on to Dr. Parisi as soon as the break.
12 DR. MATTOX: One quick question to you
13 and Dr. Parisi, the next speaker on a
14 recommendation.
15 I think we're five years away from a marker of the
16 injury that is either a mediator base, metabolic
17 based, or even genetic based. Therefore strong
18 consideration of developing a tissue, blood plasma
19 bank for later analysis. We have lost all of that
20 that has not been corrected to this point, another
21 major reason why a joint pathology center needs to
22 be maintained.

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285

1 DR. KELLY: Very good. Great idea.
2 DR. WILENSKY: We are going to take a 15
3 --
4 MS. EMBREY:
5 DR. WILENSKY: Yes?
6 CAPT. MCKENNA: Could I ask one
7 question? Dr. Kelly, in terms of these screening
8 tests that you have, the goal is to make them 100
9 percent sensitive, and I realize sometimes a
10 Service member may come back and not be truthful
11 on it perhaps because they can't get on the
12 airplane, as we discussed here. But I was
13 wondering if there is any evidence or studies out
14 there to look at, what percentage of Service
15 members perhaps do not answer truthfully on these,
16 not because they are not going to get home, but
17 because they are afraid of the -- what the
18 ramifications of that might be in terms of their
19 career?
20 DR. KELLY: There isn't much data, but I
21 can tell you what we do know. In a couple of
22 studies is that in about one in four change their

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286

1 response when they're in the clinician-verified
2 setting. And it's not clear why. We don't
3 necessarily know the motivation, we just know that
4 the change was, "Oh, yeah, that really did happen
5 to me," and, "Oh, yeah. Is that what that means?"
6 And so we don't know for sure were they
7 withholding information in order to expedite their
8 exit, or if, in fact, they're just now concluding
9 more honestly something really did happen that
10 they need to address.

11 But that's as close as we've come.

12 DR. WILENSKY: Thank you very much, Dr.
13 Kelly. We're going to take a 15-minute break.
14 Dr. Parisi has generously allowed us to have that
15 break, and then have his report. Please reconvene
16 at 3:30.

17 (Off the record at 3:14 p.m.)

18 (On the record at 3:34 p.m.)

19 DR. WILENSKY: We are ready to start.

20 Please take your seat. Can we have your
21 attention, please? We're ready to reconvene. Our
22 2:30 speaker -- now at 3:30 -- is Dr. Parisi,

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287

1 Professor of Laboratory Medicine and Pathology at
2 the Mayo Clinic. As Chair of the Scientific
3 Advisory Board for Pathology and Laboratory
4 Services and the Chair of the Review Panel for the
5 Department of Defense Draft Plan for the
6 establishment of the Joint Pathology Center, he
7 will discuss the draft report of the Review of the
8 Department of Defense Concept of Operations
9 document for the establishment of the Joint
10 Pathology Center.

11 Similar to the presentations on the Task Force on
12 the Review of DOD Biological Defense Research
13 Program Review Panel update, due to technical
14 difficulties at the last virtual Board meeting, a
15 few Core Board members on the phone were unable to
16 hear questions answered. Please feel free to use
17 this opportunity to ask the questions you were
18 unable to do so in the November briefing.
19 Dr. Parisi.

20 DR. PARISI: Thank you very much, Dr.
21 Wilensky. First of all, let me point out that the
22 people that were on the Review Panel that

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288

1 remembers all the members of the Scientific
2 Advisory Board for Pathology and Laboratory
3 Services of whom Dr. Reddick, and Dr. Patricia
4 Thomas, and Dr. Florabel Mullick are here today as

5 well as selected Defense Health Board Core members
6 and other Subcommittee members were on this Review
7 Panel.
8 If we look at the review process, I just want to
9 point out the highlights of the review process, on
10 June 16th Dr. Kelly presented a question to the
11 Defense Health Board, and the details I'll show
12 you momentarily, and then this was followed by a
13 briefing at the September 4th and 5th Defense
14 Health Board meeting at which Dr. Kelly and
15 Colonel Baker presented the CON OPs, you know, the
16 concept of operation for this JPC. And that was
17 really our first involvement in this process.
18 On October 2nd, we had a teleconference with the
19 Review Panel members that was followed by a
20 document that was drafted, and then the document
21 was sent around for review. We presented the
22 preliminary review, as Dr. Wilensky told you, on

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289

1 November 20th, and the plan is to send a revised
2 report, submit a revised report to Dr. Casscells
3 in the near future.
4 Historically, the National Defense Authorization
5 Act for 2008 which became public law, the statute
6 recognized the following: The President should
7 establish and maintain a Joint Pathology Center
8 that should function as the reference center in
9 pathology for the Federal Government.
10 There was also a clause that if the Department of
11 Defense felt that this could not be established in
12 DOD, then it could go to some other federal
13 agency. But the determination was made that the
14 JPC could function within DOD.
15 In addition, GO OP specified that the JPC should
16 provide at a minimum diagnostic pathology
17 consultant services in medicine, dentistry, an
18 veterinary sciences. It should provide pathology
19 education to include graduate medical education,
20 including residency and fellowship programs and
21 CME programs; it should provide diagnostic
22 pathology research. And then the fourth item was

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290

1 the maintenance and continued modernization of the
2 tissue repository of which we'll say more in a
3 moment.
4 So, Dr. Kelly, if we go back to his original
5 question, he asked the Defense Health Board to
6 review the implementation plan for the
7 establishment of the JPC within DOD and to comment
8 specifically on the plan's appropriateness and
9 feasibility for DOD within the context of the BRAC
10 law.
11 So the Joint Group, this was a labor of many, many
12 man-hours, lots of discussion, lots of going back
13 and forth, and the review, then, is based on the

14 concept of operation that was provided in
15 September both as a power point and as a written
16 document. A Joint Pathology Working Group was
17 formed that organized -- I'm sorry, that developed
18 this CON OPs. and Dr. Kelly, I believe, was the
19 chair of that. And they provided a vision and
20 mission.
21 The vision was to be the Federal Government's
22 premier Pathology Reference Center, a supporting

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291

1 military health system, DOD and other federal
2 agencies, an otherwise federal-wide reference
3 center for pathology, and the mission would be to
4 provide world-class -- again getting back to our
5 world-class - diagnostic subspecialty
6 consultation, education, training, research, and
7 maintenance and modernization of the tissue
8 repository.
9 So the Review Panel -- I'm sorry, here we go, one
10 slide behind -- the Review Panel again spent many
11 man-hours reviewing the documents with lots of
12 discussion, and the conclusions of the Review
13 Board I am going to present now. So the panel
14 members concurred with the vision and mission that
15 we just read, and we believe that the DOD needs to
16 consider a number of other findings and
17 recommendations as the more extensive strategic
18 plan for the JBC is developed.
19 We believe that the DOD has a unique opportunity
20 to develop a Center of Excellence. The panel
21 recognize the enormous contributions of the
22 Department of Defense to medicine and the

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292

1 importance of continuing this legacy by providing
2 world-class, if you will, or excellence in
3 pathology consultation, research, and education.
4 And the AFIP might serve as a model for the JPC,
5 has been a leader in the world of pathology as is
6 well known to everyone in the room. I think the
7 spirit of the current law is actually very similar
8 to what was expressed by then President Dwight
9 Eisenhower in his dedication of the AFIP Building
10 in 1953 when he said, "And now I dedicate this
11 building to the conquest of disease so that
12 mankind, more safe and secure in body, may more
13 surely advance to a shared prosperity and an
14 enduring and just peace."
15 So again, I think the vision of this excellent
16 center, or the Center of Excellence for Pathology,
17 was really for the good of mankind and the good of
18 medicine.
19 If we look at the specifics of the plan that was
20 presented, there were several areas that were
21 addressed. One of the clinical scope of service,
22 and the CON OPs said that there would be

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293

1 subspecialty service represent ed in this JPC, but
2 the subspecialties were not specified.
3 In-theater support was mentioned, but we suggest
4 that the development of other supporting
5 diagnostic technologies could also be applied to
6 in-theater support by the JPC to the in-theater
7 soldier. The process of handling individual
8 cases, including the accession, triage,
9 disposition flow and so on reporting, and quality
10 assurance wasn't really detailed, but I think that
11 needs to be -- we believe that that also needs to
12 be better detailed.
13 The QA, the quality assurance, is a very important
14 piece of this since good treatment, adequate
15 medical treatment, good medical treatment requires
16 and accurate tissue diagnosis so that if a tissue
17 is inappropriately diagnosed or the subsequent
18 treatment may be in appropriate, and actually this
19 has not only implications to the patient's well
20 being but also it has medical/legal implications
21 as well.
22 We stress that there needs to be interactions with

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294

1 other federal agencies. For example, the VA, NCI,
2 NIH, Indian Health Service, CDC -- all these are
3 potential collaborators or partners that could
4 utilize the expertise that the JPC could provide.
5 Also the Armed Forces Medical Examiner has needs,
6 other pathology needs that the JPC again
7 potentially could provide. So the scope of the
8 activities that the JPC could do are considerably
9 broader, I think, than what was expressed in the
10 original plan.
11 The positioning of the JPC was in the Command
12 structure generated probably the most amount of
13 discussion.
14 I think we finally agreed, the Panel finally
15 agreed that the DOD was a logical choice for the
16 location of the JPC; however, there is a unanimous
17 agreement that the JPC should be at a higher
18 level. Ideally, it should be an independent
19 entity with high visibility and not buried in the
20 Department of Pathology, a hospital Department of
21 Pathology where the priorities, the vision, and
22 the mission are completely different.

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295

1 So I think we all -- there was unanimous agreement
2 about that point that the JPC really needs to be
3 at a higher level, somewhere higher in the Command
4 structure. If that is to occur, then it also

5 requires a governing board, and we suggested a
6 Board of Governors could be named to provide
7 governance. These could oversee the activities of
8 the JPC, but also provide advocacy, for example,
9 for funding issues, have connections to civilian
10 medicine, to perhaps industry, and actually make
11 -- again expand the scope of the JPC to include
12 many more activities.
13 I would suggest that the Board of Governors would
14 be a dynamic group of people, hopefully recognized
15 leaders in pathology again that would provide
16 active input into the oversight of the JPC.
17 Organizationally-wise, we suggest that the
18 workloads need to be clarified and periodically
19 assessed and utilization of business principles,
20 obviously, the LEAN and 6-Sigma, the well-known
21 business principles should be used.
22 As far as staffing, the key to the success of the

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296

1 JPC is providing appropriate administrative and
2 laboratory support staffing for the pathologists.
3 I know at Mayo our motto is each pathologist has
4 one secretary, and on some busy times -- for
5 example, I was on service last week -- and I had
6 two secretaries doing all the typing and all the
7 work.
8 So it's very important to maintain work flow, that
9 adequate administrative support be available.
10 Similarly, the laboratory has to be very
11 responsive and be able to perform stains, use
12 special techniques, and they need to do those
13 promptly and do them well so that you have to have
14 a well-staffed and experienced laboratory to
15 provide good material for tissue interpretation.
16 We also suggest that the working group identify
17 the subspecialties, as I mentioned earlier. The
18 staffing issues are significant. There's really
19 no mention of this JPC will be staffed by a senior
20 pathologist, senior seasoned pathologist or a more
21 junior-level pathologist. Considerations have to
22 be given to staff -- I'm sorry, to salary -- and

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297

1 probably even more important than salary are the
2 research and educational opportunities that would
3 bring high-quality pathologists and attract
4 high-quality pathologists to work at the JPC.
5 The work load figures that were provided included
6 cases only from the Military Health Service and
7 the VA and didn't include any outside other cases
8 from other federal agencies. And so we suggest
9 that actually a survey of other federal agencies
10 be done to determine, realistically determine, a
11 work load.
12 Also a very important piece of this is the case
13 complexity. The model that was proposed had so

14 many cases being done by X-number of pathologists.
15 I believe that that was probably inappropriate. I
16 think that the -- I suspect that the staffing was
17 based on a general pathology service, not a
18 reference center pathology service. Reference
19 center pathology service gets, typically, very
20 difficult cases, so, for example, if I have 10
21 hernia sacs and gallbladders, I can do those
22 relatively promptly. If I have one dementia case

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298

1 that's very complicated or a tumor that's very
2 complicated, that may take three or four hours.
3 So a case complexity is a very important part of
4 this, and again if it's a reference center, the
5 chances are it's going to be getting more
6 difficult, more complex cases that cannot be
7 handled at the primary hospital.
8 The crown jewel on all of this is the tissue
9 repository, and the tissue repository for those of
10 you who may not know this is comprised of millions
11 of cases. Actually 7,8 million cases,
12 well-studied documented cases, are contained in
13 the tissue repository. Within that case material
14 includes 31 million paraffin blocks and 55 million
15 slides as well as 500,000-plus wet tissue
16 specimens. This is an invaluable resource, an
17 invaluable national resource, invaluable
18 international resource.
19 I mean where else in the world could you go and
20 find 500 cases of glioblastoma? So the potential
21 use of this material is unparalleled. It's an
22 incredible resource and something that has to be

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299

1 preserved and maintained, and again, it gives rise
2 to all sorts of collaborations that could be done
3 both within the Federal Government, with other
4 civilian agencies. Collaborations could be done
5 with civilian organizations, academic and
6 industry, and this is very important in the
7 development of new probes of diseases and
8 therapeutic developments.
9 And this again is especially important as we move
10 to a model of molecular medicine and personalized
11 medicine.
12 As these areas evolve, having tissue samples is
13 going to be invaluable again, and into finding
14 probes to identify these diseases but, more
15 importantly, therapies that could potentially
16 treat them.
17 The research activities as provided, as detailed
18 involved DOD health -- I'm sorry, involved
19 primarily people within the JPC. We suggested
20 that be expanded to include all DOD health
21 agencies and that a research management process be
22 instituted to formally make the research possible

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300

1 so that you have a process in place for
2 rationalizing and improving protocols.
3 Collaboration with other federal agencies and
4 again civilian centers and industry are all key
5 and can strongly enhance the research activities,
6 and it's a win/win situation for everyone.
7 Regarding education and training, there is a
8 mention of some of the educational activities
9 would be taken over by the Uniformed Services
10 School -- Uniformed Services University of the
11 Health Sciences. These were not really detailed
12 but there really was no mention about subspecialty
13 training and pathology. There was no mention
14 about subspecialty pathology courses or the fate
15 of the radiology pathology course which annually
16 attracts over a thousand trainees in radiology
17 across the country.
18 So all these kind of things, although they may not
19 be important on a day-to-day basis, five years
20 down the road, if they disappear, they're going to
21 have a significant impact on particularly the
22 training, on the educational experience of new

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301

1 trainees in medicine.
2 Other areas of interest could be expanded to
3 include aviation and accident forensics and
4 investigations in a crisis have to be consistent
5 with treatment priorities and challenges as they
6 evolve. And this was probably going to be a
7 moving target. It's going to differ from year to
8 year.
9 Regarding the equipment and special design
10 requirements, there has to be in place policies --
11 there has to be in place the potential for making
12 the state of the art laboratories and maintaining
13 them, and providing the adequate support for them.
14 Work flow considerations we thought were very
15 important to consider. The plan, as presented,
16 included the separation of the different
17 components of the JPC, some located at the Forest
18 Glen complex and some at the Bethesda complex.
19 And even though there is a 15 or 20-minute shuttle
20 service that potentially could run between the
21 two, this was really not an ideal situation, and
22 we'd strongly recommend that all these activities

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302

1 be consolidated on one campus.
2 Again, I already mentioned the establishment of
3 state of the art laboratories. There is a mention
4 of the molecular laboratory being formed. Again,

5 that needs to be detailed and is again an
6 especially important area, as we find molecular
7 probes for identifying some of these different
8 diseases.
9 So these are our recommendations. Then we believe
10 that the DOD has an exceptional opportunity to
11 build a Center of Excellence. It has to obviously
12 be within the constraints of the law and meet the
13 federal -- meet the needs of all the federal
14 agencies. We really would want to emphasize that
15 this be an adaptable and flexible structure that
16 can evolve as different problems and different
17 issues arise. And this would also meet the
18 further future requirements of the DOD.
19 We also would want to ensure that all federal
20 agencies could take advantage of the expertise
21 that the JPC could provide. Subspecialty areas,
22 again need to be identified. The organizational

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303

1 structure should be sufficiently flexible and
2 ought to be adequate to allow for the JPC to
3 thrive. The education and training components
4 again, we certainly would like to see those
5 expanded and continued.
6 Governing structure and bodies should be involved
7 to ensure that all stakeholders are represented.
8 Performance metrics should be developed and
9 periodically reported, and we would be happy in
10 the Defense Health Board to review these on a
11 periodic basis.
12 Again, I want to emphasize to ensure that the JPC
13 thrive and do well, I think there has to be
14 sufficient funding, space, staff, equipment and
15 facilities be available to allow this center to
16 develop, and again, the key is flexibility in
17 allowing it to be potentially expandable. And
18 these would ensure that premier service is
19 provided.
20 The budget that was presented we thought was
21 probably inadequate for all the activities that
22 were projected, and these again, you have to

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304

1 include the maintenance and modernization of the
2 tissue repository. There's also a potential for
3 other funding streams. This could be done through
4 collaborative agreements with other federal
5 agencies, so, for example, the VA could provide a
6 VA piece, NIH could provide an NIH piece and so on
7 to fund different work that the JPC does.
8 So I think by some creative thinking partnerships
9 could be made with other federal agencies and with
10 civilian and industry that would fund a lot of the
11 JPC activities.
12 The Board strongly believes that the tissue
13 repository is a national if not international

14 treasure. There's really nothing else like it in
15 the world, and every effort must be made pursued
16 to guarantee that it's preserved and utilized
17 appropriately.
18 The strategic plan needs to be developed. The
19 scope and functions I think need to be more
20 clearly defined, and this will allow, then, the
21 realistic determination of work load and space
22 requirements. But I think it might be best to

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305

1 step back a bit and think about the big picture
2 here.
3 We would be pleased to be involved. Hopefully, we
4 would like to be ideally involved early in the
5 process of the development of this strategic plan.
6 And I'll leave the rest of the time for questions
7 or discussion.

8 DR. WILENSKY: Let me remind people that
9 this is the second time we've discussed the
10 report. It's really for questions that have not
11 been raised previously to raised, and also to
12 remind people we are not here to discuss whether
13 or not this Joint Pathology Center is the
14 appropriate successor to AFIP.

15 If there are comments within that -- Ed?

16 DR. KAPLAN: Kaplan. Would you repeat
17 what you said about the leadership? I wasn't
18 clear about the issue about there being senior
19 pathologists versus junior pathologists.

20 DR. PARISI: Well, you can staff a
21 pathology center with mainly junior people, or you
22 can staff them with mainly senior people. Ideally,

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306

1 you'd probably want a mix of both. But to attract
2 senior people, you need to provide them with first
3 of all salary; you need to provide them with other
4 opportunities.

5 It's very unlikely you're going to find a high-
6 level senior pathologist be attracted to someplace
7 where he's only doing case work. He wants to be
8 able to do research; he wants to have some
9 educational activities; he wants to be able to
10 teach, probably. So the makeup of the staff is
11 very important to the success of this. I would
12 see it as being headed by some senior high-level
13 pathologist and certainly each section being
14 headed by a senior-level person. That would be
15 the ideal world.

16 DR. KAPLAN: Thank you.

17 DR. WILENSKY: Dr. Casscells?

18 DR. CASSCELLS: Dr. Parisi, thank you
19 and your Task Force members for this thoughtful
20 report, and, you know, it was at the previous
21 meeting that you and I spoke, and we realized that
22 we hadn't gotten you the brief that was coming to

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307

1 you, and we got a late start on this. Thank you
2 for your patience.
3 This has been a difficult issue for us, and we've
4 got plenty of insight and plenty of advice from
5 Congress and all kinds of interested parties on
6 this and, you know, we've been caught a little bit
7 between BRAC and the National Defense
8 Authorization Act, so thank you for working to
9 bring in new ideas and to give us the flexibility
10 to retain the best, strengthen the rest and so
11 forth.
12 And I want to particularly comment Dr. Gullick for
13 sustaining the performance and morale of a BRAC --
14 it's a terrible term. It sounds like violence has
15 been done to you or something illegal. We've been
16 BRAC'd. And the fact that that term is used give
17 you some insight into how people feel. So she has
18 kept the team moving forward, and I want to thank
19 her publicly for that, and say there are
20 recommendations that I don't take exception to,
21 and we'll have an ongoing discussions, Dr. Kelly,
22 Dr. Embrey, and I, on how to implement these

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308

1 recommendations, and as soon as the discussions
2 get too hot, I'm going to resign. I think that's
3 going to be about January 20th.
4 But thank you, Dr. Parisi. I'd like to hear some
5 frank comments from other stakeholders, please.
6 DR. REDDICK: My name is Bob Reddick,
7 and I'm a member of the 10th Pathology Advisory
8 Board, and I just want to say that I totally agree
9 with Dr Parisi in terms of his presentation and
10 the information provided to you.
11 However -- and I guess we're not supposed to talk
12 about this -- but sometimes I get the feeling that
13 Rome is burning while we're fiddling, and I think
14 that we need to hopefully get on a much more
15 active way of looking into this because we
16 actually will lose a treasure. We will lose an
17 opportunity or opportunities for us in the future.
18 The question was raised earlier as to whether or
19 not there is tissue available for the traumatic
20 brain injury cases and, as a matter of fact there
21 is tissue available. The Medical Examiner for the
22 Service is here, and he can discuss those kinds of

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309

1 issues. So there are proactive things that are
2 going on, but I think, basically, we need to make
3 sure that we can continue to do those kinds of
4 things and have the Joint Pathology Center, if

5 that's what it's going to (off mike) an AFIP-like
6 Center of Excellence could do these kinds of
7 things that we've all talked about earlier today.
8 Pathology is not an isolated discipline; it's
9 intimately connected with each of the things that
10 we basically have looked at and hear about this
11 morning from initial patient care to final patient
12 care; to biopsies that come out of the theater to
13 biopsies that, or unfortunately in some cases,
14 deaths that occur on the battlefield. These are
15 all within the domains of the pathologist.
16 And, obviously, our goal is to make sure that we
17 take care of the best; that we do the best for
18 these individuals who are involved in illnesses
19 and other injuries, if you will. And so my
20 recommendation, hopefully, is that you all would
21 take this as very good information, very helpful
22 information, and as the person at the head said,

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310

1 this is a way of allowing us to continue to have a
2 Joint Pathology Center that has an excellence and
3 world-class association with it.
4 So I'm just pushing for that. Thank you.

5 DR. PARISI: Thanks.
6 DR. WILENSKY: Are there any other
7 comments or questions that we have not had
8 addressed? Ellen?

9 MS. EMBREY: One of the things that I
10 did not notice in the previous iteration was the
11 reference to forensic, and now the recent comment
12 associated with the Armed Forces Medical
13 Examiner's Office. Is it the recommendation of
14 the Defense Health Board to incorporate the Armed
15 Forces Medical Examiner in the JPC?

16 DR. PARISI: We didn't discuss that as
17 part of the subgroup, as part of our group,
18 because actually those functions were separated
19 out by BRAC, by the BRAC law.
20 On the other hand, the JPC could provide input to
21 the pathology, the further work-up of tissues that
22 are obtained from forensic cases, for example the

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311

1 TBI cases. So a detailed neuropath exam could be
2 done on those cases if that was submitted to JPC.
3 The forensic people wouldn't have the expertise or
4 time or probably the interest to really do it as
5 well as the JPC could.

6 MS. EMBREY: So the JPC would consult to
7 the Armed Forces Medical Examiner.

8 DR. PARISI: Both ways, right.

9 MS. EMBREY: Okay.

10 DR. PARISI: And that could be also
11 applied to other diseased organs, too. There
12 could be further work-up of heart, the pathologic
13 heart specimens, livers -- I mean it could be all

14 sorts of things.
15 MS. EMBREY: Also, Dr. Parisi, I know
16 the issue of -- I mean, to summarize in laymen's
17 terms, because I'm a little slow -- but what I see
18 you saying is the CON OP is good, but you can do
19 more. We need to make sure certain other things
20 get addressed as part of this.
21 And I'm particularly concerned about the reference
22 to staffing and the senior versus junior levels.

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312

1 Is there any kind of industry standard out there
2 for what a senior pathologist makes and whether or
3 not that's even possible within the Federal
4 Government structure?

5 DR. PARISI: Those data are probably
6 available. I think you could probably find some
7 numbers, and you could augment salaries, for
8 example, with grants perhaps from industry, or
9 from other funding sources.

10 MS. EMBREY: (Inaudible).

11 DR. PARISI: There was a -- this problem
12 was recognized, actually, many years ago and
13 resulted in the ARP being formed, the American
14 Registry of Pathology, which provided a civilian
15 input into the AFIP. So that is still on, and if
16 that could be adapted or involved, that's another
17 way to bring senior-level people into something
18 that's more military.

19 DR. REDDICK: The VA has instituted a
20 new pay plan, and that new pay plan offers
21 salaries that are much higher rate than what we
22 have in academics. So there are those situations

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313

1 where VA and military individuals are paid at a
2 higher rate.

3 DR. PARISI: I think the one thing the
4 Subcommittee was adamant about was the pasture,
5 the placing of the JPC within a hospital
6 Department of Pathology were -- we really don't
7 think that allows it to grow and to serve a
8 function as a reference center. Just
9 philosophically, it doesn't make a lot of sense to
10 me. It's not intuitive, so I think it really
11 needs to be at a higher level.

12 DR. WILENSKY: Please be sure before you
13 speak their comments or questions to indicate your
14 name.

15 DR. RUSSELL: I understand that GE
16 announced last year a \$50 million initiative to
17 develop an automated pathology device and series
18 of devices that I think they intend to bring to
19 the market as soon as next year or the year after.
20 Have you considered partnering with either they or
21 any other private sector --

22 DR. PARISI: Well, I think that's -- I

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314

1 think that's an excellent suggestion. That hasn't
2 been explored to my knowledge, but I think all
3 these industry partnerships are potential funding
4 streams, and it's a win/win for everyone.
5 GE is trying to go to the slideless kind of
6 platform where you can eliminate some of the
7 steps, and typical is dialog processing, from my
8 understanding.
9 DR. MULLICK: Florabel Mullick, Director
10 of the AFIP. I am speaking for myself right now
11 as a professional with many years of experience,
12 and I would like to thank Dr. Parisi that I
13 commend him for his report, because without my
14 input, he just described something that I and the
15 rest of the staff of the AFIP -- this is not about
16 the AFIP. As you heard the Professor, the AFIP is
17 BRAC, and we are already aware of that, however,
18 in designing a Joint Pathology Center for the
19 Federal Government, there needs to be a
20 comprehensive plan like Dr. Parisi described.
21 There are still a few things that need to be
22 expanded, even in this plan; however, a Joint

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315

1 Pathology Center has to be an entity; it cannot be
2 a minute part of the Department. It has to have
3 staff that can provide the final diagnosis on a
4 problem. It's not just a consultation -- anybody
5 can consult -- a final professorial diagnosis, and
6 also that the education will absolutely solidify
7 what we all have done for many, many years because
8 it's not just a basic course based on training; it
9 is that the professionals at whatever level, they
10 need to solidify what they are all about.
11 If you are a surgeon, so you take a graduate
12 course like it has been offered -- it should be
13 offered by a reference center -- that would
14 solidify that specialty, not just basic course.
15 The research, also, should be state of the art,
16 and it should have latest equipment, latest
17 techniques. So in summary, the concept of a true
18 reference center for pathology for the Federal
19 Government I believe is what we just heard Dr.
20 Parisi describe, and that has been said for many,
21 many months in other forums.
22 I have one question, and that is, what is the

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316

1 process now for this report? Dr. Casscells
2 mentioned that himself and Ms. Embrey, Ms.
3 Wilensky, I think, are going to discuss it and
4 then it goes to the Secretary of the Army, or what

5 is the process for this report now to go forward,
6 if I may ask?
7 MS. EMBREY: Once the Board -- again,
8 this is an independent set of recommendations to
9 Dr. Kelly, who asked the question for advice. Dr.
10 Kelly will, in his role as the Deputy Assistant
11 Secretary for Clinical Programs and Policies, may
12 take on your recommendation, discuss what we're
13 going to do with that, and the report to Congress
14 on our decision on the way ahead. Is that
15 correct?
16 DR. KELLY: We will go ahead and take
17 the report. It will be referred back to the group
18 that has developed the original CON OPs to revise
19 it, taking into consideration, and then with that
20 we will discuss it at the Joint Pathology Center
21 Working Group where we have representatives of the
22 involved parties, and then it will fully be vetted

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317

1 with that, and then go up the chain for decision
2 process. It's not just that the decision is these
3 recommendations; it fits into how will they be
4 applied in the setting of the CON OPs and what the
5 plan is as we go forward.
6 DR. WILENSKY: Thank you, Dr. Kelly.
7 Any further questions? Mike?
8 DR. PARKINSON: Are the risk of being
9 somebody in a dark room with gauzy cobwebs trying
10 to feel my way through this, if we just -- it just
11 kind of dawned on me, and I've heard this issue
12 several times before -- if we take Congress at its
13 word, this is to be a reference center in
14 pathology for the Federal Government. It does not
15 appear to me, and having heard this on several
16 times although not being directly involved, that
17 we have truly engaged in a meaningful way the
18 stakeholders or the customers of the Federal
19 Government.
20 I mean my own organization, the College of
21 Preventive Medicine, the AMA, John Herbold's
22 organization, the Veterinary Medical Association

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318

1 has tried to get over the concept that there was
2 one health: animal disease becomes human disease;
3 animal prions become human prions. And it seems
4 like the table, if there truly is the Federal
5 Government is a customer of this entity that we
6 need to somewhere have in the process before we
7 sign off on this and send it along, the USDA, what
8 are they doing in terms of veterinary pathology,
9 and global emerging threats? what are we doing in
10 such things as food safety in FDA, and the types
11 of things that we see now -- rapid diagnostics?
12 what are we doing in terms of Department of
13 Energy, the new concern about nanotechnology that

14 nobody is monitoring in terms of the way we detect
15 these in tissue samples? It seems as if it might
16 have been a well-meaning but a relatively cursory
17 look because it comes out of the AFIP legacy in
18 sitting at Walter Reed that perhaps the world has
19 changed in the last 24 months even around an
20 urgency and need for this.
21 Similarly, the claim that the tissue repository is
22 a, quotes,"invaluable resource," or "invaluable

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319

1 national resource," it's kind of like an art
2 collection, you know, who's willing to bring it
3 out in the light of day and pay for it? So if
4 there is indeed an invaluable resource to seven
5 million specimens at a time where we, discovering
6 diseases that are reemerging, what is the true
7 commercial potential of a business plan to take
8 that to pharma? To the new emerging technologies
9 companies? To the new -- I'm not sure that we've
10 done enough real homework here in a way to make
11 this credible to the citizens and the Congress
12 about whether or not we've done it.
13 A lot of good work, but I just, as I'm listening
14 to this again and thinking about the things that
15 we talk about -- John and others -- maybe there's
16 a lot more here, and I would hate to see us give
17 short shrift of this as it works its way up to get
18 it out, you know. We may not have done all our
19 homework. Just a hypothesis.

20 DR. WILENSKY: Dr. Kelly, why don't you
21 respond, since you're --

22 DR. KELLY: I will say that we did not
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320

1 do the Department of Agriculture; however, at the
2 working group the Health and Human Services was
3 invited, the VA has been invited and been a full
4 participant in there. So the people who are
5 currently using, saw the light and were involved,
6 I think that that is something to be developed in
7 the future.

8 I don't think that the formation is likely the
9 conclusion, and that there is more to come as you
10 look at a Joint Pathology Center and where the
11 future goes for some of these things that you're
12 talking about.

13 DR. PARKINSON: I think that we'd like
14 to encourage collaborations. I mean I think if
15 you start thinking about potential collaborations,
16 there a whole world that opens up that you haven't
17 even thought about, and I mean that could utilize
18 this material that's in the repository.

19 DR. CARLTON: : I was part of the
20 discussions that went on 15 years ago. Everybody
21 wanted this and no one would pay for it. And what
22 I don't see -- I agree with Mike Parkinson, I

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321

1 don't see that anything has changed. We're just
2 going through the whole discussion again.
3 We went to pharma, we went to all the educational
4 opportunities. We went to emergency review
5 committees, we went to every university and said,
6 "Boy, you're sending your kids for weeks or six
7 weeks, or whatever, for the formal coordination of
8 pathology and clinical science, and no body would
9 pay for it."
10 And so I haven't heard the answer to Mike
11 Parkinson's question that we fought with 125 years
12 ago that led to the ultimate position that we
13 don't have an effect 100 percent (inaudible)
14 pathology.

15 DR. WILENSKY: Yes?

16 DR. HERBOLD: John Herbold. Can I make
17 one positive statement and reinforcement of what
18 Dr. Parkinson alluded to that it's popular right
19 now to talk about one medicine, one health, one
20 ecology, and I'm one of the disciples of that.
21 But I also remind people that it's the Armed
22 Forces and the Department of Defense and the

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322

1 Military Medical Departments that actually do
2 invoke and practice one medicine, one health
3 across the social/cultural and work setting.
4 And so this is an opportunity to look at a Center
5 of Excellence to demonstrate across all the
6 functions of the Department of Defense how a Joint
7 Pathology Center would function. And then, of
8 course, I think the unanswered question is, do we
9 bring in partners and move to a setting like the
10 Canadians have with a joint food safety and
11 emerging infectious diseases, and Department of
12 Agriculture and HHS together?
13 So there is an opportunity here to take on the one
14 medicine mantra, and I thought we had a Center of
15 Excellence called the Armed Forces Institute of
16 Pathology, so I think we need to raise that to the
17 next level as we morph. We morphed from the Armed
18 Forces Epidemiology Board to the Defense Health
19 Board. I think we can morph from the Armed Forces
20 Institute of Pathology to a DOD Joint Pathology
21 Center that offers services to other federal
22 agencies.

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323

1 DR. WILENSKY: Dr. Carlton, when the
2 issue was raised previously, was there serious
3 thought given to not allowing students to come in
4 unless somebody was paying their freight?

5 DR. CARLTON: : Oh, absolutely. Those
6 discussions went on, and it wasn't a matter of
7 anybody said we want to get rid of the AFIP; it
8 was a matter of the Congress said: Here's your
9 X-number of dollars to the Military Medical
10 Services, and you went from most year to least
11 year, and what happened was then the AFIP didn't
12 get staff, it didn't get funded, and eventually we
13 stopped sending our kids there because we didn't
14 have a quality product. We didn't have the staff
15 that could handle them.

16 DR. WALKER: David Walker. I have
17 reviewed the Department of Veterinary Pathology at
18 the AFIP, and it's one of the premier departments.
19 I mean it's an outstanding residency program, and
20 one of the most difficult theory is in veterinary
21 medicine.

22 And I really strongly endorse the establishment of

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324

1 a nationally risk factor leading quality reference
2 Center of Pathology that's not only diagnostic
3 pathology, looking, like, through the microscope
4 which Joe Silva here is always joking to me that
5 that's what I spend my time doing. But also,
6 really, using the contemporary technology that
7 Mike Parkinson brought up, moving on up to that
8 next level.

9 And I think that's going to require money to
10 recruit highly-esteemed pathologists, not only in
11 diagnostic pathology to do the reference work but
12 also to do peer reviews, competitive research, and
13 to have the visionary leadership is going to see
14 what these things are to be able to look and see
15 what's going to be there down the road in the next
16 megatrend that we need to be ahead of instead of
17 behind.

18 DR. WILENSKY: Dr. Kelly?

19 DR. KELLY: Yes. Let me just make two
20 comments on some of the things that happened. On
21 the veterinary pathology, we won't go through the
22 whole history of the AFIP and the BRAC process,

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325

1 and the JPC, but there was a process in between
2 there where the AFIP was looked at and all of the
3 functions that weren't continued in the BRAC law
4 were reviewed for whether or not they should be
5 retained. And the veterinary pathology program is
6 one of those functions that the Army determined
7 that they should retain it as part of the Walter
8 Reed infectious disease -- I think it's the --
9 we're -- the Army's going to retain it. We could
10 bet where that's going.

11 So that is further under discussion now of whether
12 it should stay separate because that decision was
13 made before there was a JPC. So that's under

14 discussion, not resolved.
15 The second thing is on the tissue repository, is
16 that we contracted out independent source to
17 evaluate the tissue repository and to give us
18 recommendations on the best way that that it could
19 be used, utilized, and brought into the future,
20 and modernized. We don't have that report out
21 yet, and so it's all part of the process, but it's
22 not there. We need to press on as we're going.

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326

1 DR. WILENSKY: Adil.
2 DR. SHAMOO: A lot of things that are in
3 the repository are the historical things. They go
4 way, way, way back. I got my hands on from their
5 tissues from soldiers that died in the Pacific, a
6 scrub typhus which affected 18,000 soldiers during
7 World War II, and no one knew until that point
8 what is the target of the disease. Where are these
9 organisms growing until we could go back and find
10 those tissues in their repository and do the
11 (inaudible) chemistry on them. The actual disease
12 itself, you couldn't understand what it was until
13 at least that part was answered.

14 DR. WALKER: You know, I think a lot of
15 our functions if government. The function of
16 government is maintaining things that are good for
17 mankind. Maybe they don't general money or maybe,
18 you know, they're costly. But they're good for
19 mankind, they're good for medicine. They push the
20 envelope forward, and I see the repository in the
21 JPC in this kind of role.

22 DR. WILENSKY: I think we have had
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327

1 adequate discussion on this, and I want to make
2 sure our last presenter has fair time.
3 Our last speaker today is Mrs. Anne Moessner, who
4 is currently serving on the Traumatic Brain Injury
5 Family Caregiver's Panel. She was an Assistant
6 Professor of Nursing at the Mayo Clinic College of
7 Medicine, a traumatic brain injury clinical nurse
8 specialist in the Department of Nursing and a
9 Project Coordinator in Traumatic Brain Injury
10 Model System of Research, Department of Psychiatry
11 and Psychology, all of which are at the Mayo
12 Clinic in Rochester, Minnesota.
13 Ms. Moessner will provide an update on this
14 congressionally mandated subcommittee's
15 activities. Her presentation slides are under Tab
16 10 in your binders.
17 Thank you for your patience.

18 MS. MOESSNER: Oh, absolutely. And
19 thank you for the invitation to come today. I am
20 very pleased to be speaking on behalf of the TBI
21 Family and Caregiver Panel, as the final speaker
22 today, and objectives of my talk this afternoon

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328

1 include the following: Just reviewing the purpose
2 of the Family Caregiver Panel, review where we are
3 in the curriculum development process, describe
4 the module approach that we have developed and
5 where we are in that particular process, review
6 the time line that we're under and that we're
7 hoping for in terms of completion of the project
8 and a final report to the DHB, and then outlining
9 the agenda of our next meeting which is coming up
10 soon in a few weeks.

11 So this panel was convened as a result of the
12 National Defense Authorization Act, and this
13 mandated the establishment of a 15-member panel to
14 develop coordinated, uniform, and consistent
15 training curricula to be used in training family
16 members in the provision of care and assistance to
17 members and former members of the Armed Forces
18 with traumatic brain injury.

19 So the law stipulated that the panel be comprised
20 of several different types of individuals, so
21 those of us who are medical professionals such as
22 myself, who have a history of providing traumatic

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329

1 brain injury, care and particularly support to
2 caregivers, but also including those involved in
3 the care of individuals with combat-related
4 traumatic brain injury, including psychologist
5 with both TBI and psychological health experience.
6 We also have representatives who are themselves
7 family caregivers or represent agencies or
8 associations that advocate for families. We have
9 representatives from the Department of Defense and
10 the Department of Veterans Affairs, and they both
11 have health and medical expertise in traumatic
12 brain injury. We have a couple of members on the
13 panel who have very specific expertise in the
14 development of training curricula, and then we
15 also have family members of Service members and
16 veterans who have traumatic brain injury.
17 We have presented Colonel Jaffee, who's been up to
18 speak a couple of times today. We have presented
19 some of the basic work that we've been up to, to
20 the Defense Health Board a couple of times in the
21 past. Today again we want to review what we're
22 here for, and let you know what we've been up to,

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330

1 so I will look to Colonel Jaffee to help answer
2 questions at the conclusion.
3 So, basically, we convened for the first time in
4 January, and, you know, the role of the DVBIC,

5 which is the lead agency that's working with our
6 panel is to provide programmatic and logistical
7 support to the panel. So basically, they're
8 helping us develop the curricula, according to the
9 congressional mandate. They reviewing the content
10 for accuracy because of their obvious expertise in
11 that domain, and then also looking to help the
12 panel towards implementation of the curricula
13 evaluation and the ongoing effort for the family
14 caregiver education.
15 The tasks of the panel itself are to -- were to do
16 a literature review, The goal is that this be an
17 evidence- base curriculum and that we develop
18 consistent curricula so that all family members
19 have access to similar information, and that we
20 recommend mechanisms and a plan for dissemination
21 and again evaluation of the curricula.
22 So we've had meetings so far. Again, the first

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331

1 one was held in January of 2008. The appointments
2 were not through at that point in time, so that
3 meeting really centered around the panel coming
4 together for the first time and getting to know
5 each other, sharing ideas, discussing things like
6 what currently exists out there in the literature.
7 We did have a presentation by Dr. Mary Carlisle,
8 who had done a literature search on basically the
9 caregiving experience, and there's a lot of
10 information in the literature on traumatic brain
11 injury, common effects, helpful interventions and
12 so forth, but not very much on the caregiving
13 experience per se. So Dr. Carlisle reinforced to
14 us that there's not a lot of evidence out in the
15 literature exactly how do you support families,
16 but just that families seem to do better,
17 caregivers, if they're educated and supported in
18 some manner.
19 We talked a little bit about multimedia efforts,
20 and that we agreed as a group at that point in
21 time that the needs of family caregivers are
22 complex and that they do change over time.

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332

1 The second panel meeting, the appointments were
2 through at that point in time, so the chair
3 position was finalized at our second meeting in
4 June. We also spent more time on trying to pin
5 down what will this curricula look like? What
6 sorts of modules or must-have information should
7 be part of the curricula? So much of that two-day
8 meeting was spent on that.
9 We did in the middle of the second meeting have a
10 town hall meeting, and I'll talk about that in
11 just a minute. Today I will also report a little
12 bit more information on what happened at our
13 meeting, a very recent meeting in November, and

14 then in a bit I'll be talking about our January
15 meeting.
16 So the town hall meeting, the curriculum, the
17 panel is very interested in this curricula being
18 based on needs and on input from family
19 caregivers, people with traumatic brain injury
20 themselves. So along with having members on our
21 panel who represent people, you know, that are
22 affected by traumatic brain injury in their

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333

1 family, we did hold a town hall meeting.
2 Invitation to this meeting was widely
3 disseminated, and the meeting was attended in
4 person here in Washington, D.C., but was also web
5 cast around the country. There's a list on your
6 slide, handout as well as here about organizations
7 that were represented at the town hall meeting.
8 Some of the input, just to summarize briefly, that
9 we heard from potential end users of this
10 curricula were that family caregivers from past
11 conflicts want to mentor today's family
12 caregivers. We also heard that -- and again based
13 on my years of clinical experience, I feel like
14 this is also an essential component, families want
15 not only education but they want some reassurance
16 that they can get through this experience, and
17 they want a flavor of hope to be present
18 throughout the curricula.
19 They also specifically asked us to insert
20 vignettes or stories of hope and recovery or from
21 experiences learned from past caregivers. The
22 individuals with traumatic brain injury very

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334

1 specifically spoke to us during the town hall
2 meeting about community -- issues around return to
3 community reintegration, per se, specifically work
4 that people with traumatic brain injury do hope
5 to, intend to, plan to return to a productive and
6 meaningful life, and that this curricula should be
7 set up to educate family caregivers in such a
8 manner as to promote that thought.
9 Families want strategies to prevent burnout and
10 also, loud and clear from the people in attending
11 the meeting, not everyone has a family caregiver.
12 So we met again in November, and our recent
13 meeting was actually very successful, I feel. We
14 are a 15- person panel, but we do have some expert
15 resources assigned to the panel. We have some ex
16 officio members, and we have some contingency
17 members. So out of a total group of 22
18 individuals who have been working on the panel, 18
19 attended our December meeting, as did a large
20 contingency of folks from DVBIC who have been
21 increasingly involved and available to us as a
22 panel.

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335

1 And we have contracted out to two expert writers,
2 both Ph.D. level health writers, to work for the
3 panel, essentially. And so we've been giving them
4 information about content, and they've been
5 producing documents for us to review as a panel.
6 To start off our November meeting, we actually
7 also had a presentation by the Center of
8 Excellence for Medical Multimedia. The web site
9 is listed here. If you're not familiar with that,
10 I would encourage you to go ahead and access their
11 web site. Lt. Colonel Randy Mauffrey is working
12 for the Center of Excellence for Medical
13 Multimedia, and he and his group at the Air Force
14 base in Colorado had already begun to develop some
15 multimedia content around traumatic brain injury.
16 And he gave us an updated presentation on, for
17 example, a model of the brain that was interactive
18 whereby you could click on lobes of the brain and
19 have a quick neuroanatomy lesson. And then he has
20 other capacity within his Center as well.
21 Following that presentation, we basically decided
22 to spend the two days getting down to business and

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336

1 meeting and breaking up into modules and forming
2 work groups to really, really start hammering out
3 content. Now that we had writers that were very
4 available and invested in the project, we split
5 ourselves into groups that I feel were very
6 diverse and representative and began to process
7 finalizing the module content.
8 So here today let me review, briefly for you, what
9 the various modules look like for this curricula,
10 and we would invite during the discussion period
11 any input in terms, have we missed something here?
12 Does it look like we're going in the right
13 direction?

14 So the first module is basically an introduction
15 to traumatic brain injury starting with what types
16 of injuries are there? How do you discern between
17 a blast mechanism of injury versus a more
18 traditional direct blunt-force injury to the head
19 and skull? Learning about the brain, basic
20 neuroanatomy lessons: what are the lobes? what
21 functions do they perform? Acute care issues.
22 What does a typical Service member with a moderate

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337

1 to severe traumatic brain injury endure during
2 those first few weeks to months of acute care?
3 Complications. What are the possible
4 complications? We do hear from family members

5 that those first several weeks when someone
6 experiences a severe traumatic brain injury, they
7 don't know what the tubes are, they don't know who
8 the people are caring for them; they don't know
9 about the possible complications, but this is
10 information that they certainly do wish to know.
11 What's normal? Normal, what's an expected course
12 of recovery following traumatic brain injury?
13 There's been discussion today about natural course
14 of recovery. What are the stages that we
15 typically see in individuals as they progress
16 through recovery from traumatic brain injury?
17 What's an expected pace of recovery from this
18 particular injury?
19 And then Module I, and you'll see this throughout
20 the modules, we feel very committed to this being
21 a useful, accessible curriculum whereby the
22 information presented is practical, and it builds

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338

1 not only a knowledge, but it offers practical
2 advice and skills and information that families,
3 we feel like they could, you know, access the
4 curriculum and figure out what to do and how to
5 help. Because most family members will tell you,
6 "We want to help. We want to do the right thing,
7 we do not want to do the wrong thing." So at the
8 conclusion of Module I are some helpful suggestions
9 lists many of which were provided to us by family
10 caregivers. What did they wish they knew during
11 those first several weeks to months of recovery?
12 Module II, then, which is actually the largest
13 module, if I remember correctly, really looks at
14 what are the commonly-known effects of traumatic
15 brain injury across the domains? So physically,
16 in terms of ability to communicate with people
17 again, emotional capabilities, cognitive
18 functioning, and behavioral sequelae. So Module
19 II is really broken down into here are some
20 possible areas. These are areas people with
21 traumatic brain injury commonly struggle with for
22 some amount of time. We do try to preface all of

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339

1 the information we're giving at the beginning of
2 each module with this may apply to your loved one,
3 your service mentor, but to try to have people not
4 be overwhelmed by the amount of information. So
5 we are working out the language here that these
6 may apply; it doesn't mean your service member is
7 going to have everything on the possible lists of
8 issues to go ahead and deal with.
9 And again, under the list of each particular
10 potential issue are related strategies that are
11 intended to be practical, useful. We've spent a
12 lot of time trying to hone the language down so
13 that it's simple, meaningful, and it's not just

14 words to fill up space, but we're trying to get
15 rid of all extraneous information and get it down
16 to words again that are usable and the tips that
17 are practical.
18 Module III talks about the caregiving experience,
19 becoming a family caregiver for a Service member
20 or veteran with traumatic brain injury. And it
21 starts out by reviewing starting the journey.
22 caring for your Service member, caring for

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340

1 yourself, caring for your children, every-day
2 issues that many families encounter that they may
3 not necessarily think about until they get home.
4 Planning for the future, and then how might they
5 find meaning in the experience of caregiving?
6 The final module is very complex and is and will
7 continue to be a challenge to try to explain to
8 family caregivers recovery care, eligibility for
9 compensation and benefits, rehabilitation of
10 medical support, entitlements, benefits. We do
11 have a very dedicated and experienced number of
12 individuals that are working on Module IV trying
13 to explain to overwhelmed stressed-out family
14 caregivers, how do you work with the system? How
15 do you communicate with your health care
16 providers, your case managers in order to get what
17 you need and what are you entitled to?
18 So again, the majority of our November meeting was
19 really focused on specific work in the modules.
20 We did finally go ahead and designate a module
21 worker member to work directly with the writers,
22 with the staff at DVVIC, and with myself because

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341

1 communication was becoming complex. And so that
2 approach seems to have cleaned up the process a
3 little bit, and I feel like we've moving along
4 more quickly due to the designation of some lead
5 content experts in each of the modules.
6 Again, messages from the November meeting, aside
7 from the module work, some general messages, we
8 heard from panel members were again a tone of
9 hope, make this curriculum accessible, make the
10 language supportive, pay attention to reading
11 level, those sorts of ideas.
12 Mild traumatic brain injury, there was some work
13 done during the November meeting on the issue of
14 mild traumatic brain injury. Because this is a
15 caregiver curriculum, most people are looking at
16 it as a caregiver being an individual who is
17 assisting somebody with a more moderate to severe
18 traumatic brain injury. Or if they had a milder
19 injury, certainly there was jewels are more in
20 the moderate to severe domain. But there
21 continues to be a nagging sense among panel
22 members of the need to focus on mild traumatic

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342

1 brain injury as well.
2 As you all well know I'm sure, most people with
3 mild traumatic brain injury, you know, recover
4 relatively well in a short amount of time, but
5 those who don't have big needs, needs that can be
6 as large as somebody with a more significant
7 injury.
8 So the plan at this point in time, there's a
9 little work to develop a Module V perhaps, around
10 mild traumatic brain injury. But that will be a
11 point of discussion at the January meeting to take
12 a formal vote on what to do about that particular
13 issue.
14 Because of our time line, the panel is thinking at
15 this point in time that it is more likely that a
16 print product will be ready and rolled out before
17 a multimedia product. The idea right now is a
18 print product with perhaps a companion DVD taking
19 into account that people learn in different
20 styles. But we are continuing conversations with
21 Colonel Mauffrey about how to perhaps continue to
22 work with he and his group.

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343

1 So the time line at this point in time is since
2 our November meeting, we took advantage of the
3 momentum that had been created by breaking out
4 into specific work groups, the content from that
5 meeting and the interim time between that meeting
6 and December 5th has been forwarded to the health
7 writers. They are working on the next round of
8 revisions. The hope is that the entire curricula
9 will be back out to the panel members by December
10 22nd whereby we meet again January 8th and 9th,
11 and we're hoping again at that point in time that
12 the curricula is near final form because we have a
13 number of other issues to attack at the January
14 meeting, and I'll mention those in just a moment.
15 Following the January meeting, there is a plan to
16 pilot the curriculum, and what that looks like is
17 yet to be decided. There have been lots of ideas
18 about how to actually go about doing that, but
19 that's the activity finalized. Again, based on
20 the pilot, the curriculum will, we assume, need
21 some revision, but that by summer the hope is that
22 a print produce will be out for use with a report

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344

1 to the DHB prepared by July.
2 So the other issues that are on the table -- and
3 these are big issues that we really need to spend
4 time tweakng -- is again reviewing the final

5 content, determining who will write the preface
6 for the entire curriculum. Should that be
7 somebody from the panel? Should that be a
8 so-called VIP? Should that be a family member?
9 So that will be a point of discussion in January.
10 We do have four family members, caregivers who
11 have volunteered to be videotaped, interviewed,
12 and be part of the curriculum in terms of sharing
13 their stories. We are working on finalizing
14 graphics. We have placeholders in some of the
15 modules at this point in time. We need to do a
16 little more on graphics. We do need to make some
17 more decisions about the multimedia, multimodality
18 approach to the curriculum. The Pilot and
19 Evaluation plan needs to be finalized, the
20 communication and distribution plans for both the
21 pilot and for the end product need to be
22 finalized. There has been discussion in all of

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345

1 these areas, but not final discussion at this
2 point in time.
3 We also are looking into V and Department of
4 Defense clearance requirements, what those are,
5 does they exist, and who does this curriculum need
6 to be approved by?
7 And then a big question that has come up in the
8 panel in the last two meetings is, who,
9 ultimately, is responsible for maintaining the
10 curriculum, updating it, and so forth?
11 We feel the benefits of the curriculum are, again
12 giving it consistent message to family caregivers,
13 providing practical tools for coping and for
14 communicating, again with their health care team
15 on how to gain assistance, also giving hope while
16 navigating life posttraumatic brain injury. We're
17 hoping the curriculum is accurate, up to day, it
18 reflects current practice, it's evidence-based,
19 and again that it provides self-management skills,
20 that it's user- friendly, culturally appropriate,
21 and really that it's based on real life needs and
22 experience. And the input again on future users.

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346

1 And at this point in time, there are three, I
2 believe, other -- three or four other panel
3 members, subcommittee members here today, and as
4 it worked out, there is one from each of the
5 modules, so if you have specific questions about
6 the modules, if it looks like we've overlooked
7 content, please let us know. Again, Colonel
8 Jaffee is here as well to field any questions you
9 might have about where we are with our curricula
10 development. So, please, any questions? Does
11 anyone want to raise an issue?
12 Yes?

DR. MATTOX: As an academician,
Page 151

14 sometimes businessman, I have an economic
15 question. I guess it's to the greater Board. Who
16 owns this work product? Where is the intellectual
17 property? Other similar Curriculum, the advanced
18 trauma life support, the ACLS, the Advanced
19 Cardiac Life Support, and on and on, have made
20 millions and millions of dollars for the owners of
21 a course.

22 Sometimes the courses go to families. Soon this
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347

1 war is going to be over, and the major people with
2 traumatic brain injury are going to be civilians,
3 and therefore there is a market. And maybe this
4 isn't the right place to talk about the issue of
5 market, ownership, who sells it, to whom do you
6 sell it to, but the time to protect intellectual
7 property -- there's lawyers in the room, I
8 shouldn't even be talking -- but the time to
9 protect intellectual property is before it's out
10 in the public sector.
11 So I raise this issue.

12 DR. WILENSKY: Okay, I don't know
13 whether -- well, we can see whether we can get a
14 response to that, so if you want to --

15 DR. CARLTON: : Gail, I've got a
16 response to that.

17 DR. WILENSKY: Okay, Dr. Carlton.

18 DR. CARLTON: : what Ken is referring
19 to is when you look at traumatic brain injury in
20 the United States of America, we're dealing with
21 1.4 to 1.5 million per year, so the military's
22 less than four or five percent. And what we've

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348

1 just heard Anne describe so beautifully is a total
2 change in thinking in less than a year. A year
3 ago we talked about we've got to provide a better
4 helmet, provide ballistic protection against a 762
5 round. Now we're recognizing that the fast
6 majority, 95 percent or more, are coming from the
7 concussive effects, and now you've seen we've got
8 a curriculum for it.

9 So it's not an idle question. I think it's
10 absolutely critical and if we get Loree Sutton and
11 Mike Chappy and the group involved, and we make
12 this available as a national product, then all we
13 have to do through the SAMMR, or whoever is going
14 to do that, is establish the teaching modules for
15 the more than a million that you see in the
16 civilian side every year. I think it's a critical
17 question.

18 I think it's a critical question.

19 DR. WILENSKY: Ed.

20 DR. KAPLAN: Kaplan. May I ask a
21 related question? When these modules and
22 educational materials are printed, does it say

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349

1 "Defense Health Board" or approved by, or blessed
2 by the Defense Health Board in any way, and if
3 that's the case, does the Board have an obligation
4 to review the material before it comes out in
5 their name.
6 DR. WILENSKY: Roger?
7 COL. GIBSON: Colonel Gibson -- is this
8 on?
9 DR. WILENSKY: Um-hmm.
10 COL. GIBSON: Okay, Colonel Gibson here.
11 what Anne neglected to mention is the thing that
12 drove this was the 2007 National Defense
13 Authorization Act. Congress says, you will, DOD,
14 you will form a Task Force, you will develop a
15 curriculum for family caregivers -- and, oh, by
16 the way, you'll do it in a year -- and that was
17 the 2007 NDAA. So it's been a little while that
18 we've been working on this.
19 When they finish their curricula, this wonderful
20 group who's worked so hard give it to the DOD. So
21 who owns the intellectual capital? DOD. DOD then
22 looks at that, accepts it, rejects it, modifies

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350

1 it, keeps it up, changes it over time because it
2 is a curricula, and every one of you academics
3 know that curricula change over time, so somebody
4 -- probably the TBI External Advisory Committee --
5 will ask for updates occasionally on what's the
6 Department doing with that product.
7 The question of intellectual capital, absolutely.
8 It becomes a government product that can be
9 distributed as the government and Congress allows
10 us to do so. To that's how the -- and, yes, Dr.
11 Kaplan, the Board has -- the Core Board as a group
12 is responsible for reviewing that product between
13 signing off of it as a Defense Health Board
14 Subcommittee product, concurring, not concurring,
15 et cetera, not good enough for prime time go back,
16 or, yes, this was the greatest thing since sliced
17 bread, an go on.
18 So that's the process involved, and that's why we
19 are where we are. This isn't something we just
20 dreamed up and decided we just give away. And it
21 will be, in fact, the government product in the
22 end.

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351

1 MS. MOESSNER: Thank you, Colonel
2 Gibson.
3 DR. WILENSKY: Bill?
4 DR. HALPERIN: Men who were working for

5 CDC, there's no government copyright, so I've
6 certainly had the experience of writing a major
7 thing and then having somebody else copyright it,
8 and have the proceeds go to the other private
9 group. So it's a real dilemma how you copyright
10 government work.
11 And one way, in my experience, is to incorporate a
12 coauthor and a foundationer someplace so that they
13 have the copyright such that the proceeds of the
14 endeavor can go towards the benefit of whatever
15 you were trying to do, if you will.
16 So it's a little kind of shell game, if you will,
17 since you have no copyright. Get it to somebody
18 will, who's going to use it for whatever you
19 wanted to use it for. So that's just one comment.
20 The other comment is (inaudible) a theme that's
21 gone through a couple of the past presentations,
22 and I'm thinking, gee, there's a lot of DOD money

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352

1 going into research grants and whatever, whatever.
2 And I don't think I understand what the system is
3 for that competition, for the review, for the
4 announcement, for the use of all of those funds.
5 And I'm wondering if at some future meeting we
6 could maybe have a little presentation on, what's
7 that system? How do you get the most bang for the
8 buck if you're interested in TBI or whatever it
9 is, by getting, you know, by competing it in an
10 arena where you're going to get really good
11 products out of the grant money. So it's just a
12 request.

13 DR. WILENSKY: Dr. Carlton?

14 DR. CARLTON: Yes, Jim James just left,
15 I'm sorry to say, but a federal grant paid for
16 something called Disaster Life Support and the
17 Family, of course, is that it has spun off. That
18 federal grant then gave that to the AMA, and the
19 AMA has commercialized it. That's what's Ken's
20 talking about, who should take it and
21 commercialize it, because this is an infinitely
22 salable program?

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353

1 And that, I would suggest, is something that DHB
2 should engage for and find out, okay, who is a
3 good group to take it and run with it? And, Ken,
4 we'd appreciate your input on that because the
5 American College of Surgeons or the Committee on
6 Trauma might well be the right group. That's who
7 sees those patients.

8 DR. MATTOX: I have some ideas. We can
9 talk off line. This could fund the JPC.

10 DR. WILENSKY: Adil?

11 DR. SHAMOO: I am not an intellectual
12 property attorney, neither am I an attorney. But
13 you guys need really -- I have actually a chapter

14 in my textbook on intellectual property, and you
15 guys are really treading on territories you don't
16 know, and I, personally, do not want to encourage
17 taxpayers' money to be used for purely private
18 sector. What they are talking about, you take
19 those government fund products, and you make a new
20 product out of it, and that's the one you really
21 are commercializing. But you cannot -- and
22 moreover the entire Federal Government all the

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354

1 time has what's called shopping right to
2 reproduce, to distribute free of charge from
3 anyone as long as federal money was involved in
4 it.

5 So you need a lawyer.
6 MS. EMBREY: I'm not a lawyer, and I
7 will tell you that my understanding is that the
8 home of these curriculum outputs and the continued
9 renewal of that is in the DCoE, the Center of
10 Excellence that Loree heads up. It's a core
11 competency of her organization.
12 And so she will be the recipient of these
13 products, and it will be up to her to maintain
14 them and to update them, working with the proper
15 communities. And if that means working on ways to
16 copyright them for the benefit of the federal
17 sector, then she'll work on it.

18 DR. WILENSKY: Bill, go ahead.
19 DR. HALPERIN: I'm just wondering,
20 because I think the question was if there was any
21 feedback about them, about the presentation. And
22 just one little comment. It looked very, very

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355

1 good, but there was like one flay word "caring for
2 yourself," the caregiver. And undoubtedly this is
3 like a communicable disease. I mean the first is
4 the patient, the next is the family becomes the
5 patient, if you will.

6 So I wonder whether that, you know, whether that
7 issue -- I mean it's obviously have got to come
8 up, but is there more attention to how to prevent
9 stress-related injuries, if you will, in the
10 caregivers, and family disruption, and you could
11 just go on from there.

12 DR. WILENSKY: Barbara?
13 MS. MOESSNER: Actually, yes, there has
14 been discussion, an I'm actually going to ask Rose
15 Mary Pries, who's sitting to my right as few
16 people, just because she's intimately involved in
17 Module III, which is a large focus of that
18 particular module.
19 Would you mind, Rose Mary?

20 MS. PRIES: Not at all. Thanks, Anne.
21 Yes, we're devoting quite a lot of content in that
22 section to several things that family members can

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356

1 do related to their own self care, because we
2 recognize that without the caregiver or with
3 caregiver burn-out, it's ultimately the Service or
4 the veteran who suffers.
5 So we're dealing with substance abuse, we're
6 dealing with smoking, we're dealing with health
7 promotion, stress management, all the thing that a
8 family caregiver needs to think about and do to
9 maintain his or his or her own sanity, mental
10 health, physical health, and the ability to cope
11 on a long-term basis.

12 DR. WILENSKY: Barbara?
13 COL. JEFTS: Dr. Maddox, I want to thank
14 you for bringing up the fiance piece, because that
15 has been a discussion of ours through the panel as
16 far as who that was all going to work out, so
17 thank you as far as bringing that up.
18 The other thing that Anne didn't bring up was that
19 the definition of "caregiver," one of the things
20 we realized is that EDOD and VA both had different
21 definitions of "caregiver." So we have to then,
22 initially during our first meeting and then

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357

1 finalized during the second, as far as formalizing
2 a definition of "caregiver." So we could
3 incorporate a larger group rather than what was
4 set up through DOD.

5 DR. WILENSKY: Further comments or
6 questions? Yes?
7 DR. KELLY: Jim Kelly. The U.S. Army is
8 also working on mostly health professional
9 modules, and there have been expert panels brought
10 together for many months to do this. And this was
11 under a grant, and my understanding is that the
12 model there would be that the Army would use it
13 and make it available through DCOE again to all
14 Services. But once again, there is an expectation
15 that this be essentially public domain thereafter.
16 And one model of that is already in place with the
17 VA modules on TBI and psychological health, which
18 have been made available to the public sector
19 through HRSA here in Washington, and then passed
20 onto the AHECs, the Area Health Education Centers
21 in the United States so that the modules can then
22 go out to health professionals ad families

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358

1 everywhere in the U.S. Through the rural, largely
2 rural health education centers in this country
3 where so many of our Service members are
4 returning.

5 And so that's already in place with an MOU between
6 HRSA and the VA, and I suspect that there will be
7 lots of opportunities to do it that way, and we
8 know the mechanism for doing that, if somebody
9 wants our committee to be involved.

10 MS. MOESSNER: Great. Thank you.

11 DR. COLEND: Yeah, Chris Colenda. I
12 noticed in the discussion, having treated folks
13 with mild to moderate TBI that human sexuality is
14 a major issue for families and caregivers, so is
15 that part of the curriculum?

16 MS. MOESSNER: It is, actually, and it's
17 under the caregiver section as well as the
18 individual with brain injury section. And it's
19 addressed both the physically, you know, physical
20 functioning as well as through just changes in
21 roles and relationships posttraumatic brain
22 injury.

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359

1 DR. MATTOX: I am a little out of order,
2 maybe. I've watched, during my lifetime, the U.S.
3 Military develop gadgets and stuff and modules
4 that industry has watched and then picked up. One
5 doesn't need to go any further than the military
6 anti-shock trousers, so the Vietnamese misery
7 that made millions and millions and millions of
8 dollars for the companies that picked it up.
9 So this is very ecumenical, and it's very nice to
10 put all of this stuff in public domain. But we're
11 in a few market America where money is -- money
12 drives that machinery. And as you were
13 presenting, I saw a textbook, I saw a course, I
14 saw postgraduate courses, I saw family gatherings,
15 I saw an Internet site.

16 MS. MOESSNER: Um-hmm.

17 DR. MATTOX: I saw close to \$10 million
18 a year industry that could be developed almost
19 immediately.
20 And I'm not even on your Subcommittee. There's a
21 number of things we've talked about today that
22 this Board and its subcommittees have developed

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360

1 that could easily be put into the public sector
2 post-Gulf Wars, and somebody at some level -- I
3 agree with my colleague -- needs a lawyer.
4 The U.S. government is giving away a lot of
5 intellectual property, and so I apologize for
6 being out of order.

7 DR. WILENSKY: Now you've made your
8 point. This is an issue that we will make sure is
9 raised appropriately within the Department. It is
10 rare that I think we need more layers, but this is
11 clearly a legal issue, and we can discuss if and
12 how the Department wishes to pursue it.
13 So point made. It is an issue. The issue has

14 come up in some of the research that the NIH does
15 either singly or jointly with private drug
16 companies, so it is not one that is without
17 precedence elsewhere in the governmental -- we
18 will make sure it is at least raised to the
19 appropriate authorities that that authority is
20 clearly not us.
21 Yes?

22 DR. BREIDENBACH: Warren Breidenbach.
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361

1 I'd like to point out that when you have
2 intellectual property which you then give to
3 society, you create in economics what's called a
4 positive externality, because you're giving
5 something that you don't charge for. It looks
6 like it's for free, and it is for free.
7 I would suggest that if you maintain the
8 intellectual property and put it out in front of
9 the public and then maintain the profit motive,
10 that you would do more good for society,
11 eventually, because I believe it would then pay
12 for that product to be regenerated. And that's
13 really what you're saying.
14 I don't know how you do that legally, but I think
15 it has to be looked at very, very carefully. You
16 want to do the best for public, whether that's
17 giving it as a positive externality or that it's
18 being given as a profit motive. That's the
19 question that has to be answered.

20 DR. WILENSKY: Again, the point's been
21 raised. We will pass it along to people who are
22 in an appropriate position to decide if or how to

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362

1 proceed on this issue.
2 Mike?

3 DR. PARKINSON: Michael Parkinson. Two
4 comments as we go forward, if the DHB can be
5 useful. One is I'm concerned, I guess because
6 it's constraint of funds more than anything else
7 that you're talking about, primary paper
8 distribution when we have an entire generation of
9 soldiers who's already been connected on line to
10 their loved ones, in Iraq for six years. They're
11 used to this, they expect it, they want it. So any
12 way that we can this into web -- not CD Rom but
13 through the TRICARE portals -- to other types of
14 things, I think would be really getting to the end
15 user.

16 The second thing is, is to connect, and I'm not
17 sure if there is already in extant this notion of,
18 you know, the entire movement now in self-care and
19 consumer engagement is communities of mutual
20 interest: social networking, community support, on
21 line.
22 So to the degree that that can be linked to

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363

1 communities of interest on line with virtual
2 content, ASAP, I think will have the broadest
3 assimilation.
4 And then finally, to go through our TRICARE
5 partners who don't necessarily see themselves as
6 just the TBI community but in reading about this,
7 people will self- identify. The point was made
8 earlier that half of the people who need this or
9 more don't know they need it. So it's not going
10 through the usual channels but going through the
11 broadest lay social engagement networking ways
12 that we can, to see this thing in a viable
13 marketing is probably the way to go. And let's
14 not be restrictive, and that's not your intent, I
15 know, but the paper comment just concerned e a
16 little bit.

17 MS. MOESSNER: Right. Now, excellent
18 comments and issues that we have discussed in
19 depth, and again, it's figuring out our
20 relationship with Colonel Mauffrey, or Lt.
21 Mauffreys group, and/or putting it out if need be
22 to another group to work with us, and just the

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364

1 timing of that. And so the group is very
2 committed into this being a Web base curriculum as
3 well. The idea was to get something out quickly.
4 It would probably start as a paper product, and
5 then web soon to follow, absolutely. But thank
6 you for the suggestions.

7 MS. RANKIN: Hi, I'm Theresa Rankin.
8 I'm a national community educator with an
9 organization called Brain Injury Services. It's a
10 national model of community- based services and
11 supports for individuals not just with traumatic
12 brain injury but all of the areas of acquired
13 brain injury.

14 we're based he in the Commonwealth of Virginia.
15 My other job is as the National Outreach
16 consultant for a national multimedia project
17 that's funded by Colonel Jaffee's office, the
18 Defense and Veterans Brain Injury Center;
19 brainline.org was launched on November the 11th,
20 Veterans Day. It includes an extraordinary Web
21 management design and content-building team that
22 we actually -- I think I can say it -- stole from

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365

1 the Pentagon. They created army.mil. They
2 created a site at the Pentagon that went from
3 having 6,000 unique visitors a month to something
4 like six million.

5 I'm hearing a discussion that I know the
6 importance of from first-hand experience. I
7 survived a severe traumatic brain injury as a
8 military dependent at the age of 21. My father
9 was the base communications officer at Camp
10 Pendleton. When I was transferred from an acute
11 trauma center in Northern California where the car
12 crash happened, to the Balboan Naval Hospital,
13 there was no map. There was no guidance, and it
14 would take my family more than 10 years to bring
15 me from California to Washington, D.C., to have
16 the first access to comprehensive rehabilitation.
17 I know Anne, I know the Mayo Clinic. Over the
18 past at least 15 years I've been directly involved
19 not only with the Center for Disease Control but
20 the NIH TBI consensus conference, and I think some
21 of the knowledge that isn't on your able right now
22 is there has been over 20 years of extensive

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366

1 investment by every single state in our nation to
2 develop the kind of education, training and
3 outreach. And yet the barrier that exists is
4 you're looking at a primary population between the
5 ages of 16 and 24, who sustained a severe injury
6 that immediately puts them below the poverty
7 level. So to try to create something that is,
8 one, marketable, and, two, reaches your target
9 audience is so complex. You're looking at
10 families that, one, might even have language
11 barrier; two, a literacy barrier; three,
12 preexisting learning disabilities.
13 I'm here, I think, primarily to encourage yo to
14 take three things under consideration that in the
15 public domain, and as I think Dr. Parkinson and
16 several other individuals have identified, you
17 have this new generation that is socially
18 connected through the web. Brainline.org is this
19 project that has been launched by DVVIC to tap
20 into that social connectivity. I mean I'm the old
21 woman on the team, and I'm only 52.
22 What we're looking at is a phenomenon, not only in

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367

1 terms of a learning ability but in terms of
2 transferring knowledge that you experience into
3 direct application.
4 One of the resources that Anne might need to add
5 to her list is from the U.S. Department of
6 Treasury. They're launching an education program
7 called Relational Finances. You're looking at
8 military families who are barely above the poverty
9 level in that mainstream of enlisted. How can
10 they even cope with the fact that they are being
11 processed through a system that doesn't
12 acknowledge the fact they don't own a home, they
13 barely own a car, and now you're telling them.

14 You are not going to be responsible for an
15 individual that might need up to \$2 million worth
16 of caregiving in a lifetime.
17 I think the most important thing I can encourage
18 the Defense Health Board and Dr. Jim Kelly, who
19 knows me well, continue to engage the stakeholders
20 who weren't here today, who can tell you the hard
21 core reality. I've lived at poverty level through
22 the majority of my life, chronically unemployed,

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368

1 isolated from my family, and periodically homeless
2 because we have a system that repeatedly paralyzes
3 an individual for every step that you make toward
4 independence.
5 So the extraordinary resources that General Sutton
6 and Colonel Jaffee are developing, and soon Dr.
7 Kelly, will not be able to break through those
8 barriers until Health and Human Services, the
9 Department of Labor, the Department of Education,
10 the Department of Justice and amazingly enough,
11 the United States Department of Agriculture are
12 all on the same page. Therefore, when we walk in
13 a door, and we have the courage to ask for help,
14 that it's not the wrong door; that we're invited
15 to sit down and tell our story and not be told to
16 pull out your checkbook, it will cost you \$15 to
17 get map.
18 I am the daughter of two United States Marines,
19 and I fight the word for all those who have come
20 before me and are lost and know all those who
21 stand next to me wondering what has happened to
22 their life.

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369

1 Thank you.
2 (Applause)
3 DR. WILENSKY: Thank you for your
4 willingness to share your story with us. Is there
5 any further comment?
6 (No response) we have clearly gone
7 way beyond 4 o'clock time to
8 Finish the regular portion of our meeting, but I
9 thought it was important with all of the
10 presentations we were doing today to allow the
11 appropriate time for discussion.
12 we will have an opportunity tomorrow morning to do
13 the administrative session we were going to start
14 today. We will start tomorrow morning again at 8
15 o'clock. I've been asked by Commander Feeks to
16 remind people that if you have RSVP'd for the
17 dinner this evening, that a bus will be leaving
18 the Marriot at 6:40 for the Army-Navy Club, and
19 you need to meet in the lobby at 6:30, for those
20 of you from out of town who are staying at the
21 Marriot.

DR. POLAND: Coat and tie.

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370

1 DR. WILENSKY: Dr. Poland was asking
2 quietly behind my back what the dress was for
3 Army-Navy Club, and it's coat and tie for you
4 gentlemen who were wondering.
5 This evening, as we have already indicated, we are
6 going to be having the dinner to honor Dr.
7 Poland's contribution as President, but not in any
8 way suggesting any lack of continued involvement
9 with the Defense Health Board.
10 We're delighted that he will be continuing on, on
11 this Executive Committee position.
12 Ms. Embrey, will you adjourn the business portion
13 of the meeting, please?

14 MS. EMBREY: I would if I could mind my
15 script. Yes, I would like to conclude this
16 afternoon's meeting, and so I will read it as
17 follows: This meeting of the Defense Health Board
18 is adjourned. Thank you for all attending, and I
19 want to thank you for your tremendous support to
20 the DHB and especially the speakers today for
21 their outstanding presentations.

22 (Whereupon, at 5:18 p.m., the
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371

1 PROCEEDINGS were adjourned.)
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372

1 CERTIFICATE OF NOTARY PUBLIC
2 I, Carleton J. Anderson, III do hereby certify
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Page 162

AADHB-121508.txt

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11 or counsel employed by the parties hereto, nor
12 financially or otherwise interested in the outcome
13 of this action.

14 /s/Carleton J. Anderson, III

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