

UNITED STATES DEPARTMENT OF DEFENSE  
DEFENSE HEALTH BOARD

CORE BOARD MEETING

Cocoa Beach, Florida

Monday, March 1, 2010

- 1 PARTICIPANTS:
- 2 GREGORY POLAND
- 3 ROBERT CERTAIN
- 4 NANCY DICKEY
- 5 JAMES LOCKEY
- 6 MICHAEL OXMAN
- 7 MICHAEL PARKINSON
- 8 ADIL SHAMOO
- 9 COLONEL MICHAEL KRUKAR
- 10 COMMANDER ERICA SCHWARTZ
- 11 LIEUTENANT COMMANDER JULIA SPRINGS
- 12 CAPTAIN NEAL NAITO
- 13 ROSS BULLOCK
- 14 CHARLES FOGELMAN
- 15 JOSEPH SILVA
- 16 DENNIS O'LEARY
- 17 FRANK BUTLER
- 18 CAPTAIN ALAN COWAN
- 19 COMMANDER CATHERINE SLAUNWHITE
- 20 THOMAS MASON
- 21 RUSSELL LUEPKER
- 22 JOHN CLEMENTS

- 1 PARTICIPANTS (CONT'D):
- 2 COMMANDER EDMOND FEEKS
- 3 WAYNE LEDNAR
- 4 COLONEL DONALD NOAH
- 5 REAR ADMIRAL DAVID SMITH
- 6 CHRISTINE BADER
- 7 LARRY LAUGHLIN
- 8 COLONEL CHRIS COKE
- 9 DICK MEYERS
- 10 BRIGADIER GENERAL BRYAN GAMBLE
- 11 COLONEL JOANNE MCPHERSON
- 12 REAR ADMIRAL ALI KHAN
- 13 COLONEL SCOTT STANEK
- 14 VICE ADMIRAL JOHN MATECZUN
- 15 LIEUTENANT COLONEL KATHRINE PONDER
- 16 GEORGE LUDWIG
- 17 COLONEL WAYNE HACHEY
- 18 COLONEL MICHAEL GRINKENMEYER
- 19 COLONEL JONATHAN JAFFIN
- 20 RIDGELY RABOLD
- 21 CAPTAIN CHRISTOPHER DANIEL
- 22 COLONEL SCOTT WARDELL

1 PARTICIPANTS (CONT'D):

2 LIEUTENANT COLONEL PHILIP GOULD

3 REAR ADMIRAL SELECT CLINTON FAISON

4 ERIC CARBONE

5 LIEUTENANT COLONEL MELINDA SCREWS

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1 Health Board, I'd ask you to please join me to  
2 stand in a moment of silence to remember the men  
3 and women and families who are defending.

4 (Moment of silence.)

5 DR. LEDNAR: Thank you. Now, please be  
6 seated. I'd like now to introduce Ms. Christine  
7 Bader who has, since the last time we've met as a  
8 board, accepted the offer to be the Director of  
9 the Defense Health Board and has been serving in  
10 that capacity since early December. So she's now  
11 several months into this position. And Ms. Bader  
12 brings with her to us and for all of the work that  
13 we do together for the Department a tremendous  
14 energy, for those of you who know Ms. Bader.

15 Organization. She knows how to take  
16 complex work and turn it into a plan. She knows  
17 how to execute. Very importantly, has strong and  
18 effective relationships with leaders in the  
19 Department of Defense and the Defense Health  
20 Board. And something that we always appreciate is  
21 that she's a solutions-oriented, can-do,  
22 mission-focused person. So please join me in

1 welcoming Ms. Bader as our new director of the  
2 Defense Health Board.

3 (Applause)

4 MS. BADER: Thank you all very much.  
5 I'd like to just briefly express my sincere  
6 appreciation, my gratitude, and I'm very proud to  
7 have been selected for this position. There's a  
8 lot of work to be done, and I look forward to this  
9 -- to the way ahead. And I hope to serve you  
10 well. Thank you.

11 DR. LEDNAR: Thanks, Ms. Bader. This is  
12 an open session of the Defense Health Board, and  
13 before we begin the work of the Board, I'd ask  
14 that we go around the room, first with the table  
15 and then in the audience and introduce ourselves.  
16 Please, if you'd mention your name, the position  
17 that you serve in, and if you are on the Defense  
18 Health Board or are a liaison. If you would  
19 mention that connection so that we can understand  
20 from each other the various aspects of how we work  
21 together as a board. So can I start with Colonel  
22 Noah and then we'll go around this way.

1 Col NOAH: I'm Don Noah. I'm the Acting  
2 Deputy Assistant Secretary of Defense for Force  
3 Health Protection and Readiness within OSD Health  
4 Affairs.

5 CDR FEEKS: Good morning. Commander Ed  
6 Feeks, Executive Secretary.

7 GEN (Ret) MYERS: Good morning. Dick  
8 Myers, Core Board member.

9 DR. LOCKEY: Good morning. Jim Lockey,  
10 Occupational Pulmonary Medicine, University of  
11 Cincinnati. Core Board member.

12 DR. CLEMENTS: John Clements, the Chair  
13 of Microbiology and Immunology and Director of the  
14 Tulane University Center for Infectious Diseases  
15 and a Core Board member.

16 DR. LUEPKER: Russell Luepker, Professor  
17 of Epidemiology and Medicine at the University of  
18 Minnesota and a Core Board member.

19 DR. MASON: I'm Tom Mason, Professor of  
20 Environmental Health, College of Public Health at  
21 the University of South Florida and Core Board  
22 member.

1 DR. O'LEARY: Dennis O'Leary, I'm  
2 President Emeritus of the Joint Commission and  
3 Core Board member.

4 DR. SILVA: Joseph Silva, Professor of  
5 Medicine, University of California Davis, Dean  
6 Emeritus, and Core Board member.

7 RADM SMITH: I'm Dave Smith. I'm the  
8 Joint Staff Surgeon and the Joint Staff Lead.

9 BG GAMBLE: Good morning. I'm Bryan  
10 Gamble. I'm currently the Commander of the  
11 Eisenhower Army Medical Center and the Acting  
12 Commander for the Southern Medical Regional.

13 Col MCPHERSON: Good morning. I'm  
14 Colonel Joanne McPherson. I'm the Executive  
15 Secretary for the DoD Task Force on the Prevention  
16 of Suicide by Members of the Armed Forces, a  
17 Subcommittee of the Defense Health Board.

18 DR. FOGELMAN: Good morning. I'm  
19 Charles Fogelman. I'm Chair of the Psychological  
20 Health Subcommittee of the Board.

21 DR. BUTLER: Frank Butler, Chair of the  
22 Technical Combat Casualty Care Committee and

1 sitting in for John Holcomb, Chair of the Trauma  
2 and Injury Subcommittee.

3 CAPT NAITO: Captain Neal Naito, Navy  
4 liaison to the Board.

5 CAPT COWAN: Alan Cowan, I'm the U.K.  
6 Liaison in the field of Deployment Health in the  
7 U.S. Department of Defense. I work for Colonel  
8 Don Noah.

9 CDR SLAUNWHITE: Good morning. I'm  
10 Commander Cathy Slaunwhite. I'm a Canadian Forces  
11 Medical Officer, and I work in a liaison role at  
12 the Canadian Embassy in Washington, D.C.

13 Lt Col GOULD: Good morning. Phil  
14 Gould, Air Force liaison.

15 CDR SCHWARTZ: Good morning. Commander  
16 Schwartz, Coast Guard liaison.

17 COL STANEK: Good morning. I'm Colonel  
18 Scott Stanek. I'm the Deputy Functional Proponent  
19 for Preventive Medicine, Army Surgeon General's  
20 Office, and I'm serving as the Army liaison for  
21 Colonel Robert Mott who's currently deployed to  
22 Iraq.

1 COL HACHEY: Wayne Hachey, Director of  
2 Preventive Medicine, OSD Health Affairs, and I'm  
3 the OSD Health Affairs liaison.

4 COL KRUKAR: Good morning. Michael  
5 Krukar, I'm the Director of the Military Vaccine  
6 Agency.

7 RADM KHAN: Good morning. Ali Khan,  
8 Assistant Surgeon General and CDC liaison to the  
9 Board.

10 DR. BULLOCK: Ross Bullock, I'm a  
11 neurosurgeon from the University of Miami and head  
12 of the Traumatic Brain Injury Subcommittee.

13 RDML (sel) FAISON: Captain Clinton Faison,  
14 I'm the Chief of Current and Future Operations for  
15 Navy Medicine and here representing Admiral  
16 Robinson.

17 DR. SHAMOO: Adil Shamoo, Core Board  
18 member, University of Maryland School of Medicine,  
19 and Chair of the Medical Ethics Subcommittee.

20 DR. DICKEY: Nancy Dickey, Core Board  
21 member, President of the Texas A&M Health Science  
22 Center.

1 DR. OXMAN: Mike Oxman, Core Board  
2 member, Professor of Medicine and Pathology at the  
3 University of California, San Diego.

4 Rev CERTAIN: Robert Certain, I'm an  
5 Episcopal priest in Marietta, Georgia, and member  
6 of the Core Board.

7 VADM MATECZUN: John Mateczun, Commander  
8 of Joint Task Force National Capital Region  
9 Medical.

10 DR. POLAND: I'm Greg Poland, Professor  
11 of Medicine and Infectious Diseases at the Mayo  
12 Clinic in Rochester, Minnesota, and one of the VPs  
13 of the Board.

14 MS. BADER: Good morning. Christine  
15 Bader, Director of Defense Health Board.

16 DR. LEDNAR: Wayne Lednar, Global Chief  
17 Medical Officer for the DuPont Company and along  
18 with Dr. Poland a Co-Vice President of the Defense  
19 Health Board.

20 DR. LAUGHLIN: I'm Larry Laughlin, Dean  
21 of the School of Medicine, Uniformed Services  
22 University.

1 LTC PONDER: Lieutenant Colonel Kathy  
2 Ponder, Assistant Director of Reserve Medical  
3 Manpower and OSD Accession Policy.

4 DR. LUDWIG: I'm George Ludwig, and I'm  
5 the Deputy Principal Assistant for Research and  
6 Technology at the Army Medical Research and  
7 Materiel Command.

8 Col GRINKENMEYER: Good morning. Mike  
9 Grinkenmeyer, I'm currently the Air Force Deputy  
10 Director at the Armed Forces Institute of  
11 Pathology.

12 Col COKE: Good morning. Chris Coke,  
13 Joint Operations Director at Joint Staff.

14 MR. RABOLD: Good morning. Ridge  
15 Rabold, Project Manager, Office of the Director,  
16 Armed Forces Institute of Pathology.

17 CAPT DANIEL: Good morning. Chris  
18 Daniel, Deputy Commander, U.S. Army Medical  
19 Research and Materiel Command.

20 Col WARDELL: Scott Wardell, Deputy  
21 Chief of Staff and Acting Deputy Director of  
22 Operations for the Joint Task Force, National

1 Capital Region Medical.

2 COL BAKER: Tom Baker, I'm the Interim  
3 Director of the Joint Pathology Center within JTF  
4 CAPMED.

5 COL JAFFIN: Jonathan Jaffin, Director  
6 of Health Policy and Services, Army Office of the  
7 Surgeon General.

8 COL LUGO: Good morning. Angel Lugo,  
9 Chief of Staff, Northern Regional Medical and  
10 Walter Reed Army Medical Center.

11 MS. JOVANOVIC: Good morning. Olivera  
12 Jovanovic, support staff of DHB.

13 MS. CAIN: Christina Cain, DHB support  
14 staff.

15 MS. GRAHAM: Hi. Elizabeth Graham, DHB  
16 support staff.

17 MS. VISSER: My name is Linda Visser,  
18 and I will be the court reporter today.

19 MS. KLEVENOW: Jen Klevenow, DHB support  
20 staff.

21 LCDR SPRINGS: Julia Springs, Health  
22 Services, Headquarters Marine Corps.

1 DR. LEDNAR: Thank you, everyone. I'd  
2 encourage us all to please take an opportunity at  
3 the breaks, if you see someone you've not met  
4 before, please go up and introduce yourself. And  
5 we want everyone to feel welcome. The  
6 relationships that we build here really help to  
7 further the work that we do offline in between  
8 meetings in service of the Department of Defense.  
9 Thank you all for coming, and please reach out and  
10 make everyone feel welcome.

11 I would ask now for Commander Feeks to  
12 share with us some administrative remarks before  
13 we begin this morning's session. Commander Feeks?

14 CDR FEEKS: Thanks, Dr. Lednar. Good  
15 morning, everyone, and welcome. Thank you for  
16 being here. I want to thank the Doubletree Hotel  
17 for helping with the arrangements for this  
18 meeting. I'd like to thank Todd for the setup.  
19 I'd like to thank all the speakers who worked so  
20 hard to prepare briefings for the Board.

21 I'd like to thank my staff: Jen  
22 Klevenow, Lisa Jarrett, Elizabeth Graham, Olivera

1 Jovanovic, Christina Cain, and back at the home  
2 office, Jean Ward for arranging this meeting of  
3 the DHB. I'd like to thank Andrew on sound, who  
4 thought he was going to get away anonymous this  
5 morning.

6 This is a public meeting of the Defense  
7 Health Board, and the law requires us to keep a  
8 record of everyone who attends. So I would ask  
9 that you sign the general attendance record on the  
10 table outside if you have not already done so.

11 For those of you who are not seated at the tables,  
12 handouts are provided on the table in the back of  
13 the room. Restrooms are located outside of the  
14 meeting room just at the end of the hall. For  
15 telephone, facsimile copies, or messages, please  
16 see Jen Klevenow or Lisa Jarrett.

17 Because the open session is being  
18 transcribed by Linda Visser, I would ask that you  
19 please make sure that you state your name before  
20 you speak and use the microphone so that she can  
21 accurately report your questions. Also, if you  
22 find that your name is easily misspelled, you can

1 give your name on a piece of paper to Linda.  
2 Also, if there are other words in your brief that  
3 are likely to be misspelled, it wouldn't hurt to  
4 give her that on a piece of paper.

5 Refreshments will be available for both  
6 morning and afternoon sessions. We will have a  
7 catered working lunch here for the Board members,  
8 ex-officio members, service liaisons, and Defense  
9 Health Board staff. Lunch will also be provided  
10 for speakers and distinguished guests.

11 For those looking for lunch options, the  
12 hotel restaurant is open for lunch, and located  
13 across A1A in the Banana Square Shopping Center  
14 are a few dining options, including Sonny's BBQ,  
15 Silvestro's, and New China. There are many other  
16 dining options all within a few mile radius. If  
17 you need further information, please see a staff  
18 member of the hotel front desk staff.

19 The group dinner tonight is scheduled  
20 for 6:30 p.m. at Milliken's Reef. Milliken's Reef  
21 is located about five miles from the hotel at 683  
22 Dave Nisbet Drive in Cape Canaveral. Shuttle

1 service for the official attendees is being  
2 provided for this. We will leave the hotel around  
3 6 p.m. Return transportation from Milliken's Reef  
4 to the hotel will also be provided. And if you  
5 have not RSVP'd for the dinner, please see Jen  
6 Klevenow.

7 The next meeting of the Core of the  
8 Defense Health Board will be held June 8 and 9,  
9 2010. It will be in the National Capital Region.

10 The meeting on June 8th will take place  
11 at the Sheraton National, located in Arlington,  
12 Virginia, during which the Board will receive a  
13 series of updates on Subcommittee activities and  
14 draft recommendations.

15 The meeting on June 9th will take place  
16 at the Industrial College of the Armed Forces at  
17 Fort McNair during which the Board will receive  
18 the annual classified briefing on the Agents of  
19 Concern and the Chairman's Threat List.

20 And finally, if you would please, put  
21 all portable electronic devices on silent. And  
22 those conclude my remarks. Dr. Lednar?

1 DR. LEDNAR: Thank you, Commander Feeks.

2 We'd like to begin the work of the Board now, and

3 our first speaker this morning is Colonel Thomas

4 Baker, who is the Interim Director of the Joint

5 Pathology Center.

6 Colonel Baker is board certified in

7 Anatomic and Clinical Pathology with subspecialty

8 expertise in Renal and Transplant Pathology.

9 Prior to his selection as the Interim

10 Director, Colonel Baker served as Chief,

11 Integrated Department of Pathology at Walter Reed

12 Army Medical Center and the National Naval Medical

13 Center and as the Associate Chair of Pathology at

14 the Uniformed Services University of Health

15 Sciences.

16 Colonel Baker currently serves as the

17 Associate Pathology Consultant to the Army Office

18 of the Surgeon General and is a member of the

19 Department of Defense Laboratory Joint Working

20 Group and the College of American Pathologists

21 Cancer Committee and is the Army alternate

22 delegate to the College of American Pathologists

1 House of Delegates.

2 Colonel Baker will provide an  
3 information brief regarding issues pertaining to  
4 the establishment of the Joint Pathology Center.

5 As you may recall the Board issued  
6 recommendations to the Department in December,  
7 2008, following a review of the Department's  
8 concept of operations for the establishment of  
9 this Center. Since that report was issued, the  
10 Board has requested additional information  
11 pertaining to the Department's response to its  
12 recommendations as well as updates concerning the  
13 Department's progress in establishing this new  
14 center, the Joint Pathology Center.

15 The presentation slides that Colonel  
16 Baker has prepared for us may be found under Tab 5  
17 of your binder. Without further delay, thank you,  
18 Colonel Baker.

19 COL BAKER: Thank you, sir. I  
20 appreciate it. And I appreciate the opportunity  
21 to give an update to the Defense Health Board.  
22 This update is -- and what it's going to do, it's

1 going to highlight us points in questions that  
2 were provided to us. We had written questions  
3 that were provided to us after the last briefing,  
4 and we basically gave very detailed answers for  
5 those questions submitted. This will highlight  
6 that, and then we'll also talk a little bit about  
7 our establishment plan.

8         And after that, if there is time, I  
9 would be happy to entertain any questions, address  
10 any concerns, anything that wasn't clarified.

11         So a little bit of background  
12 information, and I think people are familiar with  
13 some of this.

14         BRAC 2005 states that the AFIP must be  
15 disestablished by September of 2011. National  
16 Defense Authorization Act of 2008, Paragraph 722,  
17 authorizes the establishment of the Joint  
18 Pathology Center within DoD in a matter that's  
19 consistent with BRAC law.

20         And the four pieces, as most of you are  
21 familiar with, with the Joint Pathology Center:  
22 Consultation -- so it's pathology consultation,

1 education, research, and then management of the  
2 tissue repository that's currently owned by the  
3 AFIP.

4 The mission was delegated to the  
5 Department of Defense in April of 2009 and was  
6 ultimately delegated to the Joint Task Force  
7 CAPMED about 10 weeks ago in December of 2009.  
8 The Joint Task Force, anticipating delegation, put  
9 together an implementation team in July to start  
10 looking at the pieces of the JPC.

11 The members of that committee included  
12 representatives from all three Services, the VA,  
13 the USUHS, AFIP, Joint Task Force CAPMED, the Army  
14 Executive Agent which oversees the administration  
15 of the AFIP and Health Affairs.

16 And the activities that were performed  
17 include, basically, taking the original concept of  
18 operations and doing an extensive gap analysis  
19 where the pieces that were missing in our original  
20 concept of operations that we need to include in  
21 the final version.

22 Based on that, we went ahead and

1 developed a detailed concept of operations with  
2 the implementation team and drafted a JPC  
3 establishment plan.

4 Prime delegation in December. This  
5 reverted to a change to a transition team mode to  
6 be able to execute the mission. And the  
7 activities that the transition team is looking at  
8 basically is developing an operation plan and then  
9 doing a lot of the nugwork of establishing the  
10 JPC. The J-shops of the Joint Task Force are  
11 assisting in personnel, equipment budgets,  
12 facility issues, all the little pieces that need  
13 to be done to establish a Joint Pathology Center.

14 So in terms of consultation in our final  
15 concept of operations, our detailed concept of  
16 operations, we have 36 pathologists. And I have  
17 them listed there, the subspecialties, as well as  
18 the number of pathologists per area. And one of  
19 the things you will see -- a lot of this was a  
20 result of the gap analysis; for example, you see  
21 there is veterinary pathology, environmental  
22 pathology, cardiovascular pathology,

1 nephropathology. Those all came up as a result of  
2 our gap analysis.

3       Take a look on the right there. You see  
4 under support services, I've listed several  
5 things. It's not inclusive, it's several things  
6 that will support the consultative service.

7       First one there is the  
8 environmental/biophysical toxicology. This is  
9 basically -- we are going to take this from the  
10 AFIP en bloc so it's the mission that the AFIP is  
11 currently doing, which is, in terms of a clinical  
12 mission, is largely DU testing as well embedded  
13 fragment testing. They do this to support the VA  
14 team follow-up program as well the embedded  
15 fragment program of the Department of Defense.

16       This is the majority of what they do,  
17 but there's also a lot of other pieces that we do  
18 for other federal agencies and elsewhere within  
19 DoD. Additionally, they also do quite a bit of  
20 original research as well as collaborative  
21 research in support of other research things. So  
22 we are going to be taking that en bloc as is.

1           The next one on the list there is cohort  
2 registries. This also came up as a result of our  
3 gap analysis. And the cohort registries, I  
4 believe the AFIP calls them the war registries  
5 right now, but these are registries including the  
6 POW agent forms, leishmaniasis, Afghanistan  
7 registries, things like that, that are used  
8 largely, you know, in terms of public health and  
9 research.

10           But I think that probably the biggest  
11 user of the cohort registries is by the VA in  
12 terms of determining benefits for -- you know, VA  
13 benefits for their beneficiaries. We see  
14 opportunity bringing this under in terms of  
15 expanding and in terms of using it for research  
16 and so on. So we see a lot of opportunity with  
17 that.

18           Automated Central Tumor Registry. This  
19 is the umbrella organization that oversees -- the  
20 umbrella process that oversees the Department of  
21 Defense tumor registry system.

22           We also see opportunity in terms of

1 opening that up and using that data board for  
2 research -- more for research and then also  
3 looking at working with the VA to kind of develop  
4 or work on more of a comprehensive military  
5 health care system tumor registry process. And I  
6 know that's one of the things that the AFIP had  
7 been working on and, and we're going to carry that  
8 on into the Joint Pathology Center.

9 Third thing there listed is  
10 telepathology. In telepathology, we're going to  
11 be taking the AFIP mission, once again in whole,  
12 in terms of providing telepathology services. And  
13 right now the biggest end-user of telepathology in  
14 the federal government or in the military  
15 health care system are the VA and the Army. And  
16 the Navy and the Air Force aren't participating in  
17 this as much as the other Services.

18 And so when we go back, when we look at  
19 it, a couple of things that we have to address as  
20 we stand up this process; number one, that there  
21 are significant firewall issues which really limit  
22 the usability of telepathology within the

1 Department of Defense. These are, you know,  
2 process services as well as across other federal  
3 agencies. So that's something we have to address.

4       Additionally, we have to address  
5 software and hardware issues, some of the  
6 antiquated equipment that the AFIP currently is  
7 using for telepathology. So that's -- we're going  
8 to get back to the basics, develop that, or  
9 address that first.

10       I've engaged the three Service  
11 consultants as well as the VA consultant in terms  
12 of coming up with an enterprise wide, you know,  
13 solutional process for telepathology. And this  
14 will include the JPC. So it's going to be across  
15 the services and in the VA but helping the JPC as  
16 a centerpiece for that, you know, kind of -- be a  
17 part of that enterprise-wide solution for  
18 telepathology. And I think whenever we get that  
19 piece in place, the next step then is how can we  
20 apply telepathology to the federal government, to  
21 the other federal agency stakeholders.

22       And one of the things that the Defense

1 Health Board brought up was the utilization of  
2 telepathology in terms of, you know, assisting in  
3 mass disaster-type situations. The Air Force is  
4 already partnering with the University of  
5 Pittsburgh on this, so I think this is a great  
6 opportunity, you know, once we get the basic  
7 issues addressed. A perfect opportunity to be  
8 able to engage with the Air Force and with their  
9 partners on this. So lots of work there, but we  
10 do have the plan in place.

11 The next one is molecular laboratories.  
12 A couple of things with molecular laboratories.  
13 We're going to be taking the molecular laboratory  
14 mission of the AFIP in whole. This includes about  
15 20 -- they do 20 probes for clinical use, largely  
16 in the diagnosis of hematologic malignancies. So  
17 we're going to go ahead and take that, you know,  
18 as is.

19 That's going to be integrated, at least  
20 initially, into the Walter Reed molecular  
21 laboratory. That's a new laboratory that's being  
22 stood up. A lot of space, very high tech, and

1 this will actually fit in there well, initially  
2 anyway, in terms of supporting the Joint Pathology  
3 Center.

4 And one of the unique capabilities of  
5 this molecular laboratory are basically some of  
6 the homebrews, some of the things that the AFIP  
7 has developed to support the diagnosis of  
8 hematologic malignancies, and that is fluorescent  
9 probes that are used on paraffin embedded tissue.  
10 That's a unique diagnostic capability. So we're  
11 going to be taking all those pieces, you know, on  
12 and off and looking for ways to improve that.

13 As a part of our strategic plan, where  
14 we want to stand up is a separate standalone  
15 molecular laboratory that will serve as the  
16 reference molecular laboratory for the Military  
17 Health System. But that's, once again, that's  
18 part of our strategic plan.

19 Next is histology, immunohistochemistry,  
20 special stains immunofluorescence. All that will  
21 be done. It would be integrated into the Walter  
22 Reed National Military Medical Center process.

1 That is, once again, going to be a  
2 state-of-the-art high-speed process. Twenty-four  
3 six services that will be provided, and we'll be  
4 doing that with quality in mind -- number one,  
5 quality, and then secondly, some of the other  
6 metrics that we have to look at like turnaround  
7 time.

8         And some of the things we've been  
9 looking at is, like, next shift turnaround time  
10 for special stains, immunos, and things like that.  
11 Many of them that are going to stand up for the  
12 Joint Pathology Center in terms of immuno stains  
13 will be about 250 stains. It's going to be a  
14 pretty robust menu as well as all the  
15 immunofluorescence stains necessary to support the  
16 Joint Pathology Center. So we have a lot of  
17 opportunity there.

18         Since our initial concept of operations,  
19 we've more than doubled the support staff to, you  
20 know, that the JPC is going to provide to Walter  
21 Reed to support this mission. So I'm comfortable  
22 that with the process in place, as well as the

1 staffing that we have in place, that that'll be  
2 enough to accomplish the mission.

3       One of the things that was brought up by  
4 the neuropathologist at the AFIP was, who's going  
5 to do the muscle biopsies? Muscle biopsy  
6 interpretations, is what we're talking about. And  
7 that's a critical mission for both DoD and the VA  
8 in terms of force health protection. So it was  
9 something that, you know, after discussing it with  
10 them, we talked about it as a part of our gap  
11 analysis and decided to include that in. That  
12 will be -- the interpretation will be done by the  
13 neuropathology branch of the Joint Pathology  
14 Center.

15       Next on the list is electron microscopy.  
16 We'll have that in place, that is also new from  
17 our initial concept of operations, support  
18 nephropathology pathology, neuropathology, and the  
19 veterinary pathology program. The personnel  
20 providing direct support to the consultation  
21 service now will be 46. We've added several  
22 administrative people throughout to really enhance

1 or better define the administrative mission in  
2 support of the pathologists.

3 In our detailed concept of operations,  
4 we've had a better opportunity to better delineate  
5 the education that we're going to be providing  
6 within the Joint Pathology Center as well as the  
7 research that we're going to be doing there as  
8 well. In terms of education, graduate medical  
9 education, we're going to continue on the AFIP  
10 mission of providing subspecialty rotations for  
11 the federal agency residency programs. Those are  
12 key, I think, you know, in terms of providing  
13 training for a lot of the programs.

14 We will also -- this will also be a key  
15 part of the National Capital Consortium's new  
16 Graduate Medical Education Pathology Fellowship  
17 Program, which is taking its first -- it's going  
18 to have its first person -- it's going to actually  
19 stand up this summer and have its first person  
20 start July 1st. So once the JPC is established,  
21 this is going to be a key part for that. And  
22 that's been our, you know, in terms of

1 establishing that fellowship, that's been part of  
2 it all the way along as this was -- the JPC would  
3 be a part of that.

4 We will continue to provide support of  
5 the oral -- the Navy oral pathology residency  
6 program, and we'll very likely provide the full  
7 third year of training for the residency program.

8 And then we hadn't really talked about  
9 the -- there will be another slide. One of the  
10 missions that we identified in the gap analysis,  
11 was the veterinary pathology mission so we will be  
12 continuing the AFIP's mission of veterinary  
13 pathology residency training, in which they train  
14 about a dozen people at any given time.

15 In terms of continuing medical  
16 education, in talking to the stakeholders and to  
17 the consultants of the various services and what  
18 it is we need to put in place, we have decided to  
19 really focus on a robust online continuing medical  
20 education offering. We're still working the  
21 details of that, but -- well, what we're looking  
22 at are webinars, teleconferences. We're looking

1 at putting together a very robust digital slide  
2 repository for continuing medical education use as  
3 well as online courses.

4 And like I said, in talking to our  
5 end-users and talking to the stakeholders, at  
6 least initially our focus is going to be on  
7 maintenance of the certification for pathologists  
8 as well as focusing on the solo or deployed  
9 pathologist. That's going to be initial, but we  
10 see opportunity to expand that mainly based on the  
11 needs of our end-users at a later date.

12 Couple of things with that. We're going  
13 to try not to focus on just the subspecialties  
14 that are provided by the JPC but rather broaden  
15 the menu in terms of educational offerings. And  
16 we'll do that through partnering with other DoD  
17 and non-DoD entities as well as other -- perhaps  
18 even civilian entities to establish course  
19 offerings for the online continuing medical  
20 education.

21 One example would be, the psychology  
22 school down at Brooke Army Medical Center wants to

1 do online education, which we would incorporate in  
2 that. We could also incorporate clinical  
3 pathology course offerings as well with them.

4 The Joint Pathology Center will not be  
5 offering live courses, but what we will be doing  
6 is actually supporting the DoD live courses that  
7 are going to be remaining; and, for example, the  
8 Armed Forces Medical Examiner and the Medical  
9 Museum will be continuing their courses. And we  
10 will provide the support for that.

11 And then there's also opportunity for  
12 support of non-DoD courses and civilian courses.  
13 And the one that comes to mind, we have been  
14 approached by the American College of Radiology  
15 through Health Affairs. They approached us about  
16 the possibility of supporting a radiologic  
17 pathology course similar to the one that the AFIP  
18 is doing right now. Since the JPC will be holding  
19 the material for this radpath course, that the  
20 AFIP is currently giving, we see an opportunity to  
21 partner with them on that. We would have to see  
22 the detailed plan, but we definitely see

1 opportunity there.

2 On the other half of the slide is

3 research. And, once again, our approach to

4 research is a little bit different than the AFIP.

5 But we see research basically, pathologist-driven

6 research, lots of opportunity through

7 collaboration. There's lots of support, lots of

8 funding available through various existing

9 established mechanisms throughout the National

10 Capital Region as well as across the Services,

11 across agency lines, and even into the civilian

12 community. So it's been -- there is a lot of

13 opportunity there for pathologist-driven research.

14 Utilization of repository. When we talk

15 about the tissue repository, that's going to be a

16 big piece of our research portfolio. And, of

17 course, the Joint Pathology Center will support

18 ongoing clinical initiatives; for example,

19 traumatic brain injury initiatives that are going

20 on in the National Capital Region Comprehensive

21 Cancer Care Center and so on. So that's going to

22 be one of its missions as well in terms of

1 research.

2       We talked about the cohort registries  
3 and the ACTUR database and better utilizing that  
4 information through research, and we will be  
5 exploring that as well as.

6       Of course, continuing the veterinary  
7 pathology research initiatives that are currently  
8 ongoing.

9       And, as I said, there's plenty of  
10 opportunity for collaboration support and funding,  
11 not just for research within the JPC, but, as I  
12 said, across Service lines, across agency lines,  
13 and the civilian community. Those already exist  
14 and the JPC will basically tag on to those in  
15 terms of finding opportunity for  
16 pathologist-driven research.

17       Tissue repository. This is a big piece  
18 of the JPC. And we recognize that tissue  
19 repositories are a valuable treasure, and we  
20 really need to come up with a good plan in terms  
21 of how to appropriately utilize it. And the three  
22 things that -- you know, in NDAA 2008 with tissue

1 repository or maintenance modernization and  
2 utilization, we'll, of course, continue the  
3 ongoing maintenance of the repository, the  
4 day-to-day maintenance that needs to go on.

5       Modernization. Right now the AFIP has a  
6 Congressionally-funded slide and document  
7 digitization project that's ongoing. We're going  
8 to continue that on, but roll that into our core  
9 budget. And one of the things with -- the best I  
10 can tell anyway -- with that project right now, is  
11 I'm not sure how the slides that are digitized  
12 must all be prioritized in terms of digitization.  
13 So we need to come up with a prioritization. And  
14 we'll be doing clinical research -- a clinical use  
15 research education and, you know, who basically  
16 determines what slides get digitized, but that's  
17 going to be a part of our ongoing modernization of  
18 the repository.

19       One of the things that came out of the  
20 Asterand report, the Asterand group looked -- did  
21 a formal survey of the tissue repository several  
22 years ago, and one of the things that they noted

1 was the material that came from BRAC facilities  
2 that's in the repository. Although it's in good  
3 condition, it's not terribly accessible in terms  
4 of research and even clinical use. So that's one  
5 of the things that we have to look at in terms of  
6 how we're going to do that for the tissue  
7 repository, how we're going to modernize that  
8 piece.

9 Utilization. Obviously we'll use the  
10 tissue that's in there for the ongoing clinical  
11 mission, the consultative mission.

12 And for education, as I mentioned  
13 earlier, we're going to look at putting together a  
14 robust online digital slide repository for  
15 educational purposes. We will be utilizing  
16 material to develop online courses and also  
17 opportunity for utilization of digitizing material  
18 for other courses that we've talked about; for  
19 example, the radpath course through the American  
20 College of Radiology.

21 The last piece there is research. And  
22 this is where we really have to do this very

1 carefully in order to really preserve and  
2 appropriately utilize the tissue repository.

3       And when we develop our plan for the  
4 tissue repository, we need to do it very carefully  
5 and very deliberately, and what we're going to do  
6 is utilize repository consensus findings from the  
7 -- that were issued in 2005 as well as the  
8 Asterand findings and recommendations. We see  
9 this as a key opportunity to engage strategic  
10 partners, engage in subject matter experts, and  
11 the people who are interested in using the tissue  
12 repository and really coming up with a way to  
13 appropriately utilize it.

14       And three of the things we want to do is  
15 ensure sustainability of the repository. It would  
16 be easy to deplete that repository if there  
17 weren't any controls, any sort of measures, doing  
18 that appropriately.

19       We want to determine how to provide  
20 appropriate access to the material for both not  
21 only federal contributors but also for the  
22 civilian community. We see an opportunity to use

1 this across into a civilian community in terms of  
2 research and recognizing that there are going to  
3 be probably competing priorities in terms of  
4 wanting to use the tissue in the repository.

5 We have to come up with a process that  
6 addresses competing priorities and how we're going  
7 to prioritize the use of the tissue in the  
8 repository. Like I said, this has to be a very  
9 careful and deliberate process, and we'll be  
10 initiating that soon hopefully.

11 Veterinary pathology service. For those  
12 of you who don't know this, this is truly a unique  
13 and one-of-a-kind service that the AFIP has, and  
14 it's known the world over so this is actually a  
15 piece that we're excited to have as a part of the  
16 JPC. And this is one of the things we identified  
17 in our gap analysis. And we will continue the  
18 AFIP mission of providing consultation within DoD  
19 and other federal agencies.

20 They do -- once again, this is a  
21 one-of-a-kind service. There really isn't any  
22 other sort of consultative service that looks like

1 this, on the veterinarian pathology side of the  
2 house.

3 In terms of education, they have a large  
4 veterinary pathology residency program. I believe  
5 it's the largest in the country. And then they  
6 also do a very unique online educational thing on  
7 a weekly basis that's available across the world  
8 through a webinar. And there are actually at  
9 least 125 participating institutions across the  
10 world that actually participate in this so very,  
11 once again, very unique.

12 The Vet Path Program will also continue  
13 its research in support of DoD priorities, and one  
14 of the things we want to do -- and this is true  
15 not only for Vet Path but the other parts of the  
16 JPC -- we want to ensure no disruption of services  
17 during the transition as we move it from AFIP to  
18 JPC.

19 We already have space identified on the  
20 Forest Glen campus of 10,000 square feet. That's  
21 going to be undergoing remodeling soon, and that  
22 will include the electron microscopy suite for the

1 Joint Pathology Center.

2 The operating budget. The Defense  
3 Health Board -- originally in our initial concept  
4 of operations, we had the Joint Pathology Center  
5 as a hospital-based process, and the Defense  
6 Health Board understandably had concerns about  
7 that. And in relooking at it, we agree it's  
8 probably best done -- the whole thing done outside  
9 of the new Walter Reed.

10 So the JPC won't be aligned -- or is  
11 aligned, actually, under headquarters Joint Task  
12 Force CAPMED at this point. And it is a distinct  
13 organization -- organization distinct from the  
14 hospitals and Centers of Excellence. I as the  
15 Interim Director report to the Deputy Commander of  
16 the JTF. And then under me, once this is  
17 established -- and this is outlined in the answers  
18 to the questions that were provided -- there will  
19 be four divisions and an Office of Director.

20 Additionally, we'll also have a board of  
21 advisors that are comprised of senior subject  
22 matter experts from stakeholder agencies and

1 services that will advise in terms of services  
2 provided, resources, and things like that. So  
3 that will all be established in a charter and the  
4 details of that will be worked out when we develop  
5 the charter for that group.

6 Budget and Facilities. In terms of  
7 operating budget, as I said, separate from the  
8 hospitals and Centers of Excellence, it's  
9 currently being refined by our budget folks at the  
10 Joint Task Force. And this will not be  
11 Congressionally funded. Our goal is to roll this  
12 into the core budget and the program monies, and  
13 this will be in the core budget for fiscal year  
14 '11. Our estimated budget at this point is 21.7  
15 million, but that will undoubtedly change as we  
16 identify some more pieces that will need to be  
17 included, things that we haven't considered.

18 Facilities. The consultative service  
19 will be in 10,681 square feet of almost -- it's  
20 space that's being renovated currently, and it  
21 will be done I think in the next couple of weeks  
22 up on the Forest Glen campus. And that will be

1 adjacent to the repository proper which will be  
2 another 32,000 square feet, about 12,000 of which  
3 is being renovated right now and will be state of  
4 the art. All that's up on the Forest Glen campus.

5       Veterinary pathology and electron  
6 microscopy, as I mentioned, identified 10,000  
7 square feet. That's not too far from the  
8 consultative and repository service, but it is in  
9 a separate building. And that will be up on the  
10 Forest Glen campus as well. So all that will be  
11 fairly close to each other.

12       The Automated Central Tumor Registries  
13 Program Management Office will be on the Bethesda  
14 Campus in about 880 square feet of administrative  
15 space. We're still working in several different  
16 directions looking for space for our  
17 environmental/biophysical toxicology lab, but we  
18 will do that. We will find space for that.

19       As I mentioned histology,  
20 immunohistochemistry, specimen accessioning,  
21 molecular labs, all these will be integrated into  
22 the Walter Reed lab space, and there is -- just

1 those areas right there are almost 8,000 square  
2 feet of space in the new Walter Reed lab. And  
3 it's actually quite a bit of space for that.

4 So integrated appropriately into those  
5 services at the new Walter Reed, this will work  
6 out actually very well and understanding that we  
7 need to look at, you know, being able to accept  
8 new missions. As missions develop new  
9 technologies, develop things like that, we need to  
10 make sure that we have an opportunity to grow in  
11 the future so we're looking at an opportunity for  
12 future modernization as well.

13 We viewed -- of course, we viewed the  
14 Armed Forces Medical Examiner and our support of  
15 their mission is critical and so we've been  
16 working that actually very closely with the Armed  
17 Forces Medical Examiner. And we've got all the  
18 pieces into place in the JPC to support that  
19 mission.

20 And one of the things I outlined in the  
21 answers to the questions that were provided in  
22 more detail is the support of operations in-

1 theater. And as I mentioned, there are currently  
2 no pathologists that are deployed to theaters as  
3 pathologists so there is no pathology capability  
4 within theater right at this moment, although that  
5 could change. But what we will do is be able to  
6 support, fully support, the pathology within  
7 theater through telepathology and consultation.

8         Additionally, the veterinary pathology  
9 program, our service has an in-theater mission as  
10 well in terms of supporting working the animals  
11 and things like that.

12         Other federal agencies. When we started  
13 this process initially, one of the things that we  
14 looked at was the workload that the AFIP provided  
15 to other federal agencies outside the DoD and VA.  
16 And then we also talked to our -- of course our  
17 stakeholders, the major stakeholders -- the  
18 Department of Defense and the VA -- in terms of  
19 what services they needed.

20         Early on we engaged the NIH as a  
21 possible and major federal stakeholder. We kind  
22 of make sure that we had all the pieces in place

1 initially for the JPC. Once the mission was  
2 delegated to the Joint Task Force, we actually  
3 engaged the other federal stakeholders through a  
4 formal process. And basically serving a federal  
5 stakeholder is -- like I said, it's a formal  
6 process so it needs to be done correctly. So  
7 we've got that survey in place, waiting for  
8 results from that. I've heard some preliminary  
9 from the FDA but not the other services -- or the  
10 other agencies.

11 Vet Path will continue to support its  
12 federal stakeholder -- or its stakeholders. They  
13 provide the National Zoo and the NIH, I believe  
14 are the two largest ones that they provide. They  
15 will continue on with that mission as well.

16 And I separated out nonmedical federal  
17 stakeholders. We've engaged them too through a  
18 survey process, and that includes the Department  
19 of Justice, FBI, Homeland Security, and agencies  
20 like that. Our goal is also to find out if  
21 there's anything that we can do as an organization  
22 to help their mission. We haven't heard anything

1 from them as well. But we feel that the way we  
2 went through this process, we've identified the  
3 big pieces that need to be in the JPC to support  
4 our federal agency stakeholders.

5 We also feel that, you know, if  
6 something does come up, our organization is  
7 sufficiently flexible to allow us to incorporate  
8 things that we haven't identified. So as soon as  
9 the surveying process is over, and we have  
10 everything in place, we'll be able to determine  
11 whether or not there are other things that we're  
12 missing in a concept of operations.

13 Opportunities for civilian  
14 collaboration. I've got four things listed there,  
15 and the top three are probably the most where  
16 we'll have the biggest opportunity to engage the  
17 civilian community.

18 We talked about utilization of tissue  
19 repository already.

20 Education in terms of helping develop  
21 course content for the online programs as well as  
22 the JPC providing support of live courses.

1           And then research of course. You know,  
2 capitalizing on existing capabilities now within  
3 the Department of Defense in terms of being able  
4 to collaborate with the civilian organizations,  
5 that will be a big piece as well.

6           Consultation. Our mission will -- you  
7 know, strictly speaking of mission, the JPC for  
8 consultation will be to the federal government.  
9 But I think when you look at some of the unique  
10 capabilities that the Joint Pathology Center will  
11 provide, such as Vet Path or embedded fragment  
12 analysis, there should be opportunity for us to be  
13 able to engage the civilian community in that  
14 respect.

15           Our plan for establishing the Joint  
16 Pathology Center. Our plan is for initial  
17 operating capabilities 1 October of this year, and  
18 it will be fully operational by September of 2011.  
19 The Armed Forces Institute of Pathology and the  
20 Army will support the Joint Pathology Center as it  
21 establishes. And when we look at a plan for  
22 establishment, the biggest thing that comes up

1 from our major stakeholders is continuity of  
2 clinical service. So that is the big piece that  
3 we are looking at is how to do this without  
4 discretion in the consultative service and the  
5 clinical service.

6 We want to do it with a well-established  
7 command in control throughout to allow the AFIP to  
8 take care of its employees during the transition,  
9 understanding that it can be a tough time for a  
10 lot of people.

11 And this here is just kind of a  
12 big-picture look at our establishment plan. I  
13 didn't really want to go into detail but just show  
14 you that we've gone through a lot of the pieces  
15 for this.

16 And then the way forward, as I said, our  
17 top priorities to ensure continuity of clinical  
18 services during the establishment. We're  
19 finalizing our establishment plan with AFIP  
20 support. We'll be initiating the hiring process  
21 probably fairly shortly.

22 Finalizing other things such as budget,

1 facility, logisticals like IT requirements. Need  
2 to implement a strategic communication plan to be  
3 able to ensure that our stakeholders know what's  
4 going on. That's a big piece as well.

5 We need to refine a lot of our  
6 processes, including one of the things that the  
7 Defense Health Board brought up was our  
8 accessioning process. How are we going to that?  
9 We've got a plan in place, but I think we've got  
10 some work to do in terms of refining that.

11 Put all of our policies and procedures  
12 in place, initiate pertinent contracts, get GME  
13 accreditation. And then somewhere in there engage  
14 our partners and develop a strategic plan.

15 And we talked about two of those pieces  
16 for the strategic plan. Lot of nugwork that needs  
17 to be done to stand up the Joint Pathology Center,  
18 but as I said, we have the full support of the  
19 Army in this as our partner in the AFIP will help  
20 us as we establish this.

21 Okay. Questions?

22 DR. LEDNAR: Colonel Baker, thank you

1 for that brief. Just as a reminder to all of us,  
2 since the last time the Defense Health Board met  
3 in November, some important decisions have been  
4 taken. The Deputy Secretary of Defense delegated  
5 to the JTF CAPMED the authority for the Joint  
6 Pathology Center which has really important  
7 clarification as to its leadership and its home.

8 Thanks to Colonel Baker and your staff  
9 and Admiral Mateczun for the very timely response  
10 back to the questions of additional information  
11 that the Board had after the last time we had a  
12 chance to meet. So thank you for that work to  
13 give us that additional information.

14 At this point I'd like to open up the  
15 floor to any questions or comments. Dr. Parisi?

16 DR. PARISI: Dr. Parisi from the Mayo  
17 clinic, and I'm a member of the Core Board as well  
18 as the Chair of the Subcommittee for Pathology and  
19 Laboratory services. Thank you, Colonel Baker. I  
20 think the response and your presentation today  
21 represented a very good beginning, but I don't  
22 think it fully addresses some of the issues and

1 concerns that we have that will ultimately  
2 determine the success of the JPC.

3         And this is something we want to see  
4 happen. We want this to be a successful venture.  
5 And we're certainly willing and able and welcome  
6 the opportunity to assist you as the plans move  
7 forward. So I just want to emphasize that.

8         There are some issues both practical and  
9 maybe philosophical which I think are not fully --  
10 have not been fully articulated or are still  
11 controversial. And one of them, just for example,  
12 the logistics of having the pathologists at  
13 remote-sited Forest Glen and laboratories at  
14 Walter Reed, Bethesda, are going to be potentially  
15 problematic.

16         So if I'm a pathologist sitting in my  
17 office in Forest Glen and the case is accessioned  
18 at Walter Reed and somebody takes the slides over  
19 to me, I determine we need special stains, they go  
20 back to Bethesda, the stains are done, the stains  
21 come back to me for further interpretation and I  
22 decide I need FISH or something, that goes back to

1 Bethesda, it seems like this back-and-forth thing  
2 is not really a very efficient and somewhat  
3 cumbersome process. And I guess I don't  
4 understand why other avenues are not being  
5 pursued.

6 I think a reference center that -- a  
7 federal reference center, all have really strong  
8 educational and research components. And I think  
9 you certainly describe the consultative part, but  
10 I think a lot of the details regarding education  
11 and research are not -- have not been fully  
12 resolved.

13 For example, I was at -- I was part of  
14 the 48th Annual Neuropathology Review Course held  
15 in Bethesda last week, and this is the 48th  
16 consecutive year this course has been given.  
17 There is no other course like that in the  
18 universe. And there were 133 registrants. And  
19 that course continually attracts more than 133  
20 people, I mean, that's probably on the lower side  
21 of number.

22 I'm a little surprised or, you know, why

1 are you not pursuing these as well? I mean, these  
2 are potentially money-making. Not only are they  
3 money-making opportunities, but they're also great  
4 networking -- everybody benefits from these kind  
5 of things. The radiology pathology course is  
6 another example. So I guess I'm a little  
7 surprised that you're not really pursuing these  
8 issues.

9         Research wise, I think you've identified  
10 some places; for example, the research for the TBI  
11 that I think is a very important ongoing function,  
12 but you said that the research was going to be  
13 pathology-centric or pathology-driven, but are the  
14 pathologists going to have laboratory space? Are  
15 they going to have the resources to develop new  
16 techniques, to explore new techniques? Where are  
17 these going to be located? Are they going to be  
18 in Forest Glen, or are they going to be over in  
19 Bethesda? And is that going to require somebody  
20 going from point A to point B all the time?

21         Even study of the TBI brains, where is  
22 the wet lab going to be? Is the wet lab going to

1 be in Forest Glen or is it going to be at Dover or  
2 is it going to be at Walter Reed? I mean, I think  
3 these are all great important logistical problems  
4 that really need to be resolved if you're going to  
5 have an efficient Center.

6       There's also an issue of scientific  
7 oversight, and I'm glad to see that you are  
8 pursuing an advisory board. I think an advisory  
9 board, though, should not be just stakeholders.  
10 It's got to be external. And I would propose, and  
11 I think we've suggested, that maybe there would be  
12 a scientific oversight review of the activities of  
13 the Center just to keep the science moving  
14 forward. So the science is driving the Center.

15       And, again, I think that's key in making  
16 a world-class pathology-type Center that I think  
17 we all want to see happen. So those are some of  
18 my thoughts.

19       Actually I've put together some of these  
20 comments on a sheet, and I think Lisa has got  
21 them. And we're going to distribute them round.

22       But I'd be happy and look forward to

1 sitting down and talking with you, talking about  
2 some of these and trying to assist you in any way  
3 possible.

4 COL BAKER: Absolutely true. Thank you  
5 very much, and I look forward to that. I think  
6 some of these do represent some philosophical  
7 differences in moving forward, but I -- you've  
8 pointed out a lot of things that we do need to  
9 address and things that we haven't quite thought  
10 through completely. And so I think there's a lot  
11 of opportunity for improvement so I look forward  
12 to talking to you about this.

13 DR. PARISI: One other thing I wanted to  
14 bring forward, and I'm sure you thought of this,  
15 but where are you going to get the people that are  
16 going to be -- where are the physicians, the  
17 pathologists coming from? Realistically speaking,  
18 in our place it takes a year and a half to get  
19 somebody aboard, you know, from the time that he  
20 signs the contract or agrees to come to the time  
21 he walks into the door. And how are you going to  
22 attract higher level or senior kind of people? It

1 has to be more than just salary, and I'm not sure  
2 that the salary can be resolved, but, you know,  
3 it's got to be laboratory space, educational  
4 opportunities. So you've got to have some carrots  
5 to draw these people to you, and I think those are  
6 very important, you know, as this evolves, and  
7 it's going to be an evolution obviously.

8 COL BAKER: Thank you, sir.

9 DR. LEDNAR: Are there other questions  
10 or comments for Colonel Baker? Dr. Oxman?

11 DR. OXMAN: Yes, sir. Mike Oxman from  
12 the University of California, San Diego. I'm also  
13 concerned with the real ability to stand up a  
14 first-class consultative service by September 11th  
15 of 2011. And that is, just to echo what Joe said,  
16 in terms of recruitment. I don't see how you can  
17 possibly recruit first-class people in that length  
18 of time so there's going have to be some method of  
19 bridging for several years, the expertise, and I  
20 don't -- you really need a plan for that.

21 The other thing I want to emphasize is  
22 that no first-class pathologist that I know would

1 accept the position that didn't have a major  
2 research component, which means space and support.  
3 And the FDA has learned this. They've had a major  
4 problem with attracting good people in the last  
5 decade because of the absence of sufficient time  
6 and facilities for combining research and service.

7 COL BAKER: Well, if I could just  
8 address very quickly, I mean, our process for  
9 hiring folks, you know, obviously since this is a  
10 newly established organization that will be  
11 assuming functions from the AFIP, we have to do  
12 what's called a transfer function of folks from  
13 the AFIP to the JPC. That will, in terms of the  
14 pathologist, that will address a chunk of those  
15 positions but not all the positions. We'll still  
16 have several open positions that will require us  
17 to put them up for competitive hire.

18 And we've actually had quite a few  
19 people, current and former staff members of the  
20 AFIP, who wouldn't otherwise be available for this  
21 transfer function; for example, the distinguished  
22 scientist at the AFIP who approached us about

1 wanting to the come over to the JPC.

2           So I agree with you, sir. I think that  
3 this could take awhile, but I'm not sure that  
4 we're approaching it from a pool of -- we've got a  
5 lot of people who are at the AFIP and want to come  
6 over. And so I think that at least is a good  
7 start.

8           I do appreciate your comment about  
9 attracting some quality people and what is it  
10 going to take, and I think we need to take a look  
11 at that.

12           DR. LEDNAR: Okay. The Joint Pathology  
13 Center is a very, very important initiative in the  
14 Department of Defense and very important in  
15 continuing support to the federal agencies as  
16 Congress has requested. So the Defense Health  
17 Board for both Colonel Baker, your staff, Admiral  
18 Mateczun, we stand ready to work with you to be of  
19 assistance in any way we can.

20           I think there's a lot of insight and  
21 expertise that can be brought to the table to help  
22 you think as you're developing the plan going

1 forward. And we look forward to continuing a  
2 collaboration with you to have a successful launch  
3 of the Joint Pathology Center later this year.

4 COL BAKER: Thank you, sir. Appreciate  
5 it.

6 DR. LEDNAR: Thank you. That concludes  
7 our discussion of the first agenda item. Do we  
8 hear Dr. Kizer dial in? Ken, are you on the line?

9 DR. KIZER: Yes, I am.

10 DR. LEDNAR: Thank you for joining us.  
11 Our next speaker, Ken Kizer was unable to be with  
12 us here today, but he is participating by phone  
13 from California, where it's still early. And Dr.  
14 Kizer, we appreciate your joining us.

15 Dr. Kizer is the Chairman of the Board  
16 of Medsphere Systems Corporation, the leading  
17 commercial provider of open source information  
18 technology for the health care industry.

19 Previously Dr. Kizer served as the Under  
20 Secretary for Health in the U.S. Department of  
21 Veterans Affairs and held the position of Founding  
22 President and CEO of the National Quality Form,

1 President and CEO of Medsphere Systems  
2 Corporation.

3 Dr. Kizer also served as Chair of the  
4 Defense Health Board's National Capital Region  
5 Basal Realignment and Closure Health Systems  
6 Advisory Subcommittee. He will be providing us  
7 today an update regarding the Subcommittee's  
8 report submitted to the Secretary of Defense in  
9 May of 2009 entitled "Achieving Word-Class."

10 Dr. Kizer's briefing slides may be found  
11 under Tab 4 of the meeting binder. Dr. Kizer?

12 DR. KIZER: Thank you. Good morning.  
13 Let me just check and see if you can hear me okay.

14 DR. LEDNAR: Sounds good, Ken.

15 DR. KIZER: Okay, thank you. And first  
16 of all, my apologies for not being there in  
17 person. I regret that and hopefully this will  
18 serve as a reasonable substitute. And actually my  
19 comments will be brief, and I don't expect that it  
20 will take the full amount of time since there is  
21 not a whole lot to report since our last  
22 discussion of this topic.

1           The slides that I have briefly recount  
2 the chronology of events that have occurred since  
3 August of 2008 when the Subcommittee was convened  
4 and we did our work and delivered our report, as  
5 was noted, in May, and that was officially  
6 delivered to the Department in July.

7           Then there was a response from the  
8 Department that listed some further comment that  
9 was discussed at some length in the meeting in  
10 November of last year. Subsequently, there was a  
11 joint hearing of the two relative subcommittees of  
12 the House Armed Services Committee in early  
13 December.

14           And there really hasn't been much of any  
15 communication with anyone since then. I've tried  
16 to follow this from afar, but we've not gotten any  
17 official information from any source. We do  
18 understand, or I understand at least, that the  
19 approval to the master plan that was required in  
20 the Defense Appropriation Act that was signed last  
21 October. We understand that the approval was  
22 granted a couple of weeks ago.

1           And other than that, the Subcommittee  
2    which was -- all of our terms officially ended  
3    September or October except for Dennis O'Leary,  
4    member of the Core Board. We've not heard any  
5    further as to reappoint, so I think everyone is in  
6    a bit of limbo. And I think some have assumed --  
7    well, I should say that they've probably moved on  
8    in the absence of any communications, assuming  
9    that nothing is pretty much going to happen in  
10   that regard.

11           And then the last item, and I think it  
12   was included in your handout, was a short  
13   commentary that was published online a few weeks  
14   ago and will be officially out in another week or  
15   two in print in the *American Journal of Medical*  
16   *Quality*.

17           And other than that, I think -- I and a  
18   few other people have some concerns about what  
19   we've heard as far as moving forward, and perhaps  
20   Admiral Mateczun in his comments can put those to  
21   rest, but other than that, I don't have much else  
22   to report since not much else has happened, at

1 least from the Subcommittee.

2 DR. LEDNAR: Okay, Ken, thank you for  
3 that update. What I would propose is that we move  
4 directly to Admiral Mateczun's comments for this,  
5 and then at the end of Admiral Mateczun's  
6 comments, we can come back and have any questions  
7 or a discussion.

8 Admiral Mateczun, I assume that's okay  
9 with you?

10 The Board is grateful to have here with  
11 us today Vice Admiral John Mateczun who is the  
12 Commander of the Joint Task Force, National  
13 Capital Region Medical. Admiral Mateczun has  
14 served as Joint Staff Surgeon and Medical Advisor  
15 to the Chairman of the Joint Chiefs of Staff as  
16 well as the U.S. delegate to the NATO Committee on  
17 Chiefs of Medical services.

18 Present in the Pentagon on September 11,  
19 2001, Admiral Mateczun subsequently served on the  
20 Joint Staff during Operations Noble Eagle,  
21 Enduring Freedom, and Iraqi Freedom. Vice Admiral  
22 Mateczun's ensuing flag assignments were as Chief

1 of Staff Bureau of Medicine and Surgery, Commander  
2 of the Naval Medical Center San Diego, and Deputy  
3 Surgeon General of the Navy.

4 He has also served as Director of the  
5 Military Health Office System Transformation and  
6 is a member of the Congressionally-mandated Task  
7 Force on the Future of Military Health Care.

8 Vice Admiral Mateczun's briefing slides  
9 may be found under Tab 11 of the meeting binder.  
10 Thank you, Admiral Mateczun.

11 VADM MATECZUN: Thank you, Dr. Lednar  
12 and Dr. Poland. Ms. Bader, congratulations on  
13 your new position. Actually, Christine and I were  
14 on the Joint Staff under General Myers together  
15 back during some of the things that Dr. Lednar was  
16 talking about. It was a privilege to serve with  
17 you. It's great to see you here.

18 Board members, distinguished Board  
19 members, guests, there has been a lot that's  
20 happened since the last time I was here. I was  
21 here in November. We had a hearing with the  
22 House, Personnel, and Readiness Subcommittees in

1 December.

2           Since that time I can tell you that --  
3 kind of bottom line is that the Department has  
4 identified \$250 million worth of budget that will  
5 go in FY10 and FY11 towards many of the projects  
6 that we'll talk about here. I'll be glad to give  
7 you some detail about how that money is going to  
8 be spent and working towards achieving world-  
9 class.

10           We go back a little bit as Dr. Kizer  
11 mentioned. I want to provide you with an update  
12 on what's been happening with these plans, talk a  
13 little bit about the background, what the DHB  
14 found, how we're adjusting, and then where we're  
15 going. And I will be glad to take any questions.

16           In 2005 we had the BRAC. I need to tell  
17 a little bit of a story here because one of the  
18 questions I get is about cost growth in the  
19 National Capital Region.

20           What happened to these projects? The  
21 projects as they were originally identified under  
22 BRAC were less than \$1 billion for both the Fort

1 Belvoir and the Walter Reed Medical Center --  
2 National Military Medical Center. And we are  
3 about 2.4 billion now. So the question is: well,  
4 what happened? Well, the Services went back after  
5 that 2005 date, said, you know, we kind of really  
6 have to go back and take a look at the space, the  
7 capabilities that we need. Added almost 70, 80  
8 percent on to that budget.

9 In addition, you may remember Katrina.  
10 Hurricane Katrina happened during this time, and  
11 the construction costs went up fairly dramatically  
12 so there was a lot of inflation and construction  
13 costs.

14 Then in 2007 -- maybe you may not  
15 remember -- the February 2007, articles in *The*  
16 *Washington Post*. Dole-Shalala, the Presidential  
17 Commission, and the Secretary's independent review  
18 group that met to go through what the Department  
19 needed to do to respond, and the Joint Task Force  
20 was formed. The Joint Task Force was formed in  
21 2007.

22 But the Department also took a hard look

1 at the construction projects that were going on  
2 and moved to enhance and accelerate, which was a  
3 second stage in the evolution of what's been  
4 happening in the NCR. That enhance and accelerate  
5 added almost another 700 million into the costs  
6 that were going on.

7 In response and since then we've been  
8 working with the DHB Panel recommendations. You  
9 know, the DHB Panel submitted its review to the  
10 DoD and to Congress in summer of 2009. And those  
11 were codified by the Congress in Section 2714 of  
12 the NDAA. So they accepted those recommendations  
13 as did the Department in its response. And the --  
14 this is the third evolution in what we're doing  
15 which is now kind of getting to world-class.

16 So let me go back and remind everybody,  
17 there's three things that have happened here, this  
18 is not all about BRAC, the Base Realignment and  
19 Closure Commission. We have BRAC, enhance and  
20 accelerate on the part of the Department, and now  
21 we have a third initiative of getting to world-  
22 class. Each of those had set different standards

1 as we've gone.

2 The Department has maintained a  
3 steadfast commitment to providing the best care  
4 for our warriors. The Secretary tells us that  
5 second to the war itself, there is no more  
6 important priority for the Department.

7 So in October of 2009, about the same  
8 time that Congress was legislating, the Department  
9 submitted its response to the Panel review,  
10 adopted the philosophy of the review itself.  
11 There's been a little bit of discussion about  
12 that, and adopting the review of the -- adopting  
13 the Panel's view of what it took to achieve world-  
14 class, the Department said, you know, this is a  
15 continuous journey, and we're committed to that.

16 Some, however, portray that, that, you  
17 know, we're just procrastinating and delaying in  
18 getting there. This is not at all the case, and I  
19 think that those of you that have been involved in  
20 performance improvement, continuance improvement  
21 of any sort realize that even, if you get there  
22 today, that doesn't mean you're going to maintain

1 it until tomorrow and into the future. So the  
2 Department is committed to achieving world-class  
3 and sustaining it into the future.

4 I kind of go through the -- a summary of  
5 the Defense Health Board's findings and  
6 recommendations. And this is exactly what we  
7 talked about last time. Let me get into some of  
8 the details about what has happened. The DoD has  
9 provided \$125 million in fiscal year '10, that's  
10 this current year, to address a number of the DHB  
11 Panel's recommendations, and I'll go through those  
12 in some detail.

13 Additionally, the Department has  
14 provided \$65 million in fiscal year '10 to achieve  
15 world-class operating rooms in Bethesda. I'll  
16 show you the plan for those operating rooms, at  
17 least the planning state that we're in today.

18 And then for fiscal year '11, the  
19 Department had requested \$80 million in the  
20 President's budget for additional parking and for  
21 wounded warrior lodging ability on the Bethesda  
22 campus.

1 Congress has appropriated some money for  
2 off-base traffic mitigation that the Department is  
3 trying to understand. And then the Department has  
4 made and will continue to make significant  
5 progress on these DHB Panel's recommendations.

6 And I'll tell you this -- and I'm going  
7 to get to this at the end again -- but I want to  
8 bottom line it here. You know, getting to world  
9 class is not going to -- as defined in the FY10,  
10 NDAA is not going to happen concurrent with the  
11 BRAC. The BRAC is over in 18 months. We have 19  
12 months left to finish the BRAC here.

13 And we've got a lot of projects left to  
14 do that will require additional projects.  
15 Construction is at saturation point on the  
16 Bethesda campus right now. The Naval Facilities  
17 and Engineering Command Commander, Rear Admiral  
18 Shear, has expressed his concern to me that we had  
19 additional projects on that campus. He's the guy  
20 that it's in charge of safety there. We have to  
21 listen to, I think, to what he says.

22 Additionally, the renovations that were

1 going on in the existing operations at Bethesda  
2 have also reached a saturation point. There's  
3 only so many things that you can move around on  
4 campus before the Commander is going to feel you  
5 starting to give me pause about patient safety.

6 So there is a lot going on on the  
7 campus. It's not going to add additional  
8 construction projects at this point in time, and  
9 I'll talk a little bit about that in our vision  
10 for getting to the rest of this world-class piece.

11 Now, here are some of the Defense Health  
12 Board's findings in relation to the construction  
13 and the state that it was back in 2008 and in  
14 early 2009 when they were looking at it. And all  
15 of these things have been resolved. If anybody  
16 has any specific questions, at the end, I provide  
17 this for your reference. I'll be glad to answer  
18 any specific questions about it. We're not going  
19 to go into each of these. But you can see there's  
20 been significant design and reconstruction. It's  
21 going to be addressed with that \$125 million that  
22 was just approved in November -- December.

1           These are the operating rooms. A  
2 significant portion of the DHB's report was  
3 addressed to the operating rooms as they existed  
4 in Bethesda. And if you see up there in the upper  
5 right-hand corner, it's kind of a layout of the  
6 operating rooms. Some of them, you'll see, there  
7 were 14 that were in the 400- to 550-square-foot  
8 range. The Defense Health Board thought that that  
9 was not world-class, set out a standard for us.

10           The three that are over kind of on the  
11 left-hand side there on the bottom, you can see  
12 them kind of clearly in a sort of light green.  
13 800- to a 1,000-square-foot operating rooms coming  
14 online with the new construction.

15           And here's our plan now to move into  
16 that world-class definition with \$65 million just  
17 approved by the Department. On the bottom on the  
18 side, you will see that there are no operating  
19 rooms left in the end state that will be in that  
20 400- to 550-square-foot range. They are now all  
21 550 square feet and above with many of them being  
22 in the 650- to 1,000-square-foot range.

1           Additionally, there is room for frozen  
2 pathology here. Although I must tell you that,  
3 you know, I defer to Dr. Baker and our experts,  
4 but there are people that believe that this is an  
5 evolving standard, that we may not need that  
6 co-placement given the communication tools in  
7 telepathology that's developing. So there will be  
8 room, though, in that kind of white space down at  
9 the bottom of the picture there for frozen  
10 pathology. And so we believe that we moved ahead  
11 to meet the recommendations there for world class.  
12 This money was just approved as of the 2nd of  
13 February.

14           Here's sort of a summary of what's going  
15 on on the Bethesda campus, and the way that I view  
16 the -- you know, how we responded to the Defense  
17 Health Board recommendations.

18           Plans meet JCAHO. There are no JCAHO  
19 deficiencies. There were -- many, many that were  
20 potential -- potential deficiencies were  
21 identified in the design and planning process.  
22 All of those are now designed out and we have full

1 confidence that there is nothing in the new  
2 construction or the renovation that will not meet  
3 JCAHO standards. That's been a primary concern.

4       Single-bed rooms. Single-bed rooms is a  
5 standard that I think we discussed last time that  
6 I was here. The Department is moving to this  
7 standard, JCAHO does not require it. Clearly it's  
8 seen as a world-class accommodation for the  
9 patients that are there. There are both infection  
10 control and privacy concerns that we have to be  
11 able to accommodate. However, there are -- after  
12 the renovations are done within the existing  
13 campus of Bethesda, there are still 50 rooms that  
14 are double that were intended to be double-bed  
15 rooms after BRAC and even after enhance and  
16 accelerate.

17       Did not move to an enhance -- into a  
18 single-patient -- single-room standard after  
19 enhance and accelerate, primarily in response to  
20 the Commandant of the Marine Corps who wanted to  
21 make sure that we have the cultural ability to  
22 house two Marines together if they didn't family

1 members present. And the Marine saw that as one  
2 of the things that they wanted to do. We're  
3 working through now, finishing that up.

4 But I've told you renovations have  
5 saturated. We can't go back in, and even if we  
6 did renovate those existing -- the remaining 50  
7 rooms into single-patients, that would leave us 50  
8 beds short. So we're going to have to look at new  
9 construction as a solution to that standard. And  
10 that will not happen until after BRAC; however we  
11 will be incorporating this into our comprehensive  
12 master plan for the future. And we'll identify  
13 the funding requirement that would be necessary to  
14 get there, and we'll put it into the plan.

15 You know, I was just up at Johns  
16 Hopkins. They have construction going on right  
17 now. They are moving to a single-patient  
18 standard. I doubt that anybody thinks that  
19 Hopkins isn't world-class, and they have a lot of,  
20 you know, two-bed rooms as well, although they're  
21 moving to the new standard. So it's an  
22 interesting evolution. Don't dispute that it's a

1 standard out there that's world-class, and we will  
2 move towards it.

3 Surgical suites, I described. Support  
4 services. Once again the requirements identified  
5 in support services will require some additional  
6 construction into the future. Not something that  
7 we're worried about in terms of the clinical  
8 capabilities but certainly -- when you're  
9 renovating an entire campus, a lot of the support  
10 services spaces will need renovation too.

11 There are -- even after we finished the  
12 renovations here in the clinical spaces, about 70  
13 percent of the space on campus will require  
14 renovation in those buildings that were built in  
15 the '40s and then in the '70s. And, in fact, as we  
16 open those buildings up, we found additional  
17 requirements for renovation to make sure that we  
18 meet code and JCAHO standards. And so we've been  
19 meeting those as we go.

20 The dialysis unit. Interestingly, there  
21 was I think some perception that the dialysis unit  
22 was going to be above central sterile processing.

1 This is not exactly true. It's not true.

2           And there are storage areas that are  
3 underneath that we put in in the design  
4 precautions to provide -- we've done a water  
5 barrier infrastructure under that dialysis  
6 equipment. We understand completely what the  
7 architects were saying, and we think we've  
8 mitigated that. And further, if we need to make  
9 further modifications, we would be able to in the  
10 master plan.

11           Patient observation. An interesting  
12 difference here between maybe military practice  
13 and what happens in civilian practice. When  
14 somebody is in an emergency department and you may  
15 or may not want to admit, if you want to hold them  
16 for 23 hours and 59 minutes, so it's not over a  
17 day, then a lot of people -- a lot of facilities  
18 are building space into their emergency  
19 departments to do that. We don't exactly have  
20 that problem.

21           We admit them if we need to, and our  
22 current plan would be to admit into the ambulatory

1 procedure unit for observation if we needed to,  
2 and that's what NNMC currently uses. So even if  
3 we admitted or didn't admit, I'm not sure that  
4 keeping them in the ED is the right way, you know,  
5 kind of for our standard operating procedures.

6         However, it does require staffing  
7 solutions to provide that observation capability  
8 whether we admit or not. So we are kind of --  
9 we're still working through that, but I believe  
10 that we have met the intent of the Board's  
11 recommendations on them. That's the Bethesda  
12 part.

13         We're working here on other things, and  
14 we're working on the master plan, somebody with  
15 the organizational and budgetary authority in the  
16 National Capital Region, and we will be responding  
17 to Congress. We have a report that is due under  
18 the fiscal year '10 NDAA by the end of March.  
19 We're working through that. We will address the  
20 issues, and I can tell you kind of where we are on  
21 some of them.

22         We know, I think, what buildings will

1 define the campus. We've got some pictures at the  
2 end. I'll show you. And how we are going to do  
3 the money? There are some other things that we  
4 are still working with the Chairman and the Joint  
5 Chiefs and with inside the Office of the Secretary  
6 of Defense's capabilities to finish up with those  
7 others. So I can't discuss that until the  
8 Department has come up with a decision. But I  
9 believe we're going to be able to respond  
10 positively to all of those questions.

11       Comprehensive master plan. The road  
12 map. This plan, you know, I'll tell you we --  
13 NDAA we've got in, you know, November; and March  
14 wasn't long after November. It's very hard to get  
15 to what we call "1391". Those are the forms that  
16 you have to submit to Congress with construction  
17 level detail.

18       I don't think we're going to have 1391s  
19 by that time, but we will be able to identify  
20 within the Department the requirements of putting  
21 the budgetary requirements to get to world-class  
22 at the best estimate. And then we'll have an

1 interview process where we'll -- and we've already  
2 contracted with design firms to turn those  
3 concepts into the 1391-level detail that would be  
4 necessary.

5       We believe that what Congress wanted and  
6 why they wanted a March report was so that this  
7 could enter into the budgetary cycles of the  
8 Department, the Planning, Programming, Budgeting,  
9 and Execution System. It seems to be their intent  
10 on having this come in, but we're not going to  
11 have 1391-level detail on it.

12       Here's what's going to go into that  
13 comprehensive master plan. Several things. We've  
14 been doing -- completing the National Capital  
15 Region market analysis. Like most markets, we  
16 have about 500,000 beneficiaries in the Capital  
17 Region. About 298,000 of those are enrolled to us  
18 but about 350,000 have used services at various  
19 points in time within the region. So we've looked  
20 out there. We believe that the market analysis  
21 supports the capabilities that exist.

22       Currently, there's always a desire to

1 review whether or not the demand has decreased.  
2 Certainly demand is not decreasing. The number of  
3 users have actually increased over the last two  
4 years. Certainly with the recession that's going  
5 on out there, a lot more enrollees have come into  
6 our system from other health care insurance  
7 systems, the programs that they had. And so we  
8 believe that we're certainly going to be able to  
9 utilize the capabilities that we're building well  
10 into the future.

11 Integrating military health care culture.  
12 Then there's a lot of talk about the Service  
13 cultures and what that means in terms of  
14 integration, and I know that any of you that have  
15 worked with the Services in a joint or combined  
16 sense before and knows that the services have  
17 different operating processes, hard to cross over  
18 between them.

19 But here, what we really are dealing  
20 with is an integration primarily of the health care  
21 cultures at Walter Reed and Bethesda. It's more  
22 about their cultures than it is about the Service

1 cultures that are out there.

2         In fact, we have identified the core  
3 values that cross over all of our cultures,  
4 particularly in relation to quality, quality of  
5 graduate medical education programs research and  
6 patient care, and the fact that patients have to  
7 come to us, particularly those wounded warriors  
8 being taken care of in the National Capital  
9 Region. Those are the overarching values that  
10 will form the basis of this culture. That will  
11 result in the joint facilities that are going to  
12 be in the National Capital Region in the future.

13         I'll show you some of the detail here  
14 within that \$125 million approved by the  
15 Department for the Bethesda campus. We are  
16 incorporating many of the end-user comments that I  
17 think were recognized by the Defense Health Board  
18 panel. And I've got a slide here that talks about  
19 some of them.

20         And for instance, here are some of those  
21 end-user -- and this is not an exhaustive list,  
22 but these are some of the end-user comments that

1 were incorporated.

2           And we're moving ahead. Now we've got  
3 an implementation team for our comprehensive  
4 cancer center concept. Like many of the end-users  
5 that were concerned came out of the Centers of  
6 Excellence for Cancer, and you'll see many of them  
7 there are oncology related. We're putting them  
8 together in a new concept. They didn't deliver --  
9 they delivered services separately before. We're  
10 putting them together in a comprehensive cancer  
11 center.

12           We are working with the National Cancer  
13 Institute, Dr. John Niederhuber, right across the  
14 street from us, to set the goal of achieving a  
15 National Cancer Institute designation as a NCI  
16 comprehensive cancer center. That would be the  
17 first cancer center in the military to do that.  
18 So we think we've certainly incorporated their  
19 end-user comments and going beyond that to take a  
20 look for a new model for the delivery of care.

21           I've got a couple of back-up slides.

22 Before I wanted to go to the conclusions, I want

1 to show you a couple of these. This is the Walter  
2 Reed campus. The last time I was here, you can  
3 see down at the bottom, the state of completion of  
4 some those buildings. The parking garage over on  
5 the left has 944 spaces, and it is now completed.  
6 So that parking garage is open, which has started  
7 to alleviate some of the parking difficulties on  
8 campus.

9       Next to that is Building A. That's the  
10 outpatient building, which is the big green  
11 building to the lower left. And you'll see that  
12 it is all closed in. They're working on the  
13 inside. They're actually putting up walls, doing  
14 the other things that are necessary there.

15       Building B is the new inpatient building  
16 where the 15 new ICU beds, and three new ORs  
17 laboratory capabilities are going to be. Working  
18 on the inside of that now.

19       And then that sort of yellow building to  
20 the right, that's the National Intrepid Center of  
21 Excellence for Traumatic Brain Injury and  
22 Psychological Health, donated by Mr. Arnold Fisher

1 and the Intrepid Foundation.

2 Well on its way to completion. They're  
3 starting to outfit that building now. They hope  
4 to have the building turned over to the Department  
5 by May.

6 So things are progressing very, very  
7 rapidly on the campus. We're working with  
8 incorporating the NICoE now into the concept of  
9 operations for the new Walter Reed Army Military  
10 Medical Center.

11 If you take a look at the campus, we  
12 think that we've arrived at a definition of the  
13 medical center. Now, I'll just -- I'll draw a  
14 line. Basically this is the central campus here.  
15 And then a couple of buildings are over there.  
16 The medical center itself will be all of those  
17 buildings. And then some of the new buildings  
18 that we're building, I'll show you, would be  
19 maintained by the medical center, not necessarily  
20 run by the medical center. And Building 17, which  
21 is sort of up in the top upper left, is also an  
22 administration building that will belong to the

1 medical center. So the medical center itself, we  
2 think, is defined.

3       So we're working to finalizing the  
4 relationship between the base commander and the  
5 medical center commander. This medical center  
6 clearly will be the main mission on the base, and  
7 so I make sure that the installation command is in  
8 support of that primary mission on the base.

9       This is the Wounded, Ill, and Injured  
10 Lodging and Admin complex. Two towers on either  
11 side of a lodging -- of an admin complex and  
12 dining facility. You'll see that we moved to a  
13 different concept here.

14       This is really a new mission for us. We  
15 haven't been involved in past wars and the  
16 rehabilitation mission, but as the Department has  
17 moved into the prosthetics and traumatic brain  
18 injury capabilities that it's had, the Secretaries  
19 and Chiefs of the Services have asked the medical  
20 personnel to rehabilitate people that otherwise in  
21 past years -- past wars would have been identified  
22 as not fit for duty and given medical boards and

1 sent to the VA for their rehabilitation.

2         Since we're dealing with these folks, we  
3 have many of them that are moving into activities  
4 of daily living as part of their rehabilitation.  
5 So once they're discharged from the medical  
6 center, they have to move in to these spaces over  
7 here as we're doing on the right.

8         And that's one of the suites you will  
9 see here over on the right. It's all ADA  
10 compliant with ample space, whether you're in a  
11 wheelchair, undergoing limb salvage, whether  
12 you're an amputee, it now has to -- we try to  
13 accommodate these new spaces or a traumatic brain  
14 injury so that there is a bedroom on either side  
15 of that common area where activities of daily  
16 living -- there's a small kitchen, a small  
17 laundry, small common living space there for them  
18 to allow that transition.

19         We find that the wounded warriors, many  
20 of whom are on campus now for more than a year,  
21 need to be able to transition sequentially into  
22 areas of a higher functioning for their

1 rehabilitative needs. So this will be a, I think,  
2 a very good space to be able to do that in.

3       There are 300. 150 of these suites are  
4 being built that will add 150 -- 306 rooms. And  
5 those will be available before the new medical  
6 center opens.

7       And then additionally, for fiscal year  
8 '11, the Department has identified now \$80  
9 million, that I indicated, to do another 100 of  
10 these suites, 200 more rooms, and add a parking  
11 garage for use with them. So I believe that we've  
12 met the needs for lodging for the wounded  
13 warriors.

14       In addition, many of them now have  
15 either family members or what we call nonmedical  
16 attendants that are working with them, and so they  
17 can now be potentially lodged, if it's necessary,  
18 you know, with that service member.

19       Right now, we don't have any capability  
20 to do that in this kind of suite or apartment.  
21 And the Mologne House on the Walter Reed campus,  
22 it's kind of a hotel room kind of function.

1           This is the Fort Belvoir campus. You'll  
2 see it's moved substantially towards completion.  
3 Once again, that's a nine-holes of a golf course  
4 that you're looking at. It's a very, very big  
5 complex. It's an aircraft carrier from the one  
6 parking garage into the middle and the length of  
7 an aircraft carrier from the middle out.

8           The clinic buildings as you come in from  
9 the parking garages, the clinic buildings that  
10 have the signature swoop which is a "green" rain  
11 collector on top. So four large clinic buildings.

12           They're nearing construction --  
13 completion. We are getting ready to start  
14 outfitting them. And then the central tower  
15 that's going up in the middle where the support  
16 and inpatient capabilities will be located. We're  
17 moving ahead really dramatically there in terms of  
18 the construction as well.

19           Conclusion. We appreciate the DHB's  
20 groundbreaking efforts in helping us to identify  
21 this new world-class standard and to work with all  
22 of the stakeholders to help us to get there.

1 We're committed to achieving the remaining  
2 standards that are left; and I'm go to reiterate  
3 it once again, this is a new standard defined in  
4 November of 2010, and we're not going to be able  
5 to have everything in place to meet that new  
6 standard. This does not mean that those  
7 capabilities that are world class today at both  
8 Walter Reed and Bethesda won't be world-class  
9 tomorrow.

10 In fact, all of these attributes that  
11 existed there at Walter Reed Army Medical Center  
12 and the National Naval Medical Center,  
13 particularly in relation to the amputee care,  
14 which I believe is the best in the world, not just  
15 world-class.

16 Open traumatic brain injury at Bethesda.  
17 Pretty much the same. Those capabilities and the  
18 rehabilitation capabilities that go with them,  
19 will be incorporated into this campus and enhanced  
20 so that the attributes of world-class that exist  
21 today are there and even better.

22 There will be more attributes of world-

1 class; for instance, this comprehensive cancer  
2 center that we're working towards. But then there  
3 are some infrastructure portions of achieving this  
4 world-class status that we will not be able to do  
5 because of saturation of the construction projects  
6 until after their completion of BRAC.

7       So sometimes in Congress they tend to  
8 view things as an all-or-none phenomenon. You're  
9 either completely world-class or you're not. The  
10 Defense Health Board Subcommittee certainly  
11 identified the attributes of world-class, set out  
12 a standard saying, you need to meet 16 out of the  
13 18 of these attributes. And we are diligently  
14 working towards doing that. But the attributes  
15 that are world-class today will certainly be on  
16 this campus in the future.

17       Then we think that we've addressed a  
18 majority of the certainly concurrent construction  
19 concerns that the Subcommittee had. In fact, this  
20 master plan that we're submitting will address the  
21 rest of those. We will be submitting that as soon  
22 as we can.

1           With the deadline of the 31st of March  
2 coming up, it's difficult to get these things  
3 coordinated through the Department sometimes. And  
4 we will be able to then, I think, discuss further  
5 what the comprehensive master plan contains with  
6 you.

7           But since some of it's predecisional,  
8 certainly the budgetary requirements for new  
9 construction, and then it would be premature for  
10 me to discuss it today other than to say the  
11 Department is committed to getting there.

12           You know, we're sometimes out of cycle,  
13 I think. You have a lot of questions as an  
14 advisory board, I need to take those back, work  
15 them in the Department, you want answers and  
16 sometimes we don't have answers yet.

17           I learned as a young commander when I  
18 went up to a Congressional Panel once, it was  
19 about the -- there was a question about research,  
20 and I had to go up to a panel of very senior Navy  
21 people who were prepping me to go give this  
22 testimony. They said, so, Doc, you know, research

1 would be a good thing, wouldn't it, if the  
2 Congressman asked you. I said, yeah, research is  
3 a great thing; and, you know, they said, that's  
4 not the right answer. The right answer is: I  
5 support the President's budget.

6 And so I learned that early, and I  
7 learned it well. And it's served me in good stead  
8 there, you know. Because what happens is, you  
9 know, you're up there as Department of Defense  
10 witness testifying. They said, well, Dr. Mateczun  
11 said research was a damn good thing. And so we're  
12 taking money from, you know, you name it, some  
13 other account, and then you're putting it into  
14 this research account, which we might all think  
15 isn't good. But I support the President's budget,  
16 you know, is our answer.

17 And so there are some things that I'm  
18 unable to talk about early, and not, you know,  
19 quite in as much detail as we like, and that's  
20 certainly the position I felt myself in here last  
21 November.

22 I knew that we were working these

1 details, that this funding was coming, but since  
2 Congress hadn't been notified and since it hadn't  
3 been completely approved, then it would have -- I  
4 couldn't come in and honestly tell you that it was  
5 going to happen. And I still support President's  
6 budget. So we are a little out of cycle on those  
7 things.

8 I think that after March when we get  
9 this comprehensive master plan submitted, I'll be  
10 able to tell you some more details about the other  
11 parts of getting to world class. I'll stop there,  
12 and I'll be glad to take any questions that you  
13 have.

14 DR. LEDNAR: Admiral Mateczun, thank you  
15 for that brief and thank you for joining us in  
16 person today to update us on this very important  
17 project. Thank you.

18 I'd like to ask Dr. Kizer, who's on the  
19 phone, if he wouldn't -- first, if you have any  
20 comments, Ken, or questions that you'd like to  
21 ask. Ken?

22 DR. KIZER: Thank you. The -- and

1 again, just let me check, can you hear me okay?

2 DR. LEDNAR: Yes, we can hear you very  
3 well, Ken.

4 DR. KIZER: Okay, thank you. Let me  
5 also thank Admiral Mateczun for his comments.  
6 This is -- much of this I'm hearing for the first  
7 time just like all of you. And also I'm mindful  
8 of his staged comments about supporting the  
9 President's budget. I've been there, and I  
10 understood it quite well.

11 There are several things that I might  
12 just put on the table that are a possible concern.  
13 One of which is not directly related to comments  
14 that Admiral Mateczun made, but just as a reminder  
15 for the Boards that the Subcommittee that I  
16 chaired was originally convened for purposes other  
17 than reviewing the Walter Reed -- or the plans for  
18 Walter Reed as worked out for. And while the  
19 design plans for those two facilities certainly  
20 bear on and are important to the charge of the  
21 Subcommittee, that Committee never actually was  
22 able to address its original charge of advising on

1 the -- an integrated care delivery network in the  
2 National Capital Region because we got psyched, if  
3 you will, on this particular matter.

4 And since the Committee has not been --  
5 I just want to remind the Board that we are aware  
6 that the purpose and charge that was given to the  
7 group has not been realized for reasons that the  
8 Board understands. So that grabs one point.

9 A second is simply that I don't feel  
10 that we are in a position to offer much in the way  
11 of constructive or other comments because we have  
12 no information and aren't officially a group  
13 anymore. Again, we listen with interest, and are  
14 supportive of what's been done, although, I think  
15 a number of the Committee members might  
16 (inaudible) if they had the opportunity to ask.

17 A third is -- in listening to some of  
18 the incentives and some of the observations from  
19 afar, it sounds a bit like there is a check  
20 strategy being followed, and that may or may not  
21 be a reason for it in that we wouldn't want this  
22 to become a -- or that approach to become a

1 barrier to looking more broadly at what's needed  
2 and the evolving needs of this campus, and this,  
3 you know, check all the trees but miss the forest.  
4 And, again, it's probably general comments than  
5 anything specific at the moment.

6         Just two or three other of -- again, not  
7 being perfect is exactly how the comprehensive  
8 master plan is being developed, but one concern  
9 that has been expressed by folks is the question  
10 of whether the approach is one of developing that  
11 master plan based on a composite of a number of  
12 the different components or whether there is  
13 overarching strategy that is going to guide the  
14 evolution of those components. And that's tied  
15 into the plan, and it's a fundamental approach.

16         And the concern -- or a possible concern  
17 is that if it is the former where the master plan  
18 is an aggregate of a bunch of component plans,  
19 that wouldn't be the spirit of -- and  
20 strategically in the long term wouldn't be the  
21 approach the Subcommittee was recommending.

22         Another issue is just the -- what might

1 be viewed as extraordinary cost escalation of the  
2 project. Two and a half million or so, another  
3 250 million has been added. I've heard that  
4 number may be in the range of 700 million. And,  
5 again, I don't know for sure, but there's  
6 certainly -- we're moving in the direction of a  
7 cost figure that might be viewed as not a good  
8 model for how to approach these facilities, and  
9 understanding the history of this is maybe  
10 unavoidable, but there's just the cost concern.

11         And then finally I guess the last thing  
12 I would (inaudible) at least at this point is what  
13 some have labeled as mission creep and the  
14 long-term viability of such. As was noted, the  
15 capability for dealing with (inaudible) has been  
16 greatly expanded, and the rehabilitation has been  
17 expanded.

18         And I think from the quality-of-care  
19 perspective that's currently being provided that  
20 the (inaudible) or whether that ultimately was  
21 going to be viable when demobilization has  
22 occurred from the current conflicts, and interest

1 shifts to other concerns, whether this ultimately  
2 will end up being a good thing for us and whether  
3 this -- the current enhancement capability -- kind  
4 of the expense of other organizations who would  
5 normally have this responsibility, is an issue  
6 that warrants being thought about, certainly if  
7 history is at all a predictor of the future.

8         We know that when -- or that interest in  
9 these types of things is ephemeral and when  
10 budgets get tighter, these are all types of things  
11 that get compromised, and that's not good  
12 ultimately for patients who come to rely on these  
13 services.

14         So that's a bit of a wandering but those  
15 are some of the concerns that I would put on the  
16 table at this point.

17         DR. LEDNAR: Thank you, Dr. Kizer.

18         Admiral Mateczun, did you want to make any  
19 comments to Dr. Kizer?

20         VADM MATECZUN: Yes. All comments that  
21 I think that we were aware of as well. I think  
22 the question of what is the strategy and how you

1 construct a Congressional report may be different  
2 things. And clearly we need to have a strategy  
3 that takes a look at where the integrated delivery  
4 system within the National Capital Region is going  
5 to move in into the future, how does the Walter  
6 Reed National Military Medical Center and the Fort  
7 Belvoir Community Hospital fit into that strategy.  
8 I couldn't agree more that there are, you know,  
9 going to be budgetary pressures too in the future.

10 In fact, right now, we're at war, you  
11 know, our casualty population over the last two  
12 months has come back up again within the National  
13 Capital Region.

14 And I think that there is a desire on  
15 the part of many people that we wouldn't have to  
16 see casualties anymore; in fact, almost everyone.  
17 It would be great if we didn't have to see  
18 casualties coming back from Afghanistan or Iraq or  
19 wherever our country sends folks.

20 Even, you know, when those casualties  
21 are not there, though, I think that part of the  
22 underlying message here is that with the

1 population studies, we have the capability to  
2 support the needs of the population and act as a  
3 worldwide referrals medical center.

4 This Walter Reed National Military  
5 Medical Center would be the military's largest  
6 medical center by almost 50 percent. So it's  
7 much, much bigger than any of the other medical  
8 centers that are out there today. And so it will  
9 continue to act as a, you know, tertiary  
10 subspecialty and super subspecialty referral  
11 center, you know, well into the century.

12 And so those patients are going to be  
13 coming and serving the needs of the population  
14 just to live within the NCR. We would able to  
15 take up the capabilities.

16 What we're searching for I think is --  
17 and I know Ms. Bader was also the Executive  
18 Director for the Military Health System of the  
19 Future, a board that met and reported out here at  
20 the Defense Health Board. Their primary finding  
21 was that we needed to find a strategy to integrate  
22 the private sector care and direct care systems

1 for the military. We're still struggling with  
2 that. We have here an opportunity to do that.

3 Right now, there is \$600 million worth  
4 of care going out into the private sector care  
5 within the National Capital Region, you know,  
6 every year. So there is plenty of opportunity for  
7 us to work with our partners and the contracts to  
8 bring some of that back, you know, in house.

9 We'd have to have the cases that we need  
10 to support our GME training programs. And, you  
11 know, the surgery, the general surgery program is  
12 now an integrated program. The RRC just  
13 accredited the joint program. It's now one of the  
14 largest surgery training programs in the country,  
15 seven chief residents working at the top end of  
16 that surgical pyramid. And so we have to have the  
17 cases to be able to support that.

18 Putting all of these things together as  
19 Dr. Kizer points out, not a trivial thing, the  
20 greater we write a report may not exactly reflect  
21 that strategy.

22 It is a challenge answering questions,

1 in particular those things that identify specific  
2 deficiencies while keeping it in the context of an  
3 overall strategy. So I agree with Dr. Kizer  
4 completely, and certainly on that. We'll be  
5 careful to try to do both the best that we can.

6 DR. LEDNAR: Thank you, sir. We have  
7 time for one or two questions. Dr. O'Leary and  
8 Dr. Silva?

9 DR. O'LEARY: Thank you for that report.  
10 I think there was a lot in there you could be very  
11 encouraged about, and you're making a huge amount  
12 of progress. Just a couple of things. I couldn't  
13 glean entirely from your comments whether you  
14 thought that it is going to ultimately be feasible  
15 to move to all single-patient rooms making  
16 announcements for the buddy rooms, but it is going  
17 to be feasible to do that.

18 VADM MATECZUN: That's going to be --  
19 well, in the master plan we will address that  
20 question.

21 DR. O'LEARY: Yeah, I figured that  
22 that's probably where you would deal with that. I

1 think that -- I like Johns Hopkins too, but  
2 they're one of a number of elite-named  
3 institutions whose physical facilities don't  
4 permit them to achieve world-class, and I think we  
5 probably do have that opportunity here.

6       The other comment is a little bit --  
7 simply to urge that you're not underestimating the  
8 challenge of creating the kind of culture  
9 necessary. It is -- you allude to more than  
10 simply melding the cultures of the various  
11 services, but it is really creating a culture that  
12 supports quality improvement, patient safety and a  
13 learning culture, particularly in an institution  
14 that's heavily involved in a graduate education  
15 and undergraduate education.

16       VADM MATECZUN: Yes. I agree  
17 completely. This is another one of those areas  
18 where I believe that the Department has to be  
19 committed to a continuous process. I could not  
20 stand here today and tell you we will have a  
21 culture in place by September 15th of 2011 that  
22 will do all of those things. And I would

1 challenge anyone to do that at any institution.

2 But we are committed to give the  
3 foundations that culture and then incorporate it  
4 into the system. It will take five to seven years  
5 is the best advice we can get before it becomes so  
6 ingrained that it's part of the culture.

7 DR. O'LEARY: And it's a continuous  
8 process because there is always a risk of falling  
9 back and I think one of the -- you know, a couple  
10 of the obvious challenges that are -- that this  
11 institution uniquely faces is the desirability of  
12 optimizing transparency and minimizing  
13 hierarchical structures which are kind of, you  
14 know, inherent problems which you're dealing with.

15 VADM MATECZUN: Thank you.

16 DR. SILVA: Thank you, Admiral, for your  
17 comments. I sort of had the same question Dr.  
18 O'Leary had. I was one that was particularly  
19 critical of you, could you employ the word "world-  
20 class," and I think you can. I think from my  
21 point of view in the future, you mentioned that  
22 there are still areas that will be developed under

1 the master plan but are deficient. It's a lot of  
2 data you present, but I'd like to see those pulled  
3 out so at some point we can continue to track  
4 them, to know if you're on target. But I really  
5 liked your report today. Thank you.

6 VADM MATECZUN: Thank you. We will be  
7 incorporating those into the comprehensive master  
8 plan I think in the way that's identifiable to  
9 everybody.

10 DR. LEDNAR: Admiral Mateczun, thank you  
11 for the very insightful and informative report  
12 that you shared with us today. Thanks to Dr.  
13 Kizer for participating remotely from California.  
14 We miss you, Ken, being here. We appreciate the  
15 time that you did spend with us.

16 And, Admiral Mateczun, the Board  
17 continues to be a resource to you, anyway we can  
18 be helpful both in looking at the master plan and  
19 moving forward to implement to achieve world  
20 class, the Board is here to be a partner with you.

21 VADM MATECZUN: Thank you.

22 DR. LEDNAR: Thank you.

1 (Applause)

2 DR. LEDNAR: We're going to take a  
3 15-minute break, and then we will reconvene for  
4 the next agenda items. So we will break now for  
5 15 minutes.

6 (Recess)

7 DR. LEDNAR: Okay. We are restarting  
8 with our next agenda item. Since we are all here  
9 to serve the men and women who defend our country,  
10 our next brief this morning is an overview of U.S.  
11 military operations throughout the world given by  
12 Colonel Christopher Coke of the Joint Staff.

13 Colonel Coke serves as the EUCOM  
14 Division Chief of the Joint Operations  
15 Directorate. This division is responsible for the  
16 monitoring and coordinating of all Joint Staff  
17 actions for operational activities within NATO  
18 Headquarters in U.S.-European Command.

19 Among Colonel Coke's numerous awards are  
20 the Bronze Star, Meritorious Service Medal, Air  
21 Medal, the Third Strike Award, Navy and Marine  
22 Commendation Medal, and two Navy and Marine Corps

1 Achievement Medals. The Board would also like to  
2 congratulate Colonel Coke on his recent promotion  
3 to his current rank as full Colonel 06. Well  
4 deserved. Let's congratulate Colonel Coke.

5 (Applause)

6 DR. LEDNAR: Colonel Coke's brief will  
7 highlight the medical and public health situation  
8 in Haiti as well as the Department's relief  
9 efforts to date. Colonel Coke's presentation  
10 slides may be found under Tab 2 of your meeting  
11 binder. Colonel Coke?

12 Col COKE: Thank you, sir, I appreciate  
13 your comments and always a pleasure to be here.  
14 And, again, I'm here from the Joint Operations  
15 Directorate and hopefully to provide you all an  
16 overview of what's going in the world, at least  
17 with our military. And, please, as I progress if  
18 there's any questions, I don't mind taking a  
19 question en route so please feel free to jump in.

20 Really, I mean, the bottom interests  
21 don't change that much. I mean, there are some  
22 nuances that take place, but again, you know, the

1 bottom line is to protect the homeland and to  
2 protect the commons. When I speak of commons, I'm  
3 talking about those means to be able to move  
4 things across the seas or the air to be able to  
5 allow the global community to trade, to interact  
6 with each other fairly and kind of on a fair  
7 field. So that's really, you know, what it boils  
8 down to, how we use instruments of national power,  
9 specifically the military in this case, to be able  
10 to sustain that, to leverage it as required. So  
11 that really remains kind of bottom line of vital  
12 interest.

13       You know, it's important to keep in mind  
14 that you have to remain relevant today, in today's  
15 fights as also being able to look out to 2020,  
16 2030 and try to, as best you can, forecast what's  
17 going to be coming, what are the adversaries in  
18 the future and what are we going to have to do to  
19 be able to posture, to be able to with deal with  
20 those. And just not from a military standpoint  
21 but from an interagency, from a -- all of  
22 government, and global standpoint.

1           And, you know, the other comment before  
2 we get started is -- and there are two very good  
3 examples. Why is it important for another country  
4 to succeed? Well, I mean, obviously there's an  
5 altruistic interest to see everybody succeed.

6           But, you know, we just look at the  
7 recent incident in Haiti and then just what took  
8 place over the weekend in Chile. Look at the  
9 capacity of those individual countries to be able  
10 to take care of themselves. And obviously there  
11 is a huge difference, you know. And I'll talk a  
12 little bit about Haiti and as far as the DoD  
13 effort to support Haiti. But it was tremendous,  
14 tremendous across the whole nation and tremendous  
15 across the globe. So a huge investment as opposed  
16 to Chile. And, of course, we'll all be helping  
17 out there as well, but it won't be to the same  
18 magnitude.

19           So that's why it is so important and  
20 vital to us that we, you know, help and foster  
21 other nations to be successful and also so we have  
22 a good trading partner as well. So moving on.

1           You know, again, we're challenged and  
2 again how we foster ourselves for today and  
3 tomorrow is where do we put up foot. And as you  
4 see -- and it's probably better to read within  
5 your slide deck -- is, you know, the preponderance  
6 of the force is obviously in the Middle East,  
7 about 220,000. Although we still have 100,000 in  
8 Europe and about 160,000 in the Pacific. Only  
9 have about 3,500 down in Southern Command.

10           Well, that presents some interest when  
11 you have an incident like Haiti, and you need a  
12 much more robust capability to be able to take  
13 care of an incident like that. So those are --  
14 that's a very real risk that you face as you look  
15 to apportion forces across the globe and where do  
16 you best put them.

17           And obviously we spent a lot of time in  
18 the Joint Staff this last month helping and  
19 supporting and actually flying people down to  
20 Miami to be able to help out Southern Command  
21 because that was a risk that we took collectively  
22 to be able to better force -- allocate forces in

1 Central Command and other areas that have, you  
2 know, more real and sustained situations to deal  
3 with.

4 Really the -- before we get on the tour  
5 of the world, it is important to also recognize  
6 and probably just as recent is the Secretary's  
7 discussion with the permanent representatives to  
8 the NATO, I believe this last Friday. We talked  
9 about being relevant and the importance to be able  
10 to transform.

11 We all know that we're out of the Cold  
12 War, but we have to be able to foster these  
13 countries to remain flexible and responsive and  
14 engage in what's happening now as well as the  
15 future. So this is a continual battle to move  
16 forward because the scene is quite different.  
17 It's not the model that we lived with, you know,  
18 20, 30 years ago.

19 AFRICOM. Again, our newest combatant  
20 command talked about this. Been here with us for  
21 about 18 months. The uniqueness of having -- and  
22 he's actually pictured there, but Ambassador

1 Holmes the Deputy for all things civilian and  
2 working with the Guiana folks as far as engagement  
3 -- a lot of theater security engagement in Africa.

4 We obviously have sustained operations  
5 in the Horn of Africa and Djibouti. But as  
6 depicted here, a lot of joint training.

7 Marine Corps working specifically in  
8 engagement in Liberia. Liberia seems to be a  
9 common place for the Marine Corps to go back to on  
10 regular occasions. But also the support, like the  
11 elections within Sudan here in April. And then  
12 Darfur, we've seen some progressions as the  
13 Janjaweed Militias deal with the differences in  
14 Islamic there.

15 So Africa continues to be an evolving  
16 project. Again, only about 3,500 people there so  
17 we recognize we're going to have to put more  
18 energy into this to be able to really move it  
19 forward.

20 CENTCOM. Really the center of efforts  
21 and the predominance of the fight right now.  
22 Really three things that come to mind: obviously

1 Iraq, Afghanistan, and piracy.

2 Iraq real quick. You know, we're down  
3 below 100,000 folks there, first time since 2003  
4 and will flow down to 50,000 at the end of the  
5 August. And now Afghanistan actually has more  
6 U.S. troops there than Iraq.

7 Again, all eyes are on the elections  
8 here in the next two weeks. And that will really  
9 set the stage for our planned, you know,  
10 responsible drawdown per se, but it's important to  
11 recognize that, you know, even though we have this  
12 off ramp built, it is condition based. And if  
13 things do not, you know, go as well as we  
14 anticipate, we do have means to be able to  
15 continue a level of engagement or, you know, hit  
16 particular areas perhaps up to the north that may  
17 need engagement beyond what is, you know, planned  
18 right now.

19 Piracy continues to, you know, be an  
20 annoyance off the Gulf of Amman and, of course,  
21 you know, the pirates continue to develop their  
22 techniques and tactics, and we continue to

1 counter. The nice thing is that it is a coalition  
2 effort, and through a lot of bilaterals as well,  
3 Russia and China are engaged as well. So we  
4 continue to work with that.

5 And then Afghanistan, and I'll talk a  
6 little bit more about Afghanistan in the next  
7 slide. But it's important to recognize that, as  
8 you'll all know, General McChrystal announced a  
9 strategy.

10 And really the focus of last semester,  
11 per se, was how to resource this. And as you know  
12 in the Presidential announcement, 30,000 was a  
13 result. But it's important to recognize that  
14 there's another 10,000. McChrystal asked for 40.  
15 Well, U.S. provides 30. And the anticipated hope  
16 was that we would be able to get 10,000 for our  
17 coalition partners. And we're about 9,500 out so  
18 we are drawing in very close.

19 But like so many things as you get close  
20 to the final objective, it gets harder and harder.  
21 But actively engaged in our partners around the  
22 world to be able to get the strength -- get the

1 people there that we need.

2           And it's important to recognize that the  
3 strategy, it's just not to fight. I mean, that's  
4 a part of it, but it's also the engagement and  
5 this recognition to be able to build a capacity of  
6 Afghanistan to solve its own issues, to build its  
7 governance, its policing, and its military.

8           And there are specific numbers that have  
9 been recognized and built into the strategy and  
10 continue to be reinforced that we need to drive  
11 through.

12           So it's just not the battalions and the  
13 air support to be able to fight, but it's also the  
14 trainers and the ability to train the police of  
15 the national military to be able to sustain their  
16 own clearing and holding operation as it is right  
17 now.

18           And I'll talk about Moshtarak in a  
19 minute, but, you know, the ability to be able to  
20 just not take an area but to be able to hold it  
21 and then to be able to allow for that governance  
22 to work within that particular sector. So let's

1 see, we'll move on.

2       We'll talk about Moshtarak here. Really  
3 centered around the Helmand River valley. You've  
4 got the Lahskar Gah and the Nad Ali and the river  
5 and then of course the valley. And Moshtarak is  
6 sort of the focus, the main effort. So why this  
7 area? Well, one, it's a stronghold of the Taliban  
8 and the insurgency. The terrain favors it. So  
9 they're drawn to it. It's also one of the more  
10 fertile areas and thus one of the higher poppy  
11 cultivation areas.

12       So this was the point of attack. We  
13 actually went in here about a year ago, year and a  
14 half ago. Just didn't have the forces to be able  
15 to hold so why bother going in if you can't hold  
16 it. It doesn't make sense. So with the plus up  
17 and the right forces in place, we're able to build  
18 up to a point that we can go in and hold.

19       This a 15,000-man operation -- men and  
20 women, sorry -- and about 8,000 were Afghanistan.  
21 It's Afghan led. Obviously with a lot of help  
22 from us and these other countries that are listed

1 right here. But it's important, the majority were  
2 Afghanistan, and it was Afghan led. And the  
3 objective is to go in and to clear and to  
4 basically take ownership of Marjah and then to --  
5 they call it sort of a government in a box, but  
6 basically with a local governance to be able to go  
7 in very quickly because remember the Taliban had  
8 shadow governance, which are actually very  
9 effective unfortunately in these areas.

10       So you've got to be able to go in very  
11 quickly and replace those that you've just kicked  
12 out, removed. And that's what we did with the  
13 government -- the governor of Helmand province.

14       So right now, we're still in some  
15 clearing operations, but now we're sort of moving  
16 into the holding and to be able to hold this  
17 territory so that now you can start building and  
18 then allow the governance to start taking effect,  
19 build that confidence within the population, that  
20 you actually have a better alternative than what  
21 was there before.

22       So this is an example. This is a huge

1 operation, nothing like this since 2001. But this  
2 is the example of General McChrystal's strategy,  
3 the ISAF strategy, of how we think we're going to  
4 get Afghanistan. It's too early to tell if this a  
5 tide breaker or a tide turner, but I think it is  
6 safe to set that we have stopped the regression of  
7 our capability and the advance of the adversaries.

8 I think we're at a point where we've  
9 stopped that momentum, and now we're trying to get  
10 it into the other directions. So I think good  
11 news so far. Okay moving along.

12 Old EUCOM. You know, we're still  
13 dealing with Russia and what does Russia mean to  
14 us and what are their intentions. And, you know,  
15 we have reminders. Georgia obviously is one. So  
16 that is always an issue with EUCOM.

17 It's important to recognize that they've  
18 continued their surveillance and increased their  
19 surveillance to not quite to post-Cold War -- or  
20 pre-Cold War levels, but they are increasing their  
21 sub activity and their aircraft activity. The  
22 Bear flights, in fact, one came very close within

1 Hawaii, 40 years since Hawaii has had a Bear  
2 flight come close to it. So that continues to be  
3 a concern.

4 But what's at hand right now is  
5 obviously supporting NATO. NATO's number one  
6 mission is ISAF, and they continue to provide that  
7 support to it. But we also have forces in Kosovo.  
8 They aren't drawing down. We'll be turning that  
9 over not before too long.

10 And then other standard maritime groups.  
11 One of the maritime groups refer back to the  
12 piracy is actually directly involved. We call it  
13 Standard Navy. Standard NATO Maritime Group I is  
14 actually engaged in kind of piracy operations.

15 The other two aspects -- the picture up  
16 top left -- is pertaining to Georgians, one of our  
17 success stories. We're going to put 750 Georgians  
18 into the fight, into Helmand actually, to work  
19 with the Marines, and they'll deploy in April.

20 The other one is relief efforts -- or  
21 not really relief efforts -- but this was the USS  
22 Grapple. If you remember, there was a Lebanese --

1 or Ethiopian flight that flew out of Lebanon about  
2 month ago, three weeks ago. So they're doing  
3 salvage ops trying to look for the black box. So  
4 still a fair amount of just theater engagement.

5       The picture down to the lower right are  
6 patriot batteries, again, where we've just evolved  
7 from an old -- or the previous ballistic missile  
8 defense program to a new one what we call Phased  
9 Adaptive Approach, which encompasses more of a  
10 robust, more low-key system such as our Aegis  
11 ships and patriots and other mechanisms to create  
12 this umbrella of protection along the same intent  
13 as what was on the old program and working with  
14 such countries as the Czech and the Polish.

15       And then Israel. Israel remains -- it  
16 is part of EUCOM but obviously also closely tied  
17 to CENTCOM, and, you know, we had Gaza a year and  
18 two months ago. Continued tensions Hezbollah in  
19 to the north and then Iran.

20       And really, you know, what's Iran's  
21 intention? There are no real defined red lines,  
22 per se, but we know that there's -- you know, Iran

1 gets too froggy frankly and Israel is going to  
2 react and how do we manage that so that we don't  
3 have sort of an implosion within the Middle East.  
4 So very -- a lot of concern there.

5 Northern Command. Again Homeland  
6 Defense. The interesting thing is it -- and I'm  
7 trying to show you on the picture I put in here --  
8 was basically Northern Command working with Mexico  
9 to put in a field kitchen to fly down to Haiti.  
10 So, again, intermittently involved.

11 To the right is basically a civilian  
12 support training team that's looking at if there  
13 was a weapon of mass destruction within the  
14 boundaries of the United States. Obviously the  
15 military provided a fair amount of support to  
16 that. And this is one of the areas that it would  
17 to basically assess, advise, and assist as  
18 required, you know, whatever that was, and this  
19 was the training evolution that took place in Las  
20 Vegas. And of course, you know, a lot of integral  
21 interagency working with just not only the first  
22 responders but also with the FBI.

1           Last thing, counter drugs,  
2 counternarcotics activity. You know, Calderon  
3 with Mexico and working to help Mexico shape  
4 because it definitely relates to us as far as, you  
5 know, our number one flow of narcotics coming up  
6 through Columbia but also Mexico as well. And  
7 then the weapons heading south.

8           Pacific Command. Again, there is  
9 security but this issue right here, North Korea,  
10 is you know, never is out of our mind. The  
11 shadows, and you probably see this in your book a  
12 lot better, but this Taepodong-2 which can't reach  
13 the United States much longer. It can't carry a  
14 nuclear warhead. Had a failed attempt at testing  
15 a little while ago. But they are moving toward  
16 that. So that's an unstable country. With that  
17 kind of capacity it's not a good thing. So our  
18 engagement obviously remains heavy there.

19           Other things. You know the regional  
20 threat things, we think things are going fairly  
21 well with Taiwan and the relationship with China.  
22 And then, of course, we have weapon sales. So,

1 you know, it's balancing all things in a broad  
2 perspective and yet at the same time, trying not  
3 to increase -- or actually diminish these natural  
4 tension lines.

5         And then the more and more engagement --  
6 a lot of success in the Philippines but continuing  
7 to work with the Philippines as far as this is an  
8 EOD team, Navy EOD team, that was working with the  
9 Philippines. But they've done a lot of good work  
10 as far as help, countering help Al Qaeda in that  
11 region.

12         Southern Command. Normally what I'd be  
13 talking about Southern Command, it would be, you  
14 know, the counternarcotics flow, the success we've  
15 had, and the work we need to do, such as Colombia.  
16 A lot due to security. Hospital ships being  
17 flowing down there engaging, and then being ready  
18 for mass migration issues that always seem to come  
19 out of Haiti and Cuba whenever there's crisis to  
20 join.

21         So having said all that, we'll just move  
22 right on to Haiti because this has really brought

1 Southern Command to bear. As you all know, fairly  
2 significant earthquake, 7 on the scale. Epicenter  
3 right near Port-au-Prince, 16 miles away from  
4 Port-au-Prince.

5 Really 3 million people affected, but  
6 200,000 and the count keeps going up and down, but  
7 between 210,000 and 230,000 people dead. And  
8 about 30,000 injured and about a million homeless.  
9 So that's what was presented.

10 In here you can see the actual  
11 population and the severity of the quake but quite  
12 a lot of population within the extreme just  
13 because of its vicinity to Port-au-Prince or some  
14 of the other capital areas.

15 The response obviously as you all have  
16 read and know was huge. And, you know, as kind of  
17 alluded to earlier, this is the poorest country in  
18 the Western Hemisphere so not much capacity within  
19 to be able to manage an incident of this scope.

20 And then a lot of things that, you know,  
21 from building codes to just governance to  
22 infrastructure to be able to support and deal with

1 this. So the DoD response, as depicted 22 ships.  
2 And it's important to talk about the type of  
3 ships. You had a carrier strike group, you had  
4 two amphibious ready groups with MEUs, Marine  
5 Expeditionary Unit forces, embark. You had  
6 standard cruisers and frigates and destroyers, and  
7 then of course you have hospital ships. So 22  
8 total.

9       And then of course coming off those  
10 ships as well as at some land base was about 83  
11 rotor wing helicopters that were able to support  
12 this effort. And then the total ground force of  
13 about 18 and a half thousand folks.

14       So that's what -- this is just a  
15 snapshot in time -- I can't remember -- 26  
16 January, but that's what we had on the ground.  
17 Interesting thing -- just a sidenote -- everything  
18 that we did within the National Military Command  
19 Center within (inaudible) unclassified. We did  
20 start migrating some things to a classified  
21 system, but complete transparency as far as what  
22 we were doing in conjunction with interagency

1 partners and nongovernmental organizations and of  
2 course other reliefs.

3       Speaking to this effort, I obviously  
4 talked about the infrastructure. Immediately both  
5 the port and the field, the airfield was closed.  
6 Got the airfield up and running fairly quickly  
7 which was fortunate to be able handle upwards of  
8 about 100 sorties a day, flights coming in a day.  
9 And we used almost every bit of those flights so  
10 about a week, week and a half into it. And then  
11 it began getting down to about 90 sorties a day  
12 going in and out.

13       And then the port. Port more  
14 problematic. Some of the pilings and things like  
15 that were severely damaged. So using some new  
16 technologies to be able to bring these sort of  
17 floating ports in and to be able to hook them up  
18 so that you can roll on, roll off equipment and  
19 things off the ships.

20       So was able to get the port up to a  
21 capacity of about -- I don't know if you've all  
22 seen those 20 cubes, but the huge containers. But

1 basically if you can imagine 200 of those being  
2 able to be offloaded at the same time.

3       So as with everything, you've got to get  
4 equipment and supplies, and I know people are glad  
5 about the prioritization of what we were flowing  
6 in but initially very difficult. But within a  
7 week we were able to get to this capacity which  
8 was important.

9       The second part of that is obviously the  
10 infrastructure within to be able to distribute.

11       This is more the military in addition  
12 to, you know, the security aspect of it. And  
13 fortunately, the security -- what we thought would  
14 be a security issue was really diminished quite a  
15 bit, which was very fortunate.

16       But our ability to focus on the  
17 infrastructure and help, provide, and supply  
18 relief efforts, you know, across into Haiti  
19 proper.

20       And this is where, you know, the  
21 helicopters obviously came in and then getting  
22 into those roads, bridges, trying to work it so

1 that we can start moving things inland.

2       On the medical end, obviously Comfort  
3 was there. 946, I think, bed capacity. Flew in a  
4 200 person augment to be able to bring the  
5 capacity up and pretty much used that capacity  
6 within the first week or two. One of the issues  
7 that did come up was, okay, you fixed the person,  
8 now what do you do post-surgery, post-medical?

9       You've got to -- so we actually -- and  
10 Haiti and DHS actually built these camps, just not  
11 camps for refugees but also camps for post-care to  
12 be able to flow these people back in because  
13 there's nowhere for them to go. Most of them,  
14 they were homeless, and there was no structure  
15 there for post-trauma care.

16       And then, again, the whole intent is to  
17 turn this over, you know, and get the military  
18 back on the road, so to speak. And that's the  
19 phase that we're kind of in right now is turning  
20 things over to USAID and getting them to take over  
21 completely. I mean, they always owned the  
22 mission. It's just basically getting the DoD

1 support out of that mission so that they can make  
2 it and continue their more enduring engagement  
3 with Haiti to get them on the long road of  
4 recovery.

5       Really, I mean, a couple of takeaways;  
6 one, it's a feel-good mission even though it's  
7 catastrophic what took place. It's immediate  
8 gratification. But more importantly is the  
9 ability of our Department to be able to mass this  
10 type of effort in concert with what is already  
11 going on in the world. It's tremendous. So we  
12 have a lot of depth and a lot of breadth to be able  
13 to do that.

14       It's also a very good strategic message  
15 to our adversaries that we have this capacity,  
16 that we're not tapped out. And so that's good.  
17 And perhaps because we were not messed with, so to  
18 speak, during this time period, maybe they're  
19 tapped out. We can only be so lucky.

20       But the point being is that we have a  
21 lot of resilience within our -- and a lot of depth  
22 and capacity to be able to do these things. So

1 good there.

2 I'll just wrap up with kind of concerns  
3 and where we're going. Interest items. Again,  
4 you know, as we move out of one and move into the  
5 other, and we're kind of at like crossroads right  
6 now. Talked about more people in Afghanistan than  
7 in Iraq, it's balancing this appropriately so that  
8 we don't off ramp too fast or we don't on ramp and  
9 overload those infrastructures and abilities to be  
10 able to absorb what it is we need in Afghanistan.  
11 So that's continued.

12 Pakistan and India. Always on our mind  
13 because we recognize that Pakistan and Afghanistan  
14 intrinsically interlink. Success in one demands  
15 success in the other.

16 Talked about Israel, Palestine, Gaza,  
17 external actors, ties into Iran and Israel. But  
18 that is one that continues to be on our minds.

19 Threats to the Homeland. Christmas Day  
20 bomber, call him what you may, we have a continued  
21 reminder that we do have a threat here at home  
22 that we need to keep engaged on.

1 North Korea, talked about that. And  
2 then, you know, the global criminality and being  
3 linked to terrorism. In the long term, again, and  
4 some of you all listened to my briefs, these don't  
5 change too much, but it's as important, as we're  
6 dealing with today's fight, that we look out in  
7 the future and we continue to try to shape what we  
8 think will be our adversaries, what we need to be  
9 able to counter those adversaries and be able to  
10 help shape leverage, you know, our foreign policy  
11 in 2020 and 2030.

12 So how do we stage ourselves? You know,  
13 if you're a F22 guy, you're probably not as happy.  
14 If you're a SOC guy, you're probably fairly happy.  
15 But that's today. We have to look toward tomorrow  
16 and try to balance that. Recognizing that, you  
17 know, cyber is very real, it shuts things down,  
18 and it's global and it's very easy. You know, the  
19 Chinese were very interested in this particular  
20 domain.

21 Terrorism, and, again, the long-term  
22 Middle East. Middle East peace, it's been with

1 us, and it will be with us for some time in the  
2 future. And, again, just because we are focused  
3 in one area does not preclude us from being  
4 focused into other areas and to build strategies  
5 and -- just mentioned Russia in passing -- but  
6 it's just not a passing, that's a very real  
7 threat.

8 China. What is China's eventual goal  
9 and how -- you know, bring them along as a friend  
10 hopefully as opposed to an adversary or somebody  
11 that we have to reckon with.

12 So and, again, this economic crisis,  
13 what is it going to unveil for us, what rocks is  
14 it going to turn over for us in the next years  
15 that we will have to deal with. The unknowns.

16 And, again, to wrap things up, one more  
17 slide. How things have changed for the  
18 commanders. And these are, you know, as you go  
19 from, you know, your company-grade-type commanders  
20 up to general officer up to, you know, the  
21 national level, you obviously go from an  
22 operational to sort of a strategic mindset. But

1 you have to recognize in today's world, very much,  
2 those actions that take place at the very -- we  
3 call them the sort of the strategic corporal, but  
4 an action that could take place on the battlefield  
5 can have a huge implication, you know.

6 That's why we are paying so much  
7 attention to civilian casualties. We're really  
8 trying to mitigate and zero that number out as we  
9 engage in Afghanistan because, you know, an  
10 inadvertent shot or inadvertent drop can really  
11 have a huge effect on the overall strategy in, you  
12 know, in winning their hearts and minds, so very  
13 important.

14 Kind of tied into it, everything happens  
15 faster and quicker. And the adversaries using all  
16 instruments. He's using cyber. He's using  
17 population. He's -- it's just not a conventional  
18 fight to them. We have to recognize that. And  
19 our response isn't just going to be conventional  
20 or unconventional. It's going to be a hybrid of  
21 the two. So we have to be able to address that.

22 And again, you know, intelligence-led

1 operations, the ability to be able to take the  
2 picture at the time and to be able to respond to  
3 that and have that level of one fidelity, but  
4 that's -- to be able to do that, it's paramount.  
5 And so this is what the commander today is dealing  
6 with. So with that, I think that is it.

7 So are there any questions or comments  
8 or concerns?

9 DR. LEDNAR: Questions for Colonel Coke?  
10 Dr. Shamoo and then Dr. Oxman.

11 DR. SHAMOO: In the media there is a  
12 great deal of writings regarding the drones, and  
13 there are two types of drones; one, presumably --  
14 again, this is from the media -- intelligence  
15 services are (inaudible). And the media claims --  
16 this is in print, that -- there's a book also --  
17 that the logic tree of how that decision is made  
18 is not known. However, the same print media says  
19 the military does have a logic tree how decisions  
20 are made. Since we're talking about  
21 counterinsurgency in civilian, my question to you  
22 is: is there a classified version of the logic

1 tree of how we make decisions to use drones in a  
2 given operation?

3 Col COKE: My depth of knowledge in this  
4 area is limited. I would say that most logic  
5 trees dealing with drones or UAVs and ISR are  
6 classified. It would not be in a, you know,  
7 public. But, I mean, I would also add that  
8 paradigms aren't changing.

9 Operation Moshtarak was completely  
10 announced at the beginning. I mean, you know,  
11 days before, the enemy knew we were coming. And  
12 so things are changing, but I cannot foresee, at  
13 least on the military side, that our specific  
14 information would be, you know, provided real time  
15 especially outside of a classified environment.

16 DR. OXMAN: Mike Oxman. I think that  
17 the humanitarian efforts by the military have  
18 enormous benefits in many areas, and I wondered --  
19 I understand that Chile has requested some -- at  
20 least some medical help. And I wonder if we're  
21 deploying anything to help them.

22 Col COKE: You know, I would imagine we

1 are, but I don't know. I flew here yesterday so I  
2 haven't been tapped in to what's going on, but I  
3 will imagine that we'll be involved, certainly not  
4 to the scale of Haiti, but we'll be flowing things  
5 there.

6         RADM SMITH: This is Dave Smith. We  
7 don't know the answer to that right now. There's  
8 a meeting -- or teleconference afternoon. The  
9 Department states working the issues to determine  
10 who is appropriate for those various requests from  
11 all the willing contributors from around the world  
12 to do that, so the answer is unknown but standby.

13         DR. LEDNAR: Any more questions for  
14 Colonel Coke? Well, before Colonel Coke gets  
15 away, this is a bit of a watershed moment because  
16 this is Colonel Coke's last brief to us, the  
17 Defense Health Board, as he's preparing to go onto  
18 his next assignment.

19         And we want to, as a Board, recognize  
20 Colonel Coke for the understanding the broad view  
21 of the Joint Chiefs, how it helps us think about  
22 what the medical and force health protection needs

1 of the force are throughout the world as it's been  
2 changing and to put it in terms that makes it  
3 easier for those of us with a medical background  
4 to understand about some of the ways that we can  
5 help.

6 So but we'd also like to give you  
7 something to take as a memento, and I'd ask Dr.  
8 Poland, Ms. Bader, and Commander Feeks to just  
9 join me up with Colonel Coke for just a moment.

10 What we're presenting to Colonel Coke is  
11 a Defense Health Board medallion which in military  
12 tradition is a remembrance as you go from  
13 assignment to assignment about the relationships  
14 you've made and the important work that's been  
15 done.

16 And as you go onto your next assignment,  
17 please keep us in mind, and we are here to serve.

18 Col COKE: Thank you very much.

19 (Applause)

20 DR. LEDNAR: Our next agenda item will  
21 be presented by Dr. Frank Butler. Dr. Butler is  
22 the Chair of a Tactical Combat Casualty Care Work

1 Group of the Trauma and Injury Subcommittee as  
2 well as a member of the Subcommittee.

3 Dr. Butler is a retired Navy Captain and  
4 former Navy SEAL who helped develop many of the  
5 diving techniques and procedures used by Navy  
6 SEALS throughout the world today. He served as  
7 the Task Force Surgeon for a Joint Special  
8 Operations Counterterrorist Task Force in  
9 Afghanistan and was the first Navy medical officer  
10 selected to be the Command Surgeon at the United  
11 States Special Operations Command.

12 Dr. Butler has numerous military awards.  
13 They include the Defense Superior Service Medal,  
14 the Legion of Merit, the Bronze Star, the Defense  
15 Meritorious Service Medal, and the Navy  
16 Meritorious Service Medal.

17 In addition, he received a Special Award  
18 for Innovations in Tactical Combat Casualty Care  
19 from the U.S. Army Medical Research and Materiel  
20 Command and was the first recipient of an award  
21 named for him and presented annually by the  
22 Committee on Tactical Combat Casualty Care for

1 exemplary contributions in the field of trauma  
2 management on the battlefield.

3 Dr. Butler is a board-certified  
4 ophthalmologist and currently serves as  
5 Co-Chairman of the Undersea and Hyperbaric Medical  
6 Society Decompression Sickness and Gas Embolism  
7 Treatment Committee.

8 As you may recall from the last Core  
9 Board meeting, Dr. Butler presented proposed  
10 Tactical Combat Casualty Care burn management  
11 strategies for the Board's consideration and  
12 endorsement, after which the Board requested  
13 additional time and information to examine this  
14 issue.

15 On behalf of Dr. John Holcomb, Trauma  
16 and Injury Subcommittee Chair, he will be  
17 presenting these proposed strategies today for the  
18 Board's deliberation in open session. These  
19 proposed strategies and background information  
20 were provided to the Core Board by Commander Feeks  
21 in preparation for today's discussion and vote.

22 Dr. Butler's presentation slides may be

1 found under Tab 3 of your meeting binder.

2 DR. BUTLER: Thanks, Dr. Lednar. It's a  
3 pleasure to be back with the Core Board and  
4 distinguished lead, liaison members, and guests.  
5 I think it is good that we have a reprise of some  
6 previous items right before lunch. So hopefully  
7 we'll move through these quickly, but we'll take  
8 the time that we need. These were presented as  
9 mentioned in November to the Core Board, and the  
10 first item is the treatment of burns in TC3. And  
11 it's a fair question to say, hey, TC3 has been  
12 around for 15 years now, why are we just getting  
13 around to burns. Well, burns have not  
14 historically been a leading cause of preventable  
15 death on the battlefield, but with the increasing  
16 incidents of wounding from these IEDs that you  
17 read about in theater, we're seeing a lot of  
18 burns. So the group tackled this, and I have to  
19 thank, at this point, the Army Institute of  
20 Surgical Research. We weren't about to tackle  
21 this ourselves internally when we had a resource  
22 like this that we could turn to. And Lieutenant

1 Colonel Booker King and Colonel Evan Renz from the  
2 Burn Center at ISR are largely responsible for  
3 what you see, and we're very indebted to them for  
4 their help.

5         So, as you know, the care on the fire  
6 part of TC3 is when you're in the middle of a  
7 gunfight and your main focus is suppressing  
8 hostile fire. In that setting and this point of  
9 the continuum of care, your attention is focused  
10 in just getting your casualties out of the burning  
11 vehicle or building and stopping the burning  
12 process.

13         So when we move into the tactical field  
14 care phase where hopefully the shooting has  
15 stopped, first, facial burns, especially those  
16 that occur in closed spaces may be associated with  
17 inhalation injuries so you have to carefully  
18 monitor the airway and respiratory status and be  
19 aware of the need for possible early intervention  
20 with their airway.

21         After that's done, you estimate the  
22 total body surface area burned to the nearest 10

1 percent using the Rule of Nines, which is a  
2 standard in burn care.

3 Okay. Cover the burn area then with  
4 dry, sterile dressings. If you've got a large  
5 burned area, we have a hypothermia prevention  
6 blanket that will serve nicely so you can just  
7 enfold the casualty in that, and it will serve.

8 Fluid resuscitation. It has been the  
9 observation of the ISR that burn casualties tend  
10 to be over-fluid resuscitative when you  
11 resuscitate them using the classic Parkland or  
12 Modified Brook's Formulas. So they have developed  
13 a new formula, the ISR Rule of Ten, which is both  
14 simpler much easier for the provider on the field  
15 to calculate and underresuscitates the casualty a  
16 little bit compared to the traditional formulas.

17 So if burn areas are greater than 20  
18 percent, fluid resuscitation should be initiated.  
19 It may be done with Lactated Ringer's, normal  
20 saline or Hextend<sup>®</sup>. If you do choose to use  
21 Hextend<sup>®</sup>, don't give more than 1000 cc's, and then  
22 follow on with Lactated Ringer's or normal saline.

1 The 1000 cc limit is because of concerns about  
2 coagulation status above that volume.

3 Okay. So the initial IV/IO fluid rate  
4 is calculated as percent burned area times 10 for  
5 adults between 40 and 80 kilograms. That's much  
6 nicer than the old formulas. If you have a bigger  
7 person, then you need to add 100 cc's per 10  
8 kilograms over 80 kilograms.

9 If you have hemorrhagic shock,  
10 hemorrhagic shock will kill you prehospital, burns  
11 typically don't. So the precedence is to treat  
12 for hemorrhagic shock if that is coexistent in a  
13 casualty.

14 Analgesia. In accordance with a  
15 previous section of the guidelines, ISR says, hey,  
16 you do not need to start antibiotics prehospital.  
17 Similarly, you don't need to spend \$200 for  
18 antibiotic impregnated dressings to put onto the  
19 burn casualties. They say that the -- you know,  
20 if you need to give antibiotics for other things,  
21 fine, but you don't need to do that for burns.

22 And then the last item: tactical field

1 care. Whatever you need to do, it's okay to do it  
2 through burned skin. This question comes up a  
3 lot; and ISR says, do what you have to do. In  
4 tactical field care, it's basically the same  
5 except that there's an extra emphasis on  
6 hypothermia.

7 In Afghanistan, you're flying over the  
8 Hindu Kush. A lot of the time, it's cold in these  
9 helicopters. And burn patients are very  
10 susceptible to hypothermia. So extra emphasis on  
11 preventing that.

12 So those are the proposed changes. They  
13 were reviewed after the TC3 Committee reviewed  
14 them -- or approved them on 3 November. They were  
15 reviewed by the Trauma and Injury Subcommittee and  
16 approved unanimously by everybody who was there  
17 for the meeting on 4 November. So one of the  
18 proposed actions for today is to re-present these  
19 to the Core Board and answer any questions and see  
20 if we can get a vote on this change.

21 DR. LEDNAR: The floor is open for,  
22 first, the Core Board. Are there any questions

1 for Dr. Butler?

2 DR. LOCKEY: This is Dr. Lockey. I'm  
3 just curious like in Afghanistan what provisions  
4 were made to heat the IV fluids. How was that  
5 done?

6 DR. BUTLER: In the tactical field care  
7 phase, there are two IV fluid warmers that are  
8 currently used more than others. One is the  
9 Thermal Angel and the other is enFlow. And we use  
10 -- absolutely use those especially if they need  
11 relatively large volumes of fluid as burn patients  
12 might. However, as you know, with heat loss, it's  
13 tough to put back in the volume of heat that you  
14 lose so the emphasis is on prevention.

15 DR. LEDNAR: Other questions for Dr.  
16 Butler?

17 BG GAMBLE: Yes, Bryan Gamble here. One  
18 of the things to remember too is these patients  
19 are polytrauma, usually complexed, so it's not  
20 just a burn isolation. One initial thing that,  
21 you know, my distinguished colleagues from the ISR  
22 noted was that using normal resuscitative measure

1 and formulas would often create secondary tertiary  
2 problems; namely, abdominal compartment syndrome,  
3 which was, again, compromised cardiovascular  
4 function and necessitate opening the abdomens,  
5 decompress the belly and improve cardio pulmonary  
6 function.

7         However, these people would then become  
8 increasingly more susceptible to intra-abdominal  
9 infection and their survival was much less. And  
10 fortunately John Holcomb and the rest of the  
11 pioneers in this field, saw this and created this  
12 formula. It really has made a substantial leap in  
13 survival of these previously wounded individuals.

14         DR. BUTLER: Thanks for that, General  
15 Gamble. And it reminds me to mention the comment  
16 that Booker King made when he was presenting this  
17 to the group in Denver. He said, it is critical  
18 to think of these patients as trauma patients with  
19 burns, not burn patients with trauma. The trauma,  
20 the other trauma, that General Gamble mentioned is  
21 what probably will kill them.

22         DR. LEDNAR: Other comments or questions

1 for Dr. Butler? Okay. Then what we have for the  
2 Board is an action to consider. There's been a  
3 lot of discussion, presentation by Dr. Butler.

4 The recommendations that have been made  
5 for the Board's consideration have been developed  
6 in the TC3, reviewed in the Trauma and Injury  
7 Subcommittee, who really are our experts on this  
8 question. We've had an opportunity as a Board  
9 since last time we've met for any additional  
10 clarification that the Board wished to have.

11 All that communication is available and  
12 transparent for anyone who's interested in knowing  
13 what those questions were.

14 So at this point I'd entertain a motion  
15 to accept the recommendations as proposed. Is  
16 there a motion?

17 SPEAKER: So moved.

18 SPEAKER: Second.

19 DR. LEDNAR: Any further discussion  
20 about the recommendations? Hearing none, then I  
21 would ask, by a show of hands, all those on the  
22 Core Board who are in favor of approving these

1 recommendations, please raise your hand and say  
2 aye.

3 SPEAKERS: Aye.

4 DR. LEDNAR: Any apposed or nay? None.

5 Dr. Butler, these recommendations are approved by  
6 the Board and thank you to you personally to the  
7 Trauma and Injury Subcommittee and to the work of  
8 the TC3. There will be many who will survive  
9 because of these recommendations. Thank you.

10 (Applause)

11 DR. BUTLER: Thanks very much to the  
12 Board for their comments and considerations. We  
13 are going to mention two quick things  
14 additionally.

15 The first is the issue of fluid  
16 resuscitation in TC3. Now, this is the iconic  
17 battlefield intervention. When you see pictures  
18 of Corpsmen and medics on the battle field, what  
19 are they doing? They're starting IVs. So that's  
20 what they do. I will tell you that in an age of  
21 evidence-based medicine, this iconic intervention  
22 is not well supported by human trials.

1           That's a huge understatement. "The New  
2 England Journal" study by Bickell in 1994 that was  
3 done at Ben Taub is perhaps the best randomized  
4 control of human trial on this, and it found that  
5 survival was improved by delaying, delaying, fluid  
6 resuscitation until the surgeons get their hands  
7 on whatever is bleeding and stop it. So that's  
8 what the original TC3 guidelines said. Don't give  
9 -- if it's penetrating torso trauma, which is what  
10 Ben Taub's study addressed, don't start fluids  
11 because the literature says you're going to make  
12 them worse.

13           Well, we got outvoted a couple of years  
14 later by a group that was convened by the Army  
15 Medical Research and Materiel Command and the  
16 Office of Naval Research. This was a huge  
17 international panel of experts. And they looked  
18 at what we had at the time and said, hey, we can  
19 do that better.

20           And this was what they recommended:  
21 that we use a tactical definition of shock which  
22 was somebody who has been bleeding and now has

1 altered mental status or an absent or thready

2 radial pulse.

3 If the person is in shock, using that

4 definition, then you treat with Hextend<sup>®</sup>, a

5 hetastarch colloid, and you only get 500 cc's, the

6 thought being if you pump too much blood in there,

7 then you may interfere with the hemostasis that is

8 hopefully ongoing in the casualty at this point.

9 Then you wait 30 minutes. If they're still in

10 trouble, then you give them another 500 cc's and

11 then you stop.

12 They also recommended that PO fluids

13 were okay, even for somebody who was going to need

14 surgery in a few hours because a dehydration is

15 more of a problem than vomiting preoperatively.

16 So those were presented at the

17 Committee, and the Committee acknowledged the

18 expertise that went into developing these

19 guidelines so that's what we've had, and we've

20 continued to have sort of a relative lack of

21 information coming in about this protocol.

22 And I want to give you a heads up about

1 a paper that is about to break that is going to be  
2 controversial to say the least. This was done at  
3 the University of Miami at Ryder, which the Army  
4 folks will know as the Level I Trauma Center that  
5 trains all the Army surgeons getting ready to go  
6 take care of our casualties in the war.

7       So they tested the TC3 Hextend<sup>®</sup> protocol  
8 prospectively in their emergency department. It's  
9 a large study: 1700 patients. There were some  
10 study design problems that I'll be glad to go into  
11 or not go into as the Board wishes. There are  
12 some study design issues that really make the  
13 efficacy that they thought they demonstrated  
14 questionable, even though they cut mortality in  
15 half.

16       Efficacy maybe is not well proved in  
17 this study; however, the issue of does it cause a  
18 clinical coagulopathy was pretty definitively put  
19 to rest. If you stick with the guidelines, you're  
20 not going to cause a coagulopathy from the  
21 hetastarch.

22       The second thing is, despite the

1 study design issues, the Level I Trauma Center  
2 emergency staff -- the emergency physicians and  
3 the trauma physicians -- looked at the data and  
4 said, okay, from now on, this is how we're doing  
5 fluid resuscitation.

6       So of civilian places that have looked  
7 at the military option for fluid resuscitation  
8 now, we have one that has done this study and has  
9 changed their standard of care to reflect what the  
10 military is doing.

11       So ISR, knowing that this was coming  
12 down the works or coming down the line, reconvened  
13 another of these large groups of experts on fluid  
14 resuscitation. This took place just last month --  
15 well, 8, 9 January.

16       About 120 people, all over the world,  
17 the leaders in the field. People who have  
18 published extensively and have lots of different  
19 opinions about fluids and how they should be used.

20       Some of the take-home points. One was  
21 that there was no evidence that made it  
22 imperative, desirable for the military to change

1 from this hypertensive resuscitation with Hextend<sup>®</sup>  
2 strategy that I just outlined.

3 The second take-home point was, there  
4 was no, zero, support for the large volume  
5 crystalloid resuscitation that's still the  
6 standard of care in most hospitals other than  
7 Ryder.

8 The third thing was is that they really  
9 came down strongly for dried plasma studies.  
10 What's special about dried plasma? Well, in  
11 addition to the volume, they provide some  
12 assistance in coagulation so maybe you can help to  
13 stop the bleeding.

14 So next slide. So we looked at this  
15 slide in November. If you look at John Kelly's  
16 paper, which came out in 2008, 982 deaths of which  
17 about 230 were potentially preventable. 85  
18 percent of those were hemorrhagic.

19 So next slide. Offered to you at that  
20 point that these were the research priorities  
21 identified by the Committee. And understand that  
22 it's -- the Board is kind of handicapped in this

1 area because they don't have the full context of  
2 the DoD research effort. Absolutely understand  
3 that.

4       However, I will just point out again  
5 that, you know, if you were looking to save  
6 American lives on the battlefield, this is where  
7 the money is: non-compressible hemorrhage control  
8 and damage control resuscitation. Now, this has  
9 come out over and over again. Everybody that I  
10 know and that deals with battlefield trauma care,  
11 I think would support this. Next slide.

12       Questions about that, before we move on  
13 to the last issue briefing?

14       DR. LEDNAR: Dr. Oxman?

15       DR. OXMAN: Is there any data on the  
16 concern about brain swelling and TBI with fluid  
17 resuscitation?

18       DR. BUTLER: There absolutely is, and  
19 the TC3 guidelines say a couple of things about  
20 it. First is, it wasn't our primary purpose, but  
21 if you wish to not cause cerebral edema, then  
22 don't give a crystalloid, which most of the people

1 out there now are. And cerebral edema is not the  
2 TBI patient's friend as you know. So Hextend<sup>®</sup>,  
3 again, remains intravascular and does not go out  
4 and contribute to cerebral edema.

5 We also have a separate section for  
6 fluid resuscitation and TBI, which basically says  
7 that the rules for uncontrolled hemorrhage do not  
8 apply for TBI. In that situation you have to  
9 restore to a full radial pulse so that you will  
10 maintain your cerebral perfusion pressure. Thank  
11 you for catching that point.

12 DR. BULLOCK: If I could just come in on  
13 that point. I think that there had previously  
14 been concern that some of these  
15 low molecular weight Dextrin-based resuscitation  
16 strategies might cause worse coagulation in  
17 intercranial bleeding, but with Hextend<sup>®</sup> that  
18 doesn't seem to be borne out. So it seems that  
19 that's another push towards using that for TBI  
20 patients.

21 DR. BUTLER: Well, good. Just move on  
22 to this last issue. I wish the Board had the

1 chance to listen in to the Thursday worldwide  
2 video teleconferences where -- they're organized  
3 by the Joint Theater Trauma Service in cooperation  
4 with CENTCOM and they're -- every hospital that is  
5 involved with the care of these patients, multiple  
6 supporting organizations, all these people are on  
7 a worldwide video conference -- or teleconference  
8 every Thursday. And we discuss every patient and  
9 what happened to them at every hospital, what  
10 their wounds were, what was done for them, and how  
11 they're doing. It's an amazing process to see.  
12 So I do that on Thursdays.

13       And one of the things that occurred to  
14 me as I looked at these patient lists, week after  
15 week, is there are a lot of spinal fractures right  
16 now. A lot of spinal fractures. So we asked the  
17 Joint Theater Trauma System to take a look at that  
18 and put a number on that for us.

19       Next slide, please. So they did that.  
20 And in their review of casualties from July  
21 through December, 2009, there were 119 spinal  
22 fractures, mostly thoracic but some cervical, some

1 lumbar. That's a lot, and it's because of the  
2 acceleration, deceleration forces of these armored  
3 vehicles with the increasing explosive quantities  
4 that you're seeing in the IEDs.

5 So 119 spinal fractures, that's bad  
6 news. Worse news is 14 spinal cord injuries,  
7 people who can't move arms, legs or don't have a  
8 sensory function there.

9 So the question that we were not able to  
10 answer is: Did it occur during transport, or did  
11 it happen at the time of wounding? The system  
12 does not have the information to answer that  
13 question for us.

14 So we entertained at the last TC3  
15 meeting after a working group headed by Dr.  
16 Holcomb, Don Jenkins from the Mayo Clinic and a  
17 number of other people. We came out with a  
18 proposed change that would spell out some  
19 techniques that people could use in a combat  
20 setting to prevent any of these spinal cord  
21 injuries from happening, if possible.

22 And I will tell you that the prehospital

1 -- once you get into the literature of prehospital  
2 spinal mobilization -- I will tell you the things  
3 that we think we know are not supported in the  
4 literature.

5       The 2009 Cochrane Review found that  
6 there was no good data to support the current  
7 standard of care, which is spinal mobilization  
8 according to various criteria. If the mechanism  
9 of injury is penetrating trauma -- there is a  
10 paper that just came out last month -- it  
11 documented worse outcomes from penetrating trauma  
12 after spinal mobilization.

13       So the Committee looked at all this and  
14 said, hey, we don't have a handle on this. We  
15 don't have enough data, the data is conflicting,  
16 we don't have a good agreement on what things  
17 ought to be done.

18       Next slide. And to put this in a  
19 tactical context, you're thinking, well, why not  
20 just immobilize? Why are we making a big deal out  
21 of it? There's a book by David Finkel called "The  
22 Good Soldiers." Anybody here look at this book at

1 all?

2           So it's an Army battalion in Iraq. On  
3 29 March, 2008, this -- they had a Humvee convoy  
4 that was hit by an IED. The driver had shrapnel  
5 to his arms and his back. The passenger in the  
6 right front seat had a traumatic left arm  
7 amputation and penetrating head trauma. The  
8 person in the right rear seat had a traumatic hand  
9 amputation. The person in the left rear seat was  
10 decapitated. The person in the turret had  
11 catastrophic torso injuries. And as soon as this  
12 went off, they were taken under fire. So there's  
13 your tactical context.

14           Now, this is what the young men and  
15 women out there are having to deal with. You've  
16 got the possibility of secondary IEDs, RPG attacks  
17 following this, you know, it is a nightmare.

18           So the combat medics in the group said,  
19 look, until we have a better handle on this, we  
20 should not try to do anything that's going to take  
21 away from the tactical context.

22           So next slide. So about the best that

1 we can do is that we said to at least be aware of  
2 trying to maintain spinal alignment and blunt  
3 trauma casualties with -- if they have neck or  
4 back pain, and there it sits for the moment.

5 Next slide. So couple of young sailors  
6 enjoying a day at SEAL training.

7 (Laughter)

8 DR. BUTLER: I'll be glad to try to  
9 answer some questions for you. There are really  
10 more questions than answers in the spinal  
11 immobilization arena, but I wanted you all to know  
12 that was an area of concern for us. And, you  
13 know, we've taken our first run at it. And now  
14 we're in the middle of a tactical pause, and we're  
15 going to readdress it.

16 DR. LEDNAR: Questions for Dr. Butler?

17 DR. DICKEY: Dr. Butler, it's my  
18 understanding that the injuries -- there's an  
19 awful lot of the spinal injuries coming out of the  
20 IEDs, as you said. What kind of work are we doing  
21 to prevent the injuries even while you're working  
22 to figure out to immobilize them. We do one thing

1 and it gets -- it gets something better and then  
2 something else gets worse. Somebody -- one of my  
3 staff tells me these look a lot like ejection  
4 injuries, and that somebody should be looking at  
5 pilot ejection kinds of intervention.

6 DR. BUTLER: Right. So when I was in  
7 Afghanistan, this IED that hit this vehicle. We  
8 were driving around in Toyota Hiluxes with no  
9 armor at all. We would have all been blown to  
10 pieces.

11 So the injuries that we're now seeing  
12 are a measure of our -- this vehicle design  
13 success. We are now surviving these IED attacks  
14 where we wouldn't have previously.

15 Now trying to figure out the -- how to,  
16 from an engineering standpoint, prevent the  
17 injuries that we're seeing. We have not been  
18 involved with the vehicle engineering, but I will  
19 say that this has come up in other contexts and  
20 special operations, and we would be glad to steer  
21 them towards some of those people if the group  
22 were approached about that.

1           We have not been doing vehicle  
2 engineering, but we ran into this in special  
3 operations with high-impact, high-speed boats. If  
4 you have to chase those pirates in the open seas,  
5 you need a high-speed boat. And you get a  
6 Cigarette racer going about 80 knots in six-foot  
7 seas, it would beat you to death.

8           And so some engineering solutions were  
9 approached, and that context that may work here.  
10 There are sort of a shock-absorbing systems that  
11 could be designed for those seats but obviously  
12 expensive and, you know, trying to figure out the  
13 risk benefit.

14           DR. LEDNAR: General Gamble?

15           BG GAMBLE: Sir, just a comment for the  
16 Board and to echo Dr. Butler's comment on the  
17 value of the Joint Trauma Registry VTC on  
18 Thursdays, it really is a critical piece to point  
19 together information from across the spectrum of  
20 care to really, in the short period of time,  
21 change the clinical practice guidelines and the  
22 care standards for those wounded in theater.

1 Another good example is, as we discussed  
2 before, was on the burn care management, which was  
3 another product of the Joint Theater Trauma  
4 Registry VTC. That was an anecdote, an  
5 observation by people across the spectrum that  
6 came together to really develop better management  
7 of care for our wounded. In fact, Dr. Don  
8 Trunkey, who I'm sure many of you know, really has  
9 espoused this as being one of the highlights and  
10 most forward-thinking advancements for medical  
11 care in this theater. Thank you.

12 DR. LEDNAR: Dr. Silva?

13 DR. SILVA: Silva. Thank you, Frank,  
14 for a nice presentation. I know for the sake of  
15 time you had to go through that last slide.  
16 Potential is I'm going to look at it in the  
17 future, but do you have a 30-second sound bite  
18 about truncal tourniquets?

19 DR. BUTLER: So the concept of a truncal  
20 tourniquet -- and there's two applications. If  
21 you read Ken Mattox's paper from some months ago,  
22 it was a thing called "Leaky Buckets." Very

1 interesting perspective for noncompressible

2 hemorrhage.

3       So if you're bleeding from your neck, we  
4 can get combat gauze on. If you're bleeding from  
5 your leg, we can get a tourniquet on. We've got  
6 it. We can take care of those kind of  
7 hemorrhages. It's the people who are shot in the  
8 belly.

9       So there are some things that you could  
10 do. What if, you had an encircling band and you  
11 raised the intra-abdominal pressure so that the  
12 transluminal pressure was reduced. Would that  
13 help? Would it cause more problems? Would it  
14 interfere with their respiration? Complex.

15       There is -- and we have actually taken a  
16 look at the T-POD. One of the sources of torso  
17 hemorrhage is an unstable pelvic fracture. So  
18 using -- there's an external binding device called  
19 a T-POD which will reapproximate the pelvis and is  
20 advertised to reduce the bleeding. The Committee  
21 looked at that and decided they weren't impressed  
22 with the evidence for the T-POD.

1           The last thing that's just come down the  
2 road -- it was demonstrated to the Committee in  
3 Denver -- for wounds of the groin, the people --  
4 Richard Schwartz, who is the Chair of the  
5 Department of Emergency Medicine at the Medical  
6 College of Georgia, had developed a device which  
7 compresses the abdominal aorta. In the area of  
8 the bifurcation, you crank that down, and it has  
9 been demonstrated in animal models to stop high  
10 femoral bleeding.

11           Again, you have the issues of what are  
12 the secondary problems that this sort of an  
13 approach might create. So we absolutely are  
14 looking at it and, you know, watching the  
15 technology develop in this area.

16           Is that enough, Dr. Silva, or were there  
17 some other specific things?

18           DR. SILVA: No. Thank you. I am aware  
19 of that in old-time (inaudible) practices, they  
20 were having some devastating hemorrhages. And  
21 there was some data on that. I think it was just  
22 a block of wood and some very strong rope which

1 they cranked down like a tourniquet. That was a  
2 last-minute effort to save someone.

3 DR. BUTLER: Well, you know, MAS  
4 trousers are an area -- and if you ever want to  
5 start a fight at the TC3 Committee, just show up  
6 and talk about MAS trousers in any context.

7 (Laughter)

8 DR. LEDNAR: Colonel and then Dr.  
9 Poland.

10 COL GRINKENMEYER: Yes, sir, Colonel  
11 Grinkenmeyer from the AFIP. We have -- we do  
12 autopsies, as you may know, on all the casualties  
13 that come from Afghanistan and Iraq. And we have  
14 advised, and some changes have been made in the  
15 vehicles that are being used based off of some of  
16 our autopsy studies.

17 And also on the hemostatic agents, we're  
18 able to look at some of these different granular  
19 products and QuickClot<sup>®</sup> and that sort of thing and  
20 evaluate it on what we see in the aftermath on  
21 those.

22 So there are some novel unique things

1 that we're looking at the AFIP with all the  
2 autopsies that we're doing to advise them to try  
3 to make changes on what's being done in the field.

4 We -- for example, as long as they leave  
5 the body armor on and we do an autopsy, we do CT  
6 scans of the entire decedent. And we can look at  
7 the body armor and evaluate the effectiveness of  
8 that and what should be changed about body armor,  
9 et cetera. I just wanted to make that comment.

10 DR. BUTLER: We are incredibly grateful  
11 for the ongoing support from the AFIP. We have  
12 interacted with them a number of times; and most  
13 recently last week, I sent out to the TC3  
14 distribution group a picture of a tracheal -- it's  
15 a surgical airway device where the autopsy was  
16 done, and it was found not to be in the airway so  
17 it doesn't do much good if it's in other fascial  
18 planes.

19 So, you know, AFIP -- Dr. Harkey came and  
20 showed us a -- two pictures actually of needle  
21 decompressions, for tension pneumothoraxes that  
22 were attempted with 2-inch needles, and the plural

1 space was here and the 2-inch needle stopped  
2 there. So these two people died. So now we're  
3 using three-and-a-quarter-inch needles which he,  
4 through follow-up CT autopsy imaging, demonstrated  
5 will work and reach the plural space of 99 percent  
6 of the population -- of the military population,  
7 which is different from the civilian population.  
8 So thank you, thank you.

9 DR. LEDNAR: Dr. Poland?

10 DR. POLAND: The Colonel's comment was  
11 the perfect segue to what I wanted to say and that  
12 is in medicine, we have traditional and  
13 time-honored ways of sharing knowledge but those  
14 are sometimes slow ways. So the example talked  
15 about, you know, the Corpsman doesn't know what  
16 the internist knows, the internist doesn't know  
17 what the ISR knows, the ISR may or may not know  
18 what AFIP knows.

19 And it's a way of saying that there are  
20 ways; for example, on the tactical operation's  
21 side. I'm very familiar with -- the Marine Corps  
22 has a Center for Lessons Learned. I think the

1 Army has a similar center, but I'm not sure about  
2 the other services. But they do detailed reviews  
3 of basically every MEU that comes back.

4 There's detailed after-action reports,  
5 thousands of pages of transcripts are generated  
6 and distilled into lessons learned which then  
7 become a part of doctrine.

8 Is there a place for us to start  
9 thinking about knitting together some of the  
10 components -- you have the ISR, the AFIP, the TC3,  
11 et cetera -- into some formal aspect of a center  
12 for lessons learned where these questions could be  
13 raised where, what the Army knows, the Navy would  
14 now know and, et cetera, through the Services.

15 DR. BUTLER: That's a beautiful  
16 question. Two-part answer. The first is both the  
17 ISR and the Navy Medical Lessons Learned Center  
18 have a quarterly newsletter, and it is a -- their  
19 newsletters have a much broader scope than just  
20 tactical trauma care. But for the articles that  
21 deal with tactical trauma care -- I write the  
22 articles for both of those newsletters every

1 quarter -- and we do -- in fact, you guys just  
2 wrote my article for the next quarter, thank you.

3 The burn care item will be featured.

4       The second thing is when we come to the  
5 TC3 meetings, we need for the group to have a  
6 common knowledge base. So everybody who has ever  
7 requested -- and that includes about a thousand  
8 people now -- we'd be glad to add the Board to  
9 this list. We do a systematic search of the  
10 literature using key search terms every month and  
11 identify the things that might change the way that  
12 we do business and send those articles out to the  
13 TC3 interest group.

14       So, please, if Core Board members or  
15 other guests have an interest in being included in  
16 that, I would be honored to do that.

17       DR. LEDNAR: For the Board, Dr. Butler,  
18 thank you for the additional information you  
19 shared with us today.

20               (Applause)

21       DR. LEDNAR: I think as we reflect on  
22 what Dr. Butler has done with us in the last 15

1 minutes, several points come to my mind; one is,  
2 rapidly, regularly, sharing experience globally,  
3 the Thursday telephone calls.

4 As we learn together, always asking, is  
5 the way we approached things in the past still the  
6 best way to go forward? And if not, what's the  
7 information we need to be scientifically rigorous  
8 to suggest that some other way is better. Look at  
9 data. Use research design. Really build a  
10 critical evidence set. Don't expect the world to  
11 stay still.

12 The types of injuries that will occur  
13 over time may, in fact, change as we get better at  
14 vehicle design and other kinds of personal  
15 protective equipment. So always thinking and  
16 always bringing good science to bear and then not  
17 taking a decade to produce the fix. So I think  
18 that's a dynamic, Dr. Butler.

19 Thank you for showing us the -- not only  
20 is it important, but it can be done, so thank you  
21 for that.

22 (Applause)

1 DR. LEDNAR: What we'll do now is take a  
2 break for lunch. An administrative session will  
3 be held over a catered working lunch right next  
4 door, beginning just a few minutes after we  
5 adjourn.

6 Ex-officio members, service liaisons,  
7 DHB staff, and the Core Board are welcome to join  
8 us. Distinguished guests and speakers are welcome  
9 to join us as well. For other attendees, please  
10 consider the several options that Commander Feeks  
11 mentioned to us earlier.

12 We will reconvene in this room for our  
13 afternoon session starting at 1:45.

14 So we'll look forward to seeing you at  
15 1:45. Thank you.

16 CDR FEEKS: A quick clarification.  
17 That's for lunch. Board members not just Core  
18 Board members are welcome to join us for lunch.

19 (Recess)

20 DR. LEDNAR: Let's reconvene for our  
21 afternoon session on a really very important and  
22 serious topic that Colonel Joanne McPherson is

1 going to brief us about.

2 Colonel McPherson is the Executive  
3 Secretary of the Department of Defense Task Force  
4 on the Prevention of Suicide by Members of the  
5 Armed Forces. This Task Force is an activity of  
6 the Defense Health Board.

7 Prior to this recent appointment,  
8 Colonel McPherson served as the Chief Financial  
9 Officer for the Air Force Medical Service, big  
10 job, and was responsible for the execution -- I'll  
11 say management rather than execution -- of a \$5.1  
12 billion annual budget supporting 74 military  
13 treatment facilities and 2.6 million beneficiaries  
14 throughout the world.

15 Colonel McPherson also served as the key  
16 fiscal advisor to the Air Force Surgeon General  
17 and major command for medical staff on all Air  
18 Force financial matters. She had some specific  
19 responsibility for financial statement preparation  
20 and audit readiness for the Air Force Medical  
21 Services in supporting Defense Health Program  
22 budget submissions and prepare the Air Force

1 Surgeon General and Deputy Surgeon to represent  
2 Air Force Medical Service financial matters  
3 appearing before the Senior Military Medical  
4 Advisory Council, Congress, or the Chief of Staff  
5 of the U.S. Air Force.

6 Colonel McPherson's presentation slides  
7 may be found under Tab 6 of your binder. Colonel  
8 McPherson, thank you.

9 Col MCPHERSON: Can you hear? Is that  
10 on? Yes. Working off of our lunchtime discussion  
11 on our friends at DTS. So there I was on Sunday  
12 evening after the great snow. I had just shoveled  
13 myself out of 27 inches on my driveway and my  
14 corner parking lot. The nice widowed lady next to  
15 us could hardly lift her hands anymore. Had gone  
16 into the Superbowl, canceling out of every party  
17 because we were too exhausted, only to find that a  
18 new Army family had not gotten their power back  
19 on.

20 Although most of us had been out all day  
21 Saturday and chunks of Sunday, at 6 p.m., they  
22 still had no power, and it was 45 degrees in their

1 house. So I invited them over, and we had a  
2 Superbowl party at our house.

3 And at 11 o'clock at night, I thought,  
4 well, I'll just double check. The airport is  
5 supposed to open at noon, and I have a noon  
6 flight, I should be safe for my trip down south to  
7 work on the Task Force and found out that even  
8 though the airport opens at noon, no noon flights  
9 were going out.

10 So after three hours on hold with the  
11 CTO people, I will have to tell you they were  
12 extremely friendly, and 2:00 in the morning, I was  
13 able to rebook myself onto my flight at 2:45 and  
14 spend the entire week working down in South  
15 Carolina when the rest of D.C. had off. I still  
16 can't quite figure out how I managed to do that.  
17 But the DTS people are very friendly, and you can  
18 do anything with those flights once you book them  
19 through.

20 So the reason I left town that day was  
21 to go ahead and start the very first of our Task  
22 Force site visits as the Task Force has taken off

1 in travel.

2           So what I'd like to do is give you a  
3 quick update on some of the issues and things that  
4 we've been working on. I first spoke to you in  
5 November about six days after I had come on to the  
6 Task Force and had just at that point been able to  
7 not speak very well, I think, to the issues.

8           I hope I -- if you have any questions, I  
9 can certainly help you this time after three  
10 months in the seat, four months in the seat. I  
11 think I've learned quite a bit, but I ask your  
12 indulgence.

13           Quick overview. I'll touch on the Task  
14 Force membership -- just to remind you since it  
15 has been three and a half months since we've been  
16 here -- and the questions that we are to address,  
17 the December and January summaries, a little bit  
18 of what we've been doing on our Task Force visits  
19 in February, and where our plans ahead are at this  
20 point in time.

21           All right. General Volpe. Since the  
22 time that we've last met, General Volpe has PCS'ed

1 from the number to a JTF CAPMED to take over the  
2 regional headquarters for the Army in Washington  
3 State. So he has been on the road pretty much the  
4 whole month of February PCS'ing. On a peril is  
5 with the Task organization, and then we have a  
6 variety of folks up there that I think some of you  
7 will recognize, certainly they are clearly experts  
8 in suicide prevention suicidology, our own Dr.  
9 Certain.

10 And then we do have in the enlisted  
11 force, we have a personnel enlisted in the Air Force  
12 and a couple of Marine Corps enlisted by a  
13 gentleman who been very great to work with as we  
14 go from base to base; especially, since our  
15 original -- our starting visits have been with the  
16 Marine Corps.

17 There's a whole list of questions here,  
18 but in general terms they fall into about three  
19 general categories: trends and common causal  
20 factors in suicides, an assessment of the current  
21 services suicide education prevention programs,  
22 what are the MOSs or the Air Force specialty code,

1 the AFCs that are most affected, and then just  
2 about everything after that has to deal with how  
3 suicides are investigated and reported. The  
4 general issues surrounding that is that depending  
5 on whether the suicide occurred on base, off base,  
6 or if it's Army, Navy, or Marine Corps.

7 A host of other chapters. The amount of  
8 data and how quickly the data is gathered and the  
9 results come out, and who gets the results are  
10 issues of concern to DoD and to Congress.

11 And as I understand it some of the  
12 concerns relate to the fact that it's a very, of  
13 course, unpleasant and emotional event when  
14 something like this happens. You may very well  
15 have your son who's newly married to a young lady  
16 who's now the next of kin. And technically then,  
17 the parents have no next-of-kin rights to know  
18 what happened to their son.

19 And these are some of the issues we're  
20 trying to tackle. Additionally, it does sometimes  
21 take a very long time for the results to get back  
22 to the family members.

1           And, again, depending on where it  
2   occurred and how the investigation is done, you  
3   tend to get different answers. We're working with  
4   the Army Task Force and DCoE and some other folks  
5   as to what is a better way to pull this together  
6   so that we have consistent information in a timely  
7   manner available to the family members who are  
8   concerned about what happened.

9           Next, please. And again, the rest of  
10   these all deal with investigations and who  
11   conducts the investigations and the timing of  
12   them.

13           So on December 14th, we tried to come up  
14   with a bit of a theme to some of the meetings so  
15   that folks could wrap their brains around what was  
16   happening.

17           And so our theme in December was  
18   investigations. And this was actually a very good  
19   meeting. We had the Army STARRS, Dr. Ursano came,  
20   we had the Army CID folks, the Air Force OSI,  
21   NCIS.

22           We also had the -- what's missing off of

1 the slide is we also had the Air Force Safety  
2 Center and the Air Force JAGs come in brief on the  
3 accident investigation boards and the safety  
4 investigation boards processes, both of which the  
5 aircraft investigation processes considered a  
6 model for excellent investigation with the goal  
7 being to prevent the next one from happening. And  
8 so clearly the Task Force is looking at that to  
9 determine if that might be a model for suicide  
10 investigations in the future.

11 Next slide. In January, we tagged on at  
12 the end of the DoD/VA conference that was held in  
13 Washington, D.C., that we finished up with two  
14 more briefings related to investigations, that now  
15 we walked away from and came over to the medical  
16 side. And we talked with Dr. Rake on the root  
17 cause analysis.

18 And then we had already heard, prior to  
19 my coming on board from the Armed Forces Institute  
20 of Pathology, but we went into very specific  
21 questions on the actual autopsy process and how  
22 that was formed into psychological autopsies.

1           And then we went into some of the  
2 research studies that are going on and the  
3 information that is available, again, some of  
4 these through the Army Task Force.

5           So the MHAT VI study, the army studies  
6 program over all, the RAND study which is about to  
7 -- the results are in at the Army, and we're  
8 waiting for them to come out publicly.

9           And then we had a Service member panel  
10 discussion with surviving folks who had attempted  
11 suicide but had not been successful but had gone  
12 on to have successful military careers. In  
13 November we have had that with several females,  
14 and in January we had some males.

15           Next slide. Where we are right now is  
16 February, March, and April are set up to be  
17 traveling pretty much every other week as we go  
18 across to all four Services and visit three to  
19 four installations on each. So Camp Lejeune and  
20 Norfolk Navy Base and Portsmouth Navy Hospital in  
21 February.

22           The slides -- oh, so we were to do that.

1 I'm sorry. We were to come back and meet in  
2 Norfolk and have a full Task Force meeting. And  
3 we were unable to do that. That was, again, the  
4 week of the big snow. And so those of us who made  
5 it out of town were able to conduct the Task Force  
6 site visits. But we were unable to get ourselves  
7 into Norfolk because five of our six speakers were  
8 out of the Mid-Atlantic area, and the sixth  
9 speaker was out of Michigan. And there was not  
10 one airport that any of those speakers could  
11 access that would get them to a Task Force  
12 meeting.

13       So what we've done is taking -- much of  
14 what we should have done in Norfolk on the second  
15 week of February, moved it to the second week of  
16 March down in San Antonio.

17       Next slide. So the time these slides  
18 were turned in, the February 22nd through 26th  
19 visits were future. We have since conducted  
20 those. It was at Beaufort, and Parris Island this  
21 past week, and another team was out at King's Bay.

22       We are looking at Fort Bliss, Lackland,

1 and then a Task Force meeting, again the second  
2 week in San Antonio. There's also now visits for  
3 the third week in March at Fort Benning and  
4 several other areas in the central part of the  
5 country.

6 Then we will have another Task Force  
7 meeting in Colorado Springs where we're rolling  
8 in. Carson was unable to host us so we are  
9 looking to work with some of the Guard and Reserve  
10 Units in the Colorado Springs area because it's  
11 been brought very forcefully to our attention that  
12 the Guard and Reserves really are tackling some  
13 very difficult issues that we think it's difficult  
14 on the active duty side to get our arms around.  
15 What is going on and how to best do the education  
16 and prevention and the resiliency building for the  
17 folks out there who are in distress due to  
18 multiple stressors.

19 The Guard and Reserve where they are --  
20 don't have these people on active duty and, you  
21 know, perhaps can't even send them downtown  
22 because that person may not have another job plus

1 does not have enough health insurance.

2           You have commander-directed issues that  
3 you are having much less flexibility on as you try  
4 to work to get your Guard and Reservist care.

5           So in the March meeting we are looking  
6 to, again, bring over some of the folks that were  
7 going to speak to us in February, specifically the  
8 Guard, the Reserves, the Coast Guard.

9           We also had lined up several apparently  
10 very successful civilian programs that have some  
11 evidence behind them as to their success. We will  
12 probably hold those a little bit longer and  
13 continue to get some research.

14           I know we're going to be working with  
15 the Air Force as well in San Antonio in their  
16 briefing that they're giving to the full Task  
17 Force on the 11th of March.

18           Next slide. That is a short overview.  
19 I could entertain questions you might have.  
20 Suggestions certainly.

21           DR. LEDNAR: Are there any questions for  
22 Colonel McPherson and the work of the Task Force?

1 I'd ask you to please use the microphone. If  
2 you'd please start by mentioning your name, it  
3 would be very helpful to the transcriptionist.

4 Are there any questions? Dr. Parisi.

5 DR. PARISI: Joe Parisi. Thanks for  
6 your report. Two quick questions. How many of  
7 you go on these -- one of these reviews? And also  
8 is the data automated? Do you have a registry of  
9 these patients that you're capturing?

10 Col MCPHERSON: I'm sorry, could you  
11 repeat the second -- the registry of --

12 DR. PARISI: Do you have a registry of  
13 the patients?

14 Col MCPHERSON: We're not specifically  
15 -- oh to the ones that we talked to who attempted  
16 suicide but survived?

17 DR. PARISI: Both the survivors and the  
18 nonsurvivors.

19 Col MCPHERSON: We -- the number who go  
20 on the Task Force trips is about six. Working  
21 around the Task Force members' schedules, which  
22 are very full, given their very high caliber. We

1 are building the Task Force trips around a variety  
2 of their clinical backgrounds and their other  
3 backgrounds trying to have at least one of the  
4 enlisted guys with us when we go, an O6 or above  
5 with us when we go and then a cross section of the  
6 clinicians when we go so that we can do a full  
7 range of questions.

8 We do have certainly a list of the folks  
9 that we have talked to who are suicide attempters  
10 and survivors. We have been working with them,  
11 and some of the folks actually keep in touch with  
12 them. The girls especially.

13 The other ones have -- for example, one  
14 of the males that we talked to has basically made  
15 it some of his life's work to go out and publicize  
16 that you can be in this kind of a depressed state  
17 and make this kind of attempt and get the help  
18 that you need and continue your career, and in  
19 this case in the Army. He's actually since been  
20 promoted as an officer.

21 So I do have that list there for the --  
22 we are pulling the data from AFME and the DoD

1 SERVE on the suicides that have occurred over the  
2 last year or two. I believe the Task Force is  
3 trying to look.

4 One of the issues that's come up is,  
5 what year were these people assessed into the  
6 Armed Services. Although there is certainly the  
7 17- to 24-year-old age range that is most prone to  
8 do this. Are there some issues or were there some  
9 standards changes when they were assessed that  
10 perhaps they had -- a waiver was provided.

11 Anecdotally, we've heard both sides  
12 that, yes, the standards were lowered a little  
13 bit, or we've also heard that the waivers just  
14 vary a bit in kind but not necessarily in number  
15 or in severity. And so we are pulling that data  
16 for the Task Force.

17 DR. LEDNAR: Dr. Mason and then Dr.  
18 Luepker.

19 DR. MASON: Tom Mason, University of  
20 South Florida. If I could, you have two slides  
21 that refer to questions to be addressed by the  
22 Task Force, and if I could just point you to the

1 ones where it says the required information to be  
2 determined by an investigation in order to  
3 determine the causes and factors surrounding  
4 suicides by members of the Armed Forces.

5 Can you give us a sense of what  
6 information is presently being collected or when  
7 we might hear from you in terms of recommendations  
8 as to information data elements that arguably  
9 should be collected, prospectively and  
10 retrospectively, among those individuals who've  
11 attempted suicide and among surviving family  
12 members of those who have succeeded in committing  
13 suicide.

14 Col MCPHERSON: Sir, I am not sure of  
15 all the pieces that are in the DoD SERVE data,  
16 that is where most of it's coming from. I know  
17 that a lot of our time has been spent on  
18 determining whether or not investigating whether  
19 or not a psychological autopsy should be done on  
20 each successful suicide. I understand that it's,  
21 give or take, \$250 an hour. Somebody has priced  
22 it out, I think the Army has done that. I do

1 sense that the Task Force is very interested in  
2 having that done. And apparently at one point in  
3 the past perhaps that was done on every suicide.

4 I will -- in June, I can brief on what  
5 the elements of the DoD SERVE are that are being  
6 pulled together, and I don't know that I will be  
7 able to give a recommendation yet from the Task  
8 Force; but, certainly, we'll have that for you at  
9 our July briefing.

10 DR. MASON: Thank you very much. One of  
11 the things that I would encourage as you have  
12 these discussions is that there are data that are  
13 starting to come together which make a strong  
14 argument for we need to pay attention at the front  
15 end in terms of suicide ideation as adolescents.

16 And some of the factors that are  
17 associated with suicide ideation -- and I'm just  
18 not talking about acne medications -- that we need  
19 to pay attention to in terms of pre -- if you will  
20 -- enlistment and certainly precommissional.

21 And that some of these issues -- I'm not  
22 looking for a recommendation, I'm just sort of

1 looking for a timeline because, you know, these  
2 issues go way beyond, way beyond just simply  
3 capturing the information that's readily  
4 available.

5         And I would be the last one to argue  
6 against that particular autopsy, but first argue  
7 for the fact that I'm willing to vet -- we  
8 collectively -- and I'm just -- I'm talking just  
9 about uniforms, anybody who is interested in  
10 suicide, is that we have yet to really figure out  
11 exactly what we should be paying attention to when  
12 and how best to anticipate persons and intervene  
13 in a very early stage.

14         Col MCPHERSON: Yes, sir. I know that  
15 there is much talk in the Task Force about  
16 collecting data on the ideations and the gestures  
17 for the active duty folks. And numerous people  
18 have brought up the issue of moving further back  
19 in time, and before the folks came on active duty,  
20 what sort of backgrounds are we seeing.

21         I believe that the Army Task Force, Dr.  
22 Cox, through a database he is establishing, is --

1 that's on the to-do list. I don't believe it's  
2 going to be in the next year or two, but once he  
3 gets this database built that has as much data in  
4 there as he can, and they try to do start  
5 beginning their predictive analyses.

6 And I do believe that they are talking  
7 about trying to step further back in time to the  
8 prior coming on to active duty for exactly the  
9 issue you brought up.

10 DR. MASON: Thank you very much.

11 DR. LEDNAR: Dr. Luepker?

12 DR. LUEPKER: Yes. Russell Luepker.

13 You know, perhaps you've mentioned this and I just  
14 missed it. You did say that you are planning to  
15 look at Reserve and Guard suicides, but isn't a  
16 large part of the question people who have been  
17 discharged and is -- are you looking at this group  
18 of people, or is the VA looking at this group of  
19 people? Those are the ones that seem to hit the  
20 newspaper more commonly than active duty people.

21 Col MCPHERSON: Yes, sir. That is one  
22 of the larger issues. My thoughts right now are

1 that there are going to be in the report several  
2 areas that we recommend be further investigated  
3 that we simply can't get to. And quite  
4 truthfully, the whole Guard and Reserve issue will  
5 be -- I think will be part of that because there  
6 are so many issues they're trying to tackle.

7       One of the concerns is that after 120  
8 days, once you come off active duty for good or  
9 for temporarily, as you are in the Guard and  
10 Reserve, you fall out of the system in terms of  
11 what DoD tasks.

12       One of our -- the Chief on the Task  
13 Force is actually their first personnel for life  
14 that he indicates that there must -- he believes  
15 there is way to keep track of these people because  
16 at age 60, should they stay in the system, they  
17 will draw a paycheck. So somebody knows where  
18 they are and that there would be a way to track  
19 them. We just have to figure out how to do it.  
20 But they don't fall out of the system and  
21 disappear. They're just in some sort of  
22 not-looked-at status during that time frame.

1           Yes, we have Dr. Jen Kemp from the VA  
2 with us, and we're very concerned about that whole  
3 piece that you talk about because as you are  
4 probably very well aware, a lot of the issues and  
5 the troubles do not arise immediately upon  
6 deployment but months and months afterwards.

7           DR. LUEPKER: Thank you.

8           DR. LEDNAR: Other questions for Colonel  
9 McPherson?

10          Col MCPHERSON: Does Dr. Certain want to  
11 add -- I mean, since he's on our Task Force.

12          DR. LEDNAR: Dr. Certain?

13          DR. CERTAIN: The other issue that we  
14 have out there with veterans is that there's -- it  
15 may or may not be reported to us by county  
16 coroners. That question may not be asked if  
17 somebody commits suicide as a veteran; and even if  
18 they do, they may or may not report it up chain to  
19 the service that they were a veteran for. And so  
20 the civilian suicides out there that are completed  
21 by veterans are outside the reporting processes.

22          As you know, the CDC does not -- is not

1 able to get a complete year to us for about three  
2 years after it's over because the states are slow  
3 to report to CDC and get to us. So we don't have  
4 a good way of -- at this point -- of knowing  
5 what's out there. And I would hope that the Task  
6 Force will add that to our recommendations to try  
7 to speed up the reporting data out of the  
8 communities and to get some kind of standard form  
9 of collection of information so that we can more  
10 readily identify the veteran population.

11 But this Task Force is limited to active  
12 duty members of the Armed Forces largely, so the  
13 Guard and Reserve, while they are on active duty,  
14 is what falls into this parameter. And we have to  
15 rely upon the Army in its continuing work and the  
16 Marine Corps and its continuing work since those  
17 are the two Services that are most affected to  
18 continue to watch after their members while they  
19 are not currently on active duty and to identify  
20 the stressors that seem to be in the theme work of  
21 leading towards suicide.

22 But it's a big issue, and this Task

1 Force clearly isn't going to live long enough to  
2 get our arms completely wrapped around it where  
3 our hope is that we can at least answer some of  
4 the questions on these two slides so that the  
5 ongoing suicide prevention folks in the services  
6 can focus their work perhaps a little better.

7 DR. LEDNAR: Dr. Parkinson, Colonel, and  
8 then Dr. Poland. Dr. Parkinson?

9 DR. PARKINSON: Yes, thanks, Wayne.  
10 Mike Parkinson. You know, Joanne knows this well  
11 because Colonel Litts is on her Task Force, but  
12 probably one of the best systematic efforts to  
13 look at this, that I was aware of, the military  
14 got us involved with it, was under General  
15 Fogleman, and we took about a year, year and a  
16 half, to -- actually lifted a CDC community  
17 prevention model and used it as the analyzing  
18 structure to kind of go through this problem block  
19 by block. And I think that model, what you're  
20 going to probably brush off again and look at it  
21 with a lot of diligence, is still very much valid.

22 And where we tend to fall down,

1 unfortunately, is uniform execution policies that  
2 actually were early on showing to mitigate -- at  
3 least be correlated with mitigation the Air Force  
4 suicide rate.

5 But if I ask myself one of the three  
6 things since 1997, which is when I think we did  
7 this, 97, 98, the first time we saw a blip in Air  
8 Force suicides.

9 There's probably three things that I  
10 think are new, and you talked about one of them.  
11 One of them is, I think, is our clinical or  
12 medical awareness of the long lasting effects of  
13 pediatric psychological trauma. I don't think we  
14 knew that 13 years ago what we do today, and that  
15 is emerging and showing a variety of different  
16 ways that it plays out. So I think that's  
17 something that we can talk about.

18 The other thing clearly was the impact  
19 of constant three, four, five times deployments,  
20 24/7 readiness, and we were just beginning to get  
21 into this notion of, you know, a mobile Air Force  
22 with people to unravel things. That's changed

1 dramatically. That's something to look at it.

2           Another thing is what I see in the  
3 civilian sector is an absolute over-medicalization  
4 of this problem. I don't see a company in America  
5 where the number one and number two prescription  
6 drug is an antidepressant or anxiolytic. We  
7 have medicalized this to the point that most  
8 people are on some type of psychoactive drug. So  
9 employers all the time will say to me, we have an  
10 epidemic of depression. I said, partly right. We  
11 have an epidemic of antidepressant prescribing.  
12 There is not really a depression epidemic. What  
13 we've got to do is get coping and resiliency.

14           So the last thing is this whole notion  
15 of individual family community unit resiliency  
16 which is really the key, and that's flip side of  
17 some the other things we've talked about here,  
18 that is the immunization, if you will, the  
19 antidote.

20           How do you train to resiliency in people  
21 who, through no fault of their own, had pediatric  
22 psychological trauma or were abused or -- so there

1 has to be something beyond what we did 13 years  
2 ago, beyond executing the policies well. I think  
3 you'll find that too. When you find it, you  
4 should call it out and say, You know, we have a  
5 good policy, didn't follow through. Because  
6 that's what we need to hear, I mean, I think we  
7 need to know.

8 Col MCPHERSON: My understanding is that  
9 the Air Force program was supposed to be  
10 promulgated DoD-wide and that there was a DoD  
11 construction started on it. I don't know that  
12 that actually got finished. I just heard that the  
13 other day, so we'll be hunting that down to see if  
14 that actually did happen.

15 DR. LEDNAR: Colonel?

16 COL JAFFIN: Jon Jaffin, J-a-f-f-i-n.  
17 I'm speaking as -- having been a member of the  
18 Army Suicide Prevention Task Force for the past  
19 year, and many of Dr. Parkinson's comments we  
20 found to be very true.

21 One, it is very hard, even when somebody  
22 in the Guard and Reserve just not actively serving

1 at the time, working with local police departments  
2 and things like that to get the information. And  
3 even then, we aren't sure.

4 We've started pushing much harder to get  
5 the epidemiologic information on suicides that  
6 occur not on active duty, and suicides that occur  
7 at the time of transition, whether to leaving  
8 service, going off active duty, or whatever  
9 because those clearly are major stress periods.  
10 It's hard. It's a very multifactorial thing.

11 We are seeing huge numbers of --  
12 especially SSRIs -- prescriptions being written.  
13 The added suicidal ideation that goes often with  
14 those may or may not be associated with completed  
15 suicides, but they're definitively a suicidal  
16 ideation trying to get a better screening tool for  
17 soldiers for the MEPS stations. And not just  
18 soldiers but any service member at the MEPS  
19 station because, again, it -- these usually don't  
20 spring de novo, but there are precursors and  
21 predictors, but it's hard to figure that out in a  
22 -- I mean, I jokingly tell people that when I came

1 on active duty, I was having my MEPS physical in  
2 1977. The extent of the psychological evaluation  
3 is to be called in a room and asked, Are you  
4 normal?

5 (Laughter)

6 COL JAFFIN: Typical wise-ass college  
7 kid, I asked him what "normal" meant. He asked me  
8 if I liked girls. I told I did, and I was fit to  
9 serve.

10 (Laughter)

11 COL JAFFIN: So far he was actually a  
12 better predictor, I haven't done any of those  
13 things to get in trouble. But the other thing  
14 that we found to build on the multiple deployments  
15 is especially in the Army. We deploy them for a  
16 year, often breaking or stretching family bonds  
17 during that year, 15 months, 16 months, 18 months  
18 depending on how long and how much training.

19 When they come home, we then scatter the  
20 unit so we break the bonds that they've build in  
21 that time period while they were away. And so the  
22 ones who are at risk are the ones who don't have

1 strong bonds to anything or anybody. And so  
2 that's another area where we've been struggling  
3 with the OPTEMPO in trying to break it. Thank you  
4 for allowing me to comment.

5 Col MCPHERSON: I would just add that  
6 when we're doing our site visits, we are asking to  
7 meet with junior enlisted, senior enlisted, middle  
8 enlisted and young officers, and then the very  
9 senior staff on the base. We are also meeting  
10 with chaplains and the other support staff as well  
11 as the medics.

12 And we're also meeting with the spouses.  
13 We ask for a number of spouses, and, by golly,  
14 those ladies are very vocal in what they see and  
15 what they think and what information they wished  
16 they had. And the things that they're wrestling  
17 with is when they see something in their soldier  
18 or their marine and how do they deal with that and  
19 who do they turn to, and is it going to hurt their  
20 career. But they're certainly the ones who know  
21 whether or not somebody is hiding something, when  
22 they go to the medics, and clearly they report

1 that everything is just fine.

2 DR. CERTAIN: And the other one category  
3 you slipped past was said -- we also -- they asked  
4 for people who have been deployed and returned and  
5 those who have not been deployed because suicides  
6 are almost as prevalent amongst the never deployed  
7 as they are most that deploy.

8 DR. LEDNAR: First Dr. Poland and then  
9 Captain Cowan.

10 DR. POLAND: Greg Poland. I just had a  
11 quick question and that is if we have anything to  
12 learn from our British and Canadian liaisons and  
13 any programs that are sort of bubbling up on your  
14 ends, and are you experiencing the same sorts of  
15 issues that we are in the U.S.?

16 CAPT COWAN: Thank you. I only work  
17 part of my time at the Department of Veterans  
18 Affairs so I have the privilege of looking at both  
19 sides of the issue. I was looking at some data  
20 that the VA produced; and what's staggering,  
21 frankly, is that those in the VA who are actually  
22 in VA health care and who have a mental health

1 diagnosis -- I just dug it out of my notes -- are  
2 42.8 per 100,000. They're almost double the risk  
3 of those on active duty.

4 There are all these pockets of people  
5 who are clearly out there at nonactive duty but  
6 clearly represent a much greater risk than those  
7 who we often focus greater on. And the VA are all  
8 up to that.

9 To answer your questions specifically,  
10 we have an organization in the U.K. called the  
11 Defense Analytical Statistics Agency. And it's  
12 they who collect the standardized data for  
13 suicides and stuff like that. And I share that  
14 with both my duty colleagues and my VA colleagues  
15 once a year.

16 And to answer your question, yes, we are  
17 seeing the same issue, but it's not to the same  
18 extent or the same depth. But it's significant  
19 enough to attract a lot of attention, and we're  
20 doing much the same sort of things as you are to  
21 try and get to the heart of it.

22 CDR SLAUNWHITE: Hello. Commander Cathy

1 Slaunwhite. In Canada there was a suggestion  
2 about two years ago that our suicide rates were  
3 going up very significantly. When that was  
4 checked into further, the data was military police  
5 reported. Suspicious deaths rather than confirmed  
6 suicide deaths.

7 In fact, in Canada in the last two years  
8 our rates of suicide seemed to have gone down  
9 amongst active duties. So I think we are well  
10 below the 10 per 100,000 agents, actually  
11 adjusted, which I think is what the number, the  
12 norm would be in Canada.

13 And I don't think we're certain why the  
14 rates have gone down, but we've had a very big  
15 focus on improving mental health services in the  
16 CF and have had very high-profile individuals, I  
17 think as your campaigns have had as well.

18 People like General Romeo Dallaire, who  
19 lost Belgian troops in Rwanda, speaking about  
20 personal struggle publicly with mental health  
21 conditions.

22 So I'm not sure if our activities result

1 in the lower numbers. The one area we are  
2 watching just now is looking for suicide deaths  
3 linked with physical injury on deployment. And  
4 there's one Quebec-based soldier who, I think, had  
5 a partial amputation of a foot; and nine months  
6 after returning home was lost to a death by  
7 suicide. So I think that's one of our watchful  
8 areas, those in rehabilitation for physical  
9 injuries, looking to see if they are a more  
10 vulnerable population.

11 GEN (ret) MYERS: Dick Myers. This question  
12 is Colonel McPherson. When you say you meet with  
13 these young enlisted, seniors, and so forth, I  
14 assume there's nobody from the command there  
15 present?

16 Col MCPHERSON: Yes, sir. We've had --  
17 only one instance -- I think there was  
18 intentionally a commander representative in the  
19 room and we asked him to leave. Otherwise -- just  
20 inadvertently sometimes had our escort in there  
21 and we asked them to leave too. So it's  
22 completely anonymous. We talked to them about

1 that. We have one of our senior dudes enlisted to  
2 pound that home. And we think we've had some  
3 pretty frank and open discussions about that.

4 DR. LEDNAR: Colonel McPherson, can you  
5 just share what's ahead in terms of time table and  
6 when the Board can expect to hear a little bit  
7 more about what you're learning.

8 Col MCPHERSON: We will go ahead and  
9 hopefully conclude our site visits by the end of  
10 April. At this point it's pretty an off-week,  
11 on-week, off-week, on-week travel schedule for two  
12 teams at any point in time. With 6 people and  
13 only total 14 on the Task Force, that pretty much  
14 covers everyone out on the road seeing multiple  
15 sites at the same time.

16 At the end of April, then we have in May  
17 we have scheduled some multiple days, sort of  
18 locked into a room to lay down what we think is  
19 going to be at least the framework for the report.  
20 We've actually started that. We work with them.

21 Almost every time we have a public  
22 meeting, we have a complete day with just the Task

1 Force members as we sit down and try to structure  
2 what we think the report is going to look like,  
3 where they think it's going to fall.

4 So then in May, the very hard bragging  
5 starts. Hopefully in June at your next meeting, I  
6 can provide a bit of an update and have hopefully  
7 General Volpe with us since we actually overlap.  
8 So we should be in town the same days that you are  
9 and perhaps can provide a quick glimpse as to what  
10 the recommendations are going to be, and then the  
11 full report in July. And then the -- up to SECDEF  
12 on the 6th of August. Is that enough detail?

13 DR. LEDNAR: That's good. Thank you.  
14 So what that means for the Board is as we talked  
15 about this morning in our administrative session,  
16 we may be looking for a date in the first three  
17 weeks of July to basically be available to Colonel  
18 McPherson and the Task Force to hear about the  
19 report because they do have a due out to Congress  
20 in August.

21 So as an activity of the Defense Health  
22 Board, it's important that we understand their

1 work, and we will be expected to take a position  
2 on it before it goes to Congress.

3 Any other questions on the support work  
4 that Colonel McPherson and her Task Force are  
5 leading? If not, thank you for the work you're  
6 doing, and we look forward to what lessons you  
7 have for us as you know them.

8 Col MCPHERSON: Thank you very much for  
9 your support.

10 DR. LEDNAR: Thanks, Colonel McPherson.  
11 Thank you.

12 (Applause)

13 DR. LEDNAR: Our next speaker is  
14 Lieutenant Colonel Philip Gould. Colonel Gould is  
15 Chief of Preventive Medicine Operations at the Air  
16 Force Medical Support Agency, Office of the Air  
17 Force Surgeon General, where his principal focus is  
18 immunization policy development.

19 In addition to serving on the Defense  
20 Health Board as a service liaison officer, he also  
21 serves as Chair of the Joint Preventive Medicine  
22 Policy Group which encourages cross-Service

1 discussion of key preventive medicine and public  
2 health issues.

3 Colonel Gould is board certified by both  
4 the American Board of Family Medicine and the  
5 American Board of Preventive Medicine.

6 His prior positions include lead  
7 epidemiologist for the DoD Global Influenza and  
8 Respiratory Virus Surveillance Program and serving  
9 as the Air Force representative to the Military  
10 Infectious Disease Research Program.

11 The Board would like to congratulate  
12 Lieutenant Colonel Gould on his recent selection  
13 for promotion to full colonel effective May of  
14 2011. So let's please congratulate Colonel Gould.

15 (Applause)

16 DR. LEDNAR: Colonel Gould in his brief  
17 will be providing us an information brief, back  
18 brief, regarding the recent Joint Preventive  
19 Medicine Policy Group response to the Defense  
20 Health Board's recommendations issued in September  
21 of 2009 regarding pandemic influenza preparedness  
22 and response in DoD.

1 Colonel Gould's presentation slides may  
2 be found under Tab 10 of the meeting binder.

3 Colonel Gould?

4 Lt Col GOULD: Ladies and gentleman,  
5 distinguished guests. The Joint Preventive  
6 Medicine Policy Group was asked to review the  
7 recommendations of the Defense Health Board to  
8 present to the Force Health Protection Council  
9 this past month, which we did. And there were no  
10 major issues raised at that time; however, they  
11 did discuss financial issues which were outside of  
12 the scope of this particular review.

13 Next slide? The Defense Health Board  
14 recommendations fell into approximately six  
15 different categories, and as you mentioned they  
16 were issued on September 11th of 2009. And these  
17 categories are listed there. And we'll go through  
18 each one of them and the recommendations that fell  
19 under that and what the Department of Defense is  
20 doing.

21 I will not claim that this is a  
22 comprehensive list; it is what those members of

1 the Joint Preventive Medicine Policy Group were  
2 aware of. These are some initiatives going on  
3 right now related to some White House initiatives  
4 that may result in newer technologies or newer  
5 developments for vaccines, et cetera, but those  
6 are as of yet in a working status.

7       Next slide. So the first two  
8 recommendations were related to the use of  
9 antivirals, and there were some efforts, of  
10 course, to reemphasize that there are select  
11 groups within the military that might benefit from  
12 the use of antivirals for peripheral access, such  
13 as recruits and deployed forces and so forth.

14       However, given the nature of the current  
15 pandemic, H1N1, being a relatively mild disease,  
16 even if there are a large number of people  
17 becoming ill, the DoD is largely following the  
18 current CDC and FDA recommendations. Also the  
19 current DoD stockpiling approach is following the  
20 national and international standards through the  
21 WHO international organizations as well.

22       We have been able to achieve additional

1 funding for antivirals as well as personal  
2 protective equipment. And those we now have are  
3 much more expanded available antivirals to most  
4 MTFs and in addition to including Relenza<sup>®</sup>  
5 approximately 1 percent of PAR in addition to the  
6 30 percent of the PAR for oseltamivir.

7 Next slide, please. The Defense Health  
8 Board recommendations recognize that the DoD is an  
9 important and integral partner in surveillance for  
10 influenza worldwide. And two DoD laboratories  
11 were the first to identify H1N1 in the world: the  
12 NHRC laboratory in San Diego -- Naval Health  
13 Research Center -- and the USAFSAM or U.S. Air  
14 Force School of Aerospace Medicine laboratory in  
15 San Antonio.

16 The next two. So I think that shows our  
17 importance to the international as well national  
18 effort for influenza surveillance. NHRC has  
19 expanded laboratory testing capacity by  
20 approximately 3 to 5 percent, and it has now  
21 tested over 15,000 specimens. The School of  
22 Aerospace Medicine has expanded by 68 times and

1 has tested well over 24,000 specimens.

2           And pretty much, we've got over 500  
3 different locations, and nearly all locations that  
4 have some DoD presence have submitted specimens to  
5 one or both of these laboratories. And some of  
6 those locations may be floating platforms in the  
7 Navy, but there are also specific locations.

8           Additionally, this says three Army  
9 MEDCENs. There are also seven MEDCENs that are  
10 going to be -- that could go forward and start  
11 testing right now once the assay becomes FDA  
12 approved. And there are also two NEPMUs on both  
13 coasts that are doing testing there.

14           Next slide, please? One somewhat  
15 curious recommendation was a request that we have  
16 a testing algorithm. The DoD has actually had a  
17 testing algorithm for quite some time, and that's  
18 sort of the bullet number one under the testing  
19 algorithm. And that was expanded in the SARS  
20 outbreak in 2003 to expand that to those people  
21 who are hospitalized as well as those who were  
22 antiviral resistant. And in this particular

1 outbreak, we've expanded it to also include case  
2 clusters of five or more in high-risk groups, such  
3 as deployed or trainees.

4       The School of Aerospace Medicine is also  
5 now at about -- not quite 100 percent but close --  
6 100 percent of all of the specimens that had the  
7 HA region of the hemagglutinin gene sequenced.  
8 And not only have they been sequenced; but,  
9 routinely interesting, three-dimensional models of  
10 this are being forwarded to the Centers for  
11 Disease Control.

12       And at the most recent WHO meeting of --  
13 to decide the next virus to go into the Northern  
14 Hemisphere seasonal recommendation for H1N1, the  
15 CDC requested from USAFSAM a copy of one of the  
16 models that was related to an Iraq specimen which  
17 they then forwarded to them. And that was  
18 presented as part of the packet to the WHO for  
19 their recommendations for the seasonal Northern  
20 Hemisphere vaccine.

21       The Joint Biologic Agent Identification  
22 System has been under Emergency Use Authorization

1 since August, and it has been validated at five  
2 CENTCOM sites. And approximately -- not quite  
3 exact -- but approximately 100 specimens at each  
4 of those locations have been tested using this  
5 system.

6 Next slide. The number of countries  
7 that have surveillance performed in part or wholly  
8 by the Department of Defense is now up to 75. And  
9 15 of the countries which provide specimens to the  
10 WHO, their sole source for that information is  
11 from the Department of Defense Laboratory Efforts.  
12 Mainly, those are in Sub-Saharan Africa and in  
13 South America as well.

14 The DoD is also actively involved in  
15 hospitalization surveillance, and while we don't  
16 necessarily coordinate our activities with the  
17 CDC, we do provide them that information.

18 And importantly also, the Military  
19 Vaccine Office, the Armed Forces Health  
20 Surveillance Center, and the FDA's Center for  
21 Biologics Evaluation Research are actively  
22 involved in looking for possible adverse events to

1 the H1N1 vaccine. And there is an additional  
2 slide in the back that shows that we've tested now  
3 over -- we've looked at the results of over 1  
4 million active duty members, and there have been  
5 no increased number of events noted in that  
6 surveillance.

7 Next slide, please. The MIDRP program  
8 held a symposium in September to evaluate the  
9 possibility of expanding the scope of MIDRP to  
10 include a respiratory disease program. One of my  
11 notations to that is the MIDRP funding has been  
12 fairly stable for many years and expanding that  
13 role would obviously require decrease in the role  
14 of other items in that program.

15 Now, again, there may be some funding  
16 coming through alternate mechanisms for purposes  
17 of respiratory disease research in the future, but  
18 as far as that -- and I'm not quite sure what the  
19 MIDRP final conclusion was, but Dr. Lednar can may  
20 be fill us in at some -- at a later point.

21 As I'm sure most of the Defense Health  
22 Board and the previous AFEB are aware, the DoD has

1 had a long involvement in respiratory disease  
2 clinical research and epidemiology. And, in fact,  
3 the development of the influenza vaccine in the  
4 40s is a direct result of the involvement. And we  
5 are currently involved with a variety of agencies  
6 and partnering on such research, such as this  
7 cross-neutralizing antibody research we mentioned.

8       The Naval Health Research Center and  
9 Navy Medical Research Center are actively involved  
10 in vaccine clinical trials, most notably the  
11 adenovirus 4/7, which we hope to have FDA approved  
12 shortly, as well as a DNA-based H1N1 vaccine.

13       Next slide. Well, we do a lot. There  
14 are some things that perhaps are better done in  
15 the civilian sector, such as multidrug antiviral  
16 therapy is probably better done in a sort of  
17 multicenter trial; nonetheless, the Navy Health  
18 Research Center is working with a pharmaceutical  
19 manufacturing to evaluate a three -- triple drug  
20 regimen involving oseltamivir, rimantadine and  
21 ribavirin.

22       The Naval Medical Research Center has

1 funded a clinical trial in convalescent plasma  
2 therapy and is working to set up a network for  
3 that. However, you know, given the relatively  
4 benign nature of this particular virus, it's going  
5 to be hard to argue for a fairly aggressive  
6 treatment, such as convalescent plasma therapy for  
7 routine patient care.

8       Next slide. As far as the vaccine  
9 distribution, the DoD was actively involved in the  
10 initial decision making; however, that was changed  
11 by the White House to some extent, although, you  
12 know, the DoD did receive a fair amount of vaccine  
13 early on, but most of that went to our deployed  
14 locations: CENTCOM, EUCOM, and Korea. And the  
15 decision to use the vaccine, which was one of the  
16 recommendations in the DHB, was actually taken  
17 away from DoD and that was national policy.

18       And there is a draft policy at ASD for  
19 signature on the use of 23-valent pneumococcal  
20 vaccine. The recommendation by the DHB was to  
21 hold off on aggressive use of this vaccine until  
22 such time PSV23 could be fully evaluated. And

1 once the PSV23 recommendation comes out, once the  
2 research is completed -- but that will be probably  
3 several years away.

4 In the interim, the ACIP has recommended  
5 that we vaccinate persons of 19 years and older  
6 who are smokers or who are asthmatic or have an  
7 underlining chronic medical condition that would  
8 compromise their ability to respond to  
9 pneumococcal disease. And so we're, to the extent  
10 possible, vaccinating those individuals.

11 I don't think it's an appropriate venue  
12 to put those into recruits although the original  
13 request for review of this policy was driven by  
14 the two pneumococcal meningitis staphs in foreign  
15 matter growth, neither of which would probably  
16 have been prevented by the vaccine.

17 Next. Communications and coordination.  
18 You know, we've been interacting with a large  
19 number of organizations, both within the U.S.  
20 government as well as some independent agencies,  
21 and we've provided a wealth of research on  
22 influenza surveillance, influenza transmission,

1 and so forth. So I think that's well stated  
2 there.

3 And as far as other informational  
4 vaccine availability, locations, et cetera,  
5 there's been an overwhelming amount of information  
6 available on a variety of websites, including  
7 Twitter and Facebook. And approximately 8.3  
8 million hits a month ago -- 8.3 million hits on  
9 the DoD Watchboard so I suspect that's higher now  
10 although H1N1 has more or less died off the map  
11 for the moment. Any questions?

12 DR. LEDNAR: Questions for Colonel  
13 Gould? Dr. Parkinson?

14 DR. PARKINSON: Mike Parkinson. Thank  
15 you very much, Phil. Very good. Just a little  
16 follow up -- a nice story for the Board. You know,  
17 we were at the Academy when the Academy outbreak  
18 had just occurred. And some of the prompt steps  
19 they took there -- I think it was last week or the  
20 week before, before I lose track, Colonel Witkop  
21 presented, I believe, the Preventive Medicine  
22 meeting in Crystal City, Virginia.

1           But I wonder for the Joint Preventive  
2   Medicine Group if in light of -- you know, we  
3   always kind of thought that the academies in  
4   concert created a unique surveillance opportunity  
5   but it never really seemed to come together at the  
6   academy level. That's what's my impression.

7           And if ever there was a time when all of  
8   these places pretty much started at about the same  
9   time with a bolus of, you know, 4,000; 8,000;  
10   12,000 people, which is different than the recruit  
11   camps, where they come in continuously on a lower  
12   level, I wonder if that outbreak in the  
13   conversation fostered any more collaboration  
14   between the academies, specifically on the summer  
15   arrivals of those new students.

16          Lt Col GOULD: Not at this time, but we  
17   could certainly raise that question. I think  
18   really the Academy demonstrates that the  
19   nonmedical measures are probably as important, if  
20   not more important, in the control of communicable  
21   diseases because while they did use the  
22   oseltamivir here for the treatment, it surely --

1 the data presented in the paper shows that it  
2 wasn't really -- didn't really do much for  
3 shortening the course of illness or for  
4 transmission purposes.

5       However, putting -- taking those  
6 individuals and moving them out of that training  
7 environment into their dorm room and then having a  
8 select group of people take care of them, I think  
9 is probably what really stopped the outbreak from  
10 progressing.

11       DR. LEDNAR: Other questions? If I may  
12 ask Dr. Poland because the Infectious Disease  
13 Subcommittee and the Task Force on Pandemic  
14 Influenza Preparedness really was the report --  
15 prompted the discussion on February 3rd that  
16 Colonel Gould is summarizing for us.

17       Greg, any comments you'd like to make?

18       DR. POLAND: None specific other than  
19 just to say how pleased I am as an individual, and  
20 I speak somewhat for my Subcommittee, with the  
21 alacrity with which the Department moved in  
22 addressing these issues and in being very

1 transparent partners with us in trying to get  
2 data, figure out what was going on. I mean, as  
3 you all can imagine during those days, people were  
4 tasked and were working 18-hour days, and no one  
5 knew exactly how severe this was going to be, et  
6 cetera.

7         We were talking a little bit this  
8 morning and maybe you can give at least order of  
9 magnitude numbers about deaths or other indicators  
10 that really show that the impact of this was  
11 minimized to the extent that was humanly possible  
12 given there were delays in getting vaccine, et  
13 cetera. So it's more -- my only comment is really  
14 to say how impressed I was with how the Department  
15 performed in this specific issue.

16         Lt Col GOULD: I believe the number of  
17 deaths of both active duty, retirees, and other  
18 dependents is under 15. 10? Oh, he just checked:  
19 10.

20         DR. POLAND: Just to put that in  
21 perspective, we heard last week among colleges  
22 that are members of the American College Health

1 Association, 91,000 college students were ill, 169  
2 hospitalized, and 4 died. We're talking about  
3 orders of magnitude larger population here with  
4 less in the way of morbidity and mortality. It's  
5 just a spectacular performance.

6 DR. LEDNAR: I think the H1N1 global  
7 experience was really quite a lesson. One of  
8 those lessons is that pandemic threats continue.  
9 We were fortunate with this particular virus that,  
10 despite how it was initially appearing in its  
11 early days in Mexico, that it did turn out to be a  
12 milder infection although it clearly did affect  
13 young populations disproportionately.

14 But pandemic threat continues with other  
15 agents so I think it's important to be sure that  
16 those lessons that are learned either in  
17 surveillance or in communication, working  
18 virtually understanding how mission accomplishment  
19 can be compromised by pandemics, and therefore the  
20 importance of pandemic preparedness on mission  
21 accomplishment is understood by the line.

22 This is a time to take advantage of

1 things being quieter and settling down into the  
2 more seasonal pattern to be sure that those  
3 lessons are fully hardwired into our institutional  
4 way to run, either in DoD or in the private  
5 sector. So I'd encourage you, do everything you  
6 can to make sure that those lessons are fully  
7 baked in to the way we operate.

8 Lt Col GOULD: I think the line is very,  
9 very acutely aware of the pandemic potential much  
10 more so than they might have been several years  
11 ago. And I think that perhaps the fact that it  
12 was relatively mild is a good thing, but they were  
13 definitely involved in most decision making.

14 DR. LEDNAR: Dr. Oxman?

15 DR. OXMAN: Mike Oxman. Just to belabor  
16 the point that the Defense Health Board and the  
17 Subcommittee of Infectious Diseases has made  
18 before with respect, although, I fully understand  
19 the issue of funding with MILVAX that the  
20 respiratory viral research is uniquely a military  
21 problem, and that, for example, the new adenovirus  
22 vaccine doesn't provide a platform for other

1 adenoviruses.

2           There is -- it's an old -- it's an  
3 ancient vaccine, and there are currently  
4 respiratory problems that are uniquely military,  
5 and there will be more for sure. So I would like  
6 to continue to plug away for the rebirth of a  
7 basic as well as clinical research program that  
8 deals with the unique military problem of  
9 respiratory disease.

10           DR. LEDNAR: Any other comments for  
11 Colonel Gould? Okay. If not, Colonel Gould,  
12 thank you for that brief and for the work that  
13 you're doing.

14           What we'll do now is we're going to take  
15 a break until 3:30. So if you would please  
16 readjournal or reconvene in this room at 3:30, we  
17 will start up for the final session of the Core  
18 Board meeting today. Thanks.

19           (Recess)

20           DR. LEDNAR: Our next speaker, unlike  
21 the agenda, is not Dr. Bill Halperin who, I'm sad  
22 to say, is here but is upstairs in his hotel room

1 sick. Ill. And it takes a lot for getting Bill  
2 knocked down to not be here, but he's feeling so  
3 ill that he's asked Dr. Tom Mason to stand in in  
4 terms of the Subcommittee update that we will be  
5 hearing.

6 So to introduce Dr. Mason, Dr. Mason  
7 currently serves as Director of the Global Center  
8 for Disaster Management and Humanitarian Action at  
9 the University of South Florida. Additionally,  
10 Dr. Mason serves as the Vice-Chair of the Medical  
11 Institutional Review Board for the University.

12 He also holds Joint Professorships in  
13 the College of Medicine, Department of Internal  
14 Medicine, Divisions of Medical Ethics and  
15 Humanities and Global Emergency Medical Sciences.

16 He has most recently been appointed as a  
17 Public Member to the Board of Directors of the  
18 American Board of Disaster Medicine.

19 Dr. Mason also serves as a captain in  
20 the ready reserve as a Special Assistant for  
21 Environmental Health in the U.S. Public Health  
22 Service.

1           Dr. Mason is going to give us a  
2 Subcommittee report, and the material that Dr.  
3 Halperin had prepared for this agenda item may be  
4 found at Tab 7. Dr. Mason?

5           DR. MASON: Thank you very much.  
6 If I could have the next slide. So very  
7 simply, we just want to tell you who we are, what  
8 simply, we just want to tell you who we are, what  
9           our charge is, and the status of our site visits  
10 and anticipating reports coming from our  
11 Subcommittee.

1           The next slide, please. It's an  
2 excellent group of guys to work with. We have had  
3 the honor and privilege to work together on a  
4 number of issues that relate -- and this is the  
5 latest task that we've been given -- if I could  
6 have the next slide -- because our mandate is  
7 exceptionally broad. We have been selected as the  
8 select Subcommittee to serve as a public health  
9 advisory board for the DoD Research and Clinical  
10 Centers for Deployment Health.

11           Right. The next slide. So what has  
12 happened over the past months is that Bill and  
13 Commander Feeks had gone to San Diego, Naval  
14 Health Research Center. We have been tasked  
15 basically with an evaluation critique commentary  
16 on the Millennium Cohort, and many of you are very  
17 familiar with when the Millennium Cohort was  
18 configured.

19           And some of the recent publications  
20 coming from the Millennium Cohort, not the least  
21 of which is one that has been discussed here  
22 several times, and that is: pulmonary conditions

1 identified among individuals with exposures to our  
2 burn pits. They went; a draft report was  
3 prepared.

4 Our entire Subcommittee, we periodically  
5 have teleconferences so that as many of us can get  
6 together to move our schedules around and spend  
7 two hours on the phone talking about what they  
8 were able to find, the directions that we're  
9 interested in going. We have prioritized some  
10 very specific issues.

11 Now, this is -- Mike, keep me honest --  
12 is this is the second time or the third time that  
13 people have actually gone to San Diego? It's at  
14 least the second. I know that there was a group  
15 because I believe you were there and Kaplan was  
16 there earlier on with Halperin. So it's at least  
17 the second time that this particular Subcommittee  
18 has gone to San Diego to ask questions.

19 As a result of their information  
20 gathering, a number of concerns and questions were  
21 raised within the Subcommittee. Then we  
22 individually ranked them to come up with some

1 subset, which we consider to be our most important  
2 priority questions and issues to address.

3       We're going back in May. We will spend  
4 a large part of a week in San Diego. We will give  
5 them a heads up well ahead of our visit in terms  
6 of these are the questions we're really interested  
7 in, and hopefully we will then be able to glean  
8 from that site visit sufficient and adequate  
9 information to put together a report. And we will  
10 definitely report out at our next meeting of the  
11 Core Board in June.

12       So, again, I'm sorry that Bill was ill.  
13 I know he will be back with us. And a number of  
14 us, we'll all be together in San Diego in May.

15       So that's really -- it's just an  
16 information update to let you know who we are,  
17 what we're doing, the mandate that we've been  
18 given, our charge, and a timeline. And this is  
19 the first of three because there are two centers  
20 which we will visit. And we will use the  
21 information that we glean from San Diego as a way  
22 in which to put together a template for the other

1 centers who are basically charged with deployment  
2 health issues. Thank you very much.

3 DR. LEDNAR: Thank you, Dr. Mason. Any  
4 questions or comments for Dr. Mason and the work  
5 of the Subcommittee? Okay, hearing none, we look  
6 forward to the learnings that will come from the  
7 site visit in May. I believe it's May 11th and  
8 12th --

9 DR. MASON: That's the plan, yes.

10 DR. LEDNAR: -- are the tentative dates  
11 at the moment for this visit to San Diego. And  
12 just part of the agenda for the Core Board meeting  
13 in June, we will have a report about what was  
14 learned during that site visit.

15 DR. MASON: Thank you very much.

16 DR. LEDNAR: Okay. Thank you, Dr.  
17 Mason. Our next speaker is Mr. Charles Campbell.

18 Mr. Campbell is a member of the Senior  
19 Executive Service and Chief Information Officer  
20 for the Military Health System. Mr. Campbell is  
21 the Principal Advisor to the Assistant Secretary  
22 of Defense for Health Affairs and to DoD medical

1 leaders on all matters related to information  
2 management and information technology.  
3 He works closely with all the Services  
4 and their Surgeons General to ensure that the  
5 military health IT programs are well managed,  
6 comply with applicable statutes and policies, and  
7 align with the objectives of the Military Health  
8 System. He oversees the Information Management  
9 and Information Technology program offices on all  
10 matters of acquisition, development, testing, and  
11 deployment of health-related software systems to  
12 the military, including the military's electronic  
13 health record.

14 Mr. Campbell spent more than three  
15 decades supporting worldwide military operations,  
16 military health care, and veteran health care with  
17 22 years of experience in the IM/IT field. He  
18 recently served as Deputy Chief Information  
19 Officer for the Veterans Health Administration.

20 His awards and decorations include the  
21 Defense Superior Service Medal, the Meritorious  
22 Service Medal, the Air Force Commendation Medal,

1 and the Air Force Achievement Medal.

2 Mr. Campbell is a real expert in the  
3 electronic medical record as it is being designed  
4 and fielded in the Military Health System.

5 And it's a real pleasure, and I really  
6 appreciate, Mr. Campbell, you're joining us today.  
7 Mr. Campbell's presentation materials may be found  
8 under Tab 8 of the binder. Mr. Campbell?

9 MR. CAMPBELL: Thank you very much.  
10 Just came in from speaking at the Health  
11 Information Management System Society, the HIMSS  
12 conference, one of the largest in the country.  
13 About 28,000 people attending that one. A very  
14 good conference. If you ever get a chance to go  
15 down there and want to learn more about health IT,  
16 that's the place to go.

17 Next slide, please. What I did was I  
18 kept the slides at real high level so we can delve  
19 down into whatever details you want to delve down  
20 into without me kind of forcing you down in there  
21 and left lots of time for questions. I'd like to  
22 answer all the questions that you have. We have

1 lots of things going on. Quick agenda. What kind  
2 of things we're going to talk about.

3       Next slide. Mission. When we talk  
4 about my job as the CIO, Chief Information  
5 Officer, it's really about information. It's  
6 about how do you get information into some type of  
7 electronic format, how then do you store it, what  
8 do you do with it, how do you then make it  
9 available to the right place at the right time.  
10 Information that is correct information, stable  
11 information, secure information, and it gets to  
12 the right person whether that person is a  
13 provider, a researcher, a business person, an  
14 administrative person. So all that information  
15 has to go to the right place, at the right time,  
16 and it has to be the right information. That's  
17 our job, plus the entire continuum of health care  
18 operations.

19       Next slide, please. So if you look at  
20 this, and we have several slides that show this,  
21 this is just one that shows from the time someone  
22 accesses into the military. We need to capture

1 that information electronically somehow in a  
2 standard way.

3 And then as they go through the process  
4 of training, receiving other types of health care  
5 all along the process, as they do get deployed out  
6 into theater, they receive care for first  
7 responders, forward resuscitative care, theater  
8 care, en route care. How do we capture that  
9 information as they fly from place to place, as  
10 they're in the ambulance from place to place and  
11 that care is being received, we have to capture  
12 all that information across.

13 And as they come back, then they go the  
14 tertiary care facilities like Walter Reed,  
15 National Naval Medical Center, if they're burn  
16 victims off to BAMC. And then perhaps they go off  
17 to the VA to the polytrauma centers.

18 And as we know, though, a lot of our  
19 care is provided outside of the direct care system  
20 and the VA system. Probably they say -- well,  
21 depending on how you look at it -- about 60  
22 percent of our care for our 9.6 million

1 beneficiaries is done outside of the direct care  
2 system. Roughly 30 or 40 percent of the care is  
3 outside the VA facilities.

4         So we have to find a way to capture all  
5 that information and bring it back in to complete  
6 that longitudinal health care record of our  
7 beneficiaries. And that just depicts that.

8         As they go across theater, come back,  
9 back again, the Guard and Reserves, we have to  
10 make sure we capture the Guard and Reserves  
11 because once the Guard and Reserves come back and  
12 demobilize, where do they go? They go back to  
13 their civilian jobs, they go back to their  
14 civilian health care organizations. How do we get  
15 that information back in so we know what happened  
16 to them and so we can make sure we do the right  
17 things.

18         Next slide. So when you look at the  
19 electronic health records and you go back a little  
20 bit to AHLTA -- why do we have AHLTA? Why do we  
21 even have AHLTA in the first place? AHLTA is  
22 really designed as an epidemiological system to be

1 able to capture computable standardized data in a  
2 way that we can do something with, do some  
3 research, do the analysis.

4       Really, really difficult to do that with  
5 the old system that we had. So when this system  
6 was designed roughly 11 years ago now, that's what  
7 it was designed to do. They used the  
8 capabilities, the technological capabilities at  
9 the time. They actually originally designed AHLTA  
10 to work on the internet. Well, the internet  
11 wasn't ready, wasn't stable to do that at the  
12 time. Of course it is now, but at the time it  
13 wasn't.

14       So they developed this new way of doing  
15 business. But they designed the interface, on  
16 that the providers used, in a way that allows it  
17 to capture that standardized computable  
18 documentation. And, of course, at the time those  
19 developed, it was -- you followed trees.

20       If any of you have been on a phone tree  
21 trying to call somebody -- your insurance company  
22 or your bank -- you know how frustrating that can

1 be going through a person, and all you want to do  
2 is talk to a person.

3 And all they want to do is document that  
4 care, and yet there is click, click, click, click,  
5 click down on the trees, to finally get to where  
6 they're able to document that piece of  
7 information. Not a great way of doing business.  
8 It was good at the time.

9 And out of that, though, came this  
10 marvelous database of information that we have  
11 that's computable and is big, and it's all  
12 available to do whatever type of research,  
13 analysis that we'd like to do with it.

14 Next slide. Just high level view.  
15 Since AHLTA has been deployed, more than 135  
16 million outpatient clinical encounters have been  
17 captured. In theater, more than 3 million  
18 outpatient clinical encounters were captured.

19 And right now, we have deployed to 67  
20 percent of DoD's inpatient beds an inpatient  
21 solution that captures that information and,  
22 again, puts that into a database where we can do

1 something with it. So just kind of an overarching  
2 view of the electronic health record. It's about  
3 145,000 encounters per working day that we capture  
4 that information and put that into our database.

5       Next slide. It's not without problems.  
6 If you imagine something that large which covers  
7 roughly 800 medical and dental treatment  
8 facilities and hospitals and clinics and also out  
9 into the theater of operations where it has to  
10 work sometimes without any communications at all,  
11 it has to have a very small footprint. To be able  
12 to capture that information, we have some small  
13 devices that allow us to capture some information  
14 with hand-held devices when you can't use a  
15 laptop.

16       We have it on, right now, 15 ships. And  
17 by the end of two more months, we should have it  
18 on 20 ships, so that continues to grow. And what  
19 they're putting out on the ships is the theater  
20 version, which is a much smaller footprint. You  
21 can't put large footprint, large servers on ships.  
22 So that continues to grow.

1           But if you look at that environment that  
2 we live in, that complexity of that, and people  
3 say, well, why can't you just take an  
4 off-the-shelf commercial package and use that?  
5 They also say, why can't you use this one: the VA  
6 system? That's one of the main reasons you can't  
7 because it doesn't work in all of those other  
8 environments. We have to have it work in those  
9 environments, have to be able to capture all that  
10 information in a way that's standard across the  
11 enterprise.

12           From the time you treat that care out in  
13 theater and all the way back, same information  
14 because all that information is shared, collected,  
15 stored and then shared off with other individuals  
16 who need that particular information. So there  
17 are some issues, though, for something that  
18 complex and that large: speed, reliability,  
19 usability, efficiency, interoperability,  
20 capability speed-to-market, health record  
21 completeness. And we'll touch on all of those.

22           Next slide. Speed and reliability. The

1 way the system was designed, it's a little  
2 complex. But it worked at the time and it still  
3 works now. So if you can imagine as we modernize  
4 our electronic health record system, we're  
5 essentially flying a large transport plane and  
6 turning it into a fiber plane while it's flying  
7 without letting it crash. It has to continue on.  
8 We can't just stop providing care. We can't just  
9 stop collecting the data, the electronic health  
10 record information. We can't stop do that.

11 But we have to modernize it at the same  
12 time in all those same places. So that's our  
13 challenge. So we take this and we say, Okay, now  
14 we look at the complexity of the particular -- how  
15 data flows; for example, if a provider is typing  
16 on and getting information for a new patient that  
17 comes in, it goes all the way through this  
18 process, all the way to the clinical data  
19 repository and pulled down that day. And that  
20 data then is transferred all the way back to the  
21 provider. It actually works, and it actually  
22 works pretty fast but not as fast as how folks

1 would like it to work.

2       There are some issues of when you talk  
3 about speed and reliability. It's not just speed  
4 of the electrons that are flowing back and forth,  
5 it's speed of the design of the application  
6 itself.

7       How many different screens do you have  
8 to get to get what you want? How many clicks do I  
9 have to do to get to all the trees to get to where  
10 I want? Those things have to be designed in there  
11 too. So lots of issues with this. We're working  
12 on this, and I'll tell you a little bit more about  
13 it when we talk about the way-ahead part.

14       Next slide, please. Usability and  
15 efficiency. So we have one standard application,  
16 say, here's the user interface you have to use.  
17 If I talk to the IT guys and say, I have an IT  
18 problem, and I talked to 10 of them and say, can  
19 you tell me how we'd solve this, I'd get 10  
20 different answers. It'd all be different. If I  
21 asked 10 providers, what should the screen look  
22 like? How many answers will I get? Well,

1 probably pretty close to 10, if not 12. And  
2 that's okay.

3       So what we have to do, though, we have  
4 to design a graphical user interface that is  
5 flexible, modular, allows the user to modify how  
6 they see fit to fit their needs. What do they  
7 want to see on the screen? What order do they  
8 want that information? It doesn't matter what's  
9 on the screen.

10       As far as what capabilities they want to  
11 pull in there, they can pull in little portlets  
12 and drag it in, pops open, just like they do  
13 nowadays with a lot of other applications. The  
14 important part, though, is the data that's  
15 underlying of that is standard. Standard data,  
16 same across the enterprise, same across the  
17 nation.

18       That's the other important part. What  
19 we're doing is we were going with the national  
20 standards -- we are actually helping drive the  
21 national standards, working with HHS and VA and  
22 others. And so those standards will be built in

1 so that the data is standardized, and it's much  
2 easier to share at that point.

3 But you've still got to get that in a  
4 way that allows the providers to be comfortable  
5 with how the system works. Don't force them into  
6 any one thing, but at least do that for them.

7 Single sign-on context management is an  
8 application -- well, it's not an application, it's  
9 capability -- that the way it is now, if someone  
10 is signed on to AHLTA, and then they have to go  
11 into, maybe, Essentris<sup>™</sup>, they have to sign off this  
12 one, sign on this one, and then go back, sign off  
13 this one, sign on this one. One at the time. Not  
14 efficient. Not effective. Can't do it that way.

15 There's two packages out there, two  
16 commercial packages, that do single sign-on with  
17 context management. Context management meaning if  
18 they're working across multiple systems --  
19 different applications -- if they're working on a  
20 patient, that same patient's information is  
21 available in all of those. So as I move from  
22 application to application, it makes sure that

1 that individual's record is the one I'm looking  
2 at; otherwise huge patient safety issues. So it  
3 has to work.

4 There's only two commercial packages  
5 that do that right now. Sentillion is one and  
6 CareFacts is the other. We tried Sentillion in a  
7 couple of different places, tested it out. Not  
8 going to work for us. We went with CareFacts. So  
9 we're starting to implement that right now.

10 So single sign-on context management, a  
11 new graphical user interface, you sign on one  
12 time, you have access to all your applications,  
13 and a graphical user interface that is much  
14 easier, much nicer to use. You can design it how  
15 you want, it's flexible, that's where we're going.

16 Next slide, please. Interoperability  
17 and capability speed-to-market. If you look at  
18 how our system, AHLTA, is designed today, when we  
19 make a change to an application, we have to load  
20 that change to that application on 110,000  
21 end-user devices across the globe. How long do  
22 you think that takes? Typically years. Years.

1 And that's how it was designed at the time. We  
2 can't do that anymore. We have to do it faster,  
3 and there are ways to do that faster. And that's  
4 the direction we're headed.

5         So we're going to virtualize the  
6 applications, meaning, we're going to have the  
7 applications and right now plan for multiple  
8 regional sites. The numbers are still to be  
9 determined, but we're looking at five. Maybe four  
10 is enough, but we're looking at five: three in  
11 the continental United States, one in Asia, one in  
12 Europe; where that data will be stored, the  
13 applications will be stored, so that you'd use the  
14 internet to access that information.

15         What does that mean from the end-user  
16 device perspective? They don't have to have all  
17 of those things loaded on their device. All they  
18 have to do is have access to the internet on their  
19 device. Does that mean we have to then  
20 standardize every single end-user device? No, we  
21 don't have to at that point. They can just use it  
22 off the internet. It will work. This has been

1    tried before. It's actually one of the best  
2    practices that are out there right now. So we're  
3    implementing that piece.

4            So if you look at this building-block  
5    approach, the bottom of that is the  
6    infrastructure. Have to fix the infrastructure  
7    first. Get that piece solid. Start building  
8    towards how we're going to build on these  
9    capabilities in a plug-and-play, modular, flexible  
10   way of doing that.

11           Enterprise service sits on top of that.  
12   Next layer, you have some services, like master  
13   patient index, terminology provisioning services.  
14   Some of these services, like identity management,  
15   who in the Department is the expert in that? It's  
16   DMDC. We're not building it. They're creating a  
17   service for us. They're creating a service for  
18   the VA. We don't want to create it, we just want  
19   to use their service. And if they design that  
20   service so that it plugs into here, we're done.  
21   It's a standard service.

22           On top of that sits the critical EHR

1 enhancements, business intelligence, surveillance  
2 teleconsultation. On top of that sits some more  
3 applications: Lab, pharm, rad, inpatient,  
4 outpatient. On top of that sits your single  
5 sign-on, context management, and your graphical  
6 user interface.

7       This is where the Department of Defense  
8 is going, and we get to be the lead. We get to  
9 lead the Department, and so the Department is very  
10 helpful in making sure we do this correct.

11       So we have a lot of support and a lot of  
12 oversight right now from the Department, which is  
13 great because they're going to make sure that we  
14 do this right, that it not only works for the  
15 Military Health System; but this capability, in  
16 the way of doing this, works for the Department so  
17 they can start heading more down this path. This  
18 is the right way to go, and this is the part that  
19 they're focusing on. So this will allow us to do  
20 things a lot faster.

21       And if a capability needs to be  
22 upgraded; for example, out of the old CHCS, what

1 do we have to do? Well, that will take -- it's  
2 going to take years because that is a tangled  
3 mess. With this approach, you can plug and play  
4 based on data standards, architectural standards.

5       So what we've done, what we're working  
6 on right now is a distributed development process  
7 that allows us -- I'll give you an example: so I  
8 have my iPhone and you see all these little  
9 applications on there. If you want to build an  
10 application on the iPhone, they will send you --  
11 well, you've got to pay for it, but Apple will  
12 send you an application developers tool kit that  
13 says, if you build to these standards, you build  
14 it this way, it will work on the iPhone.

15       We're in the process right now -- we  
16 just had Phase 1. Release 1 is out now of our  
17 distributed development tool kit that says, if you  
18 build to these standards, if you build it this  
19 way, it will work on our system.

20       We're also developing this year a common  
21 development test environment where those can be  
22 tested out. You can test out those applications.

1 You can test out those services. Is it going to  
2 work? It will replicate what's in a large MTF so  
3 that we know that this is the environment it's  
4 going to work in, and we're going to be able to  
5 test it.

6 It's not a production environment, it's  
7 a full test environment. With the test,  
8 evaluation, the security piece on there, what this  
9 does, it opens up the market to not just the large  
10 vendors, it opens up the market to medium vendors,  
11 small vendors, very agile vendors. It also opens  
12 up to other organizations in the civilian and  
13 federal government. Not just us.

14 So VA, for example, in North Chicago,  
15 they're actually developing a patient registration  
16 modular for both of us that will fit into this.  
17 They're doing that right now.

18 So this does work, it will work, and  
19 we're building the processes today that are going  
20 to allow us to do this. This is the future. This  
21 takes advantage of a lot of smart innovative  
22 people in large, medium, and small companies,

1 federal government, small mom-and-pop shops. They

2 can do this, and we'll tell them how to do it.

3 Here's your toolkit, build it to this, it will

4 work. So that's the direction we're headed.

5 Next slide. Do we have all of the

6 information in the electronic health record system

7 that we need? And the answer is no. Wait a

8 minute, let me put that right. Let me restate

9 that.

10 Do we have all the capabilities in the

11 electronic health record that the functional users

12 need? I don't need it. Functional users need it.

13 And I believe the answer is, no, we don't.

14 And I was asked the question today in

15 the morning presentation, when are you going to be

16 done with the electronic health record system? I

17 said, never. I said, absolutely never. You

18 should never be done. You should be done with the

19 project where you're working on. But what I want

20 folks to do is say, okay, that part works now.

21 What else can you do for me? I want to add this,

22 I want to add this, I want to add this.

1           A lot of times what that add-on things  
2 are, we don't know. The functional community  
3 doesn't know yet. They don't know until they see  
4 what they've got. And what they've got works.  
5 Then they want more, and that's what we want to  
6 see. We want to see more once we get the pieces  
7 working. So add on, add on, add on.

8           So there may be some capabilities you  
9 all think, gosh, we really should have this, this,  
10 and this. That's great. Let's fix what we've  
11 got, modernize it, add those capabilities in, get  
12 the functional users, the functional community --  
13 whether it's the theater community, whether it's  
14 the clinical community, whether it's the business  
15 community -- and ask them. And this is what  
16 they're doing now because we worked that out over  
17 the last couple of years. The function of the  
18 communities in charge of requirements, they're the  
19 ones who define what it is that we do.

20           Our IT folks then take that and say,  
21 okay, here's how we can do it, and more  
22 importantly, here's what it will cost you because

1 without -- if you have a plan, and it's not a  
2 funded plan, it's a hope.

3       So we're looking at this: functional  
4 community identifies additional data types, what  
5 do we need; improve the architecture so we can do  
6 the plug-and-play; images and artifacts will be  
7 one of the first data types out there.

8       So at this point can we say we can share  
9 all images and health artifacts, videos, EKGs?  
10 Can we share that across the enterprise  
11 seamlessly? And the answer is no.

12       That's what this project is. That's  
13 what the HAIMS, Health Artifact Image Management  
14 Solution, is going to do. So Phase 1: done. Now  
15 we take it out to limited user test sites -- three  
16 per service -- this year and test it out. Run it  
17 through. Run it through the patients. A large,  
18 medium, and small for each of the three services.  
19 How is this going to work? Are we going to make  
20 it work? Let's test it out. That's what we're  
21 doing right now.

22       Next slide. And, again, the important

1 part for a lot of folks to understand is, my goal  
2 is that the information only has to be entered one  
3 time. Just one. If it's standardized, you enter  
4 it one time, and you use it in a wide variety of  
5 ways.

6 Beneficiary self care. So they're  
7 working on a beneficiary portal. And you can have  
8 a personal health record, your appointment is  
9 online, secure messaging with the provider. All  
10 those things that you would want to have to be  
11 able to help the beneficiary be able to manage  
12 their information better, manage their health  
13 better, all that's going to be in there based on  
14 the information we have captured in the electronic  
15 health record system. It doesn't need to be added  
16 again.

17 Provider care, business decisions,  
18 research, command and control for surveillance,  
19 third-party billing, collections, coding, just  
20 enter it one time. I know I get a little  
21 frustrated when I go to the hospital or go to the  
22 clinic for an appointment. They always make me

1 fill out that same sheet of paper every time.  
2 Every time. Why? I don't want to fill this out  
3 again. Don't you have it on record somewhere?  
4 Well, the process is, well, you have to fill it  
5 out.

6 Okay, we're going to stop that. We're  
7 going to stop that. You only should do that one  
8 time. It's there. So couldn't we have maybe a  
9 little kiosk and just hit a couple of buttons:  
10 it's me, here I am? If you have a CAC card, throw  
11 it in there. Does it work? Yes, it's you, here's  
12 what you're going to do. And it works.

13 With the electronic health record  
14 system, the new system, here's something that's  
15 really important for you to know. Although it was  
16 in the Clinger-Cohen Act, and has been for a long  
17 time, they just added this new process back into  
18 the latest version of the NDAA, which is: you  
19 have to do your business process reengineering  
20 before you build your IT systems. Makes sense.  
21 Why is that important? Because if you don't, then  
22 you have an IT system that you're trying to cramp

1 down people's throats that they do not necessarily  
2 want to use because it doesn't match the business  
3 processes.

4 But if we typically buy COTS packages,  
5 commercial off-the-shelf packages, what do we do?  
6 Do we buy a COTS package and then rearrange our  
7 business processes to match that? The answer is,  
8 no, shouldn't be. You should take your business  
9 processes first. Make those the most efficient  
10 and as effective as possible, then find the  
11 application that best supports that new process.

12 But then your process has to work across  
13 three Services. Not one, not two, all three.  
14 Otherwise we're chasing after three different ways  
15 of doing business. Doesn't make a lot of sense,  
16 not effective, not efficient. So capture once.

17 This is just a depiction of the clinical  
18 data repository. We don't want to store  
19 everything in one place. It doesn't need to be.  
20 It's dangerous. There is no hot failover for the  
21 clinical data repository today. There's many  
22 backups. We have lots of backup. We're not going

1 to lose the data. But if this crashes, it's going  
2 to take us roughly two days to bring it back up.  
3 Two days. That's two days of no electronic health  
4 record system at all. That's not good. That has  
5 to be fixed. That's what the regionalization of  
6 that information is going to help with.

7       So for example, just like a telephone  
8 switch, they have nodes across the country. If  
9 one goes down, what happens? It just gets  
10 rerouted. The information is still there, it just  
11 gets rerouted through another way. That's where  
12 we're headed.

13       So that's why I told them today my goal  
14 is that from the end-user provider perspective the  
15 systems always work, and the information is always  
16 available. Always. That's the goal of setting up  
17 the regionalization so that they can't have that  
18 failover if something goes down.

19       The central data repository, right now  
20 it's one big thing. You have to maintain it. And  
21 to maintain it and do the maintenance on there,  
22 you have to take it down. If you have multiple

1 regionalization system efforts of the CDR, you can  
2 take one down, take it offline, reroute the  
3 information automatically, and then you can fix it  
4 without taking anybody out. That's the direction  
5 we're headed. Best practice from the industry for  
6 incorporating that into what we're trying to do.  
7 And this will work.

8       Next slide. External interoperability.  
9 As I mentioned, a lot of our care is done in the  
10 outside, in the civilian sources; however, they  
11 don't all have electronic health record systems.  
12 So how do we recapture that information? How do  
13 we get that in there? One of the solutions is  
14 this VLER project. Have you been briefed on the  
15 VLER project yet? So it's Virtual Lifetime  
16 Electronic Record. President stood up and said,  
17 we're going to do this in April. Two Secretaries  
18 staying alongside said, yep, we're going to this.  
19 And we're actually doing this, which is good.

20       It's using the Nationwide Health  
21 Information Network -- can we go to the next slide  
22 please? Let me see if it's -- oh, there it is.

1 So Nationwide Health Information Network just  
2 depicted by the ring. If you look in the upper  
3 left-hand corner, you see DoD and VA. That's the  
4 VLER Health. That's just a depiction of the two  
5 working on that particular project. But  
6 essentially it takes that standardized national  
7 data; and no matter where that care is given, it  
8 becomes visible to those who are trusted agents on  
9 this ring.

10 So the first phase, Pilot 1A, was done  
11 in San Diego with VA, DoD, and Kaiser. So if a  
12 patient shows up there -- that can receive care in  
13 multiple places -- then you can see the  
14 information from those other sources in your  
15 workflow of your particular electronic health  
16 record system. It works. It does work.

17 We're going to the site next week to go  
18 talk to the folks there. I don't think they'd  
19 formally announced that. But those of you who  
20 know where the Portsmouth area is, it's kind of  
21 somewhere in that location.

22 So this is going to work. But what they

1 found is, to make this happen requires lot of cost  
2 for the smaller medical groups. So what they're  
3 doing now is not only keeping this, but they're  
4 going to -- they're developing now which is -- I  
5 just talked with Vish and a couple of other guys  
6 working on this at the conference -- a NHIN  
7 'Lite'. That allows other users to use it without  
8 that big footprint and without having to really  
9 invest heavily into it themselves. And that will  
10 help an increased adoption amongst the smaller  
11 healthcare organizations out there where a lot of  
12 our care is given. For us that's great. We want  
13 everybody to get on this, across the nation, and  
14 it allows us to be able to get all that  
15 information back in a right way. So this is  
16 working. It's working pretty well. So far so  
17 good.

18 Right now, DoD, VA, Kaiser in that one  
19 test area are the only ones doing that  
20 bidirectional sharing of information. Only ones  
21 in the nation. So it's going to grow, but we're  
22 not there yet.

1           So the next phase will increase the  
2 organizations that are in there and will also  
3 bring in some of the commercial partners that are  
4 down in that particular area -- Sentara, Bon  
5 Secours, Riverside -- and bring those folks into  
6 the fold also so that all the care that is  
7 provided out there for our beneficiaries will be  
8 able to view that information electronically on  
9 the screen of our providers in their own  
10 electronic health record system. It's pretty  
11 cool.

12           Next slide. Well, that's it. So I left  
13 lots of time for questions. This is exciting  
14 stuff. We've made some really great progress.  
15 The great thing about having this electronic  
16 health record way-ahead plan, which I hopefully  
17 will be able to talk about in about a month, has  
18 been worked very carefully.

19           The Department has scrubbed it and  
20 scrubbed it and scrubbed it, and the Department is  
21 funding it. It's not coming out of Congressional  
22 special interest dollars. It's not coming out of,

1 you know, rob Peter to pay Paul. This is coming  
2 from the Service departments so it's coming from  
3 Army, Navy, Air Force. They're going to fund this  
4 because they understand the importance of fixing  
5 the electronic health record system. And so  
6 that's what they're doing.

7       So when we talked about having a plan, a  
8 funded plan is the right way to go, and we're  
9 there. So this next year is going to be a really  
10 exciting time because the planning -- although  
11 planning continues -- this is execution year.  
12 This is the year things start moving and start  
13 happening.

14       So it's a really exciting time when I  
15 brief this. I briefed this two different times in  
16 the last couple of days. Folks are just excited.  
17 Really excited about this. The technical people  
18 have seen what this is supposed to look like.  
19 They are really excited. The industry is excited  
20 because they want to participate in this. This is  
21 great. This is where we're going.

22       I apologize, I said, open up for

1 questions, and I kept talking.

2 DR. LEDNAR: Thank you, Mr. Campbell.

3 If I can start with two questions. One is, you  
4 mentioned that so much of the care provided to DoD  
5 beneficiaries is purchased care out in the  
6 civilian market place. Do you anticipate that  
7 this solution will become a sourcing requirement;  
8 in other words, if the Department of Defense is  
9 going to purchase care for its beneficiaries, from  
10 Kaiser, from any kind of non-DoD entity, there  
11 won't be business with DoD until and unless they  
12 agree to participate in the system.

13 MR. CAMPBELL: I agree 100 percent. So  
14 it's not in the current contracts -- the current  
15 contracts that are under protest -- but the  
16 current contracts, it's not in those to do this.  
17 I don't think it was ready at the time they  
18 started working these contracts a year and a half  
19 ago, but I completely agree. That is the right  
20 way to go, and it's to make them -- not make them  
21 -- highly encourage them through contracting to  
22 participate and share this way.

1           Now, outside of the contracts, one of  
2 the organizations is already working with us  
3 because they want to do this. They want to get  
4 out there. They want to get on that Nationwide  
5 Health Information Network. They want to do that.

6           And if they do it on their own, that's  
7 even better. You know you have the contract for  
8 them and pay for it if you do that. So they want  
9 to do this on their own because they want to have  
10 that information. They want to be the first ones  
11 out there too. So one of the large vendors is  
12 actually already working with us on that.

13          DR. LEDNAR: That's great. The second  
14 question I had is one that's an issue that's been  
15 identified by the Defense Health Board over time,  
16 and that is as -- and you sort of put your finger  
17 on it earlier when you were talking about linking  
18 together for an individual information from the  
19 point of accession through initial training, first  
20 assignment, deployment, care in theater,  
21 evacuation back, going back into a civilian  
22 setting, perhaps on active duty status. But since

1 so much of the force is in the National Guard and  
2 the Reserve, how do you see the system supporting  
3 our force who are civilian soldiers?

4 MR. CAMPBELL: Right. So there's a  
5 couple of ways we're doing this. One is from the  
6 perspective of when they're on active-duty status  
7 or when they're on reserve status and they've come  
8 into a base and they do their weekend and they do  
9 their training and/or they're active duty. Once  
10 if they're active duty, they're going to be  
11 captured in our system when they receive  
12 health care.

13 What we've done for the Guard and  
14 Reserve folks that are doing the weekend duties,  
15 is that we've given them what's called remote --  
16 enterprise remote access. It's a new capability  
17 that we put out there last year that allows them  
18 to tap directly into AHLTA and use it just as if  
19 they're sitting there, off of their internet-based  
20 system. So that's a new capability that we gave  
21 folks. So from the perspective of when you have  
22 someone in a uniform, we should be able to capture

1 that information.

2 But your question is why have two, which  
3 is okay. They demobilize, they go back to their  
4 civilian jobs, they go back to their civilian  
5 health care system. The only way we're going to  
6 get that information, the best way to get that  
7 information electronically, is through that  
8 Nationwide Health Information Network as looking  
9 at it systematically versus looking at it piece by  
10 piece.

11 There's -- we have -- I think the number  
12 was 240 -- I can't remember, but it was on one of  
13 my slides this morning. But 240,000 partners in  
14 our network that we deal with. That's a lot of  
15 folks that are out there. And some may be in  
16 hospitals, some may be in small group practices,  
17 some may be individual. We don't know. So trying  
18 to get them all quickly to get on a way that  
19 captures that information in a standardized way  
20 and bringing it in, it's going to be difficult.

21 One of the problems I know that folks  
22 have -- I mean, if I was out there as a

1 practitioner, which I'm not, but if I was, I  
2 wouldn't want to invest in something that may be a  
3 dead end. Why do I want to spend maybe \$50,000,  
4 \$100,000 on a system that may not be future-based?  
5 It may just be a throw away in a couple of  
6 years. They don't want to do that.

7       So right now, they're working with HHS  
8 to really find a way to make sure that all that is  
9 standardized. There they have the CCHIT, the  
10 certification of the different applications that  
11 people could use as a way that they can really buy  
12 into that.

13       But at this point all we get back is a  
14 lot of scanned documents which is somewhat helpful  
15 but doesn't really help when you're doing all the  
16 research and things that you need to do. You can  
17 see the scanned documents. Really hard to find  
18 through it, dig your way through those things.

19       DR. LEDNAR: I mentioned one other  
20 recent observation, and it's a troubling one. As  
21 we develop technology to have information  
22 available to providers for the same patient so

1 that you don't need to repeat tests, you've got  
2 the advantage of what is already known and  
3 documented available at the point of care. In  
4 some communities serviced by multiple health  
5 plans, there has been increasing reluctance to  
6 share information under the fear that I will lose  
7 market share.

8         So when I talk about the sourcing  
9 aspect, I think we are going to have to, for the  
10 patient's sake, somehow find a way to work through  
11 this business reluctance by some of the structure  
12 in our health care system, on the purchased side.

13         MR. CAMPBELL: And I agree 100 percent  
14 on that. If you look at the RIOs that stood up a  
15 couple of years ago -- and their purpose was to  
16 collectively look at information from a variety of  
17 different health care organizations. As soon as  
18 the grant money went away, it died because there  
19 really is no business -- there is no business  
20 reason to do that so that then does make it hard.  
21 So how then do you incentivize those folks to  
22 actually participate and share their information?

1 That's a tough one. And HHS has got to tackle  
2 that one.

3 DR. LEDNAR: Questions? Yes, Dr. Mason?

4 DR. MASON: I need some help with an  
5 acronym.

6 MR. CAMPBELL: Oh, sorry.

7 DR. MASON: No, that's okay. Back up to  
8 the slide before your question.

9 MR. CAMPBELL: Okay.

10 DR. MASON: Now, I spent 17 years of my  
11 life at the National Cancer Institute, and I would  
12 like to know what the NCI stands for. And then I  
13 want to ask another question. But first I need to  
14 know what NCI is.

15 MR. CAMPBELL: It could be the National  
16 Cancer Institute.

17 DR. MASON: Now, you've done it. I've  
18 got you where I want to.

19 (Laughter)

20 DR. MASON: I love to do this. I want  
21 you in my classroom. In a heartbeat I'll I take  
22 him in.

1           If the NCI is the National Cancer  
2 Institute, and if we reflect on the community that  
3 you highlighted, which is DoD, VA, and Kaiser  
4 Permanente, which we networked together 20 years  
5 ago because they, very simply, were willing to  
6 play with us. They understood that if we were  
7 indeed going to do population-based epidemiology,  
8 they had access to this, and it hits on exactly  
9 what you're talking about because the Guard and  
10 the Reserve in California, in large part, has  
11 civilians that are part of that network.

12           So if that's the National Cancer  
13 Institute, I would suggest, and it's really  
14 something that you may have already done, if we  
15 are really interested in building -- and I believe  
16 we are -- longitudinal records, individually  
17 identifiable, that build on clinical encounters  
18 over a person's lifetime, that places like the  
19 National Cancer Institute with respect may play a  
20 very small role from the standpoint of  
21 facilitating information. But some of their  
22 population-based cancer registries in the network

1 of not-cancer institute supported but state  
2 supported, that whole network of NATO, that whole  
3 network of registries, which are passive, could  
4 indeed facilitate a way in which to address  
5 emergent questions, which is exactly the horn of  
6 the dilemma that we're sitting on right now, is  
7 how can you, how can you basically, with not  
8 adequate information in terms of exposures that  
9 persons in and out of uniform have realized, may  
10 or may not play and be associated with  
11 biologically plausible clinical outcomes. So I  
12 was really curious as to who is around this ring.

13 I understood, you know, that network  
14 with Kaiser because it works. It syncs. But in  
15 some of the other ones, some would really  
16 appreciate some sort of free association with you  
17 in terms of how you have in mind bringing together  
18 and maintaining the contact with anyone of the  
19 number of population-based sources of information  
20 where you really don't care if the person is in  
21 three different systems. The person is the  
22 person. And you make the informed decision, which

1 we do routinely in large parts like this, which is  
2 the individual that probabilistic is the person  
3 that I want.

4 MR. CAMPBELL: Right. So just to let  
5 you know, these are notional because they're not  
6 all on there yet, however, and there will be more.  
7 But I think you bring up a very good point,  
8 though, is from the perspective of how do you  
9 identify -- first of all, so identity management  
10 -- how do you identify an individual across all  
11 variety of systems and databases and registries  
12 that are out there so that you know you're talking  
13 about the same person because it's a huge patient  
14 safety if you don't.

15 And so I know the -- I know HHS is  
16 working with a variety of folks trying to figure  
17 that out because they're doing away with social  
18 security numbers. So social security numbers go  
19 away, and then we have to modify our systems in  
20 non-exemptional security numbers, and try to find  
21 a different way to do that.

22 One of the things that we did in the

1 Department of Defense is you had a social security  
2 number, but you didn't want to use the social  
3 security number of a nonmilitary person. So what  
4 did you do? You add the member or prefix on  
5 there, the 01, the 02 that signified your spouse  
6 and your kids and things like that. But that's  
7 going away too.

8         So you have to find a way -- we don't  
9 have to find a way, the nation has to find a way  
10 to identify -- one way -- each individual so that  
11 we can track them across all those systems.

12         I think what this does, this allows a  
13 mechanism to be able to once they've done that,  
14 really find that information, wherever it happens  
15 to be, in an agreed upon standard way, be able to  
16 pull that information in so that it becomes  
17 visible. We're working on a variety of registries  
18 right now. And we have to get all that  
19 information too because people can have -- people  
20 can be in multiple registries.

21         DR. MASON: They will be. And there's  
22 -- you know, we just -- the nation just funded the

1 National Children's Study. That's 100,000 kids in  
2 100 centers followed from pregnancy --  
3 intrauterine development -- to age 21. And many  
4 of us have argued, unsuccessfully, let's put a  
5 chip on them like we do in vet medicine because  
6 they have to be followed.

7       And I would suggest to you that there  
8 are models like that right now, that are sitting  
9 out there, that they thought through, and that  
10 networking of those particular programs, which are  
11 supportive, and they are diverse, and they are  
12 dealing with -- I mean, identity management is  
13 critical because that's where we want to be. Give  
14 me two that are highly likely to be the  
15 individual, let me make the informed decision.  
16 Don't give me 20.

17       MR. CAMPBELL: Right. I completely  
18 agree. And it is an issue that they're trying to  
19 work through right now, trying to figure out the  
20 right way to do that. But you're absolutely  
21 right. There's such a diverse group of data,  
22 data storage everywhere, in a variety of different

1 formats. We've got to find a way across the  
2 nation to bring all that in together so that  
3 everybody can see all the information they need to  
4 have.

5 DR. LEDNAR: Dr. Parkinson?

6 DR. PARKINSON: Thank you very much.  
7 Mike Parkinson. I was just at an presentation; as  
8 a matter of fact, Tom, with Bill Kurtis, former  
9 CBS news correspondent, who by the way is starting  
10 a company called Tallgrass Beef in Kansas. Every  
11 single cattle they can track worldwide anytime,  
12 anyplace.

13 DR. MASON: Right.

14 DR. PARKINSON: And we can't figure out  
15 how to find the patients. So it was very  
16 interesting.

17 I think it's a lack of will rather than  
18 technology to your point. But I would -- we can  
19 talk for hours about this topic because it's --  
20 obviously this presentation, one form or another,  
21 I have seen for the better part in 20 years.

22 It's a wonderful vision, and I'm glad to

1 see the Department moving out on some things that  
2 I think are very promising. I like the notion of  
3 developing within the parameters of the same  
4 system: tailored apps. Very useful.

5 But I guess I question the commitment to  
6 the things that I think are necessary. The things  
7 that really get patients committed to a system are  
8 the fact that I make my appointments online, I can  
9 view my lab tests, I can talk to my doctor in  
10 E-Visit, I don't have to take my kid out of school  
11 to get medication adjusted.

12 And I just like some comments about  
13 where in the hierarchy I word these. This is  
14 traditionally the system that is very provider-  
15 centric. It is very facility-centric. It has not  
16 been very consumer- or family-centric. So I just  
17 like your comments of where that racks and stacks  
18 and when most military beneficiaries in the direct  
19 care system will be able to see their labs online  
20 and essentially e-mail their doctor. I mean, I'm  
21 working with large systems in Pittsburgh that do  
22 this today. So it's something about timelines.

1           Secondarily, just to -- you know, the  
2 Health Care Delivery Subcommittee of this Board  
3 has been relatively a little quiet because of a  
4 number of political issues and a number of other  
5 things, but when the time comes that that stands  
6 up, it gets a little more active.

7           I think a function by function  
8 assessment from the prospective of the  
9 patient/consumer for the 10 to 15 things I need to  
10 be able to do within a timeline is to when we can  
11 deliver that to our beneficiaries because if we do  
12 that, we can recapture market share. I don't have  
13 to send it down to TRICARE and dispute a contract.

14           So that to me -- Paul Wallace shows I  
15 have three times the number of people in my panel  
16 if I can basically have e-contacts versus  
17 face-to-face contact. I don't see that happen in  
18 our system.

19           The second point I'd like to make, and  
20 that's just to nuance your comment that you do  
21 business practice reengineering before the  
22 technology. The technology is the thing that --

1 basically the things you can do to these  
2 practices.

3       So it's really entangled. I agree, it's  
4 not one first and the other first.

5       And the thing we've not done in our  
6 system unless I -- two different presenters of the  
7 TRICARE conference; one says I'd be able to have  
8 three times the number of my patients because all  
9 my techs do everything that I shouldn't be doing.

10 Another facility says, AHLTA is terrible because  
11 it takes me all day to find the ladders and trees.

12       There's -- so a little comment on the  
13 systematic business practice reengineering  
14 standardization across all services that's  
15 happening with AHLTA today because that's where we  
16 get the efficiencies and effectiveness.

17       And if we don't have standardization at  
18 the command level, whether it's the technician to  
19 staff ratio or the flow of the patients into the  
20 clinic, the number of things that the tech does  
21 versus what the doctor does, we're not going to  
22 see effectiveness and efficiency to recapture

1 market share. And that's what I'm concerned about  
2 is somebody who sees is ready, see it just growing  
3 and growing.

4 That's a lot there. To be continued,  
5 but just broad areas. It's a wonderful  
6 presentation, but as we go forward with the DHB,  
7 those are the things we'd like to talk about more.

8 MR. CAMPBELL: And I'm 100 percent in  
9 agreement with -- especially the part about the  
10 business process reengineering. Our goal is to  
11 provide a system that allows the individuals who  
12 are part of that health care team to all work to  
13 the maximum capacity of their licensure --  
14 whatever that happens to be -- and their training  
15 and experience.

16 Standardizing that across the  
17 enterprise, the three Services, within hospitals  
18 and clinics, that's a huge challenge for the  
19 commanders and a huge challenge for the medical  
20 service leaders and Surgeons Generals to make that  
21 a reality, but they've got to find the way to do  
22 that. And if you all can help work --

1 DR. PARKINSON: Right. Let me just ask  
2 this: If I'm in a facility today, pre-AHLTA or  
3 post-AHLTA, do I have an expectation of efficiency  
4 standards or output standards afterwards based on  
5 five years of experience at this point? In other  
6 words, if we wanted to look at the scorecard the  
7 way probably Ken Kizer did in the VA facility when  
8 it put in EMR and say, what happened in your  
9 endocrinology clinic?

10 I mean, do we have metrics to be able to  
11 see whether or not that facility -- and you don't  
12 have to prescribe how to get there, but the whole  
13 notion of this is that we're getting better  
14 effective with more efficient care. Overuse,  
15 underuse, misuse and those buckets, do we have  
16 standards like that?

17 MR. CAMPBELL: We have -- I mean, let's  
18 put it this way: we have the data to be able to  
19 do that. So the data is there. It's just a  
20 matter of them, somebody in the functional  
21 community group, to say, this is what we want to  
22 do. This is what want to see out of that data

1 that we've spent so much time putting in there.

2 So capabilities are there to do that.

3 DR. LEDNAR: Dr. Oxman?

4 DR. OXMAN: I'd like to make a comment

5 -- two comments from a very different perspective.

6 I'm a relative computer illiterate unfriendly guy

7 who was dragged kicking and screaming into the VA

8 CPRS system, which is not a model of user

9 friendliness, and I have to say I'm enormously

10 impressed and sold on the tremendous advantages

11 that that offers, even for someone with my limited

12 skills and perspective. That when I write a note

13 now, and the patient goes to St. Louis tomorrow

14 that all of that information, all the laboratory

15 information, is instantly available. If somebody

16 has renal functional abnormalities or no data, and

17 their drug is prescribed, it's renally excreted,

18 that's flagged.

19 Vaccines are beginning to be followed

20 now. The savings in errors and in patient care

21 are very impressive, even to me. And so the -- I

22 think this will be an enormous advantage to the

1 quality of patient care and to cost savings both.

2 I'd also like to make a comment, and I  
3 don't understand the reasons for this, but the VA  
4 system uses the social security number. It works  
5 perfectly. There is no confusing and abandoning  
6 that is a tragedy.

7 DR. LEDNAR: Mr. Campbell, I hope you've  
8 sensed from the Board a real energy and interest  
9 in the work you're doing, in the strategy that  
10 you're pursuing. I'd also like to thank Ms. Bader  
11 and Dr. Halperin and Mr. Campbell for a prep  
12 session that was held several days ago to try to  
13 orient Mr. Campbell to some of the interests and  
14 questions of the Board because this is a topic  
15 that clearly could go in many different  
16 directions.

17 So thank you for incorporating that  
18 discussion and bringing us such an important topic  
19 to use. Thank you.

20 Oh, sorry, General Gamble. Last  
21 question.

22 BG GAMBLE: No, I was just going to make

1 a comment. You know, as a commander of a  
2 facility, I am held to efficiency standards on a  
3 monthly basis; however, some of it has to do with  
4 production which then in turn falls back on my  
5 budget. Some of it has to do with data quality, you  
6 know, that I have to report each month back up  
7 through my chain of command up through the system.

8 But the comment I'd like to just also  
9 add is that sometimes the efficiency -- don't  
10 equate efficiency with quality of care. So I just  
11 want to make sure that we don't lose that because,  
12 again, you have, you know, outcomes which are  
13 important, but you also have objective and  
14 subjective matters on the patient's behalf about  
15 whether what you encounter with that provider,  
16 that physician, that nurse practitioner, whoever.  
17 It was a quality one, and they walked away better  
18 before it as opposed to be frustrated by a system  
19 that, although it was more efficient, was not  
20 humanistic caring holistic in its approach.

21 DR. LEDNAR: Thank you, sir. And thank  
22 you, Mr. Campbell. Thank you. Our last

1 presentation today is going to be given by Dr.  
2 Charles Fogelman. Dr. Fogelman currently serves  
3 as Executive Coach and Leadership Development and  
4 Management Consulting as a principal at Paladin  
5 Coaching services. Dr. Fogelman's current  
6 volunteer activities include providing clinical  
7 services at the Adult Outpatient Behavioral Health  
8 Clinic at the National Naval Medical Center,  
9 Bethesda.

10 His previous positions include serving  
11 as President and CEO of Atlantic Coast Behavioral  
12 Health Services Incorporated as well as service on  
13 the Federal Council on the Aging, senior program  
14 evaluator at ACTION, the Federal Volunteer Agency,  
15 and Director of an Interagency Task Force on Long  
16 Term Care and Volunteerism.

17 Dr. Fogelman also chairs the Defense  
18 Health Board's Psychological Health External  
19 Advisory Subcommittee and will provide for us  
20 today a summary of the Subcommittee's recent  
21 activities. Dr. Fogelman's presentation material  
22 may be found under Tab 9. Dr. Fogelman?

1 DR. FOGELMAN: Thanks, Wayne. I'm  
2 keenly aware that I'm fundamentally all that's  
3 between you and a little bit of time in the sun,  
4 so I'm going to try to make my presentation  
5 shorter than Wayne's introduction.

6 (Laughter)

7 DR. FOGELMAN: I didn't want to be the  
8 one at the end because that limits the number of  
9 words that I can say. Some people think that  
10 psychologists are mind readers so I can do this.  
11 I have some data about that. I want to tell very  
12 briefly what we're doing. I want to do the  
13 Subcommittee membership first. You will see as we  
14 go along.  
15 The two major things that we're doing, two major  
16 questions that we're working on, and the dominant  
17 substance of the two meetings since the last Defense  
18 Health Board meeting are these two. The questions are  
19 fundamentally. What are the evaluation measures and  
20 principles behind the evaluation measures for  
21 understanding the efficacy and effectiveness of  
22 preclinical, those are the things that come roughly

1 under the heading of resilience and building kinds of  
2 issues on the one hand and clinical mental health  
3 programs on the other. Those are the things that  
4 we're working on.

5 It is as you might imagine not a small task for we  
6 have an ambitious goal of trying to bring at least an  
7 interim report on each of these questions if not a  
8 full report to the Board at its June meetings, when I  
9 hope not to be at the end of the day, unless we don't  
10 have anything to report in which case I'll send  
11 somebody else.

12 Those are the people. We've divided ourselves into  
13 one group to deal with. This is not an experimental  
14 design. It's not preclinical, it's not clinical,  
15 it's just these are the people on the Committee  
16 working on the various things.

17 In addition to the meetings we've had face to face as  
18 a whole Subcommittee, each of these groups had a  
19 series of teleconferences. And I think we have a list  
20 of those in the backup slides. And there are several  
21 more scheduled for the immediate future.

22 Let me whip through the last two meetings we've had.

1 The one of that date was the first set of people we  
2 had coming in to tell us what they thought was  
3 actually already going on in and about the Department  
4 on the two questions of what are the measures of  
5 preclinical in clinical work. And a little bit about  
6 programs in each.

7 And the meeting we had just last week, we tried to  
8 accomplish a couple of things. One thing which we  
9 thought was very important was to have people come in  
10 who actually had recently served. We had a young  
11 sergeant, and a young captain come in. The captain  
12 has the additional benefit -- additional experience  
13 benefit, not only of having recently served in, I  
14 think, both Iraq and Afghanistan, but being a Ph.D.  
15 Psychology student at the University of Michigan --  
16 where I got my degree so I thought that was nice, and  
17 I was pleased to see that we are still teaching people  
18 well because he was a smart and engaged fellow,  
19 Captain Erwin.

20 A lot of what we also do is try to get more of a sense  
21 from people wearing uniforms, not just people who've  
22 recently served but people who are on the uniform side

1 of our lives, about how they're seeing things. We've  
2 spent a lot of time talking to and listening to policy  
3 folks. So it was kind of more of an interest in what  
4 those people had to say.

5 And then we went on a tour to the Pentagon because --  
6 I don't know how this is for most of the Subcommittees  
7 that you folks are involved with, but most of the  
8 folks on my Subcommittee hadn't been in the Pentagon  
9 before, much less toured around it, much less had a  
10 very interesting private tour led by Ms. Bader to take  
11 us down some very interesting and lovely corridors.

12 And people like that a lot, especially since for the  
13 general tour we were attached to a group of high  
14 school kids, which was interesting I have to say.

15 Past and not an exact list of the future  
16 teleconferences. There are a couple of reasons we're  
17 going to West Point. One is we've never met anyplace  
18 -- well, not really met anyplace -- outside of the  
19 Washington region, and I thought it would be nice to  
20 have a small different place for folks to go. And  
21 there is currently a resilience program, an early  
22 form, at West Point. It may or may not continue, but

1 that's one of the things that we wanted to see and  
2 understand what it's about. What's good and what's  
3 not good about it, how it measures itself and the  
4 like. The rest of that is pretty straightforward.  
5 Now, this is a question which is going no where.  
6 There is -- you may be aware -- supposed to be a TBI  
7 Subcommittee. It has a distinguished and wonderful  
8 chairman, our colleague, Dr. Bullock, but  
9 unfortunately none of the members of the Committee, if  
10 I understand it, has a currently valid appointment; is  
11 that correct? So therefore that Committee has not  
12 met.  
13 And we have a working group -- or normally we have a  
14 working group -- together with that Committee to deal  
15 with this question since the ANAM covers both of our  
16 realms. So as a result -- I'm embarrassed to say --  
17 this question sits out there unanswered. Now, it was  
18 also sitting out there before we stood up so that may  
19 be information or not.  
20 And that brings us to this. I'm sorry, it was a  
21 little bit longer than Wayne's introduction, but if  
22 anybody would rather ask a question or make an

1 observation and give Wayne a chance to close up and  
2 Don a chance to hit the gavel so we can go outside for  
3 a little while, I'm happy to entertain, at least, to  
4 really wonderful questions or comments.

5 DR. LEDNAR: Dr. Fogelman's brief was a  
6 whole lot more informative than my introduction.  
7 Thank you. Questions or comments for Dr.  
8 Fogelman?

9 Thank you, Dr. Fogelman, for that brief  
10 and for all the energy that you're bringing to  
11 this important aspect of the health and  
12 effectiveness of our force.

13 What we'd like to do at this point is to  
14 ask Commander Feeks to share with us closing  
15 administrative remarks and information which we  
16 will need for tonight and for tomorrow. Commander  
17 Feeks?

18 CDR FEEKS: Thank you, Dr. Lednar. This  
19 is Commander Ed Feeks. And for those of you who  
20 are -- since we're not going to reconvene in this  
21 room and we won't be needing the contents of these  
22 binders in this room anymore, I invite you to make

1 use of the manila folder that's in the back of  
2 your binder as a compact way to take it with you  
3 if you want to. It's more economical than having  
4 us FedEx it to you once we all get home. So  
5 please avail yourself to this manila envelope in  
6 the back of your binder if you'd like to take the  
7 contents of your binder with you.

8       Secondly, if like me when you checked in  
9 you forgot to turn in the Federal Employee's  
10 Certificate in order to obtain an exemption from  
11 Florida sales tax for your hotel room, there is a  
12 copy of that form in the back or in the left  
13 envelope of your binder. It saves -- again, it  
14 saves the Government if you fill this out and turn  
15 it in.

16       Some of you may have received an e-mail  
17 copy of one that's sort of prefilled out, and  
18 unfortunately we don't have copies of that here,  
19 but if you would please turn in your certificate,  
20 the front desk should still accept it and  
21 associate it with your stay and exempt you from  
22 sales tax.

1           And for Board members, ex-officio  
2 members, service liaisons, and invited guests, bus  
3 transportation will leave from the hotel at 7 a.m.  
4 tomorrow morning to take us to site visits. We  
5 will begin at an old Navy see plane base called  
6 Naval Air Station Banana River, but it's been  
7 better known to the younger locals here since 1950  
8 as Patrick Air Force Base. We will then also go  
9 to Canaveral Air Force Station and the Kennedy  
10 Space Center.

11           Please note that you must travel on the  
12 provided transportation due to security measures.  
13 You're not able to follow the buses in your rental  
14 cars.

15           We anticipate that we will conclude at  
16 1:30 p.m. tomorrow and arrive back here at the  
17 Double Tree by 2 p.m.

18           Now, the installations that we will  
19 visit have communicated the following dress code:  
20 Flat closed-toe shoes must be worn. So no heels,  
21 peep toes, slingbacks, et cetera, are permitted.  
22 I don't know what I'm going to wear.

1 (Laughter)

2 CDR FEEKS: Long pants must also be  
3 worn. No skirts, shorts, or capri pants are  
4 permitted. Backpacks and coolers are also  
5 prohibited. We will be looking at static display  
6 aircraft tomorrow. We'll be climbing ladders an  
7 that sort of stuff, and so that's the reason for  
8 that.

9 For those of you joining us for the  
10 dinner tonight, please convene in the lobby by 6  
11 p.m. The shuttle service is being provided and  
12 will leave from the hotel at 6. And return  
13 transportation from Milliken's Reef to the hotel  
14 will also be provided.

15 And, again, if you've not RSVP'ed for the  
16 dinner, please see Jen Klevenow who's seated next  
17 to Andrew, our sound man.

18 And this concludes my remarks. Dr.  
19 Poland?

20 DR. POLAND: Well, I don't think we have  
21 any other business to adjudicate this afternoon  
22 unless there are any questions. We've gotten

1 through a tremendous amount of important issues.

2 No other questions? I think we can adjourn.

3 Col NOAH: Thanks, everyone, for  
4 attending. On behalf of Dr. Rice now -- I've got  
5 to keep this up to date -- myself, and the rest of  
6 the Office of the Assistant Secretary of Defense  
7 for Health affairs, I do appreciate what you do  
8 for us, with us, and to us. It does help us to do  
9 what we do that much better.

10 And I was actually the one who asked for  
11 those evidence-based metrics because it is  
12 incumbent upon me, and hopefully all of us, to  
13 measure our impact on what we do. So thank you  
14 for helping us do that.

15 The meeting of the Defense Health Board  
16 is adjourned. Thanks very much.

17 (Applause)

18 (Whereupon, at 4:50 p.m., the  
19 PROCEEDINGS were adjourned.)

20 \* \* \* \* \*

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1           CERTIFICATE OF NOTARY PUBLIC  
2           I, Carleton J. Anderson, III do hereby  
3 certify that the forgoing electronic file when  
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11 or counsel employed by the parties hereto, nor  
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13 of this action.

14           /s/Carleton J. Anderson, III

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