DEFENSE HEALTH BOARD

WALTER REED ARMY INSTITUTE OF RESEARCH

WALTER REED ARMY MEDICAL CENTER

DEFENSE HEALTH BOARD MEETING

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P R O C E E D I N G S

DR. POLAND: Good morning, everybody. Welcome to the second day of the Defense Health Board Meeting.

This is another first for the Board in that we are meeting in a different location for the second day of our meeting. Yesterday, we were at Walter Reed Army Institute of Research, but in some ways for the Board, this is like coming home. As the predecessor Board, the Armed Forced Epidemiological Board, we met at Walter Reed Medical Center many times. Two of our subcommittees, the Scientific Advisory Board for Pathology and Laboratory Services and the Panel on the Care of Individuals with Amputations and Functional Limb Loss are co-located on this campus.

So, Ms. Embry, would you please call the session to order?

MS. EMBRY: Be happy to. As the designated federal official for the Defense Health Board, a federal advisory committee to the

Secretary of Defense, which serves as a continuing scientific advisory body to the Assistant Secretary of Defense for Health Affairs and the Surgeons General of each of the military departments, I hereby call this meeting to order.

DR. POLAND: Thank you. If I can ask all in attendance that can to please rise for a moment of silence, particularly cognizant at this premier medical institution, many sacrifices and obvious sacrifices that people have made on behalf of our country.

(Moment of silence.)

DR. POLAND: Thank you and a thank you to the active duty reserve and veterans and their families who have sacrificed so much on this country's behalf.

I want to introduce two distinguished guests with us this morning. The first is Dr. Charles Rice at the end to my right, President of the Uniformed Services University Health Sciences, and Colonel Chuck Scoville -- if you could raise your hand so the people can identify you -- the

Executive Secretary for the Panel on the Care of Individuals with Amputations and Functional Limb Loss.

In addition, if we could go around as this is an open session, go around the table and have the Board Members introduce themselves. Also, a special welcome to Dr. Ali Khan, our new CDC Liaison, and Mr. John Kraemer who is representing the VA today as Dr. Mark Brown had a conflicting meeting.

MS. EMBRY: So, Ms. Embry, could I ask to start with you?

MS. EMBRY: I'm Ellen Embry. I'm the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness and the designated federal official for this Board.

DR. RICE: Charles Rice, Uniformed Service University.

DR. GARDNER: Pierce Gardner, State University of New York Medical School at Stony Brook.

MS. ROSSBACH: I'm Patty Rossbach. I'm

on the Subpanel for Amputations and Functional Limb Loss.

COL. SCOVILLE: I'm Chuck Scoville with the Amputations.

DR. CATTANI: Jackie Cattani, the University of South Florida College of Public Health and the Center for Biological Defense at the University of South Florida.

DR. MASON: I'm Tom Mason, professor of Epidemiology, University of South Florida, College of Public Health and the Director of the Global Center for Disaster Management, Humanitarian Action.

DR. HALPRIN: Bill Halprin, I'm Chair of Preventive Medicine at the New Jersey Medical School and Chair of Quantitative Methods at the School of Public Health of the University of Medicine and Dentistry of New Jersey.

DR. LAUDER: Tamara Lauder, Physical Medicine and Rehabilitation, Minocqua, Wisconsin.

DR. LUEPKER: I'm Russ Luepker from the University of Minnesota School of Public Health.

DR. SILVA: I'm Joseph Silva, Professor of Internal Medicine, University of California-Davis.

DR. MILLER: Mark Miller, I'm the Associate Director for Research at the Fogarty International Center, National Institutes of Health.

DR. PRONK: Nico Pronk, Health and Disease Management at Health Partners, Minneapolis.

DR. LOCKEY: Jim Lockey, Professor of Pulmonary Medicine and Occupational Medicine, University of Cincinnati.

DR. WALKER: David Walker, Chair of the Department of Pathology, Director of the Center for Biodefense, Emerging Infectious Diseases, University of Texas Medical Branch at Galveston.

DR. PARKINSON: Mike Parkinson, Chief Health and Medical Officer of Luminos which is a part of WellPoint, a health insurance plan.

DR. KAPLAN: Edward Kaplan, Professor of Pediatrics, University of Minnesota Medical School

in Minneapolis.

DR. OXMAN: Mike Oxman, Professor of Medicine and Pathology at the University of California-San Diego School of Medicine.

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

DR. MCNEILL: Mills McNeill, I'm Director of the Mississippi Public Health Laboratory at the Mississippi Department of Health.

DR. SHAMOO: Adil Shamoo, Bioethicist, University of Maryland School of Medicine.

COL. GIBSON: Roger Gibson, Executive Secretary, Defense Health Board.

DR. POLAND: I'm Greg Poland, Professor of Medicine and Infectious Disease at the Mayo Clinic College of Medicine in Rochester, Minnesota.

One other comment for any members of the public that would like to make comments at the end of the afternoon session, could I ask you to

please register or sign in with Lisa Jarrod -- Lisa, could you raise your hand so people can see you -- so that we can try to accommodate those?

Otherwise, Colonel Gibson has some administrative remarks before we begin this morning's session.

Also, I would like to -- I see that he is here -- introduce Major General Eric Schoomaker of the Walter Reed Army Medical Center, who also wanted to welcome the Board.

MAJ. GEN. SCHOOMAKER: Well, good morning. My name is Eric Schoomaker. I'm the Commanding General of the North Atlantic Regional Medical Command in the Walter Reed Army Medical Center, an internist by training and until about five weeks ago, I was a Commanding General of the United States Army Medical Research and Materiel Command which is a command at Ft. Detrick, Maryland that is very heavily involved in biodefense and protection of the joint force against emerging and existing health threats and the Center of Medical Logistics for much of the

joint force.

I want to tell you how pleased we are that you have chosen our campus here at Walter Reed.

Mike, it's great to see you and good to see so many old friends and to see so many distinguished colleagues who have chosen our campus as a site for your meeting of the Defense Health Board.

For those who aren't familiar with Walter Reed and the Walter Reed campus, Walter Reed is one of the pivotal academic medical centers and casualty receiving hospitals for the joint medical force. We do this in partnership with our tri-service medical community partners, the Air Force and the Navy. In fact, we're part of a consortium of medical facilities, clinics, hospitals, community hospitals and academic medical centers here in the National Capital Region that have responsibility for the care and health promotion, health maintenance, health improvement and ultimately health care for over

500,000 beneficiaries of federal medicine in the greater metropolitan Washington, D.C. area.

We are also privileged to be one of the principal casualty receiving hospitals for casualties of the Global War on Terrorism and have been very active as a site for that. You're going to hear something about that. I think Chuck is going to give us an update today about the program that he is privileged to lead.

We couldn't be happier then to have you here today. Frankly, we respect so much the contributions that our academic and federal and interagency partners make to improvements of the health system of the Uniformed Services and federal medicine in general.

I welcome you all here today. I hope this is a profitable and a productive two days for you. I'm personally looking forward to hearing the report of the Independent Review Group that we've hosted here and with whom we've interacted over the last several weeks since I arrived in command.

So, welcome. Don't hesitate to call upon me or my staff. Regrettably, I'm personally going to have to come and go if that's okay with you, Ms. Embry and Dr. Poland, but we want to make ourselves open and available to you for any and all needs that you might have.

Thanks very much.

(Applause.)

DR. POLAND: We'd like to present a certificate of appreciation to Major General Schoomaker to recognize his superb leadership, excellent organizational skills and outstanding professional knowledge and willingness to assist and cooperate with the Board and its work. Thank you very much.

MAJ. GEN. SCHOOMAKER: That's very kind of you. Thank you very much.

(Applause.)

MAJ. GEN. SCHOOMAKER: We in the Army have this tradition that when you do good things for us, we reciprocate. We package all of our respect for you in a coin. This is the coin of

what some would argue the most esteemed name in Army medicine, Walter Reed. This is the coin of the Walter Reed Army Medical Center -- a man who changed the lives of hundreds of millions of people worldwide.

DR. POLAND: Yes, indeed. Thank you very much.

MAJ. GEN. SCHOOMAKER: I'm happy to give that to you.

COL. GIBSON: For those of you attending the meeting, please make sure that you sign in. One of the requirements of the Federal Advisory Committee Act is that we record the names of all attendees. So we would appreciate it if you would sign the rosters as you come in, make sure. Also, to remind you of what Dr. Poland said, if you wish to make comments towards the end of the afternoon session, if time is available, we'll try to accommodate that, but you need to sign in for that as well.

Because this is an open session, it's being transcribed. Please make sure you state

your names clearly so our transcriber can accurately record your questions and comments. This is for the Board Members and the speakers.

The next meeting of the Defense Health Board will be May 3rd. At that meeting, we will receive briefings on the military vaccine program for the Department of Defense, the vaccine health care centers, a briefing on the influenza surveillance program and a deliberative session, a deliberation of the draft report from the Mental Health Taskforce. That meeting will be at the National Transportation and Safety Board Center in downtown Washington, D.C.

Finally, I want to thank my staff, Ms. Jarrod and Ms. Bennett, for their help in putting this meeting together and a special thank you to the Walter Reed Medical and Garrison staff. General Schoomaker, thank you very much. Your folks did an outstanding job of supporting us for this meeting. Thank you.

DR. POLAND: All right, our first speaker this morning will be Dr. Tom Burke. Dr.

Burke will provide an update on the activities of the Mental Health Taskforce. His slides are under Tab 3.

Tom, the floor is yours.

DR. BURKE: Thank you. Thank you, Dr. Poland. I'm Thomas Burke. I'm the Executive Secretary of the DoD Taskforce on Mental Health. On behalf of Vice Admiral Donald Arthur and Dr. Shelley McDermid, I would like to thank Ms. Embry and Dr. Poland and Colonel Gibson and the members of the Board for this opportunity to provide an update on the progress that the Mental Health Taskforce has made to date.

The first issue that I would like to address is the change in membership that we had as a result of the retirement of Lieutenant General Kiley who was the Department of Defense Co-Chair for the taskforce. General Kiley has been replaced by Vice Admiral Donald Arthur, the Surgeon General of the Navy who was appointed as the DoD Co-Chair on March 27th, 2007. We would like to thank General Kiley for his support and

his input and welcome Admiral Arthur. We look forward to equally finding support from Admiral Arthur.

The activities of the taskforce can be grouped into three general categories: Information gathering, deliberation of findings and recommendations, then administrative tasks and writing and editing the report.

So far, in the information gathering process, we have held eight full taskforce meetings approximately once a month since the taskforce was appointed on the 15th of May of 2006. During these taskforce meetings, we have had a number of informational briefings on a wide variety of topics from subject matter experts inside and outside of the Department of Defense. We've also had open town hall format sessions at each of the meetings at which time the public had an opportunity to address the taskforce and to give testimony. We also, during one of the meetings, invited the military service organizations and the veterans service

organizations to come and provide statements, and those were very helpful to the taskforce.

We've made approximately 38 site visits to military installations in CONUS, Europe and the Far East. We did not do this as a full taskforce, but we sent delegations of two to five members. We tried to have a civilian and a military person on each of the teams that went out. We completed our final site visit in February of 2007.

During these site visits, we tried to see all of the interested parties that could provide input to the taskforce about the mental health system and how it was functioning. We were sure to visit the installation commander partly out of an information gathering role and partly to reassure the commanders and the units that this was not an inspection, that this was an assessment. It was part of a federal advisory committee taskforce and that we were not there to find fault or to identify problems other than in a very general sense. We were not the inspector general.

We had posts town hall at which time, like the full taskforce meetings, we had an opportunity for the public to address the site visit team. This was an opportunity. This was just an open invitation. We did not try to select a representative sample of the community in a scientific way. This was an opportunity for people with concerns to come and make statements to the taskforce.

We visited with resident military units, whatever type of post. We tried to see the full spectrum of military installations. We visited all four services. We tried to get large posts, small posts, geographically isolated posts, posts with high turnovers due to deployment, posts with large units that were being deployed and posts with perhaps small military contingencies. So we tried to see the full spectrum and to get input from the various military units, and we were very gratified with the support that we got from the commanders of the installations and the commanders of the units in providing soldiers, sailors,

airmen and marines for us to talk to.

We visited the medical treatment facilities on base to see, to get their input on how they believe the mental health care system was working in the MTFs on post.

We also visited with the non-medical behavioral health support personnel. Behavioral health is more than just mental health care. It involves all of the groups and organizations that feed people with problems and concerns into the mental health care system and also that handle various programs that are intimately involved with mental health care but are not directly managed by the medical system such as the family advocacy program, the drug and alcohol program.

We also went off post to talk to the medical care providers in the local communities because especially in the geographically isolated locations, in places that have a lot of military providers deployed, a lot of the family care is being shifted to the Tricare Network, and we wanted to see if there were any problems

identified or any model programs that were being developed by the network providers to address that increased need.

As we went through the site visits, we had a standard list of questions that we tried to ask. We tried to touch on all of those questions, but it wasn't a rigid, formal structure. We tried to allow the people who were talking to the taskforce as much latitude as possible to express themselves in their own way and still cover all of the topics that we considered important. We wanted to look for problems, but we also wanted to look for things that were going well, model programs, especially innovative ways of approaching the problems associated with deployment, with returning troops, with families.

The exact agenda for each of the site visits varied. We negotiated that with each of the sites because we saw the full spectrum of types of military installation. Each one was a little bit different, and so we allowed the installation to provide a significant amount of

input on what was available there and on setting the exact agenda.

We also made a data call. The taskforce members assembled a long list of questions that they wanted information on. This data call was sent to the responding organizations by the Assistant Secretary of Defense for Health Affairs, Dr. Winkenwerder. The organizations that we sent the questions to were the Deputy Undersecretary of Defense for Military Community and Family Policy, Assistant Secretary of Defense for Health Affairs, the Tricare management activity and the Surgeons General of the military departments.

We also had information. We tried to gather information directly from individuals. We set up a web site, a web page on the Defense Health Board web site that was available for individuals to provide statements. We felt that that was important particularly because it dealt with mental health care issues, and the full taskforce meetings, where we took similar statements, were in an open session like this.

Everything was transcribed. It was going to become a part of the public record, and we didn't want to provide a disincentive to people who were uncomfortable with speaking about their problems and issues in an open, publicized format where it would all be recorded, and we provided them with this more private avenue to make statements.

The web page for taking these statements was closed on March 9th, but the web site for providing information to the public about the Mental Health Taskforce agendas and activities is still up on the Defense Health Board web site.

We have had an ongoing literature review. Because this was a very broad scope as part of the Congressional tasking, we broke up the work into pieces and assigned that to subgroups of the taskforce to get the actual work done and the report written, and they have done their literature review on an ongoing basis in addressing their individual taskings.

We set up a web site separate from the Defense Health Board web site on Army Knowledge

Online that was accessible. It was password protected. It was secure and was available only to the taskforce members and the staff that we could use as a virtual bookshelf to put all of the information that was being gathered by the various working groups up where all of the taskforce members could get it without having to ask and have it emailed to them. That web site is still functioning.

As we've moved out of the information gathering phase and into the deliberation of findings and recommendations, we've had sessions, open sessions, at the Washington meeting in February, and we'll have another one at the San Antonio meeting in April, where we deliberate the findings, recommendations, issues that have been discovered during the site visits and brought up by the working groups in an open session. In compliance with the Federal Advisory Committee rules, deliberation is to be held in open session, and we have done so, and it is part of the transcribed records of those meetings.

We also will submit the draft of the report for the Defense Health Board to deliberate in session on the 3rd of May of 2007.

Our remaining activities are the update briefing at today's meeting.

We have a full taskforce meeting from April 16th to the 18th at which we will have an open deliberative session and the remaining opportunity for the full taskforce to get together to work on finishing the draft of the report.

On May 3rd, we will deliver a draft. A draft of the report will be available for deliberation by the Defense Health Board. On May 15th, we plan to deliver the report to the Secretary of Defense on time.

Any questions?

DR. POLAND: Thank you, Tom. I attended one of your early meetings and was impressed with the amount of energy and diligence your taskforce has put into this. It's very much appreciated and is a tremendous effort. We look forward to receiving the draft in early May, I guess it will

be.

Comments or discussion from members of the Board?

Dr. Shamoo?

DR. SHAMOO: Cancer in the fifties was a taboo subject; breast cancer, still half and half. Mental illness remains really a taboo subject. There is a whole population whether in the civilian sector or in the military that don't come forward, and sometimes it's too late. Suicides, we have literally thousands and thousands of suicides in this country that are preventable, and most of them are due to mental illness, and there is a much larger number of injuries due to those unsuccessful suicides.

My question is have you planned to outreach to those silent individuals which are in the hundreds of thousands and how the Mental Health Taskforce is going to deal with it for future recommendations?

DR. BURKE: Certainly the issue of stigma, of access to care, of the availability of

care and of this unwillingness for people to come forward and unwillingness for people to talk about have all been issues that the taskforce has considered. We have discussed those issues at length, and I believe that all of those issues will be addressed in the report when it's delivered in May.

DR. POLAND: Mark, before you start, it did dawn on me. Tom, could I ask you to just very briefly recapitulate the tasking that you were given for this taskforce because we do have several new members of the Board who may not be familiar with that, just a brief recap?

DR. BURKE: Yes. In the FY 2006 National Defense Authorization Act, there was a Congressional direction for the Secretary of Defense to establish a Mental Health Taskforce to assess the mental health care and services provided to members of the Armed Forces and their families and make recommendations for improvements in that system.

The taskforce was to consist of 14

members -- 7 DoD and 7 non-DoD members -- representing all of the services, representing a wide variety of skill sets within the health care field: Research, academia, clinical care. One of the members was to be a Surgeon General of one of the armed services. There was to be a member that represented families.

Colonel Gibson led the effort to select the taskforce, and there were seven DoD, seven non-DoD. Lieutenant General Kiley, Surgeon General of the Army was the Surgeon General member and was appointed as the DoD Co-Chair. The membership elected Dr. Shelley McDermid, who is a Professor of Family Studies at Purdue University, as the non-DoD Co-Chair.

We have representation from all of the military services, the four military services: Army, Navy, Air Force and Marines. Because the Navy provides medical care for the Marines, our Marine Corps representative is a personnel officer and an aviator.

We have seven non-DoD members. Dr.

McDermid, as I said, and Dr. Blazer, who is the Defense Health Board Liaison, he's also a member of the Defense Health Board. We have a member from Health and Human Services, Ms. Kathryn Power. We have Dr. Tony Zeiss from the VA. We have Dr. McCormick who spent 30 years with the VA in Ohio and is now retired and is in academic medicine. Dr. Layton McCurdy who is a Professor Emeritus at the Medical University of South Carolina. We have Ms. Deb Fryar who is with the National Military Family Association. She's the family advocate member of the taskforce.

DR. POLAND: Thank you. Dr. Miller?

DR. MILLER: Thank you, Dr. Burke. Given the scope of the disease burden and long-Term nature of mental health problems, can you speak about the mandate and how inclusive the mandate includes in terms of do you include, for example, VA facilities and long-term nature of problems in mental health such as post traumatic stress syndrome? For example, what is the representation of the 38 sites that you have

chosen? What percentage of all the long-term military facilities that that represents, does it include, for example, the VA facilities?

The second question is can the Board get a copy of the questionnaires that were actually administered?

DR. BURKE: To answer the second question first, yes, I could provide Colonel Gibson with copies of the questionnaires.

Certainly, the long-term care issues were a major issue for the taskforce to look at. The tasking in the Congressional language had 15 elements plus a 16th element that said anything that the taskforce considered important was within the scope of their charter. So our examination of the issue has been very broad.

It has certainly included the issue of care for service members after they separate from the service, particularly as that involves the VA. We had a VA member, Dr. Zeiss, and Dr. McCormick who had long experience with the VA. So we had a lot of very well informed VA input to the

taskforce's deliberations.

We also spent one of our full meetings. In San Francisco, we saw the National Center for PTSD at Palo Alto, and we went to the VA Medical Center there in San Francisco.

DR. POLAND: Dr. Luepker?

DR. LUEPKER: Yes, thank you, Dr. Burke. Just a question I may have missed, are you quantifying the resources available, i.e., the number of mental health professionals on one hand available to do this and, on the other hand, the patient or potential patient as we look long-term load? Are those numbers being collected and will they be presented?

DR. BURKE: Yes, those numbers were part of the data call that we put out to the services and to Tricare, the Tricare management activity, and those numbers and the findings and recommendations that are based on those numbers will be a part of the report.

DR. POLAND: Dr. Lauder?

DR. LAUDER: Thank you, Dr. Burke, for

your input. A question I have is I know a lot of the focus is on PTSD, but is the taskforce also taking into account the probable number of traumatic brain injury patients that will eventually probably end up in a mental health system?

DR. BURKE: We're certainly looking at that as a part of the overall burden of mental health, of mental illness. We met recently with the TBI Taskforce, and Vice Admiral Arthur has had a lot of experience and interest in that. So he's bringing an additional emphasis. As the new member, he's bringing an additional emphasis on TBI and the overlap and the interconnection between mental illness and traumatic brain injury.

DR. POLAND: Captain Ludwig?

CAPT. LUDWIG: Good to see you again.

DR. BURKE: Nice to see you.

CAPT. LUDWIG: You had a very broad presentation on your group. I just wonder if I missed it or if you included the fifth armed service, Coast Guard, in any way on the taskforce

and, if not, can we talk about getting some representation on the group?

DR. BURKE: We did not have a Coast Guard member on the taskforce, and this was not an attempt to slight the fifth armed service. We also did not look at any of the other uniformed services, but the representation on the taskforce was limited to the military departments.

I would certainly be more than happy to discuss with Colonel Gibson and yourself about making sure that we have Coast Guard input.

CAPT. LUDWIG: Thank you.

DR. BURKE: Thank you.

MS. EMBRY: The Department would officially endorse that.

DR. BURKE: Yes, ma'am.

DR. POLAND: Dr. Lockey?

DR. LOCKEY: Dr. Burke, will your report identify where there are knowledge gaps in relationship to causation pathophysiology, treatment modalities in regard to military related mental health issues?

DR. BURKE: Yes, we will. The report will not go into great depth on the basic science of mental illness and mental health. It's more of a look at the care system and the resource system. But that has been considered and that will be a part of the report.

DR. POLAND: Dr. Oxman?

DR. OXMAN: Dr. Burke, has the taskforce considered or will it consider the issue of the ability of the VA to provide support for families of veterans with mental health issues?

DR. BURKE: That has certainly been part of the discussion. The taskforce was not asked to specifically recommend changes to the VA, but inasmuch as the mental health care system is indeed a system and the Department of Defense is only one part of that system and that part of the mandate, part of the emphasis that Congress placed on us was to look at care for families, certainly the way those systems, those parts of the system interact to care for families will be a part of the report.

DR. OXMAN: Thank you.

DR. POLAND: Dr. Pronk?

DR. PRONK: Dr. Burke, I was wondering if you could speak to the notion of integration of mental health services in the context of primary care type services. Does, for example, the taskforce address the issue of screening in those type of settings for mental health and then address the issue of continuity of care?

DR. BURKE: We have. We had a work group that was specifically looking at issues of continuity of care. The issue of mental health care in primary care has been thoroughly examined, I believe, by the taskforce. We've had subject matter experts. We saw, I personally was on one of the site visits at Robins Air Force Base where we talked about the way they were integrating mental health services into primary care. So, yes, that is being looked at.

COL. GIBSON: I just wanted to make one comment. The Mental Health Taskforce, what Dr. Burke is here doing today is just basically

providing us with an update of the activities that are going on.

The taskforce report, once its delivered, the taskforce will basically stand down within about 60 days after the delivery of the report. Their charge is to provide recommendations to the Department that are actionable and that the Department will respond to, so the taskforce itself is not going to run future programs, et cetera. They will do their due diligence in their report and then turn it over to the Secretary for his consideration.

Once that report is turned over, the Secretary has a period of time to then respond to Congress with his response to the taskforce recommendations.

DR. POLAND: Tom, thank you. Let me just ask two closing questions: One, anything further the Board can do that would facilitate the taskforce work and, two, any barriers that you're encountering that we can help with?

DR. BURKE: No. The Defense Health

Board has been very helpful and very cooperative as far as scheduling briefings and meetings. Our taskforce is 14 members with other full-time jobs, and they're scattered all over the United States. So bringing them together in one place can be a little problematic, and you've been very helpful as far as helping us coordinate those meetings between the Defense Health Board and the taskforce.

The barriers, certainly with a topic this broad, we could use years more of work, but we're on a schedule.

DR. POLAND: Be careful what you wish for.

DR. BURKE: Thank you.

DR. POLAND: Thank you, Tom. We look forward to your report.

Before we move on to the next topic, there are some members of the Board that weren't here when we did introductions as well as some of the liaisons and preventive medicine officers that I'd like to introduce themselves, so if we could

start on this side.

COL. BADER: Good morning. Colonel Christine Bader, the Executive Secretary for the Taskforce on the Future of Military Health Care.

DR. MULLICK: Good morning. Dr. Florabel Mullick, Principal Deputy Director of the Armed Forces Institute of Pathology and Executive Secretary of the Subcommittee of the Defense Health Board on Pathology and Laboratories.

DR. PARISI: I'm Dr. Joe Parisi, and I'm the Chair of the Defense Health Board Subcommittee on Pathology and Laboratory Services.

LT. COL. WERBEL: Lieutenant Colonel Aaron Werbel of the Joint Staff.

CDR. FEEKS: Good morning. Commander Ed Feeks, Preventive Medicine Officer, Headquarters, Marine Corps.

COL. GUNTER: Good morning. Colonel Phil Gunter, Bridge Liaison Officer to the Office of the Army Surgeon General.

CAPT. JOHNSTON: Good morning. Surgeon Captain Richard Johnston, British Liaison Officer.

CAPT. NAITO: Good morning. Captain Neil Naito, Preventive Medicine Officer, Bureau of Medicine and Surgery for the Navy.

COL. SNEDECOR: Colonel Mike Snedecor, Air Force Preventive Medicine Officer, Air Force Surgeon General's Office.

CAPT. LUDWIG: Captain Sharon Ludwig, U.S. Coast Guard Headquarters.

COL. STANEK: Colonel Scott Stanek, Preventive Medicine Staff Officer, Army OTSG.

DR. KHAN: Good morning. Ali Khan, CDC, Atlanta, Georgia.

DR. POLAND: Thank you. Our next speaker will be Colonel Christine Bader. She will update the Board on the Taskforce on the Future of Military Health Care. This is the first meeting at which the work of this Board will be discussed, and Dr. Bader's slides are under Tab 4.

COL. BADER: Good morning. Good morning, General Schoomaker, Ms. Embry, Dr. Poland and Colonel Gibson.

One quick note for the record, I am a

nurse. I am not a doctor. So I just want to make sure that I'm not inappropriately titled.

Good morning. Again, this is our first activities update for the Taskforce on the Future of Military Health Care. What I'd like to do first is just have a quick overview of our purpose, our Congressional charge, introduce you to our taskforce members, update you on our activities, our public meetings, talk about our next public meetings and our upcoming milestones.

Again, I'm here to update you on our activities to date from December when we had our first administrative meeting, when our members were appointed up to this point, the end of March, 2007.

Our Congressional charge came out of the Fiscal Year 2005 National Defense Authorization Act. We are to make assessments of and recommendations for sustaining the military health care services being provided to members of the Armed Forces, retirees and their families.

We had 10 elements for study. Our

charge is very broad. We are looking at wellness and disease management initiatives, education programs focused on prevention awareness and patient initiated health care, the ability to account for true and accurate costs of military health care, alternative health care initiatives to manage patient behavior costs including options and cost and benefits of the Universal Enrollment System for all Tricare users, appropriate command and control structure with DoD, the adequacy of military health care procurement systems, the appropriate mix of military and civilian personnel to meet readiness requirements and the high quality service requirements, beneficiary and government cost-sharing structure to sustain military health benefits over the long term, programs focused on managing the health care needs of Medicare eligible military beneficiaries, and efficient cost and effective contracts for health care support and staffing services including performance-based requirements for health care provider reimbursements.

So you can see that our charge is very broad. The members of our taskforce: We have 14 members. Half of are Department of Defense members, and the other half are non-Department members. General John Corley is a Co-Chair. He's the Vice Chief of Staff, Headquarters, U.S. Air Force.

Major General Nancy Adams is U.S. Army retired former Commander, Tripler Army Medical Center and former Acting Director, Tricare Regional Office, North.

We also have Rear Admiral John Mateczun, U.S. Navy Deputy Surgeon General; Lieutenant General James Roudebush, U.S. Air Force Surgeon General; Major General Joseph Kelley, U.S. Air Force, he's the Joint Staff Surgeon; Shay Assad, the Director of Defense Procurement and Acquisition Policy, Office of the Undersecretary for Acquisition Technology and Logistics; General Richard Myers, U.S. Air Force retired, former Chairman of the Joint Chiefs of Staff.

Our non-Department of Defense members:

Dr. Gail Wilensky was elected at our first session in December as the non-DoD Co-Chair. She's a senior fellow at Project HOPE.

Robert Henke is the Assistant Secretary for Management, the Department of Veterans Affairs.

Dr. Carolyn Clancy is the Director of the Agency for Health Care Research and Quality Department of Health and Human Services.

Robert Hale is the senior fellow at the Logistics Management Institute and member of the Defense Business Board, formerly the Assistant Secretary of the Air Force for Financial Management and Comptroller.

Major General Smith, U.S. Army Reserve retired, is the past President of the Reserves Officers Association and former Global Controller, Ford Motor Company.

We have Larry Lewin, founder of the Lewin Group and currently Executive Consultant on Clinical and Technology Effectiveness, Health Promotions, and Dr. Robert Galvin, Director of

Global Health Care, General Electric.

So you can see that we have a very broad range of expertise on our taskforce, and we're very fortunate.

Our activities to date: We will review our meetings. We've had quite a few open meetings. We have direct and written testimony, subject matter expert briefings, and we have the review of reports and studies which is ongoing. We are constantly doing research, pulling up reports that are relevant to our task, pulling out necessary information and gathering that to collate it and put it into our interim and final reports. Of course, we have to draft and submit our interim report which is due at the end of May.

Up to this point, our taskforce has decided to act in a plenary manner. Everyone is meeting together. We haven't broken down into subgroups. Perhaps we will do that after the interim report, but at this point we are pretty much all meeting together in open sessions.

We have developed a web site where we

have an open side and a password protected side just as the Mental Health Taskforce has done. On the password protected side is where we can put up our materials, begin to review drafts of our interim report, the taskforce members can provide comments without everything. At this point, there's no deliberation involved, so it's not open to the public, but it's where we can kind of make our edits and scratch out our work.

Again, we had our first administrative meeting on the 21st of December. That is where Dr. Wilensky was elected Co-Chair. It was purely administrative.

We've had public meetings. We've had five up to this point. We also had one information visit where we went to the United Mine Workers of America and talked to them about their health plan, their outreach programs and their mail order pharmacy.

Our first open session was held on the 16th of January, where we received input from Dr. Winkenwerder and Dr. Chu. Dr. Winkenwerder

briefed on the overview of the Defense Health Program, gave his system impressions and talked about management issues. Dr. Chu briefed on the military health care, gave a long view, talked to us about some recent developments and what he saw in the immediate future.

We also received information briefings. Mr. Middleton briefed on how the military health system is currently financed and Mr. Kokulis briefed on the military health care system cost drivers and legislation that was proposed last year to sustain the benefits. Much of that legislation is what brought us to the development of the taskforce.

On the 6th of February, we had additional information briefings talking about the pharmacy benefits program. We had Rear Admiral Tom McGinnis, the Chief of Pharmaceutical Operations Directorate, brief us on beneficiary and government cost-sharing structure that is required to sustain military health benefits over the long term. We also received information from

Captain Patricia Buss on cost-sharing under the pharmacy benefits program, and we were briefed by Jean Storck, Chief of Health Plan Operations, on our managed care contracts.

Major General Smith, who is on our taskforce, represents advocacy groups. He's been out and, of course, he has meetings with them and can bring back to us some of their concerns. So, during that meeting, we also had a short back brief from him on meetings that he had with advocacy groups.

On the 20th of February, we had the Surgeons General and the Joint Staff Surgeon brief us on the direct care system as well as General Kelley briefed in an unclassified manner on the deployment aspects of our military system.

We also received a back brief from General Corley and Dr. Wilensky on their meetings when we went to the Hill and spoke briefly to members of the Senate Armed Services Committee and the House Armed Services Committee exactly on what they are looking for us to do with this task. We

are going to continue to stay in touch with them to make sure that we are on track, so that we can provide back to the Secretary of Defense and to Congress what they're asking us to do.

On the 7th of March, we had presentations from industry experts. We heard from United Health Care and the Association of Retail Chain Drugstores. We also heard from beneficiary group representatives. Major General Smith coordinated with some of the advocacy groups, with NOAA, the Reserve Officers Association, family organizations. They came in and compiled responses and testimony, read them to us on what they see for the future of military health care.

For those advocacy groups that could not attend the meeting or perhaps there wasn't time enough to hear from everybody, they provided written statements. We did pretty much hear from everybody who asked to present. Those that wanted to provide a written statement, obviously we have those statements, and we are taking them into

consideration.

On the 28th of March, we heard from our managed care support contractors. We heard from Dave McIntyre representing TriWest, Dave Baker representing Humana and Steve Tough representing HealthNet.

Again, on the 20th of March was the first time we had a small group meeting. This was not a public meeting. It was just more of an informational meeting at which time we heard from United Mine Workers Association about their outreach programs and their pharmacy program for their retired beneficiaries. They will be presenting in open session at our meeting next week on April 18th.

Late last night, I returned home from our first road trip. We went out to San Antonio. We had a briefing from the commanders of Brooke Army Medical Center and Wilford Hall Medical Center. They talked to us about the market share. They talked to us about what they're doing in their facilities. We went through their burn

center and then had a tour of the Intrepid Center.

After our meetings with the commanders, we went to Sam Houston Club and had a town hall meeting, and that was our first town hall meeting. It was very informative.

Then yesterday, we had hearings outside of San Antonio. We heard from spouses, retirees, Guard and Reserve, young officers, junior officers and enlisted members.

It was a good two-day trip. Again, it was our first road trip, and we wanted to hear from folks outside of the Beltway. We wanted to get out and talk to a wide range of the population who receive the benefit of our military health care and to receive their input, their recommendations. We were obviously there as students. We were there to learn, and it was a very, very eventful two days.

So, with that, our next big milestone outside of meetings is our interim report which we will deliver to the SecDef, the Senate Armed Services Committee and the House Armed Services

Committee by the 31st of May.

Thank you for your time. Are there any questions?

DR. POLAND: Thank you, Colonel Bader. Dr. Kaplan?

DR. KAPLAN: I may be getting ahead of the story, but is there any liaison at all between the group that you're reporting on and the independent review group which we will hear more from this afternoon?

You're much more inclusive, as I understand it, but it seems to me there are areas of overlap, and I wonder if there's been any liaison.

COL. BADER: Thank you for your question, sir. Actually, Secretary Marsh, Secretary West and Arthur Fisher met with our Co-Chairs Dr. Wilensky and General Corley just last week to discuss issues of overlap. We recognize that there's overlap in the groups, and we are very hopeful that we can share information, obviously leverage off of each other's work and

collaborate.

Thank you.

DR. KAPLAN: Thank you.

DR. POLAND: Dr. Mason?

DR. MASON: Thank you, Colonel Bader.

COL. BADER: Yes, sir.

DR. MASON: I would appreciate some discussion, if you could, on points one and two that you articulated for us, specifically risk tracking and rewards and educational programs. Could you just share with us some of your thoughts?

In the civilian sector, rewards are a two-edged sword. So I'm really interested in the military setting and definitely active duty military. What is the thinking of the taskforce right now in terms of tracking which, to me, as an epidemiologist, is the established cohorts that you're going to follow for life and that you're somehow going to intervene and intercede with their practices, their behavioral practices, and in some of the issues with regard to wellness and

educational programs, please?

COL. BADER: Thank you, sir. We actually, our interim report asks us to be focused on cost-sharing and the pharmacy benefit. So, to be perfectly honest with you, sir, that's what we've been looking at for the first couple of months. That is not to say that wellness is off of our radar screen. However, at this point, I will tell you that I will be better prepared to answer the questions of the vector the taskforce is taking at the next update.

DR. MASON: Thank you.

DR. POLAND: Dr. Pronk?

DR. PRONK: Yes, Colonel, I was wondering if the subcommittee is considering the identification of best practices or benchmarks. And in that context is looking across that continuum of services that you have in your task for wellness all the way down the continuum of care, if you will. So, are you also including sort of industry benchmarks that are identified through the National Business Coalition on Health

-- for example, its evaluation -- evaluate tool or AHIP, the Alliance of Community Health Plans, those kinds of approaches?

COL BADER: Yes, actually, we have talked about that, especially some of -- the -- Dr. Galvin has brought that up a lot, Larry Lewin, in looking at industry benchmarks and how we can incorporate them into the way ahead for our reports and for the recommendations for the task force, yes, sir. Thank you.

DR. POLAND: Col. Gibson and then --

COL GIBSON: Just for the Board again, COL Bader's providing an update on their activities to date. Substantive questions with respect to the report should probably wait until the full Board gets a chance to talk to us in a deliberative session. So, the questions are fair; it's just that there are limited things that COL Bader can really address on behalf of the task force at this point.

DR. POLAND: Dr. Parkinson?

DR. PARKINSON: Yes, thank you. A

couple of questions. Why -- I'm curious -- the choice of United Mine Workers relevant to White Ride or other organizations out there -- what's -- what was the rationale with them? It would just be informative for me.

Second would be has the task force had the opportunity to dust off something that the Milbank Foundation thought was noteworthy for studying and publishing, and that was the Military Health System Optimization Plan -- it was crafted by a number of us here -- that frankly had some policy barriers put in place but it started with a readiness-based model and then said how do you move from that. It would be historically informative for the committee as well as to look at Dan Fox and David Kindig's assessment of that in 2001. It was published by Milbank Foundation.

And the third piece is the term "patient driven" -- I think there was a term in the charge about patient driven. As you know, the main -- one of the major transformations of all health care purchasing in the last five years has been

around consumer-focused or consumer-driven health care, and I would just offer as a point of contact myself or other people in that sector, which is still about 10 million Americans are there. We have major new lessons to learn. I know Bob Galvin knows of it. G.E. has not been an early promoter or adopter of some of the models but may be informative for your committee and I would offer that to you -- not just myself but some other people.

COL BADER: Great. Thank you very much. We'll certainly look up the optimization plan, and we can talk offline about your third point.

DR. PARKINSON: Okay.

COL BADER: Regarding the United Mine Workers of America, we are always looking for, you know, a good plan, a good practice, something that's been used and has worked. A member of our task force was aware of what -- the retiree funds and their benefits and that it's been successful and that is how that was brought forward to us. Thank you.

DR. PARKINSON: Thank you.

DR. POLAND: Dr. Gardner?

DR. GARDNER: Pierce Gardner. One of the themes of the day is the transitions of the care of the service member from inpatient to outpatient and from outpatient DoD to the VA system or the private sector, and I wondered if -- I don't see any focus of sort of the systems management and the need for assistant recordkeeping and hopefully electronic records that would facilitate those I think identified glitches in the current system.

COL BADER: Well, our charge does talk about -- you know, you talk about the records system and, you know, we do talk about, you know, technology and the record system that's not hardcopy --

DR. GARDNER: Electronic?

MS. EMBRY: Electronic.

COL BADER: Thank you, ma'am. Electronic record system.

I'm looking over at Ms. Embry because we

talked about this quite a bit last week in a number of meetings.

So, although our task force is not directed to your second point to look at, you know, specifically transitions from inpatient to outpatient. That's all part of our overarching sustaining the benefit and care of the patients and care of the beneficiaries. Our charge is very, very broad, so we're going to touch on a lot of different areas.

DR. GARDNER: Thank you.

DR. POLAND: GEN Schoomaker.

MGEN SHOOMAKER: If I could just exploit the fact I'm sort of the mayor of Walter Reed, and the Board is meeting here. I'm not a Board member, I recognize, but I just wanted to follow on two comments at least -- the last one and what Dr. Parkinson talked about.

First of all, I wonder if the Board is aware or is looking into some of the efforts that GEN Kiley instituted before his announced retirement that look at changing the way we do

budgeting of our healthcare system that links rewards and reduction in risk factors for cohorts of patients and looks at clinical outcomes as a driver rather than pure productivity. I think we've all had the benefit of talking to Dr. Parkinson and others like him in the past and are looking at a radical revision in the way we do budgeting, and since fiscal drivers are so important in this particular task force -- task force attention -- I'm hopeful that that work will not be lost or be overlooked.

And I guess a follow-on to Dr. Gardner's points -- many of us who have been around the military medical system, as I have for almost three decades now, have looked at the events of the last two months or so as being perhaps the most dramatic ones that we've ever observed and have never seen, from the public through the DoD right down through my parent service, the Army, as much attention focused on interagency cooperation, the transitions, the focus on how we are going to take care of the whole person and the whole

family; and I'm more than idly curious as to how much of the work that's going to be reported out of multiple review groups, commissions, and active working groups, even within the Army alone, is going to be a part of your report or a part of your scrutiny as a task force.

COL BADER: Well, I know that we're going to collaborate, obviously with everybody's work, but we came into this with, you know, no preconceived notions, absolutely a clean slate. We have talked about incentives. We have the surgeons general. I know GEN Kiley brought up, when he briefed, some of the issues that you spoke about, and I can tell you that our task force members are open to all recommendations. I cannot tell you now exactly what they will recommend and what will come out in the report. I can tell you that they're looking at everything.

MGEN SHOOMAKER: To include all of the current recommendations that are coming forward --

COL BADER: Yes.

MGEN SHOOMAKER: -- from an independent

review group --

COL BADER: Yes. Yes. Yes.

MGEN SHOOMAKER: -- and the Shalala/Dole Commission and --

COL BADER: Our co-chair, Dr. Wilinsky, is also on the Dole/Shalala Commission. We have contacts with all the other groups. I've actually heard from their executive secretary. We are all collaborating. We are continuing to gather information. At this point, I cannot tell you what we will put in our interim report, obviously, or our final report. We're still deliberating. We're listening, we're learning, and we are considering all the information we received.

MGEN SHOOMAKER: Well, it's a very fertile -- it's a time of great opportunity for us in the uniformed services to get this right, so.

COL BADER: Yes, sir. Yes, sir.

DR. POLAND: Dr. Halperin.

DR. HALPERIN: Yes, Bill Halperin. Your mandate does sound very broad, and the meetings with the United Mine Workers health folks sets the

stage for my question. Does your mandate really address itself it to, for example, healthcare of miners per se, as in clinical care, or we all understand that a lot of the health of miners has to do with appropriate ceiling bolting so that the roof doesn't fall in and protection of miners against coal dust exposure -- both of these things mandated by the Mine Safety and Health Act of 1972. So, in fact, the health of miners depends a lot on preventive medicine, as well as clinical care. So, my question is, using the mine workers as the example but then in reference to the military in general, is your focus also on the infrastructure of preventive medicine, or is it basically healthcare as in healthcare and wellness?

COL BADER: We can actually -- as I had stated earlier, the initial charge for us for the interim report was the cost sharing and the pharmacy benefit. The second half we will now start getting more into the wellness and the prevention, and we can at that point choose

whatever avenue -- because we are so broad that we -- whatever path we would want to take. My thought right now is that we will take -- you know, we will look at, you know, obviously all aspects of preventive medicine and all aspects of wellness, and we're not -- you know, we're very broad. We have that latitude, and so I believe that we will look at all aspects.

DR. POLAND: Thank you. Let me see, Dr. Luepker and then Dr. Silva.

DR. LUEPKER: Yes, thank you. COL Bader, as I'm listening to this, I have a broad question, some of which has been touched on already. It seems like there are three areas. One is providing the highest quality care -- always a goal; second is a complex system and how it might be made better; but, third, and really the points here talk about costs which are driving many concerns in healthcare in this country. So, as you see the breakdown, is your primary push here to deal with the cost crisis, or is it reorganization, or is it how to provide better

care? And then what -- given all or probably goals -- in what proportion?

COL BADER: We are looking equally at everything, and I'm being very sincere. I mean, we're looking at efficiencies; we're looking at quality of care; we're recognizing that, you know, our goal is to maintain a healthy and fit force; we are, you know, looking at cost share -- we're looking at -- so, we're still looking at everything. We really are, and I'm being very sincere.

DR. POLAND: Dr. Silva?

DR. SILVA: Yes, I suspect by your previous answer that you'll be looking at errors in medicine, too, which is a great concern.

MGEN SHOOMAKER: I'm sorry, sir?

DR. SILVA: Errors in medicine. The Institute of Medicine highlighted this years ago, and in the public sector there are a lot of benchmarks that are driven off now, prevention of errors by healthcare systems and practitioners therein, and I guess that could fit under your

category of prevention as a broad topic.

DR. POLAND: Dr. Miller?

DR. MILLER: As a follow-up to Dr. Halperin's question, when you mentioned that you are looking at prevention services, I can see that this represents a potentially slippery slope in terms of does it also extend to potentially looked-at prevention services during combat situations -- for example, to ensure that there is adequate protection for military forces during combat protections?

COL BADER: Are you -- sir, you're talking about hardware? Are you talking about vaccines? Or when you --

DR. MILLER: Well, vaccines are implicit in terms of --

COL BADER: Right.

DR. MILLER: -- health services protection, but there are other types of combat protections as well, so does your remit include those types of prevention services as well?

COL BADER: We have not looked at that

at this point. We have not considered that. I'll take that as a note, thank you.

DR. POLAND: Dr. Parkinson?

DR. PARKINSON: Yes. Apologies for a second comment, but in the vein of Dr. Pronk's comments concerning best practices, another relatively hot-off- the-presses document that was produced by the Institute of Medicine on a committee that both Nico, myself, and several people like Martine (off mike) of IBM, and Pam Hymel, formerly of Lockheed, are on, and it really addresses the entire continuum issue: If you have a population of employees and family members, how do you optimize their health status with a primary prevention strategy all the way through to purchasing quality healthcare? It's called the Integrating Employee Health Report by NASA, and it's also been translated into a monograph for employers to apply in their worksite, so, again, I think both Nico, myself, and others would be resources because every employer in America is dealing with this list, as Bob Galvin knows. The

difference -- the nuance here, of course, is we run our own system within the macro dysfunction, frankly, of the U.S. health care system. So, how do you sort it out? That might be another document for you to pore over and try to apply.

COL BADER: Thank you.

DR. PARKINSON: They actually have that document.

DR. POLAND: Dr. Parisi?

DR. PARISI: Thank you for your report, COL Bader. Just a quick question. Has the task force made any recommendations or had any considerations for the handling of pathology specimens, especially vis-à- vis the BRAC closing of the AFIP? Do you have any -- have you given any thought to how things will be handled there?

COL BADER: No, we have not made any recommendations on that issue. I can certainly take that back. Thank you.

DR. POLAND: No other comments? COL Bader, thank you very much for your interim report. We will move on now to Dr. Joseph Parisi.

He will discuss the mission and vision of the Scientific Advisory Board for Pathology and Laboratory Services. This was a handout that Board members received a moment ago.

DR. PARISI: Good morning. Thank you, Dr. Poland, COL Gibson, Ms. Embry, and Board members and guests. I'm Dr. Joseph Parisi. I'm Chair of the Defense Health Board Subcommittee on Pathology and Laboratory Services. I'm a pathologist, and I have subspecialty expertise in neuropathology and have spent most of my professional career doing that. I was privileged to be a staff neuropathologist and then chair of the Neuropathology Section at the AFIP from 1981 through 1990 and was a member and then recent Chair of the AFIP Scientific Advisory Board.

As a pathologist, I am at a bit of a disadvantage this morning, because we're very visual people and I like to have slides up and things so that I can point to them. So, the best we could do is provide you with a handout that I hope will be somewhat satisfactory.

If we look at the expanded mission of the new Defense Health Board, as it's been defined, it includes the word "treatment," and I think this is a very important inclusion. Appropriate treatment, and an effective treatment in fact, requires pathology input, and it requires accurate and timely diagnoses be made, so excellence in pathology is really a central key to excellence in medicine, and it's a key component I think in many -- potentially all -- issues that will be considered by the Defense Health Board.

I think this -- the importance of pathology actually has been recognized. If you look at the logo of the new health board, you'll see that it includes a microscope, which is sort of the universal association -- universal symbol of pathology or the practice of pathology throughout the world. So, I think it's already been recognized as a key component.

If you look at the subcommittee, this is really an extension of the earlier AFIP Scientific Advisory Board, and it's -- so it has very close

ties to the Armed Forces Institute of Pathology and we'll detail some of those in a moment.

A proposed mission -- and again this is still an evolution, but as I see it the proposed mission of the subcommittee is to provide the Department of Defense with timely scientific and professional advice and guidance, and that is pertaining to all aspects of pathology including consultation for practice of pathology, education, and research; and we hope to do this through several means. We hope to collaborate with other civilian and DoD institutions and agencies; emphasize state-of-the-art diagnostics; promote quality assurance and best practices; monitor events with hard pathologic data; and promote excellence in medical practice through the AFIP's core strengths, which include consultation, education, and the very advanced tissue repository of carefully categorized and studied cases.

So, basically, as I see it, the mission of the subcommittee is to be a resource on all things pathology to the Defense Health Board.

However, there are several unknowns. The current mission of the DHB is being -- is in evolution, and I think the -- it's obviously been expanded beyond what the former committee's charge was.

Also, there are considerable unknowns regarding the fate of the AFIP with the recent BRAC recommendations.

The AFIP, as a bit of background, has served as the center of military pathology for decades. It's provided pathology expertise for the military and civilian medical communities worldwide. It's also been very important in the training of military pathologists by providing educational courses, as well as first-hand experience for trainees and new people into the -- in the subspecialty areas of pathology. It's always been the go-to place for difficult and unusual cases, and it has a vast repository of these cases that are available for future study.

The AFIP really has had a major, positive impact on the practice and science of pathology -- the practice and science of pathology

and medicine to both the military medicine and civilian medicine worlds, not only nationally but also internationally, and actually I know of no pathologist who's in practice today who hasn't been somehow directly or indirectly influenced by the AFIP through its courses, its consultations, or its publications. So, it's really been a major role in defining pathology.

On the next page, I just put a couple of the important AFIP activities. A primary mission, of course, is to provide accurate diagnoses, and I think when patients come to physicians they want to know "what do I have?" and that's really the basis of all treatment strategies.

The AFIP also maintains this very active national tissue repository that contains over three million cases that have been carefully categorized and studied, and these are under active investigation and really require and are best served by practicing active pathologists who can provide continual input into the cases.

As a bit of background, the AFIP

actually was established in 19 -- I'm sorry, it was established in 1862 as the Army Medical Museum as a repository for injuries and disease specimens of Civil War soldiers. It was expanded in 1888, and in 1946 the Scientific Advisory Board was established. This was the precursor to the current subcommittee. The Scientific Advisory Board was established to provide guidance and advice to the DoD and the director of the AFIP.

However, the AFIP became a victim of the recent BRAC recommendations. This again is background. I've included some of the details. In May of 2005 the Secretary of Defense announced recommendations to close or realign military facilities and, yes, as part of the base realignment and closure, and part of this of course was to close Walter Reed Army Medical Center. But also a corollary to this was to disestablish the AFIP, and the recommendations at that time were the Medical Examiner's office and the DNA registries would move to Dover Air Force Base in Dover, Delaware; some of the educational

services would move to Fort Sam Houston in Texas; the museum and repository would remain in DoD; and other services provided by the AFIP would be discontinued, transferred to other parts of DoD, or contracted. However, the details and the plans were really not provided for what would happen.

The -- this announcement actually was followed by a relatively vigorous grassroots groundswell of support for the AFIP from individual pathologists, individual practitioners, professional pathology organizations, and other medical organizations who all strongly felt that the AFIP should be kept in tact. However, the BRAC Commission recommendations went forward in September. President Bush signed this on September 15th, and Congress approved the BRAC report in its entirety on November 9th.

So, the BRAC is really a law now and we're under -- we're assuming the -- we're under the assumption that things will go forward as have been defined in the BRAC law. However, there are some wrinkles and uncertainties that have been

thrown into the equation. For example, even as early as last week or as recently as last week, the Kennedy Amendment to the Emergency Supplemental Appropriations Bill that was passed by both the House and Senate recognized and stipulated that none of the funds in this or any other action be used to reorganize or relocate functions of the AFIP. What impact this will have is still uncertain and remains to be seen.

In summary, I think that the Subcommittee of Pathology and Laboratory Services -- their vision of our subcommittee is really still in evolution. This is a coolly -- a changing environment. We have evolving missions at multiple levels. I think the AFIP activities have been and they are key factors in military pathology excellence and we would like to continue to build on the existing AFIP stress. However, because of the uncertainties, we really don't where all these will lead.

Dr. Florigal Mullick, who is the Executive Secretary for our subcommittee, actually

has been appointed the new AFIP director, and I'm very glad that Dr. Mullick could be here today. That appointment will become effective on June 29th. I can really think of no other individual more capable to guide the AFIP during these times than Dr. Mullick.

I wanted to reassure the Defense Health Board that the Pathology Subcommittee is committed to supporting the activities and the missions of the Defense Health Board in every manner possible.

I'll be happy to entertain any questions.

DR. POLAND: Thank you, Dr. Parisi. Dr. Oxman?

DR. OXMAN: The museum and collection of pathology materials is immensely valuable, and they've been valuable to a large extent because of the intimate association of expert pathologists with them both physically and intellectually, and it appears that that linkage is going to be broken under the new organization plan. Can you comment on what you think the impact of that loss will be

on the utility and, in the long run, the preservation of that irreplaceable collection?

DR. PARISI: I think you've hit upon a very important point, Dr. Oxman. It's very important to keep the registry alive. It's very important to keep active input by practicing pathologists -- young people, older people, doesn't matter -- by practicing people who have important questions to answer that the repository can provide answers to, especially as newer techniques become available. These tissues are a really irreplaceable and invaluable source, so I see the separation from active pathology providing input to the repository. If that link is lost, it's going to be a real tragedy because it'll basically become a warehouse and we'll have very little say in what comes in and goes out and how that is intellectually used.

The repository, as you know, has been the very rich resource that has been the basis of much of our understanding of diseases. If you look at our understanding of disease processes,

much of it comes from very (off mike) papers and reports that originated at the AFIP -- observations that originated at the AFIP -- and to lose that would be a real tragedy not only nationally but internationally.

DR. POLAND: Any comments or questions, Dr. Silva?

DR. SILVA: Thank you for your report. Are there any plans to set up a digitalization process to help maintain the collection of all over the long haul?

DR. PARISI: The digitalization of slides -- first of all, we're talking about millions and millions of slides. It's very costly. It's time consuming at this point, and most pathologists till like to have the glass in their hand and to look at the images under the microscope themselves, so there has been talk about that. I think it's a possible evolutionary step. It's certainly not ready at this time. I think as the technologies improve and the digitization algorithms improve, that's probably

going to become more reasonable, but I think at the current state-of-the- art, it's really not practical.

DR. POLAND: Dr. Luepker?

DR. LUEPKER: Yes. Thank you, Dr. Parisi. I'm curious -- being not very familiar with the AFIP other than its rather substantial history -- how are activities currently broken down? How much is the museum and maintaining the museum? How much is education and training? How much is active pathology for inpatients our outpatients?

DR. PARISI: Well, I'll be happy to answer some of these and Dr. Mullick perhaps would like to come in as well. Educationally it provides courses that are really not available anywhere else on the planet -- very rich, well-taught courses taught by experts in the field, very detailed, that are attended year after year after year by thousands of physicians that are both actively practicing physicians, as well as trainees.

The museum has been very, very active. They have several traveling exhibits. I think they've become better known in recent years, and again Dr. Mullick can probably provide more of the details, but I think the museum activities have certainly increased the awareness of the museum and the importance of these sorts of collections.

The consultation services -- the AFIP still maintains a subspecialty kind of organization so that if you have a soft tissue case it goes to a soft tissue specialist. If you have a brain tumor, it goes to the neuropathologist, and those activities are still continued. So --

DR. LUEPKER: Do you continue to add to the collection in the museum?

DR. PARISI: The repository is continually added so that when a case is accessioned to the AFIP, it actually becomes part of the registries, part of the repository.

The collections -- there have been several additions to the collections over the

years. I don't have a list of those specifically, but there have been several important collections that have come to the AFIP.

The museum has also been very active in developing some traveling exhibits having to do with health care, as well as attracting school tours and more individuals coming on campus to actually see the museum in person.

DR. LUEPKER: Thank you.

DR. POLAND: Maybe Dr. Mullick would like to say something?

DR. MULLICK: Yeah. First of all, I would like to emphasize that neither Dr. Parisi nor I are here to lobby for AFIP or any such thing. The BRAC law is the BRAC law, and we are following it. We have a plan. We have timelines, so that is one issue.

The reason that Dr. Parisi said he had to discuss some of these and I concurred is because the AFIP for hundreds of years has been tied very closely to the Department of Defense, military pathology, Veterans Administration

pathology, and civilian pathology. So in making plans for a charter or anything of that sort for a Pathology and Laboratory Subcommittee for the Department of Defense, these factors we felt needed to be in the question because there are still many uncertainties as of training of military residents.

The second opinion of military cases -- they will be contracted out, but then that brings a number of other uncertainties. Where will these placements be? If I send the case from a military placement to Dr. Parisi, he is definitely not going to return it to me to put it in my repository.

So, those are uncertainties that I think we can address at the task force, but at the moment it is kind of like in flux. The BRAC plan probably will not be implemented for another two years, so we have, like, the status quo kind of thing for two years, but major changes have to be addressed. There is a measurement of a Pathology Management Office I think, but that will be a

virtual office to manage and quality control contracts, the contracts that will go to the civilian (off mike). So, is it a composite of issues that are very uncertain. The level of training of the military pathology is another issue and so on and so on.

At the moment, the AFIP is functioning as always. To our big surprise, despite the fact that the BRAC law is final and we are in the process of maybe this week or next week sometime starting to implement some of the timelines, the staff is mostly in place, very dedicated. Not too many talks about we are leaving nothing unmasked, but of course the number of cases have been reduced -- they're civilian -- even though the military cases have increased, so it's kind of like business as usual. Less cases, relatively speaking, because of the civilian portion, but the VA sends us almost 20,000 cases a year and the military is increasing their second opinion.

Then I emphasized that the museum, which is the National Museum of Health and Medicine,

with thousands of artifacts, the best microscope collection, the (off mike) collection worth millions of dollars, or that remains in DoD, that remains and the plan is to go out to Bethesda. I think a new building will be built. The plans are like that.

The repository, which is where all the slides and gross tissue and actual fixed organs are housed -- that will also remain, and in the discussions that we've had, it has been emphasized that it needs to remain an active, not a warehouse type of system with -- then involving many talks with Dr. Winkenwerder's office, Dr. Jones (off mike), and all of agreed that it should be an active repository with some pathology stuff and so on, because it should not be a warehouse or -- we are already aware and concerned about that, and I think it would probably (off mike), but, again, uncertainties. We still don't know who is going to see the contract for evaluation of the status of the specimens. The value has been determined, but we need to know exactly what is fixed, what is

not fixed.

Everything is automated as far as the slides but not the gross -- I heard -- they were talking about imaging. We were fortunate to receive congressional money, and we've had a contract in place for the last two years where all of the specimens are being imaged, including the radiology pathology collection and the (off mike) medicine (off mike), so that is going well, and the contract was renewed so that I think the repository is going to be great state with all the actuals that still ongoing. So, so far nothing has died, even though we are in the process of still providing service.

But, again, this is not lobbying for AFIP. We understand the law, and we have a plan, and we are going by the national capital area business plan that's in place. But because pathology at the AFIP has been so tied with the military pathology, the VA, and the civilians, we feel that the task for this committee, the mission, the vision has to include all those plans

which are in flux.

And I finish there.

DR. POLAND: Thank you. Ms. Embry? I represent the Department at these meetings, and one of the things that I think would be extraordinarily helpful is for you and for Dr. Parisi to perhaps since now you're moving from an operational role to an advisory role that it would be most constructive for you to make recommendations or provide some guiding principles that you believe are essential that the Department needs to continue to perform at a certain level that we need to incorporate into our departmental plans, because it is kind of an awkward situation because you are currently running our capability and now you're also supposed to be advising us on it. So, for the next two years I think while we are trying to shape those plans, when you're wearing your hat as an advisor as part of this Board, I think it would be very helpful to advise through the Board what it is that we absolutely need to preserve in terms of capability and

services.

DR. MULLICK: Right, and the committee is composed of a wide variety of experts -- national pathologists who are experts in their own field. Also we -- I have contacted the three military consortiums for pathology to be on the committee -- as well as the Veterans Administration director of the laboratory -- so that all of us when we have our first meeting we will all be thinking along those lines and we will definitely take up your recommendation, Dr. Embry.

MS. EMBRY: Well, I think we need to be able to use that. We do have a change in leadership, as you know --

DR. MULLICK: Right.

MS. EMBRY: Dr. Winkenwerder is leaving and departing very soon, and Dr. Casscells, who will be the new Assistant Secretary, will be arriving on board very soon. Dr. Tornberg, who was the other Deputy for Clinical Plans and Policy, who had oversight over the AFIP, has departed.

DR. MULLICK: Right.

MS. EMBRY: So, I -- if there's anything that you could do to convene your committee and make your recommendations as early as possible so that the new team is informed without a whole lot of background --

DR. MULLICK: Um-hmm.

MS. EMBRY: -- and is aware of the requirements that we need to incorporate in our plan by this December.

DR. MULLICK: Right.

DR. POLAND: Dr. Mason?

DR. MASON: I'm Tom Mason at the University of South Florida. There's another dimension. It's the intersection epidemiology and pathology, and as a visiting scientist to the AFIP I very proudly sent my graduate students to the AFIP to work with unique pathologic information -- not necessarily the slides but the information on cases that get sent to the AFIP worldwide for referral for review, and that has led to graduate degrees, and I would argue that many of us who are

presently educating the next generation of public health practitioners would be very interested in and very concerned about the maintenance of all of these data on individuals from whom pathologic specimens have been sent to AFIP but with adequate information on the persons themselves to facilitate research into ideology.

DR. POLAND: Thank you. Other --Dr. Walker.

DR. WALKER: I agree wholeheartedly with Dr. Paris is about the key issues of pathology and driving the diagnosis and monitoring the patients with disease in the military certainly as well as civilian world. But beyond the issues of the AFIP, which has served (off mike) referral, anatomic pathology function, is the anatomic pathology practice outside in the hospitals that needs to be addressed by this subcommittee? And there's all the laboratory medicine, microbiology, clinical chemistry, blood banking, hematology, molecular diagnostics -- which I think really are what also need to be included in the emphasis and

advice given, because those are just as key to care of the patient as the anatomic pathology.

DR. POLAND: Um-hmm. Dr. Oxman.

DR. OXMAN: I would request that in advising the Department of Defense and the Defense Health Board that the subcommittee attempt to address this concern, and that is what has made the AFIP and the collection of monumental value has been the fact that people have referred their cases for second opinions to a group that provides internationally recognized expertise. If that expertise is contracted out and is no longer available in close association with the collection, then those consultations will stop coming and the collection will stop growing and stop being useful. I think it's also important to recognize that when one goes back to look at issues like pandemic influenza and current concerns one goes back and uses new techniques and new ways of looking at the old and invaluable cases. I'm very concerned that with what has happened that whole process and that whole value

will be lost. So, I would like to request that the subcommittee address this or attempt to address this very directly and very undiplomatically perhaps in its report, because that's the only way it's going to be a useful report.

DR. POLAND: Thank you. Any other comments? None, okay. Thank you very much, Joe, for your report. Our next speaker and last speaker before we break for the morning session is COL Skoville. He's the Executive Secretary for the Panel on the Care of Individuals with Amputations and Functional Limb Loss. This is, again, our first interactions as we evolve into the Defense Health Board with this panel.

So, COL Scoville?

COL SCOVILLE: Thank you. Ms. Embry, Dr. Poland, distinguished Board members. The Panel on Care for Individuals with Amputations and Functional Limb Loss is looking at a population currently at the total of 572 individuals with major limb loss across all four services. Twenty-

three percent of these have upper extremity involvement, 20 percent have multiple limb involvement. We established the Board of Directors of Amputee Patient Care back in September of '03 to provide oversight to the newly developing pattern of care we'll be providing to the individuals coming back from Afghanistan and Iraq with limb loss.

We had several preparatory meetings where you establish the missions, goals -- well, visions and priorities of the panel, and then we became a subcommittee of the Defense Health Board in October of 2006.

The Board membership was selected based on their training and experience in the field of amputee patient care and included GEN Fred Franks, retired; GEN Baloney, amputee, who had navigated the military system to return to duty and (off mike) Vietnam era wound; Dr. Alcide LaNoue, former Surgeon General, who had run one of the amputee care centers during the Vietnam war era; GEN Fox, who had been the commander at Brooke Army Medical

Center; Dr. Doug Smith, a distinguished civilian orthopedic surgeon, one of the most renown in amputee care in our country; Pedish(?) Shinseki to represent the family members of individuals with limb loss; Doug McCormick who is an above-knee amputee who has expertise in legal and legislative issues related to amputee patient care and services for individuals with disabilities. Patty Rossbach, is sitting with me, the president of the Amputee Coalition of America, an advocacy group looking into issues related to amputee care. Two members which were originally working with us, Judge Jack Farley got recalled to his position as the judge on the Court of Veterans Appeals and with the recall was unable to ethically be on our Board and make decisions which would affect activities he may have to rule on in the courts; and Dr. Cussman with the VA with his advancement and increased responsibilities. We are looking to add a member to the Board to represent San Diego and the Navy, as we have expanded services to that area, and again to gain additional representation

for the Veterans Administration on the Board.

The charter that the Board developed was to provide infinite advice and recommendations on matters pertaining to the care and treatment of patients with amputations or functional limb loss within the Department of Defense. Our vision is to do a collaboration of a multidisciplinary team to provide world renowned amputee care, assisting our patients as they return to the highest levels of physical, psychological, and emotional function.

Originally we focused just on the individuals with major limb loss, and we realized that there were a large number of individuals also with functional limb loss, that have had knee fusions, multiple fractures, nerve damage, and (off mike), ultimately resulting in amputation but even if they did not result in amputation severely limited the individual, so we've expanded our scope to look at how we're providing care for that population as well.

The main issues that the panel has been

looking at -- early on we looked at the extent of care. When we first started, the focus was on should we get the individuals basically functional and discharge them from the service and return them to the community and let them fend with the Veterans Administration with local care provided through veterans benefits, or should we work to return them to the warrior/athlete level, realizing that they were tactical athletes prior to injury and that was kind of their goal -- to return to that level. With the Board's Guidance, we've gone to that warrior/athlete. We've been successful in having 63 individuals return to active duty; 8 have deployed back into theater for a second or third rotation.

The next issue is location of care and number of sites. We started initially with care provided just at Walter Reed. Questions about is it better to provide care close to home and have the patients scattered across the country or develop a focus of care? The (off mike) from Vietnam that the members of the Board brought

stated that it was probably best to provide a central focus of care, and we're doing research efforts to look at, to validate that, but that seemed to be the best plan, and as Walter Reeds capacity was reached, we were approaching the capacity -- we just opened Brooke Army Medical Center as a second center for care, and with the Navy's desire to be involve and patients coming from the West Coast, we've opened the center out at San Diego as a third center for care, resources, long-term sustainment for the program.

Amputee care in the military in the past was designed to provide initial care and discharge the patient into the VA health care system. As we have individuals returning to service with major limb loss and we're working to bring them to that level, that warrior/athlete level where they can make a decision of returning to service or returning to the civilian community based on items other than limb loss, the requirements for the program, physical requirements and the long-term requirements for the program are an issue that

we're starting to look at and how do we program for this and plan to -- how can we sustain this program long term, because limb loss is a life-long condition to deal with.

Facilities -- we have had -- the facilities were designed initially for the short-term care. We have made renovations to facilities, and we have developed new facilities to provide the care.

The panel very early walked through, looked at our facilities that exist in (off mike) made recommendations on items we could do to improve our capabilities within existing facilities in the development of future goals or facilities.

Return to duty -- MEB/PEB. This has been evidenced more recently, but we looked at this very early in our meetings, and the issue was one of timing of the MEB/PEB. You wanted to keep the patient on active duty and within the system to get the maximum benefit of care without them feeling that they were being forced out. They

pushed me out early. I didn't get everything I needed. And at the same time, you wanted to program the Board so that they were getting their Board completed as they were nearing that maximum benefit of care.

So, they didn't feel like they were trapped in a system and couldn't leave and trying to decide first -- you know, it went back to the how long are we going to keep them? Are we going to return them to a high level of function? Are we going to send them to other systems using TRICARE within the military system or others? So, that became one that I think we're still looking at and working with to come up with what is the optimal solution. Much of it's individualized and working with the individual patients on what their goals and expectations.

DoD -- the VA DoD joint efforts to transition care into the VA system. We have the accessibility to the newest, greatest technologies for our patients. We work with the appropriate technology for the patient. Sometimes, you know,

the high-end microprocessor knee is not the appropriate technology for the task, so it's providing the appropriate technology. But as the prosthetic companies provide us with new componentry, no one else in the country has that. And the VA is working with us, so they are ready to provide this continuation of care. We have -- with members of the Board working with VA, we've been able to establish a training program where VA prosthetists and therapists come and spent a week with Walter Reed or Brooke Army Medical Center looking at what we're doing, and we do ongoing training and education programs.

Research focus -- again, we've discussed this with the Board members, looking at the wide spectrum of where we should head with our research. We have DARPA that is getting congressional funding for research. We don't want to duplicate what they're doing. We have the VA that is getting funding for research. We don't want to duplicate what they're doing, so looking at focusing the research on short-term achievable

goals that are aimed at the young, healthy individual that is looking to return the highest level of activity is kind of the guidance we're getting from our Board on that.

Command and control is an issue that I don't think we've come to a resolution yet on. The amputee care started at Walter Reed, kind of Army centric early on. The Department of Navy is now being involved with San Diego. With the Center for Intrepid opening in San Antonio, we have a number of groups that are now moving forward and trying to make sure that we aren't developing differences in care, differences in philosophy at multiple sites where patients go (off mike). "I didn't get to go there, so I didn't get this" is an issue, and it's one of the topics that our next meeting is going to be looking at and addressing.

The facilities -- the Center for Intrepid down in San Antonio, is an incredible facility. We've had over 600,000 Americans contributed to it. It is a monumental structure

to provide world class care. The same capabilities will be available here at the Military Advanced Training Center at Walter Reed. Our building -- they put up structural steel. It started going up in December of 2006. We have a ribbon cutting we're looking at planning right now for 13 September. The contract completion date is 22 November for joint occupancy, so we're well ahead of schedule on the contract side. We will have very similar capabilities to the Center for Intrepid. The Center for Intrepid was designed off of our plans for the Center here at Walter Reed.

And San Diego is developing the comprehensive Combat Casualty Care Center, making modifications to their existing facilities to be able to provide, again, a comprehensive program.

One point about the centers that we're creating is in the center here at Walter Reed, for example, we will have the -- the psychologists will be housed near the veterans benefits counselor; the vocational ed and rehab counselor;

the VA social workers; the MEB/PEB counselor; the physical therapists, occupational therapists; the physiatrist; the physician that is the lead for the program. We're bringing all of the individuals the patient has to interact with on a daily basis into one central location, and by bringing the MEB/PEB individuals into the same building, as we work the Medical Board process the patient doesn't have to go running all over or the MEB counselor does not have to go running all over to say this is the last piece of paper I need and get delayed in the process. So, our Board -- now panel -- has been moving, providing guidance to us as we've evolved from an initial care program to a fully evolved advanced rehabilitation program for our individuals with limb loss.

The panel is, again, a subcommittee of the Defense Health Board and will exist at the pleasure of the Board and as long as we need to.

Any questions at this time?

DR. POLAND: Thank you. Thank you, COL Scoville. We're anxious to engage with you on

this very important work. It ties in obviously with a number of themes that we've talked about this morning and this afternoon.

Any comments or questions from the Board members?

Dr. Lauder.

DR. LAUDER: Thank you very much, Dr. Scoville. That was an excellent presentation, and a very well thought out task for us, and I commend you on it, particularly with your expansion of patients with, shall we say, "relative amputations," and so I commend you on that.

I have a couple of questions, and one is you seem to have everything well thought out looking at a lot of different issues. Are you looking at the number of staff to do this immense amount of work, and by that I mean you did mention physiatrists, but I know there's a small number of physiatrists within the military system as well as therapists and prosthetists. Are there enough people to do the job, question number 1?

COL SCOVILLE: I believe we do have

enough staff. At this point we've been able to use a variety of approaches to providing staff. Some of the staff is involved with research with the patients, so as we're treating and using advanced technologies, we're researching that advanced technology so we're able to use some of the research dollars for some of that staffing. Some of the staff is provided through core dollars, because it has always been our mission to provide care for limb loss, albeit at a lower level. Some of the staffing is provided through Dollars for the Global War on Terrorism, and some of the dollars have been provided through congressional add-ins, so we've been able to maintain the appropriate staff level for the patient population, and if you look at our population, if you ask most individuals how many individuals there have been with major limb loss from Iraq and Afghanistan, you usually get a number much higher than the 572 that we have.

Amputation is the most visible of wounds; and other issues, like TBI and mental

health issues, aren't visible. If you look at their numbers, they're probably higher, and if you look at the resources that we have, I believe we're probably well resourced for the population that we're serving.

DR. POLAND: Please.

DR. LAUDER: Can I just follow up with this same issue?

DR. POLAND: Yes.

DR. LAUDER: The same people that are working with the amputee population are also going to be working with the traumatic brain injury population, and so that's the same core of therapists and physiatrists and mental health staff that are going to have to work with both sets of patients, and I guess that's where some of my concern comes in.

COL SCOVILLE: Yes, and a number -- by virtue of the injury, most of our individuals' limb loss has been the result of some form of blast trauma, and many have at least a mild traumatic brain injury, so there is overlap

between the two very closely. We have recently -- I know at Walter Reed we've been expanding the number of individuals we have to deal with -- the traumatic brain injury population as well. We've created a weekly clinic where we're bringing in -- we've always had a weekly clinic for our amputee patients where we bring in all of the subspecialties once a week and bring the patients in for an assessment -- how are they doing -- and making sure we're touching base with the patients, knowing where they're going, and that everyone involved on the team knows where they're going.

We've been doing the same with the traumatic brain injury. We created a weekly clinic every Wednesday in physical medicine with our physiatrists, and because Walter Reed has the physiatry residency program, we're able to really meet the need right now. We're working, again, to gain staff as we expand the TBI mission and role.

Yes.

DR. POLAND: Dr. Oxman and then Dr. Luepker.

DR. OXMAN: I would like to also commend the subcommittee for really approaching the whole comprehensive care of these individuals. I wonder -- because the combination of severe traumatic brain injury and limb function loss escalates the challenge, I wonder how many of the individuals have been able to look at and are caring for now are in that category and what you think about the capacity to deal with the increasing number of those that will be flowing into the system.

COL SCOVILLE: I think we've been fortunate that the number of people with the severe traumatic brain injury and with limb loss has been relatively low. For that population, the traumatic brain injury is the most significant wound. The ability to manipulate prosthetic devices, the ability to plan for moving with the prostheses is paramount to being able to do the therapy for the amputation, so it's been -- the emphasis has been -- with that population, the emphasis has been more on the traumatic brain injury and resolution of that and working with

very simple prosthetic componentry and evolving the prosthetic componentry as a traumatic brain injury resolves.

We've had, unfortunately, several individuals that have had loss of eye sight as well as loss of upper limb, which makes that a catastrophic injury. So, there are those issues, and those we work very closely with the VA with their traumatic -- with their polytrauma centers that they've established where they're doing the traumatic brain injury -- the blind rehab, the prosthetic rehab -- and we work the patients back and forth, so they'll go with the VA and spend some time focusing on certain issues there. They'll come back to us and we'll focus on issues, and it's a very close tie for those patients. But we can always do -- you know, we can always do more.

DR. POLAND: Dr. Luepker.

DR. LUEPKER: Yes. Thank you for an excellent report. I wonder if I'm effectively reading between the lines or over- interpreting

something you said. You know, it's apparent that the ways we now have to deal with limb loss -- the technology is extraordinary, and enormous advances have been made -- but I wonder if you set goals of return to active duty, and you mentioned eight people who have done that, you know, where does that leave the large number of people who will be discharged to the VA as opposed to --

COL SCOVILLE: Well, the goal is not to return to active duty. The goal is to get them to a level of capabilities where they can make a decision of "do I return to active duty or do I go and do other things?" I've had a large number of individuals that have been capable of returning to active duty that have participated on our 10-miler team, that have run marathons, that because of the benefits they join the military to get the GI Bill, to get educational benefits. They have those educational benefits; they also have the veterans benefits related to the disability.

And it is -- we've even counseled individuals that returning to duty is not the

right choice for them, that they need to move into the civilian sector because the benefits of staying on active duty versus taking a medical discharge -- it's much more advantageous for them to return to the civilian sector. An example -- we had an individual who was a reserve service member that wanted to go back into the active reserve. His wife was pregnant, his unit was ready to demobilize in two months. He wanted to be back with his unit when they demobilized. He would have gotten continual care for his limb loss because of the medical connection there, but the health care benefits for his wife during the pregnancy would cease once the unit demobilized and he was no longer active reserve. So, we have to work with them more frequently on what is the right decision for the individual. But the goal is not to say "you need to go back to duty." The goal for us is to try to achieve with each patient -- and we will not achieve it -- but our goal is to get each patient to a level where they can make an educated decision on whether they return to

active duty or don't return to active duty based on things other than limb loss.

DR. POLAND: Dr. Lauder?

DR. LAUDER: This is Dr. Lauder. I have another question. I guess I need further information from you or perhaps there is a question in this as well. I'm not sure best how to term it, but my question focuses around the most appropriate prosthesis versus the best prosthesis, and for each individual there's an appropriate prosthesis for their level of activity.

COL SCOVILLE: Yes.

DR. LAUDER: And that stems down a long line of cost containment from where that individual goes after active duty and where he can get his prosthesis, because most private insurances do not pay for most prosthetics. So, I guess I'm trying to find out where is this individual if he doesn't have a high level of disability or -- I mean, is he going to continue to get it through the VA system, or is he going to

be left out on his own then later to have to pay for a very expensive high-level prosthesis or what's kind of the result?

COL SCOVILLE: The individuals are -- as they -- if they remain in the military and their care is provided through the military, if they are medically discharged from the military, they have dual eligibility both through the VA system and through the military, either, you know, through the TRICARE system whether they are close to a military base in the TRICARE prime or they are remote and they've got TRICARE standard. There are still the benefits and the links to the military system into the VA. I work very closely with Fred Downs, who is the lead for Veterans Affairs with the durable medical equipment, which includes prosthetic devices, wheelchairs, the racing bikes that are specially designed for individuals with limb loss, and our goal is to make sure we don't let the guys slip through the cracks. And as I said earlier, we make sure we provide the appropriate technology. We look at

what the individual wants to do. You know, if they're going to be out hunting and slopping through the woods, you don't want to give them a computer chip in their prosthesis because it's going to malfunction out in the middle of the woods and they're kind of stuck there. So, we may give the individual three, four, five different prosthetic devices for various activities based on what their returning to, or they may get one because that's what their goals are, what they're functional needs are. It's meeting the individual needs of the patient, and it's a combination of the military, the VA, and the VA contracts or works with civilian prosthetists across the country. They have a network of providers, and they will move the patients to the appropriate site for the care that's needed.

DR. LAUDER: And has that been paid for?

COL SCOVILLE: Yes.

DR. LAUDER: Completely for the patient.

COL SCOVILLE: That -- there are a couple of issues where is not completely paid for,

and we're working those right now through various channels.

DR. POLAND: Dr. Walker.

DR. WALKER: Could you explain to me the system for a long-term, hopefully long follow-up for the outcomes and complications if they occur?

COL SCOVILLE: We have a database we've developed, which we're getting each of the patients to either agree to be a member of or not or bringing them back for research related to long-term outcomes. We are doing phone contacts with them. Definitely they're calling us. They see something on the news about a new foot that's out or a new ankle that's out or a new hand that's out and we get five or six phone calls right -- you know, when there's something on the news, because the patients want to know what it is and if it is a significant enough improvement that would warrant replacing their current prosthetic device. Some of the knees were just upgraded, and it's inappropriate to give them, you know, the new model, because it's not significantly different

except in very specific patient situations, and we'll have the patients' records and history and skill sets evaluated by our team of, now, OT/PT, social worker, physiatrist and determine is this an appropriate device for this patient and then work with the patient to either educate them as to "it really doesn't make a different in the activities you're doing" or "this is really important" and work through the system to get them the updates. But we have a number of research protocols looking at long- term follow-up with the patients.

DR. POLAND: Dr. Cattani?

DR. CATTANI: Jackie Cattani -- sorry. Are there differences in benefits that are available in the long term based on whether someone is active or a reservist in terms of the new technology that we develop follow-up for amputees that were reservists?

COL SCOVILLE: No, none that I'm aware of.

DR. CATTANI: They're all eligible.

COL SCOVILLE: They're eligible. They're medically retired or they're continuing on active duty and we're providing the same care to all groups.

DR. POLAND: Did you have something?

MS. ROSSBACH: No, I just wanted to reaffirm that nobody was going to go back into the civilian sector and depend upon third-party payers within civilians to pay for their prostheses, because we all know they don't pay, so I wanted to make sure but --

DR. POLAND: Okay. Thank you very much. COL Gibson has some comments.

COL GIBSON: Today's presentations will be available on the Defense Health Board website by the end of the week. The transcripts for this morning's session will also be available through the Defense Health Board website in about seven days. The website is www.ha.osd.mil/dhb.

DR. POLAND: Okay, this concludes the morning session of this meeting. We will break for lunch. We will return at 2 p.m. to deliberate

the draft findings and recommendations of the independent review group.

Ms. Embry, would you adjourn us, please?

MS. EMBRY: This morning session is hereby adjourned.

(Whereupon, a luncheon recess was taken.)

A F T E R N O O N S E S S I O N

DR. POLAND: If I could have people take their seats, please, we'll begin the Afternoon Session.

Good afternoon, to everybody. And welcome to this session of the Defense Health Board.

Ms. Embrey, would you like to call this Open Session of the DHB to order?

MS. EMBREY: Yes, Dr. Poland, I certainly would.

As the designated Fellow Official for the Defense Health Board, a Federal Advisory Committee to the Secretary of Defense, which serves as a continuing Scientific Advisory Body to the Assistant Secretary of Defense for Health Affairs and the Surgeons General of each of their Military Departments, I hereby call this afternoon's meeting to order.

Dr. Poland.

DR. POLAND: Thank you. The tradition we have at the Defense Health Board, we usually do

it at the very opening of the first day, but given the significance of this afternoon's meeting, I'd like to do the same today, and, that is, to ask all that can to stand for one minute of silence to honor those that we are here to serve, men and women, who served our country.

(Moment of Silence.)

DR. POLAND: Thank you. You may be seated. Before we begin our deliberations, I would like to welcome the co-chairman and members of the Independent Review Group who the Secretary of Defense charged to report on rehabilitative care and administrative processes at Walter Reed Medical Center and the National Naval Medical Center.

Since its establishment by Secretary Gates as a Defense Health Board Subcommittee on March 1st of this year, the group is fully engaged in gathering information on the issues at these two medical centers, as well as identifying the underlying issues challenging the provision of high quality care and treatment for our military

members and their families.

I would like to personally, on behalf of the Board, commend the efforts of the group and their staff for all their hard work. I speak for the entire Board when I say our service members deserve the finest medical care available and to be treated with the dignity due to anyone who places him or herself in harm's way to protect this nation and our freedom.

I also want to say a personal "hello" to a number of distinguished guests who are with us today.

RADM Brusick Core (?) is here with us; RADM John Mateczun. I'm not sure if he actually made it or not. Okay. Dr. Charles Rice, President of UCIS; RADM Adam Robinson; Major General Eric Schoomaker; and, RADM Mark Tedesco. Before we begin, I would also like the Board and IRG members to introduce themselves, and I'll start by asking the Assembly, and we'll work our way around both sides of the table.

MS. EMBREY: I'm Ellen Embrey. I work

for the Department of Defense. I'm the Designated Federal Official for the Board and for the IRG. And my official duties in the Department is as the Deputy Assistant Secretary of Defense for Force Protection and Readiness.

SECRETARY WEST: I'm Togo West, and I'm one of the two co-chairs of the IRG.

SECRETARY MARSH: My name is Jag Marsh. I am the other co-chair. I'm former (off mike) of Virginia, former Secretary of Army, as was Mr. West.

MR. BACCHUS: My name is Jim Bacchus, and I'm one of the members of the Independent Review Group.

MR. SCHWARZ: I'm Joe Schwarz, former member of Congress, practicing physician, and member of the IRG.

MR. ROADMAN: I'm Chip Roadman. I'm the former Surgeon General of the United States Air Force, retired in 1999, and member of the IRG.

MS. MARTIN: I'm Cathy Martin, retired Navy Admiral, and I'm a member of the IRG.

MR. FISHER: I'm Arnold Fisher, and I'm a member of the IRG.

MR. HOLLAND: I'm Commander Major Holland, retired, from -- the last assignment was the Senior Most Advisor to the Assistant Secretary of Defense for Reserve Affairs.

MS. ROSSBACH: I'm Patty Rossbach, and I'm a member of the Panel on the care of Individuals with Amputations and Functional Limb Loss.

DR. GARDNER: Louis Gardner, a Board member and Professor of Medicine and Public Health at the State University of New York at Stoneybrook.

MS. KITTANI: Jacqueline Kittani. I'm a consultant to the Defense Health Board and Professor of Public Health at the University of South Florida, College of Public Health.

DR. MASON: I'm Tom Mason, Professor of Epidemiology, University of South Florida, College of Public health, and also the director of the Global Center for Disaster Management and Managing

Assistant.

DR. HALPERIN: Bill Halperin. I'm Chair of the Department of Preventive Medicine at the New Jersey Medical School and Chair of the Department of Quantitative Methods in the School of Public Health, both in Newark, New Jersey.

MS. ROTTER: Tanya Rotter (?), Board Member, Physical Medicine/Rehabilitation, Minneapolis, Wisconsin.

DR. RUSSELL: Kissan Russell (?), Rutger, Board Member, and I'm Professor of the Epidemiology in Medicine at the University of Minnesota.

DR. SILVA: Joe Silva (?), Board member, Professor of Medicine, University of California-Davis.

DR. MILLER: Mark Miller, Board member and Associate Director for Research at the Fogerty International Center, National Institute of Health.

DR. BRONCK: Nico Bronck (?), Board member, Vice President for Health and Disease

Management, Health Partners, Minneapolis.

DR. ROCKIE: Jim Rockie (?), Board member, Professor of Pulmonary Medicine, Environmental Health, University of Cincinnati, College of Medicine.

DR. TEIR: (off mike) Teir (?), Pathology, Director of the Center for Bio-Defense, Emerging Infectious Diseases, University of Texas Medical Branch at Galveston, and Board member.

DR. PARKINSON: Mike Parkinson, Board member, Chief Health and Medical Officer of Luminos (?), a consumer-driven plan, which is a subsidiary of Well Plan(?).

DR. CAPLAN: Edward Caplan, a Board member, Professor of Pediatrics, University of Minnesota Medical School, Minneapolis.

DR. OXMAN: Mike Oxman, Board member, Professor of Medicine and Pathology, at the University of School of Medicine, in San Diego.

DR. CLEMONS: John Clemons, Board Member/Chairman of Microbiology and Immunology, at Tulane University School of Medicine, in New

Orleans.

DR. McNEIL: Neils McNeil (?), Director of Mississippi Public Health Laboratory, in Jackson, Mississippi.

DR. RISSI: Jeff Rissi (?), a Board member and Professor of Pathology at Mineo (?) Clinic, Rochester, Minnesota.

DR. NIGEL: Nigel (?), Board member, Bio-Emphasis, Professor at University of Maryland, School of Medicine.

DR. GIBSON: Roger Gibson, Executive Secretary, Defense Health Board.

DR. POLAND: I'm Greg Poland. I'm President of the Defense Health Board and Professor of Medicine and Infectious Diseases at the Mayo Clinic, College of Medicine, in Rochester, Minnesota.

For those in attendance today, this session of the Defense Health Board provides the Independent Review Group an opportunity to deliberate their draft findings and recommendations in a forum open to the public.

The discussions will remain between the members of the Defense Health Board and the members of the IRG.

If time allows, at the end of the session we will hear from those who submitted statements prior to the meeting.

If you wish to speak, we ask that you register at the desk just outside the doors to the members right.

Everyone has the opportunity to submit written statements to the Defense Health Board. Statements may be submitted today at the Registration desk, outside the double doors, or by e-mail, to the following address: Dhb@ha.osd.mil, or they may be mailed to the Defense Health Board. The address is also available on flyers located at the Registration table.

I'll ask now if Secretary Marsh and then -- I'm sorry Secretary West and then Secretary Marsh would like to make any opening remarks, and then I will make a set of opening remarks.

SECRETARY WEST: Secretary Marks is a

veteran of World War II. His service far -- to the nation far proceeds mine, and so I am going to ask him to go first, and then I'll follow.

SECRETARY MARSH: I was going to let you go first.

(Laughter)

SECRETARY MARSH: As I indicated earlier, my name is Jack Marsh, and I had the opportunity to co-chair with a very distinguished American, to my left, Togo West.

A couple opening comments. First, Mr. Chairman, I thank you for this opportunity to appear before your Board and appeal the members of your Board to consider as a another role these suggestions and recommendations that our Panel makes, because we think they'll make a contribution to the medical/health community of our great nation.

You know that there's always been an American ethic, and the American ethic is -- as Togo said, I'm said a veteran of World War II. The American ethic is America always takes care of

its wounded, and that's -- we've gotten to be certain that we continue to emphasize that ethic.

And what we're endeavoring to do in this report is to bring to your attention a number of things to improve and strengthen and correct some of the deficiencies that we've observed in the medical system as it relates, principally, to Walter Reed and to Bethesda, although our observations about Bethesda were not as deep or as concerned as about Walter Reed. But there's a difference between the two hospitals.

But I would point to you that we have on this Board, and I would suggest in your questions, that you direct many of your questions to the members of the Board who have skill and expertise in medicine and in nursing.

And there are a whole range of things that contributed to this report, and they were major contributors to the report.

We place a great emphasis on families. We place an emphasis on the Guard and on the Reserve. In doing that, we do not diminish our

emphasis on the active force and recognize it, but we do emphasize families, and families impact on the active and the guard and reserve.

As a father who had a severely wounded son, I can emphasize with the concerns that people have about medical treatments and how they are treated.

And I think you are going to find that the trauma care that exists for those who are wounded and injured is outstanding. And, yet, it's after the hospitalization and stabilization and the outpatient status that would emerge you begin to see so many of these problems occur.

Now, we are on the view -- and I need to emphasis -- first, re-solicit the help of the Board. Your expertise and background could carry great weight, not just in the Department of Defense, but in our country, because of your recognized leadership.

But we're going to need, in order to implement this, the help and support from the other services of the Department of Defense.

We're going to need the help of the Department of Defense, the Veterans Administration, OMB, OPM, and, above all, we're going to need the help of the Congress of the United States that has ultimate responsibility for the creation, maintaining and support, of our medical system, and our Armed Forces.

We have reason to think that some of the observations that we make here are systemic. Although we were charged to look at Walter Reed and, to a lesser extent, Bethesda, we did encounter indications that some of the problems that we addressed principally here at Walter Reed do exist in other military medical facilities of our Armed Forces.

We did not pursue that, but we point out the fact that that could be the case.

I think you will find what we call in our report the confluence of the circumstances that led to the perfect storm here at Walter Reed.

One: The increased flow of casualties from the War, significantly, above what they had

anticipated. The implementation of A-76, a federal government-wide program, begun in the 1960s, administered OMB, that impacted adversely at this time of confluence; BRAQ (?), the decision that was made to close the Army's hospital at this time, was another circumstance.

And then the large number of soldiers, who would go into the status of "whole-ropers", would place an enormous requirement on the facility.

So these are the things that we will lay out. We invite you to look at it and read it, but we, more importantly invite you to give your support to redeem these things, in the Department of Defense, in the Congress of the United States. We think that it can be done. We're confident that people will respond to that.

I think you for attendance here today.

DR. POLAND: Secretary West.

SECRETARY WEST: Thank you, Dr. Poland, as always.

Secretary Marsh, thank you for giving

eloquent and thorough coverage to what we on the IRG have been concerned with.

There is, of course, a wealth of good news about these two facilities, Walter Reed Army Medical Center, the National Naval Medical Center, Bethesda. But we were not called in to being, to search out the good news.

The fact is, if you listen to Talk Radio and hear what's going on, you hear people calling in all over the place, saying how much they admire what has happened to them at Walter Reed, how grateful they are for it.

By the same token, when I had a chance to just sit in the lobby and talk to patients coming in, every one of them -- the outpatients who were coming here, who are true outpatients, who are coming out from far outside the area, for care at Walter Reed, spoke glowingly of the care they received here.

So having mention those two balancing items, one that we were not called in to find the good news, we were called in to find out what, if

anything, there needed to be done, let me say this: Walter Reed Army Medical Center bears the motion distinguished name in American military medicine.

It, and its colleague to the North, the National Naval Medical Center in Bethesda, set the standard for health care in DoD.

Recent reports, the activities that have called us into being for our review suggest, however, that, although Walter Reed's rich tradition of flawlessly rendered medical care of the highest quality, remains to this day unchallenged, its highly-prized reputation does not remain unchallenged.

Fractions fractures in its continuum of care, especially as it pertains to care and support for its outpatient service members have been reported by being reviewed not only by us but by veritable, I don't know, cavalcade, of panels, organizations, officials, and, yes, even those who report upon the daily national life, either electronically, or in daily, or periodic

publications. And justly so.

Failures of leadership. Virtually incomprehensible inattention to maintenance of non-medical facilities, and a repeatedly, almost palpable disdain for the necessity of continuing support for recovering patients and their families have led the growing list of indictments of this once, and still proud, medical facility.

Our report is likely to be replete with findings and recommendations covering a wide range of issues and circumstances that have been brought to our attention. They appear to converge, however, around four core concerns, and my co-chair touched on them so I will try not to be redundant. Let me pose them, then, as questions.

First: Who are we? The country, in the case of Walter Reed as an Army, in the case of both medical centers, as centers of medical assistance and support.

Unfortunately, if one considers the reports we have heard in the IRG, as we've gone about our business, from service members and their

families, about the lapses and support of them during their rehabilitation phase of care at Walter Reed, we would conclude that we may be answering that question in ways that are not attractive to us, as a nation or as services.

We say so much about ourselves as a nation and about military services, about attitudes we displayed towards those who look to the nation for support during the most vulnerable times of their lives. And we, on the IRG, in view of that, are considering a number of recommendations and findings involving the assignment and training of case workers, increases in the number of case numbers, and adjustment to the case worker to patient ratio, assignments of primary care physicians. All the questions about how do we demonstrate our attitude about those who have served and suffered.

Secondly: Who are we, and what are we to become? That is actually my question that frames Secretary Marsh's reference to the BRAQ and A-76 procedures, and the potential difficulties;

in fact, the difficulties they've inflicted on Walter Reed, and may inflict on both institutions. I won't touch on that further. The point is that is our second concern.

The one thing that I would point out is that we will have a recommendation about BRAQ and about the need for proper transition.

Thirdly: How are our service members doing? At every turn the IRG has encountered service members and families, health care professionals, and thoughtful observers, who point out how challenging the traumas associated with TBI, traumatic brain injury, and PTSD, post-traumatic stress disorder, have become, and how further challenging they have been in terms of both DoD and Department of Veteran Affairs diagnosis and treatment.

We believe, and are likely to conclude, that there is need for greater and better coordinated research in this area. We anticipate a substantial recommendation with respect to Centers of Excellence.

And, fourth -- now, this is the last one, so let me just tell you that I had a little disagreement with the person assisting me in typing this up, although it's been -- it's a question.

The question says: How long? I originally had it say, "How long, oh, Lord, how long?" It refers to the Disability Review process.

If there is one issue that has generated unanimity on the IRG, and we have proceeded with remarkable unanimity and consensus, I would virtue to say -- but, Dr. Poland, you'll hear from our members shortly whether I'm right or not -- I would virtue to say, on this, we are as unified as any organization will be, and that's very unified.

And our belief that the horrors that are inflicted on our wounded service persons and their families, in the name of Physical Disability Review, known as Department of Defense, as the MEBPE process, simply must be faced.

It is, I'm sure, no surprise to the

members of the Defense Health Board, as it was no surprise to us in the IRG, that each part of the governmental process can make sound arguments to defend and explain why three, and in the case of the Army, four separate Board proceedings, with associated paperwork demands on the wounded service member and family, accompanied by delays and economic dislocation for assisting family members, and characterized prominently by inexplicable, to the service men, differences in standards and results are justified.

We, however, are a nation that values the good sense of common men and women. That's why we call it common sense. And common sense says that, from our service members and family's point of view, this must seem a wildly incomprehensible way to settle for service members and families the question of whether the member must leave the service and, if so, under what circumstances.

We will, undoubtedly, have a recommendation of some consequence. Well, it

certainly is some sense of unanimity from us on how that system might need to be combined and consolidated into a reasonable process from the service member's point of view.

Thus, virtually every finding and recommendation we will make can be traced back to these four concerns:

One: Leadership and attitude. That's the first two. Transition from Walter Reed Army Medical Center to Walter Reed National Medical Center.

Three: The extraordinary use of IED, devices in the current wars, and their impacts on the brains and psyches of our service members, and how we should deal with that.

And, four: The longstanding and seemingly intractable problem of reforming the disability review process.

To be sure, it was the degradation and facilities that first caught the eye of media reporters. Important as that is, we believe that there is far more to be dealt with here in

applying painting rooms or crawling around basements to finally deal with electrical problems.

We have experts of every sort assigned to us, to our staff. And we've got, as you heard, members of the health community on the IRG, with experience and expertise.

And, yet, none of these concerns is our bottom line. Not break, not failings, not breakdowns, and not culprits. This is, I would suggest, our bottom line: We are the United States of America. These are our sons and daughters, and brothers and sisters, and maybe an uncle and aunt, even a grandparent or two, who sit, if they can, who lie, who find themselves before us, in the car as it is in the rooms, if they are fortunate, walking along the pathways here at Walter Reed and at Bethesda.

Their families are our families, and we are their neighbors, their fellow citizens, their anguish is ours. We can and must do better.

Thank you.

DR. POLAND: I'd also like to make a few remarks on behalf of the Defense Health Board and then open it up for individual Board comments and questions. To start with, we very much want to thank the Independent Review Group for rehabilitative care and administrative processes at Walter Reed Army Medical Center and National Naval Medical Center for the serious and focused attention they have given the matters before us today.

I personally attended one of their meetings on behalf of the Defense Health Board and was impressed with their engagement and their own frustrations at the current system and resulting issues. Let me assure everybody in attendance here today that I observed what I would call a let's roll up our sleeves and fix these problems and let's do it now attitude.

So we thank Secretaries West and Marsh, as well as the other IRG members for providing the DHB with preliminary information despite a very, very tight and accelerated time line.

Now, there are soldiers sitting before me, and sailors, and air men, and their family members, and I want to speak to you, and this is a little personal. Up until a few months ago, for the last 52 years, direct members -- immediate members of my family have served in the Marine Corps, they have been wounded in combat, and I know the frustrations first hand of what that means.

I have a son hoping to enter the Air Force, and I, myself, served as a VA physician for two years and saw first hand the kind of care we're capable of giving when it's called upon. So these issues for me today that we're going to talk about are not academic, these are personal. I also want to start with what is perhaps an obvious statement, that the willingness of our citizens to participate in the future defense of our country is in direct proportion to how they see us treat the current members of our military.

What might not be obvious is that these words were first spoken by General George

Washington in the 1700's. But General Washington's words had historical precedent. In 1636, the pilgrims of Plymouth Colony passed a law which stated that soldiers disabled during war with the Indians would be supported by the Colony. It's instructive to listen to how the law read. If any man shall be sent forth as a soldier and shall return maimed, he shall be maintained competently by the Colony during the rest of his life. Later, the first U.S. Congress in 1789 also recognized the country's responsibility toward wounded and disabled veterans and passed a law to provide pensions to disabled veterans and their dependents. The Continental Congress of 1776 encouraged enlistments during the Revolutionary War, how, by providing pensions for soldiers who were disabled.

It's further instructive to recall the last words of President Abraham Lincoln's second inaugural address in 1965, after the bloody Civil War, when he stated, "Let us strive on to finish the work we are in, to bind up the nation's

wounds, to care for him who shall have born the battle, and for his widow and his orphan." In 1811, the first domiciliary and medical facility for veterans was authorized by the federal government progenitor of the modern day VA system, whose mission is, and it's important that we say these words, to serve Americans, veterans, and their families with dignity, with compassion, and be their principal advocate in ensuring that they receive medical care, benefits, social support, and lasting memorials promoting the health, welfare, and dignity of all veterans in recognition of their service to this nation; to care for him who shall have born the battle, and for his widow and his orphan.

One hundred and forty-two years later, we must hear this call to do what is right and to reaffirm our duty to provide what we must to our wounded warriors and their families.

The problems we are here to discuss today do not represent the failings of any one person or any one entity, as Secretary West

alluded to. To believe otherwise is to prove the old saw that for every complex problem, there is a simple, but wrong solution.

Rather, this is a systems failure, a complex tangle of chronic, acute, anticipated, and even unanticipated problems that have come to light. For some of these issues, the causes are clear and the solutions immediate. There is no need for debate or hesitation; these are issues for which standards of care and standards of management already exist, we need only implement them. For other issues, we need to be clear that simple solutions don't exist. For example, an unanticipated result of the current Gulf War is that of the severely multiply wounded soldier who, because of modern medicine and the unparalleled ability of our nation's military medical system to provide immediate outstanding quality medical care, that soldier now survives, but also now requires significant medical and rehabilitative medical support further exacerbated by a new type of injury, at least in terms of the magnitude of

cases, that of concussive blast injuries leading to traumatic brain injury or TBI that requires life long care and support.

Thus, while there are some immediate administrative solutions to the current set of problems, there are other issues whose solutions will not be simple, which will not be immediate, that will not be inexpensive, and that will not be one time fixes. This is exemplified by the findings and recommendations of the Department of Veteran Affairs OIG report on medical treatment of veterans after a traumatic brain injury.

Finally, the DHB has carefully reviewed the terms of reference for the IRG, they are specific, yet broad in scope, certainly broader than what can be addressed, much less data collected and understood within the time lines allowed to the IRG.

But it is important to point out that the IRG has put its finger on the key pressing and compelling issues that deserve both immediate and sustained attention. With that, what I would like

to do is now open up the floor for the board members to ask questions and have dialogue with the IRG members. Thank you. Doctor Silva.

DR. SILVA: Joe Silva; within the board, were there data that there's a stacking up of patients awaiting processing? Should there be a fast track system set up, if so, for those that have had unusual waits or unusual family and personal circumstances?

SECRETARY MARSH: Mr. Chairman, I would suggest that someone with particular expertise in that area might respond that either -- Congressman Schwarz, do you want to take that?

MR. SCHWARZ: The short answer, Doctor Silva, is yes and yes, but we were able to track, and I'd like to say Sergeant Major Holland, Doctor Roadman, and myself, but other members, as well, Congressman Bacchus, as well, tracked numbers of people who were medical holds and holdovers. There is a distinction in the definition there that we'll let Doctor Roadman get into.

But the answer is yes, and that, indeed,

is one of the problems, much more a problem here than at Bethesda, because of the numbers of wounded here at Walter Reed are far greater than those at Bethesda. And the problem is the fact that the administrative wheels turn slowly. And then there are problems with domiciling these people, because there certainly wasn't room here, some of them living on the economy. We can give you specific cases where we have been involved in trying to resolve some of these problems. And I must say, after pointed out to the command here at Walter Reed, they acted rapidly and I think quite appropriately to try to alleviate some of the problems. But the answer to your question, short form, yes and yes.

DR. SILVA: Thank you.

SECRETARY MARSH: Chip, do you want to add?

DR. ROADMAN: No, sir. Well, since Congressman Schwarz decided I was going to talk about hold and holdover, the hold is active duty people waiting for their boards, holdover is

guard, or reserve components, guard and reserve in holdover. There probably have been in the past administrative reasons for doing that because of administrative reasons.

It produces a significant problem, and there is a perception that within the treatment facilities, there is a stratification based on whether you're active duty or whether you're guard reserve, and we believe that the hold/holdover separation actually reinforces that what we have, in short hand, called a caste system, and believe that that should be corrected.

I understand that that is being corrected at the local level, however, it is still in the Army Regulations that those are there, and this is illustrative of the point that I think is important, and that is, local commanders struggle to try to do the best they can with policies that are given to them, there are unattended consequences of policies, and as those policies become non-functional or actually have a negative impact, we need to have a good way to very rapidly

get those out of the regulations and change the system, because we can't afford to have guard reserve component members thinking they have a different standard or a different administrative standard of care.

MR. HOLLAND: Mr. Secretary, let me follow up on that. We do not want anyone to perceive that we also want our service men and women to be looked at a number, they're not a number, they're very important entities. Their situation should be looked upon as such, and then the length of their time to complete the process, whether it is both for their rehab care or their MEB PEB process should be looked at as an individual and take into consideration their situation.

So we want to make sure that no one thinks, okay, let's speed the process up and churn them out like you do widgets in a plant. These are not widgets, these are our great men and women that are fighting our war today for freedom and that's very important.

DR. POLAND: Doctor Mason.

DR. MASON: A follow-up command, Sergeant Major. In the report as we have seen it, you make reference to case management and case managers and improved training and sort of the nurturing and availability of case managers; could you or any other member of the IRG share with us some of the specific ways in which to improve on that set of circumstances?

MS. MARTIN: You hit it right on as far as case management. We discovered that one of the issues was essentially the number of case managers that were dealing with many, many, many injured warriors. And I believe some action has already been taken to hire more case managers.

But it's more than just hiring people and throwing people at it, it's, number one, looking at the entire process and how individuals are actually taken care of, how their cases are managed, if they have a primary care manager to really assess the case, as well as how the case managers are trained. And so many of our

recommendations are based on case management and some real good solid recommendations on how this can be addressed.

DR. MASON: Thank you.

DR. ROADMAN: This gets us into some of the conversation that we had in our closed session. When we say case manager or we say primary care provider, those have a very specific meaning to each of us who grew up in our medical silos. What we are talking about here is the fact that the system is confusing enough if we're seeing multiple providers, and let me go on and develop this.

Our problem that we've seen is that many patients are treated with their diagnosis in series rather than in parallel, and what really means is, the most obvious injuries are treated immediately, which is, in medical triaging, is an appropriate way to be going after that. However, at the same time, there has to be a holistic approach to the patient, because although there may be a traumatic amputation, there also may be

supratentorial damage that's not obvious, and we're talking about a brain injury, TBI, mild to moderate, non-penetrating type of injury, and that might be treated later, and a delay in diagnosis and treatment is actually detrimental to the ultimate recovery of that patient.

So when we talk about case management, we're really talking about a shepherd. Now, there is no -- there's actually no personnel number for shepherds. But somebody needs to shepherd the patients through this terribly confusing system, both in clinical care and in recovery, that is actually their advocate, that is actually looking out for them.

So when we say case manager, when we say all of those issues, we're not talking about a personnelist approach, we are talking about an individual who can lead somebody through and explain the ramifications of their decisions and explain how to engage in an appointment system and explain how to get to their treatment. So we need to pull it out of the bureaucratic definitions.

As you think about our point, our point was, individuals need help, and so we have to have a structure that does that.

DR. POLAND: Congressman.

MR. BACCHUS: Two points, first of all, following up on what Doctor Roadman just said, pervasive in all we saw throughout our investigation was the impression that the wounded service men and women are expected to take the initiative in trying to deal with the system, they're expected to initiate any actions themselves.

It seems to us that they have a hard enough time being wounded and trying to recover without having to work their way through that bureaucratic process. So as General Roadman said, we want case management to be a matter of taking the initiative for the wounded service man or woman and being their advocate.

Second, I wanted to follow-up on another point he made a moment ago about the reserve and the guard. Now, I may have a certain point of

view here, at one time I was an enlisted man in both the guard and the reserve, but it seems to me, and I think it seems to all of us that both the reserve and guard, on the one hand, and the regular forces on the other are all at risk of their life and limb for our country in the Middle East, and they should all be treated equally in the way that they are treated when they return home when they are wounded in the service of their country.

And we would like to underscore that fact going forward as others respond to our recommendation.

DR. POLAND: Doctor Lauder.

DR. LAUDER: Following along with this conversation, in the case management, I might suggest that we start thinking of military medicine in a different light given the unique subset of patients that we have particularly from this war, i.e., traumatic brain injury and the multiple wounded, and that is that we think of a transitional step between acute in-patient and

out-patient care. And we need this transitional step, and whether you call it a transitional unit or a step down unit, what it is, it's a continuum of rehabilitative care, which is really I thin crucial to the subset of patients.

And that might be within -- well, typically, an example is, typically that is a unit that's within the medical treatment facility or the hospital if it's in the civilian world, where they go from being an acute in-patient to this secondary area before they become an out-patient, where this case management can take place, and it's a transition of having to function on their own and get to an appointment on their own, and I think it's very crucially important for this subset of patients.

DR. ROADMAN: I represented nursing homes and assisted living after my extended active duty, and one thing that is clear is that rehab medicine is different than acute medicine, and actually the approaches to it are different, so what you're saying is right.

What we have in the civilian sector is really almost a geriatric model with a few exceptions of young people. And actually, with the military now, with the number of survivals with very serious wounds, what we're starting to see is a younger population, and as you know, in our payment systems, in our bureaucracy, in health care in general in our country, we aren't prepared to deal with the young rehab nearly as well as we are the geriatric rehab.

So I think there's a learning curve here for us that actually we need to be defining what is right rather than taking what experience we have with the geriatric patients and superimposing that, because the needs are different, and I think a lot of thought has to go into how we do that, but the point being, we need to take people from very serious injuries in the acute and recognize that they're going to have to deal with these injuries for the rest of their lives, and we need to prepare them to be able to do that.

DR. LAUDER: And again, just to refer to

the OIG report from the VA, I think that they utilize a set of measurement outcome criteria for traumatic brain injury, but the subset of measurements that they use come from facilities that have a lot of experience in dealing with the continuum of rehabilitative care and particular with traumatic brain injury, and we may use those as model systems to look to for assistance.

DR. ROADMAN: You know, it sounds like you and I are going to have a dialogue all afternoon. And this gets to the same point I was trying to make, and that is, a traumatic head injury and the acceleration/deceleration type injuries that we see in the civilian sector, from motorcycles and automobile accidents and those types of issues. The data is coming out that those are pathophysiologically and neurologically different than what we see with acceleration/deceleration, and so although I think we have a model for that, I think we need to be very careful.

And it gets us into one other area where

the military will once again be defining leap forward in clinical medicine, and that is with TBI and PTSD, as being different types of rehab than what we see in the civilian sector. So once again, I think there's a learning curve, that's a start, but there are absolutely large differences, and so we need to be amenable to change rather than a cookie cutter.

DR. POLAND: Doctor Luepker.

SECRETARY MARSH: I might mention on the case managers, the ratios are way, way too high. There are not enough case managers and that needs to be addressed, and I believe that steps are being taken to do that. One of the reasons I think we found at Bethesda, their case manager ratios were lower, the number of wounded patients were lower, but nevertheless, getting those ratios into a better relationship is a must, and I hope that that's happening in the Army, I believe it's happening here at Reed.

DR. POLAND: Doctor Luepker.

DR. LUEPKER: I just wanted to follow on

something Doctor Roadman said about PTSD and TBI. I mean that is, in many ways, I think the looming burden here and as yet isn't confronted both with the short and long term need, and research is needed to better understand these.

But the impact on the individual service person and their families is enormous. And the treatments that are frequently needed are emotional and behavioral, not traditional treatments. And the question is, have you thought or discussed the need for mental health professionals to deal with this problem currently and potentially in the future?

MR. SCHWARZ: If I might address that partially. I was impressed with the expertise the mental health professionals here at Walter Reed had in dealing with PTSD. Much thought has gone into it, I believe much serious research, much detailed following of patients, going all the way back to my war, to Vietnam, and I believe that both in-house here, clinically and research, Doctor Hogue has done superb work in PTSD.

I don't feel that the boat is being missed there. The boat is being missed with traumatic brain injury, and the reason is that there was no realization going into this war that somewhere in the neighborhood of 75 to 80 percent of the injuries, the wounds, were going to be blast. But people sitting inside a Humvee 1114 or a Bradley or a Cougar vehicle, Cougars are better because the bottom is triangular, and what happens are different than what has happened in other wars, and we're behind the curve on that. And one of the things that we will do in this report, in its final iteration, is strongly encourage all branches of the service, all the medical services, to get up to speed on precisely what is the pathophysiology of the closed head injury due to blast. And if I might defer to our good friend, Mr. Fisher, here has some ideas about what we might do and a way to house a facility that deals precisely with that issue.

MR. FISHER: My idea, although it's still under investigation because I need to know

more about it, is that I think we need a center in which research and diagnosis comes from one particular place before we send these TBI patients out to be worked on either at Richmond, or at Palo Alto, or Tampa, or Minnesota.

We need to bring in civilian neurologists to work with the military medical field. We need to have a center for research. We need to follow these victims of TBI to where they go next and to keep track of them and not to just send them out and let them fend for themselves. It's something that I would like to investigate more.

There is a civilian army out there that is willing to build a center for traumatic brain injury, just like the army of intrepid foreign heroes fund that built the center for the intrepid in San Antonio. And I would like any help I can get to further this investigation of a center for TBI.

MR. SCHWARZ: May I make one more comment, and that is, at the National Naval

Medical Center, Doctor Moritides, and I believe, Admiral Robinson, am I properly correctly pronouncing her name? Maria Moritides is doing some superb work precisely on traumatic brain injury. And I spent an afternoon in her lab doing what needs to be done. Much more needs to be done, but they're doing superb work there, and I saw some of the work done with some patients and ongoing with some patients on cognitive rehabilitation with this injury.

And so I think both the Army and the Navy, and the Air Force, I'm sure, as well, General Roadman, know what need to be done here, but we're a little behind because there was no anticipation going into this war that this, using the phrase that we use in our report, this would be one of the signature injuries, one of the signature wounds of this war.

MR. HOLLAND: Excuse me, sir. I'd like to follow up on that and take it to the non-medical piece to this, is the idea that we must be able to evaluate our men and women on the

battlefield and know what kind of blast they were involved in. To ask an individual that has just had a traumatic event happen to them in their platoon what went on, you need to ask everyone, because you'll get, if there's ten still standing, ten different stories. So we must be able to evaluate it, whether it's putting a device on their helmet, on their uniform, whatever, but this is the only way we're going to be able to truly track this and we must get this started from the very beginning and not the back end of the process.

SECRETARY MARSH: Chip.

DR. ROADMAN: If I can jump in, and I think what I heard was, we need to do research on this, and so you all are going to have to forgive me. I think of myself as an operator, not an academic, I don't have a ph.d. What we need is the relative right answer.

Actually, the operators don't need a double blind study over 20 years to determine what's going on. We need very quickly evolving

research on the types of injuries, the types of therapy.

And let me tell you how really difficult the problem is that the practitioners are facing.

We've got a lot of good people doing a lot of good work. The problem is, it's not coordinated, it doesn't have a common definition. If you take the VA and you take the defense VA system, they have a different definition from what is being worked in a lot of different facilities, so no wonder it's confusing, the definition for the community is not the same.

In addition to that, when you go and do a medical record, there is no code in the ICD 9 or 10, or coming back into the what is it for, the other coding book. I'm just an obstetrician, okay, I may not know all these numbers, as a matter of fact, I've read more regs lately than I've ever wanted to read, but the fact of the matter is, there's not a number that goes on a medical record that says mild traumatic brain injury, even though that's the diagnosis. And if

you put the ICD 9 in there and you finally work it through the system, it comes out with a psychiatric diagnosis.

Now, no researcher can prospectively or retrospectively gather data if there's not a number that identifies what they are.

There are about 20 different things that could be TBI. It is imperative that tomorrow we put a number on TBI so that we can prospectively track that, so that Mr. Fisher's group can actually put these people into a prospective longitudinal study in order for us to know what happens with the natural disease of the course with treatment of the course, but also what happens, that we can track them and make sure that they're getting the therapy that they need.

Now, that may be a rambling issue, but there are systemic issues that need to be fixed today in order to be able to take care of these patients today.

DR. POLAND: Doctor Kaplan.

DR. KAPLAN: This brings up a point that

maybe has been talked around, but I'm not sure that I've got an answer for it, and that is the point of uniformity which you just referred to. We've heard about the difference between Bethesda and Walter Reed, we've talked and heard about the difference, or postulated differences between active duty reserve and national guard. In your report, are you going to come across as a uniformed set of suggestions that will cut across services, that will cut across all these -- dislack of uniformity, or did I misunderstand?

DR. ROADMAN: No, you hit it on the head.

MR. SCHWARZ: Yes.

DR. KAPLAN: Yes to which one?

MR. SCHWARZ: Yes to uniformity.

DR. POLAND: Doctor Oxman.

DR. OXMAN: I'd like to go back to something that Secretary West said. He pointed out that one of the important issues was the continuity of care. I think it's important to recognize that these seriously wounded warriors

will have wounds that will effect all the rest of their lives and that their families are seriously wounded and will remain seriously wounded for the rest of their lives.

And so I think it's crucial that we provide for a continuity of care that extends between the acute care and the out-patient care at Walter Reed or the Navy, but also into the VA.

And one of the problems that I have when I take care of patients at the VA is, it's against the law for me to take care of the patient's wife. And for the seriously wounded warriors, I think it's essential that, and that may take a congressional action, but it's essential that we provide the ability to take care of them and to provide care for their families for the rest of their lives, in a setting in which they're put first on the list. And so I hope that the IRG will add that item to its final report.

SECRETARY WEST: You know, I'd like to respond to that, but I'm not sure I could put it any better than you just did. I don't think

there's anybody on the IRG that would disagree with you, or anybody who worries about the effects of war on our service members and their families that wouldn't. And, yes, we're going to have to exert whatever muscle we can find, whether it's legislative or intellectual or just shouting at the top of our voices to try to get that done.

It's an important part; if you circle back, the patient's recovery does not just depend on the patient, it depends on the family member, which, in turn, comes back and effects the patient. So you're right, I think we are alert to it.

I would also remind us that all of these considerations, as we talk about the chemical and the medical considerations, all tie back to other parts of what is effecting our service members and their families as they find themselves in that unique place that we're calling rehabilitation or that part of the continuum, where they have had the crucial work done and they're now going through rehabilitation, or, and I hate to mention

these dreaded words, going through the physical disability review process. Now, I'm going to try not to mention it every single time that I get the microphone, but everything eventually relates back to that process, as well, its impact on the morale and the thinking and the psyche of the families, but also it's important to know to get the number, to know how we are dealing with TBI, to know how our review boards are going to deal with it and how that's going to effect what happens. And we call them patients, and that's a fair term, a lot of clinicians here, wounded service members, and how that's going to effect them for the rest of their lives.

So even as I listen to us talk, I also reflect on the fact that at least, I won't say a percentage, but a significant part of the process here that is effecting mindsets, recovery, how people feel has to do with the uncertainty of it all, not just the uncertainty of life, the uncertainty of their lives and what's going to happen.

I should be leaving this to the Sergeant Major to say, but I do want to add this in. It is common to hear commanders and others say, well, you know, I talked to the service member who's there and who was in the process, in rehabilitation, and I asked them what do they want, sir, I want to go back to my unit, I want to go back, I don't want to go on to civilian life, I don't want to go to VA, and you can attribute all sorts of things to that statement, don't want to be part of VA, don't want to have to face the fact that they cannot return to their unit and do what they were doing, that they're not going to be the same again, and they're hoping that they will, and our purpose is to get as many back to active duty as possible. But the fact is, the uncertainty of it all has as much an impact in terms of what we are hearing from members and their family as anything else. They're not complaining to us by and large, although some do, don't misunderstand, some do, that they're not getting good medical care in the rehabilitation part.

The reason I say some do is, we've got some stories. One service member whose doctors told him several different things, he didn't know what to do. But the real concern that seems to effect them as much as anything is, they don't know what's going to happen and they don't know what is happening.

We spoke about complex solutions to complex problems. There are some solutions here that at least to our members and their families don't seem all that hard to figure out. Tell us what's happening, tell us where we're going, let us know what's happening with the process and how it works, and please, don't besiege us with all the paperwork that goes with it.

SECRETARY MARSH: To add to what Secretary West mentioned on the families, you'll find in this report significant emphasis on the families, because it perceive -- and they do play a very valuable role in recovery. But they don't know what's available to them. There can be transportation, there can be certain assistance in

remuneration, they don't know that, and the process breaks down in trying to get them that assistance. There needs to be greater instruction for families on benefits and assistance. There are rules in this. As I understand the rule, if the attending physician makes the determination that a family member should come to the bedside of a wounded soldier, or a marine, or air man, or navy, that's what is required.

But many times families, and we know we had instances where they pick up, they come up here, they sustain significant financial hardships in travel and rooming and lodging, it is a very, very difficult situation.

And the question was asked, something about regs, not only do you get to -- need the service regs in sync, you've got to get the DOD regs in sync, and how you can have a situation where the DOD regs and the service Army, Navy, and Air Force regs are out of sync, it seems to me Defense should take the lead and get that straightened out. And I think we're going to have

to have Defense take the lead to get the family situation straight also.

DR. POLAND: Doctor Shamoo.

DR. SHAMOO: This comment, question is really for everyone, including the advocacy and families of service men. I'm concerned that the IRG will be out of business in a few weeks, the immediate attention will fade in a few months maybe, and who's going to sustain that these serious reforms, we could differ here and there, but to me, what's important are these serious reforms which will take some of them a few months, some of them up to a few years, to sustain them to get done. We shouldn't be back here in three, four, five years and we're discussing the whole thing all over again, not that we will do all of them 100 percent, but at least to sustain it. How we go about to do that?

MS. EMBREY: I can speak to that. I'm the designated federal official at this board, I represent the Department, I'm here at the pleasure of the Assistant Secretary, Doctor Chu, and the

Secretary of Defense, and he is most concerned with these issues, he established this Independent Review Group to make recommendations to him, he's quite serious about the outcomes and the recommendations, he will weigh these recommendations, along with those of other ongoing studies that should conclude within the next several weeks, and I believe that he has reform on his mind, and he will hold all those who have accountability in the system responsible for making those changes.

SECRETARY MARSH: Jim.

MR. BACCHUS: Let me add a word if I might, Mr. Secretary. I think it's probably apparent to all here that there is a strong consensus among all the members of the IRG about the recommendations we'll be making. We have no political acts to grind, none whatsoever. Our sole goal has been to help secure and ensure the very highest standard of treatment for our returning wounded service men and women. We have received strong support from the Department of

Defense, from the Secretary, from our great staff, and from everyone at Walter Reed and at Bethesda. We expect the same strong support going forward. You have just heard from the administration. We assume that the administration will take our recommendations, implement those that can be implemented through the executive branch administratively, and recommend that the rest be approved by the Congress.

We assume that the Congress, on a bipartisan basis, will want to do their very best for our wounded service men and women. It is true that we will cease to exist here in a week or so, but I think you can count on each and every one of us to be relentless in voicing these views going forward.

DR. POLAND: I'd like to ask a question that -- because I had a chance to chat a little bit about it with Admiral Martin, she might be best poised to illuminate us about this. I found one of the findings and recommendations particularly insightful and not necessarily

anticipated, and that is, when there are inadequate facilities, difficulties, particularly with hiring and retaining nurses, although other categories of health care providers are involved, and a sense of an overwhelming number of really horrific wounds, that there begin to play a compassion fatigue, I think was the word that was used, which means that this is having an effect not only on the wounded service member and their families, but also the care givers, and in turn, when they're effected, it further effects the wounded service member and their families. Can you talk a little bit about the issues that contribute to this compassion fatigue?

MS. MARTIN: Well, I think, as Secretary Marsh started out by saying this all created what we call a perfect storm, and it's layered onto the compassion fatigue as the shortage of staffing, whether it be because of a 76 study, whether it be because of military to civilian conversions, whether it be because of the announcement of BRAC and individuals leaving the system, or whether it

is because individuals have been treating wounded warriors for such a long period of time and very stressed, this all has a tremendous, tremendous impact on the staff.

And we saw that from the very beginning, and it's not just the physician, the nurse, the technician, or the hospital coreman taking care of the wounded warrior, I believe it goes throughout the facility.

And that begins to grow and to feed, so it might start at a certain point, but it travels throughout the laboratory, x- ray, and all of a sudden you have this uncontrollable, more or less, culture that is brewing.

And individuals, especially here at Walter Reed, also know that eventually they're going to be moving from this great facility to another unknown facility that they might not have worked at or never even passed by. So all of those pressures have been building up here at Walter Reed, and perhaps to some extent at the National Naval Medical Center, but within the

National Capital area for several years now. And certainly, we put compassion fatigue, that label, on the pressures and the stressors that the health care providers are feeling. But I think it's much more than just those at the bedside, I think it extends throughout the entire compound or campus here, perhaps not just in the hospital.

But that's something that leadership, starting from the Secretary of Defense all the way down has to look at and really address, because in order to relieve that, we're going to have to start looking at the culture, both the Army culture and the Navy culture, and looking at how we're going to blend that, and most importantly, how we're going to communicate that message that sends a positive signal all the way through our entire organization, both at Reed, as well as at the National Naval Medical Center.

And that's going to be very, very tough, that's going to take, I think, a lot of emphasis and an awful lot of work, and it's more than just, as I kind of mentioned with case manages, more

than just throwing bodies and people at it.

DR. POLAND: Congressman Bacchus, would you like to make a comment?

MR. BACCHUS: Just very briefly. I agree with every word that Admiral Martin just said, but I want to underscore something that we'll be addressing our recommendations. If we're going to keep nurses, if we're going to hire nurses, especially in this part of the country, we're going to need to pay nurses a whole lot more, and I believe that the United States of America can find the money to do that.

DR. POLAND: Doctor Parkinson.

DR. PARKINSON: Thank you, Doctor Poland. You know what, a comment and then a question. The military and, by extension of the VA, have so much more than the civilian sector in terms of our culture, teamwork, (off mike) capitalizing on that and really making both care we deliver and care we purchase uniquely tailored to the needs of that special population of service members is something that I would suggest your

group is now focusing us on.

What is different about getting rehab to a service member who comes back with signature injuries of the war versus rehab? And your report has helped focus, at least this board member, on what is the cultural and historical benefit of the military to the country.

So when you look at military medicine, we have preventative medicine at Walter Reed because of the tradition of Walter Reed, and preventative medicine and a healthy fighting force, immunizations, hygiene, personal protective equipment. We have state-of-the-art combat casualty care that advances surgical practice all throughout the United States. Unfortunately, we advance surgical care every time we go to war. But the third major area, if you put preventative medicine, critical care, and combat surgical support is re-entry, recovery, and rehab. We have not committed ourselves in a systematic way to the third leg, if you will, of a comprehensive health system. And the report and the ways that you've

looked -- the term that just captured my read, and maybe it's been used elsewhere and I just missed it, signature injuries of the war, if you create best practice models that are military unique and VOV -- DOD VA friendly, then we have something to shoot for, and then all of us can sit down and say, what's the legislative barriers we have to stop or build, what's the regulations and policies we've got to get rid of yesterday which we control, what are the attitudes that we've got to inculturate (?) in our people, in our care providers, you've got it.

So I think -- this is a comment just to get some response, because your report crystallized it for the board in a very real way, and the first way I've seen it with that signature issue.

MR. SCHWARZ: Let me start and then pass it to Doctor Roadman. Understanding, as I look at this table of, in great part, medical academics across the way, but superb clinicians, you know, the bench research that I do is mostly with a

number 10 bog parker (?) blade, and I expect -- that's a surgical, that's a scalpel for those of you who -- and Doctor Roadman the same. But nevertheless, we did address this. And one of the things, a given, and had you gone on a minute longer, I think you would have stated it very clearly, that rehabilitation for the wounded warriors in this conflict, in every conflict, but perhaps more particularly in this conflict, is different. This is not civilian rehabilitation, the injuries are different.

As an example, I had it pointed out to me today, something I knew, but it was appropriate to point out to me that in the civilian world, only about two percent of amputees are upper appendage amputees, whereas military injuries, it's 20 percent. So looking at what you do with amputees, people have lost arms and hands, the rehabilitation for the closed head injuries, for the TBI, which we know is going to be different, and as the research goes on, the rehabilitation will continue to focus on how different it is.

But we have pointed out in our report, and I know Doctor Roadman will put the code (?) on this for me very nicely, that this is a different type of rehabilitation and there's no reason that the military cannot and I think probably does recognize it and bring it right up to speed where it ought to be.

But it is different than rehabilitation in the civilian world, the injuries are different, the wounds are different, the magnitude of the soft tissue injuries are different, more amputations, more closed head injuries, and that's something that needs to be concentrated on; Chip.

DR. ROADMAN: Yeah; it's more amputations of young people. I mean a below the knee amputation for a diabetic is not an unusual thing, and you know, we know how to do that, that's been done for a long time, but these are young people that are going to return to a very active life and they've got to be able to have good prosthetic care, as well as rehab.

Now, Mike, Doctor Parkinson, you asked a

specific question, like what kind of regulations do we need to go and fix.

Doctor Schwarz and I walked in today and we saw the most amazing thing down in the prosthetic lab. We saw a young man that had lost his arm about mid-forearm, he was being fitted with a prosthesis that was computer activated from his flexor and his extensor muscles in his arms, and he could grab with an imposing thumb objects.

Now, that will return him to a relatively useful life of using his hands. We thought we understood that. Let me tell you about what we learned. If somebody, a guard or reserve has an amputation, most likely they will get a 30 percent retirement and go out and be eligible for care. And I have always been using East Moose Breath, Idaho as where the retiree goes.

Now, in East Moose Breath, there is one primary care doctor, and that's for 60 miles around, and so this individual actually, by regulation, is not eligible to sign up for Tricare Prime, it is not in the geographic span with

coverage of providers. Now, here's the deal; Tricare Standard will not pay for per diem and travel for a prosthetic patient to go and get the care that they need, whether they need to go to Florida or they need to come here or somewhere else; if they're in Tricare Prime, they will. But because of geography, they can't sign up for Prime, and because they are who they are, where they're injured, the type of injury they have, they don't get equality of care, which is the conformity and consistency that we talked about, because of bad luck, that's not acceptable.

And so the rules have to be changed for people that need the type of ongoing care, and it can't be determined by living in East Moose Breath versus living some place near Chicago.

That doesn't meet the who are we test as Americans for our fighting forces; does that make sense to you?

And so I believe that instead of waiting around to figure out what these loop holes are for the people in these emerging diseases, our

bureaucracy needs to actually do it prospectively and say, and what's the worst case that can occur, and do that before the problem rather than after the problem; does that answer your question?

MR. SCHWARZ: Yes, sir.

DR. POLAND: Doctor Halperin.

DR. HALPERIN: Thank you. Bill Halperin; these are obviously complex systems that we're talking about, and sometimes structural changes have to be made because there's a new phenomenon and we have to keep pace with the new phenomenon. But in order to improve quality in complex processes and improve satisfaction, decrease errors, I think modern management would suggest continuous collection of appropriate data.

And I wonder whether that is an issue which needs improvement in this situation, whether it's been one that's been focused on by the IRG, whether continuous quality improvement needs data looking at centennials or indicators that would tell us whether, you know, the vacancy rate for essential people we need, like nurses going up, or

the delay time towards resolution of a claim is too long, or whether, when you go to a restaurant, you know, were you happy with the meal, were you happy with the process, what's the satisfaction level of the clients. So my question is, what do we know about the collection of continuous quality data and are we -- do we need to improve it?

MR. SCHWARZ: I believe that the IRG agrees with your premise, which, of course, because we agree with it, it makes it correct, and we have addressed that in a general way in our report. But, you know, I certainly agree with your premise, and I would expect the rest of the group does, as well.

And it's not something that has gone unnoticed, that we do need to collect every single shard of information that we can, especially about, as we have coined the phrase, the signature wounds, the signature injuries of this war, which are different than those of previous wars.

DR. ROADMAN: Well, you know, I have to tell you, I get angry every time I go through a

grocery store and I watch them ring up a can of peas and it automatically reorders and we can't get x-rays from one facility to another.

Now, that's not an accurate comparison, but in today's environment where we have "a digital world", we have a Giant that can run an empire out of Bentonville, Arkansas, and we have problems getting electronic records from -- or we have trouble getting physical exams from retirement to the VA, that makes absolutely no sense at all.

And I will tell you that we have been working on that as far back as when I was a young colonel, emphasis on young, and we hit administrative road blocks, and we hit leadership road blocks, and this isn't a technical problem, this is a decision to get on with doing it.

And hopefully we can spur that type of activity. And everybody has their individual interest in doing their form versus somebody else's form, and leadership has to say noted, fix it, and then we will make progress. But it's a

leadership issue, not a technical one, and it can be done, but it's not.

SECRETARY WEST: We were asked a question earlier about whether the large number of service members returning from the two war zones, whether there was a stacking effect, and the answer was yes. Let me say, sometimes systems and processes that seem to work just fine, that contribute to a perfectly well functioning organization, organizations with great prestige, don't show their flaws until they are stressed to such an extent as every system in American military medicine and perhaps in all of DOD is being stressed by the fact of war.

I made a comment, one of the lines in my opening statement, which I am sure was hurtful to some of the professionals who heard it, about a perceived disdain for the importance of support during the rehabilitation period is undoubtedly driven by a kind of compassion fatigue.

Now, I might say, compassion fatigue was voiced at Bethesda Naval, where, in fact, as you

pointed out, the real stressors which are showing the actual effect and relationships as perceived by patients are being shown up here at Walter Reed, because there is no doubt about it, health care professionals don't go into the business because they want to be mean to people, they go in because they are moved by a concern for what they're going to be doing.

So every single health care professional, we can assume, here at Walter Reed or anywhere else around the country, around the world, who wears a uniform, or even those who don't, is in the business to make our service members feel better, to do good things for (off mike) -- and their families. So when there is a perception of a reaction or an attitude from a deliverer of services, you can look for the reasons. It doesn't make it any better for the receiving service members, but I think a lot of it is driven by the lack of staffing, by the stress that our systems are being put to and our people are being put to. That's one example, the example

you mentioned is another.

You're right, Doctor, we have been working on the, and this is an important part of the hand off, on the interface between VA and DOD, so that records can be transmitted to help service members, who will become veterans for as long as the memory of man and woman runs. Certainly, back when I was Secretary of VA, and even before then when I was Secretary of the Army, there was a big piece in the paper about how proud VA is of their electronic record system, so what.

They can't get the records in their interface with DOD, and moreover, within DOD there are so many different systems, we will be working at it for a long time. This time, when all of us are being stressed by war, is when those failures, or those that lack, will show itself up most clearly. What will we do about it?

We will write our report, we will put out our recommendations, we will have the support of DOD, the Congress has already indicated it's going to hear our report and then start asking

questions right away, there is another review group looming, a panel by the President, who will look at it all; these issues and the resolutions that we propose, and the issues that have been brought up by family members are not going to go away this time, because there is so much attention being focused on.

DR. POLAND: Dr. Lauder.

DR. LAUDER: I've heard several times about the differences in the rehabilitation care for this war, being the traumatic brain injuries from IED's and multiple traumatic injuries, especially upper extremity injuries, and that is true, and I think that we all recognize that. The basis, however, for good rehabilitative care and the continuum of care standards for the rehab patient is not different despite the diagnosis and the etiology of the problem, meaning that there is a standard of continuum of care that should occur, regardless of the diagnosis. What happens in their therapy or what happens within their doctor's office will be different because of the

diagnosis, but there still needs to be this smooth transition.

Having said that, what I might -- a suggestion, you make a nice comment and it's completely appropriate, and noting the declining numbers of mental and behavioral health staff, and the need to look into that, I might suggest broadening that to looking into the providers that are needed within a rehabilitation team, to include but not limited to, physical medicine and rehabilitation doctors, therapists, social workers, and as we have already mentioned, nurses. So that would broaden that and go with, I think what we're trying to achieve.

DR. POLAND: Any other comments or questions from the Board; Doctor Shamoo?

DR. SHAMOO: This may not be within the pervial (?) for the IRG (?) or us, but some of you have contact maybe with the Presidential Commission. Pre-college -- there is a great deal of help for disabled individuals, whether they are veterans or not, and I'm emphasizing here issues

of education and training, that is vocations training, because we want our veterans to become independent and productive citizens.

That is the ultimate goal, it's really not making them (off mike), and however, post high school, there is very little help for the disabled in terms of helping them in their disability, whether it's a cognitive or visual, whatever it is, in helping them get that education and training, whether it's a community college, or four year college, to become productive citizens.

Is there any way, shape, or form we could insert something there so there will be at least some kind of a long range attention to either give to colleges some incentives or the VA System can, you know, like the GI Bill is different, of course, to help them in post high school education?

MR. MARSH: I don't know of any specific recommendation. It appears in the report in reference to that, although, I think the observation that you're making about some type of

GI Bill benefits for them would be exceptionably helpful. Of course, there are certain GI Bill benefits now administered somewhat differently in the Armed Forces, but what you're suggesting is something, I think is worthy of consideration.

DR. POLAND: Okay. What I would like to do now is several things so that you know the flow of what we're planning. I'll ask Ms. Jared (?) to assist us in having the, I think it's two members of the public who have registered to make comments. I'd then like to ask some of our distinguished guests if they would like to make some comments. I'll then ask Secretaries Marsh and West for any closing comments they have, and then I will finish with a closing comment on behalf of the Board, with the name for us to finish roughly around 4:00 or so. For the members of the public and for the others that we'll ask to make statements, if we could keep that to under five minutes, please; Ms. Jared?

MS. JARED: Kathy Moakler?

DR. POLAND: Welcome, Ms. Moakler.

MS. MOAKLER: Good afternoon. My name is Kathy Moakler, I'm the Director of Government Relations for the National Military Family Association, and I'd first like to thank the Board for providing a forum for the IRG to present their findings, and I would like to thank the members of the Independent Review Group for the timely and efficient study, and especially, as you can tell because of the families in our name, for your concern for the families of the wounded, because we believe behind every wounded service member is a wounded family, and we are concerned of about the care for the caregivers, to make sure that they have access to the resources and training that they need. We will provide a statement to the IRG with some of our concerns in the future, but we appreciate the concern that you have for families, thank you.

DR. POLAND: Thank you, and thank you for coming.

MS. JARED: M.A. Parker -- just signed in.

DR. POLAND: Okay; no other -- Ms. Jared, no other members of the public? Okay. Any of our distinguished guests that would like to make a comment, and I might specifically see General Schoomaker, if you might, given your previous command, like to make a comment about the TBI research that we know is going on. Thank you.

MAJ. GEN. SCHOOMAKER: Yes, I'm Major General Schoomaker, I'm the Commanding General of the North Atlantic Regional Medical Command in Walter Reed, and as I mentioned this morning, until about six weeks ago, I was the Commanding General of the United States Army Medical Research and Material Command at Fort Detroit. Is this okay?

SPEAKER: Yeah.

MAJ. GEN. SCHOOMAKER: I have a couple of comments. First of all, I'd like to thank the group too. I was sitting and listening to you, and having interacted with the Review Group over the last few weeks, I was impressed that you got right to the heart of so many of the problems that

many of us have recognized and have recognized for some time about our system, and have been, as it is so well outlined at the local command level or at the provider level, hamstrung to do anything about, because these are our system's issues, many of them.

So I'm please and impressed that you have found so many of the things that we have to go after, and I can tell you since, certainly since taking command here in the Army, has thrown the full rate of the Army behind us. I've never been in a situation, in my professional like, and in my career, in which the Army has leaned so far forward to help us so aggressively, and has sent the message repeatedly that don't wait until the last report of the last paragraph, start to solve problems that you see can be solved on the ground, across the region, across the entire medical department, if necessary, and has given me a very very good staff and to assist me, to include a (off mike) General Armor Officer taken out of the Armor Center to help me.

And so to answer the question that was posed earlier, what reassurances do we have that we're going to continue on this, and to know that we're not going to be here three to five years from now asking why didn't we solve it back then.

I can tell you that for this soldier -- we're going to solve this problem, and I think the Army has told us, and the Department of Defense says that we will not rest until these problems are settled. Included in there, I think are some of the great insights here that have been brought out about the need for us to focus on primary care, and what we're developing here is the triad, of a primary manager, a case manager, and a command and control element through the Warrior Transition Brigade, and before I go any further on that, I'd just like to explain that one of the things that I think we've all struggled with is terms, is definitions.

We use the word wounded warrior, for example, in the Army, in association with a specific kind of a severely injured soldier who

has 30 percent or more disability, may have lost a limb, or eyesight, and yet the majority of the people that we're talking about here, frankly, are not battle injuries.

We have a large number of soldiers, just as any conflict, who don't battle injuries, they have non-battle injuries, they have illnesses or injuries that are a part of training, that are a part of deployment, and that are a part of life, frankly.

We have a soldier with a severe cerebellar neurologic disease that is unassociated with Blast, and he asked the question, am I no less a wounded warrior than someone who's been subject to Blast, I raised my hand to defend the nation, I've gone on deployment, and a degenerative neurologic disease has caught me, don't I have the same kind of priority for care, and the answer for us is absolutely.

So what we've begun to call these is warriors in transition, they're in transition back to active duty because the vast majority of our

soldiers to go back to active duty and we're very please with that, of those brought back from fears (?) of operation, the vast majority as in (off mike), have returned to active duty; that's the motto of the Army Medical Department, "to conserve the fighting strength."

And those that can't go back, we've put them into a single category, addressed earlier, the med hold med holder, over segregation, as General Roadman has said, has created this impression of two classes of care, which was initially addressed -- developed for administrative reasons and we said there's no reason to do that any longer, and so we are making those changes as we go, and I don't want to go into all of the details, but I wanted to assure the Board and the Independent Review Group that we are aggressively going after everything we can do as we see the solutions.

Let me talk briefly about TBI and traumatic brain injury and post traumatic stress disorder. I talked offline before the meeting

with several of the Board members, just to share a little bit of what I'm beginning to grasp better.

I'm an internist, I'm not a neurologist, I certainly am not a nurse surgeon, I have not been directly involved in the treatment of these folks, as many of our staff have, both in the Navy and the Army here, and what I think we've got at this point, is an emerging science that we don't fully understand yet, both around post traumatic stress like symptoms and the post traumatic stress syndrome fully expressed, and here the Army has taken a very aggressive lead in trying to understand through cohort (?) studies and longitudinal studies as to how post traumatic stress like symptoms emerge and then how they become fully expressed post traumatic stress syndrome, if not symptomatically managed, and the milder forms of traumatic brain injury where we might have a diffuse neuronal dysfunction that results from some aspect of Blast to include concussive injury, but has a gross overlap of symptoms between the two, and at this point, not

having a goal standard or a biomarker that we can say, they have no way right now of putting a thermometer into someone's brain and say you've got a Blast induced neuronal dysfunction that results from concussive injury or non-concussive injury, and you have an emotional response -- our blunt instruments are just that, they're blunt and they can't separate these two syndromic kinds of categories yet, and we need good, hard, basic science and longitudinal studies that have been referred to.

I think we have an instrument for that right now. The Congress and the National Defense Authorization Act of '06 created language that said to the Department of Defense, coordinate, integrate all of your Blast related injury prevention, mitigation, and treatment programs into one executive agent. That executive agency was passed through the Secretary of Defense, the Deputy Secretary of Defense to the Army, the Secretary of the Army passed that to the Army Surgeon General, who then passed it to the United

States Army Medical Research and Material Command at Fort Detroit, and they have spent the last year working closely with Health Affairs and the other services to bring together a comprehensive review of all of the research in Blast, from adequate brain injury, eye, traumatic amputation, hearing, all aspects of Blast.

So we have a great instrument right now, we have a great vehicle for that in the MRMC, and I would very strongly submit, Mr. Fisher, that that's a place that you could focus some of the energy for building centers of excellence.

My counterpart Commander for the National Naval Medical Center is sitting right behind me here, and Admiral Adam Robinson, and I've talked about the fact that the new Walter Reed National Medical Center, I think is an excellent venue for a center of warrior care in which we place research and clinical trials, programs like around traumatic brain injury, and other aspects of warrior care, and that becomes the center, and Mike, I have to commend you for, I

think a really tremendous insight into heretofore ignored area for us, or at least undervalued area for us, and that's in the rehabilitation area.

Ma'am, we have essentially what you described as a step down unit, it's called a malone house; it's exactly what the malone house is, and we don't understand it the way that you just described it, but it's an intermediate or a halfway house of sorts, in which families and soldiers together recovering, and it's beyond this campus in proximity to the hospital, in proximity to life support services, and get that intermediate step down kind of approach, but we didn't do it prospectively, and we didn't do it coherently, and we didn't do it as intelligently as we probably needed to, and what we need to better understand, Mike, is what you pointed out, is what are the essential natures of rehabilitation, especially within the military context.

What makes the soldier who has been injured, him or herself or the marine, and I use

that as a generic term for all of the injured or ill warriors, what makes them so bound to their colleagues and their comrades who have gone through this that they want to get back and help so actively in that rehabilitation process, and they're vital to that? It's not the same thing; it's not like the rehabilitation that many of us have seen for other categories of injury element.

So I'll close by just saying how profoundly pleased we all are that the group has done as thorough a job as they have in such a short period and contract a telescope kind of study time, but I think it's giving us some tremendous tools and insights for making improvements.

DR. POLAND: Thank you. In just a moment I'm going to ask Secretary Marsh and West to make closing comments and then I will. First, though, may I ask our -- do we have any wounded soldiers or veterans here with us today? If so, would you please stand or raise your arm, and if your family members are with you, would they also

stand that we might recognize you? Thank you, thank you very much. Did you want to make a comment?

MAS. SGT. CHENARD: (off mike)

DR. POLAND: Please, there's a microphone right there.

MAS. SGT. CHENARD: Thank you very much one and all. Master sergeant Chenard, I've been here almost a year. My injuries are nothing compared to some of my colleagues. Everything that you've said here is resonating very deeply into our hearts and our minds, and we thank you. I didn't hear anything about TSDLI, for some of the troops, it's becoming really hard to apply the administrative requirements.

The requirements will become more and more difficult. I can't think of anything more adversarial than a soldier being told by a PDB he or she got 20 percent, and oh, by the way, if you disagree with that and want to contest that, you know, we can turn around and give you nothing. I'm going to leave that sentence open.

I want to thank the Marine Corp yesterday for putting in the newspapers that they've started their own brigade, and they mention the term Ombudsman, and in the earlier discussion that we heard, we have case managers, we have platoon sergeants, we have primary care, they all seem to have a track or lane that they have to follow. The Ombudsman, on the other hand, he or she appears to have more leeway, as in crossing lanes, the whole purpose being to assist the soldier, he or she, in obtaining documents they need to help the medical staff do what they have to do, the (off mike) to properly diagnose clinically and otherwise in putting the narrative summary, the data that needs to be in there, so -- and that needs to be in there, and I might add, needs to stay in there without any changes until it reaches the hands of the PEB (?) individuals, so that they can properly evaluate the soldiers; all right.

If you need more details on that at some other time, I'll be glad to give it, but I think

you all know what I'm talking about. An Ombudsman might be the solution to that.

I'd like to be able to encourage everybody to understand it's been talked about in a circular way here with very good intention, I just want to reiterate when you're all pumped up and you're in a combat zone, and all of a sudden you get injured, one moment you were talking to your troops or aiming a weapon or communicating on a radio, the next thing you know, you're so doped up at some local hospital because your colleagues were able to transport you there in lightning speed, a big difference between now and Vietnam, as brought up by Doctor Schwarz, and now you're in (off mike), you're semi-conscious, you're told a few things, and low and behold, you're back state side in one of our medical treatment facilities being very appropriately and warm and cared for by our staffs, who can not get enough credit for everything that they do; all right.

I had an operation at the Navy and I'm here to tell you that the cohesion, the

integration to everything -- thank you Admiral Robinson, and your staff was just phenomenal. I couldn't tell what uniforms were treating me, but they did a fantastic job, and I thank them, and I may speak for a lot of others that I might add.

So coming back to -- you're wounded, you get back state side, and you're kind of groggy, and then all of a sudden you go from being a healthy service member to gosh, I got to take how many pills a day, and then you're asked to be -- you have to make some decisions, and this may take a long time for your body to wean itself off the effects of the medication, some -- most of the effects will help you, and as we all know, there are side effects and some of us react very differently, and all of this is going very fast, even though weeks and months and a lot of appointments are going by, and then the family never, of course, comes into the picture and he or she is totally unfamiliar with how the system works, let alone the medical environment.

So there's a lot of dynamics going on,

and in spite of all of that, we seem to make it through the process. But just please think about the soldier and how he or she feels with all of these chemicals in the body and all of these emotions bubbling up, that's the part that we often, I think occasionally lose track of, not intentionally, but it happens and it effects a lot of people, and I ran out of thoughts, I'm sorry.

DR. POLAND: Thank you, thank you for your comments. Admiral Robinson, any comments that you'd like to make?

ADM. ROBINSON: Good afternoon to everyone. I'm Adam Robinson, the Commander to National Naval Medical Center, and I think that General Schoomaker summed up a lot of the issues that we talked about. I'd like first, to thank the IRG for all of their help, and for their discussions, and also everything that they've done to bring many issues forward. With traumatic brain injury, it is a very interesting injury.

The comment that I'd like to make is that at National Naval Medical Center, with our

continue of our care, trauma service, which includes traumatic brain injury, we're dealing with new diagnoses and new treatments, and instead of being able to do the typical studies that will take years and that will have prospective or have a very controlled situation, we're finding that we are actually making enrolleds (?) and defining new areas that we're going to need to get out to everyone much sooner.

This is akin, and I'm sure that this isn't exactly right, but it's akin to having a new treatment for a bad illness, in which half way through the study you realize that the treatment works so well, you can't continue to study it any longer, you really just have to make your findings known and you can get out. So with traumatic brain injuries, I'm in no way saying that National Naval Medical Center leads the way, but with the -- because of how we have done care and because we're getting all of the penetrating head injury and most of the concussive head injuries at National Naval Medical Center, we've actually

concentrated in this area. We need to get that information out to the line, to the line hospitals, to the Veterans' Administration, because we need to do that, and I think it will make it different.

The issue that I'd like to also talk about is, the rehab issue, which I think is an incredibly important issue and the sustainment of care issue, which goes with that, and the two areas that we have been credited with doing it remarkably well by several members of the Defense Health Board, have been the preventive medicine and the combat surgical support, and then the third part that we haven't done as well is the rehab care, and I'd only like to comment that in military health system, the rehabilitative care has usually been not done as much.

We're not really set to do that, and I'm speaking from the Navy point of view, particularly, but the systematic rehabilitative services have traditionally been the purview of Veterans' Affairs, and Veterans' Affairs has been

resourced to do that.

I'm not suggesting to you that we don't need to do that now on the military health systems side, but I think that's a tremendous change in the model, and as we do that, we need to do it with our eyes open, we need to understand what we're doing, we need to be resourced appropriately, and we then need to make sure that we change many of the laws and many of the other things so that we can give the sustainment of the care to the member once they may have transitioned from an active status or reserve status to a retired status, and I think that's very important and we need to discuss that openly, and we need to make sure that we clarify that.

I think that we need to partner with Veterans' Affairs, and Veterans' Affairs' hospitals, and we need to partner with them on a daily basis with every injury in our poly trauma centers, and in our traumatic brain injuries, and I would suggest that we're doing that, in no way we're not, and VA is very receptive, but we need

to do it even more robustly.

And then lastly, just in the national capital area, and I think that General Schoomaker, again, would agree, we absolutely do need to go ahead with the integration of Walter Reed and Bethesda, both of the institutions, essentially, will close, they will come back as the Walter Reed National Military Medical Center, that is absolutely the thing we should do. General Schoomaker and I are absolutely locked in arm and arm with that.

In order to do it correctly, I'll just leave with this one thought, and that is it needs to be integrated health care system, it needs to have the robust med center, research, graduate medical education at the Walter Reed National Military Medical Center, and we need to partner with Navy, with Army, with the Air Force, and with Uniformed Services University, President Rice is behind me also, in order to have the integrated health care system that will actually give the care and then give the sustainment to that care to

the beneficiaries in the national capital area. I'd like to end by just thanking the Defense Health Board and also the IRG for all of the work that they've done and for bringing this front and center to not only DOD's attention, but also the American public. Thank you very much.

DR. POLAND: Thank you. Secretary Marsh, would you like to make any closing comments?

SECRETARY MARSH: Just a few; Secretary Togo West talked with me, and I said I would -- he suggests that I close, but I'm doing this on his behalf, as well as my own. First, an administrative announcement; the lady who represented the family group, who wanted to make a statement, if -- we need to get that statement within the next 48 hours because -- our report is going to be completed and we will not be able to print it unless we do. I would like to thank General Schoomaker, it was a month ago, Eric, that we were out here, when you just assumed the command, and the Admiral, Admiral Robinson, for

everything you all have done to help us. If I could mention to the members of the Board, the Health Board, you people enjoy enormous prestige in a very critical field (off mike), and you have great influence, and you can help through your member of Congress, when you leave the (off mike) and go back home, and let me suggest that you bring to their attention, because it'll have great weight because of your background, this effort that we're trying to do here on behalf of our government.

I might mention to the Health Board, you need to look at enlistment of doctors. We are having problems getting doctors in the National Guard and the Reserve, and there's a capability that you could use to take in older doctors in their 50's, but they have to sign an eight year obligation, and that's counted productive.

Finally, I would thank two groups of people, two different groups. You saw the tremendous abilities and expertise of why this committee was able to draw on great talents, and

I'm referring to the members here seated to my right. They have done -- really worked unbelievably hard, and this report reflects in large measure their inputs, and the second group that I would like to cite, are those who worked as staff members for the IRG. They too have done a yeomen (?) service. Both of these reports and efforts are a reflection of their efforts and also the input of my colleagues here on the IRG, and my good friend Togo West. Thank you very much.

DR. POLAND: Thank you, sir. Secretary West? Well, I will again thank the IRG and the Secretary's Co- chairs for the work that they did. We did have a few comments as a Board, one was to consider in the -- as we go forward, development of a set of guiding principles, many of which we've talked about that would be transparent in public as to what the ultimate solution to the current issues would look like, and some of those might include principles requiring that the eventual solutions be patient centric, that they adhere, of course, to the highest standards of

clinical care, that they be evolutionary over time, cost effective, and actionable.

The other idea that we had was the development of a road map or a pathway of the ideal medical care and support pathway from the point of acute injury all the way through chronic rehabilitative care that would involve both patients and their families, and again, this pathway or road map should be patient centric.

We also look forward to the development of metrics, measures, and timelines for this medical care and support road map. A definition of the personnel resources and ancillary services need to achieve the road map, and finally, as is endorsed in your report, the idea that someone, a specific individual, must be in charge of this process and have definable authority and accountability for -- and the sustainability of this process.

I'll summarize by saying that the bottom line is that we develop solutions that get the right people delivering the right services at the

right time and at the right locations to the right consumers. In this regard, the IRG has appropriately titled its report rebuilding the trust, and I think it's an appropriate one.

Finally, it's absolutely clear that the root solution here to the many issues is legislative appropriations. The military, medical, and VA systems must be sufficiently resourced to enable them to provide the health care, acute and chronic, that our wounded warriors and their families deserve. It is part of the cost of war. These individuals and their families have paid a high price. It is our country, you and I that are in debt to these heroes, and it is time we paid our debt; to care for him who shall have born the battle and for his widow and his orphan. It is a moral imperative from which we dare not shrink, and just as we don't leave our acutely wounded soldiers behind battle lines, we can not leave them medically behind the lines either. Thank you all very much for you attention. Ms. Embrey, would you adjourn the

meeting?

MS. EMBREY: This meeting is officially adjourned.

(Whereupon, at 4:09 p.m. the PROCEEDINGS were adjourned.)

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