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DR. POLAND: Good morning, everybody.

Welcome to the second day of the Defense Health Board's meeting here in San Antonio. We have a number of important topics to discuss, so we're going to try to get started a minute or two early here and try to keep everybody focused and on time. We've got an aggressive agenda. And being where we're located in the U.S., a lot of people who've got to catch planes otherwise stay until the next day. So we'll try to keep things on time if not a little sooner.

Dr. Kilpatrick is the DFO. Would you call the meeting to order, please?

DR. KILPATRICK: Good morning. As the duly appointed alternate designated federal official for the Defense Health Board, which is a federal advisory committee to the Secretary of Defense, and serves as a continuing independent scientific advisory board to the Secretary of Defense,
Defense via the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the military department, I hereby call this meeting of the Defense Health Board to order.

DR. POLAND: Thank you. And as is our practice, prior to the start of every official meeting, we'll stand for a minute of silence to honor those who have served our country.

(MINUTE OF SILENCE OBSERVED)

DR. POLAND: Thank you. We have a number of distinguished guests with us today. Dr. Chip Roadman, Retired Air Force Surgeon General and also a member of the IRG. Major General Michael Tucker. Brigadier General Retired William Fox from the amputee panel. Colonel Jim Neville, who was here yesterday. I don't see him right now, Air Force Institute for operational health. Colonel Mike Bunning, the Associate DFC Corps Chief and others. Since this is an open session, before we start, we'll go around and introduce ourselves. We'll go first around the table and then to both sides.
DR. POLAND: We're honored as our first speaker to have Brigadier General Michael S. Tucker, Deputy Commanding General North Atlantic Regional Medical Command, with us today. General Tucker entered the United States Army as a private in 1972 and served as a Calvary scout for the 1st Battalion 35th Armor (off mike) in Germany. He was accepted in 1979 for Officer Candidate School where he graduated as a distinguished military graduate. He had a very distinguished career as outlined in the bio which you have in your briefing books. He's currently serving as the deputy commanding general North Atlantic Regional Medical Command and Walter Reed Army Medical Center. General Tucker is here to speak on the Army Medical Action Plan for wounded warriors. As members will recall the IRG group, a DHG subcommittee led by secretaries Togo West and John Marsh investigated the issues at Walter Reed Army Medical Center earlier this year and developed a series of recommendations.
General Chip Roadman, here with us today, was a member of the IRG. The Army Medical Action Plan was developed and implemented in response to the IRG's recommendation. So, without further ado General Tucker.

BG TUCKER: I heard a medical joke the other day where a physician called a patient in and said I've got some results back from your test and I've got some good news and bad news. And the patient said, Well go ahead and give me the good news. Well, the good news is that you've got 24 hours to live. And he said, Well, you've got to be kidding me, that's good news? What's the bad news? I've been really trying to get a hold of you. I've been calling since yesterday. So just when you think you're having a bad day.

I am so not a doctor. I'm an Army Calvary officer. I have been all my life. I was in Nirvana running the tank school at Fort Knox, Kentucky. And in early March, after 2-18 -- nation had 9-11, Walter Reed had 2-18, I got a call from General Cody and he said, "I need your
help. We've got some problems at Walter Reed." I said, "Sir, I'm tracking problems at Walter Reed." I had seen the newspaper and CNN. And he said, "Well, I need you to come and help me with that." "Sir, I'm not tracking that. I'm out here at Fort Knox, life is good, you know, da-da-da-da-da." He said, "I need your help. Can you come?" And of course you know how you answer those kinds of questions. That was Thursday, I reported on Friday and I've been there ever since. So as I began to get my hands around this problem of soldier, wounded, ill and injured care, initially at Walter Reed, I began to discover that the problem is not isolated at Walter Reed. Walter Reed was nothing more than a microseism for the rest of the Army and I'll share that with you today. At Walter Reed in some sorts found itself in a perfect storm. Next slide.

This is a spin chart, so just kind of hang on to your seat when we get this thing turning because it goes pretty fast. This thing links like a hundred different slides. So if I
get off key, we'll be here until midnight trying to get out of this thing. But I click on the Washington Post article. So there's Staff Sergeant Shannon on 2–18. You may recall his face, he was on the newspaper last Saturday in Washington, he's a Calvary Scout 101st shot in the left, with a sniper, has a pretty good case of TBI and some rotary cuff problems. And of course that's the famous building 18. What I determined was that cases like Staff Sergeant Shannon explained about were certainly not isolated that there were many more, even worse and more surprisingly there were building 18s, so to speak, across the entire Army, there were lots of building 18s out there. Go back to the perfect storm here.

So Walter Reed -- USS Walter Reed, we got the Navy to commission this. General Schoomaker, we sat down, we came up with this as we can harvest facts, and as you well know we have an unprecedented battlefield survival rate. Some statistics reflect that if metal entered your body
in WWII, if metal entered your body on the battlefield in WWII, you had about a 20 percent chance of survival. Today that's 92 percent. The physical disability evaluation system was written in 1947, so essentially it was written to handle 20 percent survivability; it's now handling 92 percent. And the injuries that our surgeons are dealing with are injuries that are certainly peculiar -- not peculiar to war, but are characteristic of war, but what's different is that these soldiers never survived those injuries before. So the surgeons up there in the 16 operating rooms at Walter Reed who conduct up to 15 major operations a day up there. It's just phenomenal, are dealing with injuries that we really haven't had to deal with before because they didn't survive those injuries and they're able to give these kids a quality of life that not only are they alive, but they're giving them a quality of life later on. The Army's been enormously criticized for hanging on to soldiers. There's the DoDI, the Department of Defense
Instruction that says once a soldier, marine, airmen or coast guard are unfit for military duty, no longer medically retainable is the term, that they automatically go to the VA. True statement? Everybody understands that? That's what it says. They go to the VA. The Army doesn't do that necessarily in all cases. The Army will continue to try to rehab you. Our surgeons don't want to let you go. The parents certainly are not going to let you go until your rehabilitative state is stabilized. If you're in 6 of 26 operations, complex operations, you may want to see that through if you're a surgeon and many of you are surgeons and you can certainly appreciate that. Before I go further, let me say thank you to all of you for doing what you're doing for the DoD, and I just appreciate you taking time out of your schedules and your professional regimen to come together on this Board and help advice the DoD. It's tremendous and I think it's great and speaks well for our country and our open transparent new government. That's one of the
things that we differ on is we will hang on to a
soldier. We will never leave a fallen comrade,
never, ever will we leave a fallen comrade and we
enjoy a pretty high return to duty rate. In fact,
in about the 365-day mark, we're up in the 80
percent of return to duty. That's what we try to
do is return to duty. The Army is about soldier
and it's hard to replace a staff sergeant, it's
hard to replace a Sergeant first class and so we
want to rehab these soldiers and get them returned
to duty. Now that's generating a lot of fault,
I'm sure, as to how we're going to tool this
health system in the future. But this kind of
came to us as we began to mine our way through the
problems that we had.

Every medic in the Army is an EMT.
Every single medic in the Army is an EMT who gets
recertified every year. Every soldier, now,
effective this summer every soldier that graduates
boot camp, basic training in the Army, becomes a
certified combat lifesaver. That's a lot of
syringes and IVs at basic training. It's kind of
a scary thought, but every soldier is a combat lifesaver. Every combat lifesaver carries a combat lifesaver bag. They can put an IV in, they can do a bypass to your airway, they can -- and they also carry the HNCON bandage, which you're familiar with that no kidding stops the bleeding, and we developed a new first aid kit called an IPAC. When I deployed my armor brigade out of Germany to replace a third IV in April of '03, my first aid kit was a small little gauze pad with to strings hanging off of it. The same first aid kit I had when I came into the Army as a pilot in 1972, the same one. Six months later we had an IPAC that has a no kidding tourniquet in it that you can put on with one hand. We found out a phenomenal thing about operating in the desert, about tourniquets, is that there's not a lot of sticks in the desert. (off mike) no stick, you can't lose either, kind of stuck in there (off mike), but I just share those with you because those have helped us
with the survivability and we get you to a combat area hospital alive there's a 97 percent chance you're going to remain alive. Again, unprecedented in military medicine. So that causes you to be a victim of your own success, so to speak. Hallelujah, thank the Lord; we're a victim of our success. Soldiers are surviving injuries that they've never survived before.

We have medical regulating challenges. Transportation commander in St. Louis was bickering the larger portion of our soldiers ride into Walter Reed. They come into Landstuhl, get stabilized sometimes only hours, and then they're back up to Walter Reed. So we've made great strides at de-regulating that to the point to where we can vector you to other places where healthcare can be provided as good, if not better, than it could have been at Walter Reed. I know that's working because the commanders out here at
San Antonio, and at Madigan, and at Womack at Fort Bragg, and at Eisenhower down in Augusta, are complaining because their populations are getting too large. That's a good thing. We also have set it up so that as you fill out your pre-deployment form, where you talk about your next of kin, you also can identify if we can provide -- if you have a medical condition that can be treated at more than one location, where, based on your family care plan, where would you prefer to be cared for? Now we can vector you in closer to home because we do know that soldiers heal quicker and better when they're closer to family and that way we don't have to move the family. I mean, it's a terrible thing when mom and dad are running the company store and their son is in a traumatic injury and now they have to uproot themselves from Topeka to get all the way up to Walter Reed and live in a hotel room for 11, 12, 14 months. It's just ridiculous. As you well know Walter Reed is a tertiary care center, you don't go on sick call at Walter Reed, you go there -- you get referred to
Walter Reed, but yet right now we have 738 wounded soldiers there and about 350 families. Now we stood up a wounded warrior clinic to handle those people and these soldiers, that population. But you can kind of see as well we had problems with that. And Walter Reed is a terrific medical center, but it's not a very good Marriott resort. It's trying like the dickens to be a good Marriott resort and these families show up and they're part of the equation. I spend a lot of time talking to soldiers, wounded, ill and injured soldiers, but I spend more time talking to families, because the families are in your face if they think their son or daughter or loved one is not getting the proper care, as you would be in someone's face if you felt the same way. So that's part of the equation, we have to take care of them, see to it that their needs are met.

BRAC and A76, you know, BRAC says that if you're under Walter Reed, which is about 100 years old, and there's a water pipe leaking and you say, well it's leaking right here, there's the
leak right there, let's get that fixed. Oh, wait
a minute, it's starting to leak here, it's about
to rust through here, it's coming undone down
here; we need to replace the whole pipe. Well
BRAC says no, you can't do that you just got to
fix the leak. So you find yourself dying of a
thousand cups. In A76, the privatization of the
contracts was causing people to leave (off mike)
job is not going to be here. We're going to move
this whole thing to Walter Reed and we're changing
contracts and the new contractor doesn't want you
so people are leaving, but the buses from Andrews
Air Force Base kept coming. The buses kept
coming, three days a week, 41 passengers. The
buses never stopped coming, but, yet the place is
falling apart. I mean, there was no one there for
four months. There was no one there to fix the
leaks, fix the lights, fix the heat, fix the air
conditioning, fix electricity. No one. No one on
the other end of the phone.

And then this longstanding PDS system
that I just described. Then we have this
fragmented wounded warrior command and control.
The TDA, the table of distribution allowances, for medical hold soldiers in the Army, was 200 and we didn't fill that 200 as we should have. We didn't keep that full up at 100 percent. So the medical command had to back fill that. The MEDCOM had to pull a soldier out of lab, a lab tech, someone out of pharmacy, someone out of records, and poof, you're a platoon Sergeant, take care of these wounded soldiers. The soldier may not have even been to NCO education system or leadership courses, but you had to do something because the buses were still coming. When we rebuilt the barracks in the Army -- when we rebuilt barracks in the Army, and I was a battalion commander at Fort Stewart when the big surge was happening, we didn't rebuild any medical hold barracks. Wounded, ill and injured soldiers are like broken furniture. What do you do with broken furniture? You put it down at the end of a dark hallway in a storage room, up in the attic, down in the basement, but you put it out of sight, out of
mind. So what I came to the conclusion with, as I briefed General Casey on the second day in the job as the Chief of Staff of the Army, Sir, this is not a MEDCOM problem, this is a Army problem. This is an institutionalized Army problem. We didn't man the TDA; we didn't give them any facilities to stay in. And Walter Reed was subject to a perfect storm. By the way, I've been out to 39 camp installations and I got Walter Reed's everywhere. So, sir, we got to fix this. And he said, You're exactly right. So that's what we're doing and we stood up the Army Medical Action plan. By the way, where we had 200, we put in 2,463 Calvary members to watch after their soldiers. Where we had 200, we're putting 2,463 soldiers off the line, coming back, that are now becoming squad leaders, platoon Sergeants, company commanders and staff officers in warrior transition units across the Army, 35 of them to handle the 10,000 medically non-deployable soldiers on active duty in the United States Army. 10,000 medically non-deployable soldiers on the
active roles in the Army. That counts a little bit against your end strength and if your force managers, that's a big deal and we've got to put (off mike). Next slide. I just wanted to kind of give you an appreciation for the work at Walter Reed that's going on. I mean that's a lot of patients. I know that a lot of you work in large medical facilities, but these are pretty respectable statistics. It's a busy place obviously. And you know nothing ever was wrong inside that building, our problems related to the outside of the building. And when I got to Walter Reed I got all those doctors in a big room and boy, there's a lot of doctors there. I said, "Listen, if you think I just want to get up there on the fourth floor and tell you how to do your job, you're out of your mind. Okay? I am not going to put my finger in your rice bowl. But I will tell you this: If you're doing something stupid, you will stop it immediately. That's an order. No one in this organization will continue to do anything that's stupid anymore. So just
knock it off. You're not authorized to do
anything stupid." It's amazing is how simple that
sounds, but they were -- one of the 06 doctors
said, Are you serious, sir? Yeah, I'm serious.
You are not authorized to do anything stupid.
It's kind of profound. Next.

So we set up an AMAP cell. Go to the
sync conference. So we had a conference out at
Lands Down, Virginia, out near Dulles airport,
because this is a huge problem. So brought in
about 160 people from 40-plus different agencies.
These are the field units, these are actual
regional medical commands in the Army, hospital
commanders, a lot of people from Army agencies,
DoD agencies, VA; and we worked from Monday until
Friday until 11:00 at night. It was not your
typical conference, look, see, drink coffee, eat a
donut, that's real nice, nice to see you again,
have a nice day I'm going back home and look at my
slides. We rolled our sleeves up every night
until 11:00 and we dug our fingers into the dirt
of this problem and we raked it clean. We got
every old car tag, every boot, every root, every beer can, anything under there that dealt with the entire scope of this problem, the entire scope at echelon and we discovered about 156 things that are just all messed up. We obviously discovered that things are at echelon. Some things are right there at Walter Reed, some things are at the MEDCOM, some things are at the Army level, some things are at DoD, some are at VA and some are in legislation. So we broke it down and conducted -- go back to the spin out. I went out to the school of advanced military studies at Fort Leavenworth, Kansas, that's where we teach our strategic thinkers. The other services have a similar program. These are like Jedi knights and we teach them how to do critical thinking and I hired me about six of these high speed guys for about 45 days, I locked them up in a room, threw a bunch of coffee and donuts in there and locked the door and we made sausage, because we took these findings and we created -- we did an old Army, military decision-making process, MDMP, it makes your gum
bleed. It's taught at Leavenworth. Everybody in
the Army that's ever been to Leavenworth knows it,
but it no kidding is a fine filter. And you can't
do MDMP by the book and let some problems still
remain. You have to address it and you have to
decide what you're going to do about it. It's
really good. So we did MDMP because you had to
create an execution order for implementation of
the Army Medical Action plan, because if I just
did a MEDCOM order, people stick their nose up at
it. I need to do an Army order signed by the vice
chief of staff of the Army, signed by a four-star
that says, you will do this, you will do that.
And we did. We created a "no kidding" execution
order. We published it on the 2nd of June and
it's terrific. It's got legs, the thing is
holding ground, but it's making commanders do what
they should have been doing all along, but we just
didn't know what we didn't know. Go to the Triad.
At the heart of this program is the
wounded soldier in transition. We call them
warriors in transition. General Casey said,
"Mike, this is not a status. These are warriors. I want them to be treated like warriors and they'll act like warriors. We're not giving up on these kids." I said, "Sir, you're exactly right.

And we created this definition. So their job is to heal. When I talked to the soldiers in a town-hall meeting once a month and I talk to them in the morning, all 700 of them, I listen up. Make sure that you are perfectly clear with what I'm about to tell you, because your job is to heal. That is why you're on active role, that's why you're drawing a pay check, that's why you are breathing oxygen. Your job is to heal. That means that going to physical therapy, occupational therapy, taking you treatment, doing all your rehab, taking your medications as prescribed is your job. That is your job and I will hold you accountable for doing your job. And I've now got squad leaders at a ratio of one to 12 and a platoon Sergeant at one to 36. Kind of a novel concept came out of FM7-8 the Infantry platoon, a proven way to command and control soldiers. So
now I have soldiers at a command, lead to lead ratio that is commensurate with the level of command and control that they have to have with these soldiers. Because reality is, the soldiers who needed the most help in the Army go the least. The guys, who should have been cared for the most, got cared for the least. When they asked me about well what do you think these billets should be? You want them to have good facilities, what do you want a Taj Mahal? I said, No. A warrior in transition should live in barracks on any camp or station that is as good if not better than any soldier living on that camp or station. That's all I'm saying. They should live in barracks that are as good, if not better. And they need to have concerned leadership at ratios at the level that it needs to be to care for these soldiers. So at the heart of this thing if obviously this mission and then this soldier has this triad of support; a squad leader, a registered nurse case manager and a primary care manager. Primary care manager is a doctor, now this will knock your socks off, at a
ratio of 1 to 200. Now some of you who are physicians, don't you wish you only had 200 beneficiaries to deal with? 1 to 200 and that's being serious about this problem. Now we're putting 2,463 leaders in there and I'm putting physicians in there at 1 to 200, so you can see the price we're paying. And you know, it's not new work, it sounds like new work, but as I've taught the commanders out in the field who are busy as hell fighting this doggone war, God bless them, I tell them, sir, this is not new work. We're making up lost ground. We've lost ground with American people. We've lost ground with the Army leadership and we've got to make this ground back up and we're doing so in a big way. We pick the families up at the hospital; we bring them into this thing called the Soldier family assistance center. This thing is like -- we have a thing in the Army called ACS, Army Community Services, which is kind of like a community center where people can get counsel on check cashing and how to raise your kids and how to take care of the
pets and where's the day care located, and where's
the youth activity sports program, school
immunizations, everything is all there. Well this
is the ACS on steroids, focused on these families
because these families have different issues than
a normal family would have. First of all, what
you see depends on where you sit. Their world has
been turned upside down. They sent Johnny to war,
Johnny came back without any legs and now I've got
to quit my job, I'm a schoolteacher, I can't teach
anymore, I've got to go to Walter Reed and be
non-medical attendant for my son or my daughter.
My world is upside down. I've got to make things
easier for them, not harder. But the bureaucracy
will make things awful damn hard if left on its
own, it will absolutely drive you insane. So we
now extend this to the families coming here. They
don't go anywhere else. They get an ID card, they
get all their paperwork done, they get (off mike)
they get their per diem payments; they get all
their benefits explained to them and linked to
them. All the charities in the world, 360-plus,
get plugged into the family right there. One spot. They go nowhere else. They don't get told, go to this building, go to that building, go down here, go over here, see this person, don't forget the Irish make the team, can't make it that time, one place. Making it easy for these families.

And then they go down that long hallway to meet their warrior in transition. When I called the nurse case managers, I said; Tell me how you spend your time? Well, we're helping soldiers get promoted, we're helping them get their pay, we're trying to get their family in from the airport, I'm trying to make them make their appointments.

You know they've got an appointment in orthopedics, but they've got to go get an MRI first. Tracking them down, where are they convalescing, it's just so much work. I said, You're not doing any case managing. How do you do case managing? The whole point is that this person does all those things I just mentioned now.

So nurse case managers can focus on their core competencies of case management. It's enormous.
And then we also have included and access to care. These soldiers receive routine care in three days, three days. Specialty care no more than seven days and that moves them back to the head of the line of all the beneficiaries. Now the Veteran's Service organizations got up on their hind legs about this, the Veteran's Service Organization, big time, and I spoke to them at a conference at the Pentagon and the MSO organizations. I said, I'm sorry, but these soldiers are products of this war. We can no longer allow them to languish in the system. I'm going to see a psychiatrist on the 1st of July and my next appointment is the 3rd of August, because I put back in line behind another beneficiaries. What am I doing between now and the 3rd of August, working on my Nintendo handicap? What am I doing? I've got to get back in line and I've got to go back to the head of the line. I've got to see that psychiatrist when the psychiatrist wants to see me next, or when that orthopedic surgeon wants to see me next, not go back behind the line. So we moved them back to
the head of the line, access to care, it's had
enormous effect and efficiency. And I told the
VSOs, I said, First off you're all veterans so you
should understand. But number two, if this was
your love one standing in line, I think you'd want
them to move to the head of the line too. And
they powered down with that. They understood once
it was explained to them. But we've got to do
that. The only person to get in front of this
soldier in line is another soldier who is on a
prepare-to-deploy order, because they're going out
the door and we've got to get them fixed so they
can get out the door. That's the only person that
gets in front of them. But they're warriors in
transition, that's why they call them warriors in
transition, because they're going to transition
back to duty or they're going to transition to the
VA and be a citizen. But they're in transition
right now. That's why we call them transition.
And by the way, when we built the warrior in
transition unit, we combined reserve and active
duty together. They were different medical
holder, we combined them together. We should take the have and have not's and put them together. And then we took the injuries, the nature of the injury. If you stepped in a pothole on the streets of Arumadi (?) and twisted out your ACL or you stepped in a gopher hole in Camp Shelby, Mississippi, both of you did that in the line of duty, both of you did that serving your country. You're both equally injured. You're both equally have a physical impairment. Whether it's having your leg torn off in central corridor in a Humvee accident at the national training center or having your leg torn off with an IED in Telefar; it doesn't matter. And I think as some of the commissions come out they're trying to develop a two-tier system. Well, the physical disability evaluation system creates a two-tier system anyway. I mean, it does, based on percentages. That will take care of itself; but if we come in from the start and say all you people are over here and all you people are over here. I don't think that's a good thing. That's a slippery
slope. You know in the Army we say, and I've mentioned it before, that we will never leave a fallen comrade. There's a period at the end at the end of that statement. It's not comma, with the exception of dot, dot, dot. We will never leave a fallen comrade, period. If you are hurt, ill or injured while serving your country on active duty then we're with you and we're going to stay with you and we're going to see you through this and I think we've got to hold our ground in that. So anyway, we take care of the families, we're taking care of the soldier and we're trying to prepare them for this transition to VA/VA assistant, or more importantly back to being on active duty. Next.

I just want to share with you just a taste of some of the things inside our execution order, show you about ten of the things in here. As I told you, we stood up these warrior transition units across the Army that means we've got leader for every 12 soldiers. I did have one leader for every 50 to 60 soldiers and that wasn't
necessarily a qualified leader, it was the best we
could do. Now I've got 1 to 12 and it works. We
have put this nurse case manager at a MEDCEN,
that's 1 to 18 and at MEDAC, it's 1 to 36, because
MEDCENs have more polytrauma cases and the case
management is a little more complex. Next slide.

We have put these facilities at the top
priorities on our camps and stations. We have
town hall support for this population to discuss
their issues. We now put them on par with keen
essential. If you're in a 10 to 11 month
rehabilitative regimen, you know, why don't I just
put you in government quarters. Why don't I
create an Army Fisher house? Why can't I do that?
I have vacant quarters everywhere and you're in
proximity to the medical treatment facility and I
can do that, so we did. And we're doing it right
now and it makes sense because the soldier would
heal quicker in a home than he will in a hotel
room, because you've got a kitchen, you can move
around, he can be with his family. It's very
important. Next.
We pick them up at the airport, I told you that. We've created this handbook to put things in living room language so that these families can understand. Now an Army spouse will understand Army speak. They've been kind of raised in that. But mom and dad from Topeka, who sent their single son to war, do not understand Army talk. So we've got to put this thing in perspective for them. And we hired a family-readiness support assistant. Now these families get together in the lobby of the Malone house at night and they've got issues. They've got enormous issues that are particular to their population, which you can appreciate. Who's going to help to channel that energy? We have these people for our regular combat units already, the deployable units, so we're building a family readiness group and then we have this full time support assistant who is a GS employee that's now trained to help these people, getting guest speakers, take them out to see things, do meetings with them. And then everything for these warriors
in transition and their families is that doggone exception to policy, because they're out of the norm. They're not in the normal cycle; they're not in the normal paradigm of PCSing from one station to another, moving. They're out of whack, so they have these enormous exceptions to policy so we're having to consolidate a policy. And what we started with -- I said take every exception to policy over the last four years and make that policy because if it's not illegal, immoral or unethical, I'm just going to do it and ask for forgiveness. So we're putting it in as policy. I've got the draft right now. It's about an inch thick and it's going to be terrific because it's going to create a policy for this population, which we should because the bureaucracy will absolutely take you to your knees. It is designed to protect the government, but in doing so it filters out those most deserving and it doesn't do it on purpose, but it just does it because it's institutionalized and there's 100,000 people in that system that have been there their whole life
and I call them toads in the road, they're just going sit there -- but you know what happens sometimes with toads in the road. We've got the standard operating procedure for these warrior transition units. It's like the Dennig principle; we've got to reduce variation here. You can achieve enormous efficiency by whether you have two black-belt Linksys projects going on right now with the MEB; we're making great headway with that. Then we've established this PTSD/TBI awareness training. We had a problem out at Fort Carson, Colorado you may have heard of or read about. But here's the typical vignette, actually this vignette happened and the secretary sent me out to take a look at this. So I'm late for formation, I'm late to get to PT. My excuse is I thought I set my alarm clock, but I didn't. I got lost coming to work this morning. I got in a fight with my wife, I'm just all confused and I think I've got this PTSD thing or TBI, Sarge, what do you think, says the private to the staff sergeant. And the staff Sergeant says, Hey,
listen Jones. I have seven IEDs down-range; you
only had one, what's your damn problem? I think
you're weak, why don't you just rough-up and move
out like a soldier. Now, if you're the soldier
standing three ranks back and you hear that
conversation, are you likely to come forward
yourself? So as we begin to go out there -- and
Marie Dominguez, by the way is my executive
officer and she's like a "no kidding" doctor. We
went out there and we interviewed chain of
command, hospital staff and then late into the
night all those soldiers. And so what it kind of
came to me was, back in the '90s had a heck of a
problem with sexual harassment. We didn't know
that women didn't want -- we didn't know that
women didn't want you to put your hands on them.
We didn't know that. We didn't know that women
didn't appreciate an off-color joke and we were
really messed up. So we had, in fact, in the '90s
I'll forget I was the tank battalion commander
Fort (off mike) Georgia. We did a thing called
"Leader teach," and this thing was given to me.
Listen up, Tucker, you will brief this program, do you understand? I opened the book -- this is the instruction: Open the book, read first sentence and I (off mike) this thing, so you couldn't screw it up. It was terrific. I was on the tank range, got everybody out of their tanks up under a big old tree by the tower and I gave them this "Leader teach," and we were better for it. We woke up and we smelled the coffee. I called General Cody that night from Fort Carson, I said, Sir, we've got to do "Leader teach" just like we did in the '90s with sexual harassment, because people at that lowest echelon do not get it. So we're doing it. We're going to be complete by the 19th of October across the entire Army; we're doing PTSD/TBI Leader Teach. It's a terrific program. You can get it, it's on the web, it's all over the place. And we got another package for family members. But what it does simply is it makes sure that staff sergeant understands, number one, how to recognize it and number two, what his or her responsibilities are in facilitating that soldier
to get the treatment. But there's an obligation
and a responsibility to get that soldier to
treatment. Don't give the soldier the high sign,
because what happened in many, many cases was the
soldier obviously had to seek other ways to cope
with this program, turns to drugs, turns to
alcohol, DUI, wrecks a car, drives without a
license, character of service changes, soldier is
discharged bad conduct discharge, how much VA can
you get with that? None. And the truth is that
this could have all be prevented, we could have
saved this soldier, we could have stopped that
from happening. So it's just an education and
awareness thing. And it's having great success.
We sent it out to every prominent psychiatrist,
mental health professional in the civilian sector,
let them look at it first, to give endorsement.
Is it what you think it should be, what do you
think? We tweaked it and it's a great program,
it's very important. Next slide.
We have joint patient tracking. We can
track a soldier from the time they enter the
combat support hospital. Actually we can get them
at the ford surgical unit and track them all the
way through the system. A web-based program. We
sent a letter to the commander; Jones is in our
capable hands within 24 hours after arrival. I
mean, I had soldiers who were injured and they
just kind of went off into the dust. I didn't
know where the hell they went and you'd hear about
it by rumor mill about a week or two later,
sometimes three weeks later. Yeah, Jones has made
it. Wow, I hope he's okay. Now we send a letter
saying he's here, he's okay. If you want to send
him an e-mail you can do so at this e-mail
address. The soldier come up on army knowledge
online. If you want to come visit, this is how
you visit. If there's any awards due to this
soldier let us know we'll present these awards.
By the way we got the award backlog completed at
Walter Reed. We do award ceremonies, Purple Heart
ceremonies there once a month and they're
terrific. We do them at Joel auditorium and
there's not a dry eye in the house. I mean, it's
just unbelievable. And those soldiers, to a
person, when I present them their award and I say,
Would you like to say something? And they hobble,
limp, roll up on the front of that stage, and the
first thing that comes out of their mouth is: I
just want to say thank you to the doctors and the
nurses putting me back together. The first people
they thank and I think it's great.

I told you we allow these soldiers to
get a preferred treatment location. It just makes
sense. And the VA's been very receptive to allow
us to co-locate VA LNOs with our nurse case
managers because there was this chasm. I mean,
you know people falling into the cracks so to
speak and so now with the VA LNOs shoulder to
shoulder with nurse case managers, there's a lot
more sharing. It's more of a seamless transition.
I'll tell you that we've been accused of being
like this. I think now we're kind of like this,
but where we need to be is this. At 60 days, my
perspective, at 60 days out from discharge, I
should have a VA counselor already assigned, I
should have a VA doctor sign, I should know which
VA center I want to be treated at. I should have
my first appointment. I should know what my
benefits are going to be. I've submitted for my
benefits and they have been pre-approved waiting
my DD214. Pre-approved. I know what my VA benefits
are and they have been pre-approved. I know what
they are and I know what to expect. I'm going to
discharge you before the 27th of the month so that
my VA check comes on day number 30 when I get out.
And I know what my VA benefits are going to be and
that will happen as well 30 days out. If we do
that, we'll be fine. We'll have truly seamless
transition. But until we get there -- what's
happening is the soldiers give -- you're going to
be discharged on the 10th of the month and here's
a phone number for the VA, have a nice day. See
you later. That is wrong. If you don't believe
it, ask soldiers, they'll tell you. That is so
wrong. And the VA doesn't want it that way and
the Army doesn't want it that way and the
government doesn't and the people damn sure don't
want it that way, but it's that way. It drives me
crazy. So we're going to bring them in their
shoulder to shoulder. You can't get out. We're
going to set up so the VA has to stand up there;
no, no you can't get around me. Here I am. I'm
the VA and I'm in your face. I think that's the
way to go. I've talked to the VA, I spoke to
Admiral Cooper and Dr. Kusman, I think is his
name, both of those great people want to help and
get this thing fixed for our soldiers, our
sailors, airmen and marine. Next slide.

We created a My MEB. We have a thing in
Army AKO, you may have heard of Army knowledge
online, and other people are doing it too. But
you can now go into your MEB file. You log on and
you can look at your medical evaluation board.
You can see the chronology of your treatment. You
can see exactly where your file is right now,
which is really good. You can see the exams, I
mean, it's just crazy. Because, as you well know,
you will police up yourself real quick and so the
physical evaluation board liaison officers and the
MEB docs and all that they're all on the hot seat now because soldiers are saying, Hey, wait a minute. This form is wrong. This I is not dotted, that T is not crossed, that data is incorrect, that Social Security number is not right. So it's good. It's self-cleansing and they've got every right to see their own file. In fact, we're creating my PEB now as well along with the physical disability agency. I told you we've got a physician dedicated -- we also have an MEB doctor. We have a doctor at each MTF that's dedicated to do MEBs. And I told you about the access to care standard. And then finally, General Casey kind of laughs at this, a soldier will go out and rob a bank and steal a car and we'll give him a doggone lawyer to represent him. Guaranteed. We're going to give him a lawyer. But a soldier going before a physical evaluation board that's going to affect his healthcare and his family for the rest of his life, on his own. Have a nice day. So now we have 18 lawyers that we've activated to act as legal advocates for that
soldier to help them make those decisions and work their way through that. Go back to the spin.

Publish an order. You can see here where these warrior transition units are located by size, the color code. And so you can -- you now it's one thing to publish a piece of paper and say, Okay, all you knuckleheads need to start doing these things. But you've got to go out and check too. You've got to go out and say, okay. So we've created staff assistant visits. Go back to the spin out and go to the SAVs.

So we go out and we check these larger sites. There's 22 people on each team. They are subject-matter experts. There are four teams and they check these units on 409 different items, 400 different requirements. When I get the trends and I'll brief those trends to the secretary of the Army and the vice chief of staff of the Army every month. I'll do it again on the 1st of October and it's just terrific. We follow that with a BTC with every MTF commander and warrior in transition unit commander across the Army and General Cody
will absolutely crush their knuckles if they don't
do what they're supposed to. Go back to the spin
out and go into Leadership business.

So you can see this is a cohort of a
population and there's the windows of the
population. Go to the next slide.

This is where we combine active duty and
reserve component soldiers. You can see that
built the warrior transition unit. My problem is
that half of my population of the 10,000 are still
in their units out there, drives me crazy. These
soldiers are still out there in their infantry
platoon and they're not medically deployable.

Why? Why haven't they moved over to the warrior
transition unit? Because they're the permanent
staff duty officer, they're the permanent charge
of quarters, their the PowerPoint Ranger in the
operations staff, so we're having to pull them out
and get them over to warrior transition to get
them healed and General Cody is absolutely
ruthless with commanders because they want to hold
on to these kids, so we're moving them across.
Next.

An article came out in the Associated Press last night -- go to ANAM. How many of you have heard of ANAM? That's what it is. It is the famous baseline. We now have it. 101st Airborne in Fort Campbell, Kentucky, just completed it and we're moving it out to every unit before it deploys. It establishes the baseline. You cannot cheat this form. We do a post-deployment health assessment, PDHA, but that's kind of a hit-and-miss form. You know some kids get that form and say I'm not going to check anything on this form that's going to prevent me from going on (off mike) leave and I don't want to end up on the 5th floor in a padded room in any hospital. Have a nice day. I'm not going to do that. So this test, you've got to by firing on all cylinders up here. This measures your cognitive response. You can't cheat. You've got to remember number sets, color combinations, symbology relationships. I took this test, it made my head hurt. If you're drinking the night before, don't take this test,
because it's a hard test, but the beauty of the
test is you can't cheat on it and it will
establish a "no kidding" baseline that we put in
your digital medical record and so we can track
you and establish a baseline before you deploy.
When you come back we do another baseline on you
and we can account for what happened in between
and I think it's terrific.

We've got a handheld down at every unit.
Every medic platoon has these which can send
information wireless to this CHCS computer into
the theater management database into their central
deposit recovery reservoir, whatever that thing
is. Central data registry. And AHLTA, as you
well know is kind of our digital medical record.
But that's the way we can enter -- Go to the MACE
form.

This is a DoD form. It's been out since
August of '06, but when I talked to commander's
down-range, some are using it, some are not. This
is a great form. And I go out and talk to
commanders in the field, Listen you've got to
start using this form. When (off mike) fog at
night and they've had -- you do your post-patrol
report what happened, we had an IED at checkpoint
Okay, get them down to the (off mike) station ASAP
and fill out a MACE form on them and get it put
into AHLTA, because that way when they come back
into the PDHA and health assessment we've got a
record of this event and we can get you into more
high-level care if we need to as we're screening
you when you get back. Very important we close
that loop. Go back to the spin out. Go to the
recommendations.
I think this came out of one of your
papers and what I want to do is focus in on some
of your observations from where we sit. These are
things you said consider, this is from the IRG,
and develop a set of highest clinical standard,
evolutionary, cost effective, actionable. We see
that in the Army Medical Action Plan that I've
shared with you today, from the Army's perspective
being a subset of a subset of a subset of this
larger problem at DoD and VA is that AMAP is our
answer to that concept. The road map is this
holistic rehab. We put a vocational/occupational
therapist in the warrior transition unit down at
the company level, because it's more than just
your legs. We want to have a holistic approach to
rehab. We want to get your brain working. We
want you think about what you want to be when you
grow up. What are your aspirations? What are you
goals? What do you want to be? And get you
thinking about that as well and then set the
conditions to allow you to do that and we've hired
four more college education counselors at Walter
Reed because at Walter Reed, not going to class,
not taking college education is the exception.
Not taking college education classed is the
exception. I am tired of soldiers up there
working on their Nintendo handicap in their spare
time. I want them to get their head working as
long as they can cognitively do so. It's terrific
because it's a win/win. It's a win/win. You
can't just go off. So once you get them started
you can nudge them along and give them some
support they'll do and they feel better about
themselves and that's part of healing. So that's
how we kind of see that. These metrics. We have
got metrics that make your head hurt and we brief
them every Friday. We have them called gumball
charts. We track every single thing required in
that execution order and we have commanders brief
either amber, green or red in that area. And why
are they not green? And when are they going to
get green? Because my glide path takes me out to
January '08. I had initial operating capability
on the 3rd of September which means we're all
here, we're doing this now, we may not be at full
operational power yet, but we're 50 percent.
Actually we're at 54 percent and then 100 percent
in January. And we've got a plan to measure that.
And the department of Army IG we have trained on
how to inspect the AMAP program. So the
department of Army IG team will go out and start
doing compliance visits in November and they'll be
armed and dangerous and check these units. Then
these resources, the (off mike) road map, the
warrior transition unit TDA, 2,463 soldiers off of
our end strength to man the CODRE positions in
these warrior transition units across the Army and
my office has stood up. My office will remain.
There will always be this Army and Medical Action
plan team in the office of the surgeon general.
Again, this holistic rehab in the developmental
phase so that we define responsibility, who is
responsible for what at each step. Next.

We're endorsing and got approval to use
the CEP, which stands for Center for Enhanced
performance up at West Point in New York. A lot
of NFL teams are using that program. It deals
with the -- Marie, which two of these -- mental,
motivational and emotional. It helps enhance
those to help you achieve what you aspire to do.
It helps you reach your potential whether you
realize you can reach it or not. It's a great
program. In fact, the Redskins are wanting to
come over and use it. Next. Go to Commanders
intent.
When I go out and talk to people I share this with them. This, in the world of priorities, this has a priority. It really does. When I'm sitting with a General, usually it's a 3-star General or post commander and I've been out and I've noticed that their warrior in transition barracks are not exactly up to par, you know, they're not manning their WTU, warrior transition unit, to standard. I'll have a little office call with a high ranking officer and I'll have this hard copy and I'll just kind of slip that across the coffee table as we're talking. And I talk about nesting yourself with the commander's intent. Sir, we've got to ask ourselves, are we nested with the commander's intent. Now just to be frank with all of you, who else has to say something here? Who else do we need to hear from so that we get it, so we understand where we stack up, where this problem stacks up in the hierarchy of all other things competing? Especially from the Army perspective. From here down I get it. I don't need anything else to work from here down.
This is good enough for me. But Lord have mercy, so usually when I get this in front of them and they take time and read it, the lights come on and things start to happen. You can appreciate that they're out there fighting this war. They're turning brigades around like a turnstile. I mean, 10th Mountain Division, Fort Drum, New York, God bless them. If all the brigades of the 10th Mountain Division came home to Fort Drum, New York, they'd have to live in tents because they only have enough barracks for two of their four brigades and they just hot bed them. They don't have to worry about it because they've always got two deployed all the time. It's not a big problem. We're not all home. Oh, my goodness. It's like having all your kids come home to see you and you're living in a one-room trailer park. They can't all come to see you; they've got to stay in a hotel. So anyway, this kind of helps us out. Go back to the spin and go up to the way ahead.

This is kind of my road map. You see
full operational capability out here. I keep
telling Secretary Gerren (?) that -- he says, What
happens here? I said, Sir, that's when I work
myself out of a job. Because if I'm still -- sir,
if I haven't accomplished what you want me to do
by that day you need to fire me because I've been
ineffective. But anyway we do strategic
communications. Today is part of that strategic
communications. We've got to get the word out
what we're doing. Congressional engagement. Been
on the hill 19 times. I just found out last night
I'll be up there on number 20 tomorrow in my Class
A uniform, which is just fine because I want to
maintain an extremely high level of transparency.
The Army's been accused of being kind of close
holed and you can't see and we'll tell you about
it later and submit your request and original
forms on the 15th Sunday of the 14th month type of
organization. I tell professional staffers, come
any time you want. Bring your member with you.
Anytime you want. Just call me before you come so
I'm there, because if I'm not there I can get
there. But I have nothing to hide from you.
That's done us a lot of good too. I've been very
honest and very forthright with them. You can
see, we've got a pretty good plan and we track
what we're doing. The MEDCOM has enormous
tracking mechanisms. It makes my head hurt
because where I come from we didn't have that good
tracking.
This kid here, he's an inspiration.
He's on Delta Force down-range. He is one of how
many, Chuck? Nine?
CHUCK: We had nine return to duty.
BG TUCKER: Nine return to duty that are
down range? Chuck's sitting over there with a
duffle bag full of legs. 59 amputee return to
duty. So kids like this, you can imagine when the
Iraqi's see that, what kind of statement that
sends. And every time the President comes to
Walter Reed, and he comes there a lot, he will
talk with the soldiers and he'll say, You know,
what do you think? What's going on? Sir, I just
want to continue to serve my country. I don't
want to quit. I'm a soldier. I want to continue
to serve. And the President says, every single
time, I want soldiers like this to stay in our
military. If they want to serve, we need to find
a way for them to serve. I think it's important
we allow them to do that. Go back. Go to the
families and leaders and I'll end with that one.

This Sara Wade and her husband Ted.

Sara Wade, her husband had no right arm. Am I
correct, Chuck? He's got right arm prosthetic,
has moderate TBI. He can't remember what he had
for breakfast. Sara had to quit her job. I'm
thinking she was a teacher in Chapel Hill, North
Carolina. She had to quit her job and she cares
for her husband. And they've been going out to
see Chuck at the prosthetics lab at Walter Reed
for about a little over two years. Never got
compensated for it, drive from Chapel Hill to
Walter Reed and the bureaucracy said, Well, yeah,
we can reimburse you for that, but we need every
single gas receipt, every time you went to
McDonald's, every time you stayed at the Holiday
Inn, da-da-da-da-da. I got with Chuck and went up into the computer up there where he logs in people being seen and treated. When the soldier arrived, when the soldier left, gave that to TRICARE and I said, You have got 48 hours to give this family their money and I'm not kidding with you a bit. You've got 48 hours. And they gave them a check for $14,900. Staff Sergeant (off mike) poly-amputee, multiple amputees. That's his mother. Re-enlisted in the Army for a $6,000 bonus. Was in an IED that created these injuries about a month later. The bureaucracy went after him because he hadn't fulfilled his re-enlistment contract for $6,000. This woman -- he can't even feed himself, he can't dress himself, his mother had to quit her job to care for her son and we're going after them for $6,000. That is but two cases that just puts tears in your eyes and there are hundreds. Those are the things that keep me up at night. I can tell you that since we've started the Army Medical Action Plan, stood up the warrior transition unit -- on the 15th of June we
stood it up, like no kidding. We're doing fine. All those people are doing fine. They've got leadership, they're getting tracked. It's these older cases, because they left Walter Reed in 2004. Was it the spring of 2004? 2005. And they were before we had any of this. So I think we got it right. We're going to have efficiencies in our system. Our access to care is efficiency in the system. The triad of support of the nurse case manager, the primary care manager, squad leaders putting efficiency in the system. The Lean Six Sigma for the MEB. The single physical evaluation that we're going to do that Dole-Shalala came up with. So as we continue to move out, the Army is moved out at a blistering pace. One of the commanders said, How can you move out so fast without all the resources necessary? I said, Well, when you find yourself in what we call an engagement area, and as a Calvary officer, an engagement area is where you're on the battlefield and you're stuck in a mine field and the enemy is shooting artillery at you and firing you with
direct fire weapons. You're in an engagement area. And there's only one thing to do. Get the hell out of it, real quick. So we got out of the engagement area. We moved out really fast.

When I briefed General Casey on this, as I talked a bit earlier, I said, Sir, I've got some things here. I call them low hanging fruit. Quick victories. Got about 10 things here we can do. How much time you need? Sir, I need about 75 days to get these things done. He said, you got 30. So that kind of sent a message to me and I moved out. I didn't even look back at that point. When he said that, I moved out. And I've had enormous support from the highest level of the Army and the government on this program.

I'll just leave you with this. These soldiers in the warrior transition unit, I've discovered because the Cadre is enormously strapped, these soldiers need enormous amount of care. You take the first guy in the formation, in the rank, he's missing two legs, this soldier is missing a foot, this soldier's missing an arm,
this soldier is blind, this soldier can't remember what he had for breakfast, this soldier has such traumatic injury that he can't even wear a uniform without having a mental breakdown and you're going to stand in front of them as a squad leader using the leadership skills that were very effective for you in your last unit and you go stand in front of them and call them to attention and one of them doesn't act right you're going to say, Okay, let's all get down and knock out 20 push-ups. You see what I mean? The skill sets that they come to us with, may not work and so we develop a certification course for these squad leaders and platoon Sergeants because the skill sets that have made them very successful so far in the Army may not work here. So all these kids are on a different emotional plain. Some of them are enormously fragile and right behind them is a family, standing right there. Sometimes they'll just come to formation so they're a factor to deal with that normal squad leaders and platoon Sergeant off the line are not normally having to
deal with. So we've got to include sensitivity
training, give these CODRE skills that they need
to help to do their job because we're asking a
hell of a lot of them. I've got some Sergeants in
there who just came off of being a DI, drill
Sergeant duty and said, Sir, this job is hard.
We're working until 11:00 every night. Being a
drill Sergeant was a walk in the park compared to
being a leader for these soldiers. We're going to
do the job, sir, but it was not what I thought it
was going to be and we'll get it done. But these
people need a lot of help; they need a lot of
leadership. That's a big calling for these kids
and we're going in for special duty pay for them
and get them certified and get them the skills
they need and God bless them for coming out and
doing this work. So that's kind of what I've got.
I'm more than willing to entertain some questions
that you may have and I appreciate your time this
morning.

DR. POLAND: Thank you, very much,
General Tucker. This has obviously been an area
of great concern to the nation, but also to this Board. I'm very pleased to see as a part of your presentation, the DHB recommendations, pleased to see the progress that's been made and the obvious planning and the obvious passion that you for this mission. Much appreciated and the nation is grateful for that.

I'll start with one question. In my mind, all of this traces back fundamentally to a leadership issue. My question is, well, the Marine Corps has something called a "Lessons learned" unit, which they're finding of immense value. There are lessons learned from this, let's call it an engagement. How will those lessons learned get institutionalized in the Army and taught and learned by the next generation. When you and I are gone, how will Army remember this and learn from this and move forward from this?

BG TUCKER: That's a great question. I think, first of all we'll never go back. We will never go back to where we were in terms of the care of ill and injured soldiers. Number two,
training this consolidated policy that I talked
about, this one-inch stick, puts everything into
policy that's been wrong and it crosses so many
different echelon's of commands and directorates
in the Army, most of them within HRC and G1
personnel, but there's a lot finance and there's a
lot of legislation, but all that's going in there
to correct it for the long term. We have a
lessons learned organization that we filter back
in. Then once a month -- we do a BTC once a week
to track our progress here, but once a month, I do
a lessons sharing BTC with all the MTF and
transition commanders and I'll do one tomorrow in
fact, where we talk and share with each other the
stories, like some of these I've shared with you.
The story of Staff Sergeant Shannon in last
Saturday's Washington Post will (off mike) one
person brought the whole program down and how can
we prevent one person taking down the whole
program.

DR. POLAND: You're going to send a big
message.
BG TUCKER: Big time. But that's a great question. We've moved at a blistering pace and what scares me right now is that the VA and DoD are down here and they're moving out. Not at the same pace we are because we're a little smaller, we're a little more nimble and agile and we can move out pretty fast. But the VA and the DoD can't move out as fast just because they're behemoths, I mean, they're huge and they've got a lot of strings tied to them that I don't have tied to me. So they're starting to move on this particular subject and it scares me to death, because tactically I'm way out in front and my flanks are exposed.

DR. POLAND: That actually leads to the next question and that is, for the purposes of the Board here: What are areas that we could be helpful? What are barriers that we could help look at or make recommendations on?

BG TUCKER: I think Dole-Shalala is spot on. I think their recommendations are sound. They've had good studies. They've listened to the
field. I'm afraid of the definition. I think the first thing that has to happen is we must define who this soldier is, who this soldier, sailor, airmen or marine is that we're going to take care of. That's the first thing I deal with the Secretary General; sir, let me define for you the warrior in transition. The warrior in transition is a medically non-deployable soldier going through an MEB who require rehabilitative treatment that will exceed six months. If you approve that definition then everything else will become relatively simple, at this point, in terms of who the population is. So I think we should try to prevent a have and have not approach. Because to do so otherwise is a slippery slope and we will remain under attack from America for not taking care of people who are serving their country.

I think we need to work really hard at defining who the recovery care coordinator is or I believe -- I brief the SOC, by the way on Monday this week, the SOC staff, not the SOC proper, that
I believe they're calling it Federal Care Coordinator now or Federal Recovery Coordinator now is what they're calling it (off mike) recovery is federal now. Define what that job is because it brings to this point, when you ask for help; we've got to make sure that we've got seamless transition. If you were to ask me where do you see the biggest void in the continuum care that we all often -- we often throw that term out quite easy, the continuum of care -- the continuum of care is at risk when you go from active duty to release from active duty. That's where you're vulnerable, that's your point of risk and so we've got to pile on and we've got to make sure that this is seamless and just at the Army level, I mean, we have worked with the VA, kind of in a side bar relationship, to bring in where we have VA representation on camps and stations, we have gotten permission to move them physically on our camps and stations in with the nurse case managers, and they're willing to do that. Why? Because it's for the right reasons. I mean, you
need to go see the VA; where are they? They're at
some building on post at the end of a long dark
hallway and have a nice day. No. Or the VA is
calling you, hey, I understand you're going to
release from active duty in 60 days, I need to get
an appointment with you to come in and start
talking about your VA benefits, start lining you
up and get your applications put in, you see. So
those are two areas that I'm concerned.

DR. POLAND: Let me give the
opportunity, first, for General Roadman to make
any questions or comments that he may have as he
was part of the IRG.

LT GEN ROADMAN: General Tucker, thank
you. I really appreciate all the work you all
have done. Quite frankly my emotions have gotten
a booster shot here going through looking at this
and the town hall meetings that we had.

I agree with you that you are way out
ahead of the headlights in fixing this problem
that is larger than Army, much larger than Walter
Reed. I disagree with you with the issue of the
large bureaucracy cannot move out. My impression from listening to things that we've had already is that in -- and I like to frame it this way: If we go to war will the bureaucracy come in on our side? Quite frankly, I think the answer at this point is, no. That they are going to continue at the same pace, same rate, business as usual while we're taking casualties and not solving the fundamental issues, which are much larger than what you have to deal with. They have to deal with guard and reserve issues, they have to do with people who are in the shadows of the bureaucracy. I think you are, as I listen to you, you're absolutely on the right track. Our problem, as we present this to be comprehensive, is that the signal-to-noise ratio becomes very difficult to pull out and I think the presentation is absolutely complete. The real issue is: Will our nation accept its moral obligation to care for our wounded warriors? And then the bureaucratic approach that we take is how we fix that. But I think quite frankly the DHB has got to be the
conscience of the Department of Defense. And I worry. I wanted to make some wrap-up. My view of transition from the AFEB to the DHB, actually the epidemiology part is the easy part. What this Board is now going to take on is the culture, the tendency to worry about the cost rather than worry about what should we have done. And I don't -- I really don't mean to get emotional Greg on doing this, but I think, General Tucker you're absolutely on the right track. I think the volume of the tasks present will overwhelm even the 2,000 people that we have now in support. I think there will be a tendency in this next year for the administration to be a lame duck for another year as the new administration comes in to be on the learning curve and it will be a fight between the rational approach to what we're doing to gain the minds of the people who are in power and that's where you have great opportunity to have the story correct, to be pressing forward because there will be a fight by the staff to regain the minds of the
leadership, so there's an opportunity that is
coming here to make fundamental change, but only
if we get it concise, right and boiled down to the
moral obligations that we have. I didn't mean to
make a sermon.

DR. POLAND: No. That's exactly right.

LT GEN ROADMAN: Yeah, I did. But I
think that I am quite frankly worried. I don't
believe that we can institutionalize this as
lessons learned because there is always a fight by
the bureaucracy in peacetime to whittle this down
to efficiency and effectiveness, which takes away
our surge capability and then we will always be on
the low side of the power curve fighting our way
back up having to call air strikes on our own
position in order to get out the engagement zone.
So I applaud what you're doing. I applaud the
speed that you're doing it and quite frankly am
embarrassed that I don't think the support systems
are there to make that job executable, otherwise I
have no opinion.

DR. SILVA: Thank you for the Board.
We've all been very much bothered by what we see in the newspaper too. I just have several very quick comments; it may not need a response, but just to put them up on your radar screen and the Board's.

First is the VA. I visited our VA and the blemish you felt at Walter Reed they feel, because many citizens just don't differentiate between where the problems in care are, so there is (off mike) much as your problem is the VA and the general citizen country problem.

You refer to some manuals that sound fascinating and if Roger we could get the links to those I'd like to see what they look like and maybe the other armed services too would like to look at. What is the written (off mike) related to transition?

The only other comment is that you still have got to go back to a root analysis. I mean, changing the faucet, it sounds like you've done it. In the military you can sort of get people to incorporate it or you beat the tar out them, I
guess the military way. But how about high-level military and officers resigned over this issue? How do you deal with a facility on BRAC? What are politicians going to do about the restraints when you're BRAC to clear? What's their overload? And let me just flip over the coin for you. How does a top-level person, when they're looking at overload ask for help at an early stage so it doesn't boil out of the pot and it's just splattering all over the place?

BG TUCKER: I think that, first of all the key infrastructure at the BRAC-identified institution like Walter Reed Congress came back and said, Knock it off. And they gave us all the money we needed to keep Walter Reed. In fact, the word was, the day you leave Walter Reed I want you to turn around and look back at it and be very proud of how well the building is being taken care of and nod it's on its last leg and it's about to crumble to dust. So we have done a complete stem to stern analysis in pumping millions of dollars back into the infrastructure of Walter Reed for

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that purpose and I think that's a very important lesson we learned, unfortunately, the hard way.

The standing up of the Walter Reed national medical center at Bethesda has really caused a clash of cultures so to speak. So simply between us and the Navy, because the Navy doesn't do warrior transition units? I'll just be frank with you, the Navy said, come on over, we want you to come on up here to Bethesda, but leave that warrior transition unit thing down there at Walter Reed, we don't do that. We said, Yes, well, we do do that. So we're in a big -- I talked to the -- he's already been designated as the JTF commander up there, Admiral Madsen, and we're toying with the concept of building a joint warrior transition unit. I mean, if we're going to go joint, let's go joint, because one of the concerns is we've got to have equality across all services in terms of this type of level of care. So I've got enormous fidelity of care with this triad of support on every one of my wounded, ill and injured soldiers. (off mike) Raynor had the very same thing with a
sailor or an airmen, clearly should have the same. So we're concerned about that, but he's on the team. But boy do we have a clash of cultures that we have now kind of overcome to try to get an overarching joint operation affair in charge of the entire national (off mike) and to leverage the capability in the national (off mike) region to spread that burden of crossing all the medical facilities in the NCR and build surge capability as well. Very important. Those are great points, sir.

DR. SHAMOO: Thank you General for your report, excellent report. I really want to associate my opinion with General Roadman's comment. I agree fully with what he said. I just want to add what we are hearing from you and others really is post-event action. What is lacking in all this I think is it's not anticipatory. The post-event planning, whether it's post invasion, post-Washington Post article, or post-9-11, we -- what I would like to see the DHB is to be somehow a beacon to the DoD on
medical issues in terms of anticipating the event and have a planning for those events even though they may not happen. That planning could collect dust; it's okay. There's that one in ten, if you hit it right, you may do a great service to the country and I'm going to be very blunt, as some of you know, I'm not; and that is, there's a lot of talk about the next war. Have we done any pre-planning for that event? I have seen none and I wish there will be even though I pray to God we'll never have one.

BG TUCKER: I think we need to do better at integrating -- we need to look at our entire medical capability, not just in the DoD, but in the entire -- there's an enormous capability out there using the entire network. We've got to look hard at where those obstacles are that are preventing us from doing that. We work well at the VA in some locations. Not in all locations. We could do better work with the VA in all locations and use that capacity where we need to and use other service hospitals where we need to.
We could do better at that. I think we should have a joint medical unified command in my opinion. I'm a Calvary officer, but I'm just telling you since mining this dirt now since March, it's very evident to me: Why don't we have a joint unified medical command? So we can get the synergy of all these great medical facilities and medical centers across the DoD alone and utilize them for surge capabilities for the next war, because the buses kept coming to Walter Reed, but there was enormous capacity across the United States that wasn't be utilized, and that would be a step in that direction, sir. Thank you.

DR. POLAND: One more comment, Mike.

DR. OXMAN: First of all, thank you for an inspiring report and obviously making enormous end roads in the problem. I think you mentioned that your concern then is when in the transition to the VA. I think that's a major concern and I don't think that enough thought has been given to that and I think it's going to be a critical issue and I think we need to help you work with the VA.
to do what needs to be done and which I think is
going to be a challenge.

But in addition, I believe that our wounded now, your wounded warriors are unique in the history of our country's battles that they are more dependent on the society for a longer period of time than ever before as are their families. I think that one of the things that I hope we will do which will require legislation is to have the support and care for the family in the same place and integrated with that for the warrior, which means that the VA, if that's where it happens is going to need to be tasked to take care of the family, not just the warrior.


DR. POLAND: Mike, go ahead. I saw your hand up there.

DR. PARKINSON: General, a couple of observations and I want your reaction to these. We toured the Intrepid yesterday, as you know. And in your presentation today an Army policy the
term "warrior" has pretty much come to replace soldier, as best as I could tell. And I'm very concerned about the law of unintended consequences for anything we do. And while warrior connotes one function of DoD a high level, it's certainly not what -- if you read the papers and what many countries around the World want from DoD it's not just warrior, it's many other things. So that aside, what I'm concerned about is the physician is the law of unintended consequences when with tremendous respect and awe, I see nine wounded warriors going back to active duty in theater, but are we sending an inadvertent message as we celebrate their return that either hurts or further psychologically damages some of our troops. And if that is so, are we monitoring that or looking for that just as an aside. As a physician seeing the facility and seeing your presentation here.

The other thing I would just say gets to this notion of using the full MHS. One of the things I'm also concerned about as an Air Force
retiree is what appears to be the Army's desire to take care of its own. Call everybody a warrior, warrior in transition, either into the Army or out, is that what we're doing is codifying and perhaps solidifying, inadvertently, the walls between the Army and the Navy and the Air Force at a time when heaven knows the Air Force is never going to have as many feet on the ground as the Army or Marines do, but we need to be sharing the emotional support as a service. As a military family. Are these expressions and are these practices and of these ways in a way, inadvertently, creating a bigger distance that doesn't get to what you just said you want, which is that the entire breadth of the MHS and military family, the entire breadth of the DoD/VA continuum do that.

Final question is: Have you looked at stationing or seeking to station "no kidding" active duty Army warrior transitions unit in every VA hospital in the country, period? Not based on need, but it's an infrastructure you have to have.
And if there's 5,300 or whatever that number was, out there -- and one final question it seems like a huge one. You can't have it both ways. If there are Army commanders who've got 2,600 or 2,700 folks in their units which by the way seems to be the goal of the warrior in transition program, I guess, to get them back into the functional Army service and they're doing a valuable function even if it's a PowerPoint Ranger, someone's got to do it.

BG TUCKER: Yeah, but they're not healing.

DR. PARKINSON: Do we know that?

BG TUCKER: We know that.

DR. PARKINSON: How do we know that?

BG TUCKER: Because we're treating them in our MTFs. They're on permanent profile. We know where they're at. We know what their status is and they're stagnant. They're not healed.

DR. PARKINSON: I guess these, as we go forward, some of these things are thing the DHB can help you with. What are the measures of --
because at face value it seems they're in a unit, they're there. I mean, if they're going locally to a VA where you had an Army thing perhaps they got some healing plan, et cetera. These are just some impressions and hopefully this will be the first of many engagements with the DHB, because we need to --

BG TUCKER: That's important. The triad establishes a healing plan, a holistic healing plan for every single soldier and builds a glide path for their progress and then monitors they're progress in conjunction with the primary care physician who is part of that team who can make sense of all this because many soldiers are seeing multiple specialists, seven, eight, nine specialist. Well, that's all (off mike) but who's giving the horizontal integration to that, it's the primary care manager.

The warrior, the term warrior was we chose a neutral term. All the Army ethos says soldier, soldier, soldier. We chose warrior because we felt it to be a neutral term that would
apply to all services. Plus a person in the military is somewhat as a warrior in society, so to speak. That was the intent to kind of choose a neutral term. But that's a great point; we need to be sensitive to it.

DR. POLAND: Thank you very much, General Tucker.

(COIN PRESENTATION MADE)

COL GIBSON: While Dr. Poland is walking back up here, please make sure you sign the attendance rosters and the other roster that's going around is the CME roster. We have two -- we can get two CME credits out of this, so please sign it. Your attestation forms for the Board members are in the book and I believe Karen has others for the other attendees.

DR. POLAND: Our next speaker this morning is Retired Colonel Dr. Charles Scoville, Chief of the Amputee Service Integrated Department of Orthopedics and Rehabilitation, National Naval Medical Center at Walter Reed Army Medical Center, and the executive secretary for the panel of the
care of individuals with amputations and functional limb loss, which is one of our DHB subcommittees. Colonel Scoville will update the Board on the panel's activities. Colonel Gibson and I, last week, were privileged to attend one of their day-long meetings and the opening ceremony of their medical advanced training center, sort of a sister institution to CFI, and just like CFI was equally impressive. So, Chuck, you have the floor. Chuck, I guess you have one of your panel members here with you?

COL GIBSON: General Fox, you want to make some comments?

GEN FOX: No. Well, I apologize for not being here yesterday. Flying across the world with Project Hope now as the prior commander of Brooke Army Medical Center and integral in establishing the CFI and very proud to do so. A lot of the issues that were raised today by General Tucker, I have intimate familiarity with. I will say that it is an honor and privilege to be a continuing part of the Defense Health Board and

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in particular continue to work on this panel.

Some of the subjects that will come up, I'll have some comments with that Chuck will bring up.

DR. POLAND: Welcome.

GEN FOX: Thank you.

COL SCOVILLE: We established the --

initially tried to establish a FACA committee for the care of individuals with amputation and is expanded to include, and we are working on the actual definition of what functional limb loss will include. But back in early 2004, our panel came up the vision for the panel is for a collaboration of multi (off mike) provide amputee care. With 600 patients they return to a lifetime of highest physical, psychological and emotional function, so it kind of sets the bar really high for us to begin with and we continue to work on that.

Mission statement we developed goes right along with what our vision was. And we look at the personal goals as continuing to be a productive members of our society. I think we
spent almost a full day on just trying to figure out how to word this to show the continuity of care well beyond, just their time in the military and as a healing service member.

A very long list of goals. If you look at the goals (off mike) and touch on them briefly, this again was established about February of 2004, and we've come a long way in reaching or moving towards those goals and they are as applicable today with the need to continue on each of those paths as they were when we established them in 2004. Looking at them, as a prepared for this, our standard question -- really how well we hit the target at that time of what the needs were. So the same standard for surgical, prosthetic rehabilitative care and care and management of amputee patients. We have developed a number of new techniques. Monday, Tuesday and Wednesday of this week, we were at the Center for Intrepid, developing a textbook for military medicine on the care of the amputee patient. Because there has been such significant change in what we're doing
now compared to when the textbook was published in
2001, I think is the last version. So just in aive, six-year period there's been tremendous
advances.
Focused early on with assisting the
family members and empowering them so that the
decision making was on the family members and the
patient part. It wasn't the military saying, this
is what you will have, this is how you're going to
be cared for, and the programs evolved around
that. Once you read down through those -- I think
this is also in your book.
As you saw yesterday at Center for
Intrepid, we have been leveraging leading-edge
technology. Many of the things you saw in Center
for Intrepid -- if you had a chance to go through
the MAPC at Walter Reed, they are one of a kind or
the two facilities, two-of-a-kind capabilities
that don't exist anywhere in the world.
And we have done a lot on collaborating
with outside facilities. On Wednesday at Brooke
Army Medical Center we did two surgeries on
individuals with shoulder disarticulation. The nerve endings that normally go to the arm, median nerve, ulnar nerve, radial nerve, musculotaneous nerve were transposed into spatial of the pectoralis muscle and the latisimus muscles to drive the next generation prosthetic device. So as they think of closing their hand, the median nerve fires, muscles fire and the motive that drives the hand closes that hand.

The duties of our Board functions solely as an advisory committee under the FACA committee. (off mike) service and provide advice to Walter Reed, BAMC -- actually, I changed that and I don't see the change; provide advice to the DoD and through the commanders of Walter Reed, BAMC and San Diego Naval Medical Center regarding the program services and the effective organizational planning. So the Board has continually been the driving force in what we do. As we look at what direction we should head, one of the things we need to address; it's been the Board's action that have helped keep our focus on what our mission is.
Current scope. Individuals with amputations and functional limb loss. We, as a Board, in our last meeting we spent a lot of time discussing what functional limb loss is and is it the scope of our Board; should we expand our focus or not. We came up with kind of a definition and said, no, we're not sure that's really what we want. Our Board decided that their focus should be primarily on the individuals with amputations. As we try to expand more, we lose some of the visibility and as programs and things come up, the term now "blast trauma" they become more and more diluted and the patients with amputation get lost.

Expanding the role. There was discussion on whether our Board should become the board for the rehabilitation medicine or maintain focus on the small population of amputee patient population. The amputee population is only about -- is 2.4 percent of all of the injuries being evacuated from theater, so a very small number. Today, there are now 698 individuals with limb loss, major limb loss, from this conflict. But
it's most visible and it's one of the more recognized. Now, TBI is becoming the other signature wound of this conflict, but amputee care has been one of the more recognized and things that we do and the way we progressed has driven a lot of the other things that go on, the return to duty aspect in general.

At our last Board meeting we just -- we looked at what are the current issues that are facing amputee care and what the roles of our panels should be and we looked at both external issues and internal issues. Internal issues being those that we can manage locally at our three centers. We've done very well with Walter Reed, the Center for Intrepid, and San Diego Naval Medical Center working together and kind of on a good working relationship keeping continuity and similarity of care. At a higher level, there's a need for advocacy for funding for the care and research for patients with limb loss. Early in the conflict we got Congressional ads that addressed this. More recently the Congressional
funds have been bundled under blast trauma and are
being paid by the (off mike) for Surgical Research
and TBI issues and there is no money identified
specifically for amputee care. Not a tremendous
issue if you look at it as a large brush stroke,
but as it has been pointed out, there are a number
of individuals who have lost their limbs in
training, in motorcycle accidents, because of
tumor, for a variety of reasons; and we have
changed the standard of care for those patients.
We no longer treat them for a very brief time and
say you cannot be retained in the military and go
to the VA. The budget that was built for us prior
to the war was built on that quick treatment and
discharge. Now we have a population, in addition
to the war wounded, that are expecting and deserve
the high level of care and there is a price tag
that goes along with that. When our budget comes
entirely out of GWOT dollars and is not
specifically identified for amputee care there is
no budget line and we keep going back and trying
to pull from other sources to cover the costs of
caring for that. That's about -- on average we're
looking at 40 to 50 individuals a year that lose
limbs that are on active duty that are unrelated
to the global war on terrorism.

You need to ensure that patients with
limb loss and families receive all necessary and
(off mike) health support. This covers every
meeting; every topic that's been discussed here
has included that. One of the problems we're
having at Walter Reed and at other facilities,
there's only a certain pool of people that can
provide the support that have the training. And
not only is the Army competing for those people,
but other services and civilian communities are
competing for the same population. It's difficult
to fill the vacancies that we have in this area
and at Walter Reed you get -- one step more
difficult is people look at that BRAC process and
gee, Walter Reed is closing, will I have a job in
three years, what's going on with the whole budget
cycle.

Recommend establish an executive agency
in amputee care. You've seen the Center for Intrepid. On 15 October, San Diego will open up their combat casualty care center and Walter Reed opened our center last week. We have worked very well together in making sure that we have similarities in care, but there is no one that has authority of any of the three sites. I work for Walter Reed. I am, because of friendships, able to work with San Antonio and San Diego. The Army, when San Diego said we're going to stand up amputee care with you or without you, the Army sent a physiatrist, and a physical therapist that had served in amputee care at Walter Reed for a year out to San Diego to help them set up the program out there so they didn't have to go through the same lessons learned that we did at Walter Reed and at Brooke Army Medical Center. So we've worked well together, but there is no executive agency, there is no lead agency that says they're responsible for seeing that all of our sites have similar capabilities. It works good right now with the personnel. If I go
somewhere or if Becky Hooper goes somewhere else, you can give them personnel they can very quickly diverge without senior leadership capability.

A need for better clarity on COED, COR versus fit for duty findings and the effect on the service members. That one I can guarantee the MEBP, the counselors that are telling them about this that are at the GS-6, GS-7 level don't understand it because I don't understand it. Most of our patients (off mike) don't understand it. We have individual soldiers like Major Rozell who fought to be found fit for duty. When he retires there is a presumption of fitness because his injury was long before he was able to serve his final year of service, so he has no medical retirement potential from the military. He'll get benefits from the VA for disability, but he does not get a medical retirement from the military after serving a career as a below-knee amputee. If he goes through the COED/COAR process that changes, but he is unsure of which way he should go. He's looked through all the papers and goes,
I don't know. He just had another surgery that took nine more inches off his leg, went from an ankle to below knee so he can fit more of the new componentry in so he can run his IMA a little bit faster and he has not yet gone back to another board since he doesn't know what's the best thing to do. I haven't found anyone who can really explain to him, so there's a lot of confusion in that and as the boards and new things come through with Shalala, et cetera, that may change, but it's currently an issue that is above the Army level and needs higher-level intervention.

Internal issues. Looking at new panel members and getting those through the nomination process at the Defense Health Board level and DoD level where we would identify them, send their names forward to be nominated and then appoint to our Board. We have a number of people that have been working on the Board since 2003 and we are down to six members right now and need to increase our numbers again.

Reviewing the process of transition from
inpatient to outpatient and socialization to a new environment, at both Walter Reed and San Antonio, we've identified that as the patients get discharged into at Walter Reed the Malone House or into the Fisher houses, they're changing their whole social environment and their support agencies and things change. So we're studying with our psych-liaison officers in touch to figure out is there a way we can do that better and help them make that transition.

The next thing came up and I'm not quite sure yet -- and this was, our meeting was last Thursday, so I'm not quite sure how we address this, but we have service members that are 18, 19, 20 years old that are placed in the Fisher house, and we have newly married or have very young children, and we have service members that are 37, 38, 39, 40 that are placed in the same Fisher House. They share common living areas, they share common kitchens. An issue that came up down here recently is one of the family members wanted to have a dog in the house and very young and had
young kids and wanted a dog and one of the other families was allergic to dogs. And they get into the who does, how do you, the social activities, who parties in the room, how loud they are and things. It's becoming a bit of an issue in our Fisher houses that the populations are staying for longer periods of time. Average length of stay, when I started in August 2003, we kept patients for about two and a half months at Walter Reed with limb loss. And then they were either sent back to their unit or sent to the VA. We had the typical peripheral vascular disease treatment protocols for amputees. You got them up moving on a temporary leg and got them out close to home. We've changed that philosophy tremendously. We now treat them as tactical athletes; we restore them to the highest level of function based on the guidance of our Board. And this, then, patients are staying in Fisher Houses for a longer time so this becomes an issue. Terry Howe is dressed to address spouse and children's needs. We talked about Camp Noah, peer visitors and things which
we're going to expand on within the programs now
and then developing a web-based chat room for the
patients and families. AKO has commanders online
which allows junior commanders a chance to get in
talk with one another. Look at this, this needs
to be a ground up delivered and we have one of our
amputees that has now volunteered to now do this
for us. So they're going to be developing a
web-based program.

Our future direction. For our Board
eye want to maintain their focus on patients with
limb loss and they want to be addressing the co-
morbidity issues related to patients with limb
loss, particularly at TBI and PTSD and then
remaining focused on the goals that we established
back in 2004. One other thing we're looking at is
the sustainment of amputee care as we move
forward. As this war ends and we have a patient
population that dwindles; how do we maintain the
expertise, the focus, the knowledge, the skill
bases and things that we've already gained?

BG (Ret) FOX: Thanks, Chuck. One of
the things, Dr. Poland and to the esteemed group
here, one of the things that is clearly evident as
we've committed enormous public/private resources
to the quality of care and to the applicability of
state-of-the-art research to recovering those
soldiers, sailor, airmen, marines that have severe
limb loss or the worse case, amputations, we've
committed enormous resources to that on a
doctor/nursing, medical technical side and the
multi-disciplinary aspects for a full recovery as
expeditious as possible with the intent to return
back to duty. The clear intent, I think, of
everybody involved from all services and the
surgeon general's with their concurrence and
approval have put into place a sequence of events
which now have led to sustain this beyond the
level of a conflict you need to have substantial
patients to take care of. Very much like the burn
center that was established, the Institute of
Surgical Research at Brooke Army Medical Center.
We shifted to taking on civilian patient care as a
means of retaining the number of patients and
therefore the capability and therefore the
research ability and the education requirements
for teaching people how to maximally take care of
to the state-of-the-art level burn care. The
similar sort of circumstances are now coming to
ear or will come to bear upon these now three
amputee care centers, one of which is the -- I
would say the most modern, state of the art, but
you saw yesterday at the Center for the Intrepid.
Walter Reed now has the second one that's really
upgraded itself as well; San Diego will be shortly
behind with a greater and greater facility. An
enormously powerfully talented faculty to take
care of those injured soldiers, sailors, airmen,
marines now. The question is, for all of us I
think, to look at the ways and means to adequately
get the financing, resourcing amputation
populations in post-conflict era to retain this
same level of expertise for yet the next conflict.
We will have, I think by all evidence, and Chuck
has got some data on this on pre-conflict periods
where you have relative peace, of the number of
kinds of injuries you'll see throughout the 
services which would qualify for care in these 
kinds of amputee care centers, but there's 
certainly not enough for cohort recovery, which is 
the optimal way to recover these kinds of 
casualties where they're being recovered side by 
side with somebody going through the same stages 
or similar stages of recovery. Then you'll have 
the demand for the number of patients that one 
needs for, again, education, research and 
development of continued state of the art. So we, 
in my mind, have faced, and the Board's mind, have 
faced yet a challenge now to take on a 
subcommittee just specifically have people put in 
their -- who want to look at models that we can 
incorporate and present to the Department of 
Defense as a way of sustaining these going 
forward.

The question is: Do you need all three?

I guess that would be one of the questions. The 
second question is: What kind of commitments, 
financial and what kind of models can we use to go
forward? It is not an insignificant cost, I might
to care for those at state of the art levels and
they're civilian patients. So that funding is
Department of Defense funding and it needs to have
a funding stream. I think the commitment has been
made here, but we need, as Chuck outlined, a
funding commitment and a long-term commitment by
the Department of Defense that, yes, we are going
to maintain this and we're going to use this kind
of model and this kind of funding stream to ensure
that we never drop below what we think is ultimate
state of the art kind of care, so that we don't
have to go through this rapid ramp-up again of
these kinds of commitments with not having some of
this architecture in place and the funding in
place.

DR. POLAND: It strikes me, too, that
you also have opportunities as, in a sense, ISR
has, in a sense how AFIP had where you have the
opportunity to establish yourself as, I like the
term "state of the world" centers that then as those numbers dwindle, increasingly become VA and civilian national referral centers for these sorts of severe injuries that there's almost no place else that's going to have the kind of equipment that CFI has. Nobody else would have the volume that would justify that.

BG (Ret) FOX: There's some complexity, I might add with that, because if you take the VA model and the VA care in post-conflict era, you may not have the patient cohorts that you're seeking to maintain return to duty. They're a different population. A diabetic who has lost a limb and needs to be recovered certainly want to recover as much functional limb utilization as they can, but their ability to go to the step of these kinds of young soldiers, sailors, airmen, marines and their desire to get at a different level is -- so there are some models out there which would suggest we could go to major insurance companies who work with large corporations that have industrial accidents, that population, and
offer them certain kind of rates for full recovery
and that will allow us to evacuate in the kind of
casualties from across the country that are young,
relatively healthy individual which we can give a
standard of care -- the highest quality of care,
but for a standard rate and that will allow us to
maintain that. Then it becomes, in essence, a
national resource which would shift to soldiers,
sailor, airmen, marine care in times of war.

DR. POLAND: Okay. Comments? Dr.
Lednar.

DR. LEDNAR: I think the thinking of
these three centers as really a national resource
as in the private sector I think of specialized
care needs and centers of excellence, there's a
way to sort of bring these two together. I'd like
to suggest in making them very visible to leading
health insurance, I think there will be actually a
lot of interest. It may not be in any one company
or any one local areas, sort of a high volume,
clearly these are special need patients.

I think one of the other potential
advantages of having not just young -- call it
civilian injuries who work side by side with the
military is to see the commitment that's possible
and focus on getting well and getting back to
work. That would be of a great assistance to
every patient.

BG (Ret) FOX: What we were looking for
Dr. Poland from the Board, the (off mike) Board at
large is sort of the commitment that, yes you
should, indeed you should explore it and in the
ways and means that we can use, either perhaps
even members of this Board to come onto that
committee. I had presented a structure and
outline proposal that as we folded up underneath
the Defense Health Board it maybe shifts. We've
not yet gotten the approval nor have I set into
cement the members to go ahead and explore,
really, three or four basic key topics to this
issue of sustainability of these centers of
excellence.

DR. POLAND: I think we're going to

engage some more on that and I think we can be
helpful that way.

DR. HALPERIN: Aside from workers' compensation and industry, you might also look to the federal government the National Institute for Occupational Safety and Health within the CDC, which is very interested in the whole area of trips and falls and prevention of injuries, but it seems like a very logical next transition to the rehabilitation of the injured.

COL GIBSON: Britt, can you bring those slides back up, please?

DR. PARKINSON: Chuck, great presentation. Again, thanks for yesterday. I struggle a lot just -- and again the purpose of the DHB is for us to have the -- this is an open forum to talk. The last time this country had anything that represented a significant surge in amputation as a result of war that was sustainable, frankly, was the Civil War. We established something called the Veteran's Administration as a result of that. Large numbers of people thinking up (off mike) that the country
responded and said there's an infrastructure
sustainability need here, we've got to have
something like this to take care of the veteran.
As a citizen, putting aside the wonderful work
we're doing, is that infrastructure or model of
sustainable amputee centers of excellence at the
magnitude and volume, obviously we have an acute
need with a big surge in Iraq war with 798
individuals going to what, I don't know. The
Board, as it's currently constructed, said no we
don't want to go into the broader issues of job
and worksite training, TBI, PTSD, because the
numbers are too big and frankly we come out of an
amputee, physical therapy, physiatrist, whatever,
which is wonderful, but then we've got to be very
frank about the need for three centers when we do
have occupational and safety and health where we
don't have occupation amputation in this country,
thank God, by and large; or if we do they are in a
handful. It is a resource of tremendous
opportunity perhaps, but I still struggle with, as
you heard my earlier question, is most of these in
the volunteer Army the majority folks, to my knowledge, are the volunteer services are coming in to get an education. They're coming in to do an in and out by and large. They're not going to do 20 years. Okay. Where's the job training, where's the language skills, where are the mathematics? And they're going to back to Topeka and they've got to get a job. So when I see the recommendation of the Board saying we want functionality around can I balance and the wonderful things we saw, all of which are critically important, to go to the next step and say we've got a challenge to sustain these things, is I'm not sure we're asking the right question in terms of macro need in the MHS infrastructure and the VA/MHS and even the HHS national need. So we've opened a lot of Pandora's boxes here today, but for this person, I'm not sure that we're asking or framing the right issues in the macro sense, in the historical sense around either amputee care or around the broader needs of the wonderful men and women you're taking care of in
the amputee center. So there's no answers in there and there's just questions. And as we go forward and talk and work with those committees but you're right up against it now. So that's where you can start from the science and say, what are the totals, what's the end, what's the denominator, what's the plan, what's the goals? And what's the best use of the American's citizen's resource, public or private, to do those things. I just don't -- we can have more dialogue, but that's where I'm coming from. It's not clear to me that the goals to sustain three centers of amputee care in the way they currently think. So we just need to -- just my reaction.

BG (Ret) FOX: If I might speak -- at least our Board's position is exactly in line with that. There is a deep emotional and an absolute desired need -- there's an actual need to establish the centers to deal with the amputees that we're seeing. The larger question is is exactly what we're trying to grapple with now. What does the public need? What does the military
need? What do the veteran's need? And can these
merged together and can we have a model that going
forward allows us to sustain the state of the art
capacity and capability. Don’t forget that the
CFI was built on private dollars, private
donations, $58 million worth, with a commitment
that DoD accepted would be sustained. So we have
already bought into at least one for sure has got
a sustainment built in as an agreement that we
would accept it under those conditions. So I
think these are very, very relevant questions.
They're obviously absolutely essential in terms of
going forward and this Board has got the talents,
expertise to help with us tackling this in a
bigger --

DR. POLAND: Colonel Gibson, I think you
have a comment.

COL GIBSON: Britt, go to that slide
that says "External" at the top. I'm doing my
FACA job here. These issues have come from the
panel, from the subcommittee to the Board in the
form of recommendations that the Board needs to
deliberate and then assist and basically provide
the second signature on the recommendations as
they go forward to the Department. I'd leave
those up there, make sure that we have a copy of
that that gets to all of our Board members and we
will be circulating the report or the
recommendations for comment, not only with the
panel members but with the Board in the very near
future.

BG (Ret) FOX: One thing we do know --
and as you talk about numbers, we're just starting
to look at Gulf War I; there were 14 known
amputees from Gulf War I initially. Looking at
the VA database and doing a query on Gulf War I is
one of the search terms, amputation is another
search term and combat injury as the third, there
are now about individuals and we're now trying to
get through the HIPPA thing so we can find out who
those individuals are. But there are about 46
individuals listed as amputees from Gulf War I, so
(off mike) salvage may take the number we have and
triple it over the next five to ten years, which
again gives us a growing population. We've had a number of people that have had limb salvage that are now two or three years out that have come back and said, I'm tired of trying to deal with a fused ankle, a numb foot, I'm watching my comrades through the basic (off mike) with me three years ago running iron man and I'm still hobbling around, please do an amputation so I can become more functional. As we get advances in prosthetics and advanced capabilities with that, that number may become even larger, we don't know. We do have a study, a metal study, which is looking at the amputation and limb salvage and what long-term results are from those and how many of those will turn over. There is an unknown number of individuals right now that may continue over the next five to ten years to give us a fairly large population of amputee patients.

DR. POLAND: Dr. Lednar, do you have a question?

DR. LEDNAR: I appreciate, Dr. Scoville, the so-called -- the intellectual honesty of that,
just how many cases do we have? What do we project for the future? Percentage of all the injuries coming out of theater that really relate to the needs for amputee care. One possibility perhaps of looking across these three centers and to take advantage of the learning that has come so far, but I think that if we would say today versus six months ago what we thought was possible, we are in a different place; just hearing yesterday the surgeries that were done. I think that part of sort of managing this resource is insuring that going forward the commitments that are made on amputee care are preserved. But if there is additional capability in capacity across these three centers or there's new technology for care in areas we haven't even thought of yet, but in the wisdom of the caregiver, they're beginning to see and develop, is how to manage that best use of the full resource, staying true to the delivery of the amputee care as a priority and delivering on that. But I think what Dr. Parkinson raised is a really important question we also have to keep
visible and that is: This is a precious resource, but an expensive one and how do we size it? And at some point it may be a question about exit strategy for one or more of these centers.

DR. POLAND: This I think will be part of how the Board will engage with the panel. I mean, we're not going to solve those issues this morning, but I think the concept is a clear one, that we already need to looking -- I like the comment that General Roadman said, is what's the CFI after the next and it's not too early to begin thinking about that and planning for that.

DR. SILVA: It was very much what Wayne had rendered. I don't know if you know the full need out there, not only United States but worldwide. I mean, there are a lot of kids that have limbs blowing off in areas that we put mines or other armies, so I think we should advocate for your future and help in ways is to start deciding a business plan once we're out of Iraq. You have such a good skill set there including the training center for orthopedic physicians around the United
States. And the Shriner's should be applying. So there are opportunities there for survival and sustainability.

DR. POLAND: Thank you very much. Our next speaker and I want to keep going on this string because they're so nicely related is Colonel Tony Carter from the Office of the Deputy Secretary of Defense for Force Health Protection and Readiness, who will speak regarding the activities of the Department's red cell on traumatic brain injury. We think he will be followed by Colonel Ireland, Program Director for Mental Health Policy at the Office of the Deputy of the Assistant Secretary of Defense Program policy, who will speak on psychological health. Colonel Carter the floor is yours.

COL CARTER: Dr. Poland, thank you. Dr. Kilpatrick, General Fox and distinguished members of the Board, I'm here to present an update. I think some of you may recall I was here before to talk about TBI and the Department of Defense's reaction to the Defense Health Board's
recommendation on TBI. What I would like to do today is just to give you an update on what we are doing in the Department of Defense with TBI as a result of our involvement in the wounded, ill and injured senior oversight committee action that was set up by the Secretary of Defense. Next slide, please.

I'm sure all of you are familiar with what the SOC, Senior Oversight Committee is doing in the effort on the part of the Secretary of Defense to organize the Department's response in conjunction with the VA to the issues that were brought forward by the Walter Reed incident. So what we have is a Senior Oversight Committee, an overarching integrated product team which consists of -- which is led by the principle deputy of personnel and readiness. And we have eight LOAs, or lines of action. TBI, PTSD, psychological health is LOA 2. Next slide, please.

The outcome that is desired of this LOA is to provide service members, veterans and their families with comprehensive, standardized
screening, diagnosis, treatment, et cetera; also
to provide continuing education and outreach on
TBI for all members of the Department of Defense
and for family members and the communities. Next
slide.

The charter is to build an integrated,
comprehensive DoD/DVA program to identify, treat,
document, and follow up those who have suffered
TBI. The emphasis here has been on mild TBI,
because in general, moderate and severe TBI have
been well recognized and there are treatment
guidelines for those conditions. But it's mild
TBI, which you've seen in the news in other
contexts, football, for example, is a more recent
context in which we seen newspaper articles about
kids who play on football teams and who suffer
TBIs and refuse to tell their coach because they
don't want to come out of a game. That goes on in
major league -- or in the NFL. The key players in
the military department, OSD/HA, DVA and civilian
experts. Next slide.

These are the deliverables. The most
important things that we've been working on in the
Red Cell, which the cell that is sort of doing the
work behind LOA 2, are three things actually: The
spend plan. You all know that we got $900 million
out of Congress in the supplemental for
TBI/psychological health and 600 million was for
(off mike), 300 million was for research. So we
had to figure out how we were going to spend that
money. And there was another mandate that came
out about the Center of Excellence and Dr.
Scoville talked about who is the overarching
authority within DoD for management of amputees,
which we were talking about. Who was going to be
the overarching authority within DoD for
management of TBI? That was going to come out of
this center of excellence. Next slide.

So we were going to do all these things
and then the whole issue was this was of such
import that we had to start. We had to get
started on many of these issues and even the
absence of research, even in the absence of
something -- a firm standard accepted by all. So
what we're going to do was to make sure that we did start on the basis of expert opinion for those things that did not have research to back it up and then what we do is spiral development. Make sure that we use the $300 million of research funds that we had to fund appropriate research and then use those research results to make changes in what we did and the programs that we had so that we could improve as we went on. Next slide.

Lots of groups -- yes, sir?

DR. LEDNAR: I don't want to interrupt your train of thought, but may I ask for the 2007 deliverables you identified, seeing as there are about only 12 weeks left in this calendar year, are any of those deliverables in jeopardy of not being delivered?

COL CARTER: What I will do is go back to that later to talk about what we've done. So there were lots of groups. This was the internal review group that was set up by the Secretary of the Army to review the whole issues of Walter Reed and actually the Department of Defense actually,
because they also reviewed Bethesda and had a mandate to review any other medical centers that were thought to be perhaps problematic. So these were the recommendations for LOA 2, specific to TBI, that that group came up with. Lots of recommendations. Next slide.

There were the task force GWOT recommendations also from the process -- from the process viewpoint and the outreach viewpoint and they had lots of recommendations too relevant to TBI and psychological health. Some of those were the same recommendations that the Defense Health Board gave with regard to post-deployment health reassessments, TBI questions to the PDHA/PDHRA, the post-deployment health assessment, the post-deployment health reassessment, which occurs three to six months after return from theater and also a periodic health assessment to find out for that population of people who do not deploy, whether they've had incidents in the previous year that may have been TBI or created of TBI. Next slide.

These were other issues, recommendations
related to coordination with external activities for those who suffered TBI. Next slide.

What has the Department of Defense done, what is it doing? I think I told you before that we had implemented the military acute concussion evaluation in theater, the clinical practice guideline for evaluation of people who have suffered or potentially suffered a TBI in theater. We had a comprehensive review including the Mental Health Task Force report came out and right after that we had a mental health summit to decide what to do with the recommendations of the Mental Health Task Force. TBI summits, which I summarized the last time. And then we developed TBI psychological health Red Cell, which was a group within force health protection and readiness comprised of individuals past the services to address these issues and to come up with a comprehensive plan for the Department of Defense how we were going to deal, first of all with the recommendations that were brought forth from the various commissions, because that was our first
priority is to be able to respond to those
recommendations and decide whether or not they
were reasonable recommendations for us to follow
and then recommendations that would be applicative
and recommendations that we really could not do.
We have -- today is the last day of a three-day
training course for DoD healthcare providers.
It's being held in Bethesda. We have, of course,
the Defense and Veteran's Brain Injury Center
which has been in existence since '92 and when we
talk about the center of excellence you'll see how
that is going to folded into the center of
excellence. The Center of Excellence for TBI/PH
is supposed to stand up on 30 November, 2007, and
then we're revising the PDHA/PDHRA/PHA to include
in-depth TBI screening questions. Next slide.

There was the all Army activities
message that was sent out to Army leaders on
traumatic brain injury. The TBI task force set up
by the Army starting I think last February or
January and those -- the result of that task force
were incorporated into the Red Cell so that we
could use that as a basis because they did a lot of really great work. The 101st Airborne pilot project to do an ANAM screening on all those people who are going to deploy, the plan is to do a pre-deployment cognitive assessment, send them to theater, send the result of the pre-deployment cognitive assessment to theater so that if someone is involved in a potential TBI producing incident then they can be -- their score can be -- it can reassessed with ANAM and then the score compared to the pre-deployment score to see what happened with that. Then there's an in-theater screening documentation process where all those people who are exposed to blast or other potential TBI-producing events and then there's a universal post-deployment screening at Camp Pendleton and at Fort Carson and Fort Bragg and that is going to expand throughout the Department of Defense. Next slide.

We're the Center of Excellence. We have -- I'll talk about that a little more, but we're working a concept of operations for the Center of
Excellence has gone through a lot of variations. Every day it seems to change, but we're still working it. We're working options for Fisher building. Mr. Fisher has graciously decided he wants to fund the Center of Excellence, but our problem has been that this is a fast moving train and every day the concept of what it is that we're going to build changes. The original thought was that we were going to simply build Fisher houses that were going to be sort of transitional centers for soldiers and their families, service members and their families to live in and learn how to deal with some of the problems that they have as a result of TBI and have a sort of therapeutic environment in the Fisher houses, specifically geared toward those with TBI and with psychological health issues of PTSD. We presented that to Mr. Fisher and Mr. Fisher thought that was good, but he thought that there were other possibilities so we came back to him with six other possibilities and then we ended up, last I heard, with the sort of completion of some of
those things which we're not really quite sure we
wanted. So it's a process and evolution. We had
a meeting with him yesterday and we're still
trying to decide exactly what it is that he wants
to build for us that we would like to have. I
think our final determination is that we would
really like for him to build us a center of
excellence on the Bethesda canvas because, number
one, if we used MILCON, if we wait for MILCON it
will be years before we get one. If we allow him
to do it, it will be a year. And we're not sure
he's going to agree to that, but that's our try.
So the spend plan for the 600 million and 300
million research, you know, of all the
recommendations that came down, what we wanted to
do was to take a look at all the recommendations,
combine those that could be combined, throw out
those that really did not apply and then take a
look at what remained in the rack and stack for
priority and then for short-term, mid-term, long-
term projects. We wanted to be able to identify
the current programs the services had for TBI and
we wanted to be able to coordinate with other LOAs, the disability evaluation system plays a big role, the case management because those guys need to know exactly what it is that we need to have to help people who have TBI who then go out to the community, the data sharing because the VA needs to know what we have found -- or what we have done with those people who have TBI, and facilities. The last thing we needed to do was to come up with a comprehensive plan, because simply reacting to recommendations does not make a comprehensive plan. We have no idea if we just take all of those recommendations and follow those recommendations you can't say that that's going to be a comprehensive plan with no gaps. So we were going to go from a sort of a clean slate and decide what it was we needed to do for TBI from entry into the system to separation from the system and on into VA care and then make that as efficient and as appropriate as possible.

LT GEN ROADMAN: Excuse me. Has that been done?
COL CARTER: The last part?

LT GEN ROADMAN: Yes.

COL CARTER: No, sir. This is the part that we are now starting to work on. We have a six sigma expert that has come in to help us look at the process of intake -- from when we recruit someone, how we evaluate that person on recruitment and so on and just go through the system. Next slide.

We had a lot of quick wins. Memo drafted for HA signature with standardized definitions and which list the current ICD-9 codes under which TBI is categorized. Those are various areas that TBI symptomatology falls under. We have gotten the codes approved which will come into place in October so that we can better track the people that we have with TBI. We are working with DVA to come up with a TBI ICD-9 coding system so that in October of '08, we'll have actual codes other than V-codes under which to categorize TBI. And then work also with the VA on, not so much clinical guidelines, clinical practice guidelines,
but current practice guidelines that we can use
until the DoD/DVA clinical practice guidelines too
comes up with an evidence-based guideline. We're
trying to get the DoD/DVA expert panel. There's
already a process to come up with the clinical
practice guidelines and we're trying to accelerate
that process a bit so that we can get those
guidelines created and out early, and then
consolidate the existing clinical management
guidelines and publish for immediate use. Next
slide.

Neurocognitive baseline testing, which
is a little bit controversial because we're not
sure that that does anything, but we now have a
mandate to do it. So we're going to publish an
OSD-HA policy that's now in staffing to establish
the ANAM for now as the tool of choice, establish
pre-deployment baseline requirements and then
establish in the PHA a yearly assessment.

Education and training, again, today is the last
day of training at Bethesda for this group of 800
providers and then we will publish a directive for
services to conduct sort of a stand down, which
the Army, by the way, has already done for TBI
awareness training throughout the ranks. Next
slide.

So the general areas that we looked at
and we came up with the spend plan are -- our
approach to this was to come up with a general
plan and then ask the services to come back with
programs that they wanted to implement that had
relevance to these areas: Access to care,
resilience promotion, transition, coordination,
surveillance and screening and so on. Next slide.

We have a staffing plan for TBI care
which is a little more difficult to come up with
than for psychological health because -- but what
we did was come up with: What do you need in a
major medical center to take care of a certain
number of people who have TBI? And then we funded
hires for proponency staff for the services who
requested it, for regional staff and for local
staff so that they could have adequate resources
to address TBI or to train individual providers at
the site to become their SME for TBI.

Psychosocial support, we wanted to make sure that the families had support because that's been a big problem with families who see their loved ones and they're changed and they're not really quite sure what to do or what that means to make sure that the families are educated and understand what they should do should they see these changes. Then, telehealth is another issue. A lot of our reserve component individuals are maybe in rural areas and may have difficulty accessing healthcare, mental healthcare or TBI assisted care. So we're using telehealth as a way to approach that. Next slide.

Education and training, a little repetitious there, I'm sorry. We wanted to develop a standardized, comprehensive, integrated education package using the Center of Excellence finally who will eventually take over responsibility for this DVBIC and contact the support with coders, legislators, providers and so on as the audience. Then, research I'll talk about a little more direct (off mike) later. But
this was the resilience promotion part. You know resilience promotion for TBI specifically was a little bit difficult to figure out because we don't know how to make people -- how to protect people against TBI before they get into the event. We're waiting for research. Some of the research proposals that we received talked about pre-treatment and immediate post- treatment in order to mitigate the effects of TBI. We haven't really gotten to the resilience part for TBI yet. Next slide.

Transition and care coordination, TBI registry, which is something that we need to do to make sure that we follow down the line what happens to people who suffer TBI. This first bullet here, identify and screen those who have left service without proper TBI screening, can be -- that's a very difficult task. Program and locate TBI resources, where patients live is another problem where we interface with the case management plan of action in order to make sure that they understand where our people can go who
have TBI. They don't stay in military facility. Then, benefits, recommendations for benefits for people with TBI. I think right now we're focusing more towards functional deficits and trying to identify functional deficits and then attach what rating should be attached to that in order to provide compensation for that, then TBI specific case management considerations to the case management LOA. Next slide.

Physical disability. We're working with LOA 1 to determine transition timing. You know, when you have somebody who has mild and moderate TBI, when do you want to transition them out, begin medical evaluation for that. And then work with LOA 1 on criteria for TBI disability determinations and the issue there may become of EEFD LOA 1 proposal for disability evaluation and rating goes to the VA which I think is our current track. The transition and community care we need to make sure that we have a bidirectional information exchange with the VA, that the VA understands the people who come out of our system
who have a TBI and then the transition
coordination with LOA 3, the case management LOA
and then community resource ID so that we know
where the community resources are and then we
train them on the specific issues that can be
related to military personnel who have had a TBI.
Next slide.

Surveillance and screening. The ANAM we
already talked about. Mild TBI identification and
treatment in theater. We established the MACE as
a tool to assess all injuries, document in the
electronic medical record. And immediately upon
post-deployment the PDRA/PDHA and then we've got
the staffing augmentation required to make sure
that we can get that done because that takes quite
a bit of work. Regardless of the place that the
injury occurs, because you have to remember that a
lot of TBI occurs in CONUS, at home, at home
station, not necessarily in theater. So we have
to have a uniform assessment and treatment
standards and documentation in AHLTA. Next slide.

Quality of care. The Center of
Excellence and the DVBIC is going to be the core of TBI Center of Excellence operations. Clinical standards, and we've talked about this before. Next slide.

Training and equipment. We're funding some CT scanners, portable CT scanners so that people who have severe TBI can be scanned at bedside rather than taken to the radiologist suite. We're funding transcranial dopplers to be sent to the theater so that the neurosurgeons could do monitoring. Although, in fact, a lot of the issues with regard to spasm which is a new phenomenon for TBI actually occur weeks after and usually these guys are back home, but they might figure, with the transcranial dopplers will be useful in the theater to make decisions about whether to do craniotomies or not. Then TBI and combat stress assessment tools so that we can have uniform tool kits in theater for our mental health personnel to use. Next slide.

Colonel promotable Lori Sutton has been appointed the interim director while the Center of...
Excellence stands up 30 November, temporary leased space, hope to get the near Bethesda. Physical structure on Walter Reed national military medical center campus in Bethesda and the place has already been set out for that. Administrative structure in progress, you know the organizational charts that being worked on. It's going to have psychological health and TBI. The DVBIC is going to be the core, it will remain the DVBIC and come under that as the core for TBI. The center for deployment psychology which is going to come over and be on the psychological health side. There's going to be a telepsychological health center, there are going to be advisory boards that we've already talked about to Dr. Gibson about those being subcommittees with the Defense Health Board. And then we're hoping that this gets built by Fisher. When I get back we'll find out how the conversation with Mr. Fisher went yesterday. And then and adjoining Fisher house for TBI/PH service members and their families. Next slide.

TBI research. 150 million from '07
supplemental. The MRMC Congressionally-directed medical research program is overseeing this process. 15 percent is reserved for research projects by the Center of Excellence. They're also going to work on a central office to coordinate. One of the things you have with TBI research especially, with both PTSD and TBI is access to service members. How do you get that access? How do commanders know who they should be talking to in terms of researchers who want to come in and talk to their people or to (off mike) other people? So we're going to have a central office to help coordinate that. Then the Center of Excellence will eventually provide strategic/programmatic oversight over this whole research process and we'll also probably set up a central IRB because having individual IRBs is such a pain in the rear. Next slide.

So Phase one: fast-track intramural. All the people who are currently doing research within the VA and DoD now will be considered Phase two open solicitation for intramural and
extramural research. All the broad area announcements have been out since July and we have conducted already a programmatic review of pre-proposals to figure out which ones were just so outré that we should just forget about them. We decided to let everybody because we didn't know what actually would come when we got the final proposals. Next slide. That's it. Any questions? Usually my object is to talk so long that everybody gets tired.

DR. POLAND: Let me just describe what we're going to do here. We need to finish this part and Dr. Ireland's part by 11:30. So we're going to nix the break. There is coffee out there and if you need to grab a cup of coffee out there. If you need to grab a cup of coffee or a biologic break that's fine, but given that and cognizant of the time and the number of members that -- there are last planes out that have to be caught. Let's have any very focused questions or comments. We'll go right into Colonel Ireland's second part of this presentation.
COL IRELAND: I'll switch sides if that's all right. Next slide, please.

Basically we had 95 recommendations from the task force of mental health and we're going to go and review each one of them detail spending 3.2 seconds each. What we're going to do is slice them into various categories and then just sort of broad sweep the categories and try to meet the time line and maybe have a chance for a couple comments. As we slice the various categories there's going to be very rough status indicators.

These slides have been carved into stone a couple weeks ago. This is fluid and dynamic. Some things change, sometimes you find out more nuances you have to deal with and they go back and forth. Some things happen more quickly. So there's a rough guideline color metrically of the status as we go through these and you see the various colors. These are the categories and we'll be mentioning them again. So to conserve we'll go to the next slide, please.

One recommendation that we did not act
upon because to do so would have been to duplicate services. There's a recommendation to treat those with v-coded mental health conditions or problems within the TRICARE medical system. Because we have a fairly robust counseling system within the P & R side both in terms of the various agencies and the advocacy family support and the family support adjunctive services and military OneSource the thought was that if we need to boost the services in that regard we'll do them on that side of the fence and that we will continue to utilize TRICARE for medical care. Next slide, please. By the way, advantages to doing that are many and most in stigma reduction, not having a mental health record established and this type of thing. Looking at quality of care and clinical standards in training, the Center of Excellence has already been described which will have a central role for psychological health as well. I think the status of that has already been explained and half of the funding for it will come from the psychological health slice of the
supplemental as well. The division directors and research functions will be sliced up by departments of resilience, clinical care and standards, research, training, advocacy, family and patient education resource center and network support. Help to provide core clinical practice guidelines training for mental health providers. There are six areas of psychological health that are co-developed guidelines by the VA and DoD that are maintained by a group that actually monitors their currency and status and the plans for renewing them as we go. The Center of Excellence will provide one means in which to approach that in a system (off mike). Part of what you do then is you send an e-mail link to the guideline for all your head consultants for various mental health specialties, just have them e-mail the link to their providers or do you do some substantive training. We think we probably need to do more than that. That's part of what the Center of Excellence will do in terms of dissemination of guidelines and also conduct training and refine
and compare them to other guidelines. We've had evidence-based training and there's no evidence base established for the best treatment for combat-related PTSD but there is evidence-based protocols for other forms of PTSD and we have initiated that a year ago with 119 trained here in San Antonio with cognitive processing therapy from a VA expert and a train the trainer events. We're going to be expanding that in prolonged exposure therapy training and continue cognitive processing therapy training over the coming year in collaboration with our VA colleagues. So shared training going back and forth. We'll continue the Center for Deployment psychology work where (off mike) picks up the centralized training for psychologists in deployment health combat operation, physical train and COE will be involved in the protocols for each. With regard to training for TRICARE providers the opportunity will be extended to them but what we'll probably end up developing, for their convenience primarily, is some kind of web-based conferencing
or webcasting kind of training and we've looked at
options of that. Next slide, please.

School programs. There are a number of
them that are engaged already. This can be an
ongoing function of the COE division. We've got a
mental health self-assessment program is in
process as part of an educational activity. The
Sesame Street deployment educational program is in
gear and fully funded, nominated for an Emmy, I
understand. We have a science of suicide program
that's now integrated into the school system of
DoD and it looks like it's going to be effective
in helping kids recognize kids in trouble. We'll
be developing psychological health core curricula
both leaders, families, medical staff, caregivers.
We have some versions of this already in terms of
training programs, CD and web based to recognize
folks in distress and respond appropriately to
them. We'll be expanding these kinds of things in
providing training for our professional, military
education and in other modalities. Standing on
the return and reunion programs identifying best
practices and disseminating them. Anti-stigma campaign was recommended. We'll certainly leverage this on existing activities; for example, that's going to be the theme of our suicide prevention conference in San Diego in April this year and reducing the stigma for help. Also it will also be part of an integrated function of the COE and the services and other types of behavioral health conferences that can be assessing the needs in that area, where we need to target, what kinds of stigma campaigns and focusing on leadership attitudes as well as service members and families. The whole issue of resilience with regard to all that it's very complicated. Expanding the issue of embedded mental health providers which we're doing primarily in special operations right now. Marines are transitioning to the operational stress control and readiness program using largely enlisted, but some level of professional support in various units and there's the brigade embedded providers that the Army is using. We had a conference actually about a week, week and a half
ago, brought together the subject-matter experts in each of the services. We went through what everyone is doing. We identified core elements, essential elements and we'll be generating a product to look at how there might be a certain level of standardization for those core elements. Obviously it's, depending on the unit, there are a lot of ways that that might be done. Next slide, please.

Improve access to care. Basically there was some question about whether the reserves had adequate TRICARE coverage and it turns out that the NDAA of '07 had provided for much more robust supplementation. So on 1 October, a couple weeks, they will have less to pay for fairly full and robust TRICARE continued support. Substance abuse rehab benefits. There was some concern in some states there was only one or two programs that might qualify for TRICARE payments. It turns out that was only counting independent ones. A lot of them are attached to hospitals and have existing certifications are already included in
that, multiplied by seven or eight-fold the number of rehabilitation centers in some major states. So I think there's a matter of a clarifying what's available policy in that regard. We need to continue to look at whether it's adequate. Establish and fund long-term casualty assistance support. We're in communication with the office of primary responsibility at P & R, and we're going to leverage with them, also, what I'll be addressing next and that's in terms of what's related to our seven-day access policy. There's been a lot of coordination. We're in the second iteration of a coordination that's probably going to be signed off by the ASDE today, if it's not signed off already. But we're going to accept the seven-day access routine standard. We've had acute access walk in, I think, in all the service, forever. But to do that for routine visits, it's been highly variable from the services and locations within the services. Many have meeting that; many have not been able to. So we're going to go that and one of the ways and what we're
going to do is we're going to implement what's
going to called a behavioral health provider
locater and we're funding that with part of the
supplement through TMA so that it's not incumbent
upon the person who needs the service, but the
locater will figure out who's available to see
them, not go through a list of 100 -- not figure
out who's still seeing folks, not -- sorting it
out and a lot of folks with mental health
condition that's acute may not go through all that
labor. So we're going to buy that labor and we're
going to have the contractors be responsible in a
positive way for telling us what's available,
rather than going to a website, get all the list
of people that have ever been contracted and
figure it out for yourself. That's a major player
and what we're going to do is make sure that the
casualty assistance officer is aware of that too
and support them in whatever they need, because if
they move beyond traumatic grief counseling which
is available to family support from Military One
Source to needing clinical care, they should be
able to just transition them right to the locator. So that ties in. Increase in contractors and resource sharing as needed, more flexibility in terms of how we meet -- the public health services offered up -- neighborhood of up 200 perhaps mental health providers which may fill in some of the major gaps in care that we have especially on more remote locations. A certain degree of understanding has been worked out already. We're into the specifics now, but it looks like this is a fast moving train that may get into the system and out very quickly especially for underserved areas. Using mental health technicians more fully. Some areas are using them to do intakes on the enlisted and assisting providers preparing to see them. Certainly that's something that can be expanded and we need to look at standards as we go to (off mike) training in San Antonio that will make it easier too. Enhance recruitment and retention incentives. All three services now have the critical skills retention bonuses for psychologists targeting critical year groups.
Some are utilizing accession bonuses and re-payback programs as well. Also the multi-year specialty pay for psychiatrist has been significantly increased. Next slide, please.

Funding critical staffing needs for Army and Navy as they've already funded for this spend plan as they've identified them. We've developed a very robust staffing model, the first of its kind; expect to see a publication on this.

Literature was (off mike) all kinds of ways of staffing, RBU base, population base, no at-risk population base, at-risk and with PTSD population base and patient/outpatient ratio accounting for primary care providers doing mental health care, embedded mental health providers in primary care, and also embedded in the units, but their usually not clinical. Accounting for medical education needs we grow our pipelines primarily for all our psychiatrists; we're not getting a lot from outside and the internship for our psychologists so we have a (off mike) education. And prevention and education needs we can't be (off mike)
everybody prevention at the expense of one of the
others. So this model put in the numbers and
that's the place that we're at right now. We need
a certain level of granularity from the services
to put the number into the staffing pool to
generate what looks to be the most reasonable
approach to staffing and COE can be refining that
model over time as we look at it. Next slide,
please.

Focusing on treatment needs for females
there's active coordination between the
representative and the health affairs program
policy with the VA representative on the same.
We'll probably have a number of conferences in
this regard to sort of look at the areas in which
we need to invest more finely (off mike) in terms
of detecting problems and making services
available. We'll leverage that also with some of
our (off mike) sexual reporting program, sexual
trauma reporting. TRICARE covered intensive
outpatient. Some of that is going on already.

It's been under assessment by TMA for quite some
time. We'll probably see a more unifying policy on that evolve, but they've been looking at this and they've been paying for it in some areas already, but bottom line is it's evolving and we'll see how it works out in various areas. And we've been using it within some MTFs over time. Whether that's expanded -- I remember when we first went to that one hospital I was at, we had two suicides within the first six weeks. I was, like, What the heck is going on? You have to proceed sort of carefully with those and we'll see how the final (off mike), TMA, but they are looking at -- have been for some time. Next slide, please.

Care transitions. We're going to expand what one service is doing already in terms of handoffs. In other words, if somebody PCSs from one facility to the next make sure that if they're mental health patients there's been some kind of hand off. We do that with oversea clearances to a fair degree already, but we're doing it more robust across the service. And that's also for
DoD to DVA, but we need to think about hand offs from DVA to DoD as well. That's sort of a new domain people haven't thought about. Why should medical standards of care change when you're changing institutions, because I think it's the same medical standard? Enhancing medical documentation. There has been a mental health module proposed for two years as an application 507, I think it's called, for AHLTA. The project has been in development for some time. People are balancing the need for just a SOAP note to protect the confidentiality, reduce stigma with a wide accessibility of the charts versus more robust mental health. But that's in the works, hasn't been funded and the time line on it is not straight, but we've identified what people have thought we should be using. Now maybe we should also be coordinating that with the DVA to make sure we're on the same sheet of music. My understanding is the technical application for bi-directional visibility on the charts will be active at the end of next month. They (off mike)
(off mike) about December, we should bank on, so I think we'll probably going to be in the ballpark of November. Lots of issues with that, not time to discuss it here. Next slide, please.

Millennium cohort study had integrated for recommendation PTSD about a year or so ago and the study was actually initial before it was a study this year. Research proposal is already covered by Dr. Carter. Basically, needs assessment and he covered that as well. We're going to have integrated health assessment review tools kicking in in terms of the initial A version and assessment that has a lot of psychological health questions. And then the R version will be kicking in later. My understanding is both will be active within a year. The R will be for the periodic health assessment review tool and will cover some mental health (off mike). Expanding the periodic health assessment, will be an iterate process especially if they refine the pilots and the ANAM use and the specificity of that. And then the degree to which face-to-face mental
health assessments depending on the responses for
coupling those responses to additional skills
assessment perhaps using mental health counselor
versus a mental health provider. So all that can
be worked out COE will probably pick up on a great
deal of that. Next slide, please.

Psychological health. We have an
infrastructure proposed. We'll probably largely
go with that infrastructure, but the director of
psychological health proposed for each of the
service branches. The thought is locate them with
the chiefs of staff rather than with the surgeon
generals, couple with leadership and also to be
very sensitive to psychological health. 80
percent or more might be coming more from
personnel side rather than the caregiver side.
And one is the Bureau of the National Guard and
one is the Reserve Affairs as a Reserve forces
representative. And then they recommended full
time at each of the bases. I think the services
are going to have to work out how they do that
within the size and the requirements of their
areas. We're going to have the internal review
subcommittee by having the psychological health
counsel report to medical personnel counsel as
this membership outlined here. External we
proposed and embedded, I'm not sure it's signed
yet, a psychological health subcommittee to this
Board. Next slide, please.

Security question has been modified;
they said it was too broad. Have you been in the
mental health the last seven years; changed it to
have you psychiatrically hospitalized. And that's
been pretty much been signed off by Secretary
Gates. There's been some issue about whether a
quick conflict with some other guidance in terms
of an old executive order from the '90s. So they
based the recommendations to align some language
so it doesn't conflict and it's essentially going
to be implemented is what it looks like now. So
there's been a lot of things to make sure there
was no conflicts among legislative and DoD
regulatory, but other guidance in that regard and
I think basically the planets are in line with us
gong with Have you been psychiatrically
hospitalized. Different populations. Revise the
alcohol education policy. Basically for people
who are not referred involuntarily because they
had an alcohol event, if they want education and
they don't get an evaluation or if they do get an
evaluation, aren't diagnosed with abuse or
dependence they're not going to get a command
notification. We're working on command-directed
evaluation policy changes. That will have to be
coordinated with doctor and may or may not require
legislative change and there's lots of nuances
there that we have to go through. Personality
disorder is a personnel issue and that's another
one that has a lot of nuances so we won't discuss
it here. But having some consistency across
services with regard to the extent of the mental
health assessment prior to discharge for that is
something we can do and will do. And also work
with LOA 1 in terms of any of these. I think
that's it.

DR. POLAND: Colonel Carter, can we have
you come up too. We've got about four or five
minutes for questions. Wayne.

DR. LEDNAR: Just Colonel Ireland, and
looking through all the material that you've
presented, clearly there's a lot, especially a lot
for the medical side of this story. Towards the
end you talk about promoting a culture of
psychological health. You mention the line
commander's sort of being equipped to better
recognize, perhaps, signs in their service members
that there's a need for them to connect. What I
didn't see is can you tell us about how the
culture of psychological health will be driven
through the line commanders and their leadership
in a way that the line commanders own this issue
and it's not overly-medicalized.

COL IRELAND: I hope I didn't
communicate just the other. The reason it would
be located with chief of staff is that you would
expect that to be from the very highest level up
as a staff attitude, as a leadership attitude. If
that's not there everything else you do is smoke
and mirrors. So I think either the leaders have to own it and it be clear that they own it and have opportunities to stand in front of folks and own it, whether it's a suicide prevention brief or brief in some other resource, but that's just going to have to be coming from the leadership over and over again, that we take care of business. When you go to the target range when you can't shoot right and you get it and figure out how to do it better and if your psychological health is going haywire, you go to the psychological gym or your psychological coach, or whatever you want to call it, and you take care of business there as well. So I think that attitude has to be first. If it's not, everything is just not going to work. There's ways of just going through the motions, but no effective change. And that's a cultural transformative change. That is not legislateable, but I think it's possible with the right kind of advocacy.

DR. LEDNAR: I guess, just a suggestion of reaction. If that is true that this is a
senior-commander owned issue as a way to operate
the military effectively for mission
accomplishment, there's a way you can bring that
message very clearly front and center as you talk
to groups about it. I think that would be very
helpful.

DR. POLAND: Dr. Parkinson.

DR. PARKINSON: Thank you both.

Excellent presentation. I'm going to try to get
us up again the 158 recommendations that you both
are admirably trying to deal with. Something that
you said, the list of recommendations doesn't make
a plan which is spot on. And I think -- I'm
contrasting Persian Gulf II, if I can call the
global war against terrorism versus Persian Gulf
I. There we created a national infrastructure to
deal with something which was a great concern to
our nation's veterans and their families which
turned out to be a syndrome that wasn't a
syndrome. And we did that through the rapid
expansion of standardized protocols, tri-service
dissemination, using every medical resource and
MTF we had to do the same types of things, centrally, track, monitor, followed up and I can argue whether or not it was successful, but the approach and principles were tri-service, not primarily Army. Immediate standard protocols across the country and dramatic attention at the ASD/HA level, week-by-week with metrics. Okay, I was in the middle of that, so I know that happened.

Now we've got three real -- and I don't mean to say that, but we've got amputations, we've got TBI, which is a real, severe and repetitive concussive injuries to the brain, and truly PTSD which is well qualified with DSM 4, whatever criteria we use nowadays to do that. What we seem to have is three parallel tracks of an amputation center, of a TBI and maybe blended mental health approach. So you guys are here side by side, which is great, but get us up above here again and getting us back to this wounded warrior and the warrior in transition, why aren't these programs called warrior in transition? Why don't we have
-- in other words the ultimate destigmatization of mental health is to say, no, you're a warrior. In your mental health you're going to get your warrior mental status. Whether or not you get back to full status before you had TBI and before you had mental and emotional things that you can't deal with because you've been shot at for 14 months, are we again codifying the stigma of mental health by having the wounded warriors literally right across town in these state-of-the-art facility? And I love the fact that we're going back and forth with Mr. Fisher on what should be the content and the programs and the whatever of a COE that he graciously agrees to fund, which is over here, which is the COE for mental health. And over here is the Intrepid, which is the COE for amputated and that group has said, we don't want to do that stuff, really, we want to do amputation. Do we have a responsibility to say wounded warriors are wounded mentally, physically, emotionally, family and we insist that it be the Intrepid for everybody. We
insist we have a unified approach and everybody's
a warrior if that's what we want to do. So I
think we're codifying, yet again, in insidious and
maybe even blatant ways what we want to do.

Final comment. I'm not a neurosurgeon.

Background is in preventive medicine, primary
care. I too followed and saw the hit that the
Buffalo Bill had the other day. Dramatic
application of hypothermia in the hours sustained
after to a CNS injury apparently had dramatic
effect in reducing the amount of paralysis
post-injury. So while we're putting out RFPs,
intramurally and extramurally with TBI, are we
taking -- are we doing right now, I mean literally
today, things a neurosurgical panel that's looking
at immediate post-blast applications of
experimental therapies pursuing an IND if indeed
that's experimental to do rapid brain cooling? I
don't know, but it's physiologically appealing to
me because it really is trauma, again and again
and again that causes some degree and cold works
very well. So, that's all the way from 90,000
feet right down to what's going on in
neurosurgery. But I'm concerned that we're
slicing up body parts again and we're codifying
with brick and mortar again and we're still trying
-- just your reaction to that or thoughts.

COL IRELAND: With regard to the first
one, sir, I would hope this Defense Health Board
could help us precisely in that area, because when
we get up to that altitude, we're talking
politics.

COL CARTER: And I would say with regard
to the Center for the Intrepid is that when we
talk about the Center for the Intrepid was
created, it was created for a specific purpose,
with a specific floor plan, specific space
required for what it is. And to try to shove in
what we're trying to do into that same space would
be difficult. Now we do have interaction with
service members who are in the Center for the
Intrepid because many of them have TBIs as a
result of the initial cause of injury. I hear
what you're saying, but I'm just not sure that at
this point that's going to be feasible.

DR. PARKINSON: And I guess the final question is: Do you need a brick and mortar facility to be a center of excellence? I mean, I guess -- again, I'm not trying to be platonic here, you know, (off mike) question you can't answer, but you know what I mean.

DR. POLAND: Let me -- I need to interrupt just a bit. I apologize to the Board; I'm going to have to leave. I've never made it a habit to leave a meeting early here, but I'm giving a talk tomorrow morning and this is the last plane out. So I've asked Dr. Lednar if he would perform the remaining duties of the president for me and he's graciously agreed to do that. So, Wayne, can I turn it over to you and keep this discussion going. Thank you all very much. It's been a long three days of meeting.

Thank you.

DR. LEDNAR: Thanks, Dr. Poland. I think we'll need to bring this discussion to a close.
COL GIBSON: We've got a few more minutes that we can do.

DR. SILVA: A lot of recommendations and I'm glad you sorted it out as to what's been achieved and what's coming up pretty quickly for achievement. The research here is one that I think I would ask you to look at the speed at which you're taking that one on. Announcing the RFPs, the funding dates, because the war is moving along and you have a patient population that needs to be studied for future conflicts and so I sort of join in with you, Mike, that other technology should be looked at. Transducers, transmitting EEGs, you had CAT scan up there in the field and maybe MRI is even better. Even issues of early cooling and treatment, because that has now been shown and published in the New England Journal for neonates, the preemies. It's a very affective technique right after delivery to do brain or body cooling to reduce subsequent brain damage and retardation. It's now changed the state of art how we deal with preemies. So I think you need to
get together a panel of knowledgeable people and
move the research along and apply treatment. Just
to deal with the psychometrics it's fine, but I
think you've got into anatomical and physiological
levels to study and get some markers.

COL GIBSON: To close this out, two
things. The Board has already agreed that we are
going to provide an external advisory Board to
each one of these entities. That's going to be
our conduit to make a difference and to help them
with some of the issues that you've just brought
up and that Dr. Parkinson brought up.

One question for you Bob. I saw that --
this is kind of a closeout. I saw a campaign,
anti-stigma campaign. One of the things that I
heard Admiral Arthur and the other members of the
mental health task force say is campaigns are
wonderful and fine. We have anti-smoking
campaigns every year and everybody smokes. If the
idea is to institutionalize this issue of no
stigma for psychological problems, I assume that
with all of the slides and all of the information
we saw there, that that is the end goal for this
process, not campaigns for anti-stigma, but end
goal is institutionalize that concept.

BG (Ret) FOX: Just a comment back to
Dr. Parkinson. The points are valid that one has
to be very careful about how Centers for
Excellence are incorporated and utilized and
sustained. That's one of our issues in the
amputee care center side of the house. But I
don't think it should go unrecognized that that
center on the amputee care side is integrated into
a gradual medical education center with 23 GME
fellowship programs and residencies of which
orthopedic surgery is one. And surgical care,
general surgery and it is a level 1 trauma center.
So the integration of that kind of Center for
Excellence only brings to bear the
multi-disciplinary experience and technologies
necessary to care for the patients. It in no way
isolates those patients away from the mainstream
of patient care or graduate medical education or
the higher level of research that goes with it.
I would say that it was a very thoughtful process and it is not an isolated incident and in this case Center for Excellence has more to do with the setting and the applicability of multi-disciplinary processes in a very facile way to care for those kinds of extreme limb injuries of which amputation is (off mike).

DR. LEDNAR: General Roadman.

LT GEN ROADMAN: I think that it's really important for us to realize that there are already multiple agencies that have some of these responsibilities built into their charter and actually built into their funding system. What we have the tendency to do is recognize a problem, go build a brick and mortar organizational structure, which actually relieves people who are statutorily and institutionally responsible for delivering that particular gear. Instead of fixing the communication channels and taking out silos we build more structures and actually make the problem worse. I think we absolutely have to be
careful because everything is going to become a center of excellence, which means that the system is now fragmented more, and more and more and more. And the patient coming across that or the family trying to get that care becomes more and more frustrated. And in trying to do something right, we actually make the problem worse.

COL CARTER: About the center of excellence for TBI and psychological health, I mean the whole point of that effort was to do the integration and dissemination of information so that the care provider throughout the MHS has the same level of excellence. Instead of building several centers of excellence that provide something that the others can't provide or don't provide is to disseminate rather than to try to centralize.

LT GEN ROADMAN: Yes, sir. I understand that. And so we build a building? It isn't a brick and mortar issue. And I would use the example of DVBIC, which is used as a success story, but that actually has four institutions
nationwide involved in it. Well, four
institutions in something that's been going on for
almost eight years, is not progress. It is
actually hunkering down, building a program and
not necessarily solving problems. Those are the
things that we need to be cognizant of as a
Defense Health Board.

DR. LEDNAR: Just to close this section
of the agenda, on behalf of the Defense Health
Board, we'd like to thank both of you for the
progress report that you've made and all the
detail that you brought. And I think as General
Roadman reminds us, part of the role of the
Defense Health Board is to have the big view
across to see where the areas of linkage need to
occur to try to learn from the past. There's a
saying that "History does not repeat itself, men
do" and how we can learn from some of these
lessons of prior response to bring the integration
that we'd all like to see you succeed at. So we
look forward to your reports of continued process.

Thank you.
The end item before the Board is

Lieutenant Colonel King is here to give us a Task
Force on the future of Military Health care status
report. Colonel King.

LTC KING: Good morning, Dr. Lednar,
Defense Health Board members. I'm glad to provide
the update on behalf of Colonel Bader, who sends
her regrets for not being able to be here this
morning. That will become evident in a couple
slides from now. Next slide.

This is a brief overview of what we'll
cover. Next slide.

My main purpose for being here is just
to update you on the progress on the Task Force on
the Future of Military Health Care which you heard	
twice before. Once on the progress report and
then once before our interim report. Next slide.

Again, just a quick review, overview of
our charge that came from Congress in the NDA '07.
As you're familiar with two products, a final
report and an interim report. Next slide.

This is a review of the members of the
task force. I just wanted to highlight the fact that Major General Kelley retired and has been replaced by Rear Admiral Smith on the task force. Next slide.

However, Major General Kelley was retained as a consultant because of him being so far into the process, he stayed on as part of the task force. Next slide.

Again, as you're aware and familiar with the whole reason and purpose for the task force is to review bodies of information and review materials from subject-matter experts so that we can make recommendations ultimately on our final product. We've also included RAND as a consultant for some assistance with respect to digging into some necessary data information in an expedited fashion. Next slide.

This is a brief overview of the meetings that we've held since we last briefed the Defense Health Board. And I'll go over these. Next slide, please.

Each of these meetings is tied to one of
the elements that were in our charge from Congress. And so as you can see here in this April meeting we heard from Mr. Walker and the pharmaceutical industry and the united mine workers. Next slide.

Again we had some information regarding the finance issues and these were followed-up by subsequent meetings. Next slide.

With respect to disease management and health and wellness -- with respect to these issues it's the task force's main interest to ensure that we try and get as broad and wide of a scope as we can with respect to each of the elements. So we try and review them either from the macro level of TMA, health affairs, drill down into the service respective areas, as well as take public and/or private sector viewpoint of these various issues. Next slide.

That was followed up again by another health and wellness perspective where we drilled down into the respective services and heard from each of them as well as TMA. Next slide.
Here we dealt with the topic of acquisition and procurement issues as they relate then to how the MHS goes about procuring and getting their respective items. Again, because it was service specific, that's who we were talking to and getting information from. Next slide.

Our recent public meeting here in early September had to do with the Command and Control. This has been a topic in the D.C. beltway I know for quite some time and we were eager to hear what had been done with respect to that. Also want to make note that our website allows members to take advantage of feedback to the task force and we've made that public on previous occasions. But for your own interest, it is DoDfuturehealthcare.net and that is another avenue by which we do obtain public comment with respect to what we're going over in our respective meetings. Next slide.

This is again the reason why Colonel Bader was not able to attend. There was a concurrent meeting in Norfolk for the task force, where, again, they were delving into issues
specific to beneficiary groups and heard from them
in a panel format. Next slide, please.

Some of the issues that are discussed
are better discussed sometimes in a smaller
subgroup fashion. So some of the task force
members then have stepped up to take on a
particular subject matter of their particular
interest and they've done so in these kinds of
related disciplines. Next slide.

These subgroups then meet at their
various times and schedules that are beneficial
for their busy schedules. And when they do so,
they meet and collect their various information on
their topics and then bring that to the whole
entire task force for ultimate review and
discussion where then the whole task force then
can decide whether or not it's worthy of any
particular finding or recommendation as a whole
body. Next slide, please.

Again, we have some upcoming milestones.
One of the milestones is we'll have an October 3rd
meeting where we will discuss TRICARE for live
issues as well as the military/civilian ratios
that are inherent with respect to the services and
how those are changing and what's the best way to
go about looking at that. Again, we have the
meeting in December. I believe it's December
11th. We'll meet in front of this body to present
our final paper and that will then go forth to the
Secretary of Defense on the 20th of December. The
Secretary of Defense has up to 90 days to review
that product. While that review is going on, the
task force will begin some of the standing-down
procedures associated with the task force.
Typically the Secretary of Defense doesn't take
that long and then he forwards it to Congress.
Next slide, please. Any questions?
  DR. LEDNAR: Thank you. Questions or
comments? Dr. Parkinson.
  DR. PARKINSON: Thank you, Brian. I
have not yet gone to the website, but I will when
I leave today. Are all the comments in there
readable by other participants; in other words,
does it read like a discussion room, so you can
see comments that have come in and responses? How
-- do you mail it in and --

LTC KING: Yeah. It will bring up an
e-mail dialogue-type box where you'll type in a
particular area of your concern or interest and
then you'll have a free text area box where you
can include that. The rest of the comments are
there for review or looking at. It's just a
one-way mechanism to get them to the task force.

DR. PARKINSON: Since the last time we
met you've had some briefings from Health Ways,
Cigna, John Hopkins Health Plan. You had a task
group, a subgroup entitled "Best business and
health practices". One question is: Have you
had, through Cigna's presentation a thorough
discussion of consumer-driven health plans, both
health reimbursement accounts and health savings
accounts during the course of your deliberations?

LTC KING: No. That particular topic
was not brought up by them.

DR. PARKINSON: They probably won't.

Because this is my concern about your efforts
overall in the broad sense is that the established players in many of these industries are not interested in breakthrough models that actually save employers a lot of money. It sounds like a radical statement. But if you look at last week's pronouncement by the national association of manufacturers, which again is how do you get an affordable healthcare benefit? They have one and only one recommendation, rapidly adopt consumer-driven health plans, period. Full replacement. All stop. So they're whole thrust is to get health reimbursement accounts and health saving accounts, properly designed, executed and communicated to their members. The president of that organization is Chip McClure who is the CEO of Arvin Meritor in Detroit. I'm sure (off mike) patriotic duty and have him fly into Washington and talk to your groups to why they did and how they did, he'd like to talk to you a bit, if that's possible.

My point is here if you talk to PBMs about the pharmacy benefit and if you talk about
health plans or health insurance benefit, you may
not have the opportunity to have a breakthrough
recommendation whether DoD takes it or not is
almost not the point. My concern is is that if
the task force, which is very heavily dominated by
military members, many of your colleagues and
people from the civilian sector who one way or the
another are in the current status quo, this may be
the only time in ten years that you have a chance
to do an outside-the-box exercise. I hope the
task force is taking it as an outside-the-box
exercise, even just to say the future state would
look something like this and here's what our
practical recommendations are. From our
conversation the last time and Ms. Wilensky, who I
respect very much, I got (off mike) well, it's not
really politically feasible so we can't really go
there. What I would hope is this be a radical
outside-the-box vision where American healthcare
needs to go with models that are promising that
current employers are adopting or trying to urge
their colleagues to adopt, rather than saying the
best way to do a three-tier formulary is to make a five-tier formulary and get the cross shift in whether or not -- I understand those issues, but this is DoD's chance, probably for a decade, to come out and say this is true north. This is where you should go. I don't know if we're going to hear that December 11th and 12th. If we don't hear that December 11th and 12th, my role here is to make these comments (off mike) missed the mark. To sustain the current healthcare services, just like employers have to sustain, they cannot do HMOs and PPOs. They cannot do five-tier formularies; they cannot do narrow and narrow networks with doctors who don't take services. Those things, I hope are on are your agenda. I apologize for going into some detail, but I did it to give you a flavor of the types of things that I didn't see in the last report. In terms of the players you're talking to, I can assure you Hopkins healthcare is not going to talk about the things that a CEO of a 6,000-person company in Detroit, who is competing with India has to talk.
about. So please take those as a positive
construct and go back. If there's nothing in
there and you're not hearing from the (off mike)
who are doing those things, chances are it may not
be in your report.

LTC KING: I appreciate that. I can
take that back.

DR. LEDNAR: Just to build on Dr.
Parkinson's thought. If you can bring back to the
task force -- clearly the military has shown for
the nation real leadership. We look at the Center
for the Intrepid. If we look at the DoD response
to TBI, I mean there's real leadership in
healthcare that the DoD is brining, not just for
the military, but these clearly will have
cascading affects broadly across the nation. As
we look at, again, in the civilian sector, how
healthcare is valued in places like Detroit,
healthcare and assuring continued access to
affordable healthcare is becoming more valued by
people than even pay. So reinforce what Dr.
Parkinson is saying, this is a unique opportunity
to think about what is possible. And you can
expect that in December when the task force comes
back -- if the Defense Health Board does not hear
about very seriously considered macro issues that
are on the table today, like consumer-driven
healthcare, we're going to ask about it, because
that's not a secret. That's a very macro force
that's of great interest and pursuit by the
private sector. So we encourage you to take
advantage of some of the suggestion of some
innovative thought by people who are really
particular about kicking the tires. We're not
going to adopt something trivially. I think the
suggestion of the CEO up in Detroit is an
excellent one. So we'd encourage the task force
to stay open to possibilities because we'll
certainly be probing at that when you come back in
December. Other questions. Dr. Halperin.

DR. HALPERIN: It's my limitation, I'm
sure, but maybe when we do have this 12th meeting
there could be a digestion of what the umpteen or
(off mike) nature issues are that are being
considered and where we are with those issues. So it's not clear to me whether we're talking about healthcare, finance or whether we're talking about the structure of medicine is vis-à-vis the relationship of primary care to referrals or are we talking about completely electronic medical records. If (off mike) what the issues are maybe before the presentation in December we could have a focus of what the nature of these are that the committee is and where we stand with those issues.

LTC KING: Yes, sir. Those elements are discussed in the charge in the NDA '07. They're listed on our website. There's 10 of them altogether.

COL GIBSON: I will send out the terms of reference which spelled out very, very specifically the issues that -- and basically the NDAA 2007. It's on the website, but each of you will get that next week by the time you get back, you'll have that mail.

DR. HALPERIN: Like maybe the presentation could be where the commission is --
think what the commission is thinking about each
of those issues, so we have a sense of where we're
going.

LTC KING: I would gather from the way
and the structure of the final report, it will
very much line up with those various elements.
Maybe not in the exact same order, but it will
line up with those elements that were in the
charge and we will have particular findings and
recommendations, I would presume on those and
varying (off mike).

DR. LEDNAR: Dr. Walker.

DR. WALKER: With this final report
going forward on December 20th, will we receive a
copy of this before the meeting?

LTC KING: It's my understanding that
you'll have a copy.

DR. WALKER: Before the meeting?

LTC KING: I believe so. So that you
would have the ability to take a look at it.

COL GIBSON: This is always a problem.
And it's a problem that is built into the suspense
system for any type of task force that does these sort of efforts. They are very focused on providing a final report and it always ends up, every time I've been involved in these, it always ends up they're working to that last possible hour before they have a final product. As a subcommittee of this Defense Health Board, what we work for is to get you a draft that's pretty close. You know we're not worried about the last bell and whistle and making sure that every point is covered and we've used a than rather than a then and all of this. You need to be able to get something that you can digest early enough in the process so that you can ask the right types of questions when the presentation is made. We will take a, basically, I don't know whether it's going to be a morning or afternoon, but we will take a long time on this specific issue, very similar to how we did the IRG report and the mental health task force report. And, yes, it's the intent for this Board to get the draft report, which it will be until it's deliberated by the Defense Health
Board, with time enough to digest it before the
meeting.

DR. LEDNAR: Other questions or
comments? On behalf of the Defense Health Board,
thank you for coming and giving us this report and
for all the hard work you're putting in that will
bring this very complex challenge to a discernible
recommendation and we look forward to your report
in December.

LTC KING: Thank you, Dr. Lednar.

DR. LEDNAR: Thank you. I'd like to
start moving now towards closure of this meeting
and we'll do it in really three small steps.

First, Colonel Gibson has a few comments
to make. I do, and then we'll ask Dr. Kilpatrick,
as our designated health official to make a few
final comments and bring the meeting to
adjournment.

COL GIBSON: Thank you very much for
hanging with us for three pretty long days.
Granted we're ending at noon on the third day, but
it's been an intense morning I would say.
Number two, make sure you sign those
sign-in rosters and make sure you get credit for
you CME. I know it's only two credits, but please
get those.

Finally, if there's anything you need
shipped back home, let Karen help us with that and
we can ship your notebooks back to you so you
don't have to lug them on the airplane. Dr.
Lednar.

DR. LEDNAR: Thanks, Colonel Gibson. As
Dr. Poland's stand in, I'd just like to say
several things. One is again on behalf of the
Defense Health Board we wish Commander Carpenter
God speed and we look forward to hopefully your
continued staying in touch with us. We look
forward to your successes in your next assignment.
On behalf of the Defense Health Board, this
meeting wouldn't occur without the leadership of,
first and most importantly Colonel Gibson. It's
no small feat pulling this all together, getting
an agenda, trying to get materials identified in
advance. Those of us who need continuing medical
education to make that possible, even if it is
just a smidge, but we appreciate Colonel Gibson,
all of the leadership that you bring, because this
is clearly a very full agenda.

The work of the office, of course,
wouldn't get done without the help of Ms. Ward,
Ms. Jarik and most especially at this meeting we
all want to give a real big appreciation to both
Karen and Britt Triplett for all the work you've
done for us.

The next meeting of the Defense Health
Board will be in December. It will be in
Washington, D.C. at a location to be determined.
That will be obviously a very important meeting
given the topics that are coming up. With that
I'd like to have the final say by Dr. Kilpatrick.

DR. KILPATRICK: I just want to express
my appreciation to all the members of the Board
having been with you here these three days. The
work that you're doing and the way you've embraced
the expanded scope of the Defense Health Board,
looking at the entire image as far as where we
I need to be. I think you're in a great position as
an advisory Board to help guide and direct a lot
of the dynamic and perhaps traumatic changes that
are going within DoD to a better outcome than can
be driven necessarily internally or legislatively.
So I again want to express my appreciation for the
work that you do. The comments are extremely
important and the advice that the Board gives,
while it is recognized as advice, it comes with a
great deal of authority because of the expertise
of each of you as individuals and the Board
collectively as a whole.

I've got one more comment and then I'll
bring this to a close.

DR. LEDNAR: Before we adjourn the
meeting, a very important thank you and that is to
Dr. Jackie Cattani. Thank you Jackie for all of
the work you've graciously given, both at the
meetings and between meetings on the important
issues over the years. Jackie has shared with us
that she's elected that this will be her last
meeting with the Board and obviously the work she
does will continue to be the way we get important
work of supporting the military done in her area.
So on behalf of the Board, Jackie, we really
appreciate your being here and for all of the work
you've done over the years. Thank you.

DR. CATTANI: It's been an honor and a
privilege to serve and I have made so many good
friends and understood so much more the issues
involved. It's been one of the best experiences
of my professional career. Thank you.

DR. KILPATRICK: With that I'll bring
the meeting to closure.

(Whereupon, the PROCEEDINGS were
adjourned.)

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