

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD MEETING

Key West, Florida

Monday, March 9, 2009

ANDERSON COURT REPORTING  
706 Duke Street, Suite 100  
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1 PARTICIPANTS:

- 2 ROBERT GLENN CERTAIN, Ph.D.
- 3 JOHN DAVID CLEMENTS, Ph.D.
- 4 NANCY W. DICKEY, M.D.
- 5 WILLIAM E. HALPERIN, M.D.
- 6 COMMAND SERGEANT MAJOR LAWRENCE W. HOLLAND
- 7 EDWARD L. KAPLAN, M.D.
- 8 WAYNE W. LEDNAR, M.D., Ph.D.
- 9 JAMES E. LOCKEY, M.D.
- 10 RUSSELL V. LUEPKER, M.D.
- 11 THOMAS H. MASON, Ph.D.
- 12 MARK A. MILLER, M.D.
- 13 GENERAL (Ret.) RICHARD MYERS
- 14 MICHAEL N. OXMAN, M.D.
- 15 JOSEPH E. PARISI, M.D.
- 16 GREGORY A. POLAND, M.D.
- 17 ADIL E. SHAMOO, Ph.D.
- 18 HONORABLE CHASE UNTERMEYER
- 19 DAVID H. WALKER, M.D.
- 20 HONORABLE TOGO WEST JR.
- 21 GAIL WILENSKY, Ph.D.

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1 Now in carrying out a tradition of our Boards, I  
2 would ask that we stand for a minute of silence to  
3 honor those we are here to serve, the men and  
4 women who serve our country.

5 (Moment of silence.)

6 DR. WILENSKY: Thank you. Since this is  
7 an open session, before we begin I would like to  
8 go around the table and have the Board and  
9 distinguished guests introduce themselves, and the  
10 new Core Board and Subcommittee members, please  
11 tell us a little about yourselves. I'm going to  
12 start here and go to my right.

13 MR. MIDDLETON: Good morning. I'm Allen  
14 Middleton, the Acting Deputy Assistant Secretary  
15 of Defense for Health Budgets and Financial Policy  
16 in the Office of Health Affairs in Washington,  
17 D.C.

18 DR. POLAND: Greg Poland, Mayo Clinic,  
19 Rochester, Minnesota.

20 GEN MYERS: Dick Myers, retired Chairman  
21 of the Joint Chiefs of Staff, Core Board member  
22 and clearly retired from the military.

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1 Center, National Institutes of Health.

2 DR. DICKEY: Nancy Dickey, President of  
3 the Texas A&M Health Science Center.

4 DR. DEDRE: Thomas Dedre, Professor of  
5 Psychiatry, University of Pittsburgh.

6 DR. BUTLER: Frank Butler, former  
7 Command Surgeon at the Special Operations Command,  
8 and currently the Chairman of the Committee on  
9 Tactical Combat Casualty Care.

10 RADM KHAN: Good morning. Ali Khan,  
11 Assistant Surgeon General, U.S. Public Health  
12 Service.

13 DR. PARISI: I'm Joseph Parisi,  
14 Professor of Pathology, Mayo Clinic, Rochester,  
15 Minnesota.

16 DR. CERTAIN: Robert Certain, Diocese of  
17 Atlanta, former Air Force Chaplain, former POW,  
18 former PTSD.

19 DR. OXMAN: Mike Oxman, Professor of  
20 Medicine and Pathology at the University of  
21 California, San Diego.

22 SGT MAJ HOLLAND: Command Sergeant Major

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1 retired Larry Holland, just recently retired from  
2 active duty.

3 DR. HALPERIN: Bill Halperin. I'm Chair  
4 of Preventive Medicine at the New Jersey Medical  
5 School in Newark, New Jersey, and also Chair of  
6 Quantitative Methods in the School of Public  
7 Health at the same place, and I'm retired from the  
8 Centers for Disease Control.

9 DR. LOCKEY: Jim Lockey, Professor of  
10 Environmental Health and Pulmonary Medicine at the  
11 University of Cincinnati.

12 DR. CLEMENTS: John Clements, Chair of  
13 Microbiology and Immunology at Tulane University  
14 School of Medicine in New Orleans.

15 DR. LEDNAR: Wayne Lednar, Global Chief  
16 Medical Officer DuPont.

17 CMDR: Commander Ed Feeks,  
18 Preventive Medicine Officer at Headquarters,  
19 Marine Corps, and Executive Secretary of the  
20 Defense Health Board.

21 DR. WILENSKY: I forgot to introduce  
22 myself. Gail Wilensky, President of the Defense

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1 Health Board and Senior Fellow at Project Hope.  
2 I'm going to ask now so that we can have people  
3 who are over with you introduce themselves as  
4 well.

5 COL MOTT: Bob Mott, Army Surgeon  
6 General's Office and Army Liaison to the Board.

7 LT COL GOULD: Philip Gould, Air Force  
8 Surgeon General's Office.

9 CMDR SCHWARTZ: Erica Schwartz, Coast  
10 Guard Preventive Medicine Liaison.

11 COL BADER: Christine Bader, Executive  
12 Director of Military Health Systems, Oversight  
13 Committee.

14 DR. BENETATO: Associate Director of the  
15 War Related Illness and Injury Study Center for  
16 the Department of Veterans Affairs.

17 MS. COATES: Marianne Coates,  
18 Communications consultant for the Defense Health  
19 Board.

20 DR. COHOON: Barbara Cohoon with the  
21 National Military Family Association, and I sit on  
22 the TBI Caregiver Family Panel.

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1           MR. TOBEY: Good morning. Phil Tobey,  
2 health care architect and planner, Washington,  
3 D.C.

4           MS. HERBERT: Cheryl Herbert, President,  
5 Dublin Methodist Hospital.

6           MS. JOVANOVIC: Good morning. Olivera  
7 Jovanovic, DHB support staff.

8           DR. LUDWIG: Good morning. George  
9 Ludwig. I'm the Deputy Principal Assistant for  
10 Research and Technology, U.S. Army Medical  
11 Research and Material Command.

12           CMDR SLAUNWHITE: Good morning.  
13 Commander Cathy Slaunwhite, Canadian Forces  
14 Medical Officer in a liaison role at the Canadian  
15 Embassy, Washington, D.C.

16           COL REIST: I'm Paul Reist. I'm from  
17 the Joint Staff Operations Directorate.

18           LT COL HACHEY: Wayne Hachey, OSD Health  
19 Affairs, Force Health Protection and Readiness,  
20 and I'm the HA liaison.

21           CPT MALLAK: Good morning. I'm Craig  
22 Mallak. I'm the Armed Forces Medical Examiner.

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1           MS. GRAHAM: Elizabeth Graham, DHB  
2 support staff.

3           DR. WILENSKY: Commander Feeks has some  
4 administrative remarks before we begin this  
5 morning's session.

6           CMDR FEEKS: Good morning and welcome.  
7 First, you'll notice an empty seat at our table  
8 over to my right. Dr. Francis Ennis is unable to  
9 be with us because his sister passed away on  
10 Saturday. Let's remember that family in our  
11 thoughts and prayers. I'd like to thank the staff  
12 of the Marriott Beachside Hotel for helping with  
13 the arrangements for this meeting and all the  
14 speakers who've worked hard to prepare briefings  
15 for the Board. I also want to thank Jen Klevenow,  
16 Lisa Jarrett, Beth Graham, and Olivera Jovanovich  
17 for helping with the arrangements for this meeting  
18 of the DHB. And finally I also want to thank Ms.  
19 Jean Ward back at the home office for her  
20 invaluable assistance in putting this meeting  
21 together. If you have not already done so, please  
22 be sure to sign the general attendance roster on

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1 the table outside. For those of you who are not  
2 seated at the tables, handouts are provided on the  
3 table on the side of the room here on my right.  
4 For telephone, fax, copies or messages, please see  
5 Jen Koevanow who is over my left shoulder at the  
6 door with her hand raised. Lisa Jarrett and Beth  
7 Graham can also help with that. They're at the  
8 table just outside the door for the time being.

9 Because the open session is being  
10 transcribed, please make sure that you state your  
11 name before speaking and use the microphone so our  
12 transcriber can accurately report your questions.  
13 Also if you have one of these things, a telephone  
14 or something else that makes noise, please put it  
15 in a silent mode.

16 If time allows, the Board will take  
17 comments from the audience here at the meeting room.  
18 Members of the public who do make comments,  
19 I ask that you please sign the speaker roster at  
20 the table just outside the door.

21 Refreshments will be available for both  
22 morning and afternoon sessions. For Board

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1 Members, invited speakers and liaisons, we'll have  
2 a catered working lunch here at the Marriott  
3 Beachside Hotel just in the next room over. There  
4 are a number of restaurants nearby. I want to  
5 apologize for the condition of some of your  
6 binders. Some of them didn't take the shipping  
7 very well.

8 Finally, the next Core Board Meeting  
9 will be held on May 7 and 8 of this year in  
10 Washington, D.C., and during that meeting the  
11 Board will receive a series of updates on  
12 subcommittee activities as well as draft  
13 recommendations. Dr. Wilensky?

14 DR. WILENSKY: Thank you. Since we are  
15 here to serve the men and women who serve our  
16 country, our first speaker this morning is Colonel  
17 Paul Reist from the Joint Staff in Washington who  
18 will present an update on U.S. Military  
19 operations worldwide.

20 COL REIST: Good morning. Ms. Wilensky,  
21 Mr. Middleton, Members of the Board, ladies and  
22 gentlemen, as noted earlier my name is Colonel

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1 Paul Reist. I'm from the Joint Staff Operations  
2 Directorate. On behalf of Lieutenant General Jay  
3 Paxton, I want to thank you for the opportunity to  
4 speak today and provide you a quick overview of  
5 our global operations and all the operations and  
6 activities that our DOD forces are conducting.  
7 Although we do these kinds of briefs very often,  
8 rarely do we get a chance to do them in places  
9 like Key West, and in 20-plus years this is one of  
10 the few times if not the only time that on a short  
11 notice tasker I actually looked forward to coming  
12 and it was a place where other people pay to come.  
13 So again I thank you for that. More importantly,  
14 I want to thank you for your efforts here on  
15 behalf of all of our troops and their families.

16 My purpose today is to give you as I've  
17 noted a brief overview of the operations and  
18 activities currently being conducted across the  
19 globe. Obviously in 45 minutes it will be an  
20 overview, but I intend to leave time for your  
21 questions and I welcome them. Before I begin, let  
22 me just make one critical comment. I will discuss

1 a great number of activities and operations that  
2 are being conducted, and I know you all know this,  
3 but keep in mind that at the end of the day it is  
4 our tremendous 18-, 19-, 20-year-old young  
5 soldiers, sailors, airmen and Marines that are  
6 making things happen executing our national  
7 military strategy and for whom all of us are here  
8 today.

9           What I'd like to do is quickly take you  
10 around the globe and I want to do so through a  
11 quick tour of our geographic combatant commanders.  
12 As many of you may know, DOD accomplishes the  
13 missions assigned by the President through our  
14 geographic combatant commanders. These commanders  
15 report to the SECDEF, and they coordinate with the  
16 Chairman of the Joint Chiefs as General Myers  
17 knows very well.

18           As seen by the proximate number of  
19 forces assigned to each combatant command noted on  
20 the slide, you can quickly note that our main  
21 effort remains the Central Command Area of  
22 Responsibility and our operations in Iraq and

1 Afghanistan. In addition to those though there  
2 are many other key parts of these regions that are  
3 critical, and I'll talk about those briefly.

4 In addition to the Central Command Area  
5 of Responsibility though, it's important to note  
6 that our other combatant commanders are equally  
7 busy. All one has to do is read the paper or  
8 watch the news to understand that there are a  
9 large number of flashpoints across the globe that  
10 at any moment could quickly become our top  
11 priority.

12 Just to touch on a few as you see on the  
13 slide, within the CENTCOM AOR in addition to the  
14 fight going on in Iraq and Afghanistan, Israel and  
15 Gaza and the recent operations in Gaza are of  
16 obvious concern as we seek to establish some  
17 semblance of peace in the region. Likewise in  
18 Iran and their continued efforts to develop a  
19 nuclear capability. Outside of the Central  
20 Command Area of Responsibility, last summer's  
21 engagement in Georgia and the emergence of Russia  
22 and the great deal of uncertainty of their

1 intentions is cause for concern. Likewise in the  
2 Africa Command, the recent indictment of the  
3 President of Sudan is cause for significant  
4 concern and subsequent consequences and potential  
5 for tremendous humanitarian suffering that might  
6 result. Likewise, in Somalia with the continued  
7 lack of governance leads to a great deal of  
8 problems not the least of which is the resurgence  
9 of sanctuary for terrorists, and as we've more  
10 recently seen, the emergence of piracy is a  
11 significant concern in the region. In PACOM,  
12 North Korea's efforts to continue to develop  
13 nuclear capability and potentially to launch  
14 ballistic missiles. Likewise, in our Southern  
15 Command, Cuba is always of concern as are  
16 Venezuela and Colombia.

17 Let me start however again in our main  
18 area of focus and that is in the Central Command  
19 region. As you see here, it is of obvious  
20 strategic importance not only for us for to many  
21 of our allies and nations across the globe. In  
22 addition to fighting two wars though, security and

1 stability here hinges on more than winning these  
2 wars. It also hinges on engagement and the  
3 responsible action of several other countries in  
4 the region most notably Pakistan and stability  
5 there as it relates to our operations in  
6 Afghanistan. In addition to that, Iran's  
7 continued efforts to develop nuclear power and  
8 possibly more importantly their continued efforts  
9 to destabilize the region in Iraq and other  
10 places. Continued safe havens in Yemen and  
11 throughout other areas of the region are continued  
12 cause for concern. Engagement with these states  
13 and others is necessary to accomplish our national  
14 objectives.

15 Let's look first at our operations in  
16 Iraq. We continue to transition from our surge  
17 operations of last summer and transfer security to  
18 our Iraqi Security Forces. We continue to train  
19 them and they continue to take leadership in an  
20 increasing number of operations. As all of you  
21 know, just last week President Obama announced a  
22 timetable for the completion of our combat mission

1 in Iraq. In August 2010 our combat mission will  
2 be complete. As he also noted, there will remain  
3 a significant force there to provide training,  
4 assistance and a limited effort at  
5 counterinsurgency and counterterrorist operations.  
6 There are three critical points to the President's  
7 plan. The first of these is the withdrawal of  
8 forces. The second is the continued support to  
9 Iraq as it continues to build the capacity for  
10 governance, to provide services for the rule of  
11 law and all the other aspects that are necessary  
12 to provide long-lasting peace and stability there.  
13 Lastly, the third part of his plan as he outlined  
14 it last week is an increased emphasis on regional  
15 diplomacy.

16 There is certainly some good news in  
17 Iraq. Regardless of what you may or may not hear  
18 in the press, the security situation there is  
19 significantly improved over the same time last  
20 year. Security incidents are down by over 60  
21 percent from their highs of last summer during our  
22 surge operations. More importantly, the security

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1 incidents that we see there today is less than it  
2 has been since 2004 shortly after the initial  
3 invasion of Iraq. In addition, we're starting to  
4 see the reduction of our requirements there as  
5 we've brought home many of the surge forces that  
6 were sent there last summer. And most recently  
7 we've seen probably one of the more important  
8 signs, and that is the successful and relatively  
9 peaceful provincial elections that were conducted  
10 just recently.

11 2009 will be a year of transition in  
12 Iraq. In addition to the force reductions that we  
13 will begin in the months ahead and throughout the  
14 next 18 months, we anticipate and have seen the  
15 departure of many of the Coalition partners. The  
16 reasons for these departures are numerous. Some  
17 have to do with political will, some have to do  
18 with pure economics, others have to do with the  
19 inability to establish appropriate agreements to  
20 support their troops there. Regardless of that,  
21 the bottom line is that both Coalition presence as  
22 well as our own presence will continue to

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1 decrease. As that happens, we continue to  
2 anticipate the successful assumption of security  
3 tasks by Iraqi forces. The training will  
4 continue, and as the pictures there depict,  
5 success depends on the ability of our Iraqi  
6 partners to provide security for themselves. The  
7 pictures there represent operations just in the  
8 last few weeks, specifically in Mosul where the  
9 last remnants of al- Qaeda continue to cause  
10 concern, and Iraqi forces are leading the effort  
11 there to attempt to clear this region of continued  
12 al-Qaeda influence.

13           That is not to say there not challenges  
14 ahead. There are additional elections in the  
15 coming year that will be important to the country.  
16 In addition to that, there are still significant  
17 numbers of extremists that could possibly cause  
18 continued sectarian violence. As already noted,  
19 Iran continues to provide a malign external  
20 influence. In addition to these security  
21 concerns, other concerns exist. As is true in our  
22 own country and around the world, budget issues

1 persist. The reduced price of oil is contributing  
2 to that. The ability to provide basic services,  
3 the capacity to provide rule of law, effective  
4 governance and other necessary services continues  
5 to need attention. Lastly, the Northern part of  
6 Iraq is also cause for concern as continued  
7 tensions between the Kurdish population there and  
8 Iraq as well as their northern neighbor Turkey  
9 continue to exist.

10 Turning to Afghanistan, here the  
11 security trends are much different as I'm sure  
12 many of you have read in the papers and seen on  
13 the news. There has been a steady increase in  
14 violence since 2006. In fact, in 2008 we saw the  
15 highest levels of violence in the country since  
16 our operations began there. As you've also heard  
17 from the President and from the Secretary of  
18 Defense, we will increase our troop levels in  
19 Afghanistan and we will continue to seek our NATO  
20 allies to do the same there. Just over 17,000  
21 forces will be added to our operations in  
22 Afghanistan. The primary focus of those forces is

1 to try to respond to the increased levels of  
2 violence specifically in the South.

3           There is some good news. The good news  
4 includes the development of the Afghan National  
5 Army. We continue to see additional troops being  
6 not only fielded but trained to the level that  
7 they can conduct their own operations, where they  
8 can lead operations that we continue to support.  
9 We continue to see efforts in the Afghan  
10 Development Zones specifically around the Ring  
11 Road where increased security of the Ring Road and  
12 increased development of that critical mode of  
13 transportation will add to the reconstruction  
14 efforts and the efforts to provide services to the  
15 population.

16           Likewise here there are significant  
17 challenges. The Afghan-Pakistan border is  
18 probably the most significant of those. The  
19 continued sanctuary provided to the Taliban and to  
20 other terrorists and opposing forces continues to  
21 provide them the opportunity to operate with  
22 relative impunity and to affect the security

1 situation in Afghanistan. We certainly expect  
2 notwithstanding the addition of forces to see  
3 increased levels of violence in the year ahead.  
4 Another change is the synchronization of U.S.-led  
5 efforts with those of our allies. Part of this is  
6 being addressed by the fact that General McKiernan  
7 was recently designated as both the commander of  
8 all U.S. Forces in Afghanistan as well as  
9 commander of the NATO forces which should  
10 significantly improve our ability to coordinate  
11 those efforts. Having said that, it is  
12 anticipated that we will see continued efforts to  
13 encourage our NATO allies as well as those  
14 non-NATO countries that are participating in our  
15 operations in Afghanistan to increase their  
16 commitment there. Most notably in the near term  
17 is the Afghan election. The election right now is  
18 scheduled for August. Recently in the news,  
19 President Karzai announced that he believed and  
20 the constitution provides for the fact that that  
21 election was to occur prior to his departure from  
22 office. His term expires in March. The

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1 International Election Commission has established  
2 and as is supported by the Afghan Parliament that  
3 the election will occur in August. This is a good  
4 thing for us as we continue to flow those forces  
5 in there that will provide the security necessary  
6 for that election to occur.

7 At the same time, we anticipate here in  
8 the next few weeks as the NATO summit takes place  
9 in the beginning of April that we will see an  
10 increased call to our NATO allies to also provide  
11 forces. There are over 8,000 polling stations  
12 anticipated and the level of security to ensure a  
13 free and fair election is a significant effort  
14 indeed.

15 One other area of concern before I leave  
16 the Central Command area of responsibility is that  
17 of piracy in part due to the profitable nature of  
18 the business and the fact that many of the  
19 shipping companies find it more profitable to pay  
20 the occasional ransom rather than to establish  
21 security for their oceangoing vessels. In  
22 addition to that, the relative lack of governance

1 in Somalia, the increased incidents of piracy has  
2 been significant especially since last summer.  
3 About late August to early September we saw a  
4 significant effort by the international community  
5 to counter this. There is certainly some good  
6 news to report. We have several maritime task  
7 forces that we participate in are having an impact  
8 in this area. The first of those is Combined  
9 Joint Task Force 150. This task force dates back  
10 to the start of our operations in Iraq and  
11 Afghanistan. It was established to conduct  
12 maritime operations in the Gulf of Aden, the Gulf  
13 of Oman, the Arabian Sea, the Red Sea and the  
14 Indian Ocean. The purpose is to disrupt violent  
15 extremists' use of the maritime environment as the  
16 venue for attacks or to transport personnel,  
17 weapons or other material. This effort continues  
18 currently under the command of the Germans and is  
19 also having an impact on piracy.

20 Because of the increased incidents in  
21 the recent months, in January of this year, we  
22 established Combined Joint Task Force 151. This

1 was specifically designed to counter the piracy  
2 operations. As recently as early February, a U.S.  
3 ship was involved in its first seizure and in its  
4 first apprehension as you see in the photo there  
5 of pirates caught basically in the act of  
6 attempting to pirate another vessel.

7           Since mid February just in the last few  
8 weeks we have seen no additional pirated vessels  
9 which again is certainly a good sign. That's not  
10 to say there are not challenges here as well.  
11 There are over 33,000 ships that transit the Gulf  
12 of Aden every year. This is a significant number  
13 especially given the limited number of vessels  
14 that are participating in our counterpiracy  
15 operations. The continued lack of governance in  
16 Somalia continues to provide sanctuary for these  
17 pirates. Right now there exists no legal  
18 framework for detention of pirates once they are  
19 seized, although efforts to correct this problem  
20 are underway.

21           Moving on from the Central Command area  
22 of responsibility, turning our attention to that

1 of our most recent combatant command established 1  
2 October 2008, and that is the Africa Command.  
3 This is a change of business for us. This is a  
4 focused whole government approach to a combatant  
5 command. Unlike our other combatant commands  
6 which are primarily military organizations, the  
7 Africa Command has a complementary mix of military  
8 and civilians with interagency members in  
9 leadership positions. General Ward is the first  
10 commander of AFRICOM. However, one of his two  
11 deputies is Ambassador Mary Yates. She is the  
12 Deputy to the Commander for Civil and Military  
13 Affairs. AFRICOM's goal is to enhance the  
14 capacity of Africans to care for their stability  
15 so that development can take place and Africans  
16 can prosper. They do this through building  
17 partnerships with governments, organizations and  
18 the international community to enable the work of  
19 Africans and help them provide for their own  
20 security. There are numerous theater security  
21 cooperation events that go on to this end. Some  
22 of those are highlighted here. The Africa

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1 Partnership Station is a maritime effort and it is  
2 an international initiative aimed at strengthening  
3 West and Central African regional maritime  
4 capabilities. The picture at lower left shows  
5 some of the training going on in conjunction with  
6 our Africa Partnership Station.

7 Likewise, our Operation Enduring Freedom  
8 in the Trans-Sahara is a broad international  
9 effort to deny terrorists the resources they need  
10 to operate and survive. U.S. AFRICOM operates  
11 this with a minimum number of military forces and  
12 they do so through a series of  
13 military-to-military engagements and exercises  
14 designed to strengthen the ability of regional  
15 governments to police the large expanses of remote  
16 terrain in this region and deny its use to  
17 terrorist organizations.

18 Lastly is the Combined Joint Task Force  
19 Horn of Africa established in October 2002 to  
20 combat terrorism and bring security and stability  
21 to our regional partners there. They increasingly  
22 are conducting day-to-day operations focusing on

1 engagements with partner nations to include the  
2 provision of technical advice and mentoring.  
3 Ongoing projects include repair of municipal  
4 infrastructures, medical and education facilities,  
5 combined with engagement operations with the  
6 various governments and militaries within the Horn  
7 of Africa. Again there are significant challenges  
8 here as well. AFRICOM has some wide expanses that  
9 make transit difficult, and they do so with  
10 limited resources. As you noticed on the slides  
11 showing the various commands, only about 3,300 DOD  
12 members are assigned to the Africa Command at this  
13 time.

14           The Africa Area of Responsibility used  
15 to belong to the European commander. The EUCOM  
16 command plays a significant role in support to  
17 NATO. Their mission is to maintain ready forces  
18 for full spectrum operations unilaterally or in  
19 concert with our coalition partners. They enhance  
20 our Transatlantic security through support to  
21 NATO, promote regional stability, counter  
22 terrorism and advance U.S. interests in the area.

1 They do this through numerous operations. Many of  
2 those shown here involve our NATO allies. Joint  
3 Enterprise in 2005 consolidated NATO operations in  
4 the Balkans, specifically in Bosnia and  
5 Herzegovina as well as those in Kosovo, Macedonia  
6 and Albania. These operations continue to  
7 maintain the peace even through Kosovo's recent  
8 declaration of independence. Operation Active  
9 Endeavor, similar to the operations in the Gulf of  
10 Aden, is a NATO effort to conduct surveillance in  
11 support of the global war on terrorism. Maritime  
12 operations here are using a variety of NATO  
13 contributing nations, their ships, operate in the  
14 Mediterranean from the Straits of Gibraltar  
15 throughout the Mediterranean Sea in an effort to  
16 ensure that weapons of mass destruction or other  
17 components are not transiting illicitly.

18 Finally, OIF and OEF are both supported  
19 by the United States European Command. Not only  
20 do they provide forces to the effort, but they  
21 play a significant role in training our NATO  
22 allies who are also providing forces. In

1 addition, the United States European Command plays  
2 a role in the Middle East peace effort. They do  
3 this through their engagement with Israel through  
4 the United States Security Coordinator. In  
5 addition to this effort which has obviously become  
6 more important through the recent operations in  
7 Gaza, last summer's emergence of Russia and their  
8 operations within Georgia are cause for  
9 significant concern which continue to be a high  
10 priority for the United States European Command.

11 Moving on to our last two combatant  
12 commands, they have similar challenges that EUCOM  
13 and AFRICOM have. They have forces assigned and  
14 are primarily focused on fostering peace,  
15 democracy, freedom, promoting U.S. Interests and  
16 doing so through theater security cooperation.  
17 Within the PACOM AOR, these forces primarily  
18 include our forward deployed naval forces, air  
19 forces, and our U.S. forces that continue to be  
20 assigned to Korea. There are numerous issues that  
21 the Commander of the Pacific Command must  
22 confront, but I'd like to highlight a couple. The

1 recent attack in Mumbai highlights the tenuous  
2 situation along the Indian/Pakistan border.  
3 Increased tensions threaten to spill over into  
4 differences over Kashmir and will continue to  
5 require extended and sustained talks to challenge  
6 and maintain some semblance of normalization. In  
7 addition, recent concerns within North Korea and  
8 the continued effort by the North Koreans to  
9 develop a nuclear capability, and most recently  
10 what appears to be their intent to launch a  
11 ballistic missile in violation of U.N. sanctions  
12 continues to be a focused area for the Pacific  
13 Command as well as for all aspects of the United  
14 States government.

15           Lastly, our Southern Command, our  
16 command closest to our own continental United  
17 States and the focus of a recent trip by the  
18 Chairman just last week to this region.  
19 SOUTHCOM's area of responsibility encompasses  
20 about one- sixth of the Earth's surface, has 32  
21 countries and 13 territories, over 460 million  
22 people. U.S. forces continue efforts to interdict

1 the flow of drugs throughout the region and helped  
2 to stop more than 200 metric tons of cocaine from  
3 reaching U.S. shores in 2008. Counterdrug efforts  
4 highlight the successful partnership of our  
5 partner nations' forces, U.S. government agencies,  
6 the U.S. Military and U.S. Coast Guard units led  
7 by SOUTHCOM's Joint Interagency Task Force South.

8 One of the more recent aspects of the  
9 drug war that has been confronted by SOUTHCOM is  
10 the use of self- propelled semi-submersibles.  
11 Traffickers increasingly prefer these for the  
12 movement of narcotics at sea because of the  
13 vessel's stealthy design. SOUTHCOM continues to  
14 support Colombia in their counternarcotics efforts  
15 by providing training, logistical and intelligence  
16 support. Over 90 percent of the cocaine in the  
17 United States emanates or passes through Colombia.  
18 In addition to our counternarcotics efforts,  
19 humanitarian assistance and disaster relief are  
20 significant. We have conducted humanitarian  
21 efforts there twice in 2008, once in Haiti in  
22 September and in Costa Rica and Panama in

1 November. In both missions, U.S. troops airlifted  
2 thousands of pounds of aid to victims. In  
3 addition, two U.S. Navy amphibious ships brought  
4 health care and other relief services to eight  
5 Latin American and Caribbean nations during  
6 humanitarian and civil assistance Operation  
7 Continuing Promise, provided medical care to  
8 71,000 patients, conducted 348 surgeries and  
9 completed numerous community renovation projects.

10 Other theater security cooperation  
11 efforts include Partners of the Americas,  
12 SOUTHCOM's effort in the region to address  
13 security issues there. Last April this mission  
14 began in which four Navy ships and an aircraft  
15 carrier took part in conducting a variety of  
16 exercises and events at sea and on shore with our  
17 partner nations, some of which you see depicted  
18 here. In addition, we continue to conduct major  
19 exercises with our partner nations there.

20 In addition to these current operations  
21 that are ongoing across the globe, we continue to  
22 look ahead to what may cause us significant

1 challenges in the future. Numerous stress points  
2 exist as you see depicted here. Most recently,  
3 the global economic crisis, crises in energy, and  
4 the lack of governance continue to lead to  
5 significant challenges. There are a few areas  
6 that show positive signs. Transnational violent  
7 extremism although no longer rising probably  
8 because of military action has had an effect.  
9 Events could force this trend line to be reversed.  
10 Cyber competition and cyber warfare continues to  
11 be a significant concern. The U.S. continues to  
12 possess robust capabilities and infrastructure.  
13 However, the number of highly skilled actors and  
14 sophistication of attacks will continue to  
15 increase. We saw this most recently in Russia's  
16 operations in Georgia where they were able to  
17 employ cyber attacks against the Georgian  
18 government to defeat much of their  
19 command-and-control capability, although limited  
20 as it may have been, and even more recently within  
21 our own DOD. The competition for natural  
22 resources has become more urgent much more quickly

1 and is much more complex. Russia's natural gas  
2 capabilities and the dependence of European  
3 nations on Russia's supply is a great example of  
4 this.

5 On a day-to-day basis, there are several  
6 other things that we've talked about that in the  
7 near term that cause us concern. Many we have  
8 already touched on. One that we haven't is  
9 support for homeland defense. Operations in  
10 Mexico highlight the concerns that impact even  
11 those nations most closely aligned with us  
12 geographically. In addition, we continue to be  
13 concerned about threats to the homeland, be they  
14 nuclear, biological, counter IED or any potential  
15 for additional terrorist attacks, and looking  
16 ahead to some of those strategic challenges will  
17 force us to consider the balance of forces spread  
18 across the geographic combatant commands that I've  
19 highlighted here. Training, modernization and  
20 readiness are all significant concerns, especially  
21 readiness as we see a drawdown of forces in an  
22 effort to try to reset some of those forces, not

1 just the equipment, but the personnel as well. A  
2 growing number of ungoverned spaces continue to be  
3 a significant concern as highlighted by several  
4 points throughout, but especially in Somalia and  
5 in the Northwestern Region of Pakistan.

6 Lastly, again I'd like to thank you for  
7 the opportunity, and I'd be happy to take your  
8 questions regarding any or the regions that we've  
9 discussed or any other issues that you may have  
10 regarding ongoing operations.

11 DR. WILENSKY: Thank you, Colonel Reist.  
12 Are there any questions that people have?

13 DR. KAPLAN: Thank you very much for a  
14 very inclusive briefing. As the Defense Health  
15 Board, a question entered my mind as I was  
16 listening to you. Are there available either  
17 briefings or data from the various combat commands  
18 about their own perceptions of health problems  
19 that may be unique to each of these various  
20 commands? And if not, is it possible for this  
21 Board to see those? I suspect that issues may  
22 differ remarkably in and out of combat zones and

1 geographically.

2 COL REIST: Sir, I'm not sure if there  
3 are actually formal reports already in existence  
4 that would answer some of those questions and I  
5 would open it up to some of our liaison to address  
6 that. But we'll certainly take the question back  
7 and seek that information and provide it to the  
8 Board if it's available.

9 CMDR FEEKS: I think command surgeons in  
10 their various areas of responsibility are actually  
11 accustomed to giving briefings to the press for  
12 instance on issues in their respective areas, so I  
13 think that they are available, not necessarily  
14 from the Joint Staff but more from the surgeons'  
15 offices.

16 DR. KAPLAN: Is it appropriate for those  
17 reports or some kind of summary of those reports  
18 to be brought before the Board at least for  
19 information?

20 CMDR FEEKS: Yes, sir. These briefings  
21 are prepared for the press, so certainly. And we  
22 could do better than that, too, as a matter of

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1 fact I think more specifically for this Board.

2 Yes, sir, I'll work on that.

3 DR. KAPLAN: I think that's something  
4 that's really important in terms of fulfilling the  
5 obligation that we have to DOD.

6 DR. WILENSKY: Any other questions?  
7 Thank you very much. Our second speaker this  
8 morning is Mr. James E. Brooks, Public Affairs  
9 Officer at NAS Key West. He will brief the Board  
10 on the military in Key West past and present.

11 MR. BROOKS: Good morning. My name is  
12 Jim Brooks, and I'm the Public Affairs Officer at  
13 Naval Air Station Key West. First of all, as one  
14 of the folks that lives down here, I'd like to  
15 welcome you to Key West. I understand that you  
16 arrived a couple days ago and you had the  
17 opportunity to join some of our weather yesterday.  
18 Let me just say that was probably one of the  
19 warmest days we've had in the last couple of  
20 weeks. We've been suffering with some cold  
21 temperatures. It's been down in the low 70s, high  
22 60s for us, and that's cold.

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1           I'm a transplant from the Navy. In  
2 fact, General Myers was an old boss of mine. I  
3 was on the Joint Staff, and while some of us  
4 retire and stay working in D.C. making the big  
5 dollars, some of us decide to come to Key West to  
6 retire. But I'm very happy still working with the  
7 U.S. Navy. The alternative was teaching high  
8 school English down here, but a good decision.

9           I'm going to give you a little  
10 background on the history of the military here in  
11 Key West. The thing I would like you to take with  
12 you out of this is that the military and this  
13 community grew up together and like a brother and  
14 sister we haven't always seen eye to eye on a lot  
15 of things down here, but we're truly joined at the  
16 hip in pretty much everything we do. So what the  
17 U.S. military is doing and Key West is supporting,  
18 it affects this community.

19           It really began here in 1822. John  
20 Symington on the left, he's our founder of Key  
21 West. Over on the right is an older picture of  
22 Matthew Perry. Perry came down here as a

1 lieutenant on the USS Shark. Perry would go on to  
2 greater fame opening up Japan to the West, but one  
3 of his first jobs was opening up Key West.  
4 Symington established the city here in 1822. He  
5 had a problem with piracy, and the other thing is  
6 that they didn't have much money so what better to  
7 bring in security than to invite the U.S. Navy  
8 down. So he wrote a letter to the Secretary of  
9 the Navy. The Navy came down. Matthew Perry took  
10 a look around and said this is a really good place  
11 for a base. Of course, while he was down here he  
12 raised the flag claiming the island as Thompson  
13 Island, Thompson being the Secretary of the Navy  
14 at the time. That name really never stuck. It  
15 stayed Key West. Shortly after looking and taking  
16 an assessment of the area, Porter left.

17 Fast-forward a year later, David Porter  
18 arrives with a fleet of ships in 1823, and Porter  
19 is actually going to establish the very first Navy  
20 base here. I know you're going to be going down  
21 to Mallory Square tonight to watch the Sunset  
22 Celebration. That is the site of the first Navy

1 base. Over there there's a small shopping mall  
2 with small shops. That was the first Navy  
3 building built here and that building is roughly  
4 150 years old. So when you're down there, just  
5 always understand wherever you go in Key West,  
6 you're probably walking on property that was once  
7 owned by the U.S. Navy.

8           It was shortly after the Navy got here  
9 that the Army arrived in 1831. The base was  
10 officially established 5 years later, and it's  
11 really about where our Navy housing is, Perry  
12 Housing across from Trumbo Point. At the time  
13 that was waterfront property and that's where the  
14 Army established their base. The Army wasn't  
15 really here that long because the troops there  
16 were called up North to support the Indian wars in  
17 Florida. Congress passed the Indian Removal Act  
18 in 1830 and something had to be done with the  
19 Seminoles. Unfortunately, Major Francis Dade, one  
20 of the Army commanders here in Key West, took his  
21 company of troops up North and unfortunately met  
22 with a massacre by the Indian Chief Osceala. That

1 was eventually settled when the federal government  
2 trapped Osceala and forced him out, but Key West  
3 troops were involved with the Second Seminole  
4 Indian Wars and eventually the Army came back to  
5 Key West.

6           Some other developments. Fort Zachary  
7 Taylor which is now a state park was built here on  
8 the Island of Key West. Then shortly thereafter  
9 we had Fort Jefferson built out near the  
10 Marquesas. This fort was really never  
11 operationally manned. The advent of the rifled  
12 canon made this fort obsolete even before it was  
13 completed. It eventually became to be a --  
14 station for the U.S. Navy and also served as a  
15 prison. The most probably renowned prisoner they  
16 had was Dr. Roger Mudd. He was the doctor that  
17 set John Wilkes Booth's broken leg, and he was a  
18 prisoner out there shortly after the war.

19           During this time we're talking the 1840s  
20 to 1850s, the big Navy mission down here was  
21 piracy. Yes, we had piracy issues down here.  
22 It's also the first time that we actually really

1 see steam ships being used by the U.S. Navy.  
2 Porter used steam ships to pull flat-bottomed  
3 boats full of sailors into the mangroves to chase  
4 out pirates. Then the steam ships arrived to  
5 combat piracy. Back then piracy was defined  
6 largely for the slave trade. The slave trade was  
7 declared piracy and the Navy went out there and  
8 intercepted the slave ships. This picture  
9 actually portrays the USS Wyandotte who captured a  
10 slave ship and brought over 400 slaves into Key  
11 West, and another ship, the USS Mohawk, brought  
12 another 400 slaves. So at one point in time, Key  
13 West was trying to take care of about 1,000 slaves  
14 that were here. They were eventually repatriated  
15 to Liberia. Unfortunately, when we did capture  
16 the slaves and bring them in here, many of them  
17 were sick. We had over 200 die. They were buried  
18 in a cemetery outside of town. Now there's a  
19 monument down near Higgs Beach that designates  
20 where those graves were.  
21 Fast-forward. We're now in 1856 in Key  
22 West. Keep in mind that Key West is a very

1 Southern town. We're seeing Confederate flags  
2 being built here. We've got discussions between  
3 the Army Corps of Engineers to the Army troops  
4 here about finishing Fort Jefferson, or correct,  
5 Fort Zachary Taylor. That's the fort that's here.  
6 Fort Taylor was just about being completed and it  
7 actually would be completed in 1860, but this is a  
8 very Southern town. So Southern in fact we have a  
9 young woman here by the name of Mrs. Ellen  
10 Mallory. She is the mother of Stephen Mallory.  
11 Stephen Mallory at the time was an Alabama Senator  
12 and also on the Board of Naval Affairs. He was  
13 considered a strong proponent and extremely  
14 knowledgeable on naval operations. He actually  
15 introduced some reforms for retiring old and  
16 inefficient naval officers. He was also pushing  
17 the Navy's use of steam-powered and ironclad  
18 technology. Unfortunately when he was a Senator  
19 for the Union, he never really got those  
20 initiatives in place. When Florida and the  
21 Confederate States did stand up, Stephen Mallory  
22 became the Confederate Secretary of the Navy. He

1 was well trusted by Jefferson Davis. He  
2 understood that it was highly unlikely that the  
3 Confederacy would ever have any success against  
4 the Union Navy. He knew the Union Navy. So he  
5 actually pushed for many revolutions in military  
6 affairs such as ironclad ships and submarines.  
7 Unfortunately they didn't make a difference. But  
8 when you go down to the Sunset Celebration  
9 tonight, Mallory Square is named after Stephen  
10 Mallory, so Key West considers him a native son.

11 The Civil War here. Key West never fell  
12 into Confederate hands. This is Fort Taylor. It  
13 was completed in 1860. While Florida was having  
14 discussions on whether or not to secede, the Army  
15 Corps of Engineers had talked to the Army colonel  
16 over at the base here, the Army barracks here,  
17 about taking the fort. So during a midnight march  
18 in 1860, the 11th of December 1860, the Army  
19 commander marched his troops through the center of  
20 town at midnight to capture the fort for the  
21 Union. It surprised a lot of folks in town that  
22 the Union troops here would do something like

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1 that. There was concern whether or not the South  
2 could react to that quick enough. They didn't,  
3 and the fort was eventually reinforced with troops  
4 from Texas. So Key West never fell into  
5 Confederate hands and that was considered a very  
6 big move. A lot of folks will argue that it  
7 shortened the Civil War by 3 years because we  
8 never lost this fort largely because Key West had  
9 a huge impact on the blockade running that the  
10 Confederacy was trying to do. Key West was home  
11 to the East Gulf Blockading Squadron and we were  
12 responsible for the Florida coast from Cape  
13 Canaveral to Pensacola.

14 We had intercepted about 300 blockade  
15 runners down here. They were here during the war.  
16 We were also a staging place for a lot of raids up  
17 North along the Florida coast especially around  
18 Fort Myers going up into Pensacola. Some of the  
19 troops that supported those efforts were the 2nd  
20 U.S. Colored Troop Squadron. They supported raids  
21 into Southwest Florida specifically around  
22 Pensacola, and again they had a big impact down

1 here.

2           With that the Civil War ended and Key  
3 West again resumed its place down here as an Army  
4 base and a Navy base. In 1880, President Grant  
5 came and visited here, and actually one of the  
6 things while you're here, you're going to probably  
7 be hearing about Harry S. Truman. Key West has  
8 actually a legacy of hosting many presidents. It  
9 just happens that President Grant was the first  
10 President to visit Key West.

11           We move forward to 1884 here in Key  
12 West, again still a very big Navy town, very big  
13 Army town. We're seeing the advent of steam ships  
14 here. Locally we've got cigars being made by the  
15 box load. We have become a center of commerce for  
16 the Cuban trade. We were also becoming a center  
17 for Cuban exile groups that wanted to basically  
18 rescue Cuba from the Spanish. So our influences  
19 with Cuba are very important here.

20           Things start to heat up, and in 1897 the  
21 Navy sends USS Maine down here. If you're joint  
22 warfare qualified or a joint warfare student, this

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1 is known as a flexible deterrent action. The USS  
2 Maine comes here and actually begins a very close  
3 relationship with the city. The sailors are out  
4 in town and the USS Maine played in a baseball  
5 tournament for the Atlantic Fleet and beat a team  
6 from the USS Marblehead 18 to 3. This was a  
7 picture of the baseball team. This picture was  
8 taken here in Key West. One of the more  
9 interesting parts is that this was -- up there in  
10 the upper right was the pitcher. Unfortunately,  
11 every single one with the exception of the  
12 gentleman in the back would be killed in the  
13 explosion. Their goat mascot was left in Key  
14 West. The USS Maine left here on January 25,  
15 1898, to try to soothe some of the tensions over  
16 there in Cuba. And of course as you know your  
17 history, the USS Maine blew up on February 15.  
18 Here in Key West many of the Maine dead were  
19 brought here, not all of them, but some of them,  
20 and they were buried out in the Key West Cemetery.  
21 The Custom House in the background, that's a  
22 prominent landmark here in Key West. That's where

1 the first board of inquiry into what caused the  
2 explosion was held. The board came out and said  
3 it was a naval mine that caused the explosion. In  
4 1911 there was a second board of inquiry and they  
5 essentially reaffirmed that the sinking was caused  
6 by an external explosion. Unfortunately, the  
7 debate grew in 1976 when Hyman Rickover, the  
8 father of the nuclear Navy, opened his own  
9 investigation and he declared that it was actually  
10 a fire in the coal bunker which was located next  
11 to a magazine. It's still debated today. A  
12 National Geographic study in 1998 went back and  
13 said, no, we looked at this again using high-tech  
14 modeling devices and said it was an external  
15 explosion. So the cause of the explosion is still  
16 under debate.

17 I mentioned that many of the dead from  
18 the USS Maine are buried in the cemetery and the  
19 city went ahead and erected a memorial there. If  
20 you have an opportunity to visit the cemetery  
21 while you're here in Key West, that's definitely  
22 one of the tourist locations on the island that

1 they talk about. We also have several other  
2 casualties from the Spanish American War.

3           The Spanish American War. Key West as  
4 you could imagine was a key logistics base.  
5 Everything pretty much was staged here and came  
6 from here and also from Tampa. The war was  
7 resolved, and we move forward to 1905. Key West  
8 was one of the first places in the U.S. Navy to  
9 receive navy radio. It was still very new and  
10 nobody really knew exactly how to use it at the  
11 time so we were on the cutting edge of development  
12 on how to use radio here. Largely what they were  
13 doing was time checks and weather checks for Navy  
14 ships off the coast. Obviously time is very  
15 important to the sailor when using it for  
16 navigation, so that was a key part. Also in 1914,  
17 President Wilson was trying to coordinate orders  
18 to the troops in Veracruz, Mexico and this a very  
19 important relay station for relaying orders from  
20 Washington to Mexico.

21           While you're here you're going to hear  
22 about Henry Flagler. He's the one that brought

1 the railroad to Key West. I would be remiss not  
2 to mention the Navy's involvement with the  
3 railroad. I would say that this is one of the  
4 cases where the Navy did everything in their power  
5 to prevent the railroad from coming here. Henry  
6 Flagler had asked the Navy for some land to set up  
7 his terminus, the end point of his railroad and  
8 that was of course down by Mallory Square, and the  
9 Navy said, no, you can't have it. So Henry  
10 Flagler got an engineer by the name of John Trumbo  
11 and said "build me some land," and that's exactly  
12 what he did. They started dredging the harbor and  
13 built what is known as Trumbo Point. Of course  
14 the Navy protested that saying that Henry Flagler  
15 was taking fill from the ocean bottom that may be  
16 required for defense reasons later on in the  
17 future, and Henry Flagler politely told the  
18 Secretary of the Navy that "If you ever need it in  
19 the future, I'll be happy to put it back where I  
20 got it."

21 On to World War I. That's when Naval  
22 Air Station Key West was first established. That

1 was there at Trumbo Point. We had sea planes and  
2 what was known as kite balloons. As it turns out,  
3 we went ahead and made good relations with the  
4 railroad because we leased the land for the air  
5 station from the railroad about where our primary  
6 visitor's quarters building is is where the blimp  
7 hanger was and everything to the right of that  
8 which is where our housing is is where the air  
9 station was. We also started seeing submarines  
10 come down here. Anti-submarine warfare training  
11 was very good down here because the weather up  
12 North in Groton, Connecticut was bad, so we  
13 started seeing submarines come down here for the  
14 first time. And a man by the name of Thomas  
15 Edison came down here to do some work with the  
16 Navy Consulting Board. He actually worked a lot  
17 on anti-submarine warfare. Josephus Daniels who  
18 was the Secretary of the Navy at the time  
19 approached Edison about doing some research.  
20 Thomas Edison formed the Navy Consulting Board on  
21 Technology which was actually the predecessor for  
22 the Navy Research Lab. Unfortunately, Edison and

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1 the Navy didn't see eye to eye on a lot of things.  
2 Edison thought that naval officers and Navy  
3 leadership were not creative and very difficult to  
4 work with. So after World War I, Thomas Edison  
5 and the Navy parted ways and Edison never worked  
6 on another defense research project again.

7 Ernest Hemingway. You're probably  
8 asking how can Ernest Hemingway, probably Key  
9 West's biggest figure, factor into military  
10 history. During the 1930s, the military footprint  
11 here all but disappeared. The only sailors we  
12 really had were at the radio station and keeping  
13 the naval station in a caretaker status. Ernest  
14 Hemingway in 1935 woke up one day to find a lot of  
15 tourists on his front lawn and asked the tourists  
16 what are you doing here and they told him the city  
17 gave me this tourist map and your house is on it.  
18 Thus began a battle between Ernest Hemingway and  
19 the City of Key West. So Hemingway told the city  
20 I'm going to build a brick wall around my house.  
21 The city wasn't too keen on that idea so they went  
22 around to every bricklayer in the city and said

1 don't sell bricks to Hemingway. Hemingway  
2 happened to have some friends over at the Navy  
3 base and Hemingway got all his bricks from the  
4 Navy which the city couldn't do anything about.  
5 So when you go down there and see the Hemingway  
6 House and see the brick wall around the house,  
7 you'll know that's courtesy of the U.S. Navy.  
8 Also his boat, Pilar, was often moored in the  
9 Navy's harbor over there. It rode out the famous  
10 1935 hurricane there tied up. In 1935 the  
11 railroad was all but destroyed because of the  
12 hurricane that crossed the Upper Keys region. It  
13 essentially bankrupt the Florida East Coast  
14 Railroad which allowed the Navy to buy the  
15 property at Trumbo Point. So while we objected to  
16 it, we later on went and bought it from the  
17 railroad.

18           During the late 1930s, Key West is the  
19 one that started gearing for war. We had the  
20 neutrality patrol out there looking for German  
21 submarines. The submarines were very prevalent  
22 down here in Florida. In 1939, the Navy's first

1 amphibious aircraft started flying in the town.  
2 Key West was so happy when they arrived that they  
3 had a parade in their honor.

4           During the war as the war kept on, the  
5 Navy established its Fleet Sonar School here.  
6 From World War II all the up into the 1970s, all  
7 Navy fleet sonar training was here. We had  
8 submarines here on the waterfront and we had  
9 destroyers supporting that training evolution.  
10 When you go over to the Joint Interagency Task  
11 Force South for a tour if that's on your schedule  
12 this week, you'll be going into the original  
13 buildings from the Fleet Sonar School because  
14 that's where the command is now. During the war  
15 they would have over 18,000 students.

16           The other thing that we did here for the  
17 City of Key West is we brought water to Key West.  
18 When we were starting to expand operations here in  
19 the 1930s, we realized that the water situation  
20 was very difficult. The distilling plants that  
21 were here did not have the capability of supplying  
22 the fleet down here. So the Navy entered into

1 talks with the Florida Keys Aqueduct Authority  
2 which had stood up in 1939 wanting to bring water  
3 down here. They just didn't have the money. So  
4 between the Navy and the Aqueduct Authority we  
5 built a pipeline down the length of the Overseas  
6 Highway to bring water here, and water started  
7 arriving in 1942.

8 Key West Airport. That was just a  
9 commercial strip. The Army came in here and  
10 turned it into an Army airport. The Army at the  
11 time had the mission of anti- submarine warfare.  
12 They had the fixed-wing aircraft and they flew  
13 them out of there. But that mission had quickly  
14 changed over to the Navy and the Navy took over  
15 the airport there. That wasn't enough room  
16 really, and what we did is we used the Key West  
17 International Airport for an auxiliary field and  
18 we built a new one up on Boca Chica Key. That's  
19 where the main naval air station is now up at Mile  
20 Marker 8. By 1945, the Navy had gone from 50  
21 acres before the war to over 3,200. We're still  
22 the largest landowner in the Keys. Trust me, the

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1 local county and city are always reminding of that  
2 because they're always interested in obtaining  
3 more land.

4 We've obviously known as Truman's Key  
5 West. President Truman would make 11 trips down  
6 here, six during his presidency and five after his  
7 presidency. Here he's actually visiting one of  
8 the German submarines that we had taken after  
9 World War II and experimented with. This is down  
10 at the Truman Annex Harbor. That was the Navy  
11 base for the Navy down here for many years.

12 You're here today doing a conference.  
13 We've had many high-level conferences in Key West.  
14 Probably the most important one was the Key West  
15 Conference of 1948. This was post-World War II.  
16 We were trying to refine the roles of the various  
17 armed services especially in light of the nuclear  
18 age and the primary meeting for determining the  
19 future roles of the armed forces were decided here  
20 in Key West. We see James Forrestal right there  
21 and Omar Bradley, the first Chairman of the Joint  
22 Chiefs of Staff in that photo.

1           President Kennedy was here on two  
2 occasions, once was in 1961 to meet with the  
3 British Prime Minister. The official reason of  
4 this visit was to discuss the situation in Laos  
5 and what should be done, but given the timing of  
6 this visit in 1961, it was 3 weeks before the Bay  
7 of Pigs, many will argue that this conference was  
8 to decide or to determine whether or not there  
9 will be an invasion of Cuba using U.S. troops.  
10 Nobody seems to really know. That's something  
11 that's debated today. But given that it's 1961,  
12 tensions with Cuba are increasing now with Fidel  
13 Castro in power. Both Eisenhower and Kennedy had  
14 obviously made gestures toward Castro and getting  
15 him out of power, so it was no surprise when  
16 Castro would strike up a relationship with the  
17 Soviet Union which would then touch off the Cuban  
18 Missile Crisis that began here. Key West  
19 obviously is at the tip of the sword here. It  
20 looks like there's going to be a standoff. The  
21 crisis down here actually began in the summer of  
22 1962. We had many Russian aircraft with

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1 aggressive acts toward the Navy's S-2  
2 anti-submarine warfare aircraft flying out of Key  
3 West. We had harassment. We had a patrol boat  
4 fire on Navy aircraft. So the situation between  
5 the military forces was certainly increasing down  
6 here and the military situation was ramping up.  
7 The Army and the Joint Chiefs of Staff made a  
8 decision to buffer up the air defense forces down  
9 here and ordered down the an Army Hawk Battalion  
10 and within a very short time we had missile  
11 defenses and a command-and-control system set up  
12 around the city, and these were really set up  
13 right on the beaches to prepare for the showdown.

14 That showdown did occur, and rather than  
15 going into all the details, obviously the military  
16 situation here, the military base here played a  
17 very prominent role. Ships and submarines that  
18 were based here took part in the quarantine. The  
19 air station was extremely busy with thousands of  
20 sorties. The two most important sorties were  
21 probably with the F-8 Photo Reconnaissance  
22 Squadrons, a Navy and Marine Corps one, and this

1 is President Kennedy thanking the F-8 squadrons  
2 for the work they did in providing real-time  
3 tactical low-level reconnaissance and information  
4 that was required for determining the status of  
5 the missile bases in Cuba. But also after the  
6 situation was resolved, making sure that they were  
7 in fact dismantling them and moving them out. So  
8 here they were presenting the Navy Commendation  
9 Medal to the unit.

10 In 1965 we probably reached the peak of  
11 Navy military power in Key West. We were at  
12 10,000 military and 10,000 family members. The  
13 naval station which of course is no longer there  
14 was largely a submarine base supporting the Fleet  
15 Sonar School and we still of course had the air  
16 station down here. The Army at the time had the  
17 Hawk missile batteries that came down to set up  
18 for the missile crisis, having moved into  
19 permanent positions around the island. We had  
20 barracks built on Boca Chica to support the Army  
21 mission, and we actually had a footprint of about  
22 1,000 Army soldiers at the time here in Key West

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1 providing air defense for the city.

2           The Vietnam War came, the Vietnam War  
3 ended, and now comes the typical cutback of  
4 military standing here. That certainly affected  
5 the Keys. This was before the years of the base  
6 realignment and closure process and the Navy  
7 decided to close the naval station here. So  
8 overnight literally 5,000 civilian jobs and all  
9 the ships and submarines left here. Obviously  
10 that move pretty much devastated Key West  
11 economically.

12           In 1979 decisions were made to keep the  
13 air station open but the mission was kind of fuzzy  
14 about what the air station was going to do, but we  
15 weren't going to harm the local economy any more  
16 by closing the air station, although that was  
17 considered. Truman Annex, the old Navy base, was  
18 auctioned off by the General Services  
19 Administration and that's now an upscale  
20 neighborhood which is the Navy is having problems  
21 with regarding easements, and we actually have a  
22 lawsuit against the homeowner's association on

1 property that the Navy used to own.

2           The base was only closed for a short  
3 period when the Mariel Boatlift occurred. Truman  
4 Annex Harbor became the big place for coordinating  
5 all the boats and everybody coming in. The Navy  
6 sent in a large number of amphibious ships to  
7 provide support for the relief effort down here,  
8 and then the seaplane hangar over at Trumbo Point  
9 was actually used to process any of the refugees.  
10 The air station became a launching point for  
11 commercial flights going from here up to Tampa  
12 because the base and the infrastructure down here  
13 could not handle the influx. It was estimated  
14 that during the Mariel Boatlift, over 100,000  
15 Cuban migrants were processed through Key West,  
16 and today this is still one of our biggest  
17 concerns, a mass migration.

18           Key West was relatively quiet during the  
19 1980s and early 1990s under President Reagan. We  
20 did have a hydrofoil squadron come down here  
21 during the advent of a 600 ship Navy. That never  
22 came to pass. It was too expensive. The

1 hydrofoils ended up leaving. As an ensign surface  
2 warfare officer I had the opportunity to spend a  
3 month down here on them. It was fun ship to  
4 drive, it was a fun ship to be on, but manpower  
5 intensive and it really didn't have the legs that  
6 you really needed to do sustained operations at  
7 sea.

8           The Coast Guard came in. They took over  
9 our piers down there at Trumbo Point. They own  
10 those now under a lease from the Navy. This is  
11 the largest Coast Guard base on the East Coast  
12 today and they're our second largest tenant  
13 command that we support down here. So if you're  
14 down at Trumbo Point, you're certain to see the  
15 Coast Guard down here.

16           This brings us today back to the future.  
17 What's the future down here? I would say it's  
18 kind of a back to the future situation. Last  
19 summer we had a blimp come down here. We had  
20 blimps down here during World War II all the way  
21 up through the 1960s. We had a joint project  
22 between the Coast Guard and the Naval Air Systems

1 Command to test out a manned blimp for sustained  
2 intelligence surveillance over the Florida  
3 Straits. There's human smuggling going on there,  
4 there's a lot of drugs being run through the  
5 Florida Straits, and we're looking for a long-term  
6 sustainable something that can be there 24/7 and  
7 with the blimp they wanted to see if that was a  
8 good alternative.

9           On the upper right is one of the  
10 submersible drug runners. You heard that in your  
11 last brief. Drugs are coming in. Submersible  
12 submarines are certainly one of the ways that  
13 they're bringing them in now. If you go over to  
14 JIATF you'll see on of the ones on display  
15 that they captured. So that is an issue, and  
16 piracy still is an issue down here although the  
17 term piracy has legal connotations. We're seeing  
18 human smuggling down here and of course drugs.

19           Key West is still a test bed of research  
20 and development. Over there on the bottom right  
21 is an underwater UAV, so to speak, a wire-guided  
22 test device that was tested down here 2 years ago.

1 And of course bottom left is the F-22. We had a  
2 squadron of F-22s down here. The air station  
3 supports all the armed forces and also all the  
4 other federal agencies. Radio Marti is a program  
5 run by the State Department to broadcast  
6 television and radio into Cuba. They fly out of  
7 the air station and we support them. We also  
8 support the National Weather Service that flies a  
9 UAV out of here that flies into the storms and  
10 gathers research on hurricanes down here. So  
11 we've become a very valuable base for homeland  
12 security and many of the other federal agencies.

13 And probably most important, the base  
14 realignment and closure committees over the past  
15 several years have kept Key West off of the  
16 closure list or the realignment list largely  
17 because we're an irreplaceable training site. We  
18 have hundreds of thousands of air space to train  
19 in and we don't have the problems of commercial  
20 airliner routes. When our guys take off to train,  
21 they can begin training 5 minutes after taking  
22 off. In fact, they can begin training based upon

1     how quickly they can go through their checklists  
2     after taking off. They're right on the range. So  
3     we do support that, and everybody wants to come to  
4     Key West. I hope you enjoy your stay here in Key  
5     West, and just remember that this conference is  
6     part of our legacy of many important conferences.  
7     Thanks a lot. If anyone has any questions, I can  
8     certainly take them.

9             DR. WILENSKY: Does anyone have any  
10     questions? That was a very interesting review of  
11     the history of the military and Navy in particular  
12     in Key West. Questions anyone?

13            MR. UNTERMEYER: Yes, I have a question.  
14     Who makes those submersibles that the bad guys  
15     used?

16            MR. BROOKS: I don't know if you're  
17     going to be talking to the Joint Inter-Agency Task  
18     Force, but they're probably the best ones to ask  
19     about that. Essentially what I've seen and the  
20     one that's on display, it kind of looks like a  
21     barge that's been welded over that has the  
22     capability of bringing on water so it goes below

1 the surface. A lot of times it's towed. I don't  
2 know if they have independent propulsion systems.  
3 I understand some of them do. But the one that  
4 they do have on display was designed to be towed  
5 after being flooded.

6 DR. WILENSKY: Anything else?

7 DR. MILLER: Can you comment a little  
8 bit about the history of malaria, dengue and  
9 yellow fever in Key West?

10 MR. BROOKS: Sure. I do know a little  
11 bit about it. A lot of the research on preventing  
12 malaria or the mosquito problem was actually done  
13 down here and the original thought was what we  
14 need to do is keep the lands drained. So when you  
15 drive through the Lower Keys you'll see a lot of  
16 drainage ditches that were dug to aid in draining.  
17 That was the first attempt and that had some  
18 effect. It didn't really have a lot because when  
19 we go back and look at the history of World War II  
20 we find out that they had a huge mosquito problem  
21 at Boca Chica that they estimated would reduce  
22 nighttime work by 50 percent. They just couldn't

1 do work because of the mosquitoes. So the Navy  
2 actually went out and would dump diesel fuel in a  
3 lot of the places where the mosquitoes bred. They  
4 kept track of where the mosquitoes were breeding.

5 Now fast-forward, we do have probably  
6 the best mosquito control in the United States  
7 down here through Monroe County. Back in the  
8 1960s the military actually supported that mission  
9 with aircraft spraying for mosquitoes, but that's  
10 what I know. We had a marine hospital down here  
11 that took care of malaria and yellow fever cases  
12 that was a Public Health Service hospital. It's  
13 still down there as a high-end condo now, but the  
14 Navy provided medical doctors there and that was  
15 some of the first professional medical care in Key  
16 West.

17 DR. WILENSKY: Thank you very much. We  
18 appreciate that. Our third speaker this morning  
19 is Captain Martha Girz. She currently serves as  
20 J-3 Assistant Chief of Clinical Operations for the  
21 Joint Task Force National Capital Regional  
22 Medical, JTF CAPMED. She's also Assistant

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1 Professor of Medicine at the Uniform Services  
2 School of Health Sciences in Bethesda, a position  
3 she has held since September 2001. Captain Girz  
4 will update the Board on the Department of Defense  
5 Joint Pathology Center Work Group progress on the  
6 development of the strategic plan for the  
7 establishment of the Joint Pathology Center. Her  
8 presentation slides can be found under Tab 2 in  
9 your meeting notebooks.

10 CPT GIRZ: Good morning, Madam Chair,  
11 Mr. Middleton, Board Members and guests. Thank  
12 you for this opportunity to present where we are  
13 with the Joint Pathology Center. As Madam  
14 Chairman described my current job, I'm actually  
15 here representing the Health Affairs Work Group  
16 that's been working on the Joint Pathology Center,  
17 but I will give you an impression from both the  
18 JTF and from the Working Group.

19 We wanted to thank the subcommittee  
20 headed by Dr. Parisi for their excellent report.  
21 It had a lot of very thorough review of our  
22 concept of operations and we thank you for that

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1 review. What we're going to look at today is the  
2 recommendations. The end of the report had nine  
3 numbered recommendations. What the group at JTF  
4 and then the Joint Pathology Working Group did was  
5 actually look at all of the recommendations that  
6 were in the body of the report numbering somewhere  
7 about 30. So if it seems confusing that there  
8 were more numerated on the slides than were in the  
9 actual recommendations, those were from the body  
10 of the report. The process that we took once you  
11 delivered the report to us was that the JTF  
12 Working Group went through each of the  
13 recommendations, determined whether we concurred  
14 or nonconcurred, then brought that to the Health  
15 Affairs Joint Pathology Working Group and we  
16 discussed then those areas where we had some  
17 noncurrence.

18 Under the clinical scope of service, I  
19 actually have two slides. The first slide you  
20 will see that we concurred with all of the  
21 recommendations, both the JTF and the Health  
22 Affairs Working Group. On the second slide here

1     which also is the clinical scope of service, there  
2     was one recommendation that we had a comment from  
3     the JTF. So the recommendation was encourage and  
4     embrace civilian collaboration. We may have  
5     misinterpreted this at the JTF to mean that the  
6     Joint Pathology Center would take on civilian  
7     cases for consultation and review, and so our  
8     comment was that we were not looking to expand the  
9     mission of the NDAA 2008 when it refers to  
10    clinical cases. When we discussed this at the  
11    Working Group at Health Affairs, the  
12    interpretation there was that it really was for  
13    collaboration in research and education and not  
14    necessarily for civilian cases, and the Working  
15    Group concurred that, yes, we would definitely  
16    want civilian collaboration for research and  
17    studies, and perhaps if there is clarification  
18    from the subcommittee, that would be helpful for  
19    us to determine. The other piece was that  
20    certainly on a case- by-case basis if there were  
21    civilian consultations for clinical work, we would  
22    certainly look at that.

1           The next area was positioning of the JPC  
2     within the command structure where we had some bit  
3     of disagreement with the recommendation. The CJTF  
4     is very interested in looking at gaining  
5     efficiencies and so the initial positioning that  
6     we had putting the Joint Pathology Center under  
7     the Department of Pathology would definitely  
8     extend those efficiencies. The other piece is  
9     that it would maintain focus on the clinical  
10    services provided by the Joint Pathology Center  
11    and it's consistent with some civilian models.  
12    When we went to the Working Group, the Working  
13    Group had a long discussion about this issue and  
14    felt that perhaps positioning it in a different  
15    part of the organizational structure at the JTF  
16    may help with some of the inequities that would be  
17    perceived because it was under a pathology  
18    department. This is actually an area that's of  
19    interest to Vice Admiral Mateczun because in the  
20    National Capital Region as you well know we have  
21    many centers and institutes, some which have been  
22    directed by Congress, some which have developed on

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1 their own, and some such as the Joint Pathology  
2 Center. Vice Admiral Mateczun's interest is that  
3 these centers and institutes that fall within his  
4 joint operating area have similar function meaning  
5 that their governance looks similar, that clinical  
6 functions that occur have the same oversight both  
7 privileging and credentialing for peer review, for  
8 documentation. Any of these centers that have  
9 basic science would have good liaison with USU.  
10 And his interest is that in those areas that have  
11 the core competence, that those are the areas that  
12 are overseeing what these centers and institutes  
13 are doing. What the CJTF in conjunction with USU  
14 has done is brought forth a proposal to Health  
15 Affairs looking at how all these centers and  
16 institutes could potentially be housed within the  
17 National Capital Area potentially under the JTF.  
18 So this is an area that we're still working on,  
19 hoping to come up with a solution that will then  
20 be exportable to all centers and institutes within  
21 the DOD in terms of health. And that proposal  
22 that was brought forward is working its way

1 through Health Affairs and the service Surgeons  
2 General.

3 This was several recommendations about  
4 projected workload both of which we concur with.  
5 The tissue repository, we concurred with all the  
6 recommendations there. Research as well.  
7 Education and training. We concurred with all of  
8 those.

9 Major equipment special design  
10 requirements. The issue of a split functioning  
11 Joint Pathology Center where some of the functions  
12 would be on the Bethesda campus and some on the  
13 Forest Glen campus was a discussion I know of  
14 length for the subcommittee. Our issue at current  
15 is that given the timeline that we have, we cannot  
16 build a MILCON project. We would love to, but  
17 it's not possible to have the Joint Pathology  
18 Center open with the BRAC timelines in a single  
19 facility both because of space limitations on the  
20 Bethesda campus and the Forest Glen and because of  
21 environmental impact implications on both of those  
22 bases. But certainly we agree with the committee

1 that we would love to have the Joint Pathology  
2 Center stand up in a single building, but we don't  
3 see that it's possible currently. We are looking  
4 for options which would take us into the 2015  
5 range for bringing them into a single facility,  
6 and you all know the issue with MILCON projects  
7 and how long all of those types of processes take.  
8 So certainly we are looking at those options, but  
9 in order for us to have this stood up by the time  
10 that the BRAC law is in effect in 2011, we will  
11 need to proceed with our current plan and do  
12 future planning as we go.

13 In terms of the governance, we  
14 appreciate the guidance for establishing a  
15 governance board of federal agency stakeholders,  
16 we prefer to think of it as advisory board and not  
17 a governing board, and definitely illustrates the  
18 need for all of our DOD centers and institutes to  
19 have similar entities that oversee them. In terms  
20 of the organizational structure, we concurred with  
21 those recommendations.

22 Another area where we had a bit of

1 discussion was in the staffing. The  
2 recommendation was professional staffing issues,  
3 junior versus senior level may not be adequate.  
4 We based our staffing recommendations on mission  
5 requirements. Our goal is obviously for the  
6 highly qualified individuals. And as you know, we  
7 are DOD and we must follow regulatory hiring  
8 requirements and certainly would take any further  
9 recommendations for other models that may be out  
10 there that we haven't considered. And likewise in  
11 addition for staffing, the ratio of professional  
12 staff to admin, the comment was that it appeared  
13 inadequate. Once again we used our current DOD  
14 standards and so we would look to any models that  
15 you may have that we could then consider to  
16 address this issue. I'm subject to your  
17 questions.

18 I'm sorry. Let me just tell you what  
19 our next steps are. We are in the process at the  
20 JTF of developing the implementation plan. That  
21 will then be presented back to the Health Affairs  
22 Working Group in April with the presentation then

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1 going to the SMMAC hopefully in May. Part of our  
2 implementation plan that needs to be reflected is  
3 the report from ASTRAND which looked at the  
4 holdings in the tissue repository. We are  
5 developing a plan to take their findings which as  
6 you are aware were excellent. The state of the  
7 tissue repository is in excellent condition.  
8 There is tremendous potential there. What we want  
9 to do as we develop the plan for the JPC is to  
10 ensure that we do not decimate our national  
11 treasure but that we use it for purposes for both  
12 the DOD and medicine in general to further  
13 molecular science, pathology, et cetera. To do  
14 that we will be looking at putting together a  
15 group of subject matter experts who will help us  
16 look at the findings, look at the potential and  
17 come up with a plan so that we can appropriately  
18 utilize what's in the tissue repository and  
19 appropriately determine whether research should be  
20 done with it, et cetera. So that will be part of  
21 our implementation plan. Additionally we need to  
22 develop a process to select a director. That

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1 process we cannot determine currently until the  
2 governance issue is decided with the newest  
3 proposal from Vice Admiral Mateczun. So some of  
4 those things are on hold until we have some of  
5 those other decisions made.

6 Lastly, we are still awaiting a  
7 delegation letter. It did not make it through the  
8 last administration, so in the new administration  
9 we don't know how long it will take before that  
10 goes through. Until we are established, we have  
11 no funding, we cannot execute anything, so we can  
12 only plan, and that's where we are currently in the  
13 process. Subject to your questions.

14 DR. WILENSKY: Any questions? Dr.  
15 Parisi?

16 DR. PARISI: Thank you for your report.  
17 Actually I'm very encouraged to hear of your plans  
18 about the repository. I'm a little confused about  
19 where is the JPC going to reside? Is it still  
20 going to reside under the department of pathology  
21 at the new hospital?

22 CPT GIRZ: No, the current proposal puts

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1 the Joint Pathology Center actually under the JTF.  
2 However, the areas that have primary clinical  
3 responsibility will be embedded within the MEDCEN.

4 DR. PARISI: So administratively who  
5 will have the JPC?

6 CPT GIRZ: The JPC director will report  
7 to CJTF, to the headquarters.

8 DR. PARISI: So it's not going to be  
9 under the department of pathology?

10 CPT GIRZ: That's correct. That's  
11 correct. The clinical function will function very  
12 closely embedded in the medical center.

13 DR. PARISI: You mentioned a new plan  
14 that's being put forward. Do you have more  
15 details about the plan that you could --

16 CPT GIRZ: The plan for organizational  
17 structure?

18 DR. PARISI: Yes.

19 CPT GIRZ: It's rounding through Health  
20 Affairs currently so it's a draft.

21 DR. PARISI: One of our concerns  
22 obviously is that you want to make sure that the

1 JPC is positioned so that it has the visibility  
2 and the stature that it deserves if indeed it's  
3 going to satisfy the directive from Congress that  
4 it be a world-class diagnostic center. So that's  
5 one of our concerns, obviously, and I guess I'm  
6 still a little confused about how that's going to  
7 be positioned.

8 CPT GIRZ: The current concept is to  
9 have a director at the JTF with multiple centers  
10 underneath one of which would be the Joint  
11 Pathology Center. That director will then fall  
12 under the CJTF organizationally. Admiral  
13 Mateczun's concern is that he wants clinical areas  
14 to function with clinical areas, that they have  
15 appropriate oversight. This is a concern for all  
16 of the centers in the area because he has tactical  
17 control and will have operational control of the  
18 Walter Reed National Military Medical Center, and  
19 patient care that is being done in his joint area  
20 of operation he has responsibility for and so  
21 those areas where the competency exists is where  
22 he wants things to fall so that the proper

1 oversight is occurring. We haven't worked out all  
2 of the dotted lines. As I said, it's in a draft,  
3 it's in discussion, and the other piece that we  
4 think about is the Walter Reed National Military  
5 Medical Center is going to be unlike any other  
6 military treatment facility and so trying to work  
7 out some of these subtleties of where these  
8 centers and institutes will interface is part of  
9 our ongoing challenge. It's an attempt to address  
10 the issues of where it falls and how it's  
11 perceived, but still maintaining the clinical  
12 competency piece is paramount.

13 DR. WILENSKY: How many other centers  
14 are likely to be included along with the Pathology  
15 Center?

16 CPT GIRZ: The proposal we have is as I  
17 said is a proposal. It's a draft. Three other  
18 major centers. And then there are a whole host of  
19 clinical centers that somehow need to be tied in  
20 that function a little bit differently currently  
21 at Walter Reed and as they merge to the Walter  
22 Reed National Military Medical Center we need to

1 figure out how those are going to function as  
2 well. So it ends up if you include those it's  
3 about 10.

4 DR. WILENSKY: Do you have another  
5 question?

6 DR. PARISI: I just had one more comment  
7 about the separation of the two campuses and the  
8 manpower issues. I've been in practice for 30  
9 years and I'll tell you on a daily basis that  
10 interaction with laboratories is very important.  
11 So in spite of a very robust courier system, I  
12 question how well that's going to work. The other  
13 issue has to do with the manpower thing and it has  
14 to do with case complexity. If we're talking  
15 about very basic pathology services, I think your  
16 standards probably apply. However, if you're  
17 talking about cases that are complicated that are  
18 probably secondary or tertiary type cases, I think  
19 that you might want to reconsider your manpower  
20 numbers because the case complexity requires  
21 considerably more manpower, more laboratory tests  
22 and I think you might find that the numbers you

1 propose are probably inadequate.

2 DR. WILENSKY: Dr. Oxman?

Formatted: Dutch (Netherlands)

3 DR. OXMAN: One of the points that was  
4 made I think that the subcommittee agreed upon was  
5 that this needs to be a high-visibility,  
6 world-class operation including its clinical  
7 aspects. You keep using the term embedding those  
8 clinical aspects in the pathology department of  
9 the new medical center. I think that's a  
10 contradiction and I think that that's an important  
11 contradiction that we ought to recognize. I think  
12 that if you embed those activities in the  
13 department of pathology of the new medical center  
14 you will submerge them and they will not be  
15 autonomous, independent and world class and  
16 integrated with the other activities of the Joint  
17 Pathology Center. So I think you need to consider  
18 that very carefully. That's quite a  
19 nonconcurrence with the recommendations of the  
20 subcommittee.

21 DR. WILENSKY: Yes, Wayne?

22 DR. LEDNAR: As the JPC is beginning to

1 move into its future, and I appreciate how DOD is  
2 trying to look at all the institutes and centers  
3 in a kind of harmonized way, I don't know how  
4 similar or different the JPC's mission from  
5 Congress is to the other centers, but with its  
6 expectation to be world class, with its  
7 expectation to be a federal facility in DOD  
8 supporting other aspects of the federal  
9 government, it would be very important to get that  
10 input from those other federal stakeholders about  
11 how they might be served by the JPC. That will  
12 then drive some of the staffing issues, some of  
13 the mission requirements, some of the  
14 capabilities. And as you look for a group of  
15 external advisers, it'll be important that they  
16 are not just experienced clinical pathologists,  
17 but they really have an expertise relevant to  
18 being a world-class center of excellence and  
19 that's different than just being an experienced  
20 tertiary care center pathologist. So it's going  
21 to be an important, thoughtful exercise about the  
22 kind of perspectives that will be important and

1 then how the director the center will be  
2 rationalizing the input given the requirements of  
3 DOD.

4 DR. WALKER: I think there are two key  
5 factors that are going to make this thing a  
6 success or a failure and one is the quality of  
7 leadership that you get, and the second is really  
8 going to be the resources they'll put into it.  
9 You need a subspecialty pathology organization, so  
10 it's not just a generalist who can sit down and  
11 decide on everything but that someone that  
12 everyone will look up to that's capable of giving  
13 the best answer in the whole country. It needs  
14 visionary resource leadership, and I would say  
15 frankly my opinion is that is something that's  
16 been lacking at the AFIP. They did not utilize  
17 the repository to the level that it could have  
18 been and it's a real opportunity to improve  
19 things.

20 The third thing is military relevance  
21 and clearly that's something that they've tried to  
22 keep in balance at the AFIP by having a military

1 director there but the military director was not  
2 usually someone who was academic enough or  
3 scholarly enough to really do the job of  
4 everything else at the level of leadership that  
5 was required. Indeed, for whatever reason, I  
6 think that the military relevance of it probably  
7 was one of its downfalls, that it didn't somehow  
8 maintain that customer base as its strong support.  
9 So accomplishing all those things must be done in  
10 the new organization and I think that identifying  
11 the right leader and giving them the resources are  
12 going to be what will make it happen or not.

13 DR. WILENSKY: Commander Feeks, did you  
14 have a comment?

15 CMDR FEEKS: Yes, Madam President.  
16 First, there will be times when the slides  
17 presented are a more recent version than we have  
18 in our binders. Just for your information, the  
19 most recent version of the slides will be posted  
20 to the website and available to you that way.  
21 Second, Captain Girz, later you made reference to  
22 a body known as the SMMAC, and for the benefit of

1 those not familiar with it, can you tell us what  
2 the SMMAC is?

3 CPT GIRZ: I'm sorry. It's the Senior  
4 Military Medical Advisory Council.

5 CMDR FEEKS: Who composes that council?

6 CPT GIRZ: I'm sorry?

7 CMDR FEEKS: Who composes that council,  
8 please?

9 CPT GIRZ: The Surgeons General are  
10 represented.

11 DR. POLAND: Can I help?

12 CPT GIRZ: Someone help me.

13 DR. POLAND: The SMMAC is comprised of  
14 the Assistant Secretary of Health Affairs, Dr.  
15 Cassells, the Surgeons General, the Deputy  
16 Assistant Secretaries, the Principal Deputy  
17 Assistant Secretary, and it's an advisory council  
18 for Dr. Cassells to help make decisions about the  
19 MHS in general. It meets almost every Wednesday.  
20 So items are refreshed and renewed and they're  
21 current. The surgeons can bring topics to that.  
22 The assistant secretary or the DASDs could bring

1 topics to that. So this is the forum where the  
2 Surgeons General actually get to speak and really  
3 vote their stock on the issues in the MHS.

4 CPT GIRZ: Thank you.

5 DR. WILENSKY: Thank you from me too.  
6 Any other questions or comments?

7 MR. UNTERMEYER: You mentioned one of  
8 the areas of nonconcurrence was the question of  
9 governance. Some felt that it should be a  
10 governing board, others an advisory board. What  
11 are the arguments on both sides of that and who  
12 will decide it?

13 CPT GIRZ: I think the argument is the  
14 perception that a governing board has more  
15 authority, that it would have authority over the  
16 CJTF where this is falling and so the term  
17 governing was taken out and advisory was put in.  
18 And to your question, the proposal will go to the  
19 SMMAC and they will have discussion about that as  
20 well.

21 MR. UNTERMEYER: Is this a  
22 jurisdictional issue? Is that why people wanted

1 an advisory board rather than a governing board?

2 CPT GIRZ: Yes, I believe so. Perhaps  
3 maybe semantics, but the impression would be that  
4 it had more power.

5 DR. WILENSKY: Any other comments or  
6 questions? Thank you very much. We are now  
7 scheduled to take a break. We will reconvene in  
8 15 minutes.

9 (Recess)

10 DR. WILENSKY: Our fourth speaker is Dr.  
11 Gregory Poland. Dr. Poland will provide an update  
12 on the report of the Defense Health Board's Task  
13 Force Review of the Department of Defense  
14 Biodefense Infrastructure and Research Portfolio.  
15 Tasked to provide an external review of the  
16 department Biodefense Research Infrastructure  
17 Portfolio, this group answered a series of  
18 questions related to DOD's scientific and  
19 strategic investments, its processes and  
20 procedures related to product development and  
21 licensure, and evaluated the scientific or  
22 strategic return on investment for previous and

1 current research, development, training and  
2 education efforts. The Core Board has been sent a  
3 draft report on the 18th of February for their  
4 review and in preparation for discussion and vote.  
5 You may also find a copy of the draft report in  
6 the meeting notebooks. Dr. Poland's presentation  
7 slides may be found under Tab 3 of the binders.  
8 Dr. Poland?

9 DR. POLAND: Thank you. As Commander  
10 Feeks was saying earlier, what you'll see are  
11 slightly updated slides.

12 Just a bit of background. The  
13 Department of the Army, Office of the Surgeon  
14 General actually asked this question of the DHB  
15 and I've sort of given them one word headlines,  
16 that is, need translation and return on  
17 investment. So under need the question was was  
18 there a national or strategic need for the MSD to  
19 own and operate an infrastructure in support of  
20 mission requirements for defense capabilities  
21 abroad and homeland for biodefense. For  
22 translation, were the current processes effective

1 in transferring the results of primarily basic  
2 biologic research to advance product development  
3 and licensure. And lastly, did the current  
4 infrastructure provide scientific or strategic  
5 return on investment for previous and current  
6 research, development, training and education  
7 efforts. There were also questions about surety  
8 but those are being investigated and answered  
9 separately by the DSB rather than us.

10 We received that memo October 3 and  
11 asked for a report by December so we had a very  
12 limited timeline at a busy time of year within  
13 which to do it. So our subcommittee made the  
14 decision that this would be a high- level review  
15 with interim findings and recommendations which  
16 you've seen in the past and will vote on today.  
17 We would focus the initial review on biologics and  
18 not for example on personal protective equipment  
19 or drugs or the other aspects of biodefense.  
20 Again because of the timeline and the nature of  
21 the individuals involved, we could only look at  
22 the unclassified programs and thought all the

1 other follow-on issues that I've excluded would be  
2 topics for a separate entity. I'm reporting on  
3 behalf of a work group that included myself, Wayne  
4 Lednar, Dr. Breidenbach, John Herbold, John  
5 Clements, Frank Ennis and Joe Silva, some of whom  
6 are here today. Just to point out one thing which  
7 Dr. Clements hasn't really told the subcommittee  
8 but I think important in terms of his value to  
9 this part, and that is he's a certified U.N.  
10 weapons of mass destruction inspector.

11 We had a teleconference October 24 to  
12 review the charge, the plan of work, how we would  
13 approach it. November 7 we had briefings from a  
14 variety of entities that you see listed there on  
15 this topic. On 19 November John and myself went  
16 with a few flag officers and did site visits to  
17 Edgewood, Forest Glen and USAMRID to actually look  
18 at the facilities, see what was happening and be  
19 briefed face to face by the individuals there. On  
20 20 November this report was presented to the DHB  
21 with discussions as part of our virtual meeting.  
22 Then in December, I couldn't remember the exact

1 day, I went to the Pentagon to present to the  
2 Service Secretaries so that they heard directly  
3 from DHB.

4 Taking the first thing, need, we felt  
5 that there was no dispute that the DOD Biodefense  
6 Research Portfolio was unique and that DOD needed  
7 a BD infrastructure. This was for a variety of  
8 reasons that I'll just sort of summarize up there.  
9 One, simply having this provided in part a  
10 deterrent capability. Second was the  
11 responsiveness and turnaround of military labs  
12 which is very agile. As an example, we heard very  
13 clearly how DOD responded and assisted DHHS in the  
14 anthrax letter attacks, so it certainly provided  
15 the nation with a critical surge capacity. There  
16 is some reluctance, not always, but some  
17 reluctance in academia and industry in particular  
18 to engage in research that has a high level of  
19 risk and would result in for example an orphan  
20 vaccine. For example, pharmaceutical manufacturer  
21 X is not going to sell a lot of E. bola vaccine  
22 probably so why should they engage in the risk of

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1 developing it? This is sort of the buy versus  
2 make concept.

3           There is a surprisingly high demand for  
4 BSL-4 containment laboratories especially driven  
5 by the FDA animal rule for, for example,  
6 biodefense type vaccines which requires two animal  
7 models, so these animal ethical studies can only  
8 be done in those sorts of facilities and again  
9 that provides a unique capability to the  
10 government. They have unique aerosol and  
11 aero-medical isolation capabilities, a unique  
12 critical agent and culture archive asset and a  
13 capacity to receive unknown pathogens which very  
14 few if any other entities are willing to take.

15           Under translation we felt that the basic  
16 science research was sound but there were barriers  
17 toward advanced product development and licensure.  
18 Some of those included a fragmented organizational  
19 structure that strayed from an industry  
20 best-practices model, lack of one-person  
21 accountability and senior leadership that had  
22 experience and credibility in vaccine development.

1 There were a number of complex management and  
2 oversight issues by DTRA. A lot of intellectual  
3 capital due to difficulties in transitioning  
4 junior-level military personnel to higher- level  
5 leadership positions. And then retaining their  
6 qualified scientists primarily because a lot of  
7 money has been made available through BARDA  
8 and other mechanisms for academia to now engage in  
9 some of this work. Difficulties with separate  
10 lines of funding from different entities that were  
11 not multi-year and hence not amenable to project  
12 sustainability. A set of processes that we sort  
13 of encapsulated as being relatively more concerned  
14 with inputs rather than outputs. So we would  
15 frequently hear briefs of this is how many people  
16 we have, this is how many square feet we have,  
17 this is how many monkeys we have, rather than you  
18 would think that the sole focus would be this is  
19 how many new products, this is how many patents,  
20 so that sort of idea. Then a very complex and  
21 unwieldy table of organization with multiple and  
22 separate lines of authority. As we would be

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1 definitely were objective makers of considerable  
2 ROI, but more needed to be done. As we talked  
3 with each facility, it was obvious that there were  
4 not clear or transcendent metrics. There was not  
5 tacking of results over time. Some of them  
6 actually couldn't tell us the outputs in any  
7 simple summary form. We sensed the inability to  
8 kill nonproductive programs. I can go into some  
9 detail about that if necessary. No systematic  
10 evaluation metrics, processes or procedures to  
11 evaluate the programs and decide should a program  
12 continue to be funded. We were made aware of some  
13 programs that had been funded two and more decades  
14 in which no substantial advance had been made.  
15 Then as I said with this new directive, the  
16 people, processes, expectations and progress has  
17 sort of been further muddied.

18           Some other issues was lack of  
19 communication between the responsible entities and  
20 a strong feeling that this should be a joint  
21 program. To answer part of that concern was that  
22 the Integrated National Portfolio had really just

1 gotten feet over the year or two prior to this and  
2 we thought that was a good start as was TMTI which  
3 we thought was sort of a novel experiment, and  
4 again it's only a couple of years old and the  
5 results of that need to be watched and evaluated.  
6 We were also concerned that the extent of external  
7 scientific review and input was unclear but from  
8 what we could see inadequate.

9           The bottom line for us was the DOD  
10 Biodefense Enterprise involves thousands of  
11 people, hundreds of millions of dollars per year,  
12 and the clear expectation should be of a tightly  
13 focused, highly productive world- class program  
14 with clear priorities, timelines and  
15 accountabilities and an obvious and timely return  
16 on investment to the war fighter and to the  
17 nation.

18           So our recommendations were as follows,  
19 that productive biodefense research required  
20 centralization and joint programmatic planning,  
21 the development of clear evaluation metrics,  
22 sustained and identifiable leader accountability,

1 timelines with multi-year funding. Science  
2 doesn't progress with being funded for a year and  
3 then having a gap and then coming back to it when  
4 somebody thinks it's a priority again.  
5 Collaboration or jointness, clear priorities and  
6 biosurety. In particular, John and I reviewed  
7 some of these facilities and felt that a red team  
8 ought to be authorized to define and exploit  
9 vulnerabilities. Just as one example, I think it  
10 was the day that we were out at Edgewood, several  
11 of the contracted lawn mowers had come through the  
12 gate and not been stopped and it wasn't until they  
13 were inside the wire so to speak for some time  
14 that somebody realized nobody had inspected this  
15 truck and the people who came in with it. On  
16 their side they of course think that we've got a  
17 great program. We've got video cameras and  
18 security and fences and things like that, but you  
19 don't actually know what your vulnerabilities are  
20 until a red team tries to go in there Christmas  
21 Eve in the middle of a snow storm when the guy who  
22 was supposed to be on duty is sick and he managed

1 to talk one of his buddies who's never actually  
2 been oriented into what to do to stand duty for  
3 him.

4 DOD biodefense infrastructure needed to  
5 be retained but, again as I said, program planning  
6 and priorities need to be improved. We think TMTI  
7 might be a worthwhile model for them to watch.  
8 Systematic progress and return on investment  
9 metrics needed to be established. In particular,  
10 if you're going to fail with a program, fail  
11 quickly and kill a program if it's nonproductive.  
12 Part of that would be to expand external  
13 scientific input and programmatic review and  
14 consider industry best-practices models and  
15 benchmarks for development of products.

16 We felt it was critical that there be  
17 credible, identifiable leaders with authority and  
18 accountability in each of these units, that there  
19 be mechanisms to train future DOD biodefense  
20 scientific leadership, realistic timelines and,  
21 again, the collaboration involving not only other  
22 federal agencies, but also industry and academia,

1 and those efforts are in place but they need to be  
2 further incentivized and accelerated.

3 Further attempts to create a national  
4 integrated biodefense campus are needed and we  
5 think would have the effect of increasing  
6 accountability, enhancing stronger leadership and  
7 reducing costs and redundancies, and I mentioned  
8 the red team already. We also as I mentioned  
9 heard about the recent initiative to integrate the  
10 BD portfolio with DHHS which is called the  
11 Integrated National Portfolio. I put a couple of  
12 the committees and governance structures up there.  
13 That we think is a clear step forward, but some  
14 more thought needs to be given to being very  
15 explicit about the agenda of those two major  
16 agencies. The agenda for DOD is to prevent  
17 morbidity and mortality due to bioterrorism. The  
18 intent for DHHS is once it happens how do we grade  
19 it. Again, that focus is very different in how  
20 you would resource and carry out a program, even  
21 how you would evaluate it.

22 Finally, I do want to say because this

1 sounds like a critical report that our observation  
2 was of very highly dedicated and hard-working  
3 scientists and administrators who were determined  
4 to make a difference but they were failed in our  
5 view by a system that was slow, tolerated  
6 complexity, lack of clear priorities, inadequate  
7 accountability, redundancy, lack of funding and  
8 lack of experienced leadership. So I will end  
9 there and take questions.

10 DR. WILENSKY: Any questions?

11 DR. KAPLAN: Greg, having briefed the  
12 Surgeons General of the services, what's your  
13 feeling as to what will happen to this rather  
14 complete and constructive criticism of the present  
15 situation?

16 DR. POLAND: I can summarize the service  
17 secretaries' response to this brief in one word,  
18 amen. They felt very strongly that we had hit it  
19 right and agreed with our findings and I thought  
20 took is seriously. I subsequently received a  
21 letter from one of them thanking us for the  
22 quality of the work that we had done and the

1 critical nature that we brought to evaluating  
2 this. So I think they'll take it seriously.

3 DR. KAPLAN: And the next step is?

4 DR. POLAND: Up to them.

5 DR. WALKER: I agree with everything you  
6 said and support it, Greg. This is something I've  
7 been observing for decades and I think that this  
8 is a good way to address it. I'm also on the  
9 National Academy of Science Standing Committee for  
10 Biodefense that's sponsored by the Department of  
11 Defense. Its role is to help TMTI to accomplish  
12 its mission, to give them advice about ways to  
13 move these products and they're identifying and  
14 working on. Something I have been disturbed with  
15 by that process is the setting of priorities of  
16 what they're going to work on. We came in after  
17 they had done that. They identified viral  
18 hemorrhagic fevers which I will concur with, but  
19 then they chose -- to put all the agents into and  
20 I don't know why they didn't work on adenoviruses,  
21 hantaviruses and other -- and some things that I  
22 think really might be more important.

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1           Similarly, I notice in your report you  
2 refer to the choice of agents as inter se or  
3 meaning between cells, they had said intra se  
4 which means inside cells, but they did not do  
5 that. They chose bacteria that were mostly  
6 extracellular bacteria and didn't have any of the  
7 -- a true gap that needed to be addressed.

8           DR. POLAND: That's a fair point, David,  
9 and I think that in part it relates to the foci of  
10 content expertise that is residual there and those  
11 gaps I think are in part related to the lack of  
12 funding to bring in content experts in those new  
13 areas. Genetically engineered organisms is  
14 another clear priority that I think they're  
15 struggling with in terms of staffing. That's a  
16 tall order to say we need an FDA-licensed product.

17           DR. WALKER: I made a long comment.  
18 Actually I have a question. The question is how  
19 are they going to deal with setting priorities and  
20 identifying what their goals are going to be?

21           DR. POLAND: It's a good question and  
22 I'm not prepared to answer that, but I think as I

1 mentioned on my slides, I think it's the topic of  
2 our subsequent evaluation where we get some depth  
3 on that. In part, some of those programs are not  
4 unclassified so we didn't deal with them.

5 DR. WILENSKY: Wayne?

6 DR. LEDNAR: Greg, it was encouraging to  
7 hear in December the service secretaries  
8 appreciated this perspective. We're in a time of  
9 administration transition. Is there something  
10 that you've seen that's in place to create some  
11 continued traction moving forward with these  
12 report and the service secretaries' interest in  
13 December that there will be steps taken consistent  
14 with the direction of this --

15 DR. POLAND: There may be somebody here  
16 who can comment on that. I don't have any  
17 explicit information on that to know. Does  
18 anybody have any other information? I do want to  
19 ask both Wayne and John for any additional  
20 comments and say we're both members of the  
21 subcommittee.

22 DR. WILENSKY: Russell also had a

1 question to ask.

2 MR. LUEPKER: Wayne very effectively  
3 asked my question. You've described a dysfunction  
4 system in a critical area. You got a letter of  
5 thanks.

6 DR. POLAND: I don't want to  
7 characterize it as dysfunctional. I think what I  
8 would characterize it as is less than optimal  
9 because if you look at their prior directive, get  
10 it to the IND stage, I can show you the outputs  
11 and I would say they could reasonably declare  
12 success. But this transition to a very different  
13 mission is where I think they're going to need a  
14 lot of thought and a lot of outside advice because  
15 that's not what they've done in the past.

16 DR. WILENSKY: Greg, I actually wanted  
17 to pursue this point. I read through the  
18 executive summary that you had provided and I was  
19 surprised when I got to the end and you used the  
20 comments that you had on the final slide about a  
21 failed system that slow, tolerates complexity,  
22 lack of clear priorities, inadequate

1     accountability, redundancy and lack of experienced  
2     leadership. That seemed to me a very harsh  
3     statement relative to the other information that  
4     is in here. So I think that there needs to be  
5     somewhat of a recasting, and I'm not going to tell  
6     you which way to recast it, but that is a very  
7     harsh statement. If you want to make that harsh  
8     statement then I think you need to have a  
9     different lead-up than what you have in this  
10    written report that makes it not a surprise that's  
11    your final statement.

12             I actually from what you had presented  
13    and what I had heard at the presentation took away  
14    what you've just said at the end which is there  
15    are a number of successes that have happened at  
16    the research stage, there has been a distinct  
17    change in mission, but there hasn't been a follow-  
18    on support structure and/or maybe resource, but at  
19    least support structure and leadership change to  
20    reflect the newly articulated mission and that is  
21    a situation that can succeed. That's a very  
22    different flavor than the paragraph I just read

1 and it didn't sound like what you actually had  
2 meant at least in the written form.

3 DR. POLAND: Maybe it doesn't come  
4 across in the written form. I think it did when  
5 we presented it. That same slide was shown to the  
6 service secretaries and they agreed with it.

7 DR. WILENSKY: Again I'm not telling you  
8 that it's the wrong conclusion. I'm telling you  
9 it's a surprising conclusion given the written  
10 material that you've provided us which of course  
11 is what anyone else will see.

12 DR. POLAND: We maybe need to clarify  
13 which piece of it we're talking about.

14 DR. WILENSKY: General Myers?

15 GEN MYERS: I guess my concern is I  
16 suppose this kind of report could have been  
17 written anytime in the last two decades probably.  
18 You pick any year and you could write something  
19 like this on this issue. But I don't think it's  
20 ever been more important than it is today given  
21 our security environment. So I'm a little worried  
22 about the question that Wayne asked. So we

1 briefed the secretaries back in December. We need  
2 to brief the new group when the new group becomes  
3 the new group because we have so many actings and  
4 interims that I think this of sufficient importance?  
5 that we just do that.

6 DR. POLAND: That's actually a great  
7 suggestion.

8 GEN MYERS: I would think that would be  
9 a pretty easy thing to do, because the whole issue  
10 of priority and resources given the DOD policy  
11 change, my guess is you could ask a new secretary  
12 of any service that it's going to help or chief of  
13 service that it's going to help determine where  
14 the resources go and they probably aren't even  
15 aware of the policy change. It's a huge thing.

16 DR. POLAND: I think that's a great  
17 suggestion. It's easy for a report to get  
18 generated and put in a file and the incoming never  
19 knows about it.

20 DR. WILENSKY: That's actually one of  
21 the issues we'll discuss a little bit after lunch  
22 in terms of as we transition forward not

1 specifically with relation to this report, but in  
2 general how we try to help make that happen.

3 GEN MYERS: Just one more comment. Just  
4 talking to Chase, has anybody on Capitol Hill  
5 showed interest in this and is there any reason we  
6 can't brief interested parties?

7 DR. POLAND: I know of no reason we  
8 couldn't. I've not had any direct inquiries.  
9 Commander Feeks, I don't know if any have come to  
10 your office at all.

11 CMDR FEEKS: No.

12 DR. POLAND: I suspect that the issue of  
13 the transition has subsumed everybody's time and  
14 attention and it would be nice if we had some  
15 mechanism during those transitions to make these  
16 things more visible that occurred right in that  
17 time period. And we do have the option of course  
18 because we did say that we needed to do further  
19 evaluations. We had a matter of weeks to try to  
20 digest the enormity of the BD effort.

21 DR. WILENSKY: Adil?

22 DR. SHAMOO: Greg, you and I talked

1 about this a little while you were the President  
2 of the Board and I think John may have been also  
3 in one of the teleconferences. Anything  
4 biodefense is also bio attack and there is a huge  
5 enormous moral component to this.

6 DR. POLAND: Do you mean, Adil, in terms  
7 of offensive research?

8 DR. SHAMOO: That's correct. Anything  
9 that's for defensive can be used on offensive so  
10 there is a moral component to what kind of  
11 research, what kind of defense, et cetera. I'm  
12 saying it's devoid of that kind of discussion and  
13 I remember you and I talked about it at length,  
14 and there should be some involvement in it.

15 DR. POLAND: Part of that may be the  
16 common mistake that people who focus their  
17 professional time in an area think that already  
18 knows certain background material. To just  
19 briefly state that, since I think it was 1972 when  
20 President Nixon signed into law that the United  
21 States would not engage in any offensive biologic  
22 research, only defensive, such that even the sort

1 of if you will weapons- grade type organisms are  
2 by law in tiny quantities that merely allow for  
3 example diagnostic testing and other things like  
4 that. So there is no biologic research of an  
5 offensive nature as opposed to defensive,  
6 diagnostic, drugs and biologics.

7 DR. WILENSKY: John?

8 DR. CLEMENTS: At the outset this was by  
9 its definition an abbreviated look at a very  
10 complex problem because of the very short  
11 timeline. I had hoped that once this got to the  
12 service secretaries that would say now we would  
13 like you to go back and do a more thorough and in-  
14 depth analysis and actually take some time to look  
15 at this. So I guess that's my question of whether  
16 or not we actually might have a possibility to  
17 really get down into some of the substantive  
18 questions because the best we could respond to was  
19 the abbreviated reports that we received from the  
20 service laboratories but there really was not a  
21 chance to go in and actually look at that and try  
22 and make some sense out of all of that. So I

1     guess I have a question with a question and that  
2     is do you think we might have an opportunity to  
3     get back in and actually follow-up on this?

4             DR. POLAND: General Schoomaker asked  
5     the original question and he is still in place.  
6     Correct?

7             DR. WILENSKY: Yes.

8             DR. POLAND: So that may be the best way  
9     for us to reraise this issue.

10            DR. WILENSKY: Again this whole notion  
11     of what we do after we have reported out is  
12     something we'll be discussing further, but he is  
13     in place and I think will be for some time and  
14     part of it is whether he will express further  
15     interest in our looking at this issue or whether  
16     we have resolved what he wanted from us and how if  
17     at all that affects our next steps.

18            DR. OXMAN: Greg, you made the point of  
19     the tremendous difference between when the mission  
20     changed to have an FDA-approved product as opposed  
21     to an IND-ready product. I understand  
22     superficially why that's beneficial. On the other

1 hand, I think it makes it an almost impossible  
2 task given the diversity of the threats and  
3 potential threats. I wonder if you visited that  
4 at all and if there's any opportunity to revisit  
5 that decision because I don't think it's really  
6 possible to have FDA-approvable products in the  
7 tremendous spectrum of threats.

8 DR. POLAND: I don't disagree with you  
9 at all, Mike, and I think that is among the  
10 follow-on sorts of things we would want to get  
11 into, but clearly at a decade plus and a billion  
12 dollars, the department will have to decide what  
13 are the priorities. You can't have 30 priorities.

14 RADM KHAN: That was excellent. Thank  
15 you very much. It actually dovetails very nicely  
16 with the presentation on USAMRID that you gave at  
17 the last Board meeting in December I believe which  
18 had some of the same themes when you look at the  
19 recommendations. I have a comment and a proposal  
20 to the Board. The comment was, and apologies  
21 because I have not had an opportunity to read the  
22 full report, but the back end of your presentation

1 spent a lot of time on this product development  
2 stuff and I hope that wasn't to the exclusion of  
3 the unique role DOD has in I think you mentioned  
4 it briefly capture and discovery, surveillance,  
5 basic research. There's a lot of activities that  
6 they conduct that are critical. There is really  
7 no other place.

8 DR. POLAND: And state-of-the-art.

9 RADM KHAN: And state-of-the-art that  
10 really need to be done. I agree with the comment  
11 about products and the FDA. We have another I  
12 believe half a dozen BS-4 laboratories online or  
13 about to come online so there's lots of others  
14 ways potentially in collaboration with industry  
15 and academia to get to that product that doesn't  
16 require DOD to do it all itself, but just a better  
17 fusion from beginning to end.

18 DR. POLAND: And that's one of our  
19 recommendations, that that matrix sort of  
20 integration be incentivized and accelerated.

21 RADM KHAN: The proposal is back to the  
22 Board and to the Chairperson of the Board, the

1 proposal that actually this Board could as the  
2 external advisory committee and if there's an  
3 effort underway to take all these various  
4 components and structure them into a single unit  
5 or some unified command, this Board could serve as  
6 an external advisory committee and actually do  
7 what's really needed with the sort of critical gap  
8 analysis what is not occurring outside in the  
9 private sector that really needs to be done within  
10 DOD.

11 DR. POLAND: There is some external  
12 input that is obtained. I can't describe it with  
13 a great deal of precision, but after the point of  
14 requirements, DTRA and other agencies that  
15 actually provide funding to the different  
16 services, there is an attempt to bring, but we  
17 don't know details, outside scientists in to look  
18 at those and help make funding decisions.  
19 Lieutenant Colonel Silver, do you have more  
20 information on that?

21 LT COL SILVER: Just a little bit. I  
22 worked peripherally with the Armed Services

1 Biomedical Research Evaluation and Management  
2 Board, that is, money and evaluation of how  
3 programs are doing for the medical piece and then  
4 there's another Board for the AT&L, acquisition,  
5 that's the NBC kind of stuff. My understanding is  
6 they're combining and it may be even this week  
7 that they're meeting. So some of that stuff that  
8 you're talking about I think is underway. I just  
9 don't have enough other than what I just said,  
10 that they are --

11 DR. POLAND: Changing landscape.

12 LT COL SILVER: Yes, sir.

13 DR. POLAND: What I've heard so far is  
14 we could clarify a little better in our report  
15 what we mean by that last paragraph in relation to  
16 the change in mission.

17 DR. WILENSKY: Yes.

18 DR. DEDRE: This is an excellent report  
19 but I was wondering whether the structure proposed  
20 is the structure that would really promote  
21 efficiency because the number and the diversity of  
22 the problems involved in biodefense is such that

1 it calls for input by a large number of basic  
2 scientists coming from different disciplines.  
3 Perhaps what would better is to create a  
4 collaborative relationship between boards, the  
5 Department of Defense, university laboratories as  
6 well as industry. I don't think the DOD is the  
7 place to manufacture vaccines for instance because  
8 it has no experience in that area. Moreover, as I  
9 said, because of the diversity of basic science is  
10 needed to solve these very complex problems  
11 urgently, perhaps a different structure ought to  
12 be considered and do it like a Manhattan Project  
13 because delaying this further is highly dangerous  
14 for the security of this country.

15 DR. WILENSKY: Mark?

16 DR. MILLER: I'd like to follow-up on  
17 what Mike was asking before with the change of  
18 mission from going more of a translational model  
19 as well. I didn't hear very much talk about the  
20 budget and uniformity and FTEs and other  
21 structures over time. Has it been relatively  
22 uniform and sustained? And how has it changed

1 with the changing mission? The second comment I'd  
2 like to make is related to the previous comment,  
3 that there are wonderful public- private  
4 partnerships already. The NIH has worked very  
5 well with the BET mechanism, with CRADAS and  
6 working with universities and federal scientists,  
7 as well with the DOD to a certain extent although  
8 I think it could be a lot better.

9 DR. POLAND: I didn't get into details  
10 of that, but for example I think in the last year  
11 TMTI had established I think it was 45 CRADAs. So  
12 I mean we came in for a few weeks to look at a  
13 situation that already has changed and is changing  
14 as we're looking at it so I can't give you details  
15 because I don't know about FTEs and budgets and  
16 things like that, but it is a topic worthy of that  
17 level of depth and I'm going to be speaking later  
18 today about the concept of a summer study. This  
19 would be the kind of topic that would be amenable  
20 to it just because of the size and nature of what  
21 it is we're trying to advise on.

22 DR. LUDWIG: George Ludwig from the

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1 Medical Research and Material Command. I'm  
2 representing General Wakeman today and we are of  
3 course the largest DOD executor, the Chem-Bio  
4 Defense Program. Just a couple of comments. I  
5 would state that the Army and the military in  
6 general has a great deal of experience in bringing  
7 vaccines and medical products to FDA licensure.  
8 In fact, 30 percent of the standard vaccinations  
9 that we receive through our normal immunization  
10 process had their beginnings or at least component  
11 of their development in the DOD systems. We don't  
12 do it by ourselves.

13 DR. POLAND: That's the key.

14 DR. LUDWIG: We do it collaboration with  
15 a large number of other organizations including  
16 academia and industry. Of course, those  
17 relationships that we build over the years are  
18 exceedingly important to making sure that we do  
19 bring those products to market. In fact, the  
20 Medical Research and Material Command has over  
21 1,300 CRADAs right now, far outnumbering all the  
22 other Army cooperative research and development

1 agreements. USAMRID by itself has 700 cooperative  
2 research and development agreements. So it's the  
3 interaction of the Army and Navy laboratories with  
4 academic and industry partners which is critical  
5 for getting these products to market.

6 In addition just to relay the complexity  
7 of the issues which obviously is very difficult to  
8 go into a 3- month study, we have to remember as  
9 well that the whole entire management structure  
10 for the Chem-Bio Defense Program has changed  
11 dramatically in the last decade. In 1998, the  
12 advanced development components were separated off  
13 from the command resulting in the development of  
14 the Joint Program Executive Office for Chem-Bio  
15 Defense which is responsible for the advanced  
16 development components of the Chem-Bio Defense  
17 Program. Then in 2003 the management for the S&T  
18 components of the Chem-Bio Defense Program moved  
19 over into DTRA. So we're still in the midst of  
20 essentially a learning curve here on how to  
21 develop the program and I think that's why it's  
22 critical that input from the Defense Health Board

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1 go into the maturing of that program to making  
2 sure that we do develop it in the best possible  
3 light, but we are really still in the midst of a  
4 growing change that goes beyond just the issue of  
5 moving from IND products to FDA-licensed products.  
6 Thank you.

7 DR. WILENSKY: David?

8 DR. WALKER: I'd like to follow-up on  
9 the remarks by John Clements, and that is I  
10 suggest that we recommend that the Defense Health  
11 Board look into this in more depth.

12 DR. POLAND: Actually, we took it for  
13 granted, I don't know that we actually listed it  
14 though, and if not we should add that.

15 DR. WILENSKY: That would be a good way  
16 to suggest that we have had our initial say but we  
17 think there is more we would like to and should  
18 say on this issue.

19 DR. POLAND: We need to explicitly put  
20 that in there.

21 DR. HALPERIN: Greg, maybe this should  
22 under kind of editorial comments. There's a large

1 focus on military, academic and industry yet we've  
2 talked about the various roles of the military in  
3 surveillance and recognition of problems, et  
4 cetera, but we only talk about the U.S. Military,  
5 academic and industry, and there is this other  
6 DHHS component out there. What worries me just a  
7 little bit is for example on your future slide.  
8 It's the second to the last. I know you're trying  
9 to summarize, but the two last lines are a bit of  
10 oversimplification.

11 DR. POLAND: Yes.

12 DR. HALPERIN: DHHS to treat, but we  
13 know it's much, much more than that. This would  
14 be okay if it were just verbiage, but then there  
15 are issues like a consolidated campus. So what I  
16 feel sitting from where I am is essentially the  
17 bioterrorism people are different than the food  
18 borne outbreak people but there really is a  
19 continuum in there and there's a little sense that  
20 I feel that we're getting that lost in the report  
21 and in the presentation.

22 DR. POLAND: I understand you. For

1       example, there would be no direct connections in  
2       the example you gave of bioterrorism and food  
3       borne.

4                 DR. HALPERIN: That would be my worry.

5                 DR. POLAND: I'm not aware of any direct  
6       connection that way. It doesn't mean that there's  
7       not interest in both.

8                 DR. HALPERIN: Or that it actually does  
9       exist out there and we talked about the three  
10       entities, there are really four entities which is  
11       civilian public health in general which is DHHS,  
12       states, et cetera, academia and industry. There  
13       are really four components. And when we talk  
14       about a campus we need to think about whether  
15       that's going to be a DOD campus or that ought to  
16       be integrated with DHHS and homeland defense.

17                DR. POLAND: We weren't really  
18       commenting on that. We weren't suggesting that a  
19       campus be developed. That's already been  
20       suggested.

21                DR. HALPERIN: I'm just commenting on  
22       who ought be on the campus, and maybe not just

1 these three entities, but maybe there's this  
2 fourth entity.

3 DR. MASON: From the perspective of  
4 disaster preparedness I would argue that there are  
5 several terms that should be in there as opposed  
6 to just simply three, and at the very least  
7 whether we think about terrorism preparedness and  
8 emergency response which is an all- inclusive term  
9 which we at the CDC uses, I would suggest that we  
10 be very careful with regard to just highlighting  
11 one particular component potentially to the  
12 exclusion and use more inclusive terms that would  
13 give us then the flexibility.

14 DR. WILENSKY: Any further comments?

15 DR. LEDNAR: It's easy in this kind of  
16 discussion to focus on technologies and moving to  
17 licensure and having products to use, but coming  
18 back to Bill's point, I think very importantly in  
19 the threat assessment and the needs in GAP  
20 assessment, what we haven't heard much about but I  
21 think is an important existing relationship to  
22 just reinforce is call it the military medical

1 intelligence globally. It's always been very  
2 helpful to the Defense Health Board to have  
3 liaisons from the U.K., from Canada, from other  
4 partner military agencies because we really want  
5 to have the very best information on the threats  
6 related to our defense that we should have to  
7 protect our forces and some of that may have a  
8 different optics to our military medical specialty  
9 expertise in other countries and that's a critical  
10 input at the very front end of this whole  
11 technology development stream.

12 DR. WILENSKY: Any further comment? Do  
13 you think you have enough instructions and  
14 guidance to go forward?

15 DR. POLAND: I think we need to vote  
16 don't we?

17 DR. WILENSKY: Yes.

18 DR. POLAND: With the sort of amendment  
19 that we talked about.

20 DR. WILENSKY: Ed?

21 DR. WALKER: I'm sorry. What are we  
22 voting on?

1 DR. POLAND: Acceptance of the report.  
2 DR. WILENSKY: Right. The acceptance of  
3 the report that's put in your material.  
4 DR. WALKER: Did I understand that there  
5 were a lot of suggestions and issues offered that  
6 might modify a report? So if that's the case, is  
7 it appropriate to put this on the table until we  
8 get a final report to vote on?  
9 DR. POLAND: You could do that or we  
10 could vote with the couple of amendments that have  
11 been suggested.  
12 DR. WALKER: I would prefer to see it.  
13 Not that I don't trust anybody. That's not the  
14 point, although we could raise that question. But  
15 seriously I think it would be more appropriate if  
16 it's going to be changed or modified that we have  
17 a final report to vote on.  
18 DR. POLAND: It's the committee's  
19 pleasure.  
20 DR. WALKER: It seems that's the right  
21 thing to do.  
22 DR. LUEPKER: I think we should vote on

1 it though tentatively with the provision that they  
2 not water it down and sweep it under the rug.

3 DR. WILENSKY: I think there would be  
4 wording changes to reflect the discussion that  
5 we've had here. If it's possible to see the  
6 version that incorporates the comments that we've  
7 made in public here, that would be helpful without  
8 unduly disrupting your schedule.

9 DR. DICKEY: I'd like to second what I  
10 heard just a minute ago though, the wording  
11 changes as well as some language that suggests  
12 that this preliminary look suggests we would as  
13 the Defense Health Board like to take a more  
14 in-depth look.

15 DR. WILENSKY: Definitely that was one  
16 of the recommendations.

17 DR. POLAND: Yes, I got that.

18 DR. WILENSKY: If there is no objection  
19 then we will wait until we see a revised version  
20 and have a vote. Thank you.

21 Our fifth speaker this morning is Dr.  
22 Charles Fogelman who currently serves as Executive

1 Coach and Principal Leadership Development and  
2 Management Consultant at Paladin Coaching  
3 Services. He also provides clinical care one day  
4 per week at an adult outpatient clinic. Dr.  
5 Fogelman will discuss the recent activities of the  
6 subcommittee including a summary of the  
7 subcommittee's last meeting held at the end of  
8 January, topics for future meetings, and the  
9 questions formally tasked to the Psychological  
10 Health External Advisory Subcommittee. His  
11 presentation slides can be found under Tab 4 of  
12 the binders.

13 DR. FOGELMAN: Thank you. In order to  
14 get us back on schedule, I'm actually not going to  
15 talk. Does anybody have objection to that? As it  
16 happens, I'm glad to have reduced time because I  
17 don't have 45 minutes' worth of stuff to say. And  
18 I also want to apologize. I thought the uniform  
19 of the day was full dress Key West.

20 That's us. That's what I'm going to  
21 talk about. And there's another line here is  
22 which is we're still open -- that's us. There are

1 two of us others in the room. Want to raise your  
2 hands so people can attack you as well? I should  
3 say that nearly everybody -- we only had two  
4 meetings so far. One was utterly organizational  
5 and one as you'll was kind of start-up substantive  
6 and nearly everybody attended both meetings.

7 In this meeting we were really ambitious  
8 and we thought we'd get an awful lot done and then  
9 it snowed and people's flights started getting  
10 cancelled and people had to leave early and we  
11 didn't get quite as much done as we wanted to. So  
12 I really hoping that today I would show up and I'd  
13 have one of these great long reports that  
14 everybody can say can we change this word and that  
15 word and then vote on it, but we don't have one so  
16 I'm sorry for that.

17 Most of this represents people who were  
18 actually presented or called in because of the  
19 snow. Not everybody was there. We really had  
20 been trying to educate ourselves in a very broad  
21 way. I talked about that a little bit last time,  
22 but it continues to be true. The landscape that

1 we're trying to understand and about which we will  
2 comment we hope as time goes on is not small and  
3 is populated by not a small number of people of  
4 organizations and is characterized by not a small  
5 amount of overlap and duplication and multiple  
6 interests. But will give you some sense of the  
7 breadth of the things we've been talking about.

8           The next meeting is scheduled just a few  
9 weeks from now. The Defense Centers of Excellence  
10 has its larger physical facility in Silver Spring,  
11 Maryland, so we're going to meet at their offices  
12 because among our responsibilities as a  
13 subcommittee is to, hear are the various words in  
14 the bylaws, extend advice, make recommendations  
15 and provide external oversight to the Defense  
16 Center of Excellence operations. We're not really  
17 sure what any of that means and we're hoping to  
18 figure out more of that, and we're hoping to  
19 establish of course a helpful working relationship  
20 with the DCOE folks because that's what we want to  
21 is be helpful to them. So to that end while we're  
22 there we're going to be talking with some of the

1 directors of the various DCOE units and at least  
2 say hello to all the rest and maybe many of the  
3 other people who work there.

4           At our next meeting because there are so  
5 many overlaps that we have with the TBI  
6 Subcommittee especially because they were asked a  
7 question about ANAM and we were asked questions  
8 as well, we thought it was judicious to  
9 hear what they have learned so far because they  
10 stood up somewhat in advance of us. So we're  
11 going to meet together with them, ask them about  
12 they've learned so far and talk about how we can  
13 work together in the future since there are  
14 clearly overlapping areas.

15           We got very close to responding to the  
16 question on autism but without boring you with the  
17 details, we have to go on and gather some more  
18 information and do a procedural thing or two and  
19 with a little bit of luck at the next meeting we  
20 will actually have something to say about that.

21           This one says, "Establishment of list of  
22 issues to explore." That goes to trying to figure

1 out what we're actually doing. Since it's  
2 something I know about, I'm kind of conducting  
3 this sort of like a strategic planning exercise.  
4 We're brainstorming, we're thinking about the  
5 various things. I am dumping the contents of my  
6 now overstuffed brain because I have met with  
7 several dozen actors and made three or four or  
8 five site visits to places just to educate myself.  
9 But we're going to try to figure out what are the  
10 main things that we should be talking about, what  
11 are the main things about which we can possibly be  
12 giving sensible advice. We have some housekeeping  
13 things. We need to set up a schedule for the next  
14 year or 18 months to try to make sure that nearly  
15 everybody can in fact continue to attend. I  
16 accepted this job for these two meetings that we  
17 had so we have to determine who the continuing  
18 chair will be. And I'm going to tell everybody  
19 all about my journeys and all about the people I  
20 met. I'm reasonably confident that most of you  
21 don't want to know that. And we know for sure  
22 that one of the things we want to discuss is the

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1 concept of resilience and what makes a resilient  
2 warrior. What's a good program to create a  
3 resilient warrior? So as a substantive matter we  
4 really will be getting into that.

5 That's just to remind you. These are  
6 two questions which existed before we did and  
7 we're trying as I said to respond to them and  
8 study them and come up with answers. That's the  
9 general. What have you got to say, Wayne? I see  
10 that your hand is up.

11 Dr. LEDNAR: Thanks for that report.  
12 Obviously the subcommittee is getting its arms  
13 around its changes and trying to get some  
14 structure and coming up a steep learning curve.

15 DR. FOGELMAN: Steep isn't the half of  
16 it.

17 Dr. LEDNAR: Straight up. The thought  
18 I'm having is perhaps a logical one. As we try to  
19 come around this area of psychological health is  
20 to avoid going narrow but deep in sort of a  
21 subspecialty area around psychology and mental  
22 health, behavioral health, things like testing

1 technologies and these kinds of things, but  
2 remember the connectedness that's important and  
3 that's the psychological health with the physical  
4 health, call it the more traditional medical  
5 surgical sides of the medical system and people's  
6 needs. Secondly and perhaps most importantly is  
7 the functional impact, the force readiness, the  
8 force health protection, the ability to work  
9 individually and as a coordinated team in getting  
10 the mission accomplished. And that's not  
11 something that we as health care people often  
12 think of enough and I would encourage at the  
13 inauguration of this important effort that we keep  
14 it very visible, that this is not a silo separated  
15 from the rest of the whole taking care of the  
16 health of --

17 DR. FOGELMAN: Absolutely. I can tell  
18 you that already in our beginning strategic  
19 planning both of those things have come up and  
20 we're on board with both of those things. It's in  
21 our awareness. In terms of the specific  
22 technology, we were asked the question, we can't

1 not answer the question was asked to us. But  
2 you're absolutely right. And the notion of whole  
3 persons, whole warriors is always right in front  
4 of us. Dr. Dedre, would you agree that we said  
5 that?

6 DR. DEDRE: I've got so much business in  
7 my head, I have nothing to add.

8 DR. COHOON: I'm Barbara Cohoon with the  
9 National Military Family Association. As you were  
10 talking about resilience and you were talking  
11 about the service member, we would encourage you  
12 to also make sure you're looking at the family and  
13 its resilience because if they're taken care of  
14 back home, then the service member can totally  
15 focus on what's happening in theater or wherever  
16 they're going to protect the country. So maybe  
17 again looking at it holistically, that's it's all  
18 one family unit when it comes to psychological  
19 health.

20 DR. FOGELMAN: I think you can certainly  
21 count on Dr. Shelly McDermott Wadsworth  
22 representing that position at our meetings.

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1 DR. COHOON: That's why we're glad  
2 Shelly is on board. Thanks.

3 COL LUGO: Good morning. I'm the Chief  
4 of Staff for the DCOE so on behalf of Brigadier  
5 General Sutton I want to thank the Board and  
6 certainly you for establishing this advisory  
7 committee, the third one that we deal with, the  
8 TBI Panel and TBI Subcommittee. We look forward  
9 to working with you and our staff does. We will  
10 certainly accommodate meetings at our locations.  
11 We'll have to work through some of those because  
12 we want to make sure we have not only our  
13 directors there, but we have many component  
14 centers that we would like to work with. There's  
15 a lot of important work to be done and we will  
16 certainly be posing quite a few questions on areas  
17 for you to perhaps explore. So thank you very  
18 much.

19 DR. FOGELMAN: Thank you. We're not  
20 going to be able to meet everybody the next time.

21 DR. WILENSKY: Any further questions or  
22 comments? Thank you. Our next speaker is retired

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1 Captain Dr. Frank Butler, an ophthalmologist and  
2 former Navy SEAL. He is currently serving as a  
3 medical consultant to the Navy Medical Lessons  
4 Learned Center as well as an Adjunct Professor of  
5 Military Emergency Medicine at the Uniformed  
6 Services University of the Health Sciences. The  
7 Board believes trauma and injury treatment and  
8 prevention should be a Defense of Defense core  
9 competency and is pleased to have the members of  
10 the subcommittee participate in ensuring that such  
11 efforts optimally meet the needs of our service  
12 members. As Chairman of the Committee on Tactical  
13 Combat Casualty Care, a subpanel to the Trauma and  
14 Injury Subcommittee, he'll provide an update on  
15 the revisions to the Tactical Combat Casualty Care  
16 Guidelines after which there will be a discussion  
17 and vote. His presentation slides can be found  
18 under Tab 5 of the meeting binders. Without  
19 further delay I present Dr. Butler.

20 DR. BUTLER: Thank you. Dr. Wilensky,  
21 Mr. Middleton, Members of the Board and guests,  
22 thanks for the chance to be here today. We're

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1 going to be talking about tactical combat casualty  
2 care, and with the permission of the Board and in  
3 the interests of time, I'm going to shorten that  
4 to TC3 from here on out and that will shave about  
5 5 minutes off of the talk time.

6           Since this is a decision brief to the  
7 Board, it would normally be presented by Dr. John  
8 Holcomb who is the Chairman of the Trauma and  
9 Injury Subcommittee, but he couldn't be with us  
10 today and asked me to fill in which I am happy to  
11 do especially since we're here in Key West. I  
12 will mention at this point that this material and  
13 both the changes that you're going to see and the  
14 courses of action that you're going to see have  
15 been reviewed by the 11 members of the Trauma and  
16 Injury Subcommittee and all 11 have concurred, and  
17 that group includes three current members of the  
18 American College of Surgeons Committee on Trauma  
19 and two past members. So there is a good trauma  
20 experience base in the subcommittee.

21           As an advanced look at the proposed  
22 action, we're going to ask for the Board to

1 endorse the recommended changes and that Health  
2 Affairs endorse TC3 for battlefield trauma care to  
3 both the surgeons general of the services but also  
4 and perhaps more importantly to the line  
5 leadership as well, and we'll talk about that some  
6 more as we go on.

7           Why do we need TC3? We are blessed in  
8 this country to have a great trauma system as  
9 represented by this picture from the emergency  
10 department at Ben Taub. So why does the military  
11 need to do something different? That's a fair  
12 question, and the answer is because we are  
13 different. I'm going to ask you to image yourself  
14 as a 22- year-old Army medic taking care of a  
15 patient with this shrapnel wound to the hip in the  
16 Hindu Kush at 8,000 feet, 20 degree weather.  
17 You're 40 miles from the Pakistani border here and  
18 about 500 miles from anywhere else in the world.  
19 The equipment that you have is different, the  
20 wounding epidemiology is different. Your  
21 evacuation considerations are much different. So  
22 it is not too hard to conceptualize why we might

1 need to do something different. The trick has  
2 been to define exactly what we need to do  
3 differently.

4 The concept of TC3 started as a Special  
5 Operations research effort in the early 1990s.  
6 The paper was published in 1996. It was first  
7 used by the Navy SEALs and the Army Rangers in  
8 1997. For the next few years it was really used  
9 only very sporadically in a few groups in the  
10 military. It first got a little bit of national  
11 attention when it was published in the  
12 Pre-Hospital Trauma Life Support Manual because as  
13 you probably know, that manual carries the  
14 endorsement of the American College of Surgeons  
15 and the National Association of EMTs. So that's  
16 our first little bit of respect from well-known  
17 people in trauma areas.

18 What accelerated the use of TC3 was the  
19 war. After 2001 as we started to look at the  
20 casualties and what the implications of our  
21 fatalities were, the services quickly began to  
22 realize that we were pretty close to being on the

1 money with these recommendations. Now at this  
2 point pretty much all the services have adopted  
3 TC3 in some fashion as have the FBI pre-hospital  
4 folks, the CIA, major allied countries such as  
5 Canada, the U.K., Germany, Israel. So we've had  
6 those measures of success. One of the challenges  
7 that that has presented is with this big user  
8 base, how do we go about changing and getting  
9 endorsements for changes that we propose?

10           The group that develops these proposed  
11 changes is the Committee on Tactical Combat  
12 Casualty Care. It's been around 2001 originally  
13 funded by the Special Operations Command out of  
14 Tampa. It was after the first couple years as a  
15 pilot program taken over by Navy medicine and  
16 supported through the Navy Surgeon General, and I  
17 have to acknowledge the incredible support that  
18 we've gotten from the Army Surgeon General and  
19 MRMC, the Army Medical Research and Material  
20 Command, and the Institute of Surgical Research  
21 the last few years. The committee comprises  
22 members from all of the services and the civilian

1 sector, and we have a tremendous mix of trauma,  
2 emergency critical care, medical educators, and  
3 very importantly, we've got the combat medics at  
4 the table and that's a change from the way that  
5 things used to be done.

6 As of March 2008, we belong to you for  
7 better or worse. Who's in this group? It's a  
8 pretty interesting crowd. Some of our members  
9 have included the U.S. Surgeon General. You may  
10 or may not know that Dr. Carmona was an old 18  
11 Delta Special Forces medic back in the day and he  
12 was a tremendous participant for a while. Dr.  
13 Dave Hoyt when he was Chairman of the American  
14 College of Surgeons Committee on Trauma took part  
15 in the meetings. We've had trauma consultants  
16 from all three of the services, five trauma  
17 directors from level-one trauma centers.  
18 Currently the Vice President's physician is a  
19 committee member and they follow what we do very  
20 closely for the purposes of taking care of our  
21 nation's leaders. And we have a mix of  
22 operational guys from all over the place.

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1           I will go back and touch on a couple of  
2 the metrics that we saw before when you ask what  
3 is the evidence for this actually working. One of  
4 the studies that I think is important is one that  
5 was published by Dr. Holcomb and Howard Champion  
6 a couple of years ago and it defines or outlines  
7 that the U.S. casualty survival rate in the  
8 current war is the best in our country's history  
9 going, from 19 percent fatality rate in World War  
10 II, to 15 in Vietnam, to about 10 percent  
11 currently. That's certainly a multifactorial  
12 outcome, but one of the things that they  
13 identified as important was trauma combat casualty  
14 care.

15           The medical educators are buying into  
16 this in the services. This is quote from Bob  
17 Mabry and John McManus who are in charge of doing  
18 combat medic training for the Army and this was  
19 from their paper last year on critical care  
20 medicine. In their words, TC3 has revolutionized  
21 the management of combat casualties in the  
22 pre-hospital tactical setting.

1           To look at some specific interventions,  
2           and I will touch on this paper, one of the things  
3           that is most closely associated with TC3 and  
4           presents one of the most definitive differences  
5           between what TC3 recommends and what the civilian  
6           trauma sector recommends is the use of  
7           tourniquets. Two months ago the largest  
8           tourniquet paper as far as I know that's ever been  
9           in the medical literature was published. John  
10          Craig from the Institute of Surgical Research  
11          looked at the association of tourniquet use and  
12          survival and he has documented that tourniquets  
13          are saving lives on the battlefield. They looked  
14          at one 7-month period at one hospital in Baghdad  
15          and estimated 31 lives saved in that timeframe.  
16          When asked by the Army Medical Research and  
17          Material Command to say can you take these numbers  
18          and tell us how many lives have been saved  
19          throughout the way from using tourniquets, the  
20          number that Colonel Craig and ISR provided them  
21          was 2,000 lives. That seems like a big number,  
22          but when you look at scenarios like this, this was

1 when HM1 Jeremy Teresi from the Marine Corps  
2 Special Operations Command presented last month at  
3 the TC3 Committee. He presented one scenario in  
4 Afghanistan where his unit was ambushed. They had  
5 15 casualties. He was the only corpsman, and he  
6 was shot himself. In that one scenario they had  
7 four tourniquets applied, three lives were saved  
8 and the fourth casualty died from a chest wound.  
9 So that is remarkable input directly from the war  
10 fighters.

11           What about the concept that we've all  
12 learned when we went through medical school that  
13 if you put a tourniquet on somebody's arm or leg,  
14 that limb is going to be lost? Using the same  
15 cohort of patients described before, Colonel Craig  
16 published a paper last year where he looked at his  
17 232 patients from his hospital in Baghdad and  
18 looked at complications. In those 232 patients  
19 with tourniquets, the number of amputations  
20 resulting from tourniquet use was zero. So what  
21 about this popularly held concept that tourniquet  
22 use is going to result in extremity amputation?

1 That's starting to look like a little bit of an  
2 urban myth at this point because the mean  
3 tourniquet time in this paper was 1.3 hours. I  
4 don't want to imply that we don't have good  
5 rapport with the civilian pre- hospital trauma  
6 sector. This is an excerpt from a letter written  
7 by Dr. Jeff Salamone who's a trauma surgeon at  
8 Grady Hospital and as the Chair of the  
9 Pre-Hospital Section of the Committee on Trauma.  
10 This letter is a letter to Dr. Cassells  
11 congratulating him on the advances made by the  
12 U.S. military in saving lives with TC3. I think  
13 it's safe to say at this point if you look at  
14 civilian trauma care in the very near future  
15 you're going to see convergence toward what we're  
16 doing in the military on at least four or five  
17 pre-hospital care points.

18           What are we up to at the moment in the  
19 committee? We try to keep the guidelines updated  
20 and we do that based on input from the war  
21 fighters, from the Army laboratories, the Navy  
22 laboratories, the Air Force laboratories, and

1 based on our reading of the pertinent literature.  
2 As we update the guidelines, we also have to  
3 update the training curricula and periodically we  
4 update the Pre-Hospital Trauma Life Support  
5 Manual.

6           What specifically has been changed in  
7 our recommendations for battlefield trauma care?  
8 The first change that I will show you was one made  
9 by one of our E-7 combat medics. Whereas before  
10 we had recommended that hemostatic agents be used  
11 in what we call care under fire, that's the care  
12 that's provided while you're actually in the  
13 gunfight and there are rounds landing all around  
14 you. When you use a hemostatic agent and apply it  
15 to a wound, you have to hold pressure for 3  
16 minutes, and this sergeant got up there and said  
17 you can't do it. You can't do that on the  
18 battlefield. You'll be dead if you sit out there  
19 and hold direct pressure for 3 minutes. It's  
20 really a tactical question and we listened to our  
21 tactical expert and moved the use of hemostatics  
22 back into the tactical field care phase after the

1 gunfight is over.

2           Tourniquets. We are convinced that  
3 we're doing good with tourniquets. However,  
4 learning largely from Colonel Craig and the  
5 Institute of Surgical Research, we are polishing  
6 up our technical a little bit. First of all, we  
7 are being more specific about saying use a  
8 recommended tourniquet. We're not in the  
9 tourniquet selling business, but I will tell you  
10 that all tourniquets are not equal and the  
11 military is buying some of the ones that don't  
12 work, and the IRS has a great study from 2005 that  
13 shows you which ones do work and we are going to  
14 have a suggestion that people use those  
15 tourniquets that do work. We recommended that the  
16 tourniquets be applied over the uniform in care  
17 under fire for speed and then later on move to  
18 directly over the skin where they can be a little  
19 bit more effective. We recommend now tourniquet  
20 use for all traumatic amputations because if there  
21 is no distal extremity, you can be more aggressive  
22 in using these tourniquets. Colonel Craig has

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1 nicely demonstrated that there is a need to  
2 eliminate the distal pulse. If you put on a  
3 tourniquet and blood is still coming into the  
4 extremity but blood is not able to return to the  
5 central circulation, that is not a good  
6 physiologic state.

7           If your first tourniquet doesn't work,  
8 don't take it off and put another one, put a  
9 second one on because tourniquet effectiveness is  
10 associated with width and if you use a second  
11 tourniquet you've effectively doubled the width of  
12 your first tourniquet. Then lastly, expose and  
13 clearly mark the time of amputation. For anybody  
14 who doesn't believe that we went to this war  
15 without tourniquets in large part, take a look at  
16 this. This is what our medics were doing. We  
17 wouldn't give them a good tourniquet at the start  
18 of the war. They tried to fashion them from  
19 T-shirts and bandages. The effectiveness rate of  
20 these makeshift devices is about 25 percent as  
21 opposed to 80 to 100 percent for manufactured  
22 tourniquets. Hemostatic agents have been

1     pioneered by the Army, and clearly the Institute  
2     of Surgical Research has been the leader in this  
3     field. We're now recommending combat gauze as  
4     opposed to the older agents HemCon and QuikClot.  
5     Studies done at both ISR and the Navy have  
6     demonstrated that this is a dramatically more  
7     effective material to use. It's basically gauze  
8     with kalin impregnated in it and kalin activates  
9     the clotting system and promotes clotting in  
10    wounds. That's important if you have an injury  
11    not in your arm down here, but what if the injury  
12    is up around your axilla or on your neck or in  
13    your groin? There you can't use a tourniquet and  
14    go to one of these hemostatic agents.

15             Important in this decision were the  
16    medics saying these older agents that we used to  
17    use, the powders, those are a problem on the  
18    battlefield because it's windy and they tend not  
19    to go down into narrow wound cracks, again great  
20    combat medic input to the discussion. If any of  
21    you have followed the literature that's been  
22    recent about WoundStat, the answer to one of the

1 questions that might come up is, yes, WoundStat is  
2 more effective but we also caveat that by saying  
3 that there are some real safety concerns with  
4 WoundStat, and I'd be happy to get into that if  
5 you would like.

6 Management of tension pneumothorax has  
7 been changed somewhat. We still recommend that  
8 for someone who's shot in the chest and who has  
9 progressive respiratory distress and circulatory  
10 compromise. However, now we're more specific  
11 about using a 3.25 inch needle. It's that getting  
12 down into the weeds? It is, but there's a lot of  
13 recent literature that is showing that the  
14 standard 2 inch needle does not work reliably, and  
15 I will credit Dr. Mallak and his great team at  
16 the Armed Forces Medical Examiner's Office. We  
17 had Ted Harkey come and present to us, and this  
18 was precipitated by two cases that he looked at at  
19 autopsy where a tension pneumothorax was attempted  
20 to be decompressed with a 2 inch needle and he  
21 could see in his CT scan that it didn't go far  
22 enough, it didn't get through the chest wall. And

1 in doing further research they've now demonstrated  
2 that only about 50 percent of the time will a 2  
3 inch needle work. So now we're using a bigger  
4 needle.

5 Also there was a great paper that came  
6 out from the Canadian forces. Dr. Homer Tien over  
7 there looked at where the medics were  
8 decompressing the chest. You say the  
9 mid-clavicular line. You're a 20 year old medic.  
10 Do you really know where that is? It turns out  
11 most of these people were medial to where they  
12 should have been, and Dr. Tien said use the  
13 nipple. It's a good landmark and if you stay  
14 lateral to that you'll be okay.

15 Management of sucking chest wounds. As  
16 you know, a sucking chest wound is when you have a  
17 big hole in your chest and when you inspire the  
18 air enters not into the lung on that side but  
19 preferentially through the hole in the chest and  
20 management of that has historically been an  
21 occlusive dressing. I'm sorry, a three sided  
22 dressing. This is a representative hole in the

1 chest that might cause this type of respiratory  
2 compromise. Conventional wisdom is a three sided  
3 dressing so that if there is a buildup in pressure  
4 and you start to get tension pneumothorax that it  
5 could decompress through that third side. There's  
6 no data to show that that works and it's harder  
7 for the medics to do. So we said just put an  
8 occlusive dressing on there. Watch closely for  
9 the development of a subsequent tension  
10 pneumothorax. If that happens, put a needle in  
11 their chest.

12 Management of penetrating eye injuries.  
13 There's nothing new here. This is pretty much  
14 standard management of eye injuries. It's just  
15 that this is the first time that the committee has  
16 addressed eye injuries. Basically, if you're in  
17 the field and you can see this more subtle globe  
18 penetrating injury here -- pupil and the pigment  
19 at the limbus. A quick check of vision, cover the  
20 eye with a rigid shield, not a pressure patch, and  
21 give antibiotics. This eye might do very well.  
22 If it gets infected it will not do well.



1 situation while he's doing the documentation.  
2 This has been extremely well accepted in the  
3 Ranger regiment and I will tell you that as far as  
4 I know, that is the only group in the U.S.  
5 military that has 100 percent pre-hospital care  
6 documentation for their casualties. So we  
7 recommend going with the card that has been so  
8 successful with them. I'll just mention that with  
9 Texas A&M's help they've turned this into a  
10 unit-based trauma registry which is pretty  
11 spectacular.

12 The last change that I will mention  
13 briefly is changing the third phase of care, care  
14 under fire, tactical field care and then it used  
15 to be casualty evacuation care. Some of our  
16 medical doctrine developers pointed out that that  
17 term was a little bit outdated. If you've ever  
18 read the great book "We Were Soldiers Once and  
19 Young," it talks about how if you don't understand  
20 the difference between these two things, it can  
21 result in disaster if you have a mass-casualty  
22 situation. So we've tended in TC3 to emphasize

1 CASEVAC care which is where you call one your  
2 units or your support unit's combat capable  
3 aircraft that can fly in horrific conditions as  
4 you see here. They've got guns and they can  
5 defend themselves. They will come into a gunfight  
6 and get you. As opposed to the Red Cross marked  
7 MEDEVAC choppers which are very medically capable  
8 but in many situations they can't come in because  
9 of flying restrictions or because there's a  
10 gunfight going on. But now we're changed our  
11 thinking to incorporate both types of things  
12 because in fact in theater you're using both types  
13 of assets extensively at this point in time to  
14 clear the battlefield of your casualties.

15 So we're doing some things well. We  
16 certainly have a lot of room for improvement. One  
17 of those is that we need to train TC3 to everybody  
18 in the medical department and not just the combat  
19 medics. The combat medics got it. The doctors  
20 and the nurses not too much. You don't get it in  
21 nursing school and you don't get it in medical  
22 school. You don't get it in internship. How are

1 you supposed to know about this? They only teach  
2 it in combat medic school. So we need to do  
3 better on that. I will point out that the Army is  
4 the exception. Last month they sent out a message  
5 that said from now on everybody in the Army  
6 Medical Department, before you go to the war is  
7 going to get this training. We need this. We've  
8 talked about having a better definition of our  
9 change implementation process and when we make a  
10 change how do we get it out to all the people who  
11 use TC3.

12 This is maybe the most important bullet  
13 here. Combat leaders need to understand combat  
14 medicine. I'll give you two pretty amazing  
15 examples. We have had repeated episodes where the  
16 lieutenant or the captain has come up to his medic  
17 and said, Why are you putting on that tourniquet?  
18 You should be starting an I.V. They have an  
19 experience based on maybe a family experience with  
20 civilian sector medicine or watching TV or who  
21 knows what. But we need for them to have  
22 appropriate expectations of their medics, and they

1 don't necessarily. The second thing is that they  
2 need to incorporate medical planning more  
3 definitively into their mission planning. All  
4 combatants on the battlefield should be trained in  
5 the basic TC3 lifesaving skills. You've heard  
6 about the Golden Hour? Forget about the Golden  
7 Hour. If you get shot in the leg and you are  
8 bleeding from your femoral artery, how long do you  
9 have? You've got a Golden 5 Minutes. And if  
10 somebody doesn't get a tourniquet on, your leg in  
11 that Golden 5 Minutes, that's the ballgame. So  
12 everybody needs to know how to do this. Then  
13 lastly as we talked about, better pre-hospital  
14 trauma care documentation.

15           What is the potential for improvement  
16 with these suggestions? This is some amazing  
17 data. If you look at John Holcomb's paper from  
18 2007 where we looked again with Dr. Mallak's  
19 team's help, we went and pulled all the autopsy  
20 records for our first 82 fatalities in special ops  
21 to look at cause of death and to see if they were  
22 inevitable deaths, airplane crash, or potentially

1 preventable deaths. The number we came up with  
2 for potentially preventable deaths was 17 percent.  
3 That's a lot. More recently, Dr. Kelly in his  
4 2008 paper in his cohort had 19 percent, and in  
5 his second cohort he had 28 percent preventable  
6 death estimation. Contrast that with the  
7 presentations made by Lieutenant Colonel Russ  
8 Kotwal who is the senior medical officer for the  
9 Rangers. He presented in September at the First  
10 Responder Conference that the Ranger regiment has  
11 had 482 casualties to that point. They've had 37  
12 fatalities. But the incidents of preventable  
13 deaths was zero according to their own internal  
14 evaluation. Lieutenant Colonel Andy Pinart from  
15 the Army's Special Missions Unit 3 weeks ago came  
16 and presented his experience from his unit, 201  
17 casualties, 12 fatalities, number of preventable  
18 deaths, zero. What they have in common is that  
19 they since the start of this war have trained both  
20 their leaders and every operator in TC3.

21 So our proposed action to the Board is  
22 that Secretary Cassells endorse TC3 both to the

1 surgeons general as the basis for combat trauma  
2 training. And secondly, to the service line  
3 leadership so that they will incorporate an  
4 overview of TC3 at the entry, midlevel and senior  
5 leadership courses for their officers and  
6 enlisted. And then to train all combatants in at  
7 least the basic TC3 lifesaving skills. I will  
8 mention at this point that Secretary Cassells has  
9 gotten a little bit of a head start on this and  
10 this part has happened as of last week. He did  
11 send out a memo that Commander Feeks was nice  
12 enough to send me that said surgeons general, here  
13 are the new changes. We recommend that you take a  
14 look at them and consider them for use in training  
15 your combat medics. Please, questions.

16 DR. WILENSKY: Could I ask you to  
17 clarify with regard to what went out to the  
18 surgeons general? Did that include the use of the  
19 casualty card or was the directive more  
20 generalized?

21 DR. BUTLER: It was general, and it  
22 referred to the updated TC3 changes as a whole

1 rather than addressing specific changes.

2 DR. WILENSKY: Since I started already  
3 with my questions, I'm having a little difficulty  
4 understanding what the question is about using the  
5 casualty card. You have less than 1 percent  
6 adequate information on the one hand and 100  
7 completion on the other hand. This doesn't seem  
8 like it requires heavy lifting to think about what  
9 direction you ought to go. Maybe I misunderstood.  
10 Is there a reason that isn't a more pointed  
11 recommendation?

12 DR. BUTLER: There are three competing  
13 schools of thought to the Ranger casualty card.  
14 One is that some of the medics will say I don't  
15 have time to do this at all. There is a Standard  
16 Form 1380 which is sort of a longish card and asks  
17 a lot of irrelevant questions like your religion,  
18 a lot of demographic data that you just don't need  
19 to document care. The third competitive is the  
20 BMIST which is an electronic handheld device which  
21 the medics would be possibly given to go out onto  
22 the battlefield and actually initiate the

1 electronic medical record on the battlefield and  
2 that's not been well accepted by the medics.  
3 There have been a number of pilot programs to try  
4 to do that and somehow those things keep getting  
5 broken.

6 DR. WILENSKY: Let me I guess ask the  
7 question again. So you have one experience where  
8 it seems to me you have other options that have  
9 problems. There's clearly a difficulty of not  
10 having documentation of people who are wounded. I  
11 get the notion of not wanting to spend a lot of  
12 time when you're under fire to fill out a  
13 document. It seems to obvious. There must be  
14 something that I'm not understanding as to why  
15 this wouldn't be embraced if not accepted.

16 DR. BUTLER: I think it just a question  
17 of as a group taking a look at this and saying,  
18 yes, let's do it.

19 DR. WILENSKY: Nancy?

20 DR. DICKEY: I think my question is the  
21 same as yours. Would we create any problems by  
22 recommending strongly that the data suggests that

1 the entire trauma service ought to begin using the  
2 card?

3 DR. BUTLER: I think this Board would be  
4 doing a great service to the advancement of our  
5 knowledge base because the real missing link here  
6 is, for example, let's say that somebody shows up  
7 at your hospital who is dead who has a tourniquet  
8 on his leg and that's his only wound. Was that a  
9 tourniquet failure was it because you didn't put  
10 the tourniquet on until the person was already  
11 unconscious from shock? So we need to know how  
12 the pre-hospital care went to make appropriate  
13 judgments about the success of our interventions.

14 DR. POLAND: Frank, I just wonder has  
15 much thought been given to the next steps in the  
16 sense of sensors that could remotely send data or  
17 just a voice- activated medical record where  
18 there's no paper or writing or anything at all.

19 DR. BUTLER: It has been, and I'm  
20 thinking back years to when Health Affairs  
21 convened a group to look at this that had some of  
22 the best trauma minds in the country and there

1 were two to three really big impediments to that.  
2 Number one is we didn't have good predictors until  
3 you had somebody with essentially a blood pressure  
4 of 50/0 and at that point it's not hard to tell  
5 they're in trouble. The second thing was that  
6 tactical leaders, and I provided this input to  
7 them because as a former SEAL platoon commander, I  
8 don't want any transmissions going out from my  
9 unit that I don't absolutely have to send out  
10 because the bad guys have direction finding too  
11 and it is a tactical compromise to send out a  
12 transmission from your location. The third thing  
13 is that it's an immensely expensive and  
14 complicated thing.

15 DR. POLAND: I didn't necessarily mean  
16 that it would have to be transmitted as opposed to  
17 a pocket dictation where you could actually  
18 collect more information, you're not writing,  
19 you're not having to preserve paper.

20 DR. BUTLER: You could do that. Again  
21 you have the expense and the complexity and you  
22 wouldn't really capture the interventions that

1 were attempted unless you had some way for the  
2 medic to interact and enter data into this  
3 recorder so that you could track what was  
4 happening physiologically with what you're doing  
5 to intervene, but it is a question that does come  
6 up.

7 SGT MAJ HOLLAND: Sir, I worked on one  
8 of the task forces early on and I thought that the  
9 hand-held document was going to be at the second  
10 or third level of medical care not with my medics  
11 or my corpsmen because I want them full hands on  
12 body taking care of business and trying not to get  
13 shot too much themselves. So my real message is  
14 all these things are really great, you folks are  
15 very smart people in this room, but when I have an  
16 E-3, E-4, E-5, they're very, very smart and very  
17 creative but I think we may be looking to give  
18 them too many tools on the battlefield that will  
19 confuse the issue and I may lose one of my troops  
20 and I don't want to do that.

21 DR. BUTLER: Command Sergeant Major,  
22 that nicely sums up the unanimous perspective of

1 the medics.

2 DR. MILLER: Congratulations on a  
3 wonderful presentation. I think you raise a  
4 bigger issue. I think there's a unit experience  
5 in the medic and the trauma system that you're  
6 describing that's unique and unparalleled and you  
7 really are at the edge of the envelope in terms of  
8 your systems that you're employing, that it really  
9 begs the question that you're always want to learn  
10 and improve upon the system as best as possible.  
11 The medic cards are one step in that direction.  
12 I'm glad to see that you have also presented some  
13 peer-reviewed publications. My comment is more  
14 toward that, how can we develop systems using the  
15 cards and other mechanisms to make sure that you  
16 are constantly improving on methodologies? I'm  
17 seeing that you're advancing into I-care and other  
18 particular areas. But do you have systems to  
19 formally evaluate your programs as you're moving  
20 forward?

21 DR. BUTLER: Dr. Miller, that's a great  
22 question. The best example of that sort of a

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1 system is personified by the Joint Theater Trauma  
2 System that is run out of the Institute of  
3 Surgical Research. They take all this data that  
4 is collected in theater and very methodically look  
5 at what we can infer from that data. Colonel  
6 Holcomb is going to come in in the future with  
7 some other pretty amazing things that have  
8 occurred in the hospital-based setting. The  
9 missing link to being able to do that in the pre-  
10 hospital care arena is that we have no  
11 pre-hospital data in the Joint Theater Trauma  
12 Registry and this medic card hopefully will give  
13 us that data. But I would look at a program that  
14 is analogous to what the Joint Theater Trauma  
15 System does for in-hospital trauma to pre-hospital  
16 trauma. I think that's very, very important and  
17 should have been more specifically outlined on my  
18 slides. Thank you.

19 DR. SHAMOO: I want to go back to the  
20 data you showed saving 30 lives, an estimate of  
21 2,000. I presume these are retrospective studies.

22 DR. BUTLER: They are, sir.

1 DR. SHAMOO: Could you speak more about  
2 the quality of these data? Is it an accumulation,  
3 an individualized case study and made them into a  
4 paper or there was a systematic protocol and how  
5 was that done? Because that's really the only  
6 piece of data we have been presented which gives  
7 you the impression that these implications are  
8 real. I for one have a very difficult time even  
9 if there is a clinical trial of 1,000 patients, I  
10 don't believe one single study and especially  
11 under these circumstances should change a policy  
12 unless there are compelling reasons.

13 DR. BUTLER: To dispose of your last  
14 question first, this is not the only study. It's  
15 just the most recent. We have lots of others that  
16 I would be glad to share. But his methodology,  
17 Dr. Craig was in a combat support hospital in  
18 Baghdad and he looked at every patient that came  
19 into their hospital in a 7-month period in 2006  
20 with tourniquets on, and that was his cohort.  
21 It's interesting. There were some other things  
22 that we didn't touch on like we think we had the

1     tourniquet problem licked. Not exactly. If you  
2     read that paper, there were five people who are  
3     discussed in the paper who came into the hospital  
4     without tourniquets and who expired. But his  
5     methodology was one hospital, one time period, all  
6     tourniquets.

7             DR. WILENSKY: Are there other  
8     questions? Commander Feeks?

9             CMDR FEEKS: Thank you, ma'am. Sir, you  
10    spoke earlier of the need to educate the line  
11    commanders using the example of a line commander  
12    saying, "You should be starting an I.V." to the  
13    medic, and I submit that it might be more  
14    effective if the medic himself were taught to say,  
15    "Skipper, the doctrine has changed based on lessons  
16    learned," and I bet the line commander is going to  
17    go "Roger that!" So that would be an example of  
18    just-in-time training for the line commander.

19            DR. BUTLER: I think that does happen  
20    certainly in the Rangers and in the Army Special  
21    Missions Unit. That flow of information from the  
22    relatively young medics up to the commander

1 occurs. I don't think we can fairly represent  
2 that that happens in the 82nd Airborne and the  
3 101st and the 3rd Army Division. There's a big  
4 gap there.

5 DR. WILENSKY: Command Sergeant Major?

6 SGT MAJ HOLLAND: I just left Fort  
7 Campbell and visited with the 101st and the two  
8 brigades that just came back from Iraq. Just for  
9 everyone's purposes in here, there was a time 10  
10 years ago when if I had an infantry company I  
11 would have one combat lifesaver per 47 troops.  
12 Today I have 47 combat lifesavers and every one of  
13 them carries a tourniquet. Before the only person  
14 to carry a tourniquet was my medic or my corpsman  
15 and I think it's very, very important to  
16 understand there's already been one evolution of a  
17 change and I think what's been presented here is a  
18 very good next step of a change to help us just  
19 get better at what we do. So it's no just fluke  
20 that we're saving all the lives on the battlefield  
21 because it's great care. There is no doubt about  
22 that. But I really have to tell you there's a lot

1 of importance there.

2 Sir, I don't see a lot of officers  
3 stepping in and telling my medics or my corpsmen  
4 because the Army has gotten to the point we call  
5 our medics doc just like the Marine Corps and  
6 pretty well you're not telling a Marine Corps  
7 corpsman or a Navy corpsman what to do because  
8 he'll tell you where to stick it.

9 DR. BUTLER: I'm reminded of three  
10 instances in particular. One was when I was at  
11 the Navy Special Missions Unit and one of the  
12 assault team leaders was a civilian paramedic. So  
13 they learn a whole different system. They learn  
14 different medicine. So if you base your  
15 preconceptions about how things should go on  
16 anything but what they're teaching at the combat  
17 medic schoolhouse now, you're probably wrong if  
18 you are not a combat medic. In most cases I think  
19 you're right, Sergeant Major, but sometimes you do  
20 have an aggressive company officer who will come  
21 in and say, hey doc, what are you doing here, and  
22 it's certainly happened and I've heard that story

1 from enough combat medics to where I believe it.

2 DR. WILENSKY: Any further comments or  
3 questions? Aside from the one additional  
4 recommendation that we'd like to make, are people  
5 prepared to vote? Is there agreement? All  
6 agreed? Any disagreements? Thank you. Report  
7 accepted.

8 Our next speaker is Dr. Poland who's  
9 been serving as the Defense Health Board liaison  
10 to the Defense Science Board and has attended a  
11 few of their meetings. He will present an  
12 information brief on the Defense Science Board's  
13 Summer Studies Program, an activity that may be  
14 considered by this Board as one method for the  
15 review and examination of topics that are  
16 addressed to the Board. His presentation slides  
17 can be found under Tab 6 of your meeting binders.

18 DR. POLAND: Thank you. This is just an  
19 informational and discussion item. As Gail said,  
20 I've been to the DSB a number of times on behalf  
21 of the DHB. It's interesting to see, in fact let  
22 me just say, that DSB is a Board that is in many

1 ways analogous to the DHB. They're a DOD Advisory  
2 Committee of outside experts who provide critical  
3 advice on scientific topics. Some were nuclear  
4 proliferation, chemical weapons capabilities,  
5 mechanical and other forces involved in TBI  
6 secondary to IEDs. So they don't deal with  
7 medicine or health per se, but other sort of  
8 scientific aspects surrounding that.

9 As I sat in those meetings I was  
10 impressed that the current way in which we engage  
11 does not generally allow the DHB to offer  
12 substantive in-depth advice of really broad  
13 overarching issues. We attempt to deal with them  
14 in various ways such as special task forces,  
15 select subcommittees and other sorts of things,  
16 but nonetheless I think many of you would agree  
17 that those mechanisms are constrained by time,  
18 people and the discontinuous nature of the  
19 engagement. So we'll have a teleconference, a  
20 month later we'll have another teleconference.  
21 Three months later we'll have a meeting sort of  
22 thing. It's just the nature of the way business

1 is conducted.

2 By contrast, DSB has evolved a unique  
3 mechanism for providing really exceptionally  
4 high-level in-depth advice on broad overarching  
5 topical areas that they call the Summer Study  
6 Session. I'm just going to tell you a bit of what  
7 they do, whether we might adopt a similar  
8 mechanism and how we would morph is secondary.  
9 I'm just wanting to share the idea with you.

10 The have sessions that run 1 to 2 weeks  
11 held in various facilitating venues. I think  
12 their last one was held at Stanford. So they go  
13 there for a week or two in the summer. We  
14 couldn't make a copy of the executive summary  
15 because that alone is 100 pages. That doesn't  
16 sound like an executive summary, but it was on the  
17 future of war. Talk about an overarching topic,  
18 and it was specifically called Challenges to  
19 Military Operations in Support of National  
20 Interests. I handed out to you, you have a piece  
21 of the executive summary. They were tasked with  
22 this question, Is the United States maintaining

1 its capability to deter and defeat a nation or  
2 nonstate actor who might employ unconventional as  
3 well as conventional means in nontraditional as  
4 well as traditional ways to thwart U.S. interests?  
5 Over the course of a week or two they had a  
6 variety of experts come in in sort of a study  
7 section, almost university-like atmosphere with  
8 subject matter expert input, presentations,  
9 vigorous debate, development of overarching  
10 principles and then integration. So for the  
11 question I just read to you, they divided it into  
12 seven topic areas, the future of war,  
13 unconventional weapons and technology  
14 proliferation, the special case of nuclear  
15 proliferation, unconventional operational concepts  
16 in the homeland, what we know and don't know about  
17 adversary capabilities in regards to intelligence,  
18 and fighting through asymmetric counterforce, and  
19 lastly, strategic communication, another  
20 instrument of U.S. power. So while I'm talking  
21 I'll just pass the summary report around and you  
22 can take a glance at it.

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1 databases? How do we integrate preclinical T-1,  
2 T-2 and T-3 research? What about research  
3 oversight? What about war versus peacetime needs  
4 and capabilities? And what about this continuum  
5 from prediction and prevention all the way through  
6 chronic and rehab sort of care? Just examples of  
7 how you might take a broad overarching issue,  
8 divide it into subareas, bring together a group of  
9 experts for a week, really dig in on this and then  
10 integrate those aspects into a comprehensive sort  
11 of report.

12 Peter Drucker has said management is  
13 doing things right, leadership is doing the right  
14 things and I use that as a fulcrum, if you will,  
15 with the Board to say that service members and  
16 their families, DOD and the nation deserve the  
17 very best advice available that's thoughtful,  
18 critical, comprehensive, forward looking and  
19 characterized by impressive breadth and depth, and  
20 I present to you just one mechanism for our  
21 consideration. Should we consider a similar sort  
22 of mechanism? What sort of topics might those be?

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1 And would it actually offer advantages? Dick  
2 Myers stepped out of the room, but there may be  
3 others who have been exposed to DSB reports. I  
4 don't pretend to speak for him, but I asked him  
5 about this at breakfast and as the Chair of the  
6 Joint Chiefs he found these comprehensive, in-  
7 depth DSB reports often times critical to the  
8 kinds of decisions they would make. Comments?  
9 Discussion?

10 DR. LOCKEY: I think this is really an  
11 excellent idea. The way I've come to envision it  
12 is we have a microscope or a macroscope and we're  
13 stuck on a high level and we don't have the  
14 ability to go up and down and take a broad view.

15 DR. POLAND: That's a nice way to put  
16 it.

17 DR. LOCKEY: I'll give you an example of  
18 why your idea is so appealing. About 2 weeks ago  
19 I was asked to give a presentation on the role of  
20 epidemiology and the prevention of  
21 nanotechnology-related adverse effects. These are  
22 like atomic-level things. Naive me going into

1     this meeting, I thought I wonder if this has any  
2     relevance to the military? When I chaired a  
3     breakout session and the Navy was there, Air Force  
4     was there, they were all there. They were all  
5     dealing with nanotechnology-related particles but  
6     we as the Defense Health Board might want to say  
7     what should we be doing, how should we envision  
8     problems associated with nanotech. I think it's  
9     an example of where you would need to step back,  
10    we'd need to bring experts in. We'd need to think  
11    of how it's relevant, et cetera. But it can't be  
12    done just waiting for somebody to ask us.

13           DR. POLAND: I absolutely agree. That's  
14    an important aspect that the Board has exercised  
15    in the past where we initiate a question or an  
16    issue and not just wait to be asked. If you look  
17    in the very back of the report I'm sending around  
18    to you, you can see the lists of outside experts  
19    and presentations that they brought to bear on  
20    this topic. I will say I know that the concept is  
21    a bit frightening to say how would I take a week  
22    out. I wrestled with that myself before proposing

1 to Gail that we talk about this because I turned  
2 it around in my mind, we do it anyway, but we do  
3 it discontinuous. And are we really saying that  
4 DOD doesn't deserve a week of our time. They'd  
5 pick one issue a year. Maybe we'd do it at the  
6 committee level where each committee would pick  
7 one, or as the Board, whatever it would be, but  
8 doesn't DOD deserve that from this?

9 DR. WILENSKY: It doesn't have to be a  
10 week or nothing.

11 DR. POLAND: Right.

12 DR. WILENSKY: This is something where  
13 we could consider doing a specific topic for a  
14 several-day period.

15 DR. POLAND: Absolutely.

16 DR. WILENSKY: General Myers?

17 GEN MYERS: What I've seen in the  
18 Defense Science Board is that they may dedicate a  
19 week or I think sometimes even longer than that to  
20 the task, but people come and go as their  
21 schedules allow. And they also have a lot of  
22 outside participants which allows you to meet a

1 lot of people because you're looking for real  
2 expertise that maybe the Board doesn't have. I've  
3 participated on several of those and I've been the  
4 recipient of several of the briefings, and as the  
5 Vice Chairman of the Joint Chiefs, one of the  
6 things we always tried to do as Vice Chairman was  
7 to get out there for the debrief because they're  
8 pretty extensive. I thought it was a pretty good  
9 process, that is, listen to as any bureaucracy  
10 listens to any of this, but with that caveat I  
11 think it can be pretty influential. Thank you.

12 DR. WILENSKY: Adil?

13 DR. SHAMOO: I think the structure we  
14 have of our subcommittees, and I want to endorse  
15 really your recommendation, sometimes doesn't lend  
16 a topic only to be in a subcommittee, it's in the  
17 gray zone of two or three subcommittees or four  
18 and that will get around it, then our topic will  
19 fit exactly in a subcommittee and there shouldn't  
20 be such a mechanism and that's one of the  
21 downsides of subcommittees.

22 DR. HALPERIN: I don't understand the

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1 composition of the Defense Science Board. Do they  
2 have longer terms than we do? It seems that we  
3 have a short enough term that if we invested the  
4 energy in educating us, by the time we really  
5 understood things we'd be rotating off. The same  
6 thing happens with I think in the military where  
7 people get into the job and rotate frequently as  
8 well.

9 DR. MASON: I'd like to piggyback on  
10 what Dr. Halperin suggested. Since all of us  
11 have been on the receiving end of reports that are  
12 historic in terms of exposures, I would suggest  
13 that it would make perfectly good sense to ask a  
14 question and demand a response in a relatively  
15 short span of time. Let me be very specific.  
16 There is a growing number of members of Congress  
17 who are calling for an Agent Orange registry of  
18 our forces who are exposed in Iraq and Afghanistan  
19 and worldwide to the issues that we have been  
20 forced to address after the fact, and I'm talking  
21 burn pits and I'm talking carmide Ali. With the  
22 third Guard unit now joining the suit, leaving the

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1 suit off the table, there are some very specific  
2 issues. Is our Department of Defense actually  
3 planning and preparing to evaluate biologically  
4 plausible health events, occurrences, among our  
5 returning forces? Are they? What's the plan?  
6 Wouldn't it be nice as opposed to 5 years after  
7 the fact those of us who had active security  
8 clearances being brought to Washington to review a  
9 confidential document, to review confidential  
10 materials, to craft that into something that we  
11 could present in public? Wouldn't it be really  
12 nice to be at the front end? Wouldn't it be  
13 really nice to say here are some issues that we  
14 believe we have complementary expertise to the  
15 Science Board, could work proactively with them,  
16 to basically facilitate a more informed response  
17 to these types of challenges? So I would suggest,  
18 one, I wholeheartedly agree with you, I  
19 wholeheartedly support what General Myers has  
20 said. There are questions, there are generic  
21 holistic questions, that in our considered  
22 opinion, certainly mine, I only speak for myself,

1       that would it have been the set of circumstances  
2       which is was not that subject matter experts were  
3       actually brought to the table at the front end?  
4       Studies would have been done in a more effective,  
5       efficient and appropriate basis such that you  
6       would not then be hamstrung to evaluate something  
7       when you had nothing at all to do with the design  
8       at the front end.

9               DR. WILENSKY: Did you want to speak to  
10       that?

11              CMDR FEEKS: There is already a program  
12       in place to do occupational and environmental  
13       health site assessments preferably before we go  
14       there, but if conditions don't permit us to do  
15       that before we have troops in place in a  
16       particular place, we get to it as soon as we can.  
17       Then the service member, him or herself on the  
18       post- deployment health assessment that everybody  
19       does has the opportunity to name or to state  
20       concerns related to exposures encountered during  
21       the deployment and then during the post-deployment  
22       health reassessment that's done 3 to 6 months

1 after coming home, the opportunity is presented  
2 again. The member is asked one more time, do you  
3 have any deployment related exposure concerns? Do  
4 I'd like to say that what you're describing is  
5 probably already in place.

6 DR. POLAND: Let me sort of nudge the  
7 Board here. I didn't want to get into a specific  
8 example and I'd rather we discuss the concept  
9 rather than get down right away to what would we  
10 study.

11 DR. MASON: Here's the concept. At the  
12 concept level I would suggest that as opposed to  
13 what is presently being done, wouldn't it not be  
14 appropriate to step back a bit and say how could  
15 we actually 5 years after a potential exposure  
16 address a biologically plausible question, do we  
17 actually have adequate information on the  
18 individuals to permit recontact? I'll be very  
19 specific. I'm very concerned about the Guardsmen  
20 and the Reserves. They fall off records keeping  
21 and the disconnect and the discontinuity between  
22 some of the caregivers, between active duty,

1 Reserve, Guardsmen and VA, those are conceptual  
2 issues and I would suggest that they go beyond  
3 what we're presently doing. I'm not arguing that  
4 we're bringing persons to the table, that we have  
5 environmental health officers and that we have  
6 responded in a timely way to any one of a number  
7 of questions, but a number of the issues that  
8 we're asked to evaluate are going to take years to  
9 develop and I for one would love to position  
10 ourselves to work more proactively as opposed to  
11 reactively to these kinds of questions.

12 DR. WILENSKY: Let me just ask again to  
13 go back first to Greg's point, but to further  
14 indicate that this afternoon and again in our main  
15 meeting one of the issues we are going to be  
16 discussing is what Ellen Embrey and I have been  
17 terming the terms of engagement, how we go about  
18 as a Board deciding what kinds of issues we might  
19 wish to consider and the implications of that when  
20 we have not been requested to take on that issue,  
21 and this is obviously a case in point. But it  
22 really does differ from the issue that Greg raised



1           SECRETARY WEST: Madam Chair?  
2           DR. WILENSKY: Yes?  
3           SECRETARY WEST: Togo West.  
4           DR. WILENSKY: Go ahead, Secretary West.  
5           SECRETARY WEST: I just want to endorse  
6 your summation and your comments a few seconds ago  
7 about the way to present or to look at a proposal  
8 that could be adoptable. The fact is that for  
9 decision makers like an Assistant Secretary of  
10 Health or an Under Secretary of SECDEF, you are  
11 right that they want to see a list of potential  
12 steps that would be the subject matter as they  
13 consider whether they'd like to see us go forward  
14 with something like that. I think that's an  
15 important part of how you put together our  
16 consideration. What would be the topics or a  
17 suggested list of four or five topics that lend  
18 themselves from our perspective to a kind of  
19 summer study which is roughly an investment I  
20 would suspect in 3 to 4 days most likely seriatim  
21 all at one time in a place removed much like your  
22 meeting today where all the results can be brought

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1 together and fleshed out.

2 DR. WILENSKY: Thank you.

3 DR. LUEPKER: I just want to speak in  
4 support of this idea. I think we're at a point  
5 now trying to decide where this Board is going and  
6 how it's going to get there and if we're just  
7 reactive which historically we've tended to be,  
8 then this is fine, but if we hope to look at more  
9 depth of issues and be proactive as was said a  
10 moment ago, some structure like this may be very  
11 useful.

12 DR. WILENSKY: Mark?

13 DR. MILLER: I think the two previous  
14 speakers took the words out of my mouth whether or  
15 not we want to be proactive versus reactive as a  
16 federal advisory committee and I would bring the  
17 question back to Greg, how were these  
18 recommendations used by the Defense Science Board?  
19 Again I think it brings up the issue of process  
20 and mission and the political process as well that  
21 there should probably be some vetting of the  
22 topics so that they are acceptable and welcome to

1 a certain extent when an independent board brings  
2 up issues that they feel are important. So what  
3 I'd like to ask really is how the recommendations  
4 have been used in the past.

5 DR. POLAND: You may have missed General  
6 Myers. He looks like he's stepped out again. He  
7 felt that there were many times in which it shaped  
8 and molded what the Joint Chiefs' policy ended up  
9 being, so that's probably about the highest  
10 endorsement that we could get. I also think it  
11 could go both ways. The example I passed out to  
12 you, they were asked that question, but they have  
13 also independently raised an issue and used it in  
14 their summer session. So it could go either way I  
15 think, Mark.

16 DR. WILENSKY: This issue again as I've  
17 indicated I hopefully will spend some time  
18 discussing both this meeting and next meeting  
19 which is the terms of engagement both for issues  
20 where we're requested to look at something but  
21 more importantly because it is dicier, the notion  
22 of taking on issues that we have not been

1 requested to look at and it's an area where we  
2 need as a group to discuss and consider the  
3 ramifications. Again, more to come on this.

4 DR. OXMAN: I think, Greg, independent  
5 of whether this is initiated by us or a response  
6 to a request for advice, I think Greg expressed  
7 the frustration I felt and that is there wasn't  
8 sustained enough discussion by the Board and  
9 enough knowledge to really make me comfortable  
10 with some of the recommendations that we make. So  
11 I think this is a wonderful idea and I would  
12 endorse it independent of whether we want to be  
13 proactive or just reactive.

14 DR. WILENSKY: I also suggest that we  
15 think about whether we're willing to make this  
16 investment in time, and that other issue is really  
17 a second issue. Wayne?

18 DR. LEDNAR: Mark and Greg made two  
19 comments that fired a neuron for me. One was vet  
20 the topics, be sure that before there is a focused  
21 investment of time that it's a topic that clearly  
22 is of importance. And Greg said you don't come

1 with any higher endorsement than someone like  
2 General Myers and the Chairman of the Joint Chiefs  
3 of Staff which in civilian parlance is the CEO.  
4 Clearly the President is the Commander in Chief,  
5 but when you get to the top-of-the-line  
6 leadership, the Chairman of the Joint Chiefs'  
7 opinion is a rather important one. And for our  
8 topics, given that they are so mission essential,  
9 if that level of visibility, this is the  
10 top-of-the-line leadership, not just the top of  
11 the medical house, but the top-of-the-line  
12 leadership on important topics and the connection  
13 around the mission, that would make an interesting  
14 list of topics and probably increase the  
15 likelihood that the advice would both help to  
16 shape the thinking that would probably turn into  
17 important action.

18 DR. POLAND: Good point.

19 DR. WILENSKY: Yes, Dr. Khan?

20 RADM KHAN: Thank you very much. Greg,  
21 again excellent job, thank you, and a good thing  
22 for us to discuss. We've spent the last couple

1 minutes talking about topics. How about a topic  
2 that already exists? What you've just showed us  
3 in terms of the future of war, three of these  
4 seven items very much could benefit from our  
5 insight to think about public health diplomacy  
6 when they talk about strategic communications,  
7 talk about medical intelligence. I think we've  
8 discussed that a little.

9 DR. POLAND: Didn't escape my notice.

10 RADM KHAN: And the first time when we  
11 talked about the biodefense arena. So this is  
12 already a topic that DOD has decided is extremely  
13 important to them. We could potentially provide  
14 them more in-depth guidance than they got from the  
15 DSB.

16 DR. POLAND: Topics like humanitarian  
17 missions as an instrument of shaping U.S.  
18 interests. There's any number of them.

19 DR. WILENSKY: Again let's try to not  
20 decide the topic. Let's try to decide whether we  
21 want to go ahead with this as a concept and we can  
22 see whether we can find a time that's suitable

1 during the summer. We don't need to vote. Are  
2 people interested in seeing this explored? We  
3 won't regard it as a firm commitment but we'll  
4 take it to the next level. Thank you very much,  
5 Greg. Commander Feeks, are you going to give us  
6 guidance about our lunch and where we do it and  
7 when we reconvene or you can hand it off to  
8 someone else.

9 CMDR FEEKS: Thank you, Madam President.  
10 The schedule calls for us to break for a period of  
11 time. There will be an administrative session  
12 during a working lunch which I'm looking for a nod  
13 from my event planner. I believe it's in the room  
14 to my right just for the Board Members and  
15 liaisons. Then the public meeting will resume at  
16 2:15 here.

17 DR. WILENSKY: Thank you.

18 CMDR FEEKS: It really was a working  
19 lunch. Or shall we get lunch and bring it back in  
20 here?

21 DR. WILENSKY: It actually is a better  
22 place.

1           CMDR FEEKS: In here?

2           DR. WILENSKY: Can we do that?

3           CMDR FEEKS: Yes.

4           DR. WILENSKY: Yes, I think it would be  
5 preferable. This is really a working lunch. So  
6 if you can get your lunch. Make phone calls or  
7 whatever and be back ready to start in a  
8 half-hour.

9           CMDR FEEKS: That part of it really is  
10 an administrative session. It's only for Board  
11 Members and liaisons. So see you back here at  
12 2:15.

13                   (Recess)

14           DR. WILENSKY: Okay. Guys, people,  
15 please take their seats so we can proceed.

16           The next session is reporting on the  
17 healthcare delivery subcommittee, which I chair,  
18 which met on February 27th.

19           This is the list of individuals who are  
20 on the committee. It's quite a diverse group of  
21 experts involved in healthcare delivery and other  
22 aspects of medical care.

1           The primary purpose of the meeting on  
2     February 27th was to have a report from the  
3     Department with regard to the strategic plan that  
4     had recently been submitted to the Congress,  
5     indicating which of the recommendations from the  
6     Task Force on the Future of Military Healthcare  
7     were accepted by the Department and those that  
8     they did not concur with, and to help us  
9     understand the issues that would follow from the  
10    implementation strategies.

11           The other three areas we considered were  
12    healthcare matrices within the military healthcare  
13    system, direct care and purchase care trends and  
14    electronic health care records.

15           The primary charge for the subcommittee  
16    is to follow the implementation strategy, as the  
17    Department accepts various recommendations that  
18    were made by the Task Force.

19           Several were issues of prime interest to  
20    the subcommittee. The first has to do with the  
21    recommendation for a better way to integrate the  
22    care delivery between the direct care and

1 purchased care, particularly at the local level,  
2 where care is actually provided.

3           Several issues were raised by the  
4 department in terms of how to proceed on this  
5 recommendation, in particular, the kind of metrics  
6 that would be used to establish which of the areas  
7 were not, in fact, having adequate integration  
8 between purchased care and direct care; who would  
9 measure; and how would you know whether the  
10 integration was working or not.

11           What the Department is proposing to do  
12 is to monitor for areas in detail, where there is  
13 overlapping jurisdiction, so to speak, between the  
14 services -- San Diego, the I-25 Corridor in  
15 Colorado, the national capital region for obvious  
16 reasons, and San Antonio.

17           And we discussed the need for metrics;  
18 and discussed the need to have focus groups, and,  
19 again, to determine how you would assess whether  
20 or not this was a success or failure.

21           The committee decided it would probably  
22 be at least six months until there would be an

1 ability to have an assessment done as to whether  
2 or not there were problems with regard to the  
3 integration going on in any or all of these four  
4 areas. And then it would probably be at least a  
5 year until pilot projects to address some of the  
6 deficiencies that have been identified were  
7 actually ready to be up and running.

8 Other areas that we were concerned about  
9 had to do with cost sharing. The Department has  
10 accepted the notion of a two-step approach,  
11 resetting the cost share and stabilizing with some  
12 indexed tier to income; a decision that there  
13 would be no Tri-Care for life fee, which had been  
14 a very small fee that was being recommended; and  
15 that within the next few weeks the Department will  
16 be deciding precisely the position is going to  
17 take to go forward to Congress with regard to cost  
18 sharing.

19 In terms of the integration of medical  
20 services, the so-called unified medical command,  
21 which is an issue that is raised periodically, was  
22 basically not addressed to any detail in the Task

1 Force itself.

2 But we had some discussion about what  
3 the implications of thinking about the integration  
4 would be, how feasible, what kind of savings we're  
5 actually likely to resolve; and that these are the  
6 kinds of questions that would need to be addressed  
7 before it is likely to move beyond the steps that  
8 were undertaken about a year ago.

9 Two other areas had to do with our  
10 pharmacy -- the recommendation to change the  
11 co-pay to try to encourage that type of behavior  
12 that was being incited, particularly with respect  
13 to the use of a mail order pharmacy; and also to  
14 focus on best practices, including both best  
15 practices with regard to the clinical world, but  
16 remembering it is also very important to think  
17 about best practices with regard to acquisition  
18 and contracting.

19 There had been a discussion during the  
20 Task Force about whether or not the new contract  
21 that is in the process of being let would allow  
22 for more of a best practice focus through the use

1 of pilots or other changes than had existed in the  
2 past. What we were told is yes, that's true; that  
3 there are -- that it will be possible with the new  
4 contract to do this. However, several of us took  
5 the position that we would like to be briefed on  
6 the details of the new contract once the contract  
7 is let so we can try to assess whether or not that  
8 appears to be the case.

9 In the previous contract, there was a  
10 lot of difference of opinion, shall we say, on  
11 whether or not the contractual language was  
12 consistent with -- even allowed for best practices  
13 with regard to acquisition and other business best  
14 practices in addition to some of the clinical best  
15 practices. And we have decided the best way to  
16 resolve whether or not that is the case is to have  
17 an opportunity to actually get briefed on the  
18 details of the new contract, and, at some point,  
19 it would be possible as well to speak with the  
20 winners of the new contracts.

21 The second area that we focused on was  
22 talking about metrics measurement for healthcare

1 delivery. We had a very interesting presentation  
2 by Michael Daneen about what the Department is  
3 doing in terms in setting up an MHS, a values  
4 dashboard. We focused on the kinds of  
5 measurements that were being used and how they  
6 would apply to both direct care and purchased  
7 care, and high-priority issues and how to try to  
8 keep that in focus.

9           We talked about how perceptions appear  
10 to be a problem, more the perception than was  
11 always apparent in terms of the reality of the  
12 issue, at least in terms of direct measurement;  
13 but, nonetheless, a serious problem -- and also  
14 some of the issues that were raised with regard to  
15 slow provider communication going on between a  
16 member or dependent and the provider.

17           We had some discussion about the notion  
18 of tying these measures to the patient-centered  
19 home concepts, and how the military has attempted  
20 to use this dashboard and metric system in having  
21 a pay-for-performance system geared not to  
22 individual providers, as it is sometimes discussed

1 in the private sector, but rather providing  
2 funding for the unit or the facility that could  
3 then be used to sponsor activities of particular  
4 interest to the setting or to the individuals who  
5 are involved.

6 We spent some time talking about trends  
7 in terms of purchased care and direct care. Al  
8 Middleton was nice enough to come and provide the  
9 group with an overview in terms of what's going on  
10 with regard to budget and spending trends, looked  
11 at by each of the services, by TMA overall.

12 We talked about the effects of some of  
13 the earmarking that goes on as part of the  
14 budgeting process has in terms of flexibility or  
15 lack thereof that is available to health (off  
16 mike) in terms of setting up its spending and also  
17 talked about the effect of the stimulus bill in  
18 terms of additional monies for operating and  
19 management and also additional monies for military  
20 construction.

21 We had a long session where we were  
22 briefed by several individuals in terms of the

1 progress being made to the electronic health  
2 record system that is being developed by the  
3 Department -- reviewed some of the progress, and  
4 the availability of different components; discuss  
5 some of the interoperability issues with regard to  
6 the VA; had some demonstration of the capabilities  
7 of this system; talked about the focus between  
8 electronic medical records and the personal health  
9 record that is being considered; and discuss the  
10 role of structured text as one of the issues that  
11 seemed to be behind some of the consternation that  
12 we heard when he came to use of the Alta system.

13 We spent some time discussing what now,  
14 as other new subcommittees have done. What we  
15 have decided is that we will wait until June to  
16 meet again. We need to have some time pass until  
17 there is more of a development in terms of which  
18 the pilots or what kind of pilots are likely to be  
19 undertaken. We would like a chance to review the  
20 contract when it is actually let and released to  
21 the public so that we can assess whether or not  
22 some of these best practices when it comes to

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1 communications at least once a month, sharing some  
2 issues that individuals think are important for  
3 further consideration or issues that ought to be  
4 raised for potential discussion when we meet in  
5 June. And that will be our plan. But it seems  
6 like, at this point, we needed some curing, so to  
7 speak, to occur before we would actually be ready  
8 to take on any assessment of the implementation  
9 that HA did with regard to the Task Force  
10 recommendations that they had developed, as  
11 reflected in the report to Congress.

12 So it is also a stay tuned. We will be  
13 back -- in this case, probably not until the  
14 August meeting to share the results of our next  
15 meeting. Any questions that people have? Yes.

16 DR. MASON: Tom Mason from South  
17 Florida. Could you elaborate on what's meant by  
18 micro monitoring?

19 DR. WILENSKY: This was a term, though  
20 you notice I had it in quotes, because it was a  
21 term that HA used in describing what they were  
22 doing. And, as I understand it, although Al can

1 correct me if I've gotten it wrong, it was to go  
2 in and focus in detail -- that's the micro part of  
3 the monitoring -- in four areas of the country to  
4 see whether or not we were correct in our  
5 assessment that there was a problem at the local  
6 level in terms of integration between direct care  
7 and purchased care -- was the -- what was being  
8 provided downtown, so to speak, integrated with  
9 what was being provided on the MTF. Was the  
10 information brought back? Was there an awareness  
11 by both the direct care facility and the purchased  
12 care about what the other had done? Did people  
13 feel like they were getting the benefits of an  
14 integrated system or basically just going around  
15 to different physicians?

16 And in areas where there were  
17 overlapping services, in addition to the purchased  
18 care, direct care issue, which is true in all of  
19 these sites, how that integration seemed to go.  
20 Obviously, some of it is being pressed for other  
21 reasons -- NCR and San Antonio have their own  
22 integration issues that they are dealing with and

1 that will help better whether they are integration  
2 problems.

3 It wasn't so much whether at the  
4 Department level or the health affairs level that  
5 we thought there was an integration between  
6 purchased care and direct care, but where the care  
7 was actually provided on the ground, so to speak  
8 -- whether or not there was adequate integration.  
9 Russell?

10 DR. LEUPKERER: Yeah, thank you, Gail.  
11 I -- you know, I attended the meeting a week ago  
12 Friday, and actually learned a fair amount. But  
13 it led me to a question not only specifically  
14 about this, but probably a broader question for  
15 this committee.

16 I read the handout that was given to us,  
17 which is entitled "Responses to the  
18 Recommendations" of your Task Force by the  
19 Department of Defense Military Health System  
20 Senior Oversight Committee. And I was a bit  
21 surprised -- maybe I shouldn't have been -- to  
22 learn that they rejected some recommendations.

1 Other recommendations, they said, well, Congress  
2 has to do something about that before we can do  
3 anything.

4 And others they referred to the  
5 quadrennial, which I think meets every four years,  
6 Committee on Review of Military Compensation.

7 The question is, for this group, is come  
8 you know -- this particular committee as well as  
9 the broader committee -- so what is our  
10 responsibility for follow-up and seeing that  
11 things happen or don't happen?

12 DR. WILENSKY: Well, the first issue is  
13 that the Joint Pathology Center people may think  
14 that they are the only ones that have some of  
15 their recommendations non- concurred, but actually  
16 it is more true than not that some recommendations  
17 in almost any task force commission I've ever  
18 heard are not fully accepted by somebody,  
19 depending on whether they are going to a  
20 Department, to the President, or to the Congress.

21 That's a fact of life. The second is  
22 that there are some changes which require new

1 legislation, and some changes which do not require  
2 new legislation. And so, usually, on commissions  
3 where I am involved as a chair, having both been  
4 on an advisory commission to the Congress on  
5 several occasions and run the Medicare Program  
6 from the administration's point of view, I'm very  
7 sensitive to people who direct a department to do  
8 things that only Congress can change.

9 I usually try to have that in the report  
10 of saying, we recommend this, but we recognize  
11 that it will require a new statutory change.

12 And then there is the Quadrennial  
13 Defense Report that, as the name suggests, occurs  
14 every four years that, as I understand it,  
15 involves a broader strategic approach that the  
16 Department will take for the next four years. And  
17 there were some areas that were regarded as  
18 appropriate to be part of the next time there is a  
19 bid review.

20 So I think the more relevant question  
21 for us will be on a number of areas. For example,  
22 the integration was the overriding first

1 recommendation. The cost share change that was  
2 adopted was actually quite consistent in the sense  
3 that what we said is rather than the numbers,  
4 focus on the fact that you start -- this has been  
5 frozen in time since it was started. You need to  
6 start moving, however. Set it where you think  
7 it's appropriate. Index where you think is  
8 appropriate. He cannot stay frozen in time.

9           So I would say that on several of the  
10 major -- not all -- but several of the major  
11 recommendations, they were accepted by Health  
12 Affairs, and the subcommittee will attempt to see  
13 whether or not it appears that these changes  
14 occur, and, if so, whether they solve the problem  
15 they were meant to address. If not, how did they  
16 fall off the wagon and whether or not it was  
17 people got distracted; other issues claimed more  
18 media attention. There wasn't the funding. There  
19 wasn't -- in the case of the cost sharing, for  
20 example, while technically that was an area that  
21 the Department has under control, Congress has  
22 basically taken it away by passing legislation

1 that says thou shalt not.

2 And so, it has required now going back  
3 to use what had previously been within the  
4 statutory authority of the Department.

5 DR. LEUPKERER: So, but what you're  
6 saying at the end and to answer my question is we  
7 can ask to review these things get a response --

8 DR. WILENSKY: Oh, yeah.

9 DR. LEUPKERER: For not only this  
10 particular task force, but others we're involved  
11 in?

12 DR. WILENSKY: Oh, that -- and we should  
13 assume that part of our obligation is to follow  
14 through to see what happens, particularly since  
15 the whole charge of this -- the major charge of  
16 this subcommittee is to follow on the  
17 recommendations made by the task force accepted by  
18 the Department. So, it actually is the charge of  
19 this task force -- of this subcommittee. Yes?  
20 Bill?

21 DR. LOCKEY: As a way of background, I  
22 don't a lot about the system. The purchased care,

1       there is a contract as to what will be provided or  
2       is it open-ended.

3                 DR. WILENSKY: Oh. Okay. Yeah, I  
4       assumed -- okay. I apologize.

5                 DR. LOCKEY: And then the second  
6       question is does the contract specified that  
7       they'll use electronic medical records that are?

8                 DR. WILENSKY: No. And that's the --  
9       the second part is easy. This is the whole TMA  
10      contracts that are let. There are three that are  
11      provided. They're in the process. I'm going to  
12      say they're being recompleted. They've -- I assume  
13      actually they've been awarded. I just don't --  
14      they haven't been announced, so I don't know what  
15      the answer is. Al is shaking his head. No, they  
16      haven't been.

17                They -- the responses -- the RFP were --  
18      the RFP was let sometime ago. The responses are  
19      in. The Department is doing its thing in deciding  
20      what decisions they will make going forward.

21                They are -- they divide the country up  
22      into three big pieces. And they basically support

1 the direct care provided by the military,  
2 depending on availability and depending to some  
3 extent on the choice of the individuals -- of the  
4 beneficiaries -- as to the type of plan that they  
5 take.

6           It is a big complicated contract.  
7 There's some dispute about whether or not the  
8 contract offers the contractee enough flexibility  
9 to provide the best care possible, whether or not  
10 the incentives after support the best integration  
11 between direct care and purchased care.

12           That's part of the integration  
13 monitoring that I referenced earlier as to whether  
14 or not it's a contractual issue or whether or not  
15 it's a delivery issue and not adequate empowerment  
16 of the military person on the ground for a clear  
17 understanding of the integration between the  
18 various services, if there are multiple services.

19           So, in San Antonio, you have the Air  
20 Force and you have the Army.

21           And now going through more of an  
22 integration of their own facilities. And it will

1 be looking at how that and the integration between  
2 purchased care and the direct delivery care works.

3 You can't really at this stage have  
4 easily a requirement for electronic records. You  
5 may have noticed the private sector is not big on  
6 having much of an electronic records system. You  
7 would basically have a very small response set to  
8 this contract if that were a requirement last  
9 year, for example, just because it doesn't really  
10 exist in the private sector.

11 But it is an issue going forward, and it  
12 will be a bigger issue next time the contract is  
13 let in three to five years. Yeah.

14 DR. LOCKEY: What about specification of  
15 the contract as far as what preventive measures,  
16 let's say, screening for colon cancer,  
17 sigmoidoscopy, colonoscopy, what age, how  
18 frequent. Are those specified or is that left to  
19 the contract provider to determine?

20 DR. WILENSKY: I would guess it's not  
21 left to the contract provider to determine. But  
22 Al is probably better -- in a better position. I

1 think that there are -- there are certain  
2 requirements in terms of screening and access, I  
3 mean, as you would in other kinds of similar  
4 requirements. But, Al?

5 MR. MIDDLETON: Precisely. There are  
6 access standards to care, and they are part of the  
7 benefit, the period of time with which, you know,  
8 you're eligible for a colonoscopy, the period of  
9 time for mammographies and things like that.

10 So the purchased care side of it, which  
11 is about twice as big actually -- we purchase  
12 about twice as much care in dollar value than what  
13 we actually expend in the direct care system -- is  
14 really the wrap around contract so that if you  
15 remember the old CHAMPUS days, it's really kind of  
16 the old CHAMPUS days, where if a beneficiary can't  
17 get care in a direct care system, either there's  
18 no direct care system available or there is no  
19 space available for that beneficiary. And  
20 usually, this is retirees or active-duty  
21 dependence. And this is their insurance plan, if  
22 you will, that goes downtown -- so they can go

1 down to the local physician or the hospital, be  
2 seen, and then we have a triple option. There is  
3 an HMO portion of it. There's a PPO portion of  
4 it. And there's a fee-for-service portion of it,  
5 too. So it's a triple option.

6 And if you'd like at some point in time  
7 at the Board, we can have someone come and sort of  
8 run through the benefit. That might be useful for  
9 the Board at some point. We'd be happy to do  
10 that.

11 DR. WILENSKY: Okay. Thank you. Yeah.  
12 Spent so much time discussing TRICARE I forget  
13 that everyone doesn't automatically know it and  
14 all of its detail.

15 Where is -- we think that -- Ken -- Ken  
16 Kizer, are you on the phone?

17 MR. KIZER: I am.

18 DR. WILENSKY: Oh, good. Our next  
19 speaker this afternoon is Dr. Kenneth Kizer,  
20 Chairman of the Board of Medsphere Systems  
21 Corporation, the leading commercial provider of  
22 open source information technology for the

1 healthcare industry.

2           Previously, he served as the Under  
3 Secretary for Health in the U.S. Department of  
4 Veterans Affairs. He is also the Chairman of the  
5 National Capital Region Base Alignment and Closure  
6 External Advisory Subcommittee, and will provide  
7 an update on its recent activities.

8           The panel has indeed is a number of  
9 distinguished subject matter experts and a patient  
10 representative to participate in their review and  
11 has been diligently working on a statement  
12 defining the concept of world-class and a report  
13 regarding their findings and recommendations  
14 concerning their review of the design and  
15 construction of the new Walter Reed Military  
16 Medical Center at Bethesda and the Community  
17 Hospital at Fort Belvoir.

18           Their efforts will help develop a  
19 standard for world-class that will set a precedent  
20 within the Department and will undoubtedly leave a  
21 lasting legacy for future delivery of care for our  
22 wounded service members.

1                   His briefing slides can be found under  
2                   Tab 8 of the meeting binder. Dr. Kizer?

3                   DR. KIZER: Thank you, Gail. And let me  
4                   first check to make sure that you can hear me.

5                   DR. WILENSKY: Yes. Fine.

6                   DR. KIZER: And hopefully, everyone will  
7                   forbear. This is a bit awkward I'm sure for you  
8                   as for me trying to do this and not being able to  
9                   engage a visually or see the slides as they are  
10                  being presented.

11                  So anyway, let me move forward. What  
12                  I'd like to do is to provide an update on where  
13                  the committee is, and recognizing that we're  
14                  operating under a bit of a pressured timeline.  
15                  I'd like to review what the charge to the  
16                  committee was and what this report is all about,  
17                  to talk about what I think are the three main  
18                  points of the report, which is a definition of  
19                  world-class healthcare, a -- what our findings  
20                  are, and what our recommendations are at this  
21                  point, recognizing that the full report is still  
22                  being drafted. And so I guess I would issue a

1 caveat at the beginning that they should all be  
2 viewed as a work in progress, albeit near  
3 completion, but it's still is being refined and  
4 worked on.

5           With that, let me ask -- and I'm  
6 assuming someone there is running the slide  
7 projector -- if we can go to the second slide.

8           And I anticipate there will be a fair  
9 number of questions and or comments, so I'm going  
10 to go through these slides relatively quickly so  
11 that there will be time for further dialogue at  
12 the end.

13           But just to review, the advisory  
14 committee was initially convened to advise on the  
15 establishment of the Integrated Service Delivery  
16 Network that's being set up in the National  
17 Capital Region, recognizing that there is a  
18 similar effort underway down in the San Antonio  
19 area, although we are not charged with looking at  
20 that specific project.

21           Shortly after the advisory committee was  
22 convened, we were additionally charged with

1 conducting the independent design review -- if we  
2 go to the third slide -- of the new Walter Reed  
3 National Military Medical Center and the hospital  
4 at Fort Belvoir, pursuant to the 2009 budget,  
5 which specifically calls for the independent  
6 design review and asks that two primary questions  
7 be answered: First, will the design of achieve  
8 the goal of providing world- class medical  
9 facilities? And world-class medical facilities is  
10 the exact language that is in the law. And  
11 secondly, if not, what might be done or should be  
12 done to ensure that the construction and design  
13 do, in fact, this standard that Congress has  
14 imposed, recognizing at the outset that nobody has  
15 defined what a world class medical facility is,  
16 which is, on an editorial note, a bit of an  
17 unusual way to incorporate a design into federal  
18 law.

19 But noting that, the -- there are some  
20 corollaries. If I could go to the four slide?

21 While not specifically asked in the law,  
22 but obviously built into the questions that they

1 were asking and verbally expressed, were not only  
2 the question of what is, in fact, a world class  
3 medical facility, but was the -- or is the  
4 approach being taken at both Walter Reed and Fort  
5 Belvoir hospitals, recognizing that they are in  
6 different approaches, are they sound? Are they a  
7 good way that the Department should be looking at  
8 capital construction in the future? Is there --  
9 if that's not the case, or if these facilities are  
10 being designed to be world-class, should the  
11 construction be called to a halt? And then  
12 finally basically, were there other things --  
13 other issues -- that should be considered along  
14 with the specific construction and design issues?

15           If I could have the fifth slide. Which  
16 moves us to just a very quick review of the  
17 process that we have utilized to date, and it's  
18 quite simple.

19           The initial subcommittee, upon receiving  
20 the additional charge, supplemented its membership  
21 with a number of distinguished subject matter  
22 experts, including patient representatives. We

1 have had a number of in-person meetings,  
2 conference calls. We have reviewed reams of  
3 documents and have heard numerous, dozens of  
4 presentations, by those involved with the project,  
5 and some specifically focus on trying to define  
6 what is world-class, but largely focused on what  
7 are the plans and what is the design that has been  
8 used to date.

9           And then additionally, after we had a  
10 draft definition of world-class, I did send this  
11 out to probably about 50 healthcare luminaries  
12 around the country for their comments and received  
13 a large amount of feedback, mostly all very  
14 positive, but with suggestions for, you know,  
15 adding a change here or tweaking this or some  
16 other things.

17           And the majority of those things have  
18 been incorporated and reviewed by the committee,  
19 and the synthesis of all of this is what is  
20 reflected in the current appendix A in your  
21 binders, which I will come back to very shortly.

22           If we go to slide number six. Again,

1 just in the way of background, the term world  
2 class, as I've said, has not been officially  
3 defined or no operational definition has been  
4 advanced by any recognized body to date.  
5 Generally, what has been said is that it's taken  
6 to mean -- and this is basically what is stated in  
7 the Defense Budget Act -- that this means that it  
8 should be among the best in the world. And this  
9 is a -- this term world class has crept into the  
10 healthcare literature quite prominently in the  
11 last two years. Indeed, if you go to Google and  
12 dial in world-class medical facility, I quickly  
13 counted more than 100 different facilities that  
14 attributed that description to the services that  
15 they provide. And after I got to 100, I quit  
16 looking any further. But it's clearly a term that  
17 is now being used widely, largely according to how  
18 one perceives what they're doing, I gather.

19 I think I've talked about how we  
20 developed our definition. Basically, we looked at  
21 a large number of documents that were relevant to  
22 this. We use the committee's considerable

1 collective expertise and then asked for input from  
2 a lot of other individuals, and, again, that's  
3 what's reflected in Appendix A.

4           And if I could go to slide number seven.  
5 I am not going to attempt to go through everything  
6 that is in Appendix A. I would refer you to the  
7 document for the specifics, but a few comments are  
8 probably in order.

9           In thinking through this issue, it  
10 became clear to the committee at the outset that  
11 there are a number of characteristics or  
12 attributes of what might be considered world-class  
13 that can be measured and quantified and have been  
14 enumerated in one way or the other by other  
15 entities, other relevant healthcare bodies.

16           And then there is a number of qualities  
17 or characteristics of a world-class facility that  
18 might be considered intangible. I would say that  
19 they are things that we can't measure or quantify  
20 by current methods, so, in that sense, I guess  
21 they are in tangible, but it's somewhat like  
22 healthcare quality. If you engaged in a

1 discussion 15 years ago about what is healthcare  
2 quality, people would've said, well, you can't  
3 define it.

4           And, of course, that's -- we know that's  
5 not the case by any means today.

6           So many of these things that currently  
7 we can't measure, at some point in time, maybe  
8 they can. But I think if you read what's on the  
9 slide their in the lower half, you get a sense of  
10 what we're talking about, and that clearly, just  
11 to summarize this, that in a world-class facility,  
12 there are synergies that result from how all the  
13 pieces fit and work together.

14           The -- in trying to make this definition  
15 operational, we did look at the -- all of the  
16 different information, and it really fell into the  
17 six domains that are identified there, and each of  
18 those having a number of specific sets of  
19 conditions -- the 18 buckets, if you will, that,  
20 in many cases, refer to criteria or standards that  
21 have been established by other healthcare bodies.  
22 And I think one of the things that has become

1 clear in going over this is that, unless one is  
2 familiar with some of these, it may be hard to, in  
3 some cases, understand what exactly is entailed by  
4 some of the things that are included by reference.  
5 If we were to detail all of this information out,  
6 though, we would have a document that, just with  
7 this information, would involve multiple volumes.  
8 And the only way to reasonably do it is to include  
9 it by reference.

10 We can come back to these later at the  
11 end, but in the interest of moving through this  
12 and getting to a point where we can have some  
13 dialogue, let me move on to the eighth slide,  
14 which goes to if you want to look in your binders  
15 to the document that's entitled "Preliminary  
16 Conclusions."

17 And I'm going quickly go through this,  
18 and then to the recommendations. The  
19 recommendation stem pretty directly from these  
20 findings.

21 And again, I recognize that the full  
22 report would include all of the evidentiary base

1 upon which these findings are based.

2           But just quickly going through them, the  
3 first thing -- and I think while it's not  
4 specifically asked for, but I think it's an  
5 important finding to put on the table -- is  
6 whether we agree that the idea of having  
7 integrated delivery network is, in fact, a good  
8 idea. And there was no significant debate on  
9 that. I think there was universal agreement  
10 amongst the committee immediately that it makes  
11 sense and that this would be an important step  
12 towards better coordination all the services that  
13 are available for both active duty and retired  
14 military personnel in the capital area.

15           We also as a second conclusion felt that  
16 the processes used by the Department in  
17 approaching the construction and design at both  
18 Walter Reed and Fort Belvoir, albeit it different,  
19 were both good, and generally felt that anything  
20 that provided a shortened timeline and flexibility  
21 was better than the historical or traditional  
22 approach to military construction.

1           The -- also the committee, I think, was  
2 quite impressed by the amount of work, the  
3 dedication, the commitment, the energy that has  
4 been displayed by just a very large number of  
5 people who have been working on this.

6           But we were also impressed at the same  
7 time that their efforts have been seemingly  
8 frustrated on frequent occasion because of the  
9 unclear chain of command, the variety of ways that  
10 things are budgeted, and the fact that there isn't  
11 an overall, you know, master plan and  
12 corresponding budget to go with it that would  
13 allow us all to proceed as a singular project as  
14 opposed to the piecemeal way that it appears to be  
15 addressed. Indeed, we think that a lot of the  
16 effort -- sometimes it almost seems like it's  
17 working at cross purposes because of these things.

18           Also, we were impressed of the lack of  
19 an institutional memory and the traditional  
20 rotation of military personnel has often left  
21 significant voids in the understanding or recall  
22 of how things came to be the way that they are.

1 Things have not always been documented as fully as  
2 they might be. And, with people gone, it's  
3 unclear often why decisions have been made as they  
4 have what the basis for those were -- those  
5 decisions were.

6 In this same way, and I would just say  
7 that there also appears to be or appears to the  
8 committee that there is some significant ambiguity  
9 in the actual vision of the end result and where  
10 this is all headed, which has also had a  
11 deleterious effect on all of the hard work that's  
12 being done by very committed individuals, but who  
13 often see the endgame differently, depending on  
14 which lens they happen to be looking through.

15 Moving on to the ninth slide, the --  
16 actually, I guess I've already covered that except  
17 for the last point. I think the -- there is a  
18 strong agreement among the subcommittee that the  
19 plans for the community hospital at Fort Belvoir  
20 appear to be well conceived. They are -- that  
21 project has moved quite nicely, although it has  
22 some inherent differences than the Walter Reed

1 project have.

2           Notwithstanding basically doing it quite  
3 positively, there were some areas where  
4 improvements could be made, as I'll get to at the  
5 end.

6           If we can go to slide 10. Understanding  
7 that in any process like this, particularly one  
8 that involves a lot of input from a lot of  
9 different people that not everyone is going to  
10 have their input incorporated into the final plans  
11 and that sometimes those inputs are directly in  
12 contradiction to each other. I think anyone who's  
13 been involved in this knows very well what I am  
14 referring to, but having said all that as context,  
15 it did appear that some of the input from both  
16 patients and frontline clinicians that seems quite  
17 important was not incorporated into the end  
18 design, as will perhaps become more clear with  
19 some of the specific points. And we view that as  
20 a bit of a problem.

21           Likewise, culture, in an integrated  
22 delivery network, there is a culture that needs to

1 prevail that is not the culture that has been  
2 prevalent amongst the individual military medical  
3 services, or at least bringing them together.  
4 They haven't been melded into the culture that's  
5 going to need to be necessary or that's needed to  
6 support the integrated delivery network.

7           And somewhat on an editorial basis, the  
8 committee found it somewhat ironic, because the  
9 military, the Armed Forces, has so much expertise  
10 in developing and shaping organizational culture  
11 that this kind of stood out as very notable that  
12 this culture change seems to be occurring more by  
13 happenstance than by design, and it's clearly one  
14 of the underpinnings of the success or ultimate  
15 success of the integrated delivery network.

16           Shifting gears to point number six in  
17 your handout. There -- all of the planning that  
18 has been done has been based on a demand analysis  
19 of how things were or what the needs were in 2004.  
20 And the committee, from a conceptual perspective,  
21 thought this was somewhat problematic, recognizing  
22 that they're going to be changed needs in the

1 future, some of which will be related to  
2 population shifts and other sorts of things, some  
3 of which will be related to new technologies in  
4 healthcare that are either on the drawing board or  
5 in the approval process; and that this design  
6 really wasn't based on a dynamic demand analysis  
7 of looking at the future as opposed to a much more  
8 static demand analysis based on how things were  
9 five years ago.

10 And while no specific problem was  
11 identified as a result of this, the committee felt  
12 that this was just conceptually a problem, and  
13 indeed you wouldn't know what the specific  
14 problems were until you do the analysis and see  
15 how that jibes or doesn't comport with what has  
16 been done.

17 Next point was that there, as I've  
18 alluded to, no overall master plan for the --  
19 either for the new Walter Reed National Military  
20 Medical Center or for the integrated delivery  
21 network in the aggregate.

22 And this, again, has been -- it's

1 understandable why that might have occurred  
2 largely because of the different funding streams  
3 and planning has been predicated largely on what  
4 has been funded under the BRAC process, but that  
5 really is inadequate to lead to the desired end  
6 results of having a world-class medical facility,  
7 particularly in light of some of these significant  
8 deficiencies that exist in the current naval  
9 facility and things that, in some cases, will be  
10 made worse by renovations that are being made,  
11 which gets us to, I guess the next point or what's  
12 number eight on this tentative conclusions list.  
13 And I'm not going to go through each of these in  
14 great detail. I mean, you can read it as well as  
15 I.

16           There's a variety of problems here,  
17 including that there's some things that just don't  
18 conform with the Joint Commission Standards.  
19 There are some notable deficiencies in the  
20 surgical suite having to do with the size of  
21 rooms, number of rooms, technologies, the pre- and  
22 post-operative care areas, the flow of patients,

1 and a number of other things.

2           Likewise, the planning for where the  
3 surgical pathology, particularly the frozen  
4 sections are being done, seems to be particularly  
5 problematic in that that's a very time sensitive  
6 issue or getting a frozen section back to the  
7 surgeon. And currently the plans call for this to  
8 be located, I believe, on a different floor  
9 substantially down the hallway from, or acquiring  
10 that there be a lot of movement back and forth as  
11 opposed to being adjacent to the surgical suite,  
12 which is certainly they -- would be considered the  
13 norm today.

14           And that just seems to design in  
15 inefficiencies and potential problems that are  
16 hard to understand what the thinking was.

17           Some issues in the post-anesthesia area  
18 as far as that will be adequate and whether it's  
19 appropriate to use that for housing emergency  
20 department patients that need observation.

21           Shifting gears a bit, the overall  
22 hospital bed plan has some significant

1 deficiencies or at least certainly doesn't comport  
2 with what would be considered world-class as far  
3 as having all single-bed rooms or at least the  
4 overwhelming majority being single-bed rooms; not  
5 be able or not being large enough to cut it family  
6 members, you know, requiring movement of the  
7 patient, and a number of things in that area.

8           The plan does not call for any  
9 simulation laboratories on site, again, something  
10 that the committee found especially ironic in so  
11 far as the military or the Armed Forces have  
12 clearly been the driving force in simulation  
13 technology in the United States. They are the  
14 unrivaled leaders in this regard, and it is today  
15 certainly considered to be a state of the art  
16 requirement in a number of different areas to have  
17 simulation labs on site.

18           The IT or the information technology  
19 infrastructure -- we spent a fair amount of time  
20 trying to dissect that and understand it. And it  
21 certainly appeared that everyone was being  
22 forthcoming, but we just didn't find it adequate

1 and we're at somewhat of a loss as to why some  
2 issues related to interoperability and use of  
3 open- source software and some other things  
4 weren't considered that we felt should have been  
5 considered and had detailed answers as to why or  
6 why they were not being included in the final  
7 plans.

8           The -- and I would just underscore the  
9 absence of having a decision on electronic health  
10 record, understanding all the work that's being  
11 done on that and by others is -- it wasn't so much  
12 the issue, because the planning and the IT  
13 infrastructure could all be laid down and be  
14 agnostic to the actual specific software used.  
15 But, again, we didn't find that everything was as  
16 it might be or should be in that area.

17           The -- just a couple of other points:  
18 Medical records, we understand that the plan is to  
19 digitize all the medical records there. But  
20 there's no plan for how that's -- or least we  
21 couldn't find any plan as to how that was going to  
22 happen. And, in the event that it didn't happen

1 in time for the facility when it opens, there's no  
2 storage space included at the new facility -- and  
3 there is -- or other issues related to just the  
4 storage of medical records.

5 Technology -- no overall strategic plan  
6 for technology, and again, modern healthcare is  
7 highly dependent on a variety of very  
8 sophisticated technologies. Not having this plan,  
9 not understanding how they're going to relate  
10 together was a little bit hard to understand.

11 Other very specific issues like the  
12 location of the dialysis unit on the floor above,  
13 the central swords still processing area, and  
14 understanding the demand for changing plumbing and  
15 other sorts of things in dialysis -- this just  
16 didn't seem, at first the blush, to be entirely  
17 logical, understanding, though, it may ultimately  
18 be necessary, but that was something we felt  
19 should be re- looked at.

20 And then there were the support services  
21 in a variety of areas, whether dietary food  
22 service, materials management, parking, did not

1     seem to be adequate or, again, based on a  
2     future-oriented demand analysis, and it seemed  
3     like there may well be some deficiencies in that  
4     regard.

5             Understanding I have just thrown a whole  
6     lot of information out there that you've not had  
7     the benefit of looking at the volumes of  
8     documentation that we did, there may well be  
9     additional questions about that, but, in the  
10    interest of moving forward, let me just shift to  
11    the last area, and that's our tentative  
12    recommendations, which, I said, I think stem  
13    pretty much directly from the findings. The first  
14    and what we would consider the probably single  
15    most important recommendation is the need to  
16    empower a single official with overall authority,  
17    both organizational and budgetary authority, to  
18    pull all of the different pieces together so that  
19    there is, indeed, a, if you will, a more  
20    integrated approach to the management of this very  
21    important project. There is a need for a master  
22    plan. Indeed, we would think that that would be

1 the first item of business of this new empowered  
2 individual would be to set about developing a  
3 master plan for both the Walter Reed National  
4 Military Medical Center as well as the National  
5 Capital Region Integrated Delivery Network.

6 And those things could be done  
7 relatively quickly. We think there's a need to  
8 start engineering by design the culture change  
9 that needs to occur. The various deficiencies  
10 that have been noted need to be addressed.

11 There's a need to make sure that both patient and  
12 frontline clinician input is appropriate included  
13 into the plans.

14 We also felt that in so far as this is a  
15 substantial departure from how the Department has  
16 constructed facilities in the past that there  
17 needs to be a formal evaluation process built into  
18 this so that the -- you truly can learn from this  
19 and incorporate it into the future military  
20 construction projects and analysis of whether the  
21 design build bid -- the two different approaches  
22 being used to do two sites, you know, what their

1 relative strengths and weaknesses are.

2           And finally the -- I think an important  
3 recommendation and certainly one that will be of  
4 interest to the Congress is whether there should  
5 be any halt to the construction, and our strong  
6 recommendation is that there shouldn't be,  
7 although this is predicated somewhat on the belief  
8 that a master plan and some of the deficiencies  
9 can be corrected as that master plan is developed  
10 and the backfill redesign or construction can be  
11 accomplished while all of this is going on. But  
12 we think that stopping construction at this point  
13 would be not only costly, but very demoralizing  
14 and otherwise just a bad thing.

15           With that, let me close and open it up  
16 for questions. The committee expects to finalize  
17 its report in the next few weeks, after which it  
18 will be I assume further mulled over by this  
19 committee, by this board, and then presented and  
20 discussed, otherwise, as requested, and the  
21 committee will -- at least anticipates continuing  
22 to focus on the National Capital Region Integrated

1 Delivery Network, as with this just being the  
2 first work product that was asked in response to a  
3 specific congressional request. And, of course,  
4 we'll do whatever else is asked, if it's  
5 reasonable. So with that, let me stop and open it  
6 up. And I know, at least I understand that Cheryl  
7 Herbert and Steve Shinth and maybe others from the  
8 committee are there in attendance, and so  
9 questions can be directed to either them or to me.  
10 And we'll do our best to answer them.

11 DR. WILENSKY: There's a lot of  
12 information you have received quickly without  
13 advantage of being able to read it through, but I  
14 don't know whether there are any questions that  
15 people have? Yes, David.

16 DR. WALKER: How do you accomplish  
17 backfilling, enlarging the operating rooms?

18 DR. KIZER: I'm sorry. I couldn't  
19 understand the question.

20 DR. WALKER: Well, you --

21 DR. KIZER: It was garbled.

22 DR. WALKER: -- continue with the

1 construction and backfill renovations, and one of  
2 the recommendations is that you need a larger  
3 operating room for contemporary equipment. I'm  
4 asking how you accomplish making a larger  
5 operating room if you got one that's too small?

6 DR. KIZER: Well, we think those things  
7 would be at the top of the list to develop.  
8 There's a lot of construction going on, and there  
9 may need to be some shift in a -- you know, where  
10 specific work is ongoing, as some of these things  
11 are settled out. I frankly would defer, in part,  
12 to the architects and the construction people who  
13 did weigh in quite heavily on this, and they felt  
14 that this really wouldn't be a problem, assuming  
15 that the issues could be addressed in a timely  
16 manner, meaning any order of weeks or months as  
17 opposed to years.

18 DR. WILENSKY: Is there -- Adil?

19 DR. SHAMOO: Adil Shamoo. Sorry. Adil  
20 Shamoo. I want to congratulate you and the  
21 committee for what an incredible job. Even though  
22 some of us have problems with defining what

1 world-class is, you attempted and you've done a  
2 great job. And, to my pleasant surprise, you have  
3 almost 10 bullets on adverse events reporting and  
4 medical errors, which is wonderful. Even you want  
5 to the -- at length, even apologizing to the  
6 patient if an error has occurred. And that's  
7 extremely admirable.

8           However, world-class, however you define  
9 it, it has usually world-class research, and you  
10 do mention that, conducting research. And most of  
11 the problems at least we know in the past 20 years  
12 plaguing some medical institutions are issues --  
13 scandals within the medical research.

14           But you mention nothing about what I  
15 would urge you to mention something that that  
16 clinical research should be done in the most  
17 ethical manner; and adverse events reporting and  
18 other norms -- informed consent -- should be a  
19 high top priority to those research volunteers,  
20 because they are not only patients, they have gone  
21 the extra mile, altruistically, to volunteer  
22 themselves to the public sector.

1 DR. KIZER: You're preaching to the  
2 converted, and I would certainly agree with you.  
3 The -- I think the only thing I would say in --  
4 and not really defense but in response -- is that  
5 the comments about research or predicated on an  
6 ambient culture that includes all those other  
7 things in the thinking at least, albeit that  
8 perhaps we need to make this more clear, the  
9 thinking was that all the -- what you're talking  
10 about would, in fact, occur in research just like  
11 it would occur in patient care in any other area  
12 that might be relevant.

13 DR. WILENSKY: Ken, could you speak a  
14 little more about how exactly you get the culture  
15 change that you mentioned that needs to occur to  
16 occur? I mean, I know you raised it briefly, but  
17 I'm feeling somewhat lost as to how one makes that  
18 happen.

19 DR. KIZER: Well, one were to lay out a  
20 process without going into the details of what the  
21 culture is, I mean, you know, there is a body of  
22 literature on how integrated systems work well

1 together and what are high performing  
2 organizations. In many of the examples that are  
3 cited for health care are things like aviation or  
4 how Navy Seal Teams operate, and then there are a  
5 number of examples that come from the military as  
6 to how you get the mindset of -- or the teamwork  
7 and the mindset that we are all functioning as a  
8 singular unit as opposed to a bunch of pieces that  
9 have been put together and are somehow supposed to  
10 get it done.

11 So, to be more specific answer your  
12 question, I think you need to go and develop that  
13 -- what are those attributes of a well functioning  
14 integrated delivery health care system. How's  
15 that different, you know, the gap analysis of how  
16 is that different than what currently exists,  
17 which I think would be fairly obvious to anyone  
18 that looks into this. And then how do you  
19 engineer behavior change. And, again, the  
20 military has robust knowledge about how you turn  
21 individuals into coherent units, and that  
22 knowledge, albeit coming more from the operational

1 forces than in healthcare, that needs to be turned  
2 to the specific project, where the three services  
3 that do have quite different cultures come  
4 together and function as a singular culture, you  
5 know, regardless of which uniform they may be  
6 wearing or who issues their paychecks, although I  
7 guess they all come from the same source.

8 DR. WILENSKY: Wayne?

9 DR. KIZER: Does that answer your  
10 question, Gail?

11 DR. WILENSKY: It helps. Thanks.

12 DR. LEDNAR: Wayne Lednar. Thanks, Ken,  
13 for a very nice discussion of a lot of practical  
14 aspects of producing a world-class system. Excuse  
15 me. But a question about whether we are committed  
16 to the importance of culture. If it's important  
17 for the performance of the integrated delivery  
18 network that the purchased care and the direct  
19 provided care work together to a common good in  
20 this transformed culture, would we feel strongly  
21 enough about that that as a condition of bid, a  
22 bid would not be awarded to an external entity

1 that was not committed to conform to the DoD  
2 described culture for this network.

3 And, similarly, to the extent that among  
4 the services, there were differences in culture  
5 that we're getting in the way of quality of care,  
6 if that were to occur, that that would become a  
7 command performance aspect of those obstacles were  
8 not improved in some way. Do we feel that  
9 importantly about culture to take those steps?

10 DR. KIZER: Well, I can only hazard my  
11 own opinion, and I think it probably represents  
12 the committee's view. And the answer to both  
13 would be an overwhelming or resounding yes.

14 That -- whether that actually was  
15 carried out is an operational decision that would  
16 have to be made by those in other positions than  
17 I'm in. But yes, I mean, I think we would feel --  
18 because I think one of the things that underlies  
19 all of this concept of world-class, et cetera, is  
20 that it's more than anything else is culture. You  
21 know, you can have the great technology in the  
22 world. You can have all of the, you know, Nobel

1 laureates they are, but if they don't work  
2 together as a function team and if you don't have  
3 the right culture, you're not going to get a very  
4 good outcome.

5 DR. WILENSKY: John?

6 DR. LOCKEY: Ken, I enjoyed -- Jim  
7 Lockey. I enjoyed your presentation very much.  
8 When I think of world-class, I look at it as sort  
9 of a time-dependent, and, therefore, a transient  
10 description unless there is a culture in place  
11 that allows for continuous improvement over time.  
12 And I feel that applies to the physical facility  
13 also and how adaptable that physical facility is.

14 Was that -- was this concept taken under  
15 consideration in the design process, the actual  
16 physical plant design process? How adaptable was  
17 it over time? How can you change in a  
18 cost-effective manner?

19 DR. KIZER: Well, you know, was it in  
20 the current plans or did we think it should be?  
21 Let me just ask you to refine your question. Or  
22 maybe I can answer the question that I posed.

1           The committee feels that is absolutely  
2     critical, and we would resoundingly agree with  
3     your observation. And indeed, there is verbiage  
4     in several different sections of the definition  
5     that makes that exact point. And part of that or  
6     part of what we see missing from the current  
7     plans, particularly at Walter Reed but also at  
8     Belvoir is no apparent operationalization of that  
9     concept.

10           In other words, it seems to be pretty  
11     static, and you quite correctly point out that  
12     whatever is a cutting- edge or whatever is  
13     world-class today in healthcare is not going to be  
14     tomorrow or next week, and so there's going to be  
15     a continual need to refine process, to refine how  
16     space is used, to re-utilize things; and that all  
17     should be built into the basic design and how  
18     facilities can be retooled as the needs change  
19     without, you know, having to start from scratch.

20           And again, the architecture -- I'm quite  
21     confident that those are the types of things that  
22     can be done without a great deal of effort if they

1 are thought about and planned for from the  
2 beginning.

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3 DR. WILENSKY: Mike?

4 DR. OXMAN: Mike Oxman. I had the  
5 privilege of attending the meeting of the  
6 subcommittee in January. And I'd like to make a  
7 couple of comments and related to a little more  
8 answer to Dr. Walker's important question -- is  
9 how you can deal with the problem of 14 -- four  
10 hundred to 500 square foot operating rooms, which  
11 don't have room in them for some of the current  
12 standards of care.

13 I think the critical two recommendations  
14 of the committee, both of which have to be  
15 implemented at flank speed if we're going to also  
16 support the last recommendation and that is to  
17 continue construction and count on backfill, is  
18 that the empowering a commander with all of the  
19 funding streams in hand in directing him or her to  
20 immediately and as quickly as possible develop  
21 what doesn't exist now and that is an integrated  
22 facilities plan.

1           Without out those two components quickly  
2 accomplish, I think the last recommendation  
3 worries me.

4           DR. KIZER: And I would affirm all that  
5 you have said.

6           DR. WILENSKY: Any other comments? Russ  
7 just for a (off mike) and then Chase.

8           DR. LUEPKERER: You know, I'm listening  
9 to this. This is Russell Luepkerer. And I'm  
10 wondering if I'm in a parallel universe somewhere.  
11 You know, where you started out talking about  
12 world-class in the list of deficiencies and  
13 concerns are just enough to bring it to  
14 state-of-the- art, not excellence. But, I mean,  
15 when you see the operating rooms have problems  
16 when their information- technology isn't ready and  
17 there's no plan for things, that -- I don't think  
18 -- I don't think of world-class in that same  
19 breath.

20           DR. KIZER: Well, I don't think that we  
21 would underestimate or understate the need for  
22 some changes, the need for some changes to be made

1 quickly. But we are also mindful that world-class  
2 healthcare is also -- or what is considered  
3 world-class healthcare by many -- is provided in  
4 some facilities that are far from optimal and that  
5 we think that if many of the things that have been  
6 pointed out or addressed in a timely manner, it  
7 would indeed set the -- or lay a foundation or set  
8 the stage for this to be world- class facilities  
9 in the future, although by no means guaranteeing  
10 it.

11 The one thing I think we can guarantee  
12 is that if these things are not addressed and they  
13 aren't addressed quickly, as Mike noted, then  
14 there's no way that these facilities are going to  
15 meet the Congressional standard of being  
16 world-class.

17 DR. WILENSKY: Chase?

18 MR. UNTERMEYER: Yes, this is Chase  
19 Untermeyer. I want to add my commendations to Ken  
20 Kizer and his committee for seeking to define the  
21 undefined and maybe even the undefinable. So,  
22 everything I'm going to say is within that

1 context.

2 But I do believe that we should look  
3 upon this document as more than just answering the  
4 mail and maybe more than just an inspirational  
5 document about quality of care, but rather as the  
6 bedrock budget document that eventually were on  
7 which could be built years and years of budgetary  
8 requests by this facility or the entire Department  
9 of Defense.

10 And for that reason, what I would  
11 recommend the committee add on, because I don't  
12 think you need to take anything out, but what I  
13 think you need to add an is a degree of boldness,  
14 a degree of expansiveness about what it is that  
15 this structure requires.

16 Six domains have been spelled out here,  
17 and five of them, as I count them, Ken, relate to  
18 the quality of care, like leadership, performance,  
19 knowledge management, community and social  
20 responsibility.

21 So I just want to focus on the first  
22 domain, which is basic infrastructure. And the

1     reason I want to focus on that is that the other  
2     five I would think Congress expects the military  
3     medical system to provide as a matter of course,  
4     because we want to be a quality operation.

5             What Congress is interested in is the  
6     dollars. And dollars go toward buildings,  
7     facilities in those buildings, and staffing. But  
8     I think that the document that we send forward,  
9     even though it may cause the Department to blanch  
10    and maybe the Congress to blanch, should be  
11    absolutely in the forefront of saying we want this  
12    definition, world-class, to mean the best  
13    facilities available were the best equipment  
14    available.

15            And it also needs to speak, which I  
16    don't think it does, to the staffing in terms of  
17    having an adequate number of specialties  
18    represented or quality of specialists who is  
19    assigned there.

20            And again, the services may blanch  
21    because they have other facilities around the  
22    world they need to staff, but this is our chance

1 to define what world-class means, and I think it  
2 needs to reach out to that level. And I'll  
3 conclude by saying that I detect, and I ask Ken to  
4 correct me, a potential self-contradiction here in  
5 this section on basic infrastructure, because the  
6 overall guidance the committee is giving us here  
7 is above and beyond; that that is what makes  
8 world-class world-class.

9           And yet in the category of basic  
10 infrastructure at number B talks about providing  
11 services in the specialty areas that are  
12 reasonable and appropriate; in other words, just  
13 hitting the mark as opposed to going above and  
14 beyond.

15           Likewise in number three, it speaks to  
16 the referral and transfer patients for services  
17 not provided at the facility. Well, as a  
18 practical matter, that's probably what's what  
19 happen in some of those. But again, this is our  
20 chance to be bold, and our chance to say we  
21 wouldn't have to refer anybody; that they should  
22 be available at this facility. That's the end of

1 that.

2 DR. KIZER: Well, let me address perhaps  
3 some of that, although we could have a very  
4 lengthy conversation on this. And the first thing  
5 I would say is that nationally many of the points  
6 that maybe don't deal with basic infrastructure,  
7 but in those conditions, there are embedded  
8 specific needs or requirements that relate to  
9 construction, for example, if you look in six, 6B,  
10 having to deal with environmental responsibility.  
11 Those things directly affect construction and  
12 design. Likewise in 5B, on simulation  
13 laboratories, that has direct implications on  
14 construction and design. And actually if you go  
15 back through each of the domains, I think you will  
16 find that while some of them deal with culture and  
17 leadership and other (off mike) embedded within  
18 those are a number of specific things related to  
19 construction and design.

20 As far as personnel, actually 1B that  
21 you talked about is directly -- addresses that as  
22 far as which specialties and sub-specialties would

1 be offered there, recognizing that this is a  
2 generic definition as opposed to being specific to  
3 a military medical center, because our -- a  
4 working premise that the committee had is that you  
5 couldn't be a military world-class facility unless  
6 you were first a world-class facility.

7 But, for example, if you are in an area  
8 where there is a pediatric hospital next door or  
9 down the street, it wouldn't be appropriate to or  
10 needed for you as a world- class facility to  
11 necessarily have pediatrics there, because that  
12 would be taken care of down the street depending  
13 on, again, the specific community. And so that's  
14 why the caveat about if those services are  
15 appropriate to the needs of the patient population  
16 the community served. And we could go into other  
17 examples of where specific things, while they  
18 might be entirely appropriate and needed at Walter  
19 Reed, may not be in San Antonio were some other  
20 places.

21 Likewise, on point three there, in San  
22 Antonio, there is, in fact, a world-class burn

1 center, and so they would need to worry about  
2 that. But it really doesn't make a lot of sense  
3 because there was or -- you know, the personnel  
4 and other costs attendant to those means that  
5 there needs to be a special few of these, and  
6 facilities all over the country refer patients to  
7 -- you know, San Antonio for burn care or some of  
8 the other places.

9 So I think that much of what you're  
10 saying, Chase, and I hear what you're saying, but  
11 I think much of it actually is already included  
12 here and maybe embedded in some of the things that  
13 you may not be quite as familiar with.

14 MR. UNTERMEYER: Well, just to say -- as  
15 I again salute you for all the detail that's  
16 there. I'm -- I guess speaking more politically  
17 than medically when I say that what we need to  
18 have here or we need to add in is a budgetary  
19 strategy; that is, in order to get whatever we do  
20 get in the end, we have to reach for more than  
21 that. And that's why I recommend being bold of  
22 asking for things, even a burn clinic, if one does

1 exist, and then throwing it back to the Congress  
2 to let them tell us what they will or won't give.

3 But they're not going to give us  
4 anything more than what we ask for. And I doubt,  
5 you know, in budgetary processes between our  
6 meeting room and the Congress, anybody is going to  
7 add in anything more than what we ask for.

8 DR. WILENSKY: But don't you think in  
9 both the burning sample or the pediatric that Ken  
10 used, I'm not even sure if there really is an  
11 accessible facility that you can use. I mean, I  
12 wouldn't translate world-class means you have to  
13 in any individual have everything. I mean, that  
14 -- that just strikes me as going in a place I  
15 don't -- I mean, I agree with you strategically  
16 that if you don't ask, you won't get. But  
17 conceptually, it bothers me the notion that we  
18 need to ask for something I'm not sure you would  
19 really need, given what you have for the burn unit  
20 at Brooke. Why would you want to duplicate it at  
21 Walter Reed?

22 MR. UNTERMEYER: Well, I agree. As a

1 practical matter, it probably wouldn't happen.  
2 But -- and elsewhere in the document, we're  
3 talking about a facility that goes above and  
4 beyond and is the best. And this is just a way of  
5 defining that.

6 DR. WILENSKY: Well, but if -- I mean,  
7 it actually goes to the -- I think this issue of  
8 what do you mean by world class. And if you have  
9 a linkage, a facilitation, so that you can have  
10 the patients readily accessing what is the best in  
11 that area, then, I mean, I've read. Ken, both  
12 some of the comments that -- what you put out and  
13 some of the comments that you had back. And this  
14 notion of you don't always have to build your own  
15 if you have a credible way to link in a quick and  
16 transparent way the services that you may not want  
17 to have because it will pull you in a different  
18 direction.

19 So I actually think it's more -- not  
20 just practically -- were you not going to do that?  
21 I think you could even make a case that -- I'm  
22 mean, it's really the regionalization centers of

1 excellence and that you don't need to be  
2 everything to all people to be world-class as long  
3 as you have a way to make sure those other  
4 services are directly accessible by your  
5 populations.

6 So I actually think it gets more than  
7 just the practical politics of what you could get.  
8 But you can think about that.

9 DR. KIZER: Gail?

10 DR. WILENSKY: Yes.

11 DR. KIZER: Gail and Chase, if it -- it  
12 might be relevant. The -- I think when the  
13 Congress actually looks at this definition, and  
14 the staffers start dissecting what it all means,  
15 they're going to probably do a big wow and because  
16 there's an awful lot in here. And I would bet,  
17 shooting from the hip, that not even one-tenth of  
18 one percent of facilities in the United States  
19 could meet or even come close to meeting these  
20 requirements.

21 DR. WILENSKY: David, did you have  
22 another comment?

1 DR. WALKER: Yes, I think -- you have to  
2 remember that its relevance to the population  
3 that's going to be served. I mean, for example,  
4 I'm not sure you'd be enough business there in TV  
5 after cardiac surgery to have a pediatric cardiac  
6 surgeon and do that or liver transplantation. I  
7 mean, I don't know. Maybe it is. But I would  
8 think there would be something like that where you  
9 have to do a certain number procedures a year to  
10 maintain your ability to maintain accreditation to  
11 do it and skill to do it.

12 DR. KIZER: Yeah, and in that regard, I  
13 think transplants is a great example in the  
14 National Capital Region. If you're going to --  
15 you know, it might be realistic to expect Walter  
16 Reed to do kidney transplants, but if you needed a  
17 pancreas transplant, you would want to go over to  
18 Baltimore, to the University of Maryland, because  
19 they are, you know, one of the two best places in  
20 the world to have a pancreas transplant.

21 So, you know, those patients would be  
22 better off, you know, being transferred over there

1 than trying to establish a program at Walter Reed.

2 DR. WILENSKY: Ken, I've looked a little  
3 bit in the back of the detail that you've provided  
4 and then the recommendations with health IT. It's  
5 hard for me to believe actually I have to push  
6 this issue much with you, but would it be possible  
7 to lean a little stronger in the recommendation  
8 about doing something with regard to the health IT  
9 issues they haven't yet addressed?

10 DR. KIZER: Oh, I think we could make it  
11 stronger. Again, I think we have tried to be  
12 accurate but also, you know, not throw any stones.  
13 And, you know, I mean, personally I would probably  
14 make it significantly stronger, and there might be  
15 a number of things that I would say that the  
16 committee may or may not buy into. And I think  
17 what stated here is something that all of the  
18 committee members felt comfortable with. But I  
19 certainly would be happy to take it back to them  
20 to see if the comments couldn't be a little more  
21 direct or stronger, if that's the right adjective.

22 DR. WILENSKY: It's really -- and,

1 again, I appreciate -- you know this better than  
2 most people in the country that playing catch\_up is  
3 so hard. Now it may be they're already beyond  
4 that stage, and they're just going to be playing  
5 catch\_up. And that's the nature of the beast, but  
6 to the extent that there can be more pressure put  
7 on to try to have the integration and  
8 interoperability coming in, but, I mean, this is  
9 not don't go ahead, but just really pressing to  
10 remember how hard it's going to be to fix it after  
11 the fact.

12 DR. KIZER: Right. And I think the most  
13 important thing there is to make sure that the  
14 right infrastructure exists so that whatever  
15 decision is made as far as the software  
16 application, understanding that, you know, an  
17 electronic health record is all software, and that  
18 it's hardware agnostic.

19 You know, as long as the appropriate  
20 infrastructure is there, any decision could be  
21 accommodated, albeit it would be certainly nice if  
22 the issue were resolved sooner than later, and it

1 would make it a lot easier to move forward more  
2 quickly if the issue were resolved.

3 DR. WEST: Madam Chair, Togo West.

4 DR. WILENSKY: Yes, Togo. Go ahead.

5 DR. WEST: I suggest that the admittedly  
6 fine work done by Dr. Kizer and his committee be  
7 allowed to remain within the tone and language  
8 that he has chosen thus far. If we of the Defense  
9 Health Board really want to make it stronger, then  
10 I would suggest we simply add in a one- page  
11 forwarding or commentary on that to point out the  
12 areas in which we want to make it stronger. I  
13 think Ken's language is appropriate to a desire to  
14 make a point, but also make sure that the point is  
15 accepted, understood, and acted on.

16 DR. KIZER: Thank you, Togo.

17 DR. WILENSKY: Mike.

18 DR. OXMAN: Mike Oxman. I think the  
19 important issue and the reason why an integrated  
20 facilities plan is crucial is that although we're  
21 not doing -- you're not going to want to do and  
22 Chris transplants this year or next year at the

1 National Military Medical Center. Five years from  
2 now, you may want to do them. They may become  
3 much more routine. And under those circumstances,  
4 you want to be sure that your facilities plan  
5 includes options for future change.

6 DR. WILENSKY: Any other comments?  
7 Chase.

8 MR. UNTERMEYER: No comment, ma'am --  
9 Madam President. But the question is what is the  
10 plan for dealing with this -- the schedule and  
11 whatever deadlines we're under?

12 DR. WILENSKY: We will await a heads up  
13 when they're ready for us to read something. It  
14 will be circulated, and we will figure out a  
15 mechanism to be responsive in a timely way.

16 DR. KIZER: All right. Then let -- just  
17 if I could respond to that. Our intent and part  
18 of the reason for including just the findings and  
19 recommendations is that these, you know, seem  
20 reasonable, assuming that they are, in fact,  
21 evidence-based, which they are, then we will as  
22 quickly as possible put together the final report.

1 Our hope would be to have it done certainly within  
2 the next two to three or, you know, weeks or  
3 something along those lines, if at all possible,  
4 and get it to the Board for final action and  
5 hopefully transmittal to the Secretary and the  
6 Congress, because we are mindful that the clock is  
7 ticking and this construction is proceeding and  
8 the need to get an appropriately empowered figure  
9 in place and the master plan all are predicated on  
10 that being done in a timely manner.

11 DR. WILENSKY: Barbara. Do you have the  
12 last comment?

13 DR. COHOON: Sure. Hi, Dr. Kizer.  
14 Thank you very much as far as including the piece  
15 on making sure that patients and providers have  
16 input. As you know, our association, along with  
17 many others, have been providing input when asked,  
18 and we are finding that sometimes they reach out  
19 and sometimes they don't. But when they do, it's  
20 very effective.

21 I notice that a lot of the comments that  
22 you've had and recommendations as far as making

1       sure they backfill renovations and that the BRAC  
2       process and its funding stream aren't necessarily  
3       aligning properly, but yet I don't see a  
4       recommendation for added funding to make sure that  
5       processes go forward, because it's going to take  
6       extra money if you can't enlarge the ORs and all  
7       those other things. And they really don't have  
8       that extra money in their budget to be able to do  
9       those things.

10               MAJOR HOLLAND: Ma'am?

11               DR. WILENSKY: Oops.

12               MAJOR HOLLAND: Command (off mike) Major  
13       Holland. Now I may get thrown out of here in a  
14       minute, but when Secretary West, I know you're on  
15       the phone, sir, but if you remember when we did  
16       the independent review group, we -- what of our  
17       recommendations was to create a czar over this  
18       project. And no disrespect to our great navy or  
19       the great Army or the other services, but I also  
20       feel like there's a tug-of-war here, and I don't  
21       think we've laid that on the table. And if that's  
22       what the case is, then, you know, maybe General

1 Meyers could help us figure out what level -- what  
2 level -- sorry, I just put that in your basket,  
3 sir -- at what level should that individual come  
4 from and then the working group to work for them,  
5 because, you know, all the folks that are  
6 responsible for different things -- the commander  
7 of Bethesda and the commander of Walter Reed --  
8 they also report up to some other folks that have  
9 their idea of how this should be done and since we  
10 are going for world class and whatever, but those  
11 recommendations, even to the point of these  
12 operating rooms, because we were still having  
13 problems in the ICU at Bethesda and at the ICU in  
14 Walter Reed, when our severely injured was coming  
15 in with all kinds of extra equipment to hook up to  
16 them to keep them alive, and we didn't have any  
17 room.

18 So it's not like this is a new issue,  
19 ma'am. And so, I think we've danced around it  
20 nicely and the people that put the report together  
21 did a lot of good research, but we need some help  
22 to fix this, ma'am.

1 DR. WILENSKY: That's why we're here.  
2 Thank you very much, Ken. We look forward to  
3 seeing the report, and we will respond as quickly  
4 as we can when it arrives.

5 DR. KIZER: Thank you, Gail. And thanks  
6 for your patience and tolerance of the logistics  
7 problems here.

8 DR. WILENSKY: Sure. Commander Feeks  
9 has a comment.

10 COMMANDER FEEKS: Commander Feeks. I  
11 just wanted to give credit where it's due to the  
12 degree of cooperation that I have seen between the  
13 Army and the Navy, between Bethesda and Walter  
14 Reed on the campus at Bethesda -- to my eyes has  
15 been truly remarkable, even if we find some ways  
16 in which it falls short of what we'd like to see.  
17 I can add -- and here expose my ignorance -- but  
18 I've learned recently that part of the problem is  
19 that BRAC money is being executed by the Army  
20 under public law, and the renovation money is  
21 being executed by the Navy. And it isn't up to  
22 the services to change that.

1 DR. KIZER: Well, I think you highlight  
2 the -- one of the basic points that they were  
3 trying to make is that this -- it's not because of  
4 good people not trying hard, but there is just --  
5 you know, there are barriers thrown in their path  
6 that they individually can't surmount.

7 DR. WILENSKY: Yeah. Yes.

8 GENERAL MYERS: Yeah. Yeah. Just one  
9 comment --

10 DR. WILENSKY: Sure.

11 GENERAL MYERS: -- to kind of --

12 DR. WILENSKY: Sure. General Myers.

13 GENERAL MYEERS: -- piggyback back onto  
14 Larry and also onto Secretary West. It sounds to  
15 me, from what you just said, made it that we got  
16 -- we do have some issues. The report points them  
17 out maybe more subtly than I was -- maybe it's  
18 more serious than I was attuned to.

19 But with that kind of situation, I mean,  
20 who's really in charge I guess is the question.  
21 And do they have the competence? I mean, it can't  
22 be run as oh, I'm going to do that as part of my

1 other duties running the whole Bethesda today. I  
2 mean, you can't do it as a part-time job, it  
3 doesn't seem to me. This is a huge effort. And I  
4 think if we do a cover letter that we ought to get  
5 the sense of the Board and see what we can come up  
6 with, and whether the committee agrees or not, it  
7 ought to be our business.

8 And I'm not denigrating anything that's  
9 been done. But I've seen enough in my 40 years of  
10 military service to know if you don't have  
11 somebody -- some belly button you can poke and  
12 say, here it is, and that's full-time -- this is  
13 something this large -- and you're going to be  
14 shorting the effort. That's my view.

15 CAPTAIN GIRZ: Hi, Martha Girz, JTF.  
16 That belly button is actually JTF. Dr. Kizer, I'm  
17 surprised. Did you not have a presentation by the  
18 JTF when you were going to your committee? I  
19 mean, Admiral Mateczun is the over -- over all of  
20 the Joint Operating Area, so actually this whole  
21 process, we claim from the JTF.

22 Now, given the fact that the money is

1 coming from different places we're working with,  
2 as you have all noted, cultures that are sometimes  
3 clashing. But we are certainly working on those  
4 issues from the JTF. So I know that Colonel Barb  
5 Jeffs was involved at least as a -- sitting in on  
6 the committee, and I don't know if any of her  
7 input was asked for or not from the JTF.

8 But certainly Admiral Mateczun is well  
9 aware of all of these issues, and trying to work  
10 them. But, as we've said, some of it is law. So  
11 we're not Congress. But we appreciate you  
12 bringing them forward.

13 DR. KIZER: I heard much of what you  
14 said, but not all of it. But Admiral Mateczun  
15 participated in a number of the committee's  
16 meetings. You know, he's no, I think, stranger to  
17 what's being recommended, and I have great  
18 admiration for what he has done and the barriers  
19 that he's confronted. And, you know, I think that  
20 there are some that are above his pay grade,  
21 frankly.

22 DR. WILENSKY: General Myers, go ahead.

1                   GENERAL MYERS: I guess my comment would  
2     be I think the JTF probably is exactly the right  
3     place. Admiral Mateczun is probably exactly the  
4     right person. But anytime you give somebody a  
5     task not only do you have to give them the  
6     responsibility, you have to give them the  
7     authority. And if our Department of Defense is  
8     too -- I'll use a French word here -- stupid to  
9     understand that, then they've got to get over  
10    this.

11                   So there are no barriers. So you have  
12    -- I'm not talking czars here -- you just have  
13    somebody that is was responsible, that has the  
14    authority, and, at the end of the day, you hold  
15    them accountable. And you can't do that if it's  
16    all fuzzed up over many different organizations.  
17    And that's -- and in the end, who's it going to  
18    hurt? It's going to hurt the troop walking in the  
19    front door. That's who it's going to hurt. So,  
20    we should not be embarrassed to lay this on the  
21    line and tell them they don't know how to manage,  
22    which it would not be the first time.

1 DR. WILENSKY: When we have the report,  
2 I would be glad to have a discussion with you  
3 about what kind of a covering transmittal you  
4 would like to have go with that.

5 GENERAL MYERS: Yeah, I'd be happy to  
6 help.

7 DR. WILENSKY: But if you think this  
8 area is an issue without a clear authority, when  
9 you look in San Antonio, that is much more of an  
10 issue of who is likely is in charge of resolving  
11 disputes, who has either authority, yet alone  
12 accountability. I mean, it's -- I mean Admiral  
13 Mateczun, whether or not he has sufficient  
14 authority is one thing, but when you look in San  
15 Antonio, it's nowhere near that (off mike), at  
16 least as I look at it. But that's not to in any  
17 way denigrate what you just said.

18 GENERAL MYERS: Dr. Wilensky, the only  
19 thing I would just -- this is Myers again. The  
20 only thing I would say is that if you can't hold  
21 somebody accountable, then there is no  
22 accountability. And I don't think anybody in

1 Congress or anybody in the Department of Defense  
2 intends that. So, I think we need out with that.  
3 I mean, if we can help. Nobody intends that but  
4 at the end of the day when Mateczun points to the  
5 Navy public works who points to the Army, who  
6 didn't get us the funding in time, who points to,  
7 you know, somebody else somewhere, then there's no  
8 accountability. We get what we get, and we  
9 deserve it.

10 DR. WILENSKY: Okay. We will eagerly  
11 await your final report, Ken.

12 DR. KIZER: Thank you so much.

13 DR. WILENSKY: Sure. Thanks.

14 DR. KIZER: Bye now.

15 DR. WILENSKY: We are going to have our  
16 last formal speaker. That speaker this afternoon  
17 is Ms. May Campbell-Kotler from the Defense and  
18 Veterans Brain Injury Center.

19 She is manager of the Office of  
20 Education for the Defense and Veterans Brain  
21 Injury Center, the primary TBI operational  
22 component of the DCoE.

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1           DVBIC is the lead agency providing staff  
2 support to the TBI Family Caregiver Panel  
3 Subcommittee of the DHV.

4           May comes to DVBIC following a career in  
5 public health at the local level, most recently in  
6 aging and disability service, where she was  
7 engaged in policy and program development for  
8 family caregivers.

9           The update on the progress and status of  
10 the curriculum and the presentation slides are  
11 under Tab 9 of your binder. Thank you.

12           DR. CAMPBELL-KOTLER: Actually, they  
13 were placed on the tabletop, I believe -- at least  
14 on the chair setting. But everyone should have  
15 the slides, a copy of the slide.

16           Can everyone hear me?

17           DR. WILENSKY: I have one under Tab 9.

18           DR. CAMPBELL-KOTLER: Oh, good. Good.  
19 Okay.

20           DR. WILENSKY: Yeah. Somebody  
21 mysteriously came by and dropped them in.

22           CDR FEEKS: And if I could interject

1 quickly, for the sake of the transcriptionist, our  
2 speaker's name is Margaret Campbell-Kotler. My  
3 apologies to Dr. Wilensky. K-o-t-l-e-r. Thank  
4 you.

5 DR. CAMPBELL-KOTLER: Thank you. I'd  
6 also like to say that we're not going to be taking  
7 a vote today. I expect that at the August meeting  
8 of the Defense Health Board, we will have a  
9 curriculum ready for the Defense Health Board's  
10 review and hopeful approval.

11 I'd also like to recognize Dr. Barbara  
12 Cohoon is in the audience, who is a member of the  
13 TBI Family Caregiver Panel. Glad to have her with  
14 us.

15 Okay. Okay. So given the hour, some of  
16 the information I have here is information that  
17 some of you have heard before at the December  
18 Defense Board Meeting, so we'll review the  
19 purposes of the Family Caregiver Panel; bring you  
20 up-to-date on where we are on the curriculum.  
21 I'll review the modules just briefly; talk about  
22 some decisions we've made about -- not pilot

1 testing, but qualitative process review,  
2 refinement and distribution; go over the timeline,  
3 which continues to change; and then I talk about  
4 our last meeting.

5 As most of you know, the Family  
6 Caregiver Panel was authorized by the 2007  
7 National Defense Authorization Act, creating a  
8 panel of members to develop this curriculum to  
9 help families who are caring for their loved ones  
10 who've had a traumatic brain injury, whether  
11 they're active duty or veterans.

12 And the law stipulated the categories of  
13 individuals that should be included -- medical  
14 specialists with experience in TBI, family  
15 caregivers, representative organizations, DoD and  
16 DBA health and medical personnel, as well as  
17 experts in development of training curriculum and  
18 family members of members of the Armed Forces who  
19 had sustained a TBI.

20 The panel members were not appointed  
21 until the 6th of March, 2008, so this project has  
22 had a delayed timeline, simply because of those

1 reasons.

2           The role of the DVBIC as part of the  
3 DCoE is to provide the staff support to the panel  
4 in helping them develop the curriculum, to try to  
5 assure accuracy, and to be responsible for  
6 dissemination, implementation, and ongoing  
7 maintenance of the curriculum once it's produced.

8           The panel members were asked to review  
9 the literature to assure an evidence base for the  
10 curriculum, developed a consistent curriculum, and  
11 to make recommendations on dissemination of the  
12 curriculum. The benefits of this curriculum we  
13 anticipate will be a consistent source of  
14 information for family caregivers, tools for  
15 coping and gaining assistance, and giving --  
16 sending a message of hope and recovery as they  
17 navigate life after a TBI.

18           We're hopeful that the curriculum will  
19 be attractive and usable. They'll teach skills  
20 for communicating with healthcare personnel and be  
21 user friendly, culturally appropriate, and based  
22 on real-life needs and experiences.

1           So we've divided the curriculum into  
2           four modules. In module one -- and this  
3           development has taken place between our November  
4           meeting at our January meeting. Anne Moessner,  
5           the Chair, was the lead content oversight for the  
6           -- on the introduction to TBI, talking about the  
7           brain -- causes and types of TBI, acute care  
8           issues, complications, recovery, helpful  
9           suggestions.

10           Module 2, the lead content oversight was  
11           Dr. Sharon Benedict from the VA, and that was  
12           looking at -- or helping families understand what  
13           the effect of a TBI can be on physical, cognitive,  
14           communication, behavioral, and emotional aspects  
15           of living.

16           Module 3, the lead Rosemary Pries. And  
17           that was really the caregiver support curriculum  
18           chapter, starting the journey of caring for the  
19           family member who has had the TBI, helping  
20           children cope, addressing family needs, planning  
21           for the future, how to be an advocate.

22           And module 4 the lead content oversight

1 was Dr. Barbara Cohoon and this is on navigating  
2 the system, understanding the military and  
3 veterans health care system, eligibility for  
4 compensation and benefits, entitlements related to  
5 employment -- not benefits related to employment  
6 and community reintegration.

7           At our January 8th and 9th meetings, we  
8 had fairly good attendance by panel members -- 17  
9 of the 22. Five DVBIC staff and our curriculum  
10 writers were in attendance.

11           I'll go over many of the outcomes of  
12 that meeting, but we were -- two of the highlights  
13 were consensus to work on the multimedia component  
14 of the curriculum with the Center for Excellence  
15 in Medical Multimedia, which is located at the  
16 U.S. Air Force Academy; and also consensus to work  
17 with the Henry Jackson Foundation, which provides  
18 a lot of administrative support to DVBIC for  
19 graphic design and packaging of the curriculum.

20           We also -- there were some issues that  
21 had been raised at the December Defense Health  
22 Board Meeting that the Family Caregiver Panel

1 reviewed, one of which was differences in  
2 definition of family caregiver. The Panel  
3 definition, which you see first, is a fairly broad  
4 definition: Any family or support person relied  
5 on by the service member or veteran; anyone who  
6 assumes responsibility is the person that we want  
7 to receive this curriculum and who we consider a  
8 family caregiver.

9 In contrast, the DoD-VA definition  
10 really uses the term committed designee rather  
11 than caregiver and is much more legally driven,  
12 perhaps benefits driven, legally designated by the  
13 service member and veteran who provides support  
14 deemed necessary by a medical authority for the  
15 care of an injured or ill service member or  
16 veteran.

17 So it's important, as we go forward,  
18 particularly as we look at dissemination that --  
19 certainly that the caregiver curriculum not be --  
20 be not limited to those persons that fall into the  
21 category of committed designee, nor do we want  
22 someone who receives the curriculum to assume that

1 they are in the category of committed designee.

2 And I suspect that that will recur, but  
3 it is something for everyone to be aware of.

4 The other issue that was raised by the  
5 Defense Health Board at the December meeting was  
6 the intellectual property issue. And we were very  
7 pleased that the Board was so impressed with the  
8 content we were developing that they were  
9 concerned about this.

10 We did turn to the Counsel for the  
11 Defense Health Board for an opinion, and basically  
12 copyright protection is not available for any work  
13 of the United States government. And,  
14 unfortunately we cannot designate our right to  
15 copyright to a nonprofit organization for that  
16 reason.

17 Also any publisher can republish a U.S.  
18 Government work. The publisher cannot claim  
19 copyright unless they've added original content,  
20 and only the original contents can be copyrighted.

21 So basically, once this is done, it will  
22 be out in the commercial world and individuals

1 will be able to utilize the content.

2           At the January meeting, we also had some  
3 discussion of the overarching issues of the  
4 curriculum, for example, the appropriate literacy  
5 level. And we've got module one written in both  
6 the eighth-grade and 10th grade level of literacy.  
7 And we're having people at Walter Reed take a look  
8 at that. Also, we're finding some family  
9 caregivers to informally look at those two  
10 together some input about what the literacy levels  
11 should be. We are very heavily toward feeling  
12 that it should be at the eighth-grade level. And  
13 I suspect that's where we'll find the curriculum  
14 written.

15           We also -- and the Panel members were  
16 very clear about this -- they felt that medical  
17 providers, healthcare providers would need an  
18 orientation to the curriculum so that they would  
19 be able to direct the family to the portion of the  
20 curriculum that could be most helpful to them. We  
21 haven't decided as a panel yet how that's going to  
22 be done. And, of course, there were a lot of

1     tweaking of the specific modules. Additions and  
2     changes were recommended. I didn't think that we  
3     would go into that to great detail.

4             We did have a very, very substantive  
5     discussion on mild TBI and concussion. There was  
6     a strong feeling that we should be including in  
7     the family caregiver curriculum something about  
8     the mild TBI, particularly for those folks who  
9     have a sequela, who are suffering headache,  
10    insomnia, other problems related to a TBI, you  
11    know, three months post injury and the impact that  
12    that has on families.

13            We were also concerned, though, about  
14    the message that we would be sending by  
15    incorporating mild TBI in a family caregiver  
16    curriculum, sending a message that perhaps if you  
17    had a mild TBI, you would need a family caregiver,  
18    which is definitely not the case.

19            So we've compromised by creating a  
20    standalone product. We're calling it module five,  
21    but it will probably be a standalone and not part  
22    of the curriculum, which will pretty much take a

1 lot of the information out of the existing  
2 curriculum and repackage it directed toward  
3 individuals who have had a mild TBI and are having  
4 some problems beyond the point at which we would  
5 expect recovery. And that will be coming along as  
6 well. I believe it was the Module 1 group who  
7 comprised primarily of clinicians who volunteered  
8 to write this portion of the manual.

9           So after we concluded all of this  
10 discussion, we created new working groups --  
11 Design and Editing, which Anne Moessner is  
12 chairing; Multimedia, which is being chaired by  
13 Michael Welsh, who experienced a TBI in theater;  
14 Qualitative Process Review -- Dr. Rosemary Pries  
15 from the Veterans Administration; and  
16 Dissemination, Colonel Nancy Fortuin and Dr.  
17 Megumi Vogt from the DCoE.

18           The Design and Editing Group actually  
19 met with the grant writers and with the HJ of  
20 graphic staff, so they really rolled up their  
21 sleeves and got into the nitty- gritty of how this  
22 module would look, what kind of features they

1 wanted, and they decided we wanted close  
2 coordination with the Center for Excellence in  
3 Medical Multimedia to ensure continuity of design  
4 between the print and the online versions.

5 We also agreed to 200 copies as an  
6 initial printing this spring for the qualitative  
7 review process, which I'll go into, I think, in  
8 the next slide. Oh, no.

9 The Multimedia Work Group participate --  
10 had a conference call with CEMM. This work --  
11 this site will be 508 compliant. We'll work  
12 towards the Spanish language version, and it was  
13 recommended that there be links from DoD sites to  
14 the multimedia site, and we'll have to work on the  
15 details of how that takes place.

16 Qualitative Process Review Work Group.  
17 The Panel members felt very strongly that we  
18 needed to get some focus groups together of family  
19 caregivers to assure that the curriculum that we  
20 were envisioning was indeed going to be helpful to  
21 make sure we've covered -- provided the  
22 information that they want. And, yet, this is not

1 a research project. This is a qualitative process  
2 review. And we hope to -- we do want to certainly  
3 gather caregivers, a variety -- severity of injury  
4 of their loved one, different types of  
5 relationships to the patient, active duty versus  
6 veteran status, geographically distributed, as  
7 well as representation by the various service  
8 areas.

9           They developed some sample questions,  
10 and the goal would be for 150 participants.

11           The Dissemination Work Group felt --  
12 really raised a number of questions: When will  
13 the curriculum best be given to families and who  
14 should be the person who gives the curriculum to  
15 families; that commands would need some kind of a  
16 brief tool summarizing what the curriculum is  
17 about, with contact information -- phone numbers  
18 and websites, provider instruction prior to the  
19 curriculum being provided; distribute widely and  
20 often; need for a timely and massive marketing  
21 campaign; and dissemination of the mild TBI  
22 information will take a different route of the

1 caregivers.

2           So we've made a lot of progress since  
3 the January 8th, 9th meeting. In the graphic  
4 design area, we are looking at four separate  
5 modules, each with a spiral binding and also three  
6 holes so they can be maintained together in a  
7 binder, but also taken out separately and maintain  
8 their integrity.

9           We're -- the Panel Editing and Design  
10 Group have been asked to provide input on the  
11 logo, and, as I mentioned earlier, we're looking  
12 at literacy levels, and the content of all the  
13 modules has been finalized. This is a -- the  
14 Editing and Design Group were asked to take a look  
15 at two concepts that HJF Graphics has developed  
16 for the curriculum. And the majority of Panel  
17 members in the Design Graphic Group voted for the  
18 blue version, which looks more springlike.

19           And we will use some form of a tree, I  
20 think, as a consistent logo through the  
21 curriculum, not necessarily this particular one.

22           But they certainly wanted bright

1 cheerful colors. The Center for Excellence in  
2 Medical Multimedia is reviewing all of the modules  
3 to assure that the website covers all the topics  
4 of the curriculum. Their website is TBI the  
5 Journey Home, and there will be a button dedicated  
6 to the family caregiver curriculum, which will be  
7 the caregiver's journey.

8 And we will be posting the curriculum  
9 modules as a PDF on the site.

10 This is a sample of the webpage as it  
11 will look. What will happen here -- and we've had  
12 a -- since even this slides were put together, we  
13 had a telephone conference call between CEMM and  
14 Henry Jackson and the staff at DVBIC. One of the  
15 things that we're going to do is etch the skeleton  
16 of a tree into the granite-looking appearance  
17 where it says traumatic brain injury: the journey  
18 home, and that logo will appear then on every  
19 page. Also, where you see caregiver's journey,  
20 that will also have the tree logo so that there  
21 will be some consistency between the two products.

22 Also we're going to look at the color

1 scheme that we're using for click at the bottom to  
2 be sure that it's consistent with the modules,  
3 that where we're talking about the brain, that  
4 that is the same color scheme we're using for  
5 Module 1, which is about the brain and how it  
6 works and what happens when there is some injury.

7 I did want to mention and this slide  
8 does not show that is at the bottom of the slide,  
9 we're planning to have DHB, the Defense Health  
10 Board, as well as CEMM, the Center for Excellence  
11 in Medical Multimedia credited at the bottom of  
12 the page -- of each page.

13 Right now, the writers are interviewing  
14 family caregivers so that we include real-life  
15 stories in the curriculum, and we're looking for a  
16 variety of stories. We're looking for the  
17 20-year-old service member with a young spouse or  
18 with a girlfriend who is his primary caregiver.  
19 We're looking also at more mature families as  
20 well. Just -- we're looking for minority  
21 families. We're looking for differences in  
22 severity of TBI.

1           And I think that those are -- we've done  
2           about five or six interviews, and we have about  
3           four or five more to do.

4           We also are working on piggybacking onto  
5           an existing contract with TMA to obtain the  
6           consultants to conduct focus groups, and those  
7           would be held at various DVBIC sites around the  
8           country.

9           So, on the timeline, we're looking at  
10          April and May at the earliest for the multi-site  
11          focus group to refine the curriculum; June for  
12          revising the critical mass needed; a panel meeting  
13          in June or July to do a final review of the  
14          curriculum.

15          There is a report to Congress due in  
16          August, and then August we will also have the  
17          review and approval of the curriculum by the  
18          Defense Health Board, and hopefully dissemination  
19          would begin in September.

20          Our Panel meetings will be in June or  
21          July. We'll review the final print product, the  
22          fund marketing and dissemination plans, and

1 discuss maintenance of the curriculum content. So  
2 that's my presentation. Any questions?

3 DR. WILENSKY: Thank you very much. Are  
4 there any questions? Yes.

5 DR. DETRE: I believe and think I  
6 believe that any of these problems exist in pure  
7 culture; for instance, there are people who  
8 believe that PTSD is alone a psychological or  
9 psychiatric disorder without TBI or those who have  
10 mild TBI or even more severe one don't have PTSD.

11 My superstitions aren't true. But what  
12 is really important that at least in my experience  
13 earlier with different conflicts is that two  
14 issues complicate the clinical picture and the  
15 management of families where there is a member who  
16 is suffering from any one of these disorders.

17 And the two issues are substance abuse,  
18 particularly alcoholism, which I'm sure needs to  
19 be included in the curriculum, and consultants  
20 need to be made available to family caretakers,  
21 because they won't be able to handle it alone.

22 And the second, which is rarely

1 mentioned, although it is in the clinical  
2 literature and it's in the legal literature: The  
3 number of separations and divorces in families.

4 Now that complicates matters from a  
5 legal point of view in a sense that you can assign  
6 or they may mistakenly assign the caretaker a  
7 position who in fact is already conflicted by  
8 threatened separation or divorce.

9 So I believe whoever is going to be the  
10 consultant should have at least minimal knowledge  
11 of the legal complications involved.

12 DR. CAMPBELL-KOTLER: Thank you, and we  
13 have included information about PTSD in the --  
14 under -- in Module 2 on effects, also  
15 substance-abuse we've addressed. I think that  
16 care managers, who perhaps will be the folks who  
17 provide this curriculum are going to have to be  
18 knowledgeable about how to make referrals to the  
19 kinds of mental health or other resources that the  
20 families really need.

21 There's just so much a book can do. But  
22 I think it can be -- perhaps it can be a jumping

1 off point. People may not realize what they are  
2 experiencing, and when they read some of the  
3 reactions of other caregivers, they may realize  
4 that they are not alone, which may help the  
5 situation; and also recognize that help is  
6 available. And it may actually ease the process.  
7 That's my hope.

8 DR. DETRE: May I suggest --

9 DR. CAMPBELL-KOTLER: Yeah. Well, we'll  
10 be -- we do conduct family group meetings now in  
11 our DIVBik education and that is certainly  
12 something that we can easily implement. Yeah.  
13 Thank you. Thank you.

14 DR. WILENSKY: Tom?

15 DR. MASON: Tom Mason. Just a quick  
16 question for you. I was just talking with my  
17 colleague. What about the gender of the caregiver  
18 --

19 DR. CAMPBELL-KOTLER: Right.

20 DR. MASON: -- because they're a big  
21 cultural differences of a man taking care of his  
22 significant other and a woman taking care of her

1 significant other and how you might actually train  
2 for this particular aspect?

3 DR. CAMPBELL-KOTLER: Yeah. We are  
4 looking for vignettes, if we can find them for  
5 that, and also in our focus groups it's certainly  
6 something that we've thought about, but the  
7 numbers are just so different in size that it will  
8 be hard to find.

9 DR. MASON: Understood, but, you know,  
10 since more and more women are placed in harms way  
11 --

12 DR. CAMPBELL-KOTLER: Mm-hmm.

13 DR. MASON: -- and potentially impacted  
14 and definitely going in the direction of moderate  
15 traumatic brain, which is tough; you know, the  
16 idea of being able to incorporate some of those  
17 gender-specific issues, which are culturally  
18 laden, no question, I think would be very  
19 important to address.

20 DR. CAMPBELL-KOTLER: Okay. I'll make  
21 sure when we go back and look at the caregiver  
22 module again and make sure that we have addressed

1 some gender-specific issues.

2 DR. WILENSKY: Mike?

3 DR. OXMAN: Given the young age group of  
4 many of the users, have you considered also  
5 including a option of a DVD format instead of --  
6 or as an alternative to the printed one? Because  
7 not everyone who uses DVDs has Internet access.

8 DR. CAMPBELL-KOTLER: We have not at  
9 this point. We're just looking at web-based  
10 access, but there probably is no reason why we  
11 couldn't also provide DVD.

12 DR. WILENSKY: Greg?

13 DR. POLAND: Yeah, I was going to make  
14 the same point that, you know, not everybody  
15 learns, you know, visual -- by reading, but by  
16 other mechanisms. A couple of comments. One to  
17 further what Tom said. The other thing is just as  
18 parent -- just as grandparents are taking care of  
19 children, it may be that a parent or a grandparent  
20 may end up being the caregiver, so looking sort of  
21 across -- or in some cases even an older  
22 adolescent. So looking across that age spectrum.

1           I also wondered about -- and I know this  
2           is not in your original charge -- but think with  
3           an eye toward the future thinking toward expanding  
4           to some sort of educational curricula, not  
5           caregiver curricula, for young children, maybe in  
6           the form of the storybook or something.

7           And then -- because you mentioned the  
8           design and multimedia aspects, I thought I'd  
9           mention and maybe you know and it was just new to  
10          me, but it is barely scratching the surface of  
11          medicine this new concept of knowledge encounter  
12          research. It's called KER. And at least one unit  
13          I know of has demonstrated with fairly simple  
14          graphics really impressive gains in knowledge  
15          compliance and reduction and inappropriate  
16          behaviors or inappropriate uses of medications,  
17          for example.

18          So I know it's late in the game, but you  
19          might look into that.

20                 DR. CAMPBELL-KOTLER: Thank you.

21                 DR. WILENSKY: Dr. Roper?

22                 DR. ROPER: Thank you. Dr. Allan Roper.

1 Was there a perusal at least of the public sector  
2 material on head injury that is disseminated by  
3 American Head Injury Society and various large  
4 institutions like University of Miami? I'm  
5 asking, in part, because my sense is this far  
6 surpasses anything that's been done, number one.  
7 And although there are military images throughout  
8 it, from what you showed, it probably is going to  
9 be picked up avidly, very quickly. And some  
10 thought might be given to that going forward.

11 Is there an alliance, for example, with  
12 the American Head Injury Foundation or the Brain  
13 Trauma Institute or any of these publicly  
14 supported entities?

15 DR. CAMPBELL-KOTLER: We have used --  
16 we've referred to information that the Brain  
17 Trauma Foundation, the TBI Model Systems Network,  
18 and a lot of the material that they've developed.

19 We've tried to use everything that we  
20 could that was in the public domain and was  
21 available. We have not developed those  
22 relationships going forward, but I think, as we

1 look at dissemination, that's something that we  
2 should be looking at in terms of alliances with  
3 other organizations, such as the ones you've  
4 mentioned, to get the word out about this  
5 curriculum.

6 DR. WILENSKY: Thank you. Yes.

7 MR. KAHN: That was excellent. Thank  
8 you. Very nice progress since the last  
9 presentation.

10 DR. CAMPBELL-KOTLER: Thank you.

11 MR. KAHN: A question for you about  
12 monitoring and evaluation: So I see that you do  
13 have what you're calling qualitative review  
14 process --

15 DR. CAMPBELL-KOTLER: Mm-hmm.

16 MR. KAHN: -- so some form of monitoring  
17 and evaluation. And I would suggest that you not  
18 be concerned about terms of research or  
19 non-research to really have a robust evaluation of  
20 the product before it's put out there.

21 My specific question to you is -- does  
22 your charge include after the broad dissemination

1 some continued monitoring and the evaluation to  
2 see broadly after you've gone to these 150  
3 families, but as you disseminate it a lot more  
4 broadly, you know, is it really what you want and  
5 how do you change it and make it more of a dynamic  
6 product than a static product once it's out there.

7 DR. CAMPBELL-KOTLER: Yes.  
8 Unfortunately, there isn't an ongoing evaluation,  
9 a review process, built into the charge to the  
10 Panel. That certainly is something. When we  
11 looked at all of this, we really decided that the  
12 evaluation process was really a next step; was a  
13 next part of the process, and would require its  
14 own funding and would require its own search for  
15 who would best do that research.

16 So that's a next step that I guess the  
17 Defense Health Board would need to think about as  
18 well and we really -- we consider what we're doing  
19 right now in the qualitative -- as qualitative  
20 input. We're trying to be representative and to  
21 try to get the best input we can, but by no means  
22 do we consider this research.

1           If we were to consider it research, we'd  
2     have many other restrictions and parameters also  
3     to face, which would very much slow down the  
4     process.

5           DR. WILENSKY: Thank you very much.

6           DR. CAMPBELL-KOTLER: Okay. Thank you.

7           DR. WILENSKY: We'll look forward to  
8     seeing the curriculum when it's developed.

9           DR. CAMPBELL-KOTLER: Yes. Thank you.

10          DR. WILENSKY: Greg, are you ready to  
11     give us- Greg Poland will give us an update on the  
12     issues we raised earlier this morning.

13          DR. POLAND: So with regards to the  
14     questions raised this morning. It was asked of me  
15     if I could make a couple of changes and then would  
16     that be acceptable to the Board in terms of a vote  
17     on the biosururity question that was asked to us.

Deleted: -

18     So there were three changes that a small group of  
19     us could recollect being recommended.

20          The first was a change in that final  
21     paragraph, so we would indicate here this. But in  
22     the context of a major change of mission to

1 developing FDA-approved products, blah, blah,  
2 blah.

3           The second was to take recommendation  
4 two, you have those slides in your folders there,  
5 and divide it so that we would add the point that  
6 was raised about collaborations involving -- we  
7 had academia and industry there, but adding other  
8 federal agencies.

9           And then divide the last piece of  
10 recommendation two so that it still reads in a way  
11 that makes sense to the red team being a separate  
12 recommendation.

13           And then finally this one. Given the  
14 restricted time frame within which this task force  
15 developed these initial recommendations, we  
16 recommend that the DHB Task Force further engage  
17 in a more comprehensive overall evaluation of the  
18 DoD defense infrastructure and research portfolio.

19           So comments on any of those three  
20 changes and then if you find them acceptable.

21           DR. WILENSKY: Any -- any comments? We  
22 were just having a discussion about whether we

1 have -- we should vote for these separately and  
2 then the full. But since we hadn't voted for the  
3 full one anyway --

4 DR. POLAND: Right.

5 DR. WILENSKY: -- my assumption is we  
6 can just do it once. Those was -- this high level  
7 negotiation was going on there.

8 Every comfortable? Any dissent? We  
9 have it.

10 DR. POLAND: Okay. Thank you.

11 DR. WILENSKY: Thank you. We just did  
12 -- we just did. Yes, that was the vote.

13 CDR FEEKS: For the sake of the  
14 transcription, what we've just done is accept the  
15 report, as amended, by unanimous vote. So Dr.  
16 Poland's report is accepted, as amended.

17 DR. WILENSKY: Yes. If I -- I will try  
18 to make that clearer in the future, but I will  
19 always ask for first indication of consent and  
20 indication of dissent. If there's any indication  
21 of dissent, and then we'll have a more there a  
22 discussion and either find a consensus or at least

1 be clear about the numbers.

2 So when I -- there doesn't appear to be  
3 any dissent, I don't usually bother. But that is  
4 what I meant.

5 Do you think we need a small  
6 administrative session?

7 COMMANDER FEEKS: I don't have any  
8 items.

9 DR. WILENSKY: Okay. Yes. Would people  
10 like to have a short administrative session before  
11 we end the day? I'm not sure if we need any.  
12 We've been at this for a long time. Okay.

13 I will turn it over to you for some  
14 administrative comments.

15 COMMANDER FEEKS: Thank you, Madam  
16 President. This is Commander Feeks. For Board  
17 members, ex officio members, liaisons and  
18 speakers, tomorrow's briefing at the Special  
19 Forces Underwater Operations School, which is  
20 where Green Berets learn to become combat divers.  
21 It's located on Trumbo Point. It will be -- the  
22 brief there will be preceded by breakfast at the

1 Mess Hall there.

2           It is kindly requested that you bring exact  
3 change. They deal in cash only. The cost of the  
4 breakfast is \$2.30, so exact change, please.

5           For those of you joining us for the  
6 dinner tonight, vans will be available outside the  
7 hotel at 6:00 p.m. to take us to the restaurant,  
8 and these vans are vans we've chartered. They're  
9 not the hotel shuttle, because there are too many  
10 of us to fit all in one shuttle.

11           And that concludes my administrative  
12 remarks. Madam President.

13           You'll be walking around on an aircraft  
14 -- if I call it ramp -- a concrete parking ramp.  
15 You won't be on the runway, but you'll be on a  
16 concrete parking ramp. You'll also be walking  
17 across some grass, if that helps over at the  
18 diving school. So, you know, short sleeves I  
19 would say. I don't require a coat and tie  
20 tomorrow, and I'm going to be in Charlie's  
21 tomorrow.

22           SPEAKER: They won't be wearing ties.

1                   COMMANDER FEEKS: Is that enough to go  
2 on for tomorrow. All right, sir.

3                   DR. WILENSKY: Seven -- we meet at 7:30,  
4 I believe.

5                   COMMANDER FEEKS: Yes, ma'am. Sorry.

6                   SPEAKER: Can we leave our materials  
7 here.

8                   COMMANDER FEEKS: I think it's safe to  
9 leave your materials here, but not your  
10 electronics.

11                  DR. WILENSKY: This concludes the public  
12 portion of our meeting. Tomorrow morning, as  
13 you've heard, the Board members, liaisons, and ex  
14 officio members will meet in the hotel lobby, so  
15 we can board the bus and leave for the site visit  
16 at 7:30. An administrative session will follow  
17 the site visits tomorrow afternoon. Mr.  
18 Middleton, would you adjourn the Board's business  
19 meeting.

20                  MR. MIDDLETON: This meeting of the  
21 Defense Health Board is adjourned. I want to  
22 thank all of you for attending. I want to thank

1 the great support from the folks that support the  
2 DHB and particularly to thank all of our  
3 outstanding speakers for their presentations  
4 today. Thank you.

5

6 (Whereupon, at 5:15 p.m., the  
7 PROCEEDINGS were adjourned.)

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I, Carleton J. Anderson, III do hereby certify  
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